Expectations and experiences:

The contribution of supervision to the

professional development of postgraduate

General Practice trainees

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A thesis submitted to the University of Birmingham for the degree of DOCTOR

OF PHILOSOPHY

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April 2020

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Abstract

For GP trainees developing within the context of contemporary General Practice (GP) training, the supervisory relationship is considered a key source of support. Working within the paradigm of pragmatism, this research aims to understand the contribution of supervision to postgraduate GP training in the United Kingdom, and the factors that influence the supervisory experience.

Using the West Midlands region as a case study, a mixed methods approach is taken. Explicit and tacit voices from the wider profession are explored, through semi-structured interviews with experienced supervisors, and thematic analysis of the training documentation. The thesis then examines the lived experiences of 13 GP trainees through a series of narrative interviews, incorporating Figured Worlds theory to explore the contribution of supervision to the professional development of trainees, within the socio-cultural context.

This thesis illuminates the expectations from the wider profession, explicit and implicit, regarding the professional identity development of trainees. Supervision, within this context, appears to undulate between an agent of the wider profession (or institution), and an environment where trainee agency can be supported.

This thesis concludes by offering a model of supervision, to serve as a springboard for negotiation of the inherent complexities within postgraduate GP training.

Acknowledgements

Central to this research are the trainees and supervisors who generously shared their time and stories. I would like to express my immense gratitude to these individuals. Their enthusiasm and openness helped to transform the research idea into a reality.

I am incredibly grateful to my supervision team. Dr Ian Davison and Dr Josephine Brady provided a constant source of wisdom and support on this journey, and found the perfect balance of giving me autonomy, providing gentle challenge and offering encouragement. Dr Donna Dawkins became a co-supervisor with Ian for the latter part of my PhD, and I am very grateful for her insightful comments and considerable patience towards the development of my thesis. I would also like to thank Dr Deirdre Martin, who was a co-supervisor with Ian at the beginning of my research, for her valuable direction in narrative research.

I have received expert help from many places. The systematic review of the literature would not have been possible without the commitment and input of Dr Rachel Adams, Dr Adaeze Edordu and Dr Aled Picton. I would also like to mention the input from Professor David Wall and Professor John McLaughlin, who helped to shape my thinking with respect to the supervisor's experience. I am very grateful to Dr Deidre Bennett for her insights and comments on the Discussion chapter, and for developing my understanding of Figured Worlds though her own work in this area.

I would particularly like to mention Dr Mark Hirsch and Professor Helen Stokes-Lampard, who showed me what exemplary GP supervision looks like, and continue to remain an inspiration and support in my own professional development.

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Abbreviations

AoMRC - Academy of Medical Royal Colleges

AD - Area Director

AKT - Applied Knowledge Test

ARCP - Annual Review of Competency Progression

CBD – Case Based Discussion

CCT - Certification of Completion of Training

COT – Consultation Observation Tool

CSA - Clinical Skills Assessment

ES - Educational Supervisor

EWTD - European Working Time Directive

GMC - General Medical Council

HEEWM - Health Education England West Midlands

IMG - International Medical Graduate

JEST - Job Evaluation Survey Tool

JDF – Junior Doctors' Forum

LTFT - Less Than Full Time

MRCGP - Membership of the Royal College of General Practitioners

MSF – Multi-Source Feedback

PSU – Professional Support Unit

RCGP - Royal College of General Practitioners

SAS – Speciality and Associate Specialist doctor

ST3 - Speciality Trainee, year 3

TPD - Training Programme Director

TtT - Training the Trainers

Chapter 1: Introduction

Development of supervision in postgraduate General Practice training

"A GP Supervisor is a general practitioner who establishes and maintains an educational alliance that

supports the clinical, educational and personal development of the resident".

(Wearne et al., 2012 p.1169)

A key aspect of educational support for General Practice (GP) trainees in the United Kingdom is their educational supervisor. These are qualified GPs, responsible for the oversight of the trainee's educational progression throughout their 3-year training programme (Royal College of General Practitioners and COGPED, 2014). It has been argued that this clinical supervisory relationship is the "single most important factor in the effectiveness of supervision" (Kilminster and Jolly, 2000 p.827). Similar to the 'therapeutic alliance' between a client and their therapist in the field of counselling, the 'educational alliance' is considered to be foundational to the trainee's progression and development (Wearne et al., 2012; Telio et al., 2015).

Historically, in General Practice supervision, 'apprenticeship' has been used to describe the clinical supervisory process (Thomas et al., 2005) and the term 'apprenticeship model' has been cited as an underpinning theory in the learning and teaching of trainee GPs until as recently as 2009 (Royal College of General Practitioners, 2009).

'Apprenticeship' has featured within medical education for many years, and extends beyond the scope of medicine to trade and industry, mainstream education and beyond (Lave and Wenger, 1991). Traditional views of this concept viewed the student or 'apprentice' as one with minimal skills or expertise, placed within a workplace where they could learn from an expert, or 'master'. In its most basic view, the apprentice is "paid by his employer to learn" (Morris and Blaney, 2010 p.69).

However, even early traditional models recognised that the relationship was a more complex process than this simplistic statement. These models provided the means for the apprentice to learn through supervised work-based practice, with role-modelling and supervision from the 'expert', or supervisor, at the heart. Abraham Flexner, a key proponent of medical educational reform in the early 1900's, observed that Britain at that time had a strong clerkship-based system, based on traditional apprenticeships (Dornan, 2005). His recommendation for a greater emphasis on biomedical teaching within medical training was based on the foundational strength of these clerkships, because the professional values and duties of a doctor were already clearly role-modelled through this firmly embedded apprenticeship model.

Over time, apprenticeship models have been explored and considered within various theories of learning, and evolving descriptions of the apprenticeship process and function have developed. Within a 'cognitive apprenticeship', students were encultured to learn authentically through activity and social interaction, much in the same way that traditional craft apprentices would learn within the workplace (Brown et al., 1989). The supervisor's role came to the fore within the 'cognitive' component of the model, where they would deliberately expose the thought processes prior to the task, during the task and afterwards (Wooley and Jarvis, 2007). Supervisors could facilitate this process of making things visible within the context of a cognitive apprenticeship using techniques such as 'modelling' (of good practice) or by encouraging reflection and questioning by the trainee on their thoughts and actions through 'coaching' (Collins et al., 1989).

However, the workplace of medicine has changed significantly over the past century, and apprenticeship theories have changed to adapt. Traditional models suggest a close working relationship between the supervisee and supervisor. We know that in medicine today, shift work, European Working Time Directive (EWTD) and a subsequent reduced time spent in one-to-one interaction could threaten this. Education is 'less personal' (Dornan, 2005 p.93). Whilst much of this

criticism describes hospital-based apprenticeships, general practice has also seen an increase in service demand from patients, with educational time sacrificed and less opportunity for regular interaction and role-modelling in the supervisory relationship. It therefore has also been impacted by EWTD reforms (Thomas, 2005). It is the norm for a General Practice trainee to undertake their clinics in isolation. Direct observation of their performance must be demonstrated in various Workplace-Based Assessments, but these can be completed by any qualified General Practitioner within the practice, and therefore feasibly the GP supervisor may only occasionally directly observe their 'apprentice' at work. Vice versa, due to patient demand and service pressures, it may be very difficult to release a trainee from clinic duties to observe their supervisor in the job of consulting, thus reducing opportunity for role-modelling.

Traditional views of apprenticeship saw a focus on the development of the trainee, with a flow of information moving from the 'master' (supervisor) to the 'apprentice' (trainee) (Morris and Blaney, 2010). However, this stance does not reflect the viewpoint that supervisors may learn from their trainee, and are influenced themselves by the supervisory relationship. Furthermore, it is conceivable that the trainee may contribute to the wider members of the training practice in which they work, and become an influence beyond just the supervisory relationship (Morris and Blaney, 2010). Modern-day apprenticeships recognise that apprenticeship exists beyond the master-apprentice relationship, and instead speak of 'communities of practice', where the wider community of the workplace contributes to learning (Lave and Wenger, 1991). They argue that the way in which an apprentice 'legitimately' accesses a community of practice depends on the way labour is divided within that practice. Within some fields of work, division of labour may well mean that a single supervisor-trainee relationship is needed for legitimate participation. However, many general practices in the UK have multiple GP partners and salaried doctors who 'divide' the labour. The extent to which this is shared may change within the culture of the practice, but it would be conceivable that some (if not all) of the practice team would contribute to the trainee's legitimate

participation, thus forming a 'community of practice'. As a result, considering supervisory relationships through the lens of a traditional apprenticeship, as simply an interaction between supervisor and trainee, may fail to appreciate the importance of the socio-cultural context in which they are situated.

Within 'The Learning and Teaching Guide' (2009), the RCGP discusses the importance of trainee reflection as crucial element of apprenticeship, which links to cognitive apprenticeship frameworks, and it also discusses the trainee working within a 'community of practice' such as that described by Lave and Wenger (1991). This guidance appeared to more closely mirror that of a modern-day apprenticeship. However, within the profession, there also appeared to be a growing concern regarding this 'less structured' and 'organic' apprenticeship approach (Royal College of General Practitioners, 2009). In response to reduced training time (largely as a result of EWTD working patterns), and the need for greater public accountability by trainees, it has been argued that traditional models of apprenticeship are now superseded by outcomes-based approaches within postgraduate GP training (Thomas, 2005). Furthermore, the RCGP has also raised concerns of the risk of the 'hidden curriculum' within training apprenticeships, where undesirable modelling may occur from supervisors, or where their 'unconscious competence' may limit their usefulness in making salient aspects visible to the trainee (Royal College of General Practitioners, 2009 p.29). Certainly, it is noteworthy that the 'apprenticeship model' is an underpinning guiding principle outlined in the RCGP 2009 'Learning and Teaching Guide', but does not feature in the updated 2016 'Core Curriculum Statement' (Royal College of General Practitioners, 2009, Royal College of General Practitioners, 2016b).

In the rapidly changing landscape of UK General Practice, there is a case to re-examine supervision and the supervisory relationship in contemporary postgraduate GP training. Within this section of the thesis, I will consider the ways that supervision and the educational alliance have been described

within the literature. Following this, I will outline the contemporary context of GP training in the

West Midlands region of the UK, and the potential challenges to modern supervisory relationships. I

also will discuss my own personal experiences as a previous postgraduate trainee in this region,

before considering the impetus and development of my PhD research in the area of postgraduate GP

supervision and the educational alliance.

Defining Supervision

Supervision is a term that arose from fields outside of medicine, such as mental health and nursing,

originally describing one-to-one structured encounters, with the purpose to reflect on casework

(Launer, 2010). However, over time the term has extended from within these disciplines to refer to

any form of support (formal or informal) that is given to the learner within the clinical context.

Various definitions of supervision exist, supported or criticised to various extents on logical grounds,

the clinical context or the empirical research underpinning their development (Milne, 2007).

Three colleges of General Practitioners, the United Kingdom Royal College of General Practitioners

(RCGP), Australian College of General Practitioners (RACGP), and the Irish College of General

Practitioners (ICGP) have used the definition proposed by Kilminster and Jolly following their

literature review in 2000:

"Supervision involves providing monitoring, guidance and feedback on matters of personal,

professional and educational development in the context of the doctor's care of patients. This would

include the ability to anticipate a doctor's strengths and weaknesses in particular clinical situations, in

order to maximise patient safety".

(Kilminster and Jolly, 2000 p.829)

This definition suggests that supervision should support the trainee to develop not just clinically, but also personally and professionally, whilst also ensuring patient safety. However, despite the wide use of this definition within postgraduate GP education, its validity for use in a GP context has been questioned, as it was based upon a literature review which included only one paper from postgraduate GP empirical data (Wearne et al., 2012). Furthermore, critics of this definition also suggest that it fails to incorporate the complex and dynamic inter-related processes that contribute to learning in a clinical context, particularly when modern general practice training involves meaningful interaction with all staff members within the training practice, or community of practice (Lave and Wenger, 1991; Wearne et al., 2012).

Following an integrative review of the literature relating to GP supervision (with an empirical basis), an alternative definition and model were suggested, which considered the one-to-one interaction in supervision, embedded within the socio-cultural environment of the training practice:

"A GP Supervisor is a general practitioner who establishes and maintains an educational alliance that supports the clinical, educational and personal development of the resident".

(Wearne et al., 2012 p.1169)

The authors go on to suggest that the role of a GP supervisor must be considered within the community of practice, where they must broker the relationship with the trainee and practice community, whilst overseeing patient care. They also suggest that the supervisor must make the relationship safe to facilitate trainee disclosure of weaknesses, and cultivate reflection and feedback (Wearne et al., 2012).

The importance of the 'educational alliance' within this integrative review of postgraduate GP supervision mirrors a meta-analysis in the field of psychology, which found the 'therapeutic alliance' to be the most important predictor of positive outcome in psychological therapy, over and above the

approach or techniques used (Martin, Garske and Davis, 2000; Wearne et al., 2012). In Wearne's

(2012) review, the authors suggested that the quality of the educational alliance influences the

degree to which the trainee feels supported to acknowledge and address their clinical, personal and

professional weaknesses. It has been argued that this clinical supervisory relationship is the "single

most important factor in the effectiveness of supervision", and a fundamental building block in the

trainee's progression and development (Kilminster and Jolly, 2000 p.827). However, when starting to

unpick what the term 'supervisory relationship' means, there appears to be great variability as to its

definition, which is often left to the reader (Ladany and Inman, 2012).

A background to contemporary postgraduate training in UK General Practice

To attain Membership of the Royal College of General Practitioners (MRCGP) and qualify as a GP in

the United Kingdom (UK), the trainee must work in a variety of hospital and general practice-based

settings. Alongside their clinical work, they must successfully complete the requirements of the

MRCGP integrated assessment system. This comprises a series of workplace-based assessments,

written reflection on workplace-based learning within an electronic portfolio and two high-stakes

summative examinations; the Clinical Skills Assessment (CSA) and Applied Knowledge Test (AKT).

It is often the summative assessments that are in the spotlight when considering why trainees may

fail to progress adequately within their training. The first of these is the Applied Knowledge Test

(AKT), which is a summative assessment of the knowledge base underpinning independent general

practice (Royal College of General Practitioners, 2019b). The second of these is the Clinical Skills

Assessment. Usually taken in the final year of training, the exam consists of thirteen simulated

consultations, lasting ten minutes each. Candidates must interact with and manage a range of

clinical problems presented by simulated patients, portrayed by trained role-players. The scenarios

are designed to represent 'real-life' clinical situations, and test aspects of clinical care such as data-gathering, management and interpersonal skills (Royal College of General Practitioners, 2013a). Furthermore, at the time of my exam preparation, exam costs had risen to £1525 per sitting (Esmail and Roberts, 2013) and, for the 130 candidates who had failed the CSA more than 4 times in the preceding 5 years, the cost for them was removal from General Practice training altogether (Royal College of General Practitioners, 2012).

GP trainees are given a variety of forms of support throughout their training to assist them in achieving these requirements. Each trainee is allocated an educational supervisor, or 'trainer', who oversees their training throughout the 3-year programme. They will also have a clinical supervisor (CS) for each clinical placement of their training, who will be hospital consultants in hospital-based posts, and GPs in general practice-based posts. Trainees attend a regular Vocational Training Scheme (VTS), which provides a weekly half-day session of formal education and is facilitated by Training Programme Directors (TPDs).

These sources of support of provided to all trainees in the UK, and are delivered regionally. This PhD research is based in the West Midlands training region. Health Education England West Midlands (HEEWM) is responsible for the delivery of GP training in the region and **Figure 1 (Sources of Support for West Midlands GP Trainees)** summarises these layers of educational support for West Midlands GP trainees:

Figure 1: Sources of Support for West Midlands GP trainees
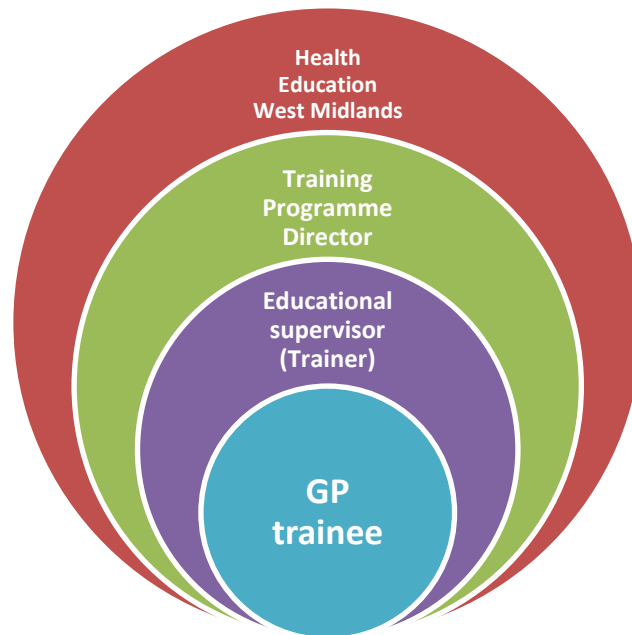
In 2012, 46 trainees in the West Midlands region of the UK required a 6-month extension to their training due to an inability to meet their training requirements within the 3-year training programme. HEEWM recognised that these trainees were a

"varied, complex and challenging group of doctors who have not benefitted from the usual support

system of a trainer and local Vocational Training Scheme"

(Houlston, 2013)

As a response, HEEWM created the role of an 'Advanced Trainer'. These were experienced trainers from within the region, who were committed to the training and support of trainees in difficulty. The group consisted of 18 individuals, who were provided with targeted training to perform the role. It appeared to be an acknowledgement of the limitations of the current educational supervisor role for this particular cohort of trainees. At the time of its introduction, around 50 (one sixth) trainees per year were in need of additional support (Houlston, 2013).

The advent of this role within the region raised questions in my mind about the potential limitations or challenges facing 'standard' supervision as a source of educational support for trainees. The creation of the new roles appeared to reflect a potential change in contemporary GP training, and pointed to a consideration of the particular challenges faced by 'standard' supervision, which led to the need for an 'advanced trainer' role.

Contemporary challenges for supervision

A growing challenge within postgraduate General Practice supervision appears to be that of sufficient training time. This firstly relates to the time a trainee spends learning in the workplace, and the subsequent time available for educational activities. Recently, changes to the working hours and patterns of GP trainees have been introduced through the provisions made in the new Junior Doctors Contract (JDC). Where previously the working week under the EWTD consisted of 48 hours, a 'working week' under the new JDC is 40 hours. These changes have been introduced to protect postgraduate doctors in training from the risk of errors related to tiredness, protect them from abuse and ultimately improve patient safety (British Medical Association, 2018). The changes mean that GP trainees may be spending less time at their training practice than before, with potentially reduced clinical contact time with patients during the same 3-year training period. The JDC makes provision for 30% of the working week to involve time for educational activities towards achieving the requirements for Membership of the Royal College of General Practitioners (MRCGP). However, the juggle between educational requirements and sufficient patient contact may place a strain on the time available for interaction with their supervisor. Certainly, in the West Midlands region, it has been suggested that some of this 'educational' time may be required for additional patient contact, to enable the trainee to gain adequate workplace-based experiences during their training time (Health Education England West Midlands. date unknown-d).

It is not just the trainee's schedule that may impact time for supervision. Secondly, the supervisor must be available for these interactions. As the patient population lives longer, and qualified GP numbers fall nationally, the demand for appointments rises. There is a growing clinical pressure on all GPs to deliver sufficient care within their communities. Time for non-clinical activities such as education and supervision is under threat. Furthermore, to enable interaction between trainee and supervisor, their schedules should coincide to facilitate supervision. As more practices open multiple sites, extended opening and weekend access, a GP supervisor may see changes to their working week which roster them into a working pattern that is different to that of their GP trainee, making time for interaction less readily available. GPs with portfolio careers, including job roles in Clinical Commissioning Groups, Primary Care Networks, universities, hospitals or other non-practice-based forums may additionally reduce their time in the practice for training.

An additional concern around the issue of 'time' in contemporary training is the duration of the 3-year training programme, which has remained at 3 years (on a full time basis) despite these contract changes, the growing complexity of ill-health patterns in patients and the upward range of conditions that are now part of a GP's regular job role. Together, the issues of sufficient duration of training, sufficient patient contact and sufficient time in supervision have led members of the profession questioning a newly qualified GP's preparedness for autonomous practice upon attaining MRCGP (Rughani et al., 2012; Gerada et al., 2012). The demands on training, and potentially supervision as a result, appear to be mounting. A solution to these concerns has been proposed in a recent RCGP vision document, where plans are to extend GP speciality training to 4 years by 2030 (Royal College of General Practitioners, 2019c). However, it is unclear whether these changes will take place within the next decade.

In addition to the potential challenges outlined, there are also financial constraints on the delivery of postgraduate GP training, with 2017 budget cuts resulting in Health Education England (of which

HEEWM is a part) tasked with cutting 30% of its spending (Kaffash, 2017). The particular ways in which this may impact supervision directly are unclear, but cuts to continuing professional development programmes for supervisors have been suggested as a possible savings strategy, which may lead to challenges for supervisor development and the quality of supervision provided.

In light of these challenges within contemporary postgraduate GP supervision, questions are raised as to the feasibility and appropriateness of a traditional 1:1 apprenticeship model. Time for meaningful educational interaction between a trainee and their supervisor appears to be squeezed whilst expectations for the capability and standards of qualifying GPs are high. GP trainees must navigate numerous examination hurdles within their training to be deemed as fit for autonomous practice, and awarded the MRCGP. In addition, it appears that some of those who do qualify may feel unprepared for the job they have trained for (Wiener-Ogilvie, 2014).

A personal perspective on supervision in postgraduate GP training

I began this research in late 2013, as a postgraduate trainee in General Practice. At this particular time, I was preparing to undertake the final summative assessment of my training programme: the Clinical Skills Assessment (CSA).

Whilst it was reassuring that considerable effort and resource was implemented by my local training region to provide additional support for those who needed it, it felt to me to be somewhat too late. At that time, a number of these resources appeared to be triggered and implemented at the point of exam failure, meaning that considerable financial, emotional and psychological cost had already been incurred by the trainee up until that point. The need for the creation of a new 'Advanced Trainer' role suggested the potential for limitations in the support provided by the standard educational supervisor role. Furthermore, the fact that such trainers were needed for around one

sixth of my colleagues raised additional questions about the demand and capacity for support for trainees facing difficulty.

Performing poorly in particular aspects of GP training requirements have been described elsewhere in the literature in relation to 'struggling' trainees, often related to problems with

"(a) clinical performance and knowledge; (b) conduct issues such as failing to follow protocol and low interest in work; and (c) problems surrounding interpersonal skills, such as teamworking and delegating"

(Patterson et al., 2013 p.330)

However, looking beyond the examination and performance statistics, the sources of these problems have been identified to be multifactorial, and at times out of the control of the trainee. Amongst others, ill-health and disruptive life events have been cited (Patterson et al., 2013).

As I spent longer on the GP training programme, and talked with my peers, I began to realise that experiencing difficulty within postgraduate GP training was relatively common, unpredictable and multifactorial. Bereavement, supporting a family member with illness, returning to work from maternity leave, physical and mental health issues and financial difficulty were some examples of those described by my colleagues. Upon returning to work after the birth of my first child, the sleep deprivation of juggling a baby and preparing for my AKT exam left me struggling. This was combined with a heavy workload from my training practice, which reflected the trajectory of a full-time trainee, despite my less-than-full-time (LTFT) employment. I had a clinical supervisor during this particular period who, whilst they executed all their formal teaching and documentation duties diligently, I had found to be fairly unsupportive personally and professionally during this time. I eventually took the difficult decision to postpone the exam to a better period in my personal life, but prior to this, had experienced a period of significant stress and discontent at work. I subsequently passed both this

exam, and my CSA, and therefore may not have been identified by regional statistics as a 'trainee in difficulty'. However, my lived experience of this particular placement suggested otherwise, and my discontent with my experience of supervision at that time is a memory that has stayed with me.

As I moved to my final placement within my training programme, placed with a different supervisor, the marked improvement in educational, professional and personal support was striking. At the beginning of my PhD research, I had been working in this supervisor's practice for around 6 months, with regular daily contact, debriefings, useful educational support and a growing professional friendship. Although I was yet to sit my CSA examination, I was confident that my supervisor had contributed significantly to my growth as a clinician and professional, and that I was much more likely to succeed with his help than without it. I felt in control of my workload, appreciated as a member of the team (despite my LTFT status) and looked forward to going to work.

The variability in my supervisory experiences appeared startling, and upon talking with my peers, I discovered similar stories of variation in experience. Although some had experienced equally supportive and helpful supervisory relationships, others had experienced distant, unhelpful or frustrating relationships with their educational supervisors.

Coupled with my questions related to the advent of 'Advanced Trainers' in our region, and a growing awareness of the scope of 'trainees in difficulty', supervision as an area of training support came into sharp focus. I wanted to understand the lived experiences of supervision, through the eyes of both the trainee and supervisor, to explore potential ways in to improve supervisory support for trainees.

Focusing on the examination hurdles themselves is an important step, and the General Medical Council has commissioned a programme of research to evaluate the reliability and validity of the assessments themselves, and the teaching and learning to prepare for them (Woolf et al., 2016; Woolf et al., 2018; General Medical Council, 2019c). However, further 'upstream', it appears that the

supervisory relationship may offer an avenue of educational support for many trainees long before

their examination revision begins, and throughout the exam preparation period.

Through the provision of an educational supervisor for the trainee's entire training, and the

resources developed to support these interactions, the RCGP considers this as a key source of

support for the GP trainee. However, in the context of a rapidly changing landscape in postgraduate

training, and my own personal observations, the apparent intentions of the RCGP did not always

appear to relate to the lived experiences of myself and colleagues.

Research aim

This research aims to explore the contribution of supervision to the development of the

postgraduate GP trainee, and consider how lived experiences of trainees and their supervisors relate

to what may be intended from the perspective of the wider profession.

Research questions

1. How is the GP trainee expected to develop professionally within postgraduate GP
   supervision?
2. How do supervisory relationships contribute to the professional development of
   postgraduate GP trainees?
3. What factors influence the supervisory experience?
4. How do lived experiences of trainees and their supervisors relate to the expectations of the
   wider profession?

Chapter 2: Literature Review

Exploring the literature on supervision in postgraduate GP training

General Practice (GP) involves continuous care of patients, within their communities, from the cradle to the grave (Royal College of General Practitioners, 2019a). As discussed in **Chapter 1**, training within this speciality requires the trainee to work in the same practice as their supervisor, and the supervisory relationship can be considered to be fundamental to their development in this context (Telio et al., 2015; Wearne et al., 2012). Quality educational alliances have been observed to benefit from the supervisor's provision of pastoral support and positive role modelling (Ullian et al., 1994; Cottrell et al., 2002; Pearson and Lucas, 2011a; Wearne et al., 2012). In contrast, threats to the quality of the relationship have been suggested when supervisors communicate insensitively or when their availability is limited (Cornford and Carrington, 2006; Aine et al., 2014). Although there is a growing body of literature related to supervisory relationships in the postgraduate GP context, it is not comprehensive. There has been little research into the contribution of the trainee to this relationship, and the particular facilitators and barriers to their contribution. Furthermore, as outlined in **Chapter 1**, the rapidly changing landscape of training in General Practice raises questions as to whether the current models of supervision outlined in the postgraduate training literature are appropriate for contemporary supervision.

Supervision is a term that arose from fields outside of medicine, such as mental health and nursing (Launer, 2010). At the outset of this research, I considered the literature beyond the field of medical education, reviewing a number of theories and models of supervision from different disciplines. Reflecting upon supervision in its broader context offered some important insights, enabling a contemplation of the various merits and challenges of these conceptualisations to the present postgraduate GP environment. By developing my understanding from reading of the wider

literature, I then developed an approach to systematically review the postgraduate literature on supervision in postgraduate GP training. The second half of this chapter outlines the findings from this systematic review, which set the scene for my approach to the research project.

Theories and models of clinical supervision

Psychological-based supervision models

In the same way that supervision arose out of mental health practice, a body of theories and models arose from the practice of counselling itself. Depending on the context of the counselling intervention, various models developed to meet the supervision needs of that particular context. Person-centred supervision arose from the principles of person-centred therapy. This concept assumes that inherent to the client (or patient) are the skills and resources to overcome their problems, without extensive direction from the counsellor. In the same vein, the supervisory relationship in this context makes the assumption that the supervisee has the resources to develop themselves, and the supervisor facilitates this process (Haynes et al., 2003).

The Royal College of General Practitioners (RCGP) curriculum has several underpinning theories which arguably sit within a person-centred view. Person-centred care for patients is a fundamental aim, and person-centred approaches to supervision (in a similar vein to the field of psychotherapy) represent an extension of this foundational approach to patient care, with the supervisor providing support to the trainee's educational development (Royal College of General Practitioners, 2009). Principles of adult learning and self-directed learning (SDL) are also hallmarks of postgraduate GP training, which overlap with person-centred approaches to supervision. For example, the implication of a personal responsibility for learning, where the majority of learning tasks are left mainly under the control of the learner, relates to the person-centred supervisory approach (Maslow, 1958; Kaufman and Mann, 2010).

Person-centred models of supervision also rely upon the quality of the trainee-supervisor relationship (Haynes et al., 2003). Quality relationships are also advocated by the RCGP:

"The relationship between GP trainees and trainers is at the heart of the teaching and learning process".

(Royal College of General Practitioners, 2009 p.43)

Furthermore, the person-centred theory of supervision also highlights the responsibility of the supervisor to create an environment that facilitates the supervisee to be open and fully engaged (Smith, 2009). Similarly, the RCGP suggests that the GP supervisor is

"responsible for maintaining the learning environment within the training practice"

(Royal College of General Practitioners, 2009 p.41)

However, within this model, the supervisor is not seen as an expert, but rather a 'collaborator'. It is in this respect that the person-centred approach may not entirely hold within the field of general practice supervision. Although much of the emphasis in learning should be the responsibility of the GP trainee, the RCGP considers the "example presented by their trainer as a doctor" as the "greatest influence" on the GP trainee (Royal College of General Practitioners, 2009 p.43). Furthermore, research involving supervisors in the postgraduate GP context, and recommendations by the RCGP for supervisors, suggest responsibility and activity beyond simply collaboration: such as monitoring of the trainee, organising the learning environment and ensuring patient safety (Royal College of General Practitioners and COGPED, 2005; Royal College of General Practitioners, 2009; Wearne et al., 2012).

Pan-theoretical models of supervision

When considering alternative models to the person-centred approach to supervision, identification of an empirical basis and subsequent rigorous study of the proposed theory provide a useful starting point. It has been suggested that models of supervision work best when they can be used pan-theoretically, and across various disciplines (Ladany and Inman, 2012). This is a desirable aspect when thinking about models of supervision that could be applied to the field of general practice supervision. There are a number of pan-theoretical models (or integrated models) within the literature which claim an empirical basis. The Integrated Developmental Model (IDM), the Systems Approach to Supervision (SAS) and the Critical Events Model of Supervision (CES), have been described as the leading models within this field, and are described in turn within this section (Ladany and Inman, 2012). I have also explored Egan's Skilled Helper model within this section, as it has been specifically discussed within the literature on postgraduate GP supervision.

Integrated Developmental Model (IDM)

Stolenberg, McNeill and Delworth (1998) based this model on the fact that trainees develop and grow in a way that can be traced, watched and charted by their supervisors. They suggest that the trainee grows both professionally, and also in domains of their clinical practice. Professionally, a trainee will change and develop in their awareness of self and others, their motivation and the level of autonomy at which they work. Suggested domains of clinical activity in this model describe aspects such as assessment techniques, treatment plans and goals and professional ethics. Although these may not be wholly applicable to general practice, it could be argued that similar areas of clinical activity could be defined for this population. Essentially, the supervisor is expected to chart and identify the stage of development their trainee has attained in each domain, and to intervene appropriately based on the developmental level (Stolenberg et al., 1998).

The model itself is highly detailed and descriptive within each developmental domain, including

clinical and professional developmental areas. The supervisee can be at one of three levels, and

although the description given so far may suggest a linear progression, the model is careful to

highlight that supervisees will develop at different rates in different domains. A criticism of the

model is that it is unclear if supervisors would use the model in the intended spirit, with clear

assessment and prescriptive action based on the developmental level of their trainee. Instead, it has

been argued that a broader approach is likely to be taken; simply that the trainee develops with time

(Ladany and Inman, 2012). Certainly this could be a criticism of the use of the model within a general

practice setting, where clinical and professional domains are extensive. It could be exhausting and

insurmountable for supervisors to continually assess and intervene. As highlighted earlier in this

section, many trainees work within a community of practice and do not always have a rigorous and

in-depth relationship with a single supervisor. This model suggests a deep and thorough awareness

and understanding of the trainee, and it is unclear as to whether this is a feasible goal for a GP

supervisor in the postgraduate training context.

Systems Approach to Supervision (SAS)

Holloway (1995) suggested this model to highlight the various roles that a supervisor may have to

undertake in supervision. Again, this is a fairly complex model, outlining a series of supervisor

functions (such as monitoring, advising, consulting and supporting) and supervision tasks (such as

counselling skill and case conceptualization). Using words such as 'intimacy' and 'attachment', the

supervisory relationship is considered to be core to the interaction, although the way in which such

relationships are created or maintained is not discussed (Holloway, 1995). The strengths of this

model lie in the recognition of the changing roles of the supervisor, and the tension of the

supervisor's role in support of the educational development of the trainee, whilst also monitoring

and judging performance. This tension of 'looking after' the trainee, or 'looking over their shoulder',

is discussed within the literature on postgraduate GP supervision, and Holloway's observations

appear appropriate in our context (Launer, 2010). The GP supervisor is deemed to be a source of support for the trainee, but also has a role in correction, critique and formative assessment. A further noteworthy aspect within the model is its consideration of supervision within the institutional context, an aspect overlooked by many other counselling-based supervision models. This is a useful consideration when thinking about a general practice setting, where the supervisory relationship sits within a community of practice, and is governed by RCGP edicts and standards (Royal College of General Practitioners and COGPED, 2014).

This model offers important areas for consideration, such as the potential for tensions in the supervisor role, and the wider institutional context, and these are important in sights at the outset of my research. However, it says little about the trainee's contribution to the supervisory interaction. With a research focus on the trainee's development, this conceptualisation may have significant limitations for the purposes of considering my research questions.

Critical Events Model of Supervision (CES)

The third model of supervision was suggested by Ladany, Friedlander and Nelson in 2005, and its foundations lie in the belief that supervision can be broken down into "meaningful critical events of learning" (Ladany and Inman, 2012 p.187). In the model, the authors list what they feel to be 'critical events' that occur in psychology supervision. Many of these could overlap with events seen in general practice training, such as heightening multicultural awareness, negotiating role conflicts and addressing problematic supervisee emotions and behaviours. Supervisors become alerted to potential critical events on the horizon when the trainee sends a signal or 'marker'. This could be something in their demeanour as they interact with a client (or patient), or relate to timekeeping, organisation or a number of other factors. Once the supervisor has identified the marker, the pair enters into a 'task environment' where the supervisor can suggest and advise on a range of techniques to help the trainee to help resolve the issue.

Similar to some of the other models within this discussion, the critical events model relies on the relationship between the supervisor and the supervisee. Within this model, a more detailed discussion is offered as to how quality relationships are developed and maintained, based on Bordin's working alliance based model of supervision (Bordin, 1983; Ladany and Inman, 2012). This is a model based on Bordin's Working Alliance Theory (between therapist and client) which suggests that there should be mutual agreement between the pair on goals and tasks of supervision, and a strong emotional bond between them, with mutual trust, respect, liking and caring (Ladany and Inman, 2012). It is emphasised that 'agreement' between the individuals, rather than the actual goals or tasks that are outlined, takes central importance in the formation of quality alliances (Bordin, 1983). It has been suggested that this model has great flexibility, and can be applied across various psychological theories and supervision models due to the simplicity of its design (Wood, 2005).

The supervisor's role in identification of potential problems within this model relates to the monitoring functions of supervision outlined by the RCGP, and the subsequent collaboration required to make sense of these problems and remediate them (Royal College of General Practitioners, 2009). The prescriptive approach to handling problems that can arise in supervision may be welcomed by many supervisory relationships, particularly in the context of a strong supervisory alliance. However, they may be perceived as overly-prescriptive by others. Furthermore, some of the critical events in this model do not relate directly to general practice training. For example, an issue such as 'managing sexual attraction' is perhaps a less common focus in the training of a GP, and this may make it difficult to directly apply to model to General Practice. In a similar vein, some of the techniques advised may fall outside of the expertise and training of a typical GP supervisor. These may include 'attention to parallel processes' and 'focus on the therapeutic process', which are terms and processes not commonly seen in the realm of general practice. It is also important to note that

there is a lack of significant empirical evidence to test this model; a criterion that Ladany himself

states as important to a successful model of supervision (Ladany and Inman, 2012).

Egan's Skilled Helper Model

Egan's Skilled Helper Model is an integrative model that arose from within the field of counselling in

the 1970's (Jenkins, 2000). Like many supervision models, it was originally developed to describe the

counsellor and client relationship within clinical practice, but was then extended to describe the

supervisory relationship in the clinical supervision of trainee counsellors. It is a three-stage model

which suggests the supervisor must assist the trainee to address the current scenario, envision the

preferred scenario, and finally develop strategies for action (Jenkins, 2000; Wearne et al., 2012).

Each of the three stages is made up of sub-stages, with a strong supervisory alliance as the

foundation. For example, in considering the current scenario (stage 1), the trainee must be helped to

tell their story, identify blind spots and gain momentum towards moving towards an alternative,

preferred scenario (Jenkins, 2000; Egan, 2010). A creation of cognitive dissonance by the supervisor,

in the context of a positive relationship, has been suggested to offer the mix of support and

challenge required in postgraduate GP supervision (Wiener-Ogilvie et al., 2014; Sagasser et al., 2017).

It follows that, in the context of a quality supervisory alliance, it may be possible for the supervisor to

help the trainee to tell their story, identify blind spots and envision how to make difficult changes.

The role of the supervisor as the 'helper' within this model is a prominent one, and it is reasonable to

assume that a typical GP trainee may well require times of prominent 'help' from their supervisor

during their educational development. Egan's model may therefore offer a useful conceptualisation

to explore this.

Like the CES model of supervision, Egan's skilled helper model builds upon Bordin's model of the

working alliance (Wosket, 2008). Egan's skilled helper model has been also been viewed to

conceptualise a process whereby quality supervisory alliances can offer a platform to teach trainees

about their role in assisting patients to be open about their struggles and make difficult changes; taking the role of 'helper' themselves (Wearne et al., 2012 p.1169). The 'helper' role of the supervisor does come into question when we consider their assessment and gatekeeper roles. On the one hand, the identification of knowledge gaps or areas for improvement may serve as the basis for highlighting blind spots for the trainee to build upon in the latter stages of the 'helping' model. However, it is unclear from the model how the various stages are navigated if the trainee perspective is at odds with that of their supervisor, or if they meet challenges or obstacles in the latter stages of the helping process. A further criticism of this model is the focus at the level of the supervisory interaction, without consideration of the wider training environment.

The supervisory relationship

A number of the theories and models in the previous discussion emphasise the importance of the supervisory relationship, or 'educational alliance'. The terms 'educational alliance', 'working alliance' and 'supervisory alliance' appear to relate to one another, and are used interchangeably throughout this thesis. Although the concept of alliance is alluded to, most of the models fail to discuss how such relationships might develop within supervision, or particular facilitators or hindrances to their development.

Bordin's 'working alliance' based model of supervision, developed from the 'therapeutic alliance' model in psychology and counselling, offers a useful springboard to consider alliances, or relationships, within supervision. It has been used as a foundational model for considering the concept of the educational alliance in the critical events model of supervision, and also has been explored in the contemporary literature on medical education (Wearne et al., 2012; Ladany and Inman, 2012; Telio et al., 2015; Telio et al., 2016). The model proposes three components: 1) mutual agreement (between supervisor and trainee) on the goals of supervision 2) agreement on the tasks required to reach those goals and 3) a strong emotional bond between them (Bordin, 1983; Ladany

and Inman, 2012; Telio et al., 2015; Telio et al., 2016; Jackson, 2019). Benefits of this model include

its trans-theoretical nature, and its foundations of negotiation and collaboration, which enable it to

be used in cross-cultural supervisory arrangements (Wood, 2005). In the absence of quality

educational alliances, it has been suggested that learners may not feel safe to disclose vulnerabilities,

or to genuinely accept feedback given from their supervisors (Wearne, 2016).

It has been argued that it is the trainee's, rather than the supervisor's appraisal of the quality of the

alliance that is particularly important. Their multifaceted judgement of the supervisor's commitment

to the alliance, throughout the course of the supervisory relationship, may impact the trainee's

engagement with teaching and learning in the context of supervision (Telio et al., 2016). This

suggests that the trainee plays an active role within the educational alliance and makes a case that,

to best study supervisory relationships, the trainee's contribution is important to consider alongside

the supervisor's role.

A systematic review of supervisory relationships in GP training: A qualitative synthesis

Within this section, I will outline the methods and findings from a systematic review of the literature on supervisory relationships in postgraduate GP training. I embarked upon this work following the exploration of the literature on supervision in its wider context, to better understand the attributes of supervision in the specific context of my research. From the literature on supervision across disciplines, a number of factors had struck me. Firstly, tensions in the role of the supervisor (between monitoring and support) appeared to exist. A number of the supervision models appeared to map out a complex interplay of supervisory functions as a response to this, many of which seemed untenable in the context of GP training. Secondly, training in general practice is developing rapidly, within the United Kingdom, and farther afield. The wider system, within the changing professional and political landscape of general practice, may shape the means by which supervisory alliances are navigated in the day-to-day interaction of GP training, and may offer important avenues for consideration (Thomson et al., 2011; Ferguson et al., 2014; Jackson et al., 2019). Apart from Holloway's relatively complex systems approach to supervision, the contribution of the institutional context was largely not discussed by the wider literature on supervision (Holloway, 1995). Thirdly, as GP training becomes 'less personal', and as the practice team becomes more prominent in the training journey of the GP trainee, the importance of the supervisory relationship is also in question. The various models and theories from the wider supervision literature did not appear to discuss supervision within the context of a wider community of practice, yet many GP trainees currently work and learn in practice teams, rather than simply in the 1:1 interaction outlined by many of the supervisory models above (Lave and Wenger, 1991; Dornan, 2005).

Perhaps most striking with the review of the wider literature was the foundational concept of the supervisory relationship. So many of the processes and functions of supervision within the models

appeared to be built upon quality supervisory alliances, yet the ways in which these relationships developed over time (or potential facilitators or barriers to their development) were not frequently discussed. Furthermore, particularly in light of my research interest in the trainee's development within postgraduate GP training, the contribution of the trainee to the relationship lacked significant exploration within the models. There was a case to re-examine the literature relating to supervision, and supervisory relationships in particular, in current postgraduate training in general practice.

I led a team of researchers to systematically review the literature to better explore these observations, and the review has since been published (Jackson et al., 2019). The methods, results and most of the discussion of the systematic review (outlined within this section) include text taken directly from this publication. I would like to acknowledge the contributions of the team in the production of this work, as without them the rigor and systematic approach would not have been possible. My team members included my lead PhD supervisor (Dr Ian Davison, ID), a researcher with experience in systematic reviews and qualitative methodologies (Dr Rachel Adams, RA), a GP trainee (Dr Adaeze Edordu, AE) and a paediatric trainee with an interest in medical education (Dr Aled Picton, AP). I designed the protocol for the review, coordinated the team, reviewed each title, abstract and full text paper and summarised the findings. My team members provided an independent check at every stage, from screening of papers to identification and summary of results, and contributed to the discussions regarding the categorisation of papers and findings.

With a focus on the supervisory alliance itself, the review aimed to understand the attributes of the supervisory relationship in postgraduate training in general practice. Bordin's 'working alliance based model of supervision', described within the postgraduate GP literature, and cited as foundational to the critical events model of supervision and Egan's skilled helper model, was used to guide the analysis (Egan, 2010; Ladany and Inman, 2012; Wearne et al., 2012).

This element of my literature review related specifically to my second and third research questions:

RQ2: How do supervisory relationships contribute to the professional development of

postgraduate GP trainees?

RQ3: What factors influence the supervisory experience?

I idenfied two specific sub-questions to begin to address these questions:

- What are the attributes of supervisory relationships in postgraduate GP training?

- What are the facilitators and barriers to quality supervisory relationships in postgraduate GP

  training?

Methods

Within Saini and Shlonsky's categorisation of qualitative synthesis methods, the approach to the systematic review most closely aligns with the integrative review methodology (Saini and Shlonsky, 2012). The aim was to summarise findings across the included studies, and integrate them into a novel conceptualisation of supervisory relationships in general practice training (Sandelowski and Barroso, 2007). The predetermined consideration of Bordin's Working alliance (well-defined and researched within the field of supervision) offered a useful starting point for the review process (Dixon-Woods et al., 2006; Saini and Shlonsky, 2012). However, through the identification of meanings, concepts and theories from the studies, additional interpretations were sought as the analysis evolved (Sandelowski and Barroso, 2007).

Ovid MEDLINE, ProQuest, ERIC and Web of Science electronic databases were searched on 1st July 2016 and then again on 18th January 2018 to identify relevant papers published between 2011 and 2018. Search terms were initially identified from an earlier published systematic review of postgraduate supervision in general practice, and supplemented by terms relating to the attributes of the supervisory relationship (Wearne et al., 2012) (see **Figure 2: Search Strategy,** for search terms, and **Appendix 1: Medline Search**). Using predefined inclusion and exclusion criteria, screening of titles for relevance was initially undertaken, with subsequent review of included abstracts to identify full text articles relevant to the research aim. These papers were put forward for quality assessment (see **Figure 2: Search Strategy**).

Quality assessment of papers

A predefined form, based on research appraisal tools, was developed through team discussion (CASP, 2013; Effective Practice and Organisation of Care, 2013; Center for Evidence-Based Management, 2014; Critical Appraisal Skills Programme, 2018) (**Appendix 2: Paper Quality Assessment**). Papers were sorted into one of 5 'trustworthiness' categories using agreed category definitions (see **Figure**

2: Search Strategy). This holistic judgement considered the processes used by research teams to

minimise bias within their study design, and the relevance of each study to our research aims

(Charrois, 2015).

5 Trustworthiness Categories:

- **Empirical research 1 (E1):** *Research article, confident appraisal of trustworthiness*

- **Empirical research 2 (E2):** *Research article. Some elements found to be lacking in terms of design, description or relevance; but an overall suggestion of trustworthiness*

- **Empirical research 3 (E3):** *Research article. Elements of study found to be lacking, which cause significant doubt about the trustworthiness*

- **Opinion piece 1 (O1):** *Confident appraisal of trustworthiness: informed through a breadth and depth of their observed or personal experiences, and clarity in relation to our research aim*

- **Opinion piece 2 (O2):** *Elements of the opinion presented cause significant doubt about the trustworthiness: lacking breadth, depth or clarity regarding source material/relevance to our research aim*

The selected articles were analysed using principles of framework analysis (Gale et al., 2013;

Parkinson et al., 2016,). Article abstract, methods, results and discussion sections were reviewed.

Through team discussion, consensus was reached to develop categories of interest to guide the

analysis. For the purposes of developing a robust framework, E1 papers were analysed first, with

subsequent analysis of E2 and O1 papers. As the first author, I reviewed all 49 papers, and each

paper was independently analysed by another reviewer. QSR NVivo Version 11 was used to record

the analysis. Themes were then identified through independent review and team discussion, and the

E3 and O2 papers coded against these. The framework analysis approach enabled the research team to consider certain *a priori* areas of interest, such as Bordin's working alliance (Bordin, 1983), but still enabled identification of emergent categories and themes.

From the outset, sensitivity to the researcher role in shaping the research process was considered, and steps taken to maintain reflexivity (Bearman and Dawson, 2013). This included formation of a research team with a variety of vantage points of postgraduate supervision. All articles were quality-assessed, categorized and analysed independently, and coding diaries kept.

Results

The search results are outlined in **Figure 2: Search Strategy**, with 49 full text articles included for analysis**.** A summary of the E1, E2 and O1 articles included for qualitative synthesis is presented in **Appendix 3 (Summary of E1, E2 and O1 papers).**

Figure 2: Search Strategy

LITERATURE SEARCH: Ovid MEDLINE, ProQuest, ERIC and Web of Science (July 2016, and again in January 2018)

Date limits: from January 2011 - January 2018

Search terms from original review used by Wearne et al (2012):

General Practice/Primary Care/Family Medicine/Primary Health Care

Supervis*/Train*/Intern*/Teach*/Educat*/Registrar/Residen*/clerk*

Additional search terms applied to provide a focus on attributes of supervision:

attribut*/characteristic/qualit*/trait/aspect/feature

N=9782 titles identified

→ Removal of duplicate titles (N=1592)

Inclusion Criteria
Postgraduate GP Supervision of sufficient duration (2 months or longer).
International papers in English language
Original research articles, recommendations or opinions
Studies addressing the supervisory relationship

Exclusion Criteria
Supervision in disciplines outside of postgraduate specialist GP training (including placements for non-GP trainees, and for qualified GPs as part of continuing professional development)
Literature reviews, editorials, magazine articles, newspapers, conference proceedings, letters, papers not in English language
Papers with a focus outside of the supervisory interaction

Title Screen (DJ) (N=8190)
Independent review of a sample of titles (ID, RA, AE, AP) to ensure consistency in approach

→ N=7804 excluded by inspecting titles

Abstract Screen (N=386)
All abstracts (DJ)
Independent review (ID, RA, AE, AP)
Disagreements resolved by consensus

← N=23 identified through snowballing

→ N=247 excluded on reading abstracts

→ Removal of duplicate abstracts (N=16)

Full Text Screen (N=146)
All full texts (DJ)
Independent review (ID, RA, AE, AP)
Disagreements resolved by consensus

→ N=97 excluded after reading the full text

Quality Assessment (N=49)

All full texts (DJ)

Independent review

(ID, RA, AE)

Disagreements resolved by consensus

Empirical research 1 (E1): *Research article, confident appraisal of trustworthiness*

Empirical research 2 (E2): *Research article. Some elements found to be lacking in terms of design, description or relevance; but an overall suggestion of trustworthiness*

Empirical research 3 (E3): *Research article. Elements of study found to be lacking, which cause significant doubt about the trustworthiness*

Opinion piece 1 (O1): *Confident appraisal of trustworthiness: informed through a breadth and depth of their observed or personal experiences, and clarity in relation to our research aim*

Opinion piece 2 (O2): *Elements of the opinion presented cause significant doubt about the trustworthiness: lacking breadth, depth or clarity regarding source material/relevance to our research aim*

Regarding the importance of the supervisory alliance, good relationships were deemed fundamental to the teaching of core clinical competencies (Saucier et al., 2012), influencing career choice (Ferguson et al., 2014), assisting struggling trainees or those in need of remediation (Patterson et al., 2013; Ahern et al., 2013), supervising trainees remotely (Wearne et al., 2015) and improving trainee confidence (Wiener-Ogilvie et al., 2014). The 'luxury' of the trainee and supervisor relationship was recognised (Charlton and Wilkinson, 2011), and trainees were keen to ensure that the 1:1 relationship with their supervisor was not lost (Hibble, 2011; Ahern et al., 2013).

A number of factors were identified as as contributors to the supervisory alliance and are discussed below.

Bond

Several studies stressed the importance of the supervisor knowing the trainee as an individual and liking them (Hibble, 2011; McLaren et al., 2013; Morgan et al., 2015b). This appeared particularly important in rural or remote supervision (Ingham et al., 2015a; Walters et al., 2015; Wearne et al., 2015). Personality 'clashes' were attributed as reasons for relationship problems or breakdown in communication (Patterson et al., 2013). For trainees, emotional distance or lack of personal contact from the supervisor was perceived to hinder their learning (Sagasser et al., 2012).

On the whole, supervisors appeared to trust their trainees; they had sufficient confidence that the trainee would report problems and ask for help when required, and they supported the trainee's autonomy in their consultations with patients (Saucier et al., 2012; Sagasser et al., 2012; Stolper et al., 2015; Sagasser et al., 2017). However, caution was advised when relying heavily on trainee self-assessment (Wearne and Brown, 2014). Poorly formulated questions from trainees were potentially linked to clinical incidents (Zwart et al., 2011), and in random case note review of trainee consultations, 30% of supervisors (19 out of 64) identifed previously undetected patient safety issues (Morgan et al., 2015a).

Trainees must be able to count on their supervisor for the support they require (Sagasser et al., 2017). However, the extent to which trainees experienced this support, or trusted it to happen, is less clear within the scope of this review. In one study, trainees went to their supervisor with questions for less than 7% (9130 out of 131583) of problems (Morgan et al., 2015c), but the reasons for this were unclear.

Agreement on goals of supervision

The supervisory relationship must navigate numerous and potentially conflicting priorities. Trainee autonomy is required for learning, but must be balanced with patient safety (Guldal et al., 2012; McLaren et al., 2013; Sagasser et al., 2015; Morgan et al., 2015b; Sagasser et al., 2017). With educational development as the goal, supervisors aimed to support the trainee's learning needs, but monitoring and assessment in supervision risked trainee openness about their vulnerabilities (Ferguson et al., 2014; Ingham et al., 2015a; Walters et al., 2015; Giroldi et al., 2017).

Goals depended on the trainee and context of supervision. In the case of struggling trainees, supervisors expressed concerns about patient safety, and monitoring of trainees' clinical performance became a prominent goal (McLaren et al., 2013).

Conflicting goals between trainee and supervisor were perceived to relate to decreased trainee confidence, inclusion in the practice and professional development (Wiener-Ogilvie et al., 2014).

Agreement on tasks of supervision

A variety of tasks were described to support the goals of supervision. Opportunistic case discussion, or 'corridor questions', appeared the most frequent supervision method, reported in surveys to be used at least weekly by 92% (Ingham et al., 2015b) to 95% (Ingham et al., 2014) of the 84 supervisor respondents. Interruptions for such encounters were perceived as stressful for some supervisors, but were generally tolerated (Ingham et al., 2015a; Morrison et al., 2015).

However, a number of papers also advocated the importance of directive supervisory activities to identify potential problems or learning gaps (Simons, 2011; Wearne and Brown, 2014; Morgan et al., 2015c; Ingham et al., 2015b; Morgan et al., 2015a; Morgan et al., 2016). Such methods included direct observation of trainee consultations (Patterson et al., 2013; Wearne and Brown, 2014; Ingham et al., 2015b), randomly selecting cases for review (Morgan et al., 2015a; Ingham et al., 2015a) or audit of test ordering (Ingham et al., 2015a; Morgan et al., 2016). The extent to which such monitoring methods were implemented by supervisors, however, appears variable (Sagasser et al., 2015; Ingham et al., 2015b; Morgan et al., 2015a; Morgan et al., 2016).

Supervisor beliefs and preferences appeared to be important factors in determining the supervisory tasks undertaken. Creating environments for feedback were associated with trainee reports of higher rates and quality of feedback, although 75% of supervisor respondents (47 out of 62) did not believe this task to be important (Pelgrim et al., 2014). Regarding agreement, some supervisors appeared to pursue their preference of a pre-determined, fixed syllabus in teaching, rather than responding to the needs of the trainee (Warwick, 2014; Ingham et al., 2015a).

Agreement on roles in supervision

Disagreement or conflict in the relationship may occur if there are differing expectations of roles within supervision (Reitz et al., 2013). The relationship was influenced by the multiple roles of the supervisor. The educator role was frequently described (Saucier et al., 2012; Sagasser et al., 2012; Foulkes et al., 2013; McLaren et al., 2013; Sagasser et al., 2015; Clement et al., 2016), which included offering a degree of challenge to the trainee (Walters et al., 2015). Supervisors ensured trainees were safe to practice autonomously, through having general oversight, monitoring progress, and acting as a gatekeeper (Morgan et al., 2015b; Oerlemans et al., 2017). Other roles included role model (Saucier et al., 2012; Jochemsen-van der Leeuw et al., 2014; Meijer et al., 2016; Giroldi et al., 2017), assessor (Patterson et al., 2013; Foulkes et al., 2013; McLaren et al., 2013; Ferguson et al.,

2014; Wearne and Brown, 2014; Morgan et al., 2015b; Sagasser et al., 2017) and mentor, through providing reassurance (Brown et al., 2012; Bowen et al., 2015; Ingham et al., 2015a; Giroldi et al., 2017; Sagasser et al., 2017) and personal support (Walters et al., 2015; Wearne et al., 2015). Supervisors also facilitated inclusion of trainees by acting as a broker with the wider practice (Sagasser et al., 2012; Wiener-Ogilvie et al., 2014; Sagasser et al., 2017).

The role of educator was considered to be in tension with the supervisor's responsibility to ensure patient safety (McLaren et al., 2013; Wearne and Brown, 2014; Morgan et al., 2015a; Sagasser et al., 2015; Sagasser et al., 2017). The supervisor was observed to move between their oversight, teaching, assessment and primary physician roles within a single supervisory interaction (Clement et al., 2016).

Few papers described the trainees' role, although some acknowledged that, like their supervisors, trainees face the similar tensions and changing of roles (Saucier et al., 2012; Walters et al., 2015; Clement et al., 2016). Explicit recogition of these multiple and changing roles in both parties was recommended at the outset of the supervision process (Saucier et al., 2012; Sagasser et al., 2015).

Power imbalance was considered a potential threat to supervisors and trainees in reaching agreement (Ingham, 2012; Longman and Temple-Smith, 2013; Wearne and Brown, 2014; Triscott et al., 2016; Clement et al., 2016), with the assessment and monitoring role of the supervisor suggested to exaggerate this imbalance (Ingham, 2012; McLaren et al., 2013; Wearne and Brown, 2014). Non-hierarchical relationships were advocated to minimise this (Ingham, 2012; Ingham et al., 2015a; Wearne et al., 2015,) and can be fostered through trainee feedback to supervisors (Charlton and Wilkinson, 2011; Longman and Temple-Smith, 2013), and through supervisors recognising and respecting their trainees (Pearson and Lucas, 2011b). Legitimate peripheral participation was discussed, suggesting that trainees are on a journey from 'subordinate' to 'autonomous practitioner' (Clement et al., 2016), moving from a peripheral position (in interactions with their supervisor and wider practice) to one of full participation (Sagasser et al., 2012; Wiener-Ogilvie et al., 2014; Clement

et al., 2016; Sagasser et al., 2017). This suggests that power imbalance, and its influence on agreement, may diminish with time. Between supervisors and international medical graduates (IMGs), differing expectations were suggested regarding roles, hierarchy and gender (Triscott et al., 2016). Generally supervisors were reported to respond to the trainee's needs, even in instances when this conflicted with their preferred supervision style (Ingham et al., 2015a; Sagasser et al., 2015). Finding common ground for roles within the relationship, and teaching content, were suggested as key elements of supervisory interactions (Saucier et al., 2012).

Clarity

Clarity emerged as a theme required for agreement, principally in terms of openness and explicit discussion.

Openness refers to the disclosure by trainees of their learning needs, and particular educational or personal problems arising (Saucier et al., 2012; Sagasser et al., 2017; Giroldi et al., 2017). Supervisors relied on trainee openness to undertake sufficient needs analysis and to tailor support (Wiener-Ogilvie et al., 2014). The supervisor's assessment role emerged as a potential threat to trainee openness (Wearne and Brown, 2014; Ferguson et al., 2014). Reassurance from the supervisor was viewed to create safety within the relationship, which subsequently encouraged trainee openness (Giroldi et al., 2017).

Supervisors often found it difficult to articulate and structure their teaching, and trainees sometimes lacked clarity on the goals or priorities of supervision (Saucier et al., 2012; Warwick, 2014; Longman and Temple-Smith, 2013; Ingham et al., 2015a; Stolper et al., 2015). To address this, supervisors were encouraged to be explicit about the purpose of the trainee's presence at the practice (Donaghy and Boylan, 2012) and about what they were trying to achieve (Saucier et al., 2012). They were encouraged to clarify their multiple roles, including their assessment role (Sagasser et al., 2015;

Wearne and Brown, 2014) and to be specific about how the trainee could access help (Ingham, 2012; Sagasser et al., 2017).

Personal attributes

Valuable supervisor attributes identified were enthusiasm (Brown et al., 2012; Garth et al., 2016), encouragement (Davies, 2012) and being inspiring (Davies, 2012). Positive trainee attributes included sufficient insight into their performance and learning needs (Patterson et al., 2013), engagement with training and supervision (Patterson et al., 2013; Foulkes et al., 2013) and willingness to receive feedback (Patterson et al., 2013). For trainees, maturity was perceived to relate to being more proactive in supervision, whilst reduced self-confidence was related to reduced openness (Saucier et al., 2012). It is suggested that, when compared to their supervisors, trainees preferred increased flexibility in work with differing career expectations and greater work/life balance (Ferguson et al., 2014).

Local environment

In a number of papers the practice team supported the workload of supervision by providing additional clinical and educational input (Pearson and Lucas, 2011b; Charlton and Wilkinson, 2011, Allan et al., 2012; Ahern et al., 2013; Wiener-Ogilvie et al., 2014; Ingham et al., 2015a; Sagasser et al., 2015; Bowen et al., 2015,), calibration of the supervisor's judgement of the trainee (Patterson et al., 2013; Sagasser et al., 2015), spotting struggling trainees (Ingham et al., 2015a) and assisting trainee orientation (Ingham et al., 2015a). Additional practice support included pacing the trainee's clinical workload to support their level of confidence (Hibble, 2011) and ensuring sufficent resource, such as rooms and equipment (Hibble, 2011; Morrison et al., 2015). Inclusion of the trainee in the practice was suggested to enhance their learning, confidence, autonomy and preparedness (Sagasser et al., 2012; Warwick, 2014; Wiener-Ogilvie et al., 2014; Garth et al., 2016; Sagasser et al., 2017). Difficult

relationships with the supervisor were suggested to negatively impact this inclusion (Wiener-Ogilvie et al., 2014).

Busy practices, where educational interactions must compete with heavy clinical workload, were perceived to hinder learning (Hibble, 2011; Sagasser et al., 2012; Guldal et al., 2012; Aine et al., 2014; Sagasser et al., 2015; Ingham et al., 2015a) and hierarchical practice cultures risked the trainee's sense of inclusion, leading to increased stress (Wiener-Ogilvie et al., 2014).

A number of studies either described or recommended supervisory arrangements that differed from the traditional 1:1 interaction between trainee and supervisor. These included vertical learning (involving various members of the practice team) (Charlton and Wilkinson, 2011; Ingham et al., 2015a; Morgan et al., 2015b) and remote supervision (Wearne et al., 2015).

Wider environment

Beyond the practice, peer support for supervisors, such as supervisors' workshops, were perceived as useful (Charlton and Wilkinson, 2011; Cabot and Estreich, 2012; Walters et al., 2015). Workshops for supervisors on the provision of feedback were evaluated as acceptable and satisfactory (Junod Perron et al., 2013; Stokell, 2014). GP training programmes providing placements of sufficient length were viewed postively, as they provide continuity and enable relationships to develop over time, with sufficient timetabled contact (Brown et al., 2012; Ferguson et al., 2014; Bowen et al., 2015; Sagasser et al., 2015; Clement et al., 2016; Sagasser et al., 2017). The workload of documentation was viewed to threaten the supervisory relationship, largely due to unwieldy software and time burden (Foulkes et al., 2013).

Theoretical propositions

Some papers considered theoretical propositions relevant to this review, including theories of adult learning (Longman and Temple-Smith, 2013; Ingham et al., 2015a,), cognitive apprenticeship (Saucier et al., 2012), self-regulated learning (Sagasser et al., 2012; Sagasser et al., 2015; Sagasser et al.,

2017), educational alliance(Morgan et al., 2015b), socio-material learning (Garth et al., 2016) and situated learning (including legitimate peripheral participation) (Warwick, 2014; Wiener-Ogilvie et al., 2014; Ingham et al., 2015a; Sagasser et al., 2015; Clement et al., 2016; Garth et al., 2016; Sagasser et al., 2017) (see **Appendix 3**). The paucity of theoretical development within these papers limits significant conclusions regarding conceptualisations, but raises the question as to whether the focus on the supervisory relationship, outside of its socio-cultural environment, is too narrow (Ajjawi and Bearman, 2012). We consider this question in relation to learning in Communities of Practice in developing Bordin's model, below.

Discussion

Despite changes to the landscape of postgraduate GP training, the supervisory relationship remains prominent, with a number of the studies highlighting the importance of 1:1 relationships between trainee and supervisor. However, these relationships must navigate numerous competing priorities and goals, balancing trainee educational support and autonomy, training programme and practice requirements, alongside patient safety. Such competing interests have been described as ubiquitous in healthcare supervisory settings, and echo the 'changing hats' of the supervisor within Holloway's systems approach to supervision (SAS) from outside the field of medical education (Holloway, 1995; Reitz et al., 2013,). Similar to the institutional considerations of the SAS model, our results also suggested contextual threats to supervisory relationships, such as the clinical workload of trainee and supervisor (which impacts on time for meaningful interaction), the documentation burden of postgraduate training and the risk that the supervisor's assessment role exaggerates the power imbalance between them (Holloway, 1995).

Whilst some principles of Holloway's SAS model were illuminated within the review, the complexity of prescribed activities within this model did not appear to extend to the literature on GP supervision. Similarly, a number of the elements from the pan-theoretical models (discussed in the

earlier section of this chapter) did not feature prominently in the literature. This may represent the

relatively under-developed literature on supervision within the postgraduate field, or it may suggest

that the experience of supervision in general practice is set apart from that of the therapist

supervisor and their trainee. Certainly, the brevity of the clinical encounter in General Practice

(usually at around 10-20 minutes for a GP trainee, compared to the longer 45-50 minute

psychotherapy appointment), the clinical caseload and the involvement of the wider clinical team

may constitute significant sources of variation in supervisory experience between psychology and GP

trainees.

Many of the attributes of Bordin's supervisory working alliance are observable within our review,

such as the personal connection and mutual trust within his concept of 'bond' (Bordin, 1983).

However, these attributes must also navigate the tensions within the broader context of

postgraduate GP training. For example, whilst supervisors appear to rely heavily on supervisory tasks

underpinned by 'trust', such as the trainee's ad–hoc self-assessment of problems, the potential pitfall

of undetected unconscious incompetence when using these methods is acknowledged (Ingham,

2015b; Garcia-Rodriguez, 2016; Sagassar, 2017). Monitoring activities to detect learning deficits are

advocated, but implemented to varying degrees by supervisors. Entrustment is an increasingly

popular term within postgraduate education, with 'entrustable professional activities' referring to

those tasks that the supervisor judges the trainee can perform unsupervised, encapsulating the

tension of trust and monitoring undertaken by supervisors (Cate, 2006; Walsh, 2016).

Agreement of goals and tasks, central to the working alliance, has been cited as mediating the

supervisor's dualistic roles of trainee development and assessment (Launer, 2010). In this review,

relationship problems arising from disagreement are described, and the pursuit of finding common

ground is highlighted by both trainees and supervisors. Agreement is an attribute of Bordin's model

and thus may offer a useful lens to consider how these tensions are negotiated. This was also

discussed in studies with IMGs suggesting that the working alliance model offers potential to

describe supervisory relationships within a cross-cultural setting (Sue et al., 1992).

Developing Bordin's model: what does our model add?

The supervisory relationship within general practice is complex. The review of the literature suggests

that the working alliance model, comprised of negotiation and agreement of goals and tasks in the

context of an emotional bond, may begin to describe this complexity. However, the findings suggest

that additional factors should be considered. **Figure 3 (Model of General Practice Supervision)**

outlines a proposed model of General Practice Supervision, which builds upon these elements.

Figure 3: Model of General Practice Supervision

Figure 3: Model of General Practice Supervision
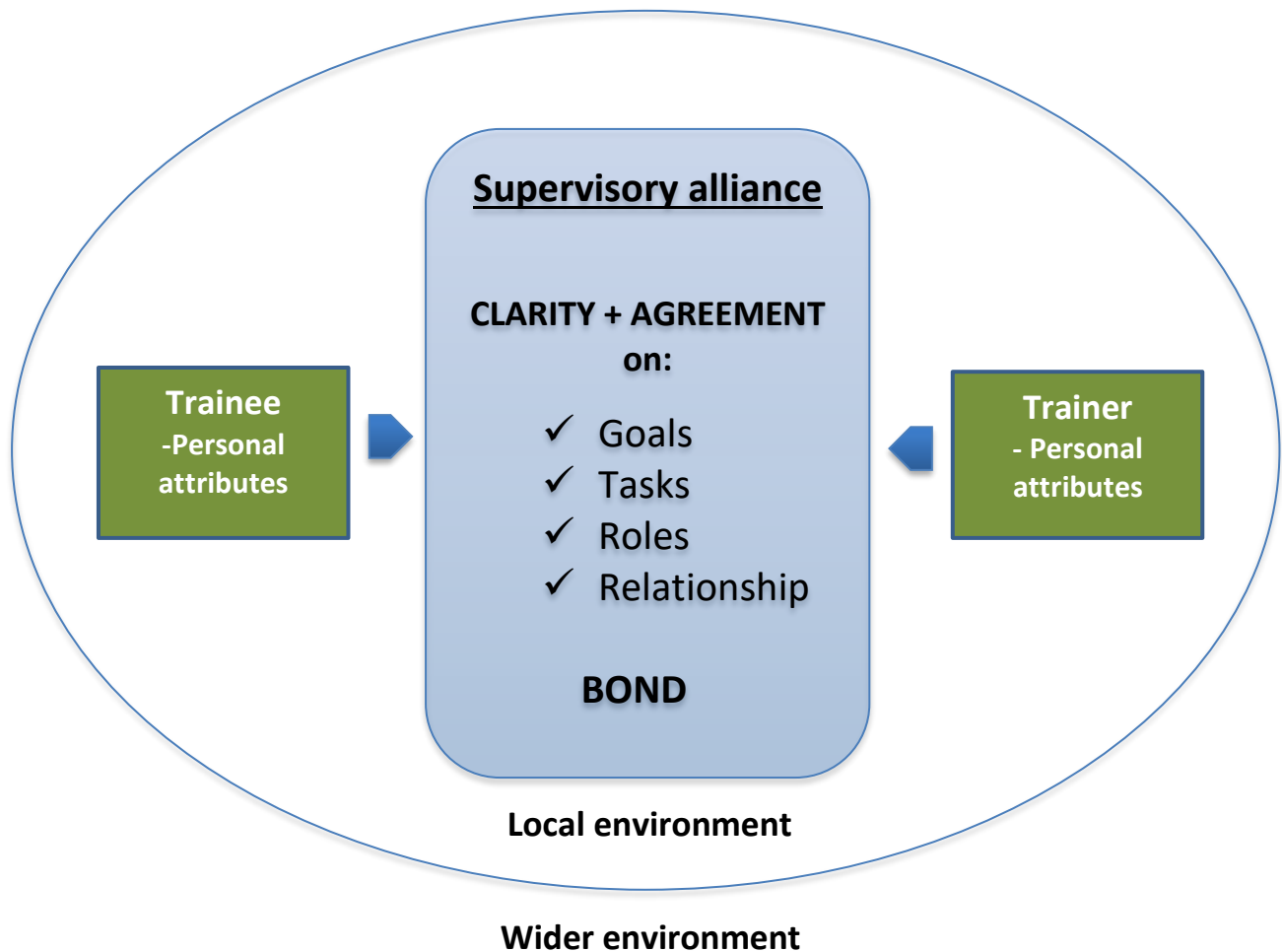
The findings from the review suggest that GP supervision can be particularly problematic where clarity is lacking. Furthermore, overestimation, often on the part of the supervisor, can occur regarding the quality of the working alliance (Hovarth, 2000; Telio et al., 2015). Clarity on goals and tasks is described by Bordin as an important element of agreement (Bordin, 1983; Wood, 2005). The research suggests that this relates to sufficient openness on the part of the trainee regarding their particular learning needs, and explicit discussion from the supervisor on their particular agenda and role. Highlighting it as a distinct element within the model enables a greater focus on the trainee's perspective of the quality of the relationship, whilst also referring to an alliance where both parties are clear on the trainee's needs and how these will be addressed.

This review indicates that navigating multiple roles is key to a successful supervisory relationship in postgraduate GP training, influenced by the particular beliefs, preferences and characteristics of the supervisor and trainee. The complexity of competing roles for the supervisor and trainee is not included within Bordin's model (Wood, 2005). The model in **Figure 3** has been developed to encapsulate the navigation of roles, and the personal attributes that can influence them.

The results from the review and wider literature advocate non-hierarchical, peer-like relationships to mediate the risk of significant power imbalance between trainee and supervisor (Usher and Borders, 1993). It is suggested that these non-hierarchical relationships develop over time, as the trainee grows professionally and the working alliance adapts. However, the monitoring and assessment roles of the supervisor raise questions as to whether this relationship is ever truly equal, and questions whether the person-centred approaches to supervision (with the supervisor as 'collaborator') reflect the reality of supervision in the GP context (Haynes et al., 2003). The dynamic and changing nature of these power relationships is represented by the term 'relationship' within the model.

The findings suggest contextual factors that may be important facilitators or hindrances to the development and maintenance of the supervisory relationship. Rising clinical workloads were cited as particular threats, as was the administrative workload related to supervision. To enable the development of relationship over time, a number of studies highlighted the importance of training placements of sufficient length, which is often determined by the wider training environment. This time to develop interpersonal continuity has been described as important for trust and authenticity within supervision (Bowen et al., 2015). The training practice also may present an opportunity to mediate the rising pressure on supervisors. In some studies, a range of practice staff facilitated learning between various trainees. This type of shared learning, in a community of practice, may

represent a contemporary change to the 1:1 supervisory interaction, and has been perceived as beneficial by participants when combined with traditional supervision (Ahern et al., 2013).

Learning within a 'community of practice' refers to the work of Lave and Wenger (Lave and Wenger, 1991), and is discussed either directly or implicitly by a number of studies in the review. Interaction with the training practice culture appeared to influence the trainee's confidence, based largely on their perception of inclusion and belonging. A focus on the 1:1 interaction alone within the educational alliance may fail to consider the important influence of the 'community of practice', and the supervisor's role in brokering this inclusion (Wearne et al., 2012). Our model conceptualised this inclusion by a circle, encompassing the educational alliance within their community of practice, or 'local environment'. The institutional influences on the relationship such as documentation burden and workload, discussed above in relation to contextual threats, have been represented within the model as the outer circle, or 'wider environment'.

Limitations

This integrative systematic review has provided a rich overview of papers with multiple research approaches, including commentaries. However, a double hermeneutic is involved as the review's conclusions represent interpretation of papers, which are social constructs in themselves (Giddens, 1984). The analytic approach and diversity in the research team attempted to mitigate this issue. The search strategy specifically aimed to review supervisory relationships of a sufficient duration, and may have under-represented supervisory experiences in locations where educational continuity is not encouraged.

At this point in my research, the model produced offered a useful conceptualisation of the contemporary literature on supervisory relationships, prior to embarking on my research design. However, like any theory or model within the literature, it requires empirical evaluation. Through its application later in the thesis, I will develop my discussion and this model further.

Conclusion

The aim of this review was to consider the attributes of supervisory relationships in general practice, and how such working alliances are created and maintained. The model presented is a synthesis of the literature findings, and describes the importance of the emotional bond in supervision, alongside agreement of goals and tasks. In addition, Bordin's working alliance model has been developed to emphasise the need for clarity between supervisor and trainee on the trainee's educational needs, and the means by which these will be addressed. Positive working alliances appear to be linked to non-hierarchical relationships and the ability to negotiate the tensions, multiple priorities and roles within supervision. Furthermore, working alliances in GP supervision may also need to consider the influence of the whole training practice and wider training environment, which appear closely linked to the trainee's learning and progression.

At the outset of my research design, these findings suggested that the supervisory alliance offered a useful lens by which to consider the contribution of supervision to the trainee's development. However, there was also a strong case to consider such alliances in their wider context, such as the training practice and institutional culture of postgraduate medical training. In the next chapter, I will discuss the theoretical approach which I felt best enabled an exploration of the contribution of supervision to the trainee's development within the socio-cultural context.

Chapter 3: Theoretical Considerations

Theoretical Perspectives

In the previous chapter I discussed the literature relating to supervision: across disciplines, and within postgraduate GP training. This began to illuminate the supervisory alliance as an important contributor to the trainee's development within their training, and also highlighted the influence of the training practice and wider institutional context. Although there was some theoretical discussion within the literature identified from the systematic review, it was relatively sparse. Within this chapter, I will develop this theoretical discussion.

Within **Chapter 2**, I had begun to explore research questions two and three:

> RQ2: How do supervisory relationships contribute to the professional development of postgraduate GP trainees?

> RQ3: What factors influence the supervisory experience?

Within this Chapter, the focus shifts to research question one:

> RQ1: How is the GP trainee expected to develop professionally within postgraduate GP supervision?

Within postgraduate GP training, the Educational Supervisor (ES) is part of a network of support for the trainee as they work towards qualification as a Member of the Royal College of General Practitioners (MRCGP). Achievement of the MRCGP requires successful completion of a series of summative and formative assessments, which aim to demonstrate the clinical and professional requirements of the Royal College of General Practitioners (RCGP). During their 3-year training programme, the GP trainee is moving towards successful attainment of the MRCGP qualification, and

also towards becoming an autonomous GP; a professional identity where the support of the supervisor and training practice will not be available. In this regard, 'professional development' in GP training relates to 'meeting the mark' with respect to their MRCGP requirements, and also to 'becoming' a qualified GP, a notion that is frequently associated with theories of identity and development of professional identity.

Identity development is an area that has been regarded to represent confusion and ambiguity, and is infrequently explored within the literature on primary care pedagogy (Holland and Lachicotte, 2007; Johnston and Reid, 2019).   However, it has been argued that general practice offers a 'rich context for identity formation', with links between practice, workplace-based learning and identity (Johnston and Reid, 2019 p.246).

The interest in professional identity development within the wider field of medical education is not new. In the 1950's, the task of medical education was described to:

"shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and provide him with a professional identity so that he comes to think, act and feel like a physician"

(Merton et al., 1957 p.5)

There has been a growing interest in this area, with appeals from medical educators to implement curricula that consider professional identity development within their design (Jarvis-Selinger et al., 2012; Cruess et al., 2014).

Professional Identity development can be viewed to take place within the context of individual identity formation, an adaptive process that has been described to occur simultaneously at the level of the individual, and also at the collective level (through socialisation of the person through their participation in work) (Jarvis-Selinger et al., 2012; Cruess et al., 2014). This chapter begins by

exploring identity formation, with a particular focus on professional identity. Relevant theories are presented in broad themes, considering concepts of self, identity and professional identity. The discussion within the chapter is then developed to consider the influence of socialisation on identity formation, including the explicit and tacit contributions of interpersonal relationships (such as supervision), and the influence of the wider socio-cultural context.   The chapter concludes by introducing Figured Worlds theory, a contextual identity theory that offers a framework to consider the trainee's development within the socio-cultural world of postgraduate GP supervision (Dornan et al., 2015).

Self and Identity

Identity: a self-concept

'Identity' at its core attempts to answer the questions of "Who am I" and "What do I stand for"? Identity can be considered as a psychological construct, or 'self-concept' (Butcher, 2017). This notion is summed up in the quote below:

> *"People tell others who they are, but even more important, they tell themselves who they are and*
>
> *then they try to act as though they are who they say they are. These self-understandings are what*
>
> *we...refer to as identities"*

(Holland et al., 1998 p.3)

In simplistic terms, 'self' is the 'mental apparatus that allows people to think consciously about themselves' (Leary, 2004 p.5). It is through such introspection that humans have the ability to make decisions, monitor and evaluate their own behaviours and inner mental lives, and begin to infer things about the behaviour and inner mental lives of others (Leary, 2004). Identity as a self-concept considers 'identity' as overarching and stable; a process whereby the individual weaves answers to

their questions about who they are. According to this Eriksonian view of identity, people will strive

for coherence and constancy over the course of adulthood (Holland and Lachicotte, 2007; Erikson,

1968; Erikson, 1980). Research with this conceptualisation of identity may consider the processes or

obstacles to achieving a consistent and enduring identity in social life (Holland and Lachicotte, 2007).

In the context of my research, 'being' a GP trainee, and developing this sense of professional identity

may relate to identity as a self-concept. Such perspectives relate to the wider discourse in medical

education on professionalism, where 'being' a doctor (and therefore establishing a sense of stable

professional 'self') relates to developing the particular emotions, experiences and behaviours

deemed desirable by the profession (Miettinen and Flegel, 2003; Butcher, 2017).

Identity: a consequence of socialisation

An alternative perspective considers identity as the consequence of socialisation (Butcher, 2017).

Social constructivists argue that 'self' (and also 'identity') are not essential properties, inherent

within a person (Bamberg et al., 2007). Instead, they are socially constructed through discourse,

relationships and social practice with others. It is through these processes of social interaction that

the individual reflects on how they are perceived by others. Through such processes, a distinctive

sense of 'self' develops (Mead, 1934; Holland et al., 1998). In this way, society can be viewed to

legitimise the identity that the individual imagines and enacts (Berger and Luckman, 1967). Identity,

which can be seen as 'kind of person' we are, must be socially recognised. Individuals will engage in

a combination of activities, beliefs, values or speaking to gain such recognition (Gee, 2000).

It has been suggested within the literature that there is a socially recognised ideal of the 'good'

doctor (Daniels, 2008; Cruess et al., 2014; Bennett et al., 2017). Although constantly renegotiated (as

conditions within and outside of medicine change), the learner's behaviour will be both guided and

constrained by this ideal (Daniels, 2008). These are important considerations when embarking on

research on professional identity development in GP training, as expectations of the 'good' GP

trainee may offer a useful lens into the way in which socialisation (and particularly supervision) contributes to identity development.

Identity: different identities and views of self

The 'Meadian' view (based on the considerations of George Herbert Mead in the 1930's) argues that the individual can have different identities and views of 'self'. Furthermore, it is possible that such differing senses of self may at times morally contradict depending on the particular social context (Mead, 1934; Holland and Lachicotte, 2007). For researchers, the approach is therefore different, as they seek to understand how the individual forms senses of self, as they relate to their various roles, culture and status. Such development of their sense of identity in these various social contexts relates to their affect, motivation, actions and agency (Mead, 1934; Holland and Lachicotte, 2007). This perspective also relates to the considerations of professional identity, and illuminates the tension between individuality and the social expectations of the profession. Trainees may have trained in a variety of hospital specialities before entering General Practice training, have trained abroad, pursue additional professional interests (such as teaching or research) or work less than full time. Home and family life provide additional social contexts, where trainees may also be spouses, parents or carers (Johnston and Reid, 2019). The trainee may have a tendency to identify with one or other of these specific groups, and this 'self-same' identification may vary between trainees, depending on their particular previous experiences (Bleakley, 2011; Butcher, 2017). Exploring professional identity development from this perspective may offer a useful means to illuminate the plural, interactive and potentially conflicting identities that are negotiated by GP trainees (Johnston and Reid, 2019).

Identity: a trajectory

Furthermore, 'self' can be considered to be an ongoing and evolving process, as the individual evaluates and assimilates social experiences, reflexively processing their understanding of

themselves through their past, present and imagined future (Giddens, 1991, Sarangi, 2010, Butcher, 2017). In this perspective, self can be considered to be both socially and cognitively constructed, and constantly changing and emergent. It is continually produced in individuals, and by individuals, as they interact with others (Holland et al., 1998).

When undertaking research within postgraduate GP training, a dynamic conceptualisation of identity development may involve looking to the trainee's past experiences, including the way that life circumstances, such as culture, gender and family, have shaped their identity (Cruess et al., 2014). Thinking of identities as growing and changing recognises the potential that realignment or readjustment of professional identity may be required, particularly when changes or transitions occur in home or work circumstances (Johnston and Reid, 2019).

Identity development and the approach to this research

A discussion of these various conceptualisations of self and identity is important when considering the professional identity development of the GP trainee.   One could argue that the new GP trainee is a neophyte within the context of postgraduate General Practice – perhaps entering this world for the first time. Identity as a trajectory, and a consequence of social interaction, may be a highly relevant consideration on their journey to 'becoming' a qualified GP. With a 'Meadian' approach to identity, we can begin to consider the trainee as one who is forming various senses of 'self'; bringing senses of self from their past experiences before GP training, and developing additional senses of self as they undertake GP training and work towards qualifying as an autonomous GP. Such an approach affords the opportunity to consider the ways in which such senses of 'self' may relate (or contradict) depending on the particular context.

With this in mind, identity development in the context of General Practice appears to require a consideration of the pleural (and interacting) senses of self, and their development over time as the trainee learns and develops within the workplace (Johnston and Reid, 2019).

The discussion above also highlights the importance of identity as a consequence of socialisation, and suggests that a study of the trainee's professional identity development also requires an attention to socio-cultural influences, such as supervision. The next section of this chapter explores these influences from a theoretical perspective.

Interpersonal interactions

From the systematic review, the supervisory alliance emerged as a key relationship in postgraduate GP training. However, interpersonal interactions with the wider practice team were also highlighted as influences on the trainee's postgraduate experience. These interactions may refer to the explicit, face-to-face interactions with peers, supervisors, colleagues or staff as the trainee works with them towards common goals. This may also include deliberate attempts to instruct or engage in an activity together. However, interaction in this context may also relate to tacit interactions, such as incidental comments that are overheard, observation of practice and involvement with particular written instructions or resources (rather than people) (Rogoff, 1995).

Whilst it is useful to consider the explicit elements of supervision in the context of our research (interpersonal engagements) the discussion above suggests that there is also a case to also attend to the more tacit interpersonal elements of supervision and training (Rogoff, 1995). In the context of this research, this might include particular socio-cultural rules, constraints or facilitators. It might also involve a consideration of the materials and resources within the training practice, and also the arrangements of activities made possible (or not possible).

The theories and models of supervision outlined in **Chapter 2** relate less clearly to the more tacit elements of the interpersonal plane. Attending to these may offer an additional lens to understand the contribution of supervision to the trainee's development.

The wider cultural and institutional influence

Within the systematic review, GP training was frequently referred to as an apprenticeship, often in the context of learning in a community of practice (Lave, 1991). In this view of modern-day apprenticeship:

"newcomers to a community of practice advance their skill and understanding through participation with others in culturally organized activities"

(Rogoff, 1995 p.143)

As discussed within the previous chapter, through the work of Lave and Wenger, this metaphor of apprenticeship focuses attention on the active role of newcomers (in our case, GP trainees), as they participate in the work of the practice, and arrange activities and support to enhance their ability to participate more fully (Lave, 1991). It draws our attention to the wider culture of the community of practice, beyond simply the trainee's development or supervisory interaction. In this context of this research, this might refer to the role of the training practice, and the various explicit and tacit interpersonal interactions with the practice team.

Situatedness; beyond the supervisory interaction

As discussed in the earlier sections in this chapter, the ongoing process of shaping and re-shaping one's sense of self and identity is a reflexive, cognitive process, which occurs within social processes. The discussion thus far has suggested that social interaction recognises and legitimises identity and the sense of self. However, it is important to recognize that 'situatedness' extends beyond interpersonal interactions, to denote the structures within which these interactions take place. Critics of interactionist theories (frequently concerned with the micro-level interaction between individuals) suggest that we must not seal off the studied interaction from the outside world (Cohen et al., 2007 p.25). Focusing only on the micro-level interaction between a GP trainee and supervisor

may risk neglecting the influence of external structures, which can govern behaviour and experience (Cohen et al., 2007).

Research that considers 'situatedness' contemplates the institutional structure and cultural technologies of the particular socio-cultural activity (in our context, postgraduate GP supervision) (Rogoff, 1995). Postgraduate GP supervision is inherently situated within the institutional structure of the Royal College of General Practitioners, which constitutes the accrediting body for all GP trainees. Furthermore, the UK General Medical Council is responsible for the regulation of all GPs, holding them to account to deliver quality care for patients. The power of these institutions, to both facilitate and regulate the trainee's development, could be viewed to represent a considerable institutional influence within the context of GP training. In addition, the potential for economic and political influences on the profession of General Practice, and those responsible for GP training, is also likely to contribute. At this stage of the research, the extent to which the trainee and supervisory relationship is influenced by the institutional context is unclear, but there is a case to consider its influence on supervision.

Considering culture

To view situatedness or the social world as simply comprising of social micro-interactions and institutional processes would be an overly simplistic assumption. Individuals live in worlds which are also defined by culture, and they understand themselves in relation to that culture. Looked at from an alternative analytical framework, the 'etic' of institutional or professional ideologies is distinct from the local cultural norms, constructed meanings and beliefs (the 'emic') of the group that is being studied (Headland et al., 1990; Weiss et al., 1992).

> *"Culture is a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies,*
>
> *procedures and behavioural conventions that are shared by a group of people, and that influence (but*

do not determine) each member's behaviour and his/her interpretations of the 'meaning' of other

people's behaviour."

(Spencer-Oatey, 2008 p.3)

When approaching research in the field of postgraduate GP training, this understanding of 'culture' recognises that, although professional ideologies and standards about developing the 'good' trainee may exist, the extent to which they are shared, embraced and implemented at local level (such as by the training practice, or the training region) may vary. A consideration of culture looks beyond institutional processes and guidance, and provides scope to explore the beliefs, values and conventions of various sources of external influence on the trainee's identity development (Matsumoto, 1996).

Exploration of both institutional and cultural influences relates to notions of status, power and position (Sarangi, 2010). Within the theatrical metaphor, where social behaviour can be viewed as a performance of actors, 'status' would refer to the parts that the actors play (Biddle, 1986 p.86). Or, in other words, the social position assumed by the actors. Linked with status are the concepts of power and position, relating to an individual's 'position in the prestige system of society', and suggest a consideration of the potential constraints, leverages, resources and values within the socio-cultural context, which may relate to cultural and institutional influences (Linton, 1971 p.112; Rogoff, 1995).

Figured Worlds

As discussed in the earlier sections of this chapter, the trainee's identity can be thought to be developing within the micro-level of the supervisory relationship, the local training environment (such as the training practice), and the wider profession.

For any given group of postgraduate GP trainees, variabilities in age, motivations and experiences are likely to exist. Trainees may have a number of responsibilities, both professionally, and in their home and family life. It is not inconceivable that a postgraduate GP trainee may intersect multiple socio-cultural contexts, simultaneously developing their sense of identity as they interact in these worlds.

Figured worlds have been described as a 'contextual identity theory', with a particular strength in recognising the intersection between the numerous socio-cultural contexts to which individuals belong (Dornan et al., 2015). Figured Worlds theory has been explored to some extent within the field of medical education, particularly with undergraduate medical students, in the figured world of becoming a doctor (Dornan et al., 2015; Bennett et al., 2017). It has also been considered within nursing, exploring identity development in student nurses (Butcher, 2017). However, within the literature on postgraduate training in General Practice, the theory has not been extensively explored.

Figured Worlds theory is a socio-cultural theory, which draws on the work of Vygotsky. However, it also is considered to be influenced by Bakhtinian traditions, particularly the concepts of 'dialogism' (where an individual's speech is considered to be inherently linked to their audience, social world and culture), and 'authoring' (where we respond to these cultural voices, and create ourselves as individuals through the stories of our lives that we tell) (Dornan et al., 2015; Bennett et al., 2017).

"The heart of Bakhtin's dialogism is that there is no word spoken (or in this case written) without its being addressed to someone. The 'self' who speaks or writes the word is not a unitary, self-sufficient construct, but stands always in relation to the other whom it addresses".

(Clark 2006 p.58)

Within the Bakhtinian view, an individual's speech, or written communication of any sort, are mixed through with multiple voices, or heteroglossia. The words we speak represent the words of others,

which themselves represent an ongoing chain of multiple voices, statements, responses and communications.

"The word in language is half someone else's. It becomes one's "own" only when the speaker populates it with his own intentions, his own accent…Prior to this moment of appropriation…it exists in other people's mouths, in other people's contexts, serving other people's intentions; it is from there that one must take the word, and make it one's own"

(Bakhtin, 1992 p.294)

Such 'Figured Worlds' can be viewed as realms in which an individual (in our case, the GP trainee) hears the voices of colleagues, supervisors, peers, relatives, politicians and patients, speaking about being a GP in dynamic (and potentially contradicting) ways (Holland et al., 1998; Dornan et al., 2015). Within a particular culture, these voices may imply that particular outcomes may be valued above others, particular significance may be linked with certain acts (and not with others), and particular individuals may be recognised (whilst others are not). In the Bakhtinian view, attending to the trainee's authoring of their experience of postgraduate supervision offers the possibility to illuminate the multiple voices of the social world of supervision. No one voice is considered as 'right' or 'wrong', but simply as offering a different perspective and window to this social world.

Figured Worlds are distillates of reality, co-constructed through the interpretations of the participants within them. Individuals live in such worlds, which are culturally defined, and they understand themselves in relation to these 'taken for granted' worlds (Hallowell, 1955). They also can have agency within these worlds, to choose certain voices, signs and symbols (encountered within the socio-cultural context) to author the story of their own identity (Dornan et al., 2015).

Structure in the Figured World

Goodenough (1994) considered the influences of institutional structures and power in the Figured World, highlighting their ability to shape the situated understandings of individuals, and their positions within the social group. Regimes of power shape what we expect and 'know' about particular normative categories. In the context of this research, this might extend to expectations of a 'good GP trainee' or 'effective supervisor'. Similar to Bordieu's concept of 'field', social groups have their 'own ways of functioning' which are separate to politics or the economy. Such worlds are governed by taken for granted 'laws' and thus the figured worlds that are lived and interpreted by the participants lie within these laws and the power structures which govern them (Bourdieu, 1993 p.162-163).

Key to the concept of Figured Worlds is that the various participants will occupy different positions in this world, and therefore different perspectives on it (Holland et al., 1998). It has been argued that the governing structure offers these particular social positions, and calls on individuals to occupy that position (Davies and Harre, 1990). Within a culture, we then afford (or offer) different subject positions to one another by the way we talk, the activities we value and the outcomes we recognise:

> *"Our communications with one another not only convey messages, but also always make claims*
>
> *about who we are relative to one another and the nature of our relationships"*

(Holland et al., 1998 p.26)

In this way, an individual's social position impacts their perspective; on the predominant culture and institutions, and also on the degree to which they subscribe to the values and interpretations of that culture. It has been argued that the individual can only look at the world from the vantage point that they have been afforded, and thus from the social position from which they are persistently cast

(Holland et al., 1998). Such perspective is not fixed, and develops over time, which suggests that, in the training trajectory of the GP trainee, the vantage point may also change.

Agency in the Figured World

To stop the discussion at this point risks an assumption that the individual is passive in social positioning; pushed into various social positions firstly by the overarching structure, and subsequently by those around them. Such a view however does not account for the individual's agency.

Those from the school of sociogenesis (which consider the formation of 'self' as a social process), argue that, whilst social interaction provides the resources (and limitations) for self-making, the individual has a degree of control and agency in their formation of 'self' (Holland and Lachicotte, 2007). Active internalisation acknowledges that society provides a framework for the individual's formation of self, but within this framework, the individual is an active agent. They have the ability to 'self-author' in relation to others; internalising their behaviour as compared to the behaviour of others, and crafting their own way of occupying the particular position that is afforded to them (Holland et al., 1998 p.272; Holland and Leander, 2004). Viewed by Mead as the "I-me" split, the 'me' is the social object, and what is learned in interaction with others and the environment. In a sense, the 'me' is the sense of self that significant others have treated the individual as being, and it is the 'me' which holds back the 'I' from breaking particular 'laws' or conventions within the culture. However, 'I' is the agent, simultaneously both the actor and the observer, and thus actively internalising social stimuli and crafting a novel and creative way to be in relationship with the generalised 'other' (Mead, 1934; Goffman, 1963; Holland and Lachicotte, 2007).

Whilst people are susceptible to situational determinants of the culture (and thus the social positions afforded to them), they can afford themselves self-control and agency if their sense of identity is challenged (Holland et al., 1998). Furthermore, it can be argued that the individual has a degree of

self-control and agency beyond simply choosing sides, or picking a particular position. Proponents of heuristic development refer to this as 'improvisation'; a process whereby the individual can respond to the situation in creative and imaginative ways (Holland et al., 1998). Alongside the products (improvisations) that arise from the meeting of the individual, culture and situation, Bourdieu argued that such products could bring about change for both the individual and the culture. Whilst in Bourdieu's view, this related to cultural change for subsequent generations, others have argued that such cultural change (albeit slow, erratic and continuous) is possible within the lifetime of the individual (Bourdieu, 1993; Holland et al., 1998).

Agency, however, is not without constraints. Mead's 'I' is an 'unruly character', requiring mediation to rein in the 'self' to one that is socially recognised (Holland and Lachicotte, 2007). This process of semiotic mediation, or 'higher order thinking' can enable the individual to organise their identity into one that fits within the cultural framework (where particular characters are recognised, and where particular activities and outcomes have more significance than others). Through this, the individual gains control over their behaviour, and is motivated to pursue activities that validate their claimed identity (for themselves and for others).

The interaction between social positioning and individual agency is particularly relevant to this research on GP supervision and expectations of the supervisory relationship. From the discussion thus far, we can see that positioning is viewed as a social work, inherently part of culture and social interaction. However, the individual can take various courses (through improvisation) in how such positioning becomes part of their identity. Such 'coming to terms' with the 'lot' they've been afforded will impact their actions, motivations and behaviour (Holland et al., 1998). In this way, research which explores the social positions of the trainee and supervisor (and the individual response to such positioning) can provide important insights to the individual, and the contribution of supervision to their identity development.

Positioning in the Figured World

'Positioning' appears to offer a valuable lens to the Figured World, and became a prominent area for exploration within my research. A more extensive discussion on 'positioning' is required to illuminate this concept:

Firstly, we must consider the ways in which individuals are positioned (and position themselves) within a culture. Secondly, it is important to think about how such positioning comes about. When contemplating the particular position (or vantage point) that is occupied by an individual within the Figured World, it also is useful to also deliberate the way in which their perspective has been shaped by their position and vantage point.

What positions can we take?

Bamberg offers a useful means to consider the ways in which individuals can position themselves (Bamberg, 1997; Bamberg and Georgakopoulou, 2008).

I.   **Level 1:** Positioning the various characters within the Figured World, in relation to one another.

II. **Level 2:** Positioning of the self (as the narrator) with respect to the audience in the interactive context (*e.g. the researcher as audience in an interview context*).

III. **Level 3:** The narrating of 'self', with respect to "Who am I"? This level relates to the way in which the narrator (individual) positions themselves to themselves, with regards to the predominant narratives.

How does positioning come about?

One means by which positioning can occur is discursively, through talk and discourse. The constructivist position suggests that "all elements of speech (alongside its content) constitute signs of the speakers claim to social position" (Holland et al., 1998 p.12). Put differently, the way in which

we talk to one another depends upon negotiations and manoeuvrings related to the position we hold. We are therefore aiming to assert our position (and that of others) within talk.

A second means by which positioning can occur is through the notion of access. Such access, or inclusion, can relate to aspects such as space, activities, time and associates. There is a sense that not everyone is afforded the same access depending on their particular social position. Relating this to figured worlds suggests that there are perspectives and vantage points that will be unavailable to particular individuals, because of the particular social position afforded to them.

What does this mean for my approach to the research?

The discussion within this chapter suggests that professional development for the GP trainee relates to both 'meeting the mark' to attain their MRCGP qualification, and also to the notion of professional identity development as they progress towards becoming an autonomous General Practitioner. At this stage, the way in which supervision contributes to this identity development is unclear. However, the dynamic and interrelated processes of identity development within the socio-cultural environment highlight valuable areas to explore and contemplate within the research design. This includes an approach to the design that acknowledges the dynamic nature of identity development, and considers the contribution of supervision over time.   The approach may also benefit from exploring the both the explicit and tacit influences of supervision on trainee development. Furthermore, an approach to the design should also consider the influences of the training culture and wider profession, which are likely to be integral to the interrelated processes of supervision and trainee development.

Figured Worlds theory offers a useful lens to begin to explore trainee professional development, and the contribution of supervision to this development. It recognises the interconnectedness between the multiple socio-cultural contexts to which postgraduate GP trainees might belong (within and

outside of supervision), and the multiple senses of 'self' that may contribute to their professional identity development (Bennett et al., 2017). Furthermore, in a context where professional institutions may have the power to both educate and regulate the trainee, Figured Worlds theory also incorporates a consideration of the contribution of structures, power and positioning (Bennett et al., 2017).

In the next chapter, I will outline my approach to the research design, which incorporates these considerations.

Chapter 4: Methodology

Methodology introduction

At the outset of the research, it was important to consider the units of analysis to best explore the

trainee's professional development, and the contribution of supervision to that development. It has

been suggested that it is common within research in developmental psychology to attend to either

the individual or the environment. For example, exploring the way in which a supervisor guides a

trainee, or the way in which the trainee constructs reality as they develop in their training. However,

it has been argued that reducing events to the interaction between separate elements neglects the

integral nature and interdependence of these elements (Dewey and Bentley, 1949; Rogoff, 1990;

Rogoff, 1995). Put differently, to separate out an event into its separate elements risks a loss of the

preservation of the essence of the 'whole'. A similar critique has been suggested within medical

education, where much of the research focuses on the isolated individual or the social interaction,

without concern for the cultural context (Ajjawi and Bearman, 2012). From the findings of the

systematic review, and the discussion on Figured Worlds within the previous chapter, there was an

emerging case to consider the interrelation of the individual and their environment as the unit of

analysis, and the mutuality of the individual and their environment as an analytical lens to explore

postgraduate supervision in General Practice (Rogoff, 1995).

Within this chapter, I will explore the ontological and epistemological premises of this research,

outlining my position as a researcher within the programme of work. In the second half of the

chapter, the research methods are described, explaining the rationale for their choice and

application.

Philosophical considerations

Within the profession of General Practice, one cannot deny the importance of evidence-based

medicine (EBM), which gives an avenue for directing treatment, finance and efforts for greatest

collective effect. This epistemological approach is what has led researchers to measure the effects of

smoking and to develop treatments for cancer, and it guides the management decisions for GPs

every day by the generation of protocols and algorithms underscored by evidence-based practice.

One could argue that it is this very evidence that has the ability to change the world, and that it

already has (Keller, 1993). However, whilst the observer may see the positivist view of the doctor at

work, I would suggest that General Practice is far from a general application of general statistical and

scientific principles. A GP is driven and passionate to know the story of their patient. Pieced

together over minutes or years, there is a pursuit of the narrative and the 'kind of person' that is in

front of them. Application of statistical probability occurs on the backdrop of individual preferences,

beliefs, values and knowledge, and the resultant management is co-constructed by the doctor and

patient. The patient chooses the story to tell, and the doctor's interpretation of this will affect the

ongoing narrative and patient's own interpretation of their illness (Reeve, 2010).

A case for pragmatism

Approaching my research from a purely post-positivist or constructivist position appeared to be at

odds with the application of evidence, interwoven with clinical interpretation, encountered on a daily

basis through my clinical work with my patients. At the early stages of my literature review and

systematic review, a number of theories had emerged from within the literature, and the findings

from the literature were underpinned by different methodological approaches. Aligning to

positivism/post-positivism or constructivism from the outset placed an emphasis to the research

design that felt somewhat restrictive when I considered the multiple perspectives that were

emerging. The paradigm of pragmatism offered a perspective that conflates these concepts; sat

between a continuum of realism and relativism, rather than conceptualising them as mutually exclusive (Butler-Kisber, 2010).

Beyond simply a 'middle ground', or technical (pragmatic) approach, the paradigm argues that the meaning of an event cannot be given in advance of experience (Denzin, 2012 p.81). An emphasis to research that started first from individual and local experience (rather than from a need to articulate a position with respect to the nature of knowledge or reality) resonated with my observations in the consulting room, where knowledge appears intimately connected to everyday experience (Butler-Kisber, 2010; Denzin, 2012).

Although everyday experience serves as the focus, pragmatists argue that it can never be fully represented. Instead, knowledge (in this paradigm) can be considered temporal, cumulative and continuous, contingent on whatever is known at a particular time, and evolving as one experience grows out of another (Munhall and Boyd, 2007). I embarked upon my research with a focus on the meanings and experiences of supervision in the context of postgraduate GP training, rather than underscoring an alignment to a particular methodological framework.

Methodological considerations

Although abstractions about the nature of knowledge and reality have not served as *a priori* considerations, acquiring knowledge in one way or another has important consequences for the methods used, and the kind of knowledge produced (Morgan, 2014). Within my research, some of these considerations were made at an early stage. For example, I chose a mixed methods approach, alongside triangulation of perspectives from various participant groups within postgraduate training. However, the active process of inquiry was emergent through my research, with a continual modification and development of the approaches used as each stage of the research progressed, as the discussion will outline in later sections. Inherent to this study was the nature of emergent

design. New approaches to observation or questioning were taken, based on important discoveries made in the earlier stages of data analysis (Lincoln and Guba, 1985). To best reflect the emergent design, I have presented the results from each stage of the research process as a chapter within the thesis. Chapters 5 and 6 conclude by considering the means by which the results informed the next stage of the research, illustrating the research journey taken.

A socio-cultural approach

When considering the most appropriate and legitimate approach to this research, the findings of the systematic review and wider reading on the relevant theories and models of supervision offered a useful springboard. The supervisory relationship does not exist in isolation, but also within a historical, political and cultural context. A research design focused solely on the interpersonal interaction between trainee and trainer may fail to provide a comprehensive understanding of the contribution of supervision to trainee professional development. Without consideration of the wider plane of the community in which supervision sits, the solutions may be 'incomplete' (Rogoff, 1995, Ajjawi and Bearman, 2012). The findings from the systematic review of the literature on supervision suggested that contextual factors were important. Rising clinical workloads, administrative workload, training placement length and contractual standards were discussed within the literature, and represent the influence of the local and wider educational environment. The influence of the socio-cultural context on supervision was emerging, and the mutuality of the individual and their environment as an analytical lens was compelling (Rogoff, 1995).

This interdependence of the individual and the social world has been considered to relate to socio-constructivist perspectives, focusing on the co-construction of knowledge through both individual and social processes (Palincsar, 1998). Early theorists, such as Piaget and Vygotsky, suggested that the individual and society are 'bound together' through the interaction of the individual with the sociohistorical context (Rogoff, 1990). Piaget's sociocognitive conflict theory considered the

disequilibrium arising within the learner, when the social environment appeared at odds with their existing understanding (Piaget, 1977; Rogoff, 1990). According to Piaget (1977), this disequilibrium forces the learner to question their beliefs or explore new ways of thinking, leading to learning and development. This early work challenged the predominantly individualistic conceptualisations of learning at the time, recognising the influence of the environment on cognitive processes and development.

However, the socio-cultural context received little further exploration in Piaget's work on cognitive development, which focused largely on the individual's cognitive processes (Rogoff, 1990). Learning as a social process, and the interdependence of the individual and the social world, is more frequently associated with the work of Vygotsky (Rogoff, 1990; Palincsar, 1998). Within Vygotsky's principles of social constructivism, social interaction is considered a precursor to learning (Ebbers, 2017). The zone of actual development is described as the level of development already reached by the learner (in which they are capable of independently solving problems). However, it is in Vygotsky's zone of proximal development where the learning takes place. This constitutes a sphere of influence around the individual, of those who are further ahead in terms of them in knowledge and skill. Through the interaction with those around them (such as peers and teachers), the learner is then enabled to mature and develop (Vygotsky, 1978).

Whilst Vygotsky's work did explore the social interactions of individuals, teachers, caregivers and peers, it has been argued that much of this work focused on children participating with a small aura of individuals around them, within a social order (Rogoff, 1990). It has been argued that this conceptualisation, where development occurs in a seamless fashion with those who are more skilled or knowledgeable within the social world, may risk an incomplete examination (Rogoff, 1995). It may be incomplete to consider that the learner develops within their social world, without also recognising that the social world itself (and the actors within it) is also involved in a process of

development. When considering GP trainees (adults, and professionals with varying clinical experiences and exposure), influence may be multidirectional, with the learner influencing their social world, alongside being influenced by it (Rogoff, 1995).

Rogoff's 3 planes of development

Rogoff has considered an alternative approach to the observation of development, conceptualised within three inseparable, but mutually constituting planes of focus. These have been termed 'personal', 'interpersonal' and 'community/institutional' planes (Rogoff, 1995). Rogoff argues that it is incomplete to consider the personal development of the learner (or trainee) within their social context, without a concern for the interpersonal or institutional interactions at play. Similarly, it is incomplete to view development as occurring only in one plane, and not in others (such as focusing only on the trainee's development, without appreciating that their supervisors and training practices are also developing, and that the trainee may be part of influencing this development) (Rogoff, 1995). Within this view, each plane can become the focus of analysis at various times, but with an acute awareness of the other planes remaining behind the scenes. In this way, each plane is not separate or hierarchical, but rather offers a different lens by which to study socio-cultural activity as a whole. To understand each plane requires a concern for the involvement of the others.

When considering Rogoff's work with regard to my own research, I designed a methodological approach that would enable an exploration of the contribution of supervision to the GP trainee's professional development across these planes: attending to the individual (personal plane), relationships with the supervisor and within the training practice (interpersonal plane) and the wider influences of the institutional culture (community plane). The contribution of supervision, within the interpersonal plane, remains the focus of this thesis. However, the approach to the research also attends to personal and community planes to better understand this contribution in context.

Applying a critical lens

I embarked on this particular area of research interest because of a discontent with the status quo in one of my own supervisory experiences, and also upon hearing the mixed accounts of both positive and negative supervision from the anecdotal accounts of my peers. The variability in our experiences, with some elements seemingly outside of our control, prompted a desire to see change within GP training. The tensions related to rising clinical workloads, service delivery and documentation burden illuminated within the systematic review also suggested a structural influence on supervision, potentially outside the control of the supervisor or trainee. The findings also suggested a complex picture of supervision, laden with values, competing roles, power imbalances and risk of disagreement. Another particularly noteworthy observation from the systematic review was the relatively 'quieter' voice of the GP trainee from within the literature.

To begin to bring about change within postgraduate training and supervision, I attempted to apply a critical lens at various stages of the research to provide greater insight into these complexities. This included a consideration of the ways in which experiences may have been shaped over time by social, cultural and wider professional influences, and an exploration of the ways in which these influences may have constrained (or facilitated) the agency of the GP trainees (Illing, 2007). I also aimed to include research that would give voice to the GP trainee, as this perspective had seemed less prominent within the systematic review of the literature.

Research (or knowledge) with this lens is itself value-laden, serving different interests. Reflexivity of the researcher is essential, to remain aware of their implicit interests and motivations, and remain transparent (Cohen et al., 2007). My approach to reflexivity is discussed in greater detail later in this chapter.

Methods

The study design involved a case study approach, with postgraduate GP training in the West Midlands as the area of observation, and supervision in the final year of GP training as the broad area of interest. Although there is often diversity in approach in case study research, common features include an idiographic approach, attention to context, awareness of a temporal element and a consideration of theory (Willig, 2008; Wells, 2011c). These facets of study were particularly important in light of my earlier observations within the systematic review on the influence of the socio-cultural context in postgraduate GP training, alongside an interest in the contribution of supervision to the professional identity development of GP trainees, over time. The case study design enabled a mixed methods approach with sufficient scope to explore the individuality and subjectivity of lived experiences within the institutional context of postgraduate GP training. It also facilitated an inherent flexibility which aligned with the iterative nature of my research and the pragmatism approach (Rosenberg, 2007).

Mixed methods were implemented, comprising documentary analysis of the training documents used within postgraduate GP training, semi-structured interviews with experienced GP supervisors and narrative enquiry with GP trainees in their final year of training. Mixed methods were chosen to provide a comprehensive view of the complexity of identity development and supervision in general practice (in the West Midlands), from the vantage points of the trainee, supervisor and wider profession. I began my approach to the case study with a broad range of focus, and narrowed this as information and situations unfolded throughout the research process (Nisbet and Watt, 1984).

Figure 4: Stages of the Research Process (below) outlines the stages within the programme of

research:

Figure 4: Stages of the Research Process

Stage 1 Results: Chapter 5	• Documentary Analysis • *The perspective of the wider profession (community)*
Stage 2 Resilts: Chapter 6	• Semi-structured interviews with experienced educators within postgraduate General Practice • *The supervisor's (interpersonal) perspective*
Stage 3 Results: Chapters 7-8	• Narrative interviews with GP trainees (preceeded by pilot) • *The learner's (individual) perspective*

Although each stage of the research placed an emphasis on a particular aspect of Rogoff's analytical

plane, there remained an awareness of the interdependence of each perspective throughout (Rogoff,

1995). Within the next section, I will outline each of these stages of research, and the approach to

the methods.

Stage 1: Exploring the expectations the wider profession through documentary analysis

This stage of the research aimed to focus on Rogoff's (1995) community plane, to consider

postgraduate GP supervision within the institutional and political context. It relates to Research

Question 1:

RQ1: How is the GP trainee expected to develop professionally within postgraduate GP supervision?

Ignoring the influence of the community plane may risk a misattribution of 'control' to either supervisor or trainee for aspects of supervision (Ajjawi and Bearman, 2012). GP training occurs in an environmental system where patient care, public accountability and trainee development co-exist. Furthermore, within this complex system, each element may be valued and perceived differently by various agents or groups, and perhaps (at times) at odds with one another. The 'community' plane constitutes the sociocultural and political influences within which supervision occurs, and where multiple interconnections exist between both trainee and supervisor (Ajjawi and Bearman, 2012). In the UK context, such interconnections could include the regional GP training scheme (which coordinates formal learning activities for the trainee, and approves and monitors supervisors), professional bodies responsible for accreditation, examination and quality assurance (such as the Royal College of General Practitioners and the General Medical Council) and the political context of postgraduate training. The development of the trainee can be conceptualised as entangled in this environment, which can and does influence the way in which the trainee learns, and the way in which supervision contributes (Ajjawi and Bearman, 2012).

An examination of the training documents pertaining to postgraduate supervision offered a useful lens into the expectations of the wider profession.

Two sub-questions were developed to guide this stage of the research:

- In the context of postgraduate GP supervision, what are the expectations from the wider profession with respect to the trainee's professional development?
- What are the expectations from the wider profession with respect to the supervisory relationship?

The following areas of influence from the wider profession were considered;

1. General Medical Council (GMC) *(professional body responsible for regulation and quality assurance)*

2. Royal College of General Practitioners (RCGP) *(professional body responsible for accreditation and examination)*

3. Regional education teams (Health Education England, West Midlands) (HEEWM) *(professional body responsible for delivery of quality education)*

4. Regional universities *(responsible for delivering 'Training the Trainers' courses (TtT))*

These were chosen as they constitute the organisations responsible for the development of a GP trainee to become a qualified GP. They monitor and set standards for the quality of postgraduate GP training and provide approval and training of supervisors.

Document search

The search strategy is outlined in **Figure 5 (Document Search Strategy).** In September 2016, beginning with the GMC, RCGP and HEEWM (above), each website was reviewed and all documents related to postgraduate GP training and supervision in circulation extracted. Upon request, 1 local university kindly provided an outline of their 'Training the Trainers' (TtT) course.

I was a GP trainee at the time of the study. I was familiar with the organisations responsible for accreditation, and was exposed to many of the documents and standards in postgraduate training. In addition to searching the websites of each organisation, I reviewed my RCGP learning electronic portfolio (E-portfolio) to identify guidance documents related to supervision. Further documents were identified from snowballing, as I was aware that my own 'insider' knowledge may have been limited in scope and awareness. The search strategy was applied again in March 2018, and also in February 2019 to provide an up to date analysis of the relevant documentation. February 2019 was

chosen as the date to end the document extraction as it coincided with the final follow-up interviews

with GP trainees.

Figure 5: Document Search Strategy

GMC website

RCGP website

RCGP E-portfolio

Health Education England, West Midlands website

local university "Training the Trainers"

Personal (DJ) RCGP E-portfolio *(Sept 2016 only)*

Title Screen: All standards, documents and guidance related to GP trainee supervision

42 documents

8 excluded after full text review–not deemed to be relevant to postgraduate GP trainee supervision

34 documents

8 additional documents identified through 'snowballing'

42 documents

March 2018, February 2019: Updated searches 20 additional documents identified

62 documents

2 excluded after full text review –not deemed to be relevant to postgraduate GP trainee supervision

60 documents

Analysis of the documents

The documents were analysed in 3 stages, which I have outlined below:

1. Thematic analysis

Thematic analysis was applied due to the advantage of data reduction, whilst still respecting the quality and context of the qualitative data (Braun, 2006; Thomas 2009; Cohen et al., 2007). Electronic software was introduced in this stage of the research to gain a sense of the relative frequency of particular institutional messages, and also to assist in the analysis of a large amount of data (Anderson and Arsenault, 1998).

All documents were uploaded to QSR NVivo Version 11. The first phase involved reading and re-reading a sample of 10 documents to become familiar with them, and consider potential patterns, noteworthy features and contradictions (Hammersley and Atkinson, 1983, Braun, 2006). The results of the systematic review of the literature (discussed in detail within **Chapter 2**) also informed the approach to coding. For example, the supervisor functions of 'assessor' and 'gatekeeper' outlined within the systematic review were used as coding labels.

 Paragraphs, sentences and phrases of text relating to GP supervision were selected as the units of analysis, and codes were ascribed to each unit (Miles and Huberman, 1994). The list was continually added through the process of coding each document. These were then refined and grouped into sub-themes. The sub-themes were reviewed in turn for agreements, contradictions and paradoxes. These were later grouped into over-arching themes, through team discussion with my supervisors and a process of reviewing (Braun, 2006). Some codes were assigned to more than one theme, to preserve the richness of the data in context (Hammersley and Atkinson, 1983). The QSR NVivo software enabled a 'count' of the frequency of each code, giving a sense of their relative importance across the training documents.

2. Evaluating the evidence

It has been suggested that researchers should review documentary data with a 'critical eye', and exercise caution when using this method of analysis (Bowen, 2009). Bowen (2009) suggested that this should include a consideration of the meaning of the document, and its contribution to the area of interest. In addition, it has been suggested that reviewers should also consider the audience for each document, why it may have been written, external or political influences at the time, omissions within the document and the particular style of language of each (Hammersley, 1983; Bowen, 2009). I created a form for each document to consider each of these aspects (**Appendix 8**: **Data form for Documentary Scrutiny**)

Due to the context-specific nature of documents, it has also been suggested that they should be evaluated against other information sources (Bowen, 2009). Completion of the data forms also formed the basis for a mapping exercise, to appreciate how the various documents related to one another (in terms of their explicit and implicit messages), and also across time. The 'Training the Trainer' guidance was not sufficiently detailed to appreciate its origins, or the intentions in its design. It was therefore excluded from the analysis of this stage.

3. Analysis of overarching messages from the wider profession

Throughout the analysis, field notes and a reflective diary were kept, and these were also reviewed in the final analysis. Each document was reviewed in isolation (by myself), and the overarching messages between the documents were considered by reviewing the results of the thematic analysis, data forms, field notes and discussion with my supervisors.

Stage 2: Exploring the perspectives of experienced GP educators

This stage of the research focused on Rogoff's (1995) 'interpersonal' plane, and particularly on the supervisory relationship and the supervisor's perspective. The findings from this stage of my

research were written up for publication, and the methods outlined within this section include text taken from this published work (Jackson et al., 2018b). My PhD supervisors at the time (Dr Ian Davison, ID and Dr Josephine Brady, JB) provided supervision of the research design and conduct, and engaged as co-authors in writing the paper.

I also presented some early findings of this stage of my research at a regional medical education conference. Feedback from the audience was particularly helpful in refining some of the themes, specifically the theme of 'Failure to Fail' (discussed in detail within **Chapter 6**). I would like to thank Professor John McLaughlin and Professor David Wall for their additional contributions and insights.

As discussed within **Chapter 2**, the 'therapeutic alliance' between counsellor and client has been found to be the strongest predictor of positive outcome in counselling (Wearne et al., 2012). Bordin, in the 'Supervisory Working Alliance' model, extended the concept of the 'therapeutic alliance' to introduce the 'educational alliance', or supervisory relationship, as central to successful supervision (Bordin, 1983). Similarly, Egan's 'Skilled Helper Model' views the supervisory relationship as akin to the therapist-client relationship. In this, the trainee journeys through a process of continual learning and change, helped and facilitated by the 'helper' (or supervisor) (Jenkins, 2000). In a 2012 integrative review on GP supervision, the 'educational alliance' and Egan's model were viewed as important theories in GP supervision (Wearne et al., 2012).

In situations where the trainee is facing difficulty in their training, additional challenges to the educational alliance are frequently imposed. These include the need to balance the educational needs of the trainee with clinical risk to patients (Byrnes et al., 2012), alongside the additional time, resource and emotional impact to the trainer (McLaren et al., 2013, Wearne et al., 2015).   In such cases, 'relationship breakdown' may result; with some trainees requiring a costly move (both financially and emotionally) to an alternative training practice (Davison et al., 2016). An approach to

the research was designed that would enable exploration across the spectrum of supervisory experience, incorporating difficult and positive experiences.

This stage of the research focused on my second research question:

RQ2: How do supervisory relationships contribute to the professional development of GP trainees?

I particularly wanted to explore the supervisor's experience within this stage of the research. This was largely because, at the time of the research, I was a GP trainee. Exploration of the supervisor's perspective offered the opportunity to consider a different perspective, and illuminate areas that may have been previously unconsidered. A number of sub-questions were developed to guide this stage of the research, to bring the supervisor's contribution into a sharper light, and to develop the analysis at the level of Rogoff's (1995) interpersonal plane.

- Which theories or models of supervision best relate to experiences of General Practice supervision?
- How do GP supervisors perceive the development needs of GP trainees?
- What methods do GP supervisors implement to support the trainee's development?

Participant sampling

Training Programme Directors (TPDs) and Associate Deans (ADs) have a role to support and oversee GP supervisory relationships, and possess a broad knowledge and experience of the supervisory process. Most TPDs and ADs also have significant personal experience of undertaking educational supervision of GP trainees.

At the time of the study, the West Midlands region was the second largest training region in the UK, with around 50 trainees per year (around one sixth) requiring additional training support such as

examination support or an extension to training (Esmail and Roberts, 2013, Houlston, 2013). I

attended a training day for TPDs and ADs in September 214. These supervisors, from various

geographical training sites within the West Midlands region, had additional roles in supporting

trainees in difficulty. This particular group was likely to have experienced both challenging and

rewarding aspects of supervision, supporting a range of trainees. Participants were purposively

sampled from this group of attendees and were invited to take part in a semi-structured interview.

Sampling was based on the AD or TPD's geographical area of work within the region, and also their

gender. Due to their duration of experience as a supervisor, a final participant was invited based on

recommendations from the training day participants. In addition to TPD and AD roles, all had

considerable experience of being a GP supervisor. 7 experienced educators were invited to

participate in semi-structured interviews.

Four educators agreed to take part in the interviews; three TPDs and one Area Director. Two

participants were male, and two were female, from four different training regions within the West

Midlands. Two participants were current GP supervisors, in addition to their TPD roles. The other

two participants had moved away from their educational supervisor roles within the preceding 6

months. The participants shared over 60 years of combined experience. The interviews ranged in

length from 35 to 41 minutes.

Data Collection

I conducted individual semi-structured interviews with experienced educators between October to

December 2014 (EE1, EE2, EE3 and EE4). Interviews as a research tool were selected to enable

collection of data rich in context and opinion, and with a degree of space for spontaneity for

participants, to illuminate the tacit understanding and interaction in the supervisory relationship

(Cohen et al., 2007). An interview guide, based on Egan's Skilled Helper Model and Bordin's

Supervisory Working Alliance, was constructed in an attempt to explore the relevance of these

models within the context of postgraduate GP training (**Appendix 7: Interview Schedule for Interviews with Experienced Educators**) (Bordin, 1983, Egan, 2010). Questions explored participants' views of the important elements of a training relationship, the training needs of GP trainees, and strategies employed by trainers to help meet those needs (Egan, 2010). However, the guide was used flexibly to also enable the interviewer to respond to the participant's agenda, and therefore to facilitate the discussion of unanticipated themes. Interviews were recorded and transcribed verbatim, and field notes were kept (DJ). Respondents were encouraged to speak freely on topics within the interview schedule, and asked to expand and clarify where necessary.

Data Analysis

Thematic analysis was undertaken, based on the six-step approach described by Braun and Clark (Braun, 2006). Following familiarisation with the data, each interview transcript was coded using sentences or phrases within the text as sampling units (Krippendorp, 2004). Initially, an inductive approach, driven by the data, was taken to formulate areas for interrogation and interpretation (Coffey and Atkinson, 1996). Codes were compared and examined for patterns within each transcript as a means to identify sub-themes. Comparison between the transcripts was undertaken, (at the level of codes, and later sub-themes) looking for similarities or patterns, and also contradictions or contrasts (Delamont, 1992). Review of field notes and reflexive accounts from the lead researcher (DJ) were considered, and team discussion (ID, JB and DJ) was used to develop and clarify the sub-themes. A final stage of analysis deductively reviewed the transcripts again, and considered these in light of the pre-defined theories of interest: the educational alliance (Bordin, 1983) and Egan's Skilled Helper Model (2010). Overarching themes were considered at a final stage, based on inductive and deductive approaches, and refined through team discussion. Early presentation of this work at a West Midlands medical education conference (The Birmingham Conference) further helped to clarify and develop the themes through discussions with audience members (Jackson, 2016).

Stage 3: Exploring the GP trainee perspective through narrative inquiry

At this final stage of the research design, I wanted to attend to the trainee perspective, and to Rogoff's 'personal plane' (1995). Within this stage of the research, I also aimed to revisit my research questions:

> RQ1: How is the GP trainee expected to develop professionally within postgraduate GP supervision?
>
> RQ2: How do supervisory relationships contribute to the professional development of postgraduate GP trainees?
>
> RQ3: What factors influence the supervisory experience?
>
> RQ4: How do lived experiences of trainees and their supervisors relate to the expectations of the wider profession?

Figured Worlds Theory

Figured Worlds Theory offered a useful lens to attend to the trainee's perspective, as an individual on a journey of professional identity development within the Figured World of postgraduate GP supervision.

The fundamental considerations of 'dialogism' and 'authoring' at the core of Figured Worlds theory were particularly pertinent to the final stage of my research, which involved narrative interviews with GP trainees (Dornan et al., 2015; Bennett et al., 2017). It is a socio-cultural theory, which offered a means to consider the individual trainee's identity development, but also to attend to the influences of interpersonal relationships, the contribution of supervision and the institutional messages of the wider profession through its consideration of power, agency, artefacts and positioning. I have discussed Figured Worlds theory in greater detail within **Chapter 3** (**Theoretical**

considerations). Within this Chapter, I will discuss how the theory informed the design for this stage of the research, and particularly how it was applied at the analysis stage.

Narrative interviews

It has been proposed that interviews can allow a more natural and everyday form of discourse, with the ability to capture information relating to culture (Coffey and Atkinson, 1996). Most people (regardless of culture or background) like telling stories, and will naturally do so unless the interview structure itself suppresses it (Mishler, 1986). Occupational stories can illuminate the cultural values and morals of a professional group, convey information regarding membership and offer insights into the historical and institutional context (Cortazzi, 2001, Butcher, 2017). To produce a narrative, or story, the participant seeks to make sense of that story, and attach meaning to it, providing insights into aspects of their identity and socio-cultural context (Ricoeur, 1988, Elliot, 2005). This forms the premise of narrative inquiry: as human beings, we give meaning to our lives, and also come to understand our lives, through story (Andrews et al., 2013). Through gathering the narrative, and focusing on the meanings that are ascribed by individuals, the researcher can explore insights that illuminate the complexity of human life within the socio-cultural world (Josselson, 2006).

However, narrative inquiry involves more than simply gathering stories. To construct a narrative, the respondent must reflect on an experience, draw on their knowledge of the past and revise it retroactively, to tell their story (Elliot, 2005). Narratives are told for a purpose, and the researcher attends to how the story has been constructed, the audience for the story, and why it has been told in this particular fashion (Elliot, 2005). Stories also offer a lens to the cultural context of the narrator, and the dialogical nature of the narrative can be understood as an artful representation of the individual's experiences, set within their past, and their imagined future (Frank, 2012). As the narrative researcher, I was aware of the selective nature of memory, and in the grounding of the narrative in what is 'tellable'. In this respect, the use of narrative interviews was not chosen to

construct meanings about the particular 'truth' of versions of events (Atkinson et al., 2003).

However, it can be argued that it is through the retrospective reflection on our experiences that we begin to understand and attribute their meaning (Polkinghorne, 1995). It was in this process of meaning-making where my interest lay, and this guided my implementation of narrative inquiry in this stage of the research.

However, there are many different nuances and viewpoints in the literature regarding this approach to interviewing (Reissman, 1993). Naturalist approaches suggest an emphasis on observation and description of the social world, taking great interest in the content of the participants' responses. Constructivist approaches on the other hand focus on the roles of the researcher and participant in co-construction, attending to the interpretive processes used by the participant to make meaning of their particular situation (Elliot, 2005). These perspectives are not necessarily mutually exclusive, and it is possible to be interested in the content of the interview itself, but to remain mindful of the role of the interviewer in the interaction, and therefore in the co-construction of that knowledge (Seale, 1998). My approach to the narratives within this research reflects this understanding.

It is also important to consider the possible limitations of this method. Stories could be told for the benefit of the researcher, and the character of the story shaped depending on the audience (Murray, 1997). Or, for some respondents, their stories of supervision may not have been considered or told before, resulting in the interview becoming a site for production of knowledge. In these instances, it may be difficult to produce a narrative at all, and could lead to limitations of account or conversation (Elliot, 2005). To attempt to mediate these risks, a careful consideration of how I would attempt to position myself as the researcher was undertaken, and I also included a follow-up interview where relevant.

Interview schedule

My approach to the interviews, and their subsequent analysis, evolved over time. A pilot stage was introduced, as means to up-skill myself in this interviewing technique and to reflect on my influence (as the researcher) in the co-construction of narratives. It became clear within the pilot interviews that my role as a participant-as-observer was of interest to the participants, and appeared to create a sense of ease and collegiality within the discussion. Introducing myself as a newly qualified GP, recently familiar with the struggles and experiences of GP training, was a useful means to position myself as an insider within the research process.

With an interest in the GP trainee's identity development within the context of postgraduate GP training, it was important to consider the scope of the narratives (Parker, 2005). Signposting participants to reflect on a particular period of time offered a focus for the narrative, but risked neglecting important experiences and stories which may have shaped the early professional life of the GP trainee, and their subsequent development within the postgraduate context. A schedule was developed to encourage narratives from the participant's early professional life, enabling reflection on a number of postgraduate supervisory experiences beyond simply their GP training experience. Other than an opening statement from myself, the schedule was designed to enable the participant (or narrator) to set the agenda for the stories that were told, and the content of the interview (Elliot, 2005, Murray, 2008). Prompts were included within the schedule in the event that the narrative was difficult to elicit, but with an aim to avoid disruption or over-direction (Murray, 2008). The interview schedule is outlined in **Appendix 10** (**Interview Schedule for Narrative Interviews with GP Trainees**).

I attempted to undertake two interviews with a number of the trainees, to consider the contribution of supervision to the trainee's development over time. The initial interview was undertaken at the beginning of the ST3 year (the final year of GP training), at a point when participants were likely to reflect upon stories of previous postgraduate supervision, and to build rapport with the participant.

A follow-up interview was carried out at least 8 months (longer, for those in part time training) into the final year of training with 6 of the trainees, after they had attempted the Clinical Skills Assessment (a high stakes summative assessment, sat in the final year of training). This second time frame was chosen firstly to ensure that the interviews did not add additional pressure at a time of high stakes assessment, and secondly to allow the trainees to explore the contribution of supervision specifically in relation to high stakes assessment should they wish to do so.

Recruitment

I aimed to recruit GP trainees in the final year (ST3) of their training within the West Midlands General Practice Vocational Training Programme. In the West Midlands, recruitment statistics for General Practice in 2014 indicated that approximately 342 trainees had entered training (Health Education England, 2014). I was aware that not all of the 342 would enter their ST3 year in 2017 (when I was embarking on recruitment for the narrative interviews) as some may have had time out of programme, extension to their ST1 or ST2 years of training, or worked in a less-than-full-time (LTFT) basis. I therefore anticipated approximately 250-300 potentially eligible trainees for sampling.

There are 5 training regions in the West Midlands, comprising of 16 different training groups (schemes):

1. *Birmingham and Solihull*

2. *Coventry and Warwickshire*

3. *Black Country*

4. *Stafford and Shropshire*

5. *Hereford and Worcester*

For the pilot study, I aimed to recruit 3 trainees. I verbally advertised the study at 2 different training scheme educational sessions and used a 'sign-up sheet' to collect the email addresses, gender and training grade of interested trainees. The 2 educational sessions had around 60 attendees,

comprising of trainees from the first, second and final years of GP training. It was difficult to

estimate the number of eligible ST3 trainees for the pilot within this group. 17 trainees (6 of whom

were ST3) expressed an interest in the study, and 4 were invited to participate. They were sampled

based on their gender and training scheme. 1 participant did not respond to requests to arrange an

interview, and therefore 3 participants were recruited to the pilot stage of the narrative interviews.

The pilot stage consisted of just one narrative interview with each trainee, undertaken at the end of

their ST3 year.

After the pilot stage, all Training Programme Directors (TPDs) from the 16 training schemes in the

West Midlands were asked to assist in the next stage of recruitment, which aimed to recruit trainees

to series of 2-3 narrative interviews. TPDs from 12 training schemes verbally advertised the study to

the trainees on their scheme, and sent out emails to eligible trainees with details of the study and a

Participant Information Sheet (**Appendix 6**). These 12 training schemes spanned all 5 training

regions within the West Midlands. I also attended 4 of the larger training schemes to verbally

advertise the study. Only 4 of the 12 TPDs provided information regarding the number of trainees

that were invited (n=91), and it is therefore difficult to gauge the total number of eligible trainees

who received an invitation. I received 26 expressions of interest to participate in the study.

Sampling

GP trainees are assessed annually at Annual Review of Competency Progression, when their

performance in workplace-based assessment, summative assessment and written reflection is

assessed by a panel of GP educators (Royal College of General Practitioners, 2008a). There are three

possible outcomes of particular relevance in this study:

Outcome 1: Satisfactory progress, proceed to the next stage of training

Outcome 2: Unsatisfactory progress, usually offered guidance on how to improve (no additional training time required, progress to the next stage of training).

Outcome 3: Unsatisfactory progress and additional training time required.

The email invitations provided information about the study, and asked interested trainees to respond to me (in an email) with a summary of their outcomes in the Annual Review of Competency Panel (ARCP) process and whether they trained full time (FT) or less than full time (LTFT). Interested trainees were purposively sampled based on their ARCP performance, gender, training region and training status (FT or LTFT).

Performance at ARCP was included as part of the sampling process, to ensure representation from across the potential ARCP outcomes. This was an attempt to capture the stories of trainees with varying experiences of educational progression, and potentially stories of success or difficulty within training. I aimed to recruit around 6 to 8 participants to take part in a series of 2-3 narrative interviews. 10 trainees were invited, and all 10 responded positively. I therefore invited all 10 respondents for interview.

Participant information

13 participants were recruited to the study in total, including the 3 trainees who took part in the pilot interviews. 6 of the 13 participants were recruited towards the end of their GP training and a follow-up interview was therefore not scheduled. For the remaining 7 participants, retention of their participation was an important aim, to facilitate the arrangement of a follow-up interview towards the end of their training. I facilitated this by scheduling an estimated 'window' for follow-up interview, based on the trainee's general predictions of their training trajectory. This was frequently different for each applicant, as a number were training on a less than full time basis, and they also had different plans for the scheduling of their summative examinations. All 7 participants responded

to contact to arrange these follow-ups, and 6 of the 7 had a follow-up interview. One of the 7 eligible

participants did not have a follow-up interview due to an emergency which prevented her

attendance at the scheduled time. She was offered to re-arrange the interview, but declined.

Timeline of interviews

Table 1: Interview Timeline (below) outlines the timeline of the initial and follow-up interviews.

Table 1: Interview Timeline

Key:

Participant (ppt) ID	Pseudonym	LTFT?	Interview 1 (stage of training)	Interview 1 (duration)	Interview 2 (stage of training)	Interview 2 (duration)
1 (pilot)	Raj	N	End of ST3	31m 39s	n/a	
2 (pilot)	Jas	N	End of ST3	48m 52s	n/a	
3 (pilot)	Preet	N	End of ST3	35m 56s	n/a	
10	Seema	Y	Late ST2	72m	Mid ST3	38m37s
11	Sarah	Y	Mid-ST4 (after CSA)	22m 32s	n/a	
12	Nat	N	Early ST3	33m 57s	Late ST3	28m 21s
13	Alison	Y	End of ST4	37m 19s	n/a	
14	George	N	Early ST3	29m 42s	Post-CCT	17m 39s
15	Esther	Y	Early ST3	22m 38s	Late ST3	13m41s
16	Stephen	N	Early ST3	31m 09s	Late ST3	16m 3s
17	Nadia	Y	End of ST3	31m 56s	n/a	
18	Ayesha	N	Early ST3	26m 44s	DNA	
19	Cara	N	Early ST3	30m 14s	Late ST3	19m 40s

Abbreviation	Description
N	No
Y	Yes
CSA	Clinical Skills Assessment (summative examination)
ARCP	Annual Review of Competency Progression (annual assessment of progression towards qualification, considered by a panel)
AKT	Applied Knowledge Test (summative examination)
n/a	follow-up interview not applicable (trainee already at the end of their training)
LTFT	Less than Full Time
Post-CCT	After the Completion of Certificate of Training (after qualification)
ST4	Some GP trainees have an additional year of training to pursue specific interests, such as research or leadership. This additional year is to enhance their breadth of experience. It is not related to an extension as part of remediation.
DNA	Did not attend for follow-up interview (and declined requests to reschedule)

Gathering and collecting the data

All interviews were audio recorded using a Dictaphone. I made minimal notes within the interview so as to facilitate active listening on my part, and the telling of the story. However, immediately after each interview I made field notes recording my initial perceptions, emotions and questions (Wolf, 1992, Wells, 2011b).

Each interview was transcribed *verbatim*, ideally within 7 days of the recording. I approached the process of transcription as an interpretive act in itself. Therefore, although this was a significant undertaking, I chose to transcribe all the interviews myself (Reissman, 2008). Applying Wilkinson's concept of 'personal reflexivity', my own contributions to the conversation were also transcribed, enabling an honest reflection of my own role in the co-construction of the narratives (Wilkinson, 1988). Although conversation analysis was not a key analytic approach, I used a number of the conventions of this approach within my transcriptions, such as recording pauses, expressive sounds (non-verbal communication), garbled speech and quotation marks (to indicate when the speaker was paraphrasing others) (Poland, 2002, Wells, 2011b).

Data analysis: The Listening Guide

It has been argued that as researchers, we need to tune into the multiplicity of voices around us, and the voices within us. Truly 'listening' can be a complicated process (Gilligan and Eddy, 2017). Individuals may have multiple, and sometimes contradictory, perspectives on their experiences, which can lead to a multiplicity of 'voices' for the researcher to attend to (Brown and Gilligan, 1991, Bright, 2015, Bright et al., 2018a). Furthermore, these voices may be influenced, and potentially silenced, by the socio-cultural world around them, meaning that it may be just as important to 'listen' to what is not said (Brown and Gilligan, 1991, Bright, 2015). An additional area of consideration is the role of the researcher in the co-construction of the individual's narrative, where

stories may be told for their benefit, and where they bring their own perspectives and understanding to their analysis.

In their 'Listening Guide', Brown and Gilligan took up this question of how to listen: recognising its complexity, and offering a means to attend to the multiple voices around the individual (Brown and Gilligan, 1991). It is based on the premise that the way in which an individual speaks (or chooses not to speak) about their experiences, relationships and others provides an insight into their perspectives and also the wider social world. In responding to, and attending to the different voices within the narrative, it also recognises the researcher's voice and the particularities of the individual's relationships with others; including their relationship with the researcher and the wider social context (Brown and Gilligan, 1991, Mauthner and Doucet, 2003, Bright et al., 2018b).

The 'Listening Guide' involves 4 sequential readings of the narrative to attend to the different voices, and their development (Brown and Gilligan, 1991, Bright et al., 2018b). It has been positioned within a number of theoretical perspectives, suggesting flexibility in its application across various methodological approaches (Bright et al., 2018b). In the first reading, the researcher attends to the plot outline within the narrative, the agents and individuals present, and their own response to the narrative (Gilligan and Eddy, 2017). The second reading concentrates on how the participant speaks about themselves, focusing the researcher's attention on the use of the pronoun 'I' within the narrative using 'I Poems'. This technique involves drawing out 'I' statements as they occur chronologically within the narrative, and arranging them into stanzas (Bright et al., 2018b). The guide can be used flexibly both methodologically and analytically, and different approaches to readings 3 and 4 are discussed within the literature (Bright et al., 2018b). Mauther and Doucet focused on relationships in their third reading, and the social context in their fourth (Mauthner and Doucet, 2003, Bright et al., 2018b). Brown and Gilligan instead refer to listening for contrapuntal

voices, where they attend to the musicality and quality of voices within their narratives, relating

these to the area of interest within the research (Brown and Gilligan, 1991, Gilligan and Eddy, 2017).

Table 2 (Forms of listening in the Listening Guide) presents these forms of listening:

Table 2: Forms of Listening in the Listening Guide

STAGE OF READING ('LISTENING')	AREA FOR RESEARCHER TO ATTEND TO	
1	The Plot: '*Who' is telling 'what' story?*	
2	Listening for the 'I': *I-poems*	
3	Relationships	Musicality and contrapuntal voices (Brown and Gilligan, 1991)
4	Structural and Cultural context	

Applying the Listening Guide to my narrative interviews

Mauther and Doucet's approach to the third and fourth reading was particularly appropriate in light

of my research interests in the socio-cultural context and the contribution of the supervisory

relationship (Mauthner and Doucet, 2003). Like Brown and Gilligan (1991), I also found that it was

helpful to listen for musicality and contrapuntal voices. These shed additional light on the stories the

participants were communicating, and on how they perceived themselves as an agent within these

stories.

Alongside the 'forms of listening' (outlined in **Table 2**, above), I was particularly interested in the

notion of positioning within the Figured World. Bamberg's levels of positioning (outlined in **Chapter**

3) offered a useful means to consider positioning in the Figured World, including a consideration of

positioning of the various characters to one another, the participant (as the narrator) to their audience, and the narrating of 'self' (with respect to the 'who am I'? question) (Bamberg, 1997, Bamberg and Georgakopoulou, 2008). I incorporated this consideration of positioning within each reading of the narrative.

Figured Worlds theory also involves a consideration of the agency, access and artefacts (Holland and Lachicotte, 2007). In addition to positioning, I contemplated on these aspects within stages 3 and 4 of listening.

A systematic and in-depth approach to the narratives heightened my awareness of my own emotions and responses. The identification of these helped me to explore and reflect upon my contribution as the researcher, and this was included within the analysis.

In the table below (**Table 3: Applying the Listening Guide to My Research**), I have outlined the listening process that I took within my own data, which is based upon the Listening Guide approach. The table been developed to summarise my approach to exploring positioning within the narratives: of the individual to themselves, to me (as the researcher), to others and to the wider social context.

Table 3: Applying the Listening Guide to My Research

STAGE OF READING ('LISTENING')	CONSIDERATIONS AT EACH STAGE OF READING
1 – The Plot	Focus on the broad story and themes What stories are told? Who is present? (Who is not present)? What is my response (as the researcher) Positioning: to me (as the researcher)
2- Listening for the 'I'	I-poems Draw out 'I' statements (short phrases containing 'I') as they occur chronologically within the transcript Arrange these into stanzas Positioning: to themselves
Additional step – Contrapuntal voices	Consideration of the tones and musicality of the narrator's voice Consideration of how these illuminate the broader story
3-Relationships	What are the key relationships within the narrative? How are these viewed? How is the individual influenced by these relationships? Positioning: to their supervisor and the wider training practice team How does this relate to access and agency?
4- Structural and Cultural context	What are the wider system 'voices'? How have these influenced the individual? Positioning and vantage point within the wider system How does this relate to agency, access and artefacts?

Looking across the narratives

I used the Listening Guide to analyse the narratives for each participant in isolation. **Appendix 11**

(Exemplar of Narrative Analysis Summary) provides an example of this for Seema's narrative, and

offers a worked example of my application of this approach.

I also wanted to be able to build a picture of the Figured World of GP training by looking across the

narratives. Using my modified listening guide as a framework, I used the same approach to 'listen'

across the narratives. A useful exercise was to map the particular stories told by the participants, as

identified in the first 'listening' of their narratives. This highlighted those areas where the participants had assigned particular meaning, and therefore opened up areas of perceived importance within the figured world. This enabled an exploration of the various perceptions of trainee identity, positions and vantage points within the Figured World.

Taking Mauther and Doucet's approach to their third and fourth readings, I then looked across the narratives to consider the broader messages around supervisory relationships and training practice relationships in the Figured World (Mauthner and Doucet, 2003). Major themes that were shared, or contradicted, were noted. Similarly, themes relating to messages from the wider professional context, trainee agency, access and artefacts were compared and contrasted.

Representing the narratives

The representation of the narratives posed a reflexive challenge, particularly in relation to textual reflexivity (Macbeth, 2001). Traditional representations of narratives have been criticised, where 'narrative logic works by erasing the ethnographer's presence from the picture…while making the ethnographer's absence felt' (Clough, 1998 p.5).

In an attempt to respond to the unstable and limited nature of interpretation in this context, I was keen to represent my own voice (as a recently qualified GP, and a researcher) within the results, in keeping with Wilkinson's concept of 'personal reflexivity' (Wilkinson, 1988, Wells, 2011d). Interwoven in the narratives of Seema and Stephen (within **Chapter 7**) I have commented in the first person and acknowledged areas of uncertainty or ambiguity where appropriate.

The themes arising from across the narratives are represented in line with Rogoff's three planes of analysis, discussed within **Chapter 4** (Rogoff, 1995). This encompassed a consideration of the trainee's development at the personal (identity) level, supervisory relationship, training practice and the wider influence of the structural and cultural context (Emerson and Frosh, 2004, Wells, 2011a).

Figured Worlds theory was of particular relevance at this final stage of my research, and the themes are discussed with respect to this theory within Chapter 9.

Ethical considerations

A tension exists in the pursuit of scientific discovery whilst protecting the welfare and rights of research participants, and research can constitute as a significant intrusion into their lives (Reinharz, 1983; DeRenzo, 2006). Engaging in ethical research therefore required full engagement with the ethics approval process at the University of Birmingham, but also required a respect of the principles of an ethical approach throughout my research practice; both in the field, and within the analysis (Macfarlane, 2010). The ethical approval documents are included within **Appendix 4** (**Application for ethical review, and request for amendments**). Through the emergent design of my research process, the latter stages of my original research design have not been implemented within the remit of this thesis, but are discussed in more detail within **Chapter 9** (**Discussion**).

Particular ethical considerations across the stages of research related to respect and beneficence for the research participants (Fisher and Anushko, 2008). Voluntary participation was invited for GP educators and GP trainees, appreciating the particular benefits and risks of the research to the participants, and attempting to minimise these risks. The participant information sheets and written consent forms are included within **Appendix 5** (**Participant Information Sheets**) and **Appendix 6** (**Participant Consent Forms**). Confidentiality and anonymity were addressed through the use of pseudonyms for the GP trainee participants. I offered to travel to each participant to minimise the intrusion of the research to their schedules, and interviews were scheduled to take place at convenient times, outside of preparation for high stakes examinations.

Participant anonymity was an important area of consideration, due to the relatively small numbers of trainees and supervisors in the region. The use of pseudonyms alone was unlikely to maintain

anonymity. In these cases, previous speciality training or countries of origin were changed, and participants were informed of the potential for this amendment.

In both the semi-structured and narrative interviews, the issue of consent to participate in a research conversation (in which the responses could not be predicted in advance, and in which sensitive content may arise), was potentially problematic (Mattingly, 2005). Prior to interview, participants were made aware of the option to withdraw before, during or after the interview. On 2 occasions, GP trainee participants became visibly upset during their narration, and their consent to the study was reviewed immediately in this instance. In both cases, an offer was made to pause or terminate the particular section of the interview, or the interview itself. This offer was declined by one participant. However, for the other participant, they requested that this area was not explored further and it was not included within the analysis.

Considering trustworthiness

Traditional views of validity in the context of socio-cultural research have been criticised, partly due to the inherent complexity in addressing pre-defined 'criteria' to answer the validity question when considering a research method in which co-construction and interpretation are integral (Smith, 1989). Hammersley re-conceptualises the concept of validity as 'trustworthiness'. Within this, he recognises that, although 'no point of absolute certainty can be reached', the reader must judge the claims of the research on the basis of the adequacy of the evidence offered, and the relevance of the findings to the particular community (Hammersley, 1992; Wells, 2011d).

Wells (2011) describes trustworthiness as the match between a study's evidence and its central claims, and develops Hammersley's framework to offer some particular areas for consideration. These are contemplated below, and discussed in the context of my research design (Wells, 2011d). The initial discussion within this section relates to the evaluation of the trustworthiness of the semi-

structured and narrative interview elements of the study. The methods chosen to evaluate the secondary data within the documentary analysis stage of the research (Stage 1) will be discussed in more detail within **Chapter 5**.

Conditions for production of the interviews

I aimed to create conditions where the participants felt a sense of safety, to disclose potentially sensitive information, and also to respond and interact with me (as the researcher) (Polkinghorne, 2007). I conveyed an openness and flexibility to arrange venues and locations in line with the participant's preference. This included meeting them on convenient times within their weekly schedule, and travelling to a number of locations (suggested by the participants), including quiet places at their weekly teaching venues, pre-booked rooms at the university, at my GP practice, quiet communal areas in hotels or at their home. On the whole, this appeared to lead to a sense of comfort and ease. However, there were a number of interruptions from staff during one GP participant's initial interview, and they would occasionally lower their voice, conveying a sense of unease. In this case, I suggested an alternative meeting place for the follow-up interview, away from the practice, to facilitate a greater sense of safety within the conversation. I found that the participant spoke more openly on this occasion.

Inclusion of narrative text

Within the thesis, I have not included the interview transcripts in their entirety, due to the risks to the anonymity of the participants. However, particularly in the narrative interviews, I wanted to ensure that there was sufficient inclusion of the exact words of the participants (Wells, 2011d). In Chapters 8 and 9, which outline the results of these interviews, I have presented large sections of the narrative accounts of two trainees (Seema and Stephen), to give adequate information for the reader. I have also included my subsequent analysis of Seema's interview (**Appendix 11, Exemplar of**

Narrative Analysis Summary), using the Brown and Gilligan's Listening Guide, to demonstrate transparency in the analytic process (Brown and Gilligan, 1991).

Claims and counter-claims

Within the research community, there is a lack of consensus regarding the utility of returning transcripts to participants, with cautions that narrators may be surprised or discouraged to find that their account may lack clarity, or have feelings of being 'objectified' (Wells, 2011d). The offer of 'member checking' through the return of transcripts was not taken up by either the GP supervisor or trainee participants.

The interviews with GP supervisors were undertaken at an early stage in my research, and the findings have been published in the literature (Jackson et al., 2018b). Each GP supervisor did express a preference to be informed of any publications related to their interviews, and each has been forwarded a full text copy of the peer-reviewed article. None have raised concerns or questions following its dissemination.

The role of the researcher in the representation of the narratives raises the question of 'who' owns the story (Estroff, 1995). As a modified means of member-checking, I presented a short summary of the original interview to each participant taking part in a follow-up interview. In these representations, I attempted to mirror the language of the narrator and the main stories that were told. This aimed to open a dialogue for participants to challenge or question the summary of the interview content. For the 6 participants involved in a follow-up interview, the summaries appeared to be generally accepted, without further comment.

Each GP trainee participant was also offered the opportunity to review the chosen pseudonym, and suggest an alternative if preferred. One GP trainee did suggest an alternative, which has been amended and used throughout.

Relevance

Relevance is frequently considered as a function of the collective judgement of the research community, and potentially difficult to determine even in the immediate phase after completion (Hammersley, 1992; Wells, 2011d). In an attempt to address this, I presented my findings from each phase of my research at national or regional conferences in medical education, to audiences of medical educators and GPs (Jackson, 2016; Jackson, 2017; Jackson et al., 2018a; Jackson et al., 2019, Jackson, 2019). On the whole, positive feedback was generally given regarding the relevance of this work. Challenges were offered from within these audiences in 2 respects. The first related to the discussion of 'failure to fail' within my interviews with GP supervisors, and highlighted a need to develop this within the discussion in **Chapter 6**. The second challenge related to a need for stronger communication of the implications of the research findings, and this discussion has been developed within **Chapter 9**.

Limitations in evaluating secondary data

Stage 1 of this research involved the evaluation of secondary data, in the form of postgraduate GP training documentation. Evaluation of the trustworthiness of this approach requires additional considerations, as the collection of the data (and information contained within the documents) lies outside the responsibility of this research design (Stewart and Kamins, 1993). Secondary data may be collected, or produced, with a specific purpose in mind. Such purposes may run contrary to my own research interests, or produce unintentional (or deliberate) bias (Reichmann, 1962). Furthermore, secondary data are also 'old data', and require interpretation in light of the particular time and context in which they were produced. As a result, scrutiny of secondary data should involve a consideration of its purpose, its authors, the time it was written, its consistency when compared to other sources and the audience (Stewart and Kamins, 1993). The steps taken to scrutinise and evaluate secondary sources of data are outlined in more detail earlier in this chapter.

A cut-off of February 2019 for the collection of documents was implemented to coincide with data

collection in the next stage of the research (interviews with GP trainees). However, it is likely that

the list of documents within this analysis is not exhaustive. The documents that were included

represent national standards and guidance for postgraduate GP training, with multiple iterations and

re-iterations between organisations and across time. It is therefore likely that this reflect many of

the predominant messages within postgraduate GP training.

The double hermeneutic of any documentary analysis exists within this review; that is to say that the

majority of the documents are interpretations by the authors, alongside my own interpretations as

the researcher. It is important to note that the authors of many of the documents represent

organisations and teams with significant knowledge and experience of GP training, and therefore are

likely to represent the opinions of each particular organisation.

Limitations in semi-structured interviews

At the time of Stage 2 of the study (semi-structured interviews with experienced educators), I was a

GP trainee within the West Midlands region. This may have influenced the participants' responses or

altered the subsequent analysis. As discussed earlier in this chapter, insider research can be

beneficial, and I drew on the perspectives of my supervisors (both non-GPs) to offer alternative

insights during the interview analysis (Merriam et al., 2001, Greene, 2014). The sample size is small.

The participants represented a modest population of experienced trainers in the region, sharing a

particular interest and experience in supporting trainees in difficulty, and in the additional role of

oversight of trainers. This cumulative experience of over 60 years, particularly in the area of 'trainees

in difficulty' provided an important voice, but also highlighted that additional voices and perspectives

were required to better understand the complexity within postgraduate GP supervision.

Limitations in narrative interviews

The aim of the narrative interviews was to provide a rich account of the complexities of supervision and its contribution to trainee development. Therefore, the approach to participant recruitment did not aim to provide generalisable findings, or to make claims about the representativeness of the trainees and the stories they told. However, recruitment of trainees from a number of training regions within the West Midlands aimed to provide narrative accounts that did not reflect a small geographical 'pocket' of nuanced supervisory experience or culture.

When considering a series of narratives, three interviews had been recommended within the literature, with the first interview used to build rapport and the life history of the participant, the second to focus on the concrete aspects of the narrative and the third to add clarification (Seidman, 1998). However, as a relatively recently qualified GP trainee (at the time of Stage 3 of the study), I was aware of potential difficulties with this approach. GP trainees may face considerable time pressure in the final year of training as a result of training requirements, and there was a risk that the research process may be perceived as a significant intrusion to their time. Due to the service-based element of GP training, identification of interview slots would require up to 6 weeks' notice, and were likely to come at a cost to the trainee's personal time for educational or clinical work. I chose to take a flexible approach to the scheduling of a third interview, and made allowance within my research schedule for this option. However, on reflection of the balance between the trainee's time, and the gathering of the narratives, I felt that sufficient understanding had developed from two interviews. From two interviews, I had the opportunity to develop the researcher-participant relationship and was able get to know the participant more as an individual (Seidman, 1998, Holloway and Jefferson, 2000). A second interview also provided a means to increase internal validity, as it was possible to check consistency across each interview (Seidman, 1998).

A number of the participants remembered stories or insights after the recording was stopped. Some of the participants asked that the tape was switched on again to add to the story. For others, they gave permission for me to make notes on this particular discussion.

I was aware of the interpretive and subjective nature of narrative interviews and analysis. Within the next section, I will discuss the way in which I addressed this with respect to reflexivity and the researcher position.

Reflexivity and researcher position

Reflexivity relates closely to the assessment of trustworthiness. Whilst a reflexive appreciation of the contribution of personal beliefs, experiences or values is an important component of this, the contribution of the researcher to the research process is often more complex (Parker, 2005). 'Self' (in this case, my own sense of 'self') can be viewed as a socially constructed notion. It therefore follows that personal confessions within the process of reflexivity are informed by "culture, locality, history, temporality and self-identity" (Parker, 2005 p.27). Wilkinson (1988) addresses this complexity by conceptualising reflexivity as 'disciplined self-reflection', within 3 levels. These include a 'personal reflexivity', where the researcher's own identity is recognised, and the relationship between the research and their life experiences, interests and values is considered. 'Functional reflexivity' considers the methodological approach to the research, and the particular biases or assumptions which may underpin it. 'Disciplinary reflexivity' looks more broadly to the way in which the discipline of interest (or sub-discipline) has formed and developed (Wilkinson, 1988; Lumsden, 2019).

Considering the introspective elements of reflexivity (personal reflexivity), a conscious reflection on the contribution of my perspective was required in each stage of the research process. The use of a reflexive diary facilitated personal reflection, and regular discussion of my findings with my

supervisors explored the possibility of alternative interpretations (Wells, 2011d). The involvement of a wider research team within the systematic review stage of the research, chosen based on their breadth of experience and perspective within postgraduate medical education, facilitated additional vantage points and interpretations on this secondary data.

When examining reflexivity in the context of the narrative interviews, I used the Listening Guide to analyse the data (Brown and Gilligan, 1991). This enabled an introspective and intersubjective consideration of the position that I had adopted vis-à-vis the narrator, their position in relation to me and the consequences for the interpretation of data (Wells, 2011d). Within collation and review of my field notes, I explored how the narrator and I responded emotionally, and my own potential for assumptions based on my reading or experience as an insider in the profession (Wells, 2011d).

The extent of empowerment of participants through their involvement in the research was also an important area to deliberate within the research design (Wells, 2011d). The desire to give voice to GP trainees foregrounded the choice of narratives as a research method, as it offered an interview approach where the participant could control the content of their narrated story. By aiming to understand the situated knowledge at the heart of relationship between a GP trainee and their supervisor, it was also important to recognise that this knowledge was situated in relationship between myself (the researcher) and that of the participant (Cohen et al., 2007 p.109). I began my research as a GP trainee, and have subsequently qualified as a GP during the course of the project. Both 'personal reflexivity' and 'disciplinary reflexivity' were particularly important to consider, in light of my role within the profession. Beginning the project as a GP trainee, it could be argued that I occupied an insider position within the field of postgraduate GP training, combining *a priori* knowledge of General Practice training, which could (and did) shape my research interests and perspective (Greene, 2014). Insider research can have many advantages, such as an intimate *a priori* knowledge of the historical and institutional context, access to the participants, and a potential

ability to produce research that more authentically reflects the culture under study (Merriam et al., 2001; Chavez, 2008; Greene, 2014). However, although the benefits of insider research offer sufficient access and insight for 'good observation', critics would suggest that adequate scientific distancing is also required, to remain aware of how one's own preconceptions may influence the process of understanding (Adler and Adler, 1987; Maykut and Morehouse, 1994).

Discussion of the findings with my supervisors invited an 'outsider' perspective, which facilitated an uncovering of tacit knowledge, which may have otherwise been lost or unreported due to overfamiliarity. Furthermore, depending on the particular stage of research or my own career trajectory at the time, the influence of my personal and professional experiences varied, and I found immense value in revisiting my results at various times to shed additional or alternative personal and disciplinary perspectives (LeCompte and Preissle, 1993; Naples, 1996).

Reflection on my position as a researcher also required a consideration of the access and position afforded to me by those I was interacting with (Flick, 1998). The concept of positioning was considered throughout the course of my research, including a consideration of how the participant was positioning themselves to me (as the researcher) within my analysis (Bamberg, 1997; Bamberg and Georgakopoulou, 2008). In considering how I would attempt to position myself (as the researcher), I was guided by the principles of respect and beneficence, aiming to avoid the misuse of power or position within the research interaction.

Presenting the research

Within Chapters 5-8, I will present the results from each stage of my research design.   Each stage of the research offers a focus at different levels of Rogoff's (1995) planes of analysis, although the mutuality of each plane is recognised throughout. **Chapter 5** outlines the results from an analysis of postgraduate GP training documentation (community plane), **Chapter 6** presents the results of semi-

structured interviews with experienced GP supervisors (interpersonal plane) and **Chapters 7 and 8**

discuss the results from narrative interviews with GP trainees (personal plane).

Chapter 5: Exploring the messages from the wider profession through documentary analysis

Table 4 (**Documents identified for analysis**) presents the 60 documents which were included in the

analysis:

Table 4: Documents identified for analysis

Source of documents	Number of documents	Documents	Document ID
General Medical Council (GMC)	11	**GMC**, 2010b. Standards for curricula and assessment systems. Manchester: General Medical Council.	46
		GMC, 2011. The Trainee Doctor. London: General Medical Council.	47
		GMC, 2013**. Good Medical Practice. London: General Medical Council.**	48
		GMC, 2013b. Role of the Trainer; Promoting, supporting and enabling training excellence	41
		GMC, 2015. Promoting excellence: standards for medical education and training	18
		GMC, 2016a. Our Role	49
		GMC, 2016b. Recognition and Approval of Trainers	50
		NACT UK, 2013. Faculty Guide;The Workplace Learning Environment in Postgraduate Medical Training General Medical Council	40
		GMC, 2010. Workplace Based Assessment: A guide for Implementation	54
		GMC, 2017**. Excellence by Design: Standards for Postgraduate Curricula**	55
		GMC, 2019**.** How we Quality Assure	64
AoMRC **(via GMC website)**	1	**ACADEMY OF MEDICAL ROYAL COLLEGES,** 2014. Requirements for Colleges and Faculties in relation to Examiners and Assessors	30
AoMRC **(via their website)**	3	**ACADEMY OF MEDICAL ROYAL COLLEGES,** 2016. Guidance for Entering Information onto E-Portfolios	59
		ACADEMY OF MEDICAL ROYAL COLLEGES, 2016. Improving assessment: Further Guidance and Recommendations	68
		MacLeod, S. 2016**.** RE: Position Statement on Trainees' Written Reflections	61

COGPED	2	DEANERY ASSESSMENT REFERENCE GROUP (COGPED), 2016. GP Specialty Trainee (GPST) ePortfolio: Guidance for Satisfactory Progression at ARCP Panels. COGPED.	23
(Deanery Assessment Reference Group)		DEANERY ASSESSMENT REFERENCE GROUP (COGPED), 2018. GP Specialty Trainee (GPST) ePortfolio: Guidance for Satisfactory Progression at ARCP Panels. COGPED.	62
RCGP website: trainer information	10	RCGP & COGPED, 2014. Standards for GP Speciality Training: guidance for deaneries.	24
		RCGP, 2008. Understanding the RCGP Curriculum :An explanatory note for GP trainers	31
		RCGP, 2013. Educational Supervisor's Review – A step-by-step guide	22
		RCGP, 2014b. The e Portfolio for GP Specialty Training A Guide for Trainers/Clinical supervisors plus additional functionality for educational supervisors	28
		RCGP, 2015a. Annual Specialty Report to the GMC	26
		RCGP, 2015c. RCGP Workplace based assessment (WPBA) Core Group Position Statement on learning log entries and validation of log entries in GP Specialty training (GPST) WPBA portfolios	21
		RCGP, 2015d. RCGP WPBA Core Group Statement to Deaneries	29
		RCGP, Date Unknown. Quality management of GP training	25
		RCGP, 2014b. Joint RCGP and COGPED Guidance on CSA preparation	4
		RCGP, 2015b. Eligibility for MRCGP examinations number of attempts permitted and consideration of mitigating circumstances	3
RCGP website/E-portfolio:	10	RCGP, 2016a. The E-Portfolio for GP Speciality Training (Including WPBA Guidance). A Guide for Trainees	7
		RCGP, 2016b. The RCGP Curriculum: Core Curriculum Statement. Being a GP	5

trainee information **RCGP website/E-portfolio:** trainee information (continued)		RCGP, 2016c. The RCGP Curriculum: Professional & Clinical Modules. 2.01–3.21 Curriculum Modules	6
		RCGP, date unknown-a. Educational Agreement and Probity Declaration	2
		RCGP, date unknown-b. MRCGP Workplace Based Assessment (WPBA)	8
		RCGP, date unknown-c. Trainee Self-Rating form, Educational Supervisors Review	1
		RCGP, date unknown – d. WPBA competencies-MRCGP WPBA competency framework	42
		RCGP, 2017**. Report on AKT Questionnaire**	56
		Williams, N., 2017**. Report on CSA Questionnaire**	57
		RCGP, 2016**.** Exceptional fifth attempts at the MRCGP Applied Knowledge Test (AKT) and Clinical Skills Assessment (CSA)	58
Health Education England, West	18	**ACADEMY OF MEDICAL EDUCATORS.** 2014. Professional Standards for medical, dental and veterinary educators. *3rd Edition*	9
		BMA & COGPED , 2012. Guide to a session for GP trainees and trainers	17
		COMMITTEE OF GENERAL PRACTICE EDUCATION DIRECTORS, 2014. Educator and Environment Approval Form	11
		COPMED, 2016. A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide). 6th Edition	16
		COPMED, 2018. A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide). 7th Edition	63
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, 2015. Educator Appraisal Guidance	12
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-a. European Working Time Directive: Guide for GP Trainers	14

Midlands website: **Information for trainers and trainees**		**HEALTH EDUCATION ENGLAND WEST MIDLANDS**, date unknown-b. The Working Week for GP Registrars in General Practice	20
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-c. The Working Week for GP Registrars in General Practice (updated)	67
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-d. The Role of the GP Trainer	66
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-e. Escalating Concerns	70
		HIBBLE, A, 2009. Being a Reflective GP. Health Education East of England	10
		PALMER, D, 2012. Guide for Educational Supervisors - Evolution of the E-Portfolio and the GP Speciality Trainee	13
Health Education England, West Midlands website: **Information for trainers and trainees (continued)**		**PALMER, D,** 2014. Friendly Guide to the E-Portfolio and MRCGP	15
		PALMER, D, 2018. Friendly Guide to the E-Portfolio and MRCGP	65
		PALMER, D, 2017. ARCP Checklist for GP Trainees	51
		GOODYEAR, H, 2017. Top Ten Examination Tips	52
		GOODYEAR, H, 2017**. Guidance on Examination Support for GP Trainees**	53
Local 'Training the Trainers' **Learning and course objectives, lesson plan.** **Teaching content not released.**	5	**GIBSON, C, LOVATT, T,** 2015a. Intended Learning Outcomes – Day 1 TtT.	32
		GIBSON, C, LOVATT, T, 2015b. Intended Learning Outcomes – Day 2 TtT.	33
		GIBSON, C, LOVATT, T, 2015c. Intended Learning Outcomes – TtT update course.	34
		GIBSON, C, LOVATT, T, 2015d. Keele University School of Medicine. Teach the Teachers course – Mapping Exercise.	35
		GIBSON, C, LOVATT, T, 2015e. Lesson Plan: Training the Trainers.	36

Thematic analysis results

From the 60 included documents, 224 codes were identified on initial analysis, and were subsequently reviewed, modified and grouped into 27 sub-themes.

These 27 sub-themes were later reviewed, and grouped into eight themes relating to the explicit expectations of the wider profession:

1. Functions of the supervisor
2. Functions and expected attributes of the trainee
3. Functions of the local training environment (training practice)
4. Hierarchy
5. Political influences
6. Quality Assurance
7. Drive for evidence
8. Dynamic supervision

The results conclude by considering the implicit expectations from the wider profession: 'Hierarchy' and 'Collation of evidence'

Themes 1-3: Functions of the supervisor, trainee and training practice:

It became apparent early in the documentary analysis that particular expectations and standards were evident at various institutional levels for the trainee, their supervisor and the training practice. The Royal College of General Practitioners and Health Education England West Midlands websites grouped their resources and guidance as relevant for 'trainees' and for 'trainers' (or supervisors). Although training practices were not afforded the same grouping on these websites, the role of the training practice was referred to across many of the documents, and there was significant overlap within the documents between the roles and interactions of trainee, supervisor and practice. Due to this overlap, the themes relating to the expected functions of the supervisor, trainee and training practice have been considered together. **Tables 5, 6 and 7 (Table 5: Supervisor Functions, Table 6: Trainee Functions and Table 7: Training Practice Functions)** provide a summary of the sub-themes

related to these functions. These tables have been constructed based on the relative frequencies of

occurrence of each sub-theme (within and between sources), with the most frequent listed at the

top.

Table 5: Supervisor Functions

Sub-theme	Illustrative Quote from Text
FUNCTIONS OF THE SUPERVISOR	
Assessor	*"The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements"* (General Medical Council, 2015)
Educational support	*"The trainer: Reviews and monitors educational progress though regular timetabled meetings with the trainee; sets educational objectives and modifies educational interventions in response"* (Royal College of General Practitioners and COGPED, 2014)
Gatekeeper	*"It is also essential, for the sake of patient safety and to support the trainee where required, that information regarding any completed disciplinary or competence issue (and a written, factual statement about these) is transferred to the next employer"* (COPMeD, 2016)
Personal and pastoral support	*"Trainers to demonstrate evidence: "Guiding personal and professional development…* *This section is about how you support trainees in their personal and professional development"* (Committee of General Practice Education Directors, 2014)
Protector	*"Standard: Ensures that trainees receive the necessary instruction and protection in situations that might expose them to risk"* (Committee of General Practice Education Directors, 2014)
Role Model	*"Standard: A supervisor* *provides a positive role model, through demonstration of exemplary clinical skills, professional behaviours and relationships"* (Committee of General Practice Education Directors, 2014)
Roles outside of supervisory relationship	*"In line with the GMC's standards, educational supervisors should be specifically trained for their role. All named trainers (named clinical supervisors and named educational supervisors) must meet the GMC criteria for recognition or approval (paragraph 4.17) and the Postgraduate Dean must ensure quality management of such arrangements to meet the GMC framework"* (COPMeD, 2016)
Broker with community of practice	*"Standard: Trainees must have the opportunity to learn with, and from, other healthcare professionals. (standard 6.17)* (Committee of General Practice Education Directors, 2014)

Table 6: Trainee Functions

Sub-theme	Illustrative quote from text
FUNCTIONS OF THE TRAINEE	
Adult learner	*"You are a self-directed adult learner and self-directed study is an important part of your development as a GP. Examples of this are reading around a topic, reflecting on your experiences, searching for evidence, or preparing for an assessment or teaching session"* (Royal College of General Practitioners, 2016b)
Workplace learner	*Regarding workplace learning: "Important experiences that might be lost in the 'white heat' of a week full of clinical demands and other pressures, can be recognised and captured, then used as springboards for further learning"* (Palmer, 2014)
Part of community of practice	*"During your training for general practice you should gain experience of working in a collaborative way with other professionals in the team. You should also participate in the practice's educational programme, audit and critical event meetings"* (Royal College of General Practitioners, 2016b)
Trainee is regulated	*"On occasion, the performance of a doctor may be poor enough to warrant referral to the GMC's fitness to practise process. Trainees, in common with all doctors, may be subject to fitness to practise investigation and adjudication by the GMC. Significant fitness to practise concerns might include serious misconduct, health concerns or sustained poor performance, all of which may threaten patient safety"* (COPMeD, 2016)
Reflector	*"A key element of professional behaviour requires you to reflect actively on your experiences and incorporate your learning into your daily work with your patients"* (Royal College of General Practitioners, 2016b)
Engaged	*Trainee should: "agree to engage in the training and assessment process (e.g. participate in setting educational objectives; participate in appraisal; attend training sessions; ensure that documentation required for the assessment process, revalidation and maintenance of the GMC licence to practise is submitted on time and in the appropriate format)"* (COPMeD, 2016)
Insight	*"The development of professional expertise throughout training is underpinned by your ability to understand yourself and to relate successfully to other people. This capability builds throughout the training programme and develops in sophistication and in breadth over time"* (Royal College of General Practitioners, 2016b)

Table 7: Training Practice Functions

Sub-theme	Illustrative quote from text
THE LOCAL TRAINING ENVIRONMENT (PRACTICE)	
Community of practice	*"training placements must be of sufficient length both to enable trainees to become members of the clinical team and to enable team members to make reliable judgments about the trainee's abilities, performance and progress"* (Royal College of General Practitioners and COGPED, 2014)
Legitimate participation (of trainee)	*"These relationships will be embedded in active, professional practice where your experiences will not only allow the acquisition of skills but, by participation in professional practice, will enable you to acquire the language, behaviours and philosophy of the profession"* (Royal College of General Practitioners, 2016b)
Organisational responsibilities	*"Standard: Working patterns and intensity of work by day and night must be appropriate for learning (neither too light nor too heavy), in accordance with the approved curriculum, add educational value and be appropriately supervised. The working week timetable should also comply with the EWTD"* (Committee of General Practice Education Directors, 2014)

The documents were clear about the importance of the supervisory relationship, describing it as a 'key relationship' in postgraduate training in General Practice (Royal College of General Practitioners, 2016b). This is, in part, related to the oversight function of the educational supervisor, in which they

"ensure continuity of supervision and effective educational handover between supervisors in differing educational environments"

(Committee of General Practice Education Directors, 2014).

The most commonly reported function of the supervisor was that of 'assessor', followed by 'educational support'. Roles such as 'gatekeeper' and 'pastoral support' were also highlighted, and the potential for tension within these roles is discussed later within the Results section. Supervisors were encouraged to support the trainee to participate within the community of practice (acting as a 'broker'), and to act as a role model. There was also an acknowledgement of their roles outside of the supervisory relationship, particularly with respect to duties as an approved trainer within the

local training region, their accountability to the GMC, and also their roles as a clinician and member of the practice team.

Table 6 (Trainee Functions) outlines the expectations of the trainee with respect to their professional development. This included expectations that they would be a workplace learner and member of the community of practice. 'Adult learner' was firmly in the foreground. Within this, the trainee was expected to be a reflector (with sufficient insight into their performance), seeing the workplace as an opportunity for learning, and actively engaging in these opportunities. There was also an expectation of commitment to life-long learning, with a long-term perspective in their approach to education and learning.

Although less explicit within the documents, the recommended trainee functions appeared to advocate a personalised and tailored approach to learning, frequently leaving space for negotiation between trainee and supervisor, based on their learning needs. For example, a 'typical' working week for the GP trainee was outlined, but appeared deliberately non-prescriptive (Health Education England West Midlands, date unknown-d; Health Education England West Midlands, date unknown-c).

"The balance between working arrangements and educational activities will need to have some flexibility based around the individual training needs of GP trainees. It may be desirable for some individuals to have additional clinics for educational purposes".

(BMA and COGPED, 2012)

A number of sources suggested that the trainee was responsible for driving the educational process, with an emphasis on self-directed learning:

[The trainee should] "Make the educational supervisor's job easier by clearly explaining how any learning needs have been met and highlighting which curriculum areas and professional competencies have been demonstrated"

(Palmer, 2014).

However, 13 references across 5 sources place significant emphasis on the supervisor's role to assist this, by planning the educational programme and provide sufficient learning opportunities for the trainee:

[The supervisor should] "Reviews and monitors educational progress though regular timetabled meetings with the trainee; sets educational objectives and modifies educational interventions in response"

(Royal College of General Practitioners and COGPED, 2014).

An alternative perspective on this particular issue could be viewed as a negotiation between trainee and supervisor, within the context of the supervisory relationship:

For example:

"Educational and training opportunities will be tailored to address individual learning needs and on occasion, for educational purposes, it may be desirable for some of your nominally 'educational' hours to be used instead, for patient contact. This should be agreed with your educational (or clinical) supervisor, as appropriate".

(Health Education England West Midlands, date unknown-d)

Beyond the supervisor, and eventual accreditation by the Royal College of General Practitioners, the trainee is regulated by the General Medical Council (GMC). Accountable to public scrutiny, the role of the GMC is to ensure that doctors are safe to practise medicine and deliver safe patient care. It

appeared that the processes required to qualify as a GP with the Royal College of General

Practitioners were not sufficient for regulation with the GMC. Thus, 19 references across 10 sources

highlight the additional expectations of the GMC for the GP trainee, and these observations formed

the sub-theme 'trainee is regulated'. Regulation in this context refers to an expectation that a GP

trainee will meet GMC requirements for registration and licensing, which are distinct from the

standards outlined for accreditation with the RCGP. Whilst there is arguably a significant overlap

between these organisations, the primary function of the GMC is to promote and protect the health

and safety of patients (GMC, 2015).

Table 7 (Training Practice Functions) relates to the contribution of the training practice to

supervision. It was evident from the documents that the supervisory relationship existed within the

community of practice, and we can see a number of expectations for the practice, particularly the

responsibility to facilitate the trainee's legitimate participation. This included the timetabling of a

formal induction programme for the new trainee, and subsequent timetabling of their working week.

This was expected to be in adherence to the European Working Time Directive (EWTD), and with

adequate scheduling of supervision (BMA and COGPED, 2012). Secondly, the practice was expected

to ensure that the intensity of work provided sufficient 'educational value' for the trainee, within the

boundaries of EWTD (Committee of General Practice Education Directors, 2014). Furthermore,

through the structure of the working week, the trainee was expected to be provided with the

opportunity to learn with, and from, the multidisciplinary team.

Legitimate participation in the community of practice was referred to 11 times across 4 sources when

considering the training environment, and it appeared that the practice, trainee and supervisor have

a role to play. The practice was expected to provide the opportunities and staff members for

participation to take place, whilst the trainee was encouraged to actively engage with these

opportunities in a move towards becoming encultured within the practice. In this, the role of the

supervisor was to broker the trainee's interaction with the practice team, supporting them to move to greater levels of participation (Royal College of General Practitioners, 2016b).

Theme 4: Hierarchy

Outside of the practice environment, three main sources of institutional influence appeared evident. These included the local deanery (or regional training body), the Royal College of General Practitioners (RCGP) and the General Medical Council (GMC).

This structure is seen most clearly within **Figure 6: Mapping of Documents**. This figure has been included within this section, to illustrate the way in which the documents were mapped to one another across various training levels, and across time. These have been labelled (in the left column) 'statutes and standards', 'guidance', guidance made easy', 'RCGP responses' and 'deanery guidance'. It is included as a larger figure within **Appendix 9** (**Mapping of Documents**). The colour-coding of the boxes gives an indication of the audience for each document:

Figure 6: Mapping of Documents

KEY:

Colour of box	Type of document
White	Documents written mainly for RCGP and other Royal Colleges within medical education
Yellow	Documents written mainly for Health Education England, and regional training bodies
Blue	Documents written mainly for Educational supervisors
Pink	Documents written mainly for GP trainees
Orange	Guidance written in response to political events
Grey	Contractual documents

The mapping process was a useful means to visualise the relationships been the organisations within postgraduate GP training, the audience for the documents and the way in which various documents had informed the design of others. It was evident that the GMC sets the standards for postgraduate training, which subsequently inform the RCGP curriculum and assessment design. The local training region (or deanery) is then responsible for the delivery of quality training programmes, and the quality of training (of both the deanery and RCGP) is later monitored by the GMC.

Routes for monitoring, escalation and navigation of these structural bodies were outlined frequently within the training documentation, and **Figure 9: Routes for Escalation, Monitoring and Navigation** (below) illustrates some of these pathways.

Figure 7: Routes for Escalation, Monitoring and Navigation

Hierarchy: delivery of supervision	Academy of Medical Educators and GMC set standards ↓ RCGP guidance must be in line with these ↓ Deanery must deliver quality training in line with RCGP and GMC standards ↓ Trainer and Practice quality: responsibility of Deanery ↓ Trainer ↓ Trainee	"Structured postgraduate medical training is dependent on having curricula that are mapped to the GMC's Good Medical Practice and that clearly set out the competences of practice, an assessment framework to know whether those competences have been achieved and an infrastructure that supports a training environment in the context of service delivery" (COPMeD, 2016) "Further to this AoME has devised a framework along 7 key competences that describe elements of training… These competences are already used as the basis for 'Training the Trainers' courses in the West Midlands and it is a requirement of the GMC to address each of these seven competences in the annual appraisal" (Health Education England West Midlands, 2015) "The trainee's educational supervisor must ensure that the trainee is aware of and understands the trainee's obligations as laid down in the educational agreement" (COPMeD, 2016)
Hierarchy in escalation: trainee routes to report concern about trainer	Discuss with trainer Letter to ARCP panel Postgraduate Dean	"On occasion, a trainee might make or be involved in a critical or serious, isolated medical error. Such situations may lead to a formal investigation and are stressful for all staff involved. The Postgraduate Dean must be kept informed in writing at each stage of any such investigation and should ensure that pastoral support is offered to the trainee throughout the process" (COPMeD, 2016)
Hierarchy in escalation: support for the 'trainee in difficulty'	Trainer ↓ Local Training Programme Director ↓ Area Director (Deanery) ↓ Medical Director (GP training) ↓ Postgraduate Dean	"An action plan to address the concerns should be agreed and documented between the educational supervisor and trainee. If concerns persist or increase, further action should be taken and this should not be left to the ARCP process. Direct contact should be considered with the TPD, the lead for professional support, trainee support groups (if appropriate), the employer and the Director of Medical Education for the LEP, alerting them to these concerns. As Responsible Officer (RO), the Postgraduate Dean will need any information that may affect future revalidation" (Royal College of General Practitioners and COGPED, 2014)

As outlined within **Figure 7**, these hierarchical pathways appeared to relate to the following areas within supervision:

- The standards for delivery of supervision

  - Many of the GMC standards for supervision informed RCGP guidance, which then (often alongside GMC guidance) informed local training region guidance.

- Monitoring of the quality of training and supervision (discussed in more detail within the 'Quality assurance' theme)

  - Both the trainee and their supervisor were described as accountable to various organisations such as the RCGP, and ultimately the GMC.

- Escalating concerns: routes for supervisors to raise concerns about trainees in difficulty

  - Hierarchical 'pathways' were described for supervisors to escalate concerns about trainees in difficulty. Whilst much of this structure appeared to exist to provide educational support to the trainee in difficulty, a number of the documents emphasised patient safety as paramount. Supervisors and local education teams were mandated to share information about poorly performing trainees when moving from one employer to the next. Concerns related to patient safety were advised to ultimately be reported to the GMC through an annual self-declaration as part of regulation.

"where it is in the interests of patient or trainee safety, the trainee must be informed that the relevant element of the educational review discussion will be raised through appropriate clinical governance/risk management reporting systems. This will usually be with the Director/Lead of medical education in the local education provider (LEP) and the Postgraduate Dean/Responsible Officer (RO) (and employer where this is not the LEP). Trainees also need to be aware that any such discussions should be reported as part of the required self-declaration for revalidation"

(COPMeD, 2016).

- Escalating concerns : if the trainee has concerns about their supervisor

  - For a trainee facing concerns about their supervisor or the supervisory relationship, the guidance was more fragmented. A review of 4 separate documents was required to put together a pathway by which to raise concerns about a supervisor (General Medical Council, 2015, COPMeD, 2016, Health Education England West Midlands, date unknown-b, Health Education England West Midlands, date unknown-a). Furthermore, after the first step of initial discussion with the supervisor in question, reporting a concern appeared to require escalation to the Postgraduate Dean. There did not appear to be a more local, accessible step available to the trainee. This was in contrast to explicit local routes of support for a trainer with concerns about a trainee; such as referral to training support groups, or the local training programme director (COPMeD, 2016). One document, entitled 'Escalating Concerns' was available to trainees on the Deanery (HEE WM) website for this purpose. However, it was not easily accessible (and not stored within the General Practice resource pages), was a generic document for all postgraduate specialty trainees, and included roles and terminology which were not explained or actually available to GP trainees (such as 'Speak-Up Guardian'). A single generic email address (to the 'quality team') was offered for raising concerns, although it was unclear who within the team would pick emails up, or the timescales for responding.

Changes in language and tone between documents

In general, standards from the GMC were more frequently written in a formal style, outlining mandatory expectations for training. In more recent years, a shift in GMC guidance appeared to suggest greater flexibility for those colleges, deaneries and supervisors responsible for implementation. For example, the 2017 'Excellence by Design' document outlines GMC (mandatory) standards across all postgraduate medical specialities, whilst allowing colleges and local training

regions to have degree of flexibility in how they translate these into specialty-specific guidance that

can respond to the changing needs of the workforce and population:

"There must be sufficient flexibility to enable organisations to manage training locally, to better

reflect their educational and service capacity and capability, provided curricular outcomes are met"

<div align="right">(General Medical Council, 2017)</div>

Documents containing more details, relating to the implementation of these standards, were evident

at RCGP and Deanery levels.

For example, the following excerpt is taken from RCGP trainee guidance, and outlines the detailed

requirements for supervisor reviews and mandatory evidence (in the form of a Multi-Source

Feedback, or MSF assessment):

"You will need a review every 6 months. You will also need a review to mark the end of an ST year.

This may cover a period less than 6 months. If so, please consult your Deanery as to what evidence

they may require.

You will need to complete 2 rounds of MSF in ST1 and ST3. The MSF should be conducted once in the

first half of the ST year and once in the second round of the ST year"

<div align="right">(Royal College of General Practitioners, 2016a)</div>

However, there were examples where organisations further down the hierarchy attempted to

'translate' the formal language of statutes and standards into more user-friendly and accessible

documents. This was most frequently seen at local training region level, where documents were

frequently written in a chatty, peer-like style, favoured the word 'should' (Palmer, 2014). Within the

RCGP documentation, a number of formal 'standards' had been issued, with subsequent publication

of a less formal, 'user-friendly' translation, usually marketed at trainees or trainers. (Royal College

of General Practitioners, 2013, Royal College of General Practitioners, 2014b, Royal College of

General Practitioners, 2016a).

There were also examples where the organisational standards and statutes appeared to be

deliberately open to interpretation by trainee and trainer, providing opportunity for influence within

the supervisory relationship. This flexibility appeared present to some extent within RCGP guidance.

For example, on the number of learning logs required for successful outcome at Annual Review of

Competency Progression (ARCP):

'There is no minimum number of learning log entries required for completion of training'.

(Royal College of General Practitioners, 2016a)

However, in a later 'translation' of this document by local training region Health Education England

(HEE, West Midlands), explicit standards were introduced, removing this option of interpretation:

"IMPORTANT

It is expected that there will be roughly 2 entries a week documented on learning log, one of which is

likely to be a clinical encounter. It would be sensible to have roughly 50 log entries over each 6

months review period. Less than this may mean that there is a lack of evidence of competence and

insufficient curriculum coverage by the Annual Review at the end of the training year"

(Palmer, 2014)

Theme 5: Political Influences

A number of documents appeared to be released in response to, and in line with, particular political

events or policy. For example, the European Working Time Directive (EWTD), which came into effect

in August 2009, prompted the writing of a series of documents outlining the typical working week for

a GP trainee, in accordance with EWTD law (BMA and COGPED, 2012, Health Education England West

Midlands, date unknown-b). These have since been updated to reflect the more recent changes

working hours since the incorporation of the Junior Doctors Contract (Health Education England

West Midlands, date unknown-d). A number of high court rulings also appeared to have influenced

the production of institutional guidance and documentation. For example, following a high court

ruling to address the differential pass rates between international and UK graduates in the RCGP's

Clinical assessment exam, a number of documents seemed to be written to provide greater clarity on

exam preparation, and also presented survey data on exam satisfaction in candidates (BAPIO Action

LTD v Royal College of General Practitioners [2014], Kaffash, 2014, Royal College of General

Practitioners, 2014c, Williams, 2017). In a recent political case involving junior doctor Hadiza Bawa-

Garba, there was concern amongst postgraduate trainees that her written reflective logs may have

been used as evidence to strike her from the medical register (Kaffash and Gregory, 2018). Health

Education England and the Academy of Medical Royal Colleges issued a number of documents in

direct response to these concerns, mandating trainees to continue to undertake written reflective

entries (Academy of Medical Royal Colleges, 2016; MacLeod, 2016).

Theme 6: Quality assurance

The GMC's role in monitoring the delivery of postgraduate training nationwide was also described,

alongside their aim to provide quality assurance within postgraduate training (General Medical

Council, 2016). This thread ran through a number of documents at all levels, and quality assurance

represents a dedicated section with the General Medical Council website (General Medical Council,

2019a). The theme of ensuring quality within postgraduate GP training appeared to be mandatory at

all levels: involving setting standards, and regulation and monitoring of the trainee, supervisor,

deanery and RCGP. This is outlined within **Table 8: Quality Assurance at Multiple Institutional**

Levels. This was a noteworthy finding, as it outlines the emphasis of the GMC to regulate the quality

of education provided by their supervisor, the training practice and the regional training body.

Demonstration of this quality by supervisors (to the GMC and regional training body) appears to

require a breadth of evidence, and emphasises the responsibility of the supervisor to the regulator

(the GMC) and to the trainee.

Table 8: Quality Assurance at Multiple Institutional Levels

Theme	Sub-theme	Illustrative quote from text
Quality assurance- GMC role	Sets standards Monitors standards	"The GMC quality assures medical education and training. There are four core elements to this: 1. Approval against standards of training programmes, curricula and new institutions… 2. Gathering evidence … 3. Visits and checks … 4. Enhanced monitoring… " (COPMeD, 2016)
Quality assurance- Monitoring of the Deanery	Quality management of speciality training Adequate training of trainers Publically available data on deanery performance in annual GMC trainee survey	"In line with the GMC's standards, educational supervisors should be specifically trained for their role. All named trainers (named clinical supervisors and named educational supervisors) must meet the GMC criteria for recognition or approval (paragraph 4.17) and the Postgraduate Dean must ensure quality management of such arrangements to meet the GMC framework" (COPMeD, 2016)
Quality assurance- Regulation of the supervisor	Annual GMC Trainee survey (reports on trainee satisfaction with supervisor) GMC approval and recognition of supervisor – including keeping up to date, peer review, demonstration of evidence	We use the Academy of Medical Educators' Professional standards for medical, dental and veterinary educators (2014) as the criteria against which all trainers in recognised roles must provide evidence of their ongoing professional development. (Academy Of Medical Educators, 2014; General Medical Council, 2019a; General Medical Council, 2019b)
Quality assurance- Regulation of the trainee	Transparent and open sharing of trainee information (if concerns about trainee and patient safety)	"It may be necessary for the TPD to provide an additional report, for example detailing events that led to a negative assessment by the trainee's educational supervisor. It is essential that the trainee has been made aware of this and has seen the report prior to its submission to the panel. This is to ensure the trainee is aware of what had been reported; it is not intended that the trainee should agree the report's content" (COPMeD, 2016)

Theme 7: Drive for evidence

The drive for evidence of quality training and supervision was a stark theme throughout, and there was a clear drive for collation of evidence relating to trainee progress, quality of supervision and quality of training of supervisors. **Table 9: Drive for Evidence** (below) suggests that much of this evidence appeared to be collated within the trainee's E-portfolio. This was used as a platform for assessment of their progress, but also to monitor the quality of supervision and training. Documentation, within the E-portfolio, included evidence of formal reviews between trainee and supervisor, assessment of trainee performance and evidence of significant and adverse events involving the trainee (Academy of Medical Royal Colleges, 2016; COPMeD, 2016; COPMeD, 2018). The E-Portfolio is also expected to be used as a platform for communication between the supervisor and trainee (in the form of educators' notes) (Palmer, 2017, Royal College of General Practitioners, 2016a). Evidence written within the E-Portfolio (including educator's notes) appeared to then be available for use by deaneries (for educational support), the RCGP (towards the trainee's eventual award of Member of the RCGP) and the GMC (for trainee regulation). Additional 'evidence' relating to the quality of supervision appeared to be collected by the GMC in the form of data from trainees in their annual National Trainee Survey (General Medical Council, 2019a). Further evidence on both the supervisor's and training practice's eligibility to provide training was collated at deanery level (Committee of General Practice Education Directors, 2014, Health Education England West Midlands, 2015).

Table 9: Drive for Evidence

Theme	Sub-theme	Illustrative quote from text
Drive for evidence	E-portfolio key evidence platform Used to monitor quality of supervision Used to monitor trainee progress	*"The E-portfolio provides evidence that a trainee is good enough to be signed up and qualify as a GP. It also importantly provides evidence of poor performance, identifying areas where additional work is required or for failing trainees to provide evidence to allow them to leave GP training and look at alternative career paths"* (Palmer, 2014) *"The quality of the clinical and educational supervisors report is used by the RCGP Quality Management and Training Standards Committee (QMTS) as a surrogate marker for the quality of the supervision process, assessed against published criteria"* (Royal College of General Practitioners, 2015b)
Drive for evidence	Documentation of supervisors' continuing professional development	*"Educational & named GP clinical supervisors; please provide evidence of the feedback of the most recent peer review of your teaching skills, the date this took place, and your personal reflections after peer review"* (Committee of General Practice Education Directors, 2014)
Drive for evidence	Documentation of training practice's assessment	*"Standard: Every trainee in the organisation must have an induction to ensure they understand their duties and reporting arrangements; their role in the inter-professional and inter-disciplinary team; workplace and departmental policies and to meet key staff. (standard 6.1)* (Committee of General Practice Education Directors, 2014)
Drive for evidence	Annual National Trainee Survey (in earlier documents appeared 'optional', but later mandatory as part of training)	*"Each year we ask doctors in training for their views on the training they receive. We also ask their trainers about the support they get in their role. Together, these results help us improve training programmes and posts across the UK""* GMC, 2019(General Medical Council, 2019a) *"Have you completed GMC and JEST Surveys? It is a HEE expectation that trainees should participate in giving feedback on their attachments"* (Palmer, 2017)
Drive for evidence	Investigation of trainees related to risk of serious patient harm (evidence released to Third Parties).	*"The Data Protection Act regulates the processing of personal and sensitive data of a living individual. Under the Act there may be certain circumstances where colleges are asked to disclose information to a third party without the consent of the data subject".* (Academy of Medical Royal Colleges, 2016)

On the whole, it appeared that the 'evidence' was used for a number of things.

- GMC monitoring of the quality of training

  - This related to the monitoring and quality assurance role of the GMC.

  - Insufficient evidence, or evidence suggesting poor quality training at either supervisor or deanery level, could trigger a GMC visit for further assessment.

- Monitoring of trainee progression towards Membership of the Royal College of General Practitioners (MRCGP)

  - For the trainee, the consequences of insufficient evidence were variable. Insufficient evidence of progression within their training could lead to a failure at Annual Review of Competency Progression (ARCP), which may lead to an extension to training, or (in some cases) a removal from the training programme.

- Evidence collated by Third Parties: for example, in investigations of trainees relating to risk of serious harm to patients.

  - A number of documents were issued to provide greater clarity on this particular use of evidence, following concerns from the profession that the GMC investigations of trainee Hadiza Bawa-Garba had used information from her trainee E-portfolio. These documents suggested that evidence could potentially be released to Third Parties in certain circumstances:

    "These are:

    1. Under section 35A of the Medical Act 1983, the GMC may ask for the release information held on E-Portfolios in a case of fitness to practise

    2. A court order or coroner's request to release information

    3. The Police may request that information is released from E-Portfolios for crime prevention purposes

4. A patient subject access request, if the patient is identifiable"

<div align="right">(Academy of Medical Royal Colleges, 2016)</div>

     ○ Specific guidance was developed for trainees, to be mindful that there was risk that their personal reflections may later be used in investigations:

"If you are unfortunate enough to be involved in an incident with a serious outcome, it is helpful to set out the narrative on paper immediately so that the events are recorded while still fresh in your mind , but formally documented reflection is probably better done after some consideration"

<div align="right">(Academy of Medical Royal Colleges, 2016)</div>

Theme 8: Dynamic supervision

There appeared to be particular areas within the documentation which suggested that navigation and negotiation would be required by a trainee and their supervisor. This theme has been labelled as 'dynamic supervision'. When considered in more detail, this appeared related to two main areas: Inherent tensions within postgraduate GP supervision, and the moving goalposts of postgraduate training standards and expectations.

Inherent tensions

Inherent tensions were frequently acknowledged as ubiquitous within postgraduate GP training. For example, when considering the tension between service delivery and trainee education:

"As general practitioners the working day is largely determined by the demand from the public for healthcare, and our carefully planned day is never quite as we anticipated. Demand fluctuates with the season, epidemics and health scares. A typical day is hard to define"

<div align="right">(Health Education England West Midlands, date unknown-b, General Medical Council, 2015)</div>

A further tension in the supervisory relationship related to the supervisor role as judge and 'gatekeeper' whilst also providing personal and pastoral support for the trainee. Supervisor as

'assessor' was the most frequently cited code within the thematic analysis, and 'gatekeeper' was also frequently cited. However, the second most frequently cited code was that of supervisor as 'educational support':

"Trainees must work in an environment where they can ask for help without fear of reprisal and where they regularly meet with a trainer or supervisor who is able to talk through difficult situations to assist learning"

(Royal College of General Practitioners and COGPED, 2014)

When applied to the situation of the trainee facing difficulty, the supervisor in this case appeared to have a role to support and encourage the trainee educationally, but also had a duty to the profession and patient safety if quality of care was threatened (in their 'gatekeeper' role).

Moving goalposts

At times, it appeared that the guidance from one institutional organisation was at odds with that of another. For example, the GMC regulation of trainees required trainees to complete an annual survey and 'Form R' (outlining their absence) as part of their regulation. Such activities were unlikely to serve an educational purpose, yet the trainee who did not complete these requirements risked an 'adverse outcome' in their training program:

'Failure to comply with requirements such as Form R return, completion of the National Trainee Survey and of other required "local" surveys may result in an adverse training outcome'

(COPMeD, 2016)

"If you are working in a GMC approved training post in the UK on the census date (19 March 2019), you should complete the survey"

(General Medical Council, 2019a)

The expectation of completion of the GMC and local training surveys was also cited within guidance from Health Education England, West Midlands:

"Have you completed GMC and JEST Surveys? It is a HEE expectation that trainees should participate in giving feedback on their attachments"

(Palmer, 2017)

However, messages from RCGP guidance appeared to be issued to the contrary:

"assessments to be completed over and above those measured in the Trainee E-Portfolio… Educational Supervisors and ARCP Panels must not deviate from the assessment package agreed between the RCGP and GMC and can only award an unsatisfactory ARCP outcome if there is plain evidence of inadequate performance in the E-Portfolio assessments or development of competence"

(Royal College of General Practitioners, 2015c)

A further example of 'moving goalposts' has been outlined within the theme of 'hierarchy' (Theme 4), when the deliberately non-prescriptive guidance on learning log entries (from the RCGP) was translated at local level to suggest a prescriptive recommendation of 50 log entries over 6 months (Palmer, 2014; Royal College of General Practitioners, 2016a).

Considering the implicit expectations from the wider profession

Following review of the documentation on GP training, it could be argued that there are unintended, implicit messages for those involved in GP supervision:

Hierarchy

On one hand, it is perhaps unsurprising that hierarchy exists within postgraduate GP training. Many could argue that the trainee, a novice within the profession, must meet sufficient quality standards to practise autonomously, and be held to account to meet these standards. Similarly, the supervisory and deanery responsible for providing this education should deliver their roles to sufficient quality, and also be held to account.

However, there is a potential consequence of this hierarchical structure to the supervisory relationship. The themes of 'evidence' and 'quality assurance' (to the public) were prominent messages. This is potentially particularly important when considering the role of the supervisor, who must provide educational support, but also that of gatekeeping and assessment. For a trainee and supervisor entering into a supervisory working alliance, there may be questions about the supervisor's commitment to their educational and pastoral roles, when (as an agent of the 'institution') their gatekeeping and assessment functions appear to predominate. Such ambiguity may impact the trust and openness at this 'interpersonal' relationship level.

When considering hierarchy within institutional structures, the concepts of power and agency arise. A useful lens into trainee agency within the hierarchical structure of GP training (and the supervisory relationship within this) is seen in the pathway for trainees who may wish to raise a concern about their supervisor. The results suggested a formal process of escalation, involving agents of the 'system' such as the 'head of school', or the Annual Review of Competency Review Panel. The formality of the route may be a deterrent for a trainee. In contrast, there are explicit local (and less formal) routes of support for a trainer who has concerns about a trainee (COPMeD, 2016).

Furthermore, there were a number of local documents suggesting that trainees who raised concerns were displaying negative attributes. Those raising concerns risked labels of 'defensive' with their 'head in the sand' (Hibble, 2009). Trainees who were 'too precise' about their working hours, risked a questioning of their suitability for work in General Practice (Health Education England West Midlands, date unknown-b). A trainee with legitimate concerns may therefore not raise them to avoid these labels or perceptions. These messages from the training documents risk construction of a passivity amongst trainees to raise concerns, thus potentially reinforcing the hierarchy above.

Collation of evidence

Whilst the requirements for 'evidence' of trainee competence or supervision quality are perhaps not surprising, there was a sense that the collection of evidence took precedence over how this information might be used to enhance or change practice. The unintended message is that recording particular supervisory activities or processes is more important than the quality or improvement of such activities. Other than the 'training the trainer' documents (Gibson and Lovatt, 2015d), the reviewed documents rarely mentioned methods to enhance the quality of supervision. In the 'Educator and Environment Approval Process' (Committee of General Practice Education Directors, 2014), an extensive collation of evidence is required by GP trainers to ensure ongoing approval. However, little information is provided on who should review this evidence, what the required 'standard' is, and what happens if the standards are not met. In this way, the notion of simply collecting evidence, rather than using it or learning from it, further drives a message of 'collection' over 'quality'.

With this in mind, there is a risk for those involved in GP training to emphasise being able to 'demonstrate' particular measurable aspects of supervision or training to those organisations at the top of the hierarchy, even if they are felt to be inappropriate or unnecessary in their context of supervision at the coalface. The drive for supervisors and trainees to provide evidence of 'quality' to

satisfy those at the top, partnered with a construction of passivity amongst the profession to challenge these demands, only seems to solidify the hierarchy in place, and ultimately appears to maintain power at the organisational and political level.

How did these findings inform the next stages of research?

From these results, we see that much of what trainees may experience within GP training is entangled in the messages from the wider profession. These include explicit messages regarding the expectations for supervision and quality assurance. However, additional implicit messages regarding hierarchy, and prioritising a collation of evidence (rather than quality evidence) also emerged. This risks a culture where trainees feel unable to challenge, and where they may sense a drive to demonstrate makers of 'quality', rather than strive for inherent quality within training. The inherent tensions within supervision and the changing messages from the wider profession suggest that trainees and their supervisor may vary in their expectations for supervision, and that significant navigation and negotiation may be required.

It would be overly simplistic to suggest that the messages from the wider profession were simply transmitted and applied to the lived experiences of supervision. Whilst the organisational standards were clear in their aim to develop GP trainees as adult learners and legitimate participants in the community of practice, the trainee's agency to both learn and shape their training environment has not been explored at this stage.

This stage of the research placed a focus on the expectations of the profession regarding supervision in postgraduate GP training. However, it is unclear from the results if these expectations and messages (both explicit and implicit) relate to the lived experiences of trainees and their supervisors. In the subsequent chapters, the opinions of supervisors and trainees are explored, to consider their lived experiences in light of these expectations.

Chapter 6: Exploring the tacit rules of supervision through interviews with experienced GP supervisors

The findings from this stage of my research were written up for publication, and the results include text taken from this published work (Jackson et al., 2018b). My PhD supervisors at the time (Dr Ian Davison, ID and Dr Josephine Brady, JB) provided supervision of the research design and conduct, and engaged as co-authors in writing the paper.

Focus on 'breakdown'

At the outset of the interviews, the intention was to facilitate open discussion, with exploration of the supervisory relationship in both 'typical' trainees and those facing difficulty. However, each participant chose to focus their responses on stories of trainee difficulty and relationship breakdown. Most of the accounts related to the personal micro-level experience of the educators as trainers, rather than in their capacity as directors and overseers of trainers. It is from this perspective of 'breakdown' that the perspectives and themes were identified. **Figure 8** (**Key themes and perspectives in the breakdown of the supervisory relationship)** outlines the key themes and perspectives identified.

Figure 8: Key Themes and Perspectives in the Breakdown of the Supervisory Relationship

	Sub-Theme	Theme
1	Academic, personal and/or professional difficulties	Trainee factors
2	Engagement	
3	Insight	
4	GP as 'best fit career'	
5	Tensions in trainer role	Supervisor factors
6	Failure to fail	
7	Goals of supervision	Lack of agreement on expectations for supervision
8	Tasks of supervision	
9	Locus of control	
10	Effect on the trainer	Effects of breakdown
11	Effect on the trainee	
12		Dynamic relationship

Theme 1: Trainee factors

Sub-Theme 1: Academic, personal and/or professional difficulties

Difficulties experienced by trainees were largely described as personal, academic or professional. Personal challenges often related to stressful home or life events whilst academic problems related to communication skills, or insufficient clinical knowledge or examination failure. Difficulties of a professional nature appeared to relate to a perception that the trainee lacked the professional attitude and behaviours associated with a career in General Practice. Within the stories of trainee difficulty, many trainees appeared to demonstrate difficulties in most or all of personal, professional and academic areas.

Sub-Themes 2 and 3: Engagement and insight

The word 'engage' was used by three out of four participants, and the fourth alluded to this concept.

'We have trainees who have problems, who have difficulties, who have complaints. But as long as they engage in that and they learn from them, then it always works.'

(Experienced Educator 1)

Engagement appeared to refer both to behaviours and attitude. The key behaviours were: timekeeping, team-working within the community of practice and being 'open' with the trainer about educational or personal struggles. 'Problem' trainees did not 'engage' with these expected behaviours. Some of the educators recognised their own role in facilitating trainee openness, and described the methods they implemented to encourage this:

'But I think if you have some underpinning principles of trust and openness and honesty and safety. Actually, what most trainees need within their training will come out. If think if there isn't that safety,

your trainee won't often talk what they need. If those principles aren't really underpinning, people will often hide deficiencies. And you can't help them if they do…

…I've done it lots of different ways. We often start off at induction period. The way we structure our tutorials tends to be, we plan them and do lots of roleplays. But with regards to the other finding out about people, it tends to be in conversations over coffee. Sometimes we get out of the building'.

(Experienced Educator 2)

When referring to a trainee's attitude, all participants expected openness to criticism and acceptance of a need to change. The onus was placed firmly on the trainee, and those who did not 'engage' were viewed to either lack 'insight, or have an 'attitude problem'

'T*here are difficult trainees who need training, and difficult trainees who have an attitude problem. Because they're the ones who will resist change. They're the ones who don't turn up on time for surgery, they're the ones who are annoying patients or who are rude to patients, and they can't see that they've got a problem.*'

(Experienced Educator 3)

Sub-Theme 4: GP as 'best fit' career

All participants described trainees where a career in General Practice did not appear to be the best fit for them. In these cases, they described trainees who had experienced multiple failures at high stakes examinations. In addition to difficulties in their relationship with the interview participant, a number of these trainees also had relationship breakdowns with subsequent supervisors:

'He then went to another advanced trainer who dealt with him…He said: "He's never gonna

get through". And sure enough he failed. He took the CSA about six or seven times'.

<div align="right">(Experienced Educator 3)</div>

Theme 2: Supervisor factors

Sub-Theme 5: Tensions in the role

The educators appeared to be aware of potential tensions to be navigated in the role of GP trainer.
One such tension was that of the need to monitor and assess the trainee's progress, whilst trying to
support and develop them:

'One of the things that you are trying to do is to remain on their side while at the same time

you're being critical of them…'

<div align="right">(Experienced Educator 3)</div>

A second tension related to the participants' desire for 'openness' from their trainees about personal
and professional struggles, whilst two of the participants had experienced trainees who did not want
to be open about difficulties, or turn to their trainer for personal or pastoral support. For some, this
appeared to relate to a fear of being labelled as struggling:

'She said, "I can't possibly work at that practice knowing people think that about me". And that was

it. She had to be moved'

<div align="right">(Experienced Educator 1)</div>

It was suggested that some GP trainers may place a heavier emphasis on 'service delivery'
(*performance*) than was appropriate for the trainee's learning needs (*development*), which
contributed to tensions faced by trainees.

Sub-Theme 6: Failure to fail

Two participants had experienced hesitancy of supervisors to 'fail' a trainee. 'Failing to fail' in these cases appeared to relate to both an avoidance of conflict or, at times, the trainer's own blind spots due to their attachment to the trainee:

'As a trainer sometimes you are so gunning for your trainee. You're so keen to see them do well. This almost wishful thought.'

(Experienced Educator 4)

Theme 3: Lack of Agreement on expectations for supervision

Sub-Themes 7 and 8: Goals and Tasks of Supervision

Common to all accounts of 'relationship breakdown' was that the trainee did not 'agree' with the particular goals suggested by the trainer. In the example below, the trainer's goal was to move the trainee towards the working pace of a qualified GP: a goal not shared by the trainee. This subsequently led to disagreement on the particular tasks the trainee was asked to do:

"[They were] *resistant to moving on to 10-minute appointments, despite giving catch-up slots. [They] refused to do more than 10 Docman a day, refused to do on-calls, so was very, very resistant to what we had to say"*

(Experienced Educator 1)

In stories of disagreement, it was frequently suggested that the trainee's lack of 'insight' contributed.

Sub-Theme 9: Locus of control

The educators appeared to differ with respect to who should be driving the supervisory relationship. Two participants recommended significant input from the trainer, particularly in the early stages of the final year, whilst the other 2 believed the trainee should be driving the learning agenda:

'Ultimately it's the trainee who has to put in the work and the learning'

(Experienced Educator 4)

The participants frequently spoke about the wider practice team, relying on colleagues for support with their trainee, and feeling a responsibility to the practice when their trainee 'caused' problems. There is a sense that 'control' in the relationship may lie beyond the supervisor and trainee.

'And because he was always running late, the patients obviously they complain and it throws off everything out of sync. He's then late for his GP tutorial. He then doesn't take a visit , because the visits have been allocated as we tend to just take our own visits, and it just fosters complaints and bad feeling from the other GPs, staff at the practice and it all sort of spiralled down from that point'.

(Experienced Educator 1)

Theme 4: Effects of Breakdown

Sub-Theme 10: Effect on the trainee:

Before relationship breakdown, the supervisors frequently described instances where they had detected trainee problems or difficulty, and attempted to remediate these. Remediation attempts typically appeared to be driven by the supervisor, without a strong sense that the trainee was involved in developing the plans for remediation. Changes were often made to work scheduling to enable more time to be spent on the areas of greatest development need:

'We would say, "This has happened three or four times now, we're going to do some surgeries, read the guidelines, look it up and come and talk to us about it".

So, yes, we kept him busy, we changed what we did and continued for him to do several surgeries every day with us sitting in'.

(Experienced Educator 4)

When supervisors felt that insufficient progress had been made, they described an escalation to sources outside of the training practice to request additional support for the trainee. It was usually accessed through a referral by the supervisor, and delivered from the local training region. This included referral for communication or professional support (to the Professional Studies Unit), or having some focused training in a particular area:

'I think what's happened with the Local Training Support Network, by having somebody who is experienced, to have a structured interview and really work out where the challenges lie, and being able to use resources such as the Interactive Studies Unit, or some advanced training, or a mentor, could work quite well'.

(Experienced Educator 2)

Exam failure was described as being a particularly emotive experience for trainees. One of the participants described exam failure as '*bereavement*' for the trainee, who were usually '*angry', 'hurt'*, and '*damaged*'.

'it's important to give them a metaphorical cuddle if you like. You need to protect them. They're very damaged.'

(Experienced Educator 3)

Many of the stories of breakdown resulted from examination failure, with the trainee subsequently moving practice: a sense that the relationship was irreparable. Linked with this was the perception that the trainee was ultimately 'at fault'. However, the participants also described some stories where trainees did subsequently succeed, and where they remained in a training relationship.

Sub-Theme 11: Effect on the trainer

Three participants described feeling '*vulnerable*' following relationship breakdown. This was expressed most frequently in terms of concern about subsequent complaints from the trainee. However, the educators also discussed feeling like a 'failure' themselves, with significant emotional distress. Two educators described a heavy reliance on documentation and evidence; being 'seen' to be supporting the trainee:

> *'Lots of trainees do complain if they've not had all the support. And that puts the trainer in a vulnerable position. So sometimes there is an element that you have to go through the process more formally to be 'seen' to be doing, rather than just doing'.*

> (Experienced Educator 2)

Supervisors often involved members of the practice team, particularly when they had to make or communicate difficult judgements about the trainee's performance:

'Well, because we share training, and there are three of us in the practice who are very much involved with it, we shared our ideas, we tried different things. And during the induction programme, when the person was sitting in they just weren't very active, and they started seeing patients with us sitting in with them. It rapidly became apparent that they hadn't got a clue as to what they were doing. And had no insight into how poor they were. So we met as a three, and then as a four'.

> (Experienced Educator 4)

Supervisors also requested support from Training Programme Directors and Area Directors (from the local training region) to communicate difficult messages about trainee performance:

'He was very defensive. He said, "No, it's not my fault".

And we showed him that we had the log-in computer records, and "80% of the time, you're logging in later than 10 minutes after you should be". And eventually we had a meeting with the Area Director and another TPD, where he was told to sort himself out'.

(Experienced Educator 1)

Sub-Theme 12: Dynamic relationship

Reviewing the responses in their entirety, the supervisory relationship appeared neither linear nor simplistic. The participants described the changing needs of the trainees throughout their final training year, and the need for the relationship to respond to these changes. It is important to note that not every 'breakdown' resulted in an end to the relationship, and stories of repair and remediation were recounted:

'I then sat him down to watch some videos. And actually I said, "Look, if you want to pass this exam, listen to what I'm telling you. Forget your prejudice. Listen to what I'm telling you. You've got to be more patient –centred. You've got to actually relate to the patients in a more positive manner."

And we sat down, I watched all of his videos, and at the end of it he said (because he'd tried it quite well, and listened to what I said), and he said, "you know something"?

I said, "What"?

"This…works"

…and he passed!! [laughs]. He was a success. He was a struggle, but he was a success'.

(Experienced Educator 3)

Developing a model

The model below (in **Figure 9: The dynamic course to breakdown, and its effects**) provides a tentative summary of the perspectives and themes that arose from within the results, incorporating the dynamism that was evident from within the experienced educator accounts. It is structured around Bordin's concept of 'agreement', a concept that emerged as central in the educator interviews (Bordin, 1983). This emergence will be elaborated in further detail within the discussion, in which I will explore the observations from within the research in light of the original theories of interest (Bordin's model of the working alliance, and Egan's Skilled Helper model). The term 'trainer' has been used within the model to describe the GP supervisor.

Figure 9: The Dynamic Course to Breakdown and its Effects

Insight

Engagement

Academic, personal and/or professional difficulties

GP as "best fit" career?

Trainee Factors

Effects on trainee: bereavement, change to work scheduling, referred for additional support

Irreparable/ Trainee moves practice

Tensions in trainer role

Failure to fail

Trainer Factors

Expectations for Supervision

LACK OF AGREEMENT

BREAKDOWN

Goals of supervision

Tasks of supervision

Locus of supervision

Performance ← → Development

Trainee drives

Trainer drives

Repair/ remediation

Effects on trainer: vulnerable, evidence-focused, escalate

Re-visiting the research sub-questions

- Which theories or models of supervision best relate to experiences of General Practice supervision?

The participants spoke frequently of a lack of trainee engagement and insight, suggesting that (from their perspective) the trainee was not always aware of the particular problem that had been observed in their attitude or behaviour. This is in keeping with Egan's 2010 model, which accepts that some 'clients' (or trainees) may have difficulty in confronting or engaging with their 'blind spots', and therefore the 'helper' (or supervisor) must facilitate this (Jenkins, 2000, Egan, 2010). Bordin's model however appears to take a slightly different view, by citing 'agreement' as central to the supervisory alliance: where supervisee and supervisor should agree on the goals and tasks of

supervision. Certainly, there were examples within the results where relationship breakdown

appeared to be associated with a lack of agreement, particularly around the 'tasks' of supervision,

such as non-attendance at tutorials, or reluctance to move to shorter consultations. In turn, these

stories of 'breakdown' were linked with the dominant view that the trainee lacked 'insight' about

their problems. Whilst this may be the case, it may actually represent a failure to agree the 'goals' of

supervision in advance (Bordin, 1983). The differences in expectations and emergent tensions

suggest that it is quite possible that trainee and trainer may have a very different understanding of

the purpose of the supervisory relationship. What is perceived as an 'insight problem' in the trainee

may in fact point towards a lack of appreciation of the differing perspectives of supervision, or a

more fundamental problem in the supervisory relationship itself.

Despite some applicability, there are frequent instances where application of these models to the

findings in this study appeared overly simplistic and, at times, contradictory. This was most striking in

two respects.

The first related to the focus on the supervisory relationship itself within these models. The

participants in the study suggested a context for training much wider in scope than the interaction

between trainee and supervisor. For example, members of the practice team were frequently

involved in assisting trainees in difficulty, and external sources of support used by trainer and trainee

in times of crisis. Considering only the trainee-supervisor interaction may fail to recognise the socio-

cultural influence of the training practice. Bordin and Egan's models suggest that the quality of the

supervisory relationship is central to achieving the eventual goals or 'help' required by the trainee.

However, based on the stories of trainees looking elsewhere for pastoral support (outside of

supervision), there is a suggestion that the supervisory relationship is perceived to be limited as a

resource, and not the 'only' solution. Furthermore, the reference by the trainers to provide evidence

and documentation suggests an accountability to the institution (and profession), in addition (and perhaps more so) than to the individual trainee.

A second observation relates to that of 'mutual' agreement of goals and tasks in Bordin's model, echoed in Egan's model by a sense of 'sharing'. In the accounts of relationship breakdown, there was little sense of mutuality or sharing of ideas. When describing situations of trainee difficulty, remediation attempts appeared to take on a top-down approach, rather than the negotiation and 'mutual agreement' outlined within these models.

- How do GP supervisors perceive the development needs of GP trainees?

The results suggested that the trainee's needs varied, depending on the particular area of difficulty (such as academic, personal or professional). However, it also appeared that the supervisors' own beliefs and preferences influenced their perceptions of the trainee's development needs, and the actions that were subsequently taken to develop the trainee. The supervisors shared some expectations for the goals of supervision, such as trainee openness about problems, an environment of trust, a willingness to engage and demonstration of sufficient insight into their difficulties. However, they had varying expectations about other goals and tasks of supervision, and placed difference emphases within the spectrum of trainee performance and development. They also varied in their perceptions on the locus of supervision ('who' should be driving the supervisory relationship). Some supervisors appeared to consider this to be the trainee's responsibility, while others conveyed a sense of personal responsibility (as the supervisor) to drive the relationship. Using Bordin's notion of 'agreement', the model in **Figure 9** (**The dynamic course to breakdown, and its effects**) offers a framework to conceptualise the educators' views on the way in which varying expectations (which may be implicit) may influence 'agreement', and subsequently contribute to relationship breakdown and its effects. The model therefore offers a tool to illuminate the tacit

mechanisms and processes that may influence expectations for supervision, from the perspective of the supervisor.

- What methods do GP supervisors implement to support the trainee's development?

The approach to supervision methods also varied, and related to the educators' beliefs and expectations regarding the goals, tasks and locus of supervision. Particular methods (which were implemented to different degrees) included changes to work scheduling, designing induction programmes that would facilitate openness and trust and the use of training practice information (such as electronic data and patient complaints) to highlight areas of difficulty. When supporting trainees in difficulty, the supervisors discussed their reliance on documentation and evidence. Involving members of the practice team was common when additional support was required for the trainee within the practice. However, if local changes had failed to lead to sufficient progress, supervisors frequently looked to the local training region to provide support for the trainee. This escalation was often implemented due to their feelings of vulnerability and fears of trainee complaints.

In situations where trainee remediation was required, it was noteworthy that the educators rarely discussed the trainee's contribution to the proposed remediation solutions.

The educators acknowledged particular difficulties with respect to their assessment and monitoring roles. They also recognised the risk of 'failing to fail' trainees (and failing to communicate with the trainee about their negative performance), either due to their own blind spots, or in an attempt to avoid conflict.

How did these findings inform the next stages of research?

The findings in this study appeared to support Bordin's view of 'agreement' as a central component in the GP supervisory relationship, and raised important questions about the way in which trainee

and trainer expectations of supervision (explicit and implicit) may contribute to goal and task agreement. However, the results also suggested that viewing the supervisory relationship in isolation may fail to appreciate its complexity. Influences from the wider profession, and impact of the training practice within the results suggested that an appreciation of the influence of the wider socio-cultural context would have a critical role in the next stages of my research.

Within Chapters 5 and 6, I have discussed the explicit and implicit expectations of postgraduate GP supervision, from the perspective of the supervisor and also the wider profession. However, the perspective of the trainee has not been explored, nor has the way in which these expectations relate to the trainee's lived experience of supervision. Within Chapters 7-8, the trainee's voice is considered, providing a focus at the level of Rogoff's 'personal plane' of development (1995).

Chapter 7: Seema and Stephen's stories

In Chapters 7 and 8, the Figured World of GP training is considered through the stories of 13 GP trainees. This offers a conceptualisation of GP training, and the agents, relationships and socio-cultural influences within it, through the lens of the learners themselves.

Within the results, the stories are retold using excerpts and **bold** to highlight particular areas of relevance. Where the participant's anonymity may be at risk, names, roles or places have been changed, and denoted with *.

I have begun by discussing the findings from two narratives in detail. This serves to illuminate the approach taken to the narrative analysis, and introduces some of the overarching themes. The narratives of Seema and Stephen have been chosen because of the richness of the stories within them, which span many of the themes that are discussed later in this chapter. Although they are both similar in age, are mature trainees (having trained in other specialties before moving into General Practice), and are parents, each narrator represents different training experiences and trajectories, offering differing insights into the Figured World of GP training. Seema, an International Medical Graduate (IMG), has experienced academic difficulties within her training, and is training in a 'less than full time' (LTFT) capacity. Stephen is a full time trainee who has succeeded in all of his summative assessments, and progressed as expected within the training programme.

A worked example of the latter stages of Seema's interview analysis is included in **Appendix 11 (Exemplar of Narrative Analysis Summary),** which highlights the ways in which the stages of the Listening Guide were applied to the interview data.

Seema

Not a 'typical' trainee

I first met Seema in the final month of her ST2 training year, as she was preparing to move to her ST3 practice. Her journey to GP training began as a mature clinician, having previously trained in *surgery (speciality changed to ensure anonymity of the participant), and qualified as a doctor in India. She perceived her previous training experiences as different to that of a 'typical' GP trainee:

*'You might find my training a **little bit different** from a normal trainee. It may not fit the, bolt of where it should fit for everybody. So it may not be relevant for you, whatever you're trying to show of the training. **It might be an odd face**.*

*Going back to it, I'm quite experienced doctor. **I'm not training at the level of the trainees that come out just out of medical school. I've done *surgery in the past**. Done the training bit at trust grade stuff with a job as well. So I know what the training in the hospital like in *surgery. *Surgery being a very kind, you can call it, risk prone speciality. So very robust supervision there even though you are experienced. I **trained in India**, came here. Thought **I'm very experienced** but still you're supervised as you would be fit to practise in the environment."*

In addition to her prior training experience, she was also a single mother, working less than full time to enable the juggling of work and childcare. She saw this as further compounding her differences when compared to other trainees:

*"Again, wherever I had issues, they were to do with the Less than Full Time. **Because I'm less than full time**, people don't see me enough and they think I'm always on annual leave and then come to clarify the times I'm working'.*

Alongside these early difficulties in juggling childcare and part-time training, Seema also discussed the way in which the training 'system' influenced the geographical location of her placements. She

felt that this further compounded her ability to work within the expected schedule and trajectory of a 'typical' trainee, due to difficulties in juggling her son's school commitments alongside a heavy commute:

*'there were issues with **the other things**, nothing to do with supervision. Like I was moving from *Wolverhampton to, I was living in *Wolverhampton. Applied for Birmingham because at Birmingham hospital I was based in *surgery so I was already applying for it. So my son, I made him sit the exam for grammar schools in Birmingham so that we'll finally relocate there. In between change of mind. Got the GP training, and then I got *Coventry. So the first choice was Birmingham, which I never got. **So there was an issue with travelling**'.*

Alongside her perceived 'differences' in experience, training and personal circumstances, Seema also had experienced difficulties in her professional and educational training. There were a number of points in her training, both within *surgery and General Practice, where professional or academic concerns were raised by supervisors. Seema viewed many of these concerns as ill-founded; based on misunderstandings and incorrect assumptions about her circumstances, particularly when her LTFT status was compared to that of full time (or 'typical') trainees. She described a particular misunderstanding during her A+E hospital placement:

*'there was an e-mail sent by this and this, and he said this and this. That, I can't remember what exactly was it. It's to do with she didn't come for the shift and clinically she hasn't improved much. Yes, clinically she hasn't improved much. **They kept going on and on about comparing**,*

"Charles has seen 500 patients and you have seen only 250 patients".

I said, "fair enough. Charles does 100% and I do 60% after which 60%, 10% is VTS. So 250 sounds reasonable to me. And moreover, he does locum".

"So, in that respect, if you're comparing, it", I said, "I'm doing very well then, If he's doing 500, and

I'm doing 250, then we're really equal".

Singled out

Seema's sense of being compared and singled out continued into the early stages of her ST2 GP

placement. She perceived that her supervisors singled her out amongst the other trainees at the

practice, and she felt heavily monitored from the beginning of the placement. One example of this

was the practice's requirement for her to discuss each clinical case with the supervising doctor, and

waiting outside their room until they were available to discuss each patient:

'then once he's finished then we'll discuss the patient. And depending who the supervisor is, they'll

say, "ok" to what you thought."

Within GP training, this is a fairly standard practice, particularly when trainees are new to the

placement and practice. However, Seema felt that her experience of supervision was different to

that of her peers at the practice, further compounding her sense of being different to the other

trainees; exposed and singled out within the practice:

'He used to shout at me, one of them. For everything he used to say, "Everybody else can do it, you

can't do it. F1 [the most junior doctor in the team] sees the patient in less than half an hour. I'm

thinking of making him go on 20 minutes. You can't see it".

*I said, " even F1 doesn't come and speak to you for every patient, **and have to come and stand in***

***front of everybody** and everybody who crosses the corridor says, "why are you standing here, Why*

are you standing here"?

So, that difference that I will notice'.

Seema also described a sense of feeling that she was a burden, or irritation to the supervisors at the practice. Despite the requirement to discuss every case, she experienced problems in accessing supervisors when she needed them. At an initial progress review meeting, she expressed this frustration and cited this as her reason for failing to progress as expected.

[By means of context, the supervisor was concerned that Seema continued to require 30 minutes to see each patient (where perhaps a typical ST2 trainee may have reduced their appointment times by this stage to 20 minutes or thereabouts)]

'Then we had a meeting after one month.

[Supervisor] "On your progress. You still on half an hour slot. And you haven't progressed".

*So, I said "**I didn't know that I shouldn't be on half an hour number 1**. Now I will. I'm prepared now. And I will try and see if I can do it".*

Before I was taking my half an hour time and waiting outside their rooms and discussing it, the patient.

Then we had another meeting after another month.

And they said, "You're still on half an hour and you haven't done anything about it and your clinical knowledge is poor".

*And I said, "Ok, about half an hour I'll try and do. **But I must admit to it, the waiting outside your room** sometimes takes 10 minutes and then discussing for another 5 minutes, so 15 minutes you can just put for every patient".*

So, they said "No, who said I see patients in 10 minutes? I don't see patients in more than 10minutes. I see patients very quickly"

*I said, "You might be, but **I still have to wait outside**".*

This was a really bad. I normally don't talk like that, because at the time I was so fed up with the training'.

She recounted particular difficulties in accessing support from two clinicians within the practice, who she regarded with suspicion, perceiving that they were deliberating trying to avoid her questions:

*'There were two of them who would say every patient um, they will take time. **Retrospectively I'm thinking they will delay it as much as they can** and then they will either come to see the patient, or they will say, "Go and find this out and that out and then come back to me again".*

Compounding her sense of being 'different', Seema perceived that the other trainees at the practice were afforded greater support from the practice team, and had a greater sense of inclusion within the life of the practice community. In the example below, she attempted to dispel this perceived suspicion by keeping her door open, and being transparent when in her room.

'My room was here, and after I've finished seeing patients I used to keep my door open so that they don't have to barge through the door. They used to sometimes just barge into the room, "What are you doing still"? Kind of thing.

*And that made me wonder, because all that's going on, **I used to think, "Are they thinking that I'm watching some movie or something on the computer**". So I used to keep the door open so that they don't have to just barge in without knocking on the door. So, those kind of things. Once I had left the*

door open, even then supervisor would pass through and the door opposite was the ST3, she said,

*"*Amy, Have you had your lunch"?*

"Yeah".

"I want you guys to have your lunch before you see the next lot of patients" and all.

But it's in a loud voice to tell that, "I'm more concerned about trainees, but not about you".

I just don't understand if it was me, or I have upset somebody'.

The Courtroom

Whilst the early stages of the narrative emphasized Seema's feelings of being different and singled out when compared to the other trainees at the practice, it later became apparent that Seema perceived ongoing battles between herself (as the protagonist) and the supervisors at the practice (the antagonists).

The chronology of these 'battles' is not clear from the narrative. However, they frequently appeared to involve instances of disagreement between the supervisor's viewpoint, and Seema's response to it. In each example, she felt accused of doing something *'wrong'*, but highlighted to me (as the researcher) the ways in which her intentions or actions were misunderstood. In this way, I felt positioned by Seema as her 'lawyer' or advocate within the narrative.

One of the earlier battles occurred around 2 months into her placement. She hadn't been paid by the practice for 2 months due to administrative difficulties, and was '*struggling with the finances*'. She recounted an email response that she wrote to her supervisor where she thought, *"If I write it, they might understand":*

'So I said, "I had to go back to India to get some finances sorted, **so can you look at that**, and that's the reason my entries are not there. Finishing after A+E, all the trainees get relaxed a little bit, ARCP done, so I didn't put any entries. I started the year, but of a struggle adjusting to things and all. I didn't put an entry there. Then immediately I went to India, so leave I don't expect to put entries". So **I kind of, legally kind of clarified** why there is no entries in that time, because this all came together"*

*So I think this didn't go down well obviously, because the last line wasn't very right, because that's the reason why there's no log entries, and probably to do with the finances as well. So they didn't like it. My finances were sorted the next day, within a day I got the pay. Which was good, and all the other trainees were happy they also got their pay. **It wasn't just to do with me** so that was sorted'.*

There was a strong sense of the trainee pushing back against the views of her supervisor throughout the narrative, rejecting the assumption of the trainer that she was a 'bad' trainee, and wanting to be understood as a 'good trainee'. I was struck by her choice of defensive language, and use of a written challenge, perhaps to offer some 'evidence' for her lack of reflective entries. However, although her financial issues were resolved, she concluded that the practice did '*not like*' the way in which she'd challenged them. As the listener, I wondered if her defensive response had further contributed to compounding her sense of being 'different' within the wider practice.

Later in the narrative, she described a similar instance of feeling misunderstood by her supervisor during a Consultation Observation Tool exercise (COT), but chose not to make an overt challenge, stating that '*nobody listens'*:

'*he sat down and filled the COT **'incompetent', 'incompetent' in everything. Incompetent** because I didn't give the Golden Silence'.*

'*Second time… I kept on asking about the pain, abdomen, and the urine dip showed blood, and I said, "There's blood in it"….And then I asked, "Are you having periods"? She said, she nodded it. And I didn't make much of it. It was just urine, blood in urine. Healthy patient otherwise. So, he did the COT in the evening and put that the urine, blood in urine, was a major issue and I didn't address this. **They should have listened to me.** Why I said, "Because she was having periods, we know coincidence there". **But nobody listens, they just talk over you.** And I was referred to PSU for that. **And I'm still thinking what has got PSU to do with blood in urine?***'

Battle-weary: confused, and silenced

Within these later 'battles', I was struck by Seema's feelings of powerlessness to both express her thoughts to her supervisor, and to feel listened to when she did express her concerns. An additional observation was that Seema appeared confused by her supervisor's decision to refer her to the Professional Support Unit (PSU), and lacked clarity about his particular concerns.

Instead of the overt challenge (seen in the earlier 'battles'), she later appeared to mount challenges to her supervisor in her thoughts alone, through an internal conversation with herself:

*'because you telling me to read everything. It's very difficult to read everything. You are a GP, **and I thought in my head,** "there's nothing, there is no way you know 100% everything. Such a wide, you tell me what are the areas I should be focusing more than others. I can't overnight in 6 months cover everything, if I'm not being very well educated'.*

The narrative interview: giving a voice back to the trainee

In one of Seema's stories, she described a busy evening surgery when she had been unable to finish her clinic paperwork before she had to leave to pick up her child from nursery. When she asked if she could come back and do it in the morning, she was told by her supervisors that she lacked organisation and time management. She described her feelings of being misunderstood, with a mismatch of expectations between herself and her supervisor:

*'And then again, that didn't go down very well. But I can't think when I'm getting phone calls after phone calls from the nursery saying that "we need to go home"…Without sorting the problem, you would be thinking, and then this goes as **time management issue**. So there is a **time management issue**. That's why I'm less than full time. Otherwise I would be full time. And that's it's interlinked. I don't have organisation. I **have** organisation**. If you adhere to my version**. Because I'm asking, I have made a plan now. I'll do the morning shift'.*

Coming back to her earlier email response (where she expressed her desire to '*put forward her perspective*'), it appeared to me that the interview itself was a platform for Seema to communicate many of the opinions and perspectives that she had felt were silenced within her placement. Throughout the narrative, she highlighted phrases or judgements that had been made about her by supervisors, and contrasted these with her own lived perspective. What they saw as a 'problem' with her performance, she saw as a misunderstanding, particularly with respect to 'who' she was; not

a 'typical' trainee, but a mature single mother, with additional roles and responsibilities. This holistic approach of bringing 'oneself' to the professional field appeared to create tension.

What's wrong with me?

At a turning point in the story, it seemed that Seema began to question her own role in the problems she had experienced, and did (in some ways) identify with the label of '*problem trainee*' (a phrase she later uses to describe herself). When attended to, there is a quieter voice within the narrative which I have labelled the 'vulnerable voice'.

*'And then, I thought there is something wrong here. **Something I've not done right** [choking up]'.*

At this turning point, Seema questioned how she might position herself differently in the eyes of her supervisor. This involved a consideration of what his expectations of her might be (humble, teachable, motivated, and engaged), and then taking steps towards meeting these expectations:

*'So I thought it was a personality issue. What I did was, maybe I'm too senior. I'm not coming across of kind of humble trainee. I've got a bit of a kind of a laid back attitude as well. **So I thought I might show that I'm learning or something. Ask questions. When I don't need to ask questions** [laughs]. So what I started doing was, I wrote a letter.*

*A referral letter and I said, "Dr *Jones, I wrote a letter, a referral letter, Can I show it to you"?*

As the listener, this appeared to be the 'olive branch' in the story; the action of writing the referral letter representing a move on her part to engage with her supervisor, and his expectations. However, in the trainer's response, the trainee's sense of disappointment and rejection is tangible:

'So, after he read it, towards the end of the day, he came to my room and said, "This is the letter you've written. Any damn F1 can write a letter".

I said, "I'm showing you that I'm doing it correctly or not". I thought in my head I think, I just kept

listening.

He said, "Any F1 can write a letter. This is not a big deal".

"So I didn't say it was a big deal. All I said was, "Am I writing the right way"?

I have never done referral letters as a *surgeon. We never needed to do referral letters, and I've never

been in that state anyway. I did medical school and after that we never wrote any letters. So it's kind

of trying to think that I could to seek help from you'.

The courtroom: who is the 'judge'?

Throughout Seema's training, she also recounted stories related to the influence of the wider

training 'system', and the Annual Review of Competency Progression assessment in particular. This

ARCP panel meets annually to discuss each trainee's performance towards pre-defined goals in GP

training, and trainees may be asked to attend the panel in person if there are concerns about aspects

of their performance.

As a new trainee, Seema had been asked to attend panel due to concerns about her punctuality and

professionalism. These concerns had been highlighted by a hospital supervisor, and documented

within her learning E-portfolio as evidence for the ARCP panel, as 'educator's notes'. Seema had

been unaware of these concerns prior to her appearance at panel:

*'**But later on I realised** educators note doesn't pop up on the E-portfolio. **That's something I don't***

***know** if you are interested. For a new trainee, **I didn't know** there was an educator note gone on the*

system until I got called on for the panel. And then they said "there is an educator note on your

*system". I said, "**No, I don't know what that means**". So they said, "Have you not read it"? I said,*

"No". So then after that they said, "You should read it". So I read it and then I realised what she was

referring to'.

In her second experience of attending ARCP panel, her awareness of the importance of evidence and documentation in the E-portfolio appeared to have increased, and she perceived the 'evidence' of her failure in the Applied Knowledge Test (AKT) as offering a credible source of evidence, unamenable to challenge:

*'I don't have a clinical knowledge. **Which I can't dispute** because by that time I had done AKT… So, later on **I realised I shouldn't have taken it, to make it documentary evidence** that I don't have clinical knowledge'.*

In both these instances of attending the ARCP panel, Seema discussed the use of documentary 'evidence'. She appeared to view the 'system' as the 'judge' within the courtroom; responsible for weighing up the evidence regarding her progression, and ultimately making decisions about her placements, trajectory and outcome. In this second panel, a decision was made to extend her training, deeming that she had not demonstrated sufficient progress in the placement thus far.

It felt (to me) that my role within the narrative was as an agent of the 'system', proving a listening ear and an opportunity, and potentially a voice, for her to present her side of the story:

*'and then I had an extension after that, **which was never discussed with me**. This was again an issue **I would like to be corrected**. Because it was discussed that this 6 months will not be counted. I had a meeting with *the head of training. This 6 months will never be counted, so I have to do it again'.*

As the story progressed, I felt that she had a growing sense within herself that she was a *'problem trainee'*. The panel's decision to extend her training, her examination failure, and accumulating documentation appeared to further contribute to this sense of self. Following this panel assessment, she used the phrase '*problem trainee*' to describe herself, and described her awareness that this label also followed her into her new extension placement:

*'Because **I was a problem trainee** here. So people knew that **I was a problem trainee'**.*

A new practice, and a different perspective

The interview ended with the trainee at a new practice, as part of an extension placement, with a new supervisor. From her reflections, it appeared that the experiences in her previous practice had impacted her confidence and self-belief, but that the new environment was beginning to rebuild this through support and gentleness:

*'So it was kind of making me feel that you are at fault. We are not doing anything wrong. It's you who's at fault. Which I don't think is the right thing to do. I'm still doing the same things. **I haven't changed anything since I've come here. Um, but I feel better. I feel better. I feel supported**. I don't know if it's from the deanery. They have said you have to be supportive. Sometimes when I'm feeling under-confident. Or when I'm feeling like, "ok, no, I'm not a great person", maybe that makes me think maybe it's not me. Maybe it's the deanery said that to them, that she [the new supervisor] has to go gently'.*

She described her tentative journey to a different position and perspective. In her new training post, she felt much of the same scrutiny and monitoring, but this time she did not reject it. Rather, there is an acceptance of the trainer's point of view:

*'so I've never had a problem. Well, I wouldn't say never. I've had a different kind of issue here. **Because I was a problem trainee here.** So people knew that I was a problem trainee. I had gone through grilling a lot as well. Although in a supportive way. I can't complain about that. **Even though grilling was there, I can understand where it was coming from**, because nobody knows me. They know that it's problem trainee. She doesn't know anything. That's the picture that was painted. So they are supporting me, at the same time they are asking me questions that normally they won't really need to know that. Every patient here also was discussed, but **I could** send a text that I've seen the patient, can I come over. If they're not free, **I can** sit in my room; finish my documentation, rather than waiting outside of their door and coming back and doing, so of all things that has changed. Here*

grilling was a different sort, which was justified. If I was a GP supervisor, I would do that. I wouldn't

take anything in my hands'.

The language changes markedly in this section of the narrative, signifying greater control on the part

of the trainee, and a different vantage point (demonstrated by the I-poem):

I poem: A different perspective

I can't complain

I can understand

I could send a text

I can sit in my room

If I was a GP supervisor

I would do that

I wouldn't take anything in my hands

If I don't know the trainee

I wouldn't

I would see

I can't complain

Final thoughts on Seema's story

In Seema's narrative, she appeared to use the opportunity of the research interview to reject the

identity of '*problem trainee'*. Instead, she emphasised her identities as '*an experienced trainee'* and

also as a *'single mother'*. In this way, she viewed that both her past experiences (of training outside

of the UK system), and competing responsibilities (of childcare) had shaped her identity as *'not a*

typical trainee'. This can be seen most clearly through the I Poems analysis of her narrative:

I Poem: I am a single mother

I started GP training

I was moving from Coventry

I was living in Coventry

I made him sit the exam

First choice was Birmingham

Which I never got

I had a few issues

I couldn't be there bang on time at 8 o'clock

I have to drop my kids

I made it very clear

I moved into hospital

I never needed to go at 8

I went there at half 8

I was always bang on half 8

I Poem: I'm an experienced trainee

I'm less than full-time

I'm part time

I'm quite an experienced doctor

I'm not training at the level of the trainees that come out just out of medical school

I've done *surgery (speciality changed to preserve anonymity)

I know what the training in the hospital is like in *surgery

I training in India

I'm very experienced

As the listener, the defensive and emotional rejections of her positioning of *'problem trainee'* were

prominent within Seema's narrative. Alongside this appeared a sense of being an outsider within the

practice, lacking access to supervisor in the ways she would expect, and (at times) confused by the

tacit and implicit cultural norms of the practice community.

The defensive voice and courtroom language formed the loudest rejections of this position and identity, claiming that she had been misunderstood and pushed out by the antagonists in her story; the supervisor and the practice. However, the quieter, vulnerable voice suggested that instead, Seema appeared to accept and internalise a sense of being a '*problem trainee'*, and desperately sought belonging and inclusion by the very individuals she had portrayed as the antagonists within her narrative. Furthermore, it was apparent that she was unclear about how to gain this access and inclusion, feeling confused by what she'd done '*wrong*', and uncertain as to how to make amends.

I-poems – vulnerable voice

I'll sort that out

I swapped it

Now I know that

I said

I didn't think of that

I shouldn't have

I said

I didn't know that

I've discussed that

I didn't know

I had opted

The change of perspective in her new placement was striking, and this narrative offers an important example to consider why this may be the case, which will be discussed in greater detail within the next chapter.

Stephen

Initial thoughts

I first met Stephen in the third month of his ST3 (final) year of training. Much of his narrative was told in what I've labelled a mature, reflective voice. Although quietly spoken, he appeared confident, competent and older than some of the other trainees in the study. Less emotive than Seema's interview, his narrative was open and reflective, often weaving abstract thought and reflection throughout his storied account.

Not a 'typical' trainee

He had trained in another specialty before General Practice, and was married with a family. He began his narrative by identifying himself as a mature trainee, and therefore not a 'typical' trainee, training in a surgical speciality before starting his GP training:

> *'Um, and then so I suppose that whole part of my career, probably for about 8 years from then was*
>
> *all based around surgical supervision. Which is very different to what I experience in General*
>
> *Practice. So being supervision for technical skills, which is maybe a bit more like "see one, do one,*
>
> *teach one". Um, but obviously you've got to see a few more now because there are a few more*
>
> *hoops to jump through'.*

Early ST3: shopping for answers, confident trainee

The stories within Stephen's narrative suggested that (on the whole) he had relatively straightforward access to a range of supervisors, and was in control of who he chose to support him, depending on the clinical situation. He did acknowledge however that this choice and ease of access was also balanced with demands on the supervisor's time; not asking one person '*too much*'.

> *'Um, so that brings me on to the job that I'm in at the moment. Which, by and large is really nicely*
>
> *supervised. Um, so I've got, each day in the practice is the named GP who does the supervision, and I*

*suppose the first GP practice I was in didn't have a named GP. Um, which had pros and cons, **because***

you'd learn who your favourite GP was to ask questions** was. And **sometimes if you wanted a

certain answer, you'd ask a certain GP**. And then you'd worry that **you're asking one person too

***much**, so you'd go and ask someone else. I'm not really sure how that works, but it gives you*

exposure'.

As the listener, these reflections conveyed an astute observation of the perspective of the supervisor; needing to balance their own clinical work with the demands of clinical supervision. Stephen's approach to asking questions also appeared to consider his own developmental needs, the clinical question, and the supervisor's tolerance to interruptions.

In his ST3 placement, the supervision system changed, and he was allocated a supervisor for each clinic. This removed the element of choice, and the concern of approaching the same supervisor too much. However, Stephen described the challenge he faced when supervised by the salaried GP, who he considered to be only slightly more experienced than him:

'The only problem that I've found in the practice that I'm in at the moment is that there's salaried GP

*who was an ST3 last year. And**, as an ST3, halfway through my training, I find asking her a bit***

***awkward sometimes.** Cos if I don't know what I'm doing and then she comes in and she looks, and,*

she obviously feels that her role is to make a decision. Which she does, but sometimes she leaves the

*room and the patient goes, "**does she know what she's talking about** "? Or…I don't know if there*

should be a certain amount of experience. Cos she's not a trainer, so whether it's the difference of

being supervised by someone who is a trainer than by someone who isn't a trainer. I don't know'.

From this excerpt, Stephen seemed (to me) to see himself as a mature professional; seeking help mainly for those clinical dilemmas that were more complex. He appeared to expect a professional dialogue that appreciated this complexity, rather than a quick 'fix' or impartation of simple

knowledge. He appeared to be looking to his supervisors for wisdom and experience, which he found to be lacking in the younger and less experienced GP.

Stephen came across (to me) as a confident trainee, where '*throughout training'* he considered that he was '*probably quite good'*.

Early ST3: making the jump

Quite early in Stephen's first interview, in what I've labelled his mature, reflective voice, he considered his GP training in light of his previous surgical experience. Different to the graduated increase in autonomy of '*see one, do one, teach one'* from his surgical days, the autonomy and decision-making required within GP training appeared to be associated with a '*fear that you're not quite doing the right thing'*. At this early stage of training, he considered '*making that jump'* to autonomous practice as an essential and inevitable part of training:

'*Um, and there's still the same thing in GP, but a bit different now that **when it comes to you making your own decisions** or doing a procedure on your own. **There's still that bit of fear** that you're not quite doing the right thing. **And I don't think there's any way that supervision can get round that. I think there's just sometimes you've got to be allowed to um, to make that jump'.***

He preferred a supervisor who was comfortable in encouraging greater autonomy, whilst also offering feedback and correction:

'*And I think that jump always feels more comfortable **when you're with a trainer who feels comfortable with you making it**. And I think if you're being supervised by someone who maybe isn't very open, then it becomes more difficult to progress because you're always left wondering what they think. And I guess throughout training a theme is that I'd like to think that I'm probably quite good. So I don't get very much negative feedback. But throughout my training **I kind of almost crave negative feedback**. And I don't think that's in a way of sort of self-flagellation. I think that's*

probably to feel comfortable that if I'm doing something wrong, that the person who's supervising me

would say it, so that they're not, they don't have worries about my performance that they're not

telling me. So I think if someone's open and they're able to give negative feedback, it's probably quite

empowering. Because then that allows you to move on. And it probably improves the training

relationship. Whereas if you're only having positive feedback, yes it's nice. And yes it's good. But it

needs to be balanced sometimes I think'.

Later in the narrative, he again considered his goal of greater autonomy within training, and growth

towards becoming an independent practitioner:

'Um, and then my experience of supervision in GP is, because you're sitting in that same room next to

somebody, it's probably the easiest supervision to access. And as I go forward, I don't know how that

*will progress. I know that I ask less and less questions. **But that safety blanket is still there**, that I can*

*pick up the phone. **And at some point I'm going to have to break free from that**. And it's*

not…because of the way that training runs, it won't happen until I'm qualified, or until I have my

MRCGP. And that's probably not ideal. At some point I should be allowed to sit in a surgery and

make my own decisions…'

In his attempts to use the *'safety blanket'* of his supervisor less and less, Stephen appeared to have a

strong sense of personal responsibility in developing as a professional, particularly with respect to

the pursuit of greater autonomy.

Early ST3 supervision: confidence in his supervisor

In his initial interview, it was clear that Stephen had a positive relationship with his educational

supervisor, who he viewed as a trainer who *'cares'*, and who was engaged and *'interested'* in the

training process.

'Um, I've got a very dedicated and devoted ES. And I think I'm really lucky actually. Cos speaking to

some people, just the whole process becomes very difficult if they're not as interested as mine is. I

can remember being worried he was a bit neurotic because he was texting me over Christmastime

*one year saying, "We need to get a review done" and thing. But it was because **he genuinely cares**,*

and he's only texting me cos he's sat down at that time of year to have a look and he's spotted

something that I haven't done. And he wants to make sure that we get it done so that nothing's

missed out on. Um, I think probably to begin with it felt a bit formal. Um, but now I'm in the practice

*and you know, **you realise you've got some common interests**. We've both got children of the same*

*age. And it becomes, **less formal**. Which makes things easier I guess'.*

The supervisor appeared to be viewed as a key source of clinical support, providing the challenge and critique that Stephen craved. There also appeared to be a personal connection, swapping stories of family life, and offering more than simply an educational or professional interaction:

Near-peers

I later met Stephen again around 6 months later, just before he completed his training. During this period, he had successfully passed his Clinical Skills Assessment on the first attempt, and had progressed in his training without educational problems.

At this point in his training, he reflected again on his relationship with his educational supervisor. In the earlier interview, they had a personal connection, whilst still maintaining a sense of distance between trainee and supervisor:

*'**But, I'm still aware that he's my ES**. There might be times that he's got to you know, pull me up and*

say, "you know, you haven't done that very well". Or…and that's fine. And he would. Cos he's

*professional. **I've got a lot of confidence in what he says** which is good'.*

In the follow-up interview, this appeared to have developed to one where Stephen recognised the supervisor's approach and opinion, but did not always take the supervisor's direction on board. The relationship described was more like peers, discussing their own preferences and professional styles, on some occasions choosing to respect their differences, and on others, finding the '*middle ground*':

*'And um, it's been quite interesting throughout ST3 as well learning what sort of doctor I am. And my trainer is probably a bit more interventionist than where I want to be. Um, bit more risk adverse, bit more investigations. But, kind of, for me, **accepting that who I want to be maybe isn't quite the same**, but still seeing that and seeing where I fail sometimes and seeing where he fails sometimes and trying to meet a middle ground. And we talked about that, which is a good thing in supervision. **And he kind of accepts that as well**. That his background's medicine, he's done MRCP, so he's very much by the book. "This is how, you know, you investigate this, this is how you investigate that'.*

…but 'awkward'

Whilst remaining largely positive, Stephen described this more peer-like interaction to be combined with an '*awkwardness*', which he attempted to understand throughout his follow-up interview:

*'It's a really positive relationship. I think it's **based on mutual respect**. Um, and certainly he…you know…so I suppose he doesn't ever voice it. But I can see from what he puts in my educator supervisor reviews that he thinks that I'm a good trainee. Um, but I, **I still feel there's a bit of a disconnect** between sort of the personal side of it. Which is where he's very friendly and we can chat about family and we can chat about other interests that we've got. And then this, this stress-based reaction, sort of doctor. When he's on call, he gets very stressed. **So I don't know** if it's the stress that then makes it feel awkward. But, or just his inner turmoil. Or **perhaps it's me**, maybe I don't react very well to criticism and that's something that I haven't realised. But nobody's ever said to me…**I dunno**. But I mean, but to describe the relationship **it's definitely a mutually respectful one**. We'd respect each other's decisions. But there does just sometimes feel that **awkwardness**. Yeah'.*

He referred to this *'awkwardness'* at a number of points in the follow-up interview, but seemed to be questioning (both to himself and to me) why it was present. Alternative reasons for the 'awkwardness' were offered, which appeared to relate to the supervisor's reluctance to deliver negative feedback or criticism of the trainee's decisions:

*'I suppose, there was the complaint at the beginning. There was a complaint about halfway through the year actually. I'd seen a middle-aged woman who had postmenopausal bleeding and I'd referred her on a 2 week wait. And she wrote this very bizarre letter saying that I'd been very courteous and kind and she'd no problems with my mannerism. But she just thought that I lacked subtlety when I suggested that cancer might be a differential diagnosis. Which is a bit of a non...well it is a complaint. You've got to respond to it properly. But it's a bit of a non-complaint, because it's a difficult thing to be subtle about. Which I've taken on board, I've tried to change practice a little bit. But I just...I felt again that my trainer's kind of awkwardness. He wasn't, didn't have the confidence just to come to me and say, "Look, there's been this complaint". He felt awkward about telling me there'd been a complaint. Um...and didn't want to shy away from it, because we discussed it, and it was discussed at the practice meeting. But he didn't really feel confident in addressing that with me. And I just find a bit odd, because he's been a trainer for a long time. **Whether he's had a bad experience** of someone not, not responding well to finding out about a complaint. But I was slightly surprised because I think we've got a good rapport. We get on with each other. And he could have even texted me and said "You know, there's been a complaint. It's not serious, but we need to talk about it tomorrow". But instead it was kind of...Practice manager told me that he wanted to speak to me, and I went into his room, **and it was all a bit, a bit school child. I dunno. Maybe that does go back to the trainee-trainer divide. And I feel I'm more of a peer. But maybe I'm still. Maybe that's my view of where I am, rather than the practice's view of where I'm at**. But yeah, I think that's about it'.*

Stephen described a sense of uncertainty about the reasons for the awkwardness he perceived.

In the discussion about *'awkwardness'*, a new voice was introduced in this interview, which I have labelled the 'uncertain' voice:

I-poem: Why is it awkward?

But I just

I felt again that my trainer's kind of awkwardness

And I just find a bit odd

I was slightly surprised

because I think we've got a good rapport

I went into his room

I dunno

And I feel

I'm more of a peer

But maybe I'm still

Maybe that's my view of where I am

rather than the practice's view of where I'm at

I think

However, when considering the I-poems in the context of this narrative, there is a shift from the references to 'I' within this except, to externalise his reflections towards his supervisor's inability to deal with the complaint. Although he asked the question *'perhaps it's me'*, the messages from these excerpts suggest an alternative perspective. Stephen appeared to express a feeling of dissatisfaction with the instances when he was treated like a 'student' by his supervisor, rather than a 'peer'. There is a sense that this is incongruent with his sense of self as a mature trainee, and a near-peer to his supervisor, and a suggestion that he is using the narrative to push back against the student-supervisor dynamic, in favour of being seen as a peer, or equal.

Relationships with wider practice

Stephen did allude to his relationships with the wider practice in both his early and later interviews. I have already discussed the way he moved between various supervisors for support in his ST2 placement. He appeared to have a strong sense of agency in the supervisors he chose, balancing an

awareness of his own training needs, and the supervisor's particular clinical experience in his decision-making.

However, he did worry that he might ask the same individuals '*too much'.* As discussed earlier, one layer of this area of concern appeared to relate to an awareness of the supervisor's threshold for interruptions for clinical questions from trainees. This relates to the notion of access to the supervisor, denoted by Stephen's perception of irritation or frustration from the supervisor during his interruptions for questions. His response was to gauge the threshold of the supervisor regarding their tolerance for interruptions. Stephen's perception of this, and the careful navigation of both his own needs and the vantage point of the supervisor, may offer an insight for the relative ease in access he perceived to have experienced.

A further interpretation of this area of concern may relate his discomfort with the student-supervisor dynamic illustrated above, where questioning an individual 'too much' may serve to further position himself as a 'student' within the relationship, a status that may be incongruent with his sense of self as a peer within the interaction.

Stephen did appear to experience a relative ease of access and inclusion within the practice team at his ST3 practice, which was felt from the beginning of the placement:

'As I was fairly new to the practice and um, I was faced with this child who'd been admitted for an

emergency procedure that I'd been the last doctor to see in the practice. Um, so that was quite a

challenging thing to deal with. But, um, the way it was dealt with by the practice was very good.

There was time taken to um, allow me to express my feelings. It was discussed at a practice meeting,

and it was done in a very non-judgemental way, which was important because if it hadn't been then it

would really have um, affected my confidence probably more than it should've done. And reflecting

on it now, um, I feel a lot better about it. Obviously it's not a good thing that you know a child was

poorly, but um, this was something that rare and, it was seen by different GPs and nobody had picked

it up. And that was kind of said to me and the time, and you obviously think as a medic, "Dismiss

that", because you want to be superman, and you think that you should be able to nail every

*diagnosis. But, particularly in GP, that's not going to happen. Um, so that was dealt with well, **and***

***allowed me to keep being confident**. And surrounding that, I suppose, the few weeks afterwards,*

everyone was very happy if I discussed any *similar presentations with them [smiles], cos, because

everyone was kind of rocked by it. And so people kind of acknowledged that this was a traumatic

*thing, and it was quite nice to feel supported in that way. That **everybody acknowledged that they***

could have missed it as well'*.

In this example, he experienced a case of a sick child where he, and others within the team, had

missed a rare and potentially life-threatening diagnosis. He described receiving support from the

practice, which was non-judgemental, and inclusive. The team's response was to suspend

judgement, share their roles in the outcome and offer support and advice in the weeks afterwards.

This validation of his experience helped his sense of confidence, and depicts a sense of inclusion in

the dynamics of the wider team.

The 'system'

In Stephen's account, the training system was less frequently discussed. Instead, he referred to

practice-based events and episodes, such as clinical cases or complaints, to consider his supervisory

relationship. His narrative appeared to be more firmly situated in the life of the practice, with the

opinion of the wider team deemed prominent in these examples. It is unclear why this is the case,

but may relate the Stephen's generally uneventful progression through the various training

requirements, where the potential 'threat' of the training 'system' was less of a reality. It also may

reflection his general sense of inclusion within the wider life of the practice, and subsequent

motivation and fulfilment found in the practice environment, with little need to look beyond its

borders.

Final thoughts on Stephen's story

Stephen appeared to move confidently between various sources of supervisory support at his ST2 practice, and experienced an ease of access and rapport with his educational supervisor. His early interview suggested a trainee who was developing his professional identity, linked to a greater sense of autonomy in his clinical practice. In his follow-up interview, it appeared that he had developed professionally, becoming clearer about who he was as a GP. Later in the year, he appeared to have moved away from needing significant guidance and direction from his supervisor. Instead, he recognised that his preferred professional approach was different to that of his trainer, and described a supervisory relationship of peers, based on mutual trust.

Stephen's experiences of being treated like a 'student' by his supervisor conveyed a sense of 'awkwardness' in his reflections. It appeared that these were particularly striking for him, because they were incongruent with his sense of self, as a confident and mature near-peer within the context of supervision and the training practice.

Reflections on Seema and Stephen's stories

I found the differences between Seema and Stephen's experiences quite striking, particularly with respect to the positions each appeared to occupy within the Figured World of GP supervision. Seema's narrative painted a picture of battling for access to support from her supervisors, craving inclusion but instead feeling on the outside of the practice and supervisory relationship. She appeared confused, and uncertain in how to navigate towards a more 'insider' position. In the times when problems occurred, she felt misunderstood, silenced, isolated and unfairly judged by her practice. In her account, her multiple identities of an experienced (not 'typical') trainee, single mother, and less than full time trainee are evident to her, but unrecognised by her supervisors. At the end of her interview, I was left with the impression that she had looked to me (as the researcher)

as a means to defend herself to the 'system', and also to herself; rejecting the idea that she was a *'problem'* trainee, whilst also exploring how and why this positioning had come about. Within the emotion of her interview was a sense that she had felt silenced and unable to challenge the labels and positions given to her; powerless within the 'system'.

In contrast, Stephen appeared to navigate the relationships and supervisory support within his practice with a greater sense of ease, and a stronger sense of agency. When he experienced a problem within his training, he was invited into discussion with the practice, where the team expressed their part in the problem, and shared the responsibility. His inclusion was almost taken for granted; alluded to, rather than battled for. Instead of craving inclusion, he pursued greater autonomy in his practice. By the end of his second interview, he came across as a more independent practitioner, secure in his professional identity and positioned as a near-peer within his supervisory relationship. However, there were times in his narrative when this identity was questioned. He experienced a 'disconnect' with his supervisor in times when he required correction or negative feedback. Stephen, in his view of himself as a 'professional', expected this correction to be delivered as a peer-to-peer discussion, but the supervisor chose to interact in a more formal manner. This led to times of distance within the relationship and an unexpected change of positioning for Stephen back to 'trainee'. In these times, he also appeared to be uncertain and confused, and unable to navigate to the peer-like position he preferred.

A number of important themes were highlighted through Seema and Stephen's stories, illuminating the Figured World of GP training. The first relates to the identities of the trainees, which appeared to be multiple and dynamic within the narrative accounts. The supervisor had a prominent position in the narrative of both trainees. However, the wider practice was also a pertinent influence, and appeared to contribute to their sense of identity. For Stephen, it appeared to legitimise his mature,

near-peer identity. For Seema, there is a sense of further positioning as outside of the practice community, as a *'problem trainee'*.

The narratives also raised additional considerations of positioning, and repositioning within GP supervision. This related to notions of access to the supervisor, and to the agency of the trainee to respond to the particular positioning they found themselves in. In Seema's narrative, her position as an 'outsider' in one practice, moving to more of an 'insider' in another appeared related to her vantage point, which seemed to change along with her position. In Stephen's story, there was a similar change of vantage point as he moved from the confident navigation of a 'peer' in his supervisory relationship, to the uncertainty of a subordinate.

Seema's narrative also referred to the subtle, yet consistent influence of the training 'system', which she perceived as a judge. Although this is less prominent in Stephen's account, its relative absence may reflect mastery in navigating the system, rather than the daunting adversary depicted in Seema's stories.

When compared to Seema's experience, the contrast in confidence and ease in which Stephen navigates his training, and his pursuit of autonomy, is striking. This observation is underpinned by significant complexity, but may relate, in some part, to gender. Although a deeper exploration of the role of gender is outside of the scope of this research, it is noteworthy, and forms an additional lens into the complexity of relationships within postgraduate GP training.

In the next chapter, I will consider the themes from Seema and Stephen's interviews in light of the remaining 11 participants' stories, and compare and contrast these experiences to build a more comprehensive understanding of the Figured World of GP training.

Chapter 8: Narrative Inquiry results: Looking across the narratives

In this chapter, the results from across all 13 narratives are discussed. Figured Worlds theory

(discussed in greater detail within **Chapter 3**: **Theoretical Perspectives**) was key to informing the

narrative analysis. Central concepts in Figured Worlds theory have been used to present the results

within this chapter.

Agents

Thinking firstly of the agents operating in the Figured World of GP training, there were four main

groups outlined by Seema and Stephen; the trainees themselves, their educational supervisors (or

trainer), the 'practice', and the 'system'.

The trainee as an agent

'Being' a GP trainee

For Seema and Stephen, 'being' a GP trainee appeared to hold different emphases. For Stephen, a

GP trainee was on a journey towards professional autonomy, working towards greater independence

in the management of complexity, and using the support of his supervisor less. For Seema, it

involved a relationship with her supervisor where she felt understood as an individual, and included

within the practice team.

Like Stephen, George, a full time ST3 trainee also reflected on the journey towards greater

independence as his ST3 training year progressed:

*'I guess, **to start with, I probably was going to seek out my supervisor more** than I was at the end of*

my ST2 placement. Just because it's a new practice and new demographic. Things work differently.

*You're not kind of comfortable in your environment. Um, and I think that now I've managed, **now***

***I've kind of gradually cut that down**; obviously become a lot more comfortable. And now I maybe will*

go to. I'll pop in to kind of knock the door of my supervisor a few times a week just with an issue that

needs to be sorted there and then. But the majority of the time it's stuff that I can kind of hold back

and speak to him at kind of a more structured time. Which kind of maybe makes more sense'.

(ppt 14, George)

Being a GP trainee for George and Stephen referred to the management of risk, and related to the

comfort in which they took responsibility for their autonomous decisions. They had a personal sense

of responsibility for their journey, consciously deciding to use their supervisor less, despite the

discomfort this may have led to.

Ayesha, who had recently moved to a practice where her workload mimicked that of a salaried GP,

accepted this workload as a rehearsal for her working life once qualified, and saw it as an

opportunity to grow in confidence and competence. In contrast to George and Stephen, it was her

supervisor who appeared to drive this agenda, although Ayesha did acknowledge the merits of it.

'My [first] supervisor… I was kind of spoon fed in the way that I learned. But I found it really good.

Um, that particular supervisor that I had would go through my surgeries you know, morning and

evening. Go through all my patients, discuss my management plans, um, so it was clinically, it was

*really, you know helpful… But my current supervisor has a different approach in the sense that **he***

***wants** me to be very independent. Find my own um, find out how I would manage this patient on my*

*own, um. **He would direct me** to the resources and lets me go and research about it and find it on my*

*own. And what this **supervisor always tells me** is, in a year's time you have to be an independent*

practitioner, and if you didn't have a colleague or anyone to discuss things with, you need to find out'.

(ppt 18, Ayesha)

The views of these trainees suggested a linear progression towards autonomous practice upon qualification, with increasing responsibility, participation in practice life and increasing management of risk and complexity. This is similar to Lave and Wenger's notion of legitimate peripheral participation, where the learner (the GP trainee in this case) moves from a position of 'newcomer' within the context of GP training, and grows to participate fully in the community (in this case, the GP practice) through increasing roles and responsibilities in the working life of that community (Lave and Wenger, 1991).

Sarah, an experienced academic trainee, who had nearly finished her training, provided a different lens. Whilst she also alluded to the need for preparedness upon qualification, she wished to be viewed as an employee within the practice, and craved some input from her supervisor whilst still in her trainee role:

*'I think the problem now is with me just doing *some days in the week, um, I kind of miss out on that. Um, and I think that **perhaps I'm not kind of assertive enough to say,** "actually, I do need a tutorial once every 4 weeks"…"**You know, I am still training, and I still do need you to sit in consultations, and I still do need tutorials, which kind of isn't happening too much at the moment**". Which would be helpful, just kind of, for further development, even though I haven't got any exams left.*

*"I guess at the moment I'm not actually, if I think about it that happy with my kind of training set up at the practice. And I think probably that's because I'm there the least. And also the most, I've been around the longest, so it's kind of like, "oh, I'll just focus on my ST2 and ST3 that have got exams and you can just kind of get on with it". Um, partly it's my fault for not making a point of that being a problem earlier on. Um [3] **It's like sometimes you do feel like you have to kind of fight for the CBD's and the mini-CEX's and the training opportunities** and the joint consultations and the tutorials'.*

(ppt 11, Sarah)

Esther, who had just returned from maternity leave to begin her ST3 year, felt that her confidence came from regular engagement with her supervisor, rather than increasing autonomy. She felt protected by her trainer, and her aim was to avoid the worry of working in isolation by regularly debriefing with her trainer.

*'Going into ST3, my educational supervisor who I'd known all along since ST1. He's great and, kept in touch with me when I was on maternity leave. Um, especially leading up to going back and he kept messaging and saying **he didn't want me to be worried** and he'd do a slow induction and um, always makes a point of going through any, going through my surgeries. If there's [patient] with any questions, he wants me to ask them, to learn, but also so that I'm not going home with any worries or any niggles at the back of my mind. And I feel that I'm learning a lot more and becoming a lot **more confident because of how he is** about that'.*

(ppt 15, Esther)

Esther's perspective may not be surprising in view of a recent return to work following a career break. However Nadia, a trainee who was just about to qualify, also wanted to ensure that she had ongoing clinical support from senior staff, even post-qualification. Upon hearing Nadia's story, I was struck by her feelings of concern about her preparedness for autonomous practice. Her training placement had provided a practice community that had enabled her to have a variety of sources of support, such as a group of senior colleagues who welcomed clinical questions, practice educational meetings, debriefs and tutorials. She painted a picture of a learning community within the practice, where even the most senior partners would share their learning needs, and where the multidisciplinary team would develop together. Her interview, undertaken a few weeks before qualification, illustrated her concerns about leaving this learning environment, and displayed her awareness that not all practices shared this culture.

From the I-poems:

I-poem: I'm not ready to be on my own

"and I think for me now

as I'm looking

at um, what sort of practice I want to go into

That is one of the things that I do ask them

Because I think

I can't

I personally don't feel

I can just make a complete jump from ST3 to going to become a GP

And that I don't need any supervision at all

or I don't need any input at all

I think I still do

I still need that support

And I would look to someone for support

when I go to practice"

(ppt 17, Nadia)

Nat offered an explanation for the tension felt between the need for increasing autonomy, while balancing feelings of also needing support. She had encountered concerns from her practice about her preparedness for practice upon qualification, particularly with recently implemented changes to the junior doctors' contract, and suggested that influences of policy and the wider training system also had contributed to the trainee's concerns about preparedness:

*'with the new doctors contract, **it's very different in terms of our day compared to the day of the partners and the salaried's**….I have asked to do shifts such as on-call and duty doctor days. But again, that's not been facilitated. But again, **I think that has a lot to do with their fear of the new contract and breaching hours**. Even though I said I was happy to even sign a disclaimer and say, "I don't mind". It's still not been done…**And that's basically what we keep hearing from here. Is that they don't think that we'll be prepared for the real world** due to the new junior doctors contract.*

They don't feel that we're meeting their expectations for workforce capacity. Um, and there's a lot of

negativity around that'.

(ppt 12, Nat)

For George, Stephen and Ayesha, 'being' a GP trainee involved a move away from the 'safety blanket' of supervisor support towards the role of a qualified GP within the practice. However, for others, 'being' a GP trainee was something distinctly different to being a GP upon qualification. For some, 'being' a GP trainee involved working in a Figured World that seemed set apart from their envisioned world of a qualified GP; with access to support when needed, and protection of their status as a GP trainee through workload and emotional, educational and professional support.

The motivations and expectations of the trainees regarding 'being' a GP trainee also appeared to be influenced by the type of person that they were; leading to a consideration of the notion of the trainee's 'identity' within the Figured World of GP training. The I-Poem method of analysis was particularly helpful in illustrating this within the narratives.

Alongside the striking differences in perspective on autonomy between the trainees, it is also noteworthy that those most confident in their pursuit of autonomous practice were the male trainees. Although three trainees alluded to the pursuit of greater autonomy, the independent pursuit of autonomy and approach to risk did appear to differ between George and Stephen and Ayesha. Sarah's reference to not being 'assertive enough', and Nadia and Esther's reflections on their lack of confidence to practice autonomously illuminate an apparent difference in confidence between some of the male and female trainees. These observations suggests an additional layer of complexity (with respect to gender) when considering autonomy and participation.

Working out identity in the Figured World

Like Stephen and Seema, the narratives from the trainees frequently outlined the multiple, and sometimes conflicting, senses of 'self' encountered in GP training.

Jas, a trainee about to qualify, outlines the inner conflict she experienced when personal problems made her ST3 year difficult, leading to problems in her ARCP assessment.

The I-poem is used to describe her feelings at the time, as she supported her husband during his period of illness, whilst also trying to juggle her training requirements:

I-poem: conflicting identities
I revised for my AKT
I felt guilty
I wasn't spending time with him
I was needing to do that so much
And I felt
I was neglecting him,
I could never be there with him
I could never
I could never do anything
I was on call
So I was
I think
I was being pulled in different directions

(ppt 2, Jas)

She also reflected on a period in her training when she was supporting both her mother and her husband:

'So I was, I think there was probably 3 dimensions that I was being pulled in different directions in my life, and GP training came right at the bottom. And I think appropriately. But, I guess I didn't feel, I never have felt confident enough to walk up to a trainer and say, "this is what I'm going through, you

know, what are you going to do about it". There's too much of a threat of like , you know, 28 days

*out of training, and you'll get an extension and I didn't want to, **I wanted to finish it as quick as***

***possible so I could you know, carry on with my life** and spend time with my husband that I needed*

to'.

From this excerpt, I was struck by the way in which Jas viewed her GP training, as something to '*finish as quick as possible'* so that she could '*carry on'* with her life. There is a sense that she viewed 'being' a GP trainee as incompatible with her own sense of self and identity as a wife and daughter; in conflict with her goals and motivations. This vantage point appeared to prevent her seeking help from her trainer in a time of personal crisis, apparently believing that the inner conflict of 'being' a GP trainee was irredeemable, and something to be endured for as short a time as possible, rather than improved.

In contrast to Seema's pursuit to be viewed holistically within her training, as both a trainee and a mother, Jas' narrative suggests a drive to keep her personal and professional identities separate. The influence of context, both inside and outside of training, remains a powerful influence in both narratives, but the trainee's differ in their self-authoring of what is means to 'be' a GP trainee, and subsequently their approach to juggling their personal and professional lives.

The supervisor (trainer) as an agent

The supervisor: different degrees of prominence

The educational supervisor, or trainer, is discussed in the narratives of all the trainees. However, the extent to which their roles were appraised, and to which the trainer was given prominence, differs.

For Esther, her trainer represented a protector, or father-like figure; guiding her through the new world of GP training as a neophyte. The trainer's role was dominant in her narrative, and he was a key shaper in her training experience.

Similarly, for George, the stories of his trainer predominate:

'My relationship with my trainer works really well. Um, and I think part of that is because, I think that we kind of practise along similar lines, in that a lot of the experience of GP is, or the way in which GPs differ is often to do with their comfort in kind of managing risk. … **I think that I match up quite nicely with my current supervisor. So I think that's quite a key to that relationship actually.** It also helps that we kind of get on from a social perspective and you know, and there's not kind of clash of personalities in other ways at all. But it works quite well because I feel that, when I'm thinking about how to manage a particular case, if I go to him, then actually his thinking is likely to be the along the same kind of lines, even if it's a more formulated opinion along those lines. So, I think that works quite well. And, almost, **he gives me a nice kind of role model** type. Um, situation where actually I, I can see myself aiming towards being a practising GP similar to the situation that he's in now'.

(ppt 14, George)

George's trainer is 'like him'; offering a role model for a relaxed approach to managing risk, and someone he can enjoy spending time with socially. Like Stephen, the relationship appears to develop to be more peer-like.

In contrast, the trainer for Cara was somewhat distant, and the voice of the trainer less dominant in her account. Cara was an ST3 trainee in a busy inner city practice.

'Well, *with my trainer, I really like him and respect him. I like his style. As in, because, I've got family. Well, not my family, but my in-laws are GPs. And they're really close to their trainers. Even after years of qualifying and see each other and all that. Whereas we are…he's my trainer and I'm

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*the trainee. It just works for me. I'm not sure I'd want someone that I was that really, really close friends with or anything. We've got a common goal which is "see those patients safely, do the best for them, um, you know, obviously my learning and then get qualified". And that, **it feels like a business thing**. But, that suits my personality and his I think as well'.*

(ppt 19, Cara)

Preet, just about to CCT, reflected on her own experiences. She, like Ayesha, had a very supportive and accessible ST2 GP supervisor. In contrast, she found it more difficult to access help from her ST3 supervisor:

*'*With my ST3 trainer, it was difficult. Sometimes we would have very annoying conversations em, and he would feel quite frustrated with me and **I would feel quite frustrated with him because I would feel like I wasn't really getting the support**. I think he probably just felt like I was maybe nagging him to do stuff or, or just adding to his workload. And that used to be frustrating for me because I'm like, "you've chosen to be a trainer, I need you to do your trainee-trainer things".*

*'cos he was either on call or stressed out or busy or just didn't really have time to help. But, I just think he had so much going on that **he just couldn't devote the actual real time that actually needed to be given** to a trainee. Which I can imagine is the case for many trainers when they're partners and dealing with all the problems that you have with being a partner'.*

(ppt 3, Preet)

For some of the trainees, the trainer's prominence increased over time. The following I-poem summarises this development within Nat's narrative:

I-Poem: the relationship's development

I think, before ST3, you don't see them

but I think when you work with someone

before I worked with him, that used to really stress

Cos I was like, "there's a deadline coming up

And I'd be hassling him

he's quite difficult to read I think initially

and I'm quite chatty

I had to then rein that in a little bit

He's more appropriate I think

I'd say we've got on really well

And I think, yeah, you get to know someone that bit more

I think out of all the partners

I think obviously with him being my supervisor

he's the one that I would say

I get on the best with

And I think cos he's been a trainer for so long

(ppt 12, Nat)

In Nat's early interview, at the beginning of her training, the voice of her trainer was almost absent,

and attempts to meet with him were often arranged through formal routes such as email and

diarised appointments when he was available. I later learned that they found it difficult to meet

together due to timetabling issues. However, in her follow-up interview, towards the end of training,

the trainer's role dominated. Throughout the training year, they found ways to meet and learn

together outside of the formal scheduling arrangements, which enabled their relationship to

develop.

Supervisor as an agent: negative experiences

For Seema, the negative experience with her ST2 supervisor was hugely influential, and shaped her overarching narrative and sense of identity as a '*problem trainee'*. Alison's story had a similar feel, outlining a supervisory experience in which she felt positioned and identified by her supervisor in a manner incongruent with her own sense of 'self', and as a result, had a negative impact on her supervisory experience. She was an experienced trainee, who worked at her practice part time following maternity leave. At the time of the interview, she was just about to qualify, and reflected on a significant challenge she experienced with her supervisor when she went to him for support:

*'I think I was finding it difficult anyway because of, I was pregnant, I was doing my CSA, I was trying to balance kind of academic and clinical life. Um, they'd asked me to do 5 sessions when I think, realistically, I should've only been doing 4 and a bit…We were also on 2 sites, and I very rarely was on the same site as him for the 5 sessions I did. So I had very little contact with him, and my time with him wasn't really kind of protected in any way. Just had to be squashed into the day. Um, and when **I went to him because I was really struggling**, I felt like… I was being pushed too, probably partly cos of being part time, and them feeling like I was further along than I actually was, **I was being pushed** to get down to 10 minutes with no breaks very quickly. When in reality I wasn't even halfway through my ST3 year'.*

*'So I went and asked about it, and said **I was struggling**. Um, **and I felt then very much it was all kind of blamed on me.** And, um, he suggested a few changes, but they were kind of a bit tit for tat changes. Like we'll kind of make this bit a bit easier, but then you have to more of this.*

So it just sounded like, "She's not coping…so we're going to have to cut it down…" Which I felt was quite an unfair representation of the situation'.

(ppt 13, Alison)

Alison's narrative is a powerful illustration of the way she felt labelled and identified as 'not coping'; something incongruent with her own self of self as someone who will 'just get on and do', without complaining. In this narrative, it is the supervisor who is viewed as the social agent who attached this label, and positioned her in this way, by failing to appreciate her concerns and understand the type of person she was.

This experience is not dissimilar to Seema's feelings of being misunderstood. Her sense of self as a single mother and part-time trainee appeared unrecognised by her supervisors, and some of the labels of 'not organised' and 'time management issue' attached by her supervisor (and also documented within her training portfolio) were incongruent with Seema's view of herself; as a busy mum, juggling her time and various commitments.

The supervisor as an agent of 'structure'

A number of the GP trainees appeared to lack clarity, or feel suspicious, about the supervisor's goals and agenda in supervision. This was evident in Seema's narrative, where she felt suspicious of her supervisor's agenda in coming into her room without knocking.

Jas perceived her supervisor's support to have been offered for the benefit of protecting herself against criticism; documented for the benefit of the supervisor and the 'system' rather than in support of the trainee:

*'So, when I failed that ARCP, I got lots of… this is interesting actually, lots of messages on my portfolio and recorded, documented, evidenced-based things on my portfolio from my supervisor like 2 weeks before. "You haven't got enough log entries". Or "I'm getting really worried about you. You haven't put, you know, enough log entries". **And I felt that was just to show**. Just to show that actually "I*

have tried to kick her up the backside, but it's not working". But just 2 or 3 weeks before. Which I

*thought was a bit nasty. **Because I'd not really been approached on a personal level***'.

The practice as an agent

The lack of contact with her supervisor was striking within Alison's narrative, due to timetabling and geographical issues. This may offer one perspective on her difficulties in her relationship with her supervisor. Referred to as '*they*' within the excerpt, it appeared that the practice administration had influenced the training location and timetable of both trainee and supervisor, leading to erratic and infrequent contact.

Nat, a ST3 at a busy practice with a number of GP trainees, had a similar experience. She perceived her training practice as a dominant constraint on her learning, through limited scheduling of interaction between herself and her supervisor:

*'Yeah. **Not having scheduled tutorials* frustrated both of us** I think. Obviously I see him most days*

anyway. So we'll have a chat most days. But yeah, the fact that we've not had a single tutorial

together. We even struggled to get. He had to come in on his off-day for my first ESR in…it would've

*been around December time. **Because they wouldn't allocate him time** in the rota for it, because we*

*hadn't given 6 weeks' notice. And I think it's the **lack of understanding between HR and admin and***

***the trainers** as to what needs to happen. How important certain things are. Such as the observed*

clinics and stuff like that. Cos you'd been battling to get an observed clinic, and they arranged that.

But they arranged it for after my final ARCP. It's just things like that. No matter how many things

he's tried and sent emails and spoke to people. Certain things just haven't happened or have been far

too difficult. Or more difficult than they should be. And again I think it's just because they're so set in

their need to have this many doctors, this many appointments across all the sites. And it's all planned

so many weeks in advance, and they can't bend the rules'.

Nat reflected that despite having a degree of control over scheduling and teaching time, the administrative staff at the practice had insufficient understanding of the complexities of the training calendar, and training requirements, meaning that their decisions were often at odds with the preferences of the trainee and supervisor. Her account is an interesting reflection on the relative lack of ability on the supervisor's part to remediate this; describing a sense of equal frustration and inability to change the status quo from both trainee and supervisor.

The scheduling and training practice culture, like Nat's experience, represented sources of constraint in Cara's learning experience:

*'I'm constantly going over my hours. So we'd have like meetings. And even…**my trainer wouldn't be***

there, *the other partner would be and another GP would be, and we'd sit and discuss it. And it'd be*

"'we'll write this up, we'll write minutes up, and then we'll do something". And I'd go away and think

"oh that's great, something's being done". And then 2 months down the line you're in the same

situation'.

For Preet and Nadia, the influence of the wider practice is tangible. This is perhaps unsurprising due to the relatively smaller role of the supervisor in their respective accounts.

'Em, and some of the other GPs were less stressed, [compared to the educational supervisor], so they

were more approachable and friendly and would, you know, if you had questions.

The good thing in that practice was we had 'Huddle'. So, em that's also what I started to do. I started to bring my clinical questions to Huddle. Em, because I didn't,…sometimes I would be able to go to the supervisor, sometimes I wouldn't. Just purely because of time. Time management. So I would just bring things to Huddle'.

(pp3, Preet)

In Preet's narrative the influence of the practice was a positive one, providing learning opportunities which were not offered by the supervisor. Having an avenue for questions and checking important to her as part of her training. When she didn't find this to be available with her supervisor, she worked to identify this resource elsewhere within the practice team.

In Nadia's narrative, the practice culture of support and learning together was also hugely influential, providing regular scheduled times to learn together, alongside the involvement of various members of staff in her learning experience.

'So, I think it is important that we gain a bit of confidence in thinking "ok, I've done this, if I have problems I can talk about cases". ***And we have the opportunity,*** *because we have 2 practice meetings on a Monday and a Friday, and we can discuss cases then. And I've always found that useful* ***because everybody is there.*** *The salaried GPs, the other trainees, um the nurses, the partners…so it's quite useful to be able to just bring them. And they do encourage us to talk about cases. And even the partners will bring the cases that they're not sure about.* ***So, you do kind of feel like everybody's on an equal or level playing field'.***

(ppt 17, Nadia)

Raj described the role of the wider practice team in providing assessment and monitoring support. In his story, the negative feedback from a partner at his practice was hugely emotive, and he perceived the hierarchical nature of relationships in his practice as contributing to the lack of support received

in the aftermath. His solution was to look outside of the practice, to the training 'system' for this support:

*'Obviously the comment that was made about me, it's anonymous. But, you can kind of figure out who wrote it. Um, so that made it really quite difficult to (1) I guess, deal with it internally within the practice because, **if I went to my supervisor for example, her boss would've been this guy**.... * So it was really quite awkward um, so, in order to kind of resolve it I had to go kind to the head of school and the dean and um, and it was through the discretion of him that I ended up moving practice. Which, **I guess needed to be done'**.*

(ppt 1, Raj)

From these examples, a number of elements within the 'practice' are highlighted. For Nat and Cara, the 'practice' represents the mainly the administrative element; the non-clinical staff tasked with scheduling patients and educational interactions. For Raj and Preet, the 'practice' relates to the wider group of professional clinicians (mainly salaried doctors and GP partners) who provide supervisory, assessment and clinical roles. In Nadia's case, the 'practice' also represents peers, learning together. The narratives suggest that the structural arrangements in the practice, and the culture of support and education, all influence the trainee's view of the Figured World of GP training, and ultimately their training experience. It is in the structure and cultural environment of the practice where the trainee's identity is worked out, and thus the practice itself has an important role within the Figured World. These observations also highlight the potential for constraints on supervision from within the training practice, but also its potential to support supervision, suggesting there is further scope to explore the reasons for this variability at the training practice level.

The 'system' as an agent

A number of the trainees reflected upon their experiences of the wider training system as part of their supervisory and training journey. This appeared to encompass GP training at various levels, and various agents. In a similar way to the practice, the trainees also had different conceptualisations of the 'system' within the Figured World of GP training.

In Raj's reflections, he looked to the training system for support with his problems with a practice team member. This involved a process of escalation of his concerns to regional GP education staff, including the '*head of school and the dean'*.

For Alison, the 'system' also appeared to be perceived as a source of vindication and support. She perceived a battle within her supervisory relationship, and felt misunderstood and misjudged by her supervisor. She described a number of ways that she challenged his view using 'the system'; harnessing support from her other supervisors, Training Programme Directors and the Professional Studies Unit, and using her E-Portfolio to document her concerns.

*'Yeah, so when I'd gone to my supervisor with all my problems, and he hadn't been particularly helpful, I then, so **I wrote a comment on my portfolio** as well. And I was referred to the PSU. Well, they said that I could go optionally. I didn't have to go. If I wanted to speak to someone kind of outside of things. **And I did want to speak to someone outside** of things.*

*"I have spoken to couple of people about whether we would **write a kind of, a letter to the deanery**. Um, signed by 10 people or something like that'.*

(ppt 13, Alison)

The 'system' was also referred to throughout Seema's narrative. Instead of a source of support, ARCP panel members were viewed as a 'judge' of her progress and contributors to her sense of self;

validating the supervisor's label of 'problem trainee', and contributing to Seema's internalisation of this label.

In Jas' narrative, the 'system' represented the training requirements and resources set by the local training programme and RCGP. Training Programme Directors (TPDs) are GPs who deliver weekly teaching and oversight for a geographical area of trainee, and were considered to by Jas to be agents within this 'system'. In Jas' view, the 'system' exerted control over her training, and was viewed as a fairly rigid entity. In the excerpt below, she described the way she tried (and failed) to address a rota dispute within her training hospital:

*'I tried to follow it up, but I just thought, I've lost the will to live. I've failed my ARCP. I did pass that AKT, so that was some good news. But it was like, **banging your head against a brick wall**. **There was nobody to go to.** What, you go to the TPDs and they're like, "We'll you need to go down the usual avenues". I talked to 2 different consultants. One was a JDF committee lead or whatever. Emailed him. **No response.** Um, and the other one was she was a Foundation doctor coordinator, and I just asked her for some advice like "what should I do"? and she said "well ,you need to get it monitored". Tried to get it monitored. And failed'.*

(ppt 2, Jas)

Nat also recognised the inflexibility within the training system, which made it difficult for her to experience the working pattern of a salaried doctor, despite her own learning goals to be better prepared upon qualification:

'I think that has a lot to do with their fear of the new contract and breaching hours'.

(ppt 12, Nat)

From these examples, the trainees appeared to have differing views on the 'system' within the Figured World of GP training. For some, it was a source of support and potential vindication for their negative supervisory experiences. For others, a judge and arbitrator, measuring their performance, and contributing to their labels about them and their sense of self. It was also perceived by some as an inflexible and rigid entity, leading to suspicion about its purpose or disengagement. What the trainees did share was a suggestion of a hierarchical structure within the Figured World of GP training, with the 'system' at the top, above their supervisors and practices.

The 'system' within GP training alludes to the structural influences within the Figured World. In the next few sections, I will consider the ways in which the various agents relate to one another within the Figured World of GP training, and the influence of position, power and agency.

Positioning

Until now, I have largely considered the various agents within the Figured World of GP training. However, within the narratives, there appeared to be considerable differences in the way the trainees interacted with these agents within the Figured World, and the types of relationships that were formed. Key to the interaction within Figured Worlds is that individuals will occupy different positions within it. Furthermore, the positions they occupy will matter; shaping their vantage point of the Figured World, and the way in which they behave and interact with others in it.

Seema perceived herself to be positioned as an 'outsider' and 'problem trainee', both by her supervisor, and within her training practice. However, to me (as the researcher) she used considerable emotion and defensive language to reject this position. Instead, she positioned herself

to me as 'not a typical trainee'; misunderstood, rather than a 'problem'. Her vulnerable voice within

the narrative also highlighted the way in which she was using the narrative to internalise, reject or

modify these messages from the Figured World, as a means to self-author her identity, asking herself

if there was '*something I've done wrong*'.

Looking across the narratives, positioning appeared to occur through both access and discourse.

These are discussed in detail within the next section.

Access

The first observation related to the notion of access. Seema's story provided an illustration of the

way in which the *degree of access* (in her case, to members of the practice team), shaped the way

she was positioned. Despite personally craving inclusion within her practice, it was the supervisor

and members of the team who positioned Seema as an outsider, by being physically unavailable

when she needed them for advice or support. She was unable to enter the room of her supervisors,

due to the presence of a closed door, and even when contact was made, there was a sense that she

was only granted access to a limited amount time to discuss her concerns.

For Stephen, provision of such access was readily available from his supervisor and practice team. He

was '*invited*' by the practice team to discuss his thoughts and feelings, and afforded their time,

empathy and support when he experienced the difficult case of misdiagnosis in a child. Furthermore,

the social and personal interactions with his supervisor, where stories of life and family were shared

openly, served to reinforce his position as a near-peer within the relationship and practice.

Discourse

In addition to access, "all elements of speech (alongside its content) constitute signs of the speakers

claim to social position" (Holland et al., 1998). This observation has already been discussed in

reference to both Raj and Seema's narratives, where they attempted to position themselves to me (as the researcher) as not 'problem' trainees.

Positioning to, and by, others in the context of the Figured World of postgraduate GP training also appeared to occur using documentation, particularly the E-portfolio. In Alison's narrative, the supervisor used the E-portfolio (where electronic conversations are recorded) to suggest that she was '*not coping*' with the pressures of GP training; positioning her as a struggling trainee:

*'And in the educators note for example he wrote um, "we've agreed to reduce her admin load". So it just sounded like, "**she's not coping**, she's doing what she should be doing, so we're going to have to cut it down to below what she should be doing". Which I felt was quite an unfair representation of the situation'.*

(ppt 13, Alison)

In response, Alison '*wrote a comment on [her] portfolio as well*' in an attempt to reposition herself using the same platform. Through her narrative, Alison also used the interview as a site to reposition herself (through discourse) as a competent and hardworking trainee to myself (as the researcher). She described herself as '*not really one of those people who crumbles at the smallest thing*,' but rather someone who will '*usually just get on and do the work*'.

Positioning and vantage point

Key to the concept of Figured Worlds is that the various participants will occupy different positions in this world, and therefore different perspectives on it (Holland et al., 1998). Looking again at Seema's 'outsider' position, I reflected that Seema's outsider *perspective* was apparent. She frequently appeared confused an unclear about the origins of her mistakes and difficulties, highlighting a lack of awareness of the cultural or relational expectations. Whilst her intentions to repair relationships and change her position within the practice were apparent within her interview, the actions she took

were different to those of the other trainees, and to what I (as a former actor within the Figured World of GP training) would expect. When she recounted the written and verbal challenges she had given to her supervisor, I found myself questioning the actions taken, which seemed incongruent with the more 'conventional' or subtle approaches taken by some of the other trainees to challenge or push back. Her responses suggested a very different vantage point.

Her story is in contrast to George's 'insider' position with his trainer, consisting of a close personal relationship, social interaction outside of the workplace. It appeared that this 'insider' positioning with his supervisor had shaped his perspective of the type of supervisor that he wanted to be, through the role-model influence of this supervisor. From this vantage point, he negatively appraised the contrasting experience of his colleagues, who experienced a directive, monitoring and 'micro-management' approach from their supervisor. However, there was a sense that he also empathised with the role of the supervisor, something which may have related to his insider position and vantage point:

'if you [the trainer] were to sit back and be very approachable not to be constantly giving out so much

information which might not be particularly helpful, then they might gain more from him. Um, he

clearly is very good, and he clearly has a lot of energy for it. But I think he maybe just goes about it

*slightly the wrong way. Um, **I think if you had something like a very under-confident trainee** who*

*needed constant reassurance and constant input then, **that trainee might match up quite well with***

***him as a trainer**. But actually, these two other trainees are very good, and fairly independent and I*

think that they just feel that it's overbearing and kind of getting in the way of them naturally

improving as they would I think'…

'but it all comes from a good place, so it's difficult to judge it too harshly'.

(ppt 14, George)

Agency

The individual's agency comes to the fore when we consider social positioning, and relates to the interaction of their view of 'self' with the social position in which they are placed. Mead views this as the "I-me" split, with "me" as the social object, related what is learned in interaction with others and the environment (Mead, 1934). "I" on the other hand is the agent, simultaneously both the actor and the observer, and thus actively internalising social stimuli and crafting a novel and creative way to be in relationship with the generalised 'other' (Goffman, 1963, Mead, 1934, Holland and Lachicotte, 2007).

This "I"-"me" split was observed in Cara's narrative. Cara was a trainee at a busy inner city practice. It became clear from her follow-up interview that she had been experiencing significant discontent with her workload and isolation at the practice. As the "I", or the 'agent' within the narrative, her discontent was apparent, and she had taken a number of steps to raise this with her practice and change her working conditions. However, she was also keen to assert that she was not '*a moaner*', and did not wish to be seen as a complainer, despite the adverse conditions she perceived. The 'me' is the sense of self that significant others have treated the individual as being, and it is the 'me' which holds back the 'I' from breaking particular 'laws' or conventions within the culture; in this case, complaining.

Cara's effort to address this "I"-"me" split was apparent in two ways. The first was an explicit admission that she did not want to be seen as a 'moaner':

*'So, I've come to a…so actually, yeah, it's good. No, it's been a good year. **I sound like such a***

***moaner.** It's been really, it's been a great year. They just…I think the practices are queued to see*

ST3's as like salaried that they get like paid to have. And we're there to learn you know'.

(ppt 19, Cara)

The second way was through use of what I have termed a 'mediating voice', where she

demonstrated 'self-talk' to remind herself (and me) of the positive aspects of her job. This voice was

frequently used after a period of discussing difficulties:

I-poem: the mediating self ("me")

But I think

I have enjoyed GP

Very glad I picked it

Yeah I am

I hope so

I think that's life isn't it

I think

I've also been fortunate

I've never had anyone that hasn't helped me

When I've asked for it

I don't think it helps you to be moany

I think you've just got to do your best

How can I help the patients?

Do you know what I mean?

I think

I've had a good chance

(ppt 19, Cara)

It was striking to realise that a number of trainees took considerable effort to represent themselves

to me as individuals who did not complain. Ayesha also described mediating her own thoughts in

response to a heavy trainee workload, where she appeared to choose to consider herself to be 'relaxed' trainee, who did not get stressed, reinforcing her sense of self as a relaxed individual:

'**I think I'm quite laid back to be honest** anyway in generally life and normally. **I try not to get very stressed**. Um, I think, you know if I'm really busy and I have a lot of work to do, I take it as a positive things and I'll think "aw, you know, I'll get this done and you know, this might help me for future". Or even if I'm stuck doing you know, 100 letters or looking at 50 letters or something, **I'll take it as a positive l**earning experience. You know, how this patient was managed in clinic, you know, what did they present with? So **I try to think of it in a different way** so, I don't really. **I try not to** get very stressed'.

(ppt 18, Ayesha)

Although Ayesha had two very different types of supervisory experiences, she appeared to view each training experience as a positive one, choosing to reflect upon the more difficult aspects (such as a heavy workload) as positive factors.

In a similar way to both Cara and Ayesha, George's I-Poem illustrates his positioning of himself to me (as the researcher) as someone who doesn't need '*help*':

I-Poem: I don't need help

I've had other hospital jobs

I did a cardiology job

where I could kind of take it or leave it

whether I wanted to go and see her

I think

I tend to be fairly hands off

I don't go looking for help

I didn't take her up on that

if I did have any issues

she was there if I needed

I guess

<div align="right">(ppt 14, George)</div>

For George, a self-described 'relaxed' individual, his relationship with his trainer appeared to reinforce his sense of self. The "me" he presented appeared congruent with himself as an agent. He found himself in a relationship with a similar type of individual, and where a relaxed approach to risk and autonomous practice was encouraged. In this way, George's identity could be viewed to be both socially and cognitively constructed, whereby society 'legitimises' the identity that the individual imagines and enacts (Berger and Luckman, 1967). Identity, which can be seen as 'kind of person' we are, must be socially recognised, and George's narrative engaged in a combination of activities, beliefs, values or speaking to gain this recognition (Gee, 2000).

Messages from the 'system': don't complain, be an adult learner

It is noteworthy that, at the time of the interviews, a campaign was prominent within the medical media to address the 'GP bashing' and negative perceptions of General Practice from with the national media and hospital culture. The message from the RCGP at the time was to highlight the positives of being a GP, as a valued and important profession, and to combat the negative reports of GPs in the press. Cara alludes to this within her narrative:

*'I think GPs, if they want people to be GPs they have to view it as **everyone's saying on Twitter**.*

As a speciality'.

These media messages may have contributed to the trainees' desire to be viewed as those who didn't complain. However, alternative, or additional, explanations are also offered within Jas' and Alison's interviews. The first relates to emphasis of being an 'adult learner' within the GP training programme. Jas discussed this within her interview, and emphasised her capability as an adult learner on a number of occasions:

*'**I get that we're adults, and we need to do the whole self-directed learning thing** but occasionally like, you know, you're doing a 9-6 job'.*

When Jas experienced problems with her rota, the solution offered by the TPDs was *'you need to go down the usual avenues'.* She subsequently described these avenues involving significant effort on her part to talk to various agents involved in the rota system, aiming to reach a solution. '*Usual avenues*' appeared to relate to an active response by the trainee, in line with the active engagement of self-directed learning. As she described it, asking for help within the Figured World of GP training actually results in being encouraged to remedy the situation yourself.

A second explanation may relate to Alison's interview, where she appeared to view raising concerns as potentially causing trouble:

'I have spoken to couple of people about whether we would write a kind of, a letter to the deanery'.

*'I said I'd only probably want to do it once I've finished training. **Cos I don't really want to get myself into trouble'.***

<div align="right">(ppt 13, Alison)</div>

These socio-cultural messages within the Figured World of training suggest that those trainees who do raise concerns are either 'not adult learners' (in the case of Jas) or 'troublemakers' (in the case of Alison). Regardless of the specific reason, the trainee's reluctance to be viewed as complainers was tangible, and it appeared that the socio-cultural message within GP training was to deter the raising of concerns by trainees.

Power within the supervisory relationship

A number of the narratives illustrated processes of heuristic development amongst the trainees, where they attempted to challenge their own claims to identity through various means (Holland et al., 1998). These offered useful lenses to the power relationships within the Figured World, and I will outline a number of these within this section.

In Alison's interview, she felt the positioning by her supervisor (as '*not coping')* incongruent with her own sense of self. Instead she viewed herself as someone who would '*just get on and do the work'*. She used the process of self-authoring within her interview to represent herself to me (as the researcher), and challenge the positioning and view of her supervisor:

'I feel like I'm not really one of those people who crumbles at the smallest thing. Um, I'm not someone who is constantly asking for dispensations. I usually just get on and do the work. So I think

for me to actually go to him and ask for support was quite a, it was quite hard for me to do that in the

first place. It's not something I naturally do'.

She also sought the support of a variety of advocates with the 'system' to reject this positioning and identity, attempting to seek legitimacy from the socio-cultural context to her claims to her identity. This included her educational supervisor, a Training Programme Director (TPD) and a member of staff from the Professional Support Unit.

I have outlined the outcome of some of these conversations below:

Conversation with her TPD:

*'but then, all his suggestions never appeared on paper and **became muted** by the time that they were*

brought back to the practice. So actually the things that he thought were unfair about how the

practice was pushing me along. He said to me, and that felt very supportive, but then he never told

the practice that or told my supervisor that. And I think that I needed that advocate'.

Conversation with a member of staff at the PSU (also a TPD):

'but she even said when we were meeting, she said, "well, he's going to be *my boss in a couple of

*months' time. He's clearly much more senior than me. **There's very little that I can say to fight your***

***corner,** because he's essentially my boss". And I felt like, whilst I completely understood that*

*situation from her point of view, I felt like as the trainee, and her as the grown-up adult, **I needed***

***someone to kind of fight my corner a little bit**, and I find it very frustrating because I know that*

people prior to me and people after me have struggled at the practice'.

However, as the listener, Alison's sense of powerlessness to change the situation through these means was striking. Ultimately, Alison did not appear to feel satisfied or vindicated following these attempts, and was still considering raising concerns once qualified.

For Raj, positioned as a 'problem trainee' in his practice, a similar overt challenge was mobilised, by escalating his concerns through formal complaint routes. In this case, he appeared to have some success, leading to a change of training placement:

'I received quite negative comments by ah my portfolio by an MSF, and it turned out to be quite a senior trainer as well. Um, and that really knocked my confidence um to such an extent that I had to take time off work. Um…And it kind of just led to kind of quite a sour kind of educational and professional working environment. Um [2], once I managed to kind of get through um, and speak to the deanery it was, it was suggested that I move training practice altogether'.

(ppt 1, Raj)

Raj appeared to successfully harness the power from within the structure of the 'system' to challenge his positioning as a poorly performing trainee, leading to a move of practice. However, invoking the structural support of 'system' was not necessarily without cost. For Raj, the process of moving practices also brought feelings of guilt, and a sense within Raj that he had caused some problems:

'they did what they had to do within the three weeks to get me through my educational supervisor review. So ,you know, I can't fault them here either. I just feel, part of me feels bad for landing them in kind of a difficult situation. Having to arrive here, and then to sort things out'.

(ppt 1, Raj)

Although empowered by the 'system' to change his training circumstances, I had a sense throughout Raj's narratives that the 'system' approach had potentially served to further position him as a 'problem' trainee; something he used his narrative interview to aim to reject. In this way, the 'system' had not changed his positioning as much as might have been suggested on initial observation. It is perhaps also important to highlight that the supervisor in both of these examples was referred to as a 'boss' in both accounts (either within the practice, or within the training 'system') reinforcing the perspective of the hierarchical relationships within the Figured World, and the powerful influence of the supervisor on the trainee's professional identity.

For both Raj and Alison, a structural approach is taken to push back against the positions afforded to them as trainees with 'problems'. However, it is interesting that, in these 'louder' examples of challenge, the trainees ultimately fail to reform and develop their identities within the existing relationships, and appear powerless to effect this change. In this way, agency is not without constraints. Mead's "I" is an 'unruly character', requiring mediation to rein in the 'self' to one that is socially recognised (Holland and Lachicotte, 2007). The socio-cultural influences within GP training (including the systems by which to seek support or raise concerns) appeared to have the potential to reinforce the very position and identity that the trainee was attempting to reject.

Cara also recounted times when she had explicitly challenged the working conditions in her training practice, rejecting the position she'd been given as an '*unpaid salaried*' GP, and reasserting the need for workload protection as a GP trainee.

*'then actually, things [working schedule] were slipping back, **so I put it in writing**. Cos I'm not*

running to the TPDs for everything, they're busy enough . But I put it in writing and I cc'ed everyone

in. And the minute I put things in writing, they've now been good as gold. So that's the example.

People just pay you lip service when you're a trainee. "Oh yeah, yeah . We'll write that up. Oh, yeah,

yeah". Nothing happens. And the minute you put it in writing, everything happens. Cos they know, if

*she is bothered to type this out, **it's just a cc to the TPD**'.*

In this case however, the structures of the training 'system' were not implicated, but simply threatened. Instead, she challenged her circumstances at the local challenge level.

Although Cara's narrative suggested a degree of success and relative power through the means of using documentation and the threat of escalation, she expressed a degree of regret that she had not felt confident enough to do this earlier, suggesting that the majority of her training year was spent battling her workload by talking to the practice administration, without much success. It appeared to take her some time to navigate the most effective means to challenge her position:

*'But I think what I would say to other ST3's is, do that sooner. 7, 8 months of always working hours and hours every day over my contracted hours. **I raised it so many times and nobody does anything.** So I would say to the ST3's put it in writing straight away. And you're not whinging if you go to your TPD. I never have done, cos they've fixed it now. But get in there early. If I'd have done that in January, I'd have been better. But I did it in, you know, the end of April [laughs]'.*

If overt challenge doesn't work, then what does?

If senses of 'self' are challenged by the social position afforded to them (or if the positions are in conflict) the individual has a degree of self-control and agency beyond simply choosing sides, or picking a particular position. Proponents of such heuristic development refer to this as 'improvisation'; a process whereby the individual can respond to the situation in creative and imaginative ways. Alongside the products (improvisations) that arise from the meeting of the individual, culture and situation, Bourdieu argued that such products could bring about change for

both the individual and the culture. Whilst in Bourdieu's view, this related to cultural change for subsequent generations, others have argued that such cultural change (albeit slow, erratic and continuous) is possible within the lifetime of the individual (Holland et al., 1998, Bourdieu, 1993).

I found it very useful to consider the artefacts within the Figured World of GP training, to illustrate the way in which the participants improvised and navigated their training using agency, potentially more effectively than the overt challenges that are discussed above.

Artefacts of training

Artefacts can be viewed to 'open up' the Figured World, and are the means by which the Figured Worlds can be learned and evoked. Such artefacts will have a history of development within the Figured World, and therefore represent that world. Put differently, artefacts can give significant insight into a particular Figured World or culture, and afford particular meaning. Developing identity and challenging (or embracing) social positioning therefore also requires mastering the cultural artefacts within that world (Holland et al., 1998).

The surgery timetable as an artefact

The surgery timetable is the electronic diary of the working day, where appointment slots are allocated and booked. Frequently, the booking of appointments is made by practice administrative staff, and the trainee (or GP) will simply work through the list in order. However, in many practices, it is possible for the medical staff to book their own patients, or amend the available slots when required. For example, as a qualified GP, I may decide that a particular medical problem will require 20 minutes of clinician time, rather than the usual 10. I may then book a 'double' slot to accommodate this when needed, ensuring sufficient time to deal with the problem and avoid running late or becoming overworked.

Mastery of the surgery timetable was an important turning point in Cara's experience of moving away from being 'overworked' within her practice. It appeared that she considered this a more effective means to challenge practice constraints than putting things in writing. She recounted the change in her approach within her follow-up interview, where she reflected on the ways in which she'd used the surgery timetable to push back against workload constraints.

'I think at the beginning*, when people would come and knock on my door, which they do 5, 6 times a clinic, I was being snappy with nice people.

"Can you come and review this wound? I've just got this prescription. We've got a phone call".

And I'd be like "agghhhhh" [frustrated sound].

*Whereas now I'll just say, "Yeah, I'll review the wound". **And I will block a slot** and I will see that patient and do it properly. And if I can't block it in the morning, I'll obviously still see them, but I'll **block it in the afternoon**. I'm probably a bit more, I've got a bit of more backbone now. To say, "Yes, I can be helpful, but **I have to protect myself as well**". "Is it a phone call? Is it urgent? If not, please **book a slot** and I will call them, back. I guarantee I'll call them back, but they don't need me right now". You know? I think the difference is, when you're just starting out, you feel that you, you want people in the practice to like you, don't you? And so you try and do everything for everyone. And you can't spin all these plates. Cos you're just learning. Whereas now, I still can't spin the plates, but I'm happy to say that'.*

(ppt 19, Cara)

In a similar way, Nat used the timetable as a means to record the less visible elements of her workload, such as phone calls to patients. Often, patients will be telephoned by the GP if they have abnormal blood test results, or to clarify onward management. These calls are initiated by the GP and usually not listed on the daily timetable (despite frequently requiring considerable time in

addition to the usual booked appointments). Nat began to add these calls to her working schedule, as evidence to the wider practice that she was working hard, and to challenge the practice administration, who had been adding things onto her schedule without warning:

*'There's certain things you have to watch out for in terms of slightly being taken advantage of. Um, with the rota. Just purely because we don't have slots for follow-up and telephone calls and things like that. So they don't see that side of things. So **I've made a point of adding things onto my schedule** so that actually they can see that my true work day is reflected'.*

<div align="right">(ppt 12, Nat)</div>

In both of the examples above, the trainees suggested that the practice administration (such as receptionists or managers) had a large sense of control over their working day, and therefore their position in the practice (as '*unpaid salaried doctors*'). Through gaining a mastery of this timetable themselves, they were able to push back against these constraints, and position themselves differently at the practice.

Whilst the timetable itself is not specifically mentioned in other accounts, both Preet and Nadia appeared to have similar means to navigate practice resources. They each had a strong sense of mastery of the scheduling of the working day, and subsequently chose how to use their time to access the support they needed. In Preet's case, her questions were saved until the lunchtime meeting, to improve access to the support she needed. Nadia navigated multiple scheduled formal learning events, saving different questions for different settings.

The surgery timetable is a useful artefact to consider. In contrast to Seema's experience of closed doors and minimal access, which appeared to reinforce her feelings of reduced agency and positioning as an outsider, mastery of the timetable afforded a greater sense of agency and control to the trainees. Without such mastery (as in Cara's early experience), the practice itself appeared to

have a strong sense of control over the education and experience of the trainee, which was often viewed to be incongruent with the trainee's expectations and preferences.

Appointment length as an artefact

The duration of allocated time to see patients also served as an artefact with the Figured World of GP training. Firstly, this suggested the degree of progress by the trainee, with more experienced trainees allocated shorter appointment lengths (closer to the 10 minutes expected within the typical schedule of a qualified GP). However for some of the trainees, appointment lengths were also a battleground area for control between trainees and their supervisors (or practices). Cara, Esther, Nat, Seema and Alison all referred to the duration of their appointment lengths. The 'battle' in this respect related to a feeling from the trainee's that they were being pushed towards service delivery by the practice or supervisor, rather than having sufficient time to learn (and sufficient control over how they chose to learn):

*'In terms of our structure of the day, that seems to be at the moment **more controlled by admin** than the doctors. So, I don't know if I've mentioned earlier that they've tried to take our catch-up slots off us. Within 2 months of starting ST3. Which we weren't happy about. Especially with preparing for CSA, cos you feel that actually if you have a question, **you've then not got that time,** you're going to be rushing **and that's not how to learn** or prepare for CSA, especially when we know that most of our colleagues are still on either 15 minutes or 10 minutes with catch-up slots. So we did kick up a bit of a fuss about that'.*

(ppt 12, Nat)

As Alison later describes, having 'control' over appointment length was important for the trainees, and potentially linked to them having control over the way they chose to learn within their training placement.

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'Whereas, at my first ST3 practice, um, it was notorious that you just got moved down to shorter appointments without anyone even mentioning it the day before…I think, it's inevitable, you need to be pushed a little bit because, I think that otherwise most people would be like "No I need the minutes! Don't!".

*'But, yeah, **I think you need to feel a bit of control over it**…'*

*'and often you can cope with it faster than you think you can when you have to do it. But just to suddenly. **To have no control over it,** and to suddenly. It makes you feel very… scared. And very [3] you're just trying to survive, and get your most out of the training'.*

(ppt 13, Alison)

The E-Portfolio as an artefact

The E-portfolio offered another important window to the Figured World of GP training and many of the trainees referred to the portfolio within their narratives. At first glance, it was used to record learning and assessment, to be judged at the Annual Review of Competency Progression (ARCP). It was noteworthy that the educational purpose of the E-portfolio was rarely discussed, and instead its assessment and monitoring purpose as more frequently alluded to within the narratives. In the eyes of the trainees, 'collection' of evidence appeared to predominate, and was a powerful source of information for those involved with assessment and monitoring. This is particularly evident in Seema's narrative, when she reflects upon the power of 'evidence' of her failed AKT examination as proof that she lacked clinical knowledge.

The 'judgement' function of the E-portfolio was viewed as a tool where trainees were positioned and 'judged' by their supervisors, through evidence and documentation. This was seen poignantly in Alison's narrative, where the E-portfolio was used by both the supervisor (to suggest she wasn't '*coping*'), and by Alison to reject this view and reposition herself.

Changing vantage points

Cara's comparison of her use of the timetable as a neophyte and experienced trainee is a powerful example of the way in which vantage point, or perspective, can influence the trainee's agency. In her novice days, she described feelings of being overworked, with members of the practice bringing many questions and queries for her to action, in addition to her scheduled clinical workload. In these early days, the practice staff appeared to have significant influence on her time and work, and she felt powerless to push back. However, as an experienced trainee, she began to learn how to use the surgery timetable to improvise her approach. This enabled her to still help out her colleagues, but to minimise the collateral damage to her overall workload.

Cara's narrative was a useful illustration of the way in which her perspective developed over time. Her awareness of her '*unpaid salaried*' position dominated much more in her follow-up interview than in her initial interview. At the beginning, she appeared to accept this level of work and treatment within the practice, despite finding it difficult, mainly because she felt that the other clinicians in the practice were already working very hard:

*'I feel like **sometimes you're the link**. You're the continuity for people. Because I'm the only one that's here 5 days a week. And that's bit different. Because, you know, there's no one else here every day. So I think "oh G**!" you know."*

*"what's difficult is the day there's only a locum doctor. **Because actually they're trying to see like an unreal number of patients**. And deal with emergencies. And supervise you. And then, on those days, I find it tricky'.*

(ppt 19, Cara)

It is only in her follow-up interview that she appeared to consider her workload as an '*unpaid salaried*', and take more steps to challenge this. Her perspective has changed from someone who

saw their workload as the inevitable in a very busy practice, to becoming aware of the need to challenge the status quo:

*'Good year, I would say. Getting better all the time, cos now I just, like don't do stuff. Do'ya know? **If all this stuff's getting dumped on me**, I'll just block off a slot for it. If I do 2, 3 visits a day, which you do, I'll just block it off in lieu…It's been really, it's been a great year. They just…I think the practices are cued to see ST3's as like salaried that they get like paid to have. And we're there to learn you know'.*

(ppt 19, Cara)

Seema's narrative also demonstrated an example of the way in which a changing vantage point relates to identity and positioning in the Figured World. For Seema, positioned as an outsider at her first practice, the trainer and practice are viewed with suspicion. Their efforts to monitor her progress were viewed with contempt, and she resented the way in which she was assessed and checked within her day to day work. However, although the same degree of monitoring was in place at her new practice, her vantage point had changed. She now had sufficient access to her supervisor, and awareness of the supervisor's role within the relationship, to be able to appreciate the monitoring aspect of the supervisor role.

Chapter 9: Discussion

Returning to my research aim and questions, this programme of research set out to understand the contribution of supervision to the professional development of GP trainees.   In particular, the following research questions were explored:

1. How is the GP trainee expected to develop professionally within postgraduate GP supervision?

2. How do supervisory relationships contribute to the professional development of postgraduate GP trainees?

3. What factors influence the supervisory experience?

4. How do lived experiences of trainees and their supervisors relate to the expectations of the wider profession?

Within the thesis, the interdependency of supervision with the GP trainee's professional identity development, interpersonal relationships and the wider professional context became a particular focus (Dewey and Bentley, 1949 p.42, Rogoff, 1990, Rogoff, 1995). This included an exploration of structural and system expectations (through an analysis of training documentation), the supervisor's perspective (through interviews with experienced GP supervisors) and the trainee's perspective of the lived experiences of supervision and identity development (through narrative interviews with GP trainees).

 Within this chapter, I will draw on the results from each of the three stages of my research to address the research questions in turn.

1. **How is the GP trainee expected to develop professionally within postgraduate GP supervision?**

   This section considers the expectations of the wider profession (both explicit and tacit) with respect to supervision and the 'good' GP trainee. Alongside 'meeting the mark' to attain the requirements for MRCGP qualification, this section also considers the trainee's professional identity development, as they journey towards 'becoming' an autonomous GP.

2. **How do supervisory relationships contribute to the professional development of postgraduate GP trainees?**

   Within this area of the discussion, I will return to Figured Worlds theory, to consider the contribution of supervision to trainee development.

3. **What factors influence the supervisory experience?**

   This section highlights the influence of the multiple and diverse identities of trainees, tensions in the supervisory relationship, the training practice and the wider training system.

4. **How do lived experiences of trainees and their supervisors relate to the expectations of the wider profession?**

   Within this section, I will consider particular areas of dissonance that emerged from within the data, where the expectations of supervisors (outlined from within the interviews with experienced educators and the documentary analysis) may be at odds with the lived experience of the GP trainees. This was particularly evident when considering expectations regarding the trainee as an 'adult learner', 'legitimate participant' and 'reflective learner'.

The chapter concludes by considering the implications of this research for postgraduate GP supervision. Following a systematic review of the literature on postgraduate GP supervision (**Chapter 2**), I proposed a model to conceptualise the supervisory working alliance and the factors that influence it. This model will be revisited in light of the research results, to offer a springboard to discuss the implications of the research.

Figure 10 below (**Outline of Discussion**) outlines the key areas discussed within this chapter:

RQ1
- Being and becoming: Expectations for professional identity development in GP training

RQ2
- The contribution of supervision

RQ3
- Factors that influence the supervisory experience

RQ4
- Supervision: Expectations and experiences
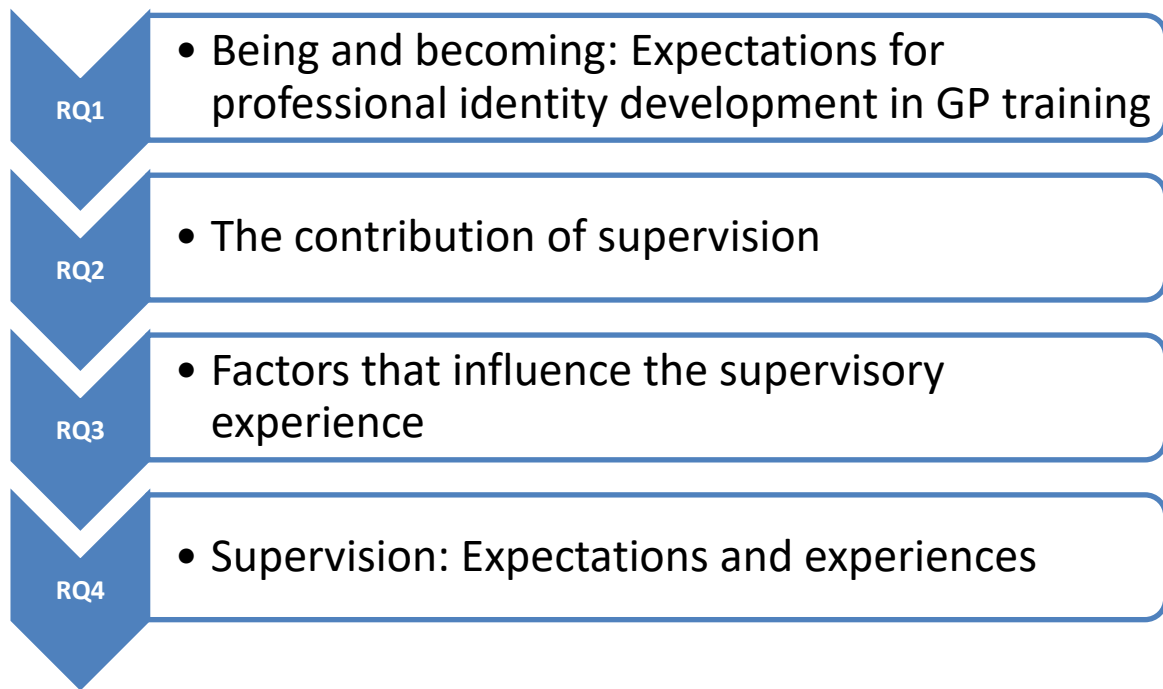
'Being and becoming': Expectations for professional identity development in GP training

Looking only to the explicit expectations regarding the professional development of the GP trainee risks a neglect of the influence of the implicit (and potentially unintended) messages from the wider profession. Understanding the contribution of supervision to professional identity development requires an appreciation of this complexity, to avoid superficial or incomplete observations and recommendations.

Within the next section, I will draw upon the results from each stage of my research to consider both the explicit and implicit expectations regarding professional development for postgraduate GP trainees.

Being a 'good' GP trainee

Based on the thematic analysis of the training documents (outlined with **Chapter 5**), I produced a short summary of the structural expectations of a 'good' GP trainee. The words in bold relate to the particular codes that emerged within the analysis:

> A GP trainee learns within the training practice, **engaging** with **workplace-based** learning, and **legitimately participating** within the **community of practice**. They are considered to be an **adult learner**, and regular **reflection** on their performance is expected, with sufficient **insight** to their areas for educational development. **Patient safety** appears paramount within GP training, and **regulation** of trainees (through review of **documentary evidence** mainly contained within their electronic portfolio) is a key element of the **quality assurance** process. The quality assurance process also extends to the **regulation of the quality of supervision**, with **contracts** in place to **direct safe working hours** and conditions for trainees.

A number of these expectations were also discussed by the experienced educators. For example, the importance of trainee 'engagement' and 'insight' emerged as a theme within the results of this stage of the research, alongside the role of the supervisor to ensure patient safety and quality assurance (Jackson et al., 2018b). These expectations of the 'good' GP trainee were also referred to in a number of the narratives interviews with GP trainees.

Perhaps unsurprisingly, the trainees were acutely aware of the institutional requirements of assessment and regulation, and frequently referred to their electronic portfolios within their narratives. This again is related to the themes within the documentary analysis, and references to workplace-based assessments, summative written assessments and Annual Review of Competency Progression (ARCP) were casually interwoven throughout the narrative accounts.

The short description of a 'good' GP trainee given at the start of this section, at first glance, does appear to run through the experiences of both the experienced GP supervisors and the GP trainees. However, through the examination of the various perspectives within my research methods, a number of additional observations emerge.

Tacit messages regarding the 'good' GP trainee

The first of these relates to a number of implicit messages which emerged regarding the 'good' GP trainee, which were most apparent through the accounts of the lived experiences of GP trainees and the interview findings with the experienced GP educators. These messages suggest a greater sense of complexity to the predominant discourse of the 'good' GP trainee. There was also a sense that some of these implicit 'truths' may be unintended.

Collation of evidence is paramount

As discussed above, the collation of evidence for assessment purposes appeared to be universally accepted as a requirement of postgraduate GP training, with the electronic portfolio serving as the major platform for this collation. Collation of evidence was intended to support the educational processes within postgraduate GP training, including formative work-placed based assessments and an ongoing process of personal reflection from the 'good' GP trainee, as an adult learner.

However, tacit messages regarding the purpose of documentation and evidence emerged. The first of these related to the perception of the educational purpose of the documentation and evidence within GP training. Whilst the requirements for 'evidence' of trainee competence or supervision quality are perhaps not surprising, there was a sense that the collection of evidence could take precedence over how this information might be used to enhance or change practice. The risk of this is an unintended message that recording of particular supervisory activities or processes is more important than the quality or improvement of such activities.

Looking within the data, a number of areas may have contributed to this particular emergent 'truth'. The first relates to the relative paucity of documentation that emphasises the educational impact of collated evidence, particular with respect to the quality of supervision (outlined within **Chapter 5**).

A second area which may have contributed to the emphasis of 'collation' over quality relates to the perceived power of 'evidence' within GP training. A reliance on collation of evidence was used by both trainees and supervisors when feeling vulnerable to judgements about their performance from within the system. This was evident in the semi-structured interviews the experienced educators, and also in the narrative accounts of the GP trainees. The implication of this was that the collation of evidence has sufficient power within the structures of postgraduate training to protect the trainee or supervisor (at least to some extent) in the event a complaint may arise.

Don't complain

Illuminated within the documentary analysis, various hierarchical pathways were mapped which related to standards for trainee performance, monitoring the quality of training (at regional level) and escalating concerns with respect to patient safety, trainee performance and supervision quality.

The training documents also suggested various sources of support for the GP trainee, which could be accessed in instances when the quality of their training experience was lacking. Some of the GP trainees, within their narrative interviews, referred to escalating their concerns with respect to the quality of their supervision. A similar sentiment was echoed in the interviews with the GP educators, who discussed their concerns that trainees could 'complain' if they did not perceive their supervision to be of sufficient quality.

However, despite the formal processes to raise complaints and concerns, and the occasional escalation of concerns by trainees, a second implicit message within the results appeared to be that 'good' trainees 'don't complain'. This tacit message was particularly evident when considering the

complexity of the process, the outcomes of raising concerns, and the consequences of raising concerns.

1. *Raising concerns: complexity as a deterrent*

Within the documentary analysis, the guidance for a trainee who wished to raise concerns was fragmented. A review of 4 separate documents was required to put together a pathway by which to raise concerns about a supervisor (General Medical Council, 2015, COPMeD, 2016, Health Education England West Midlands, date unknown-a, Health Education England West Midlands, date unknown-b). This was in contrast to explicit local routes of support for a trainer with concerns about a trainee; such as referral to training support groups, or the local training programme director (COPMeD, 2016).

At the outset, the complexity involved in raising concerns could be perceived as a deterrent for trainees, which was alluded to within Jas' narrative, as she tried to raise concerns about her work schedule. She described her decision to give up because, after consulting with various members of staff, it was like '*banging your head against a brick wall*'.

2. *Raising concerns: outcomes as a deterrent*

For a number of the trainees, the outcomes from their attempts to raise concerns were perceived to be unsatisfactory, and the sense of powerlessness was striking. 'Raising concerns' ranged from attempts to seek help and support from their supervisor, to the formal escalation of complaints. Alison's reflections on escalating concerns about her supervisor through formal routes concluded that her suggestions were '*muted*', and '*never appeared on paper*'. When Jas raised concerns with her Training Programme Directors, she perceived that she had been advised to remedy the situation herself, because there '*was no one to go to'*.

3. Raising concerns: Labelling as a deterrent

For Raj and Seema, a formal process of raising concerns did lead to an improvement in their experiences of supervision, through moving to a different practice. On one hand, these are stories of success in escalating concerns. However, invoking the structural support of the 'system' is not necessarily without cost. Although empowered by the 'system' to change his training circumstances, it also brought feelings of guilt for Raj who felt '*bad for landing them in a difficult situation*'. There was a sense throughout Raj's narrative that the 'system' approach to escalation of concerns had potentially served to further position him as a 'problem' trainee; a position he used his narrative interview to reject.

The notion of being 'labelled' when raising concerns was also evident in other stages of the research. From the documentary analysis, trainees who did not 'own' and 'internalise' negative feedback were labelled as 'defensive' with their 'head in the sand' (Hibble, 2009). It was suggested that trainees who were 'too precise' about their working hours may not be suitable for work in General Practice (Health Education England West Midlands, date unknown-b).

Within the medical profession, a casual acceptance of hierarchical structure, and concerns about consequence or retribution as a result reporting incidents or concerns, has been described within the literature (Lempp and Seale, 2004, Waring, 2005). A trainee with legitimate concerns about the feedback they've been given or their working schedule may therefore not raise them to avoid the perception of being seen as 'defensive' or, at worst, a troublemaker. These messages from the training documents risk construction of a passivity amongst trainees to raise concerns.

This was alluded to within Alison's narrative, when she decided to wait until she'd finished training to escalate her concerns *'Cos I don't really want to get myself into trouble'.*

Within the GP trainee narratives, it was striking to realise that a number of trainees took considerable effort to represent themselves to me as individuals who did not complain.

Raising concerns: more success with improvisation?

As discussed within the narrative analysis of the GP trainee's stories, the artefacts within the Figured World of GP training illustrated the ways in which the trainees improvised and navigated their training using agency, potentially more effectively than conforming to the pre-prescribed pathways outlined within the training documents. This included developing a mastery of the surgery timetable, confident use of the E-portfolio and using various methods to access support from their supervisor (rather than simply waiting outside their door).

RQ1: How is the GP trainee expected to develop professionally within postgraduate GP supervision?

Professional development in GP trainees appears to relate to both 'meeting the mark' to attain their MRCGP, and also to their professional identity development towards 'becoming' an autonomous GP. The wider profession outlines a number of explicit expectations regarding the 'good' GP trainee, which include being an adult learner, legitimate participant and reflective learner. Engagement and insight are also viewed to be important attributes. Tacit messages from the profession place an emphasis on collation of evidence, and suggest that the 'good' GP trainee does not complain. These messages appear to accentuate the hierarchy within the training system.

The contribution of supervision

Figured Worlds theory offered a useful lens to explore the explicit and tacit elements of the supervisory interaction, particularly with respect to the role of supervision in positioning, vantage

points, power and agency. I have therefore referred to this theory within this element of the discussion.

Within the Figured World of GP training, it was interesting to observe the different degrees of prominence that the supervisor had within the narratives.   Furthermore, the supervisor (and supervisory relationship) appeared to offer different roles and functions for the trainees, such as guide, protector and peer. For those with a more distant relationship with their supervisor, such as Alison and Cara, it was also noteworthy that the supervisors still appeared to have a strong influence within their narratives. This may reflect the supervisory focus of the research, but potentially may also suggest that supervisors hold significant power and influence with respect to the trainee's experience, and also with respect to their position within the practice and the wider profession.

Supervision and positioning

A number of the narratives referred to the important role of the supervisor in the positioning of the trainee, even in those relationships where the interaction was infrequent or lacked a sense of personal connection. The trainees occupied different positions within their social world, including 'outsiders', 'insiders', 'peers', 'near-peers', 'problem trainees', 'not coping' and 'unpaid salaried doctors'. Within the literature, affordances of subject positions are viewed to occur by the culture itself: in the way agents are spoken to, the opportunities they are given and the outcomes that are celebrated (Davies and Harre, 1990). Positioning appeared to occur through the degree of access afforded to the trainee, particularly the time, resources and associations with supervisors and members of the team. In Seema's narrative, she felt unable to access her supervisor behind the 'closed door' of his consulting room. This was a poignant illustration of access and positioning within the narrative accounts.

Another method of positioning occurred through discourse; in conversations with supervisors and staff, and also by the way in which the trainees were referred to by agents with in the system.

Perhaps particularly noteworthy in this research was the use of the E-portfolio in the positioning of

the trainee. Both Alison's and Jas' narratives referred to its use in this context. In Alison's case, the

E-portfolio appeared to position her as a trainee who 'wasn't coping', and in Jas' case, she was

positioned as a trainee who hadn't engaged with the support she had been offered by her

supervisor. The trainees also perceived that the supervisors were using the E-portfolio to position

themselves, as 'good' supervisors. This was also alluded to by one of the experienced educators,

who described a reliance on documentation and evidence when she felt vulnerable or worried about

a trainee complaint. These findings suggest that the use of the E-portfolio in positioning may

represent an important implication for postgraduate GP training.

A further consideration within the notion of positioning is to reflect on its impact for the trainees and

their identity development. It has been argued that the individual can only look at the world from

the vantage point that they have been afforded, and thus from the social position from which they

are persistently cast (Holland et al., 1998). Seema's shift from an 'outsider' position and outsider

perspective is a powerful illustration of the influence of positioning. Upon moving to a new

supervisor and training practice, her access to her supervisor improved, the discourse about her

performance changed (becoming more positive) and her vantage point appeared to shift, moving to

a more 'insider' perspective.

The role of supervision in trainee 'insight'

Considering 'vantage point' is particularly relevant in light of the experienced educators' views on

'insight'. The supervisor participants frequently suggested that their trainees lacked 'insight',

particularly when recounting stories of disagreement or breakdown within the supervisory

relationship. This term is also referred to within the training documentation, and frequently cited as

an important attribute of the 'good' GP trainee. I referred to this term within **Chapter 6** (following

interviews with experienced GP educators), and questioned whether the concept of 'insight' related

to a lack of agreement between the trainee and supervisor on the goals or tasks of supervision. A further development in this discussion is whether 'insight' represents a more complex term, closely related to vantage point and positioning. In the context used by the experienced educators and training documents, 'insight' (or the lack of it) appeared to be referred to as a quality inherent to the trainee. However, as discussed above, the trainee can only look at the world from the vantage point they have been afforded. The concept of 'insight' may therefore require a consideration of the trainee's position and vantage point, and the contribution of the supervisor and socio-cultural context in their positioning of the trainee.

Supervision and power

Within the systematic review of the literature on GP supervision, power imbalances within the relationship, amplified by the supervisor's assessment role, were considered a particular threat to agreement (Bordin, 1983, Jackson et al., 2019). The literature recommends non-hierarchical relationships to minimise the risk of power imbalance within supervision (Ingham, 2012, Ingham et al., 2015a, Wearne et al., 2015). A number of the experienced educator participants alluded to attempts to facilitate this within their interviews, such as sharing information about themselves to create a sense of two-way communication, or asserting that they would also learn from the trainee. Similarly, the near-peer relationships described by some of the GP trainee participants suggested a less hierarchical interaction, facilitated by supervisors sharing personal information about their family life and practice, and socialising outside of work.

However, the implicit influence of power and hierarchy within the training relationship was apparent within the results, particularly in instances of disagreement between the trainee and their supervisor. What was particularly stark within the GP trainee's narratives was the relative lack of agency for trainees who did find themselves disagreeing with their supervisors. For these trainees,

raising concerns, particularly through official routes, often led to an unsatisfactory outcome (as discussed earlier in this section).

Agency and artefacts

A second observation in this regard was the power of the supervisor to position the trainee, within the supervisory relationship, the community of practice and in aspects of their professional identity. In the instances where the trainees perceived their positioning as incongruent with their own sense of self and identity, some overt attempts were taken to raise concerns. However, these often led to unsatisfactory outcomes due to embedded hierarchical structures, and the complexity and consequences of raising concerns. For those who appeared more successful in their agential efforts, their 'challenge' was more of an improvisation, finding creative ways to manoeuvre around perceived constraints or unwanted positions. Mastery of the surgery timetable, training E-portfolio and navigating ways to gain geographical access to the supervisor (rather than simply waiting outside their door) appeared to contribute to their ability to improvise.

In a number of narratives, the silencing of the trainee's voice was evident. Attempts to negotiate or discuss their problems were deemed futile before they were tried at all, and a reluctant resignation to their positioning or circumstances was the result. Whilst these trainees did not 'agree' with their supervisor, escalation of concerns, or negotiation of goals or tasks was rare. Instead, the trainee appeared to distance themselves from their supervisor or look elsewhere for support.

Agency and engagement

Engagement was another attribute cited within the documentary analysis with respect to the 'good' GP trainee, and a term used frequently by the experienced educators in their interviews. Engagement appeared to refer both to behaviours and attitude from the educators' perspective, including being 'open' with the trainer about educational or personal struggles, and also being open to criticism (Jackson et al., 2018b). The onus was placed firmly on the trainee, and those who did not

'engage' were viewed by the supervisors to either lack 'insight, or have an 'attitude problem'

(Jackson et al., 2018b).

Rather than challenge or negotiate with their supervisor, a number of the trainees distanced

themselves from their supervisors (disengagement), or chose to improvise. In these instances, their

lack of 'engagement' may well have related to feelings of powerlessness within the supervisory

relationship. Similarly to 'insight', the extent of trainee 'engagement' may speak as much to the

socio-cultural context as to the trainee's personal attributes.

Within the systematic review, reassurance from the supervisor was suggested to create safety within

the relationship, encouraging trainee openness (Giroldi et al., 2017, Jackson et al., 2019). Silencing of

Seema's voice within a difficult relationship with her supervisor led to pushing back and

disengagement with the remediation and monitoring attempts of her training practice. However,

she alluded to a greater sense of safety upon moving to a new practice, which appeared to relate to

her relationship with her supervisor, vantage point, positioning and engagement with the monitoring

processes in place. These findings suggest that, in cases of trainee disengagement, it may be

important to consider power imbalances and the creation of safety within the relationship, rather

than simply making attributions related to trainee insight, attitude or engagement.

It is also important to note the stories of relationships which were described as positive, but in which

hierarchy did appear to feature within the interaction. These included Jas' relationship with her ST2

supervisor (who drove the relationship and learning), and Ayesha's story of her supervisors goal-

setting and directive style. These observations challenge a broad non-hierarchical approach to

supervisory relationships as a recipe for success, and suggest that other elements of supervision may

contribute to positive alliances and training experiences.

Supervision as an agent of 'system'

When considering the role of supervisors in the assessment and monitoring of the trainee (outlined within the training documentation, and referred to by both the trainee and experienced educator participants) it is perhaps not surprising that a number of the trainee participants perceived their supervisors as agents of the 'system', or structure. The trainees also alluded to additional perceptions (related to both power and positioning) which seemed to reinforce this message.

Seema, Alison, Jas and Raj all described encounters with supervisors where they perceived that the 'system', rather than the trainee, was the supervisor's first concern. In Seema's story, the judgement and monitoring function (inherent within the training system) was also attributed to the supervisor, who was perceived with suspicion. In Jas and Raj's narratives, the trainee perceived that the supervisor was particularly concerned about protecting themselves from the scrutiny of the 'system', instead of acting as an advocate for the trainee. Overt attempts to challenge the supervisor (in Alison's narrative) involved escalation to the 'system', and appeared (in the trainee's eyes) to find favour with the supervisor.

The contribution of the supervisory alliance

Within the systematic review, a model of the supervisory alliance in postgraduate GP training was suggested, highlighting the need for clarity and agreement on the goals, tasks, roles and power relationships in supervision (in the context of an emotional bond) (Jackson et al., 2019). From the results of this study, a number of the facets of the model of the supervisory alliance relate to the experiences of supervision from within the results.

From the systematic review, the literature highlighted the fundamental importance of the supervisory alliance in contributing to teaching, career choice, remediation and trainee confidence (Saucier et al., 2012, Patterson et al., 2013, Ahern et al., 2013, Ferguson et al., 2014, Wiener-Ogilvie et al., 2014). Similarly, within the narrative interviews, positive supervisory experiences were also

described, and it is important to recognise the balance of these experiences. A number of the trainees were incredibly grateful for the role their supervisor played in their development within postgraduate GP training. Positive experiences related to the supervisors' roles in educational support, protection (from the demands of juggling training and family life), personal support, near-peers and role models.

However, it was frequently the examples of negative experiences, dissonance or irregularities which illuminated the complexity within supervision and its contribution to postgraduate GP training. Similarly, despite 60 years of cumulative supervision experience to draw upon, the experienced educators chose to reflect on their negative experiences, as these served as a site for reflection and learning. Although these negative accounts are more heavily represented within this discussion, it is important to note the positive experiences of the supervisory alliance, from the persepctive of both trainees and supervisors.

RQ2: How do supervisory relationships contribute to the professional development of postgraduate GP trainees?

The supervisory relationship appears to be an important influence on the professional development of postgraduate trainees, even in instances where interaction is infrequent, or the personal connection is distant. Supervisors can have a prominent role in the positioning of trainees, and this appears to also relate to the trainee's vantage point and perspective. Trainees may be referred to as 'disengaged' or 'lacking insight'. However, attempts to remediate these attributes that focus solely on the trainee may neglect the influence of the socio-cultural context, positioning and vantage point. Supervisors appear to undulate between an agent of the 'system' and a source of professional support for the trainee, which may accentuate the power imbalance between them. Greater trainee agency was evident through learning to improvise, particularly through mastery of the surgery timetable, E-Portfolio and geographical access to the supervisor.

Factors that influence the supervisory experience

Multiple and diverse trainee identities

There is a tendency within the medical profession to create narrow sets of uniform goals and expectations for how trainees are or 'ought' to be (Bennett et al., 2017). However, there is variability in the extent to which trainees (as agents) ascribed to the multiple voices around them regarding the 'good' GP trainee, and variability in the ways they self-authored themselves as professionals (Bakhtin, 1992; Bennett et al., 2017).

Diverse interpretations of the trainees' view of a 'good' GP trainee were particularly apparent with respect to perceptions of adult learning, autonomy, participation, escalation of concerns and negotiating multiple identities. This diversity appeared to relate to the trainees' multiple and (at times) conflicting identities   Trainees have a number of responsibilities, both professionally, and in their home and family life. Professional identities appeared to develop simultaneously as the trainees intersected with multiple socio-cultural contexts. Jas' narrative referred to her conflict between meeting the requirements of training, and supporting her husband in her identity as a wife. Esther's story focused on her reliance on her supervisor to support her to juggle the demands of training and her developing identity as a new parent, whilst Alison's and Sarah's narratives highlighted their identities as academic trainees, parents and GP trainees.

Observations from the results suggest that GP trainees will construct their own diverse professional identities, influenced by the multiple identities of the trainee, the multiple voices of the Figured World and the way in which they internally ascribe to these voices (Archer et al., 2016; Bennett et al., 2017). Acknowledging the influence of the multiple and diverse identities within GP training appears to be particularly important for supervisors within this context.

Tensions in the supervisory relationship

From the systematic review of the literature, it was apparent that supervisory relationships must navigate numerous competing goals and priorities. These included the balance of trainee support and autonomy, the demands of the training programme and the practice and the facilitation of training whilst also ensuring patient safety (Jackson et al., 2019). The research findings also suggested numerous examples of tensions and competing priorities across various aspects of supervision. These tensions appeared contribute to the variability in perceptions and lived experiences of supervision amongst the trainees.

The first observation relates to the supervisor's multiple and (at times) conflicting roles, spanning both support and assessment. This was suggested from both the documentary analysis, and also alluded to by the experienced educators themselves. A number of the GP trainees appeared to lack clarity, or feel suspicious, about the supervisor's goals and agenda in supervision. It seemed that the supervisor's multiple roles contributed to this confusion or suspicion, and may have placed constraints on trainee openness and vulnerability within the alliance.

A second observation related to the degree of openness and clarity within the alliance. The supervisors appeared to vary in their views of how the goals and locus of supervision should be emphasised within supervision. Despite this variability in perception and expectation from the supervisors, it wasn't clear from the narrative interviews if these tensions, multiple roles, goals or locus of control were explicitly discussed with the trainees. The lack of discussion and transparency regarding these tensions may have contributed to the trainee's lack of clarity and (at times) suspicion about the roles, function and agenda of their supervisor. An example of this was Jas' suspicion regarding her supervisor's use of the E-Portfolio comments section. Although it was never discussed, Jas perceived her supervisor's goal to be appeasement of the 'system' ('*just to show*' her support) rather than to offer meaningful '*personal*' support during a difficult time in Jas' training.

The training practice

The training practice itself also appeared to have a prominent influence on supervision, and this influence often required navigation and negotiation. The narrative interview results highlighted the impact of structural arrangements in the practice, and the culture of support and education on the trainee's experience of supervision. Nat, Sarah and Alison's narratives illustrated the potential for the training practice to constrain resources, scheduling or opportunities for supervision, while Stephen, Esther and Nadia had contrastingly positive experiences where education and supervision were prioritised and facilitated within the practice culture.

One particular emergent area of discourse in this respect related to a concern amongst GP supervisors and training practices that trainees were spending insufficient training time with patients as a result of the workload scheduling arrangements in the Junior Doctors Contract, but that they were powerless to challenge this. The fear of '*breaching hours'* appears at odds with the deliberately non-prescriptive guidance of the EWTD and Junior Doctors Contract documentation. The implementation of EWTD and contractual changes at the level of the training practice potentially represents an area where universal 'truths' may have emerged regarding an inflexible training contract, which are only partly rooted in fact.

A second area of influence within the training practice related to the involvement of other clinicians and staff on the trainee's development, leading to the trainee operating within a wider practice culture (or community of practice) (Lave and Wenger, 1991). Seema's narrative illustrated the differences between 'insiders' and 'outsiders' at the practice. 'Insiders' were afforded time, trust and autonomy, whilst those on the 'outside' were closely monitored, yet afforded less access to the time, space or association of the staff. Based on the results from the narrative interviews, some practices appeared to have a culture of learning and development, shaping their views of professional practice, and creating a non-hierarchical environment where all clinicians were open

and honest about their learning needs.   In contrast, others appeared hierarchical, and unamenable to challenge, whilst others appeared to prioritise service delivery over education in their treatment of trainees as 'unpaid salaried' GPs.

The experienced educators referred to their experiences of the enabling influence of the practice team, who could be approached to offer support in supervision, and in confirming or communicating judgements about a particular trainee's performance. However, they also referred to their feelings of responsibility to the practice team when their trainee 'caused' problems, and where the presence of trainees at the practice had *'foster[ed] complaints and bad feeling from the other GPs'*.

The wider training system

The influence of the tacit messages from the 'system' (regarding hierarchy and collation of evidence) has been discussed in the first section of this chapter (in relation to RQ1).

Within the narrative interviews, a number of the trainees discussed the structural influence of the training system, where they largely appeared to be referring to the accrediting body of the Royal College of General Practitioners and the various local educational staff who supported the assessment and training of GPs in the region. Largely considered to be at the 'top' of the hierarchy by a number of trainees, the training 'system' appeared to be considered as the structural influence within the Figured World of GP training. It was perceived as a judge, source of support and advocacy, or a 'stick' that they could threaten to use to protect them from their practice culture or workload.   For others, the system was an inflexible, structural phenomenon, incapable of flexing to personal or educational needs, and therefore attempts to interact with it were minimal. It was interesting to observe that, for some trainees, interacting with the system as a source of support risked labelling them as troublemakers, 'problem' trainees, or not demonstrating sufficient evidence of adult learning to help themselves.

RQ3: What factors influence the supervisory experience?

Supervision occurs within the context of the training practice, and is influenced by the way in which educational opportunities are scheduled, and also by the culture within the practice (which can support or hinder supervision). The wider profession is perceived to influence supervision in a 'top-down' fashion, through policy, evidence and quality assessment of supervision. It appears to be a source of support for trainees, but interacting with the 'system' it not without problems due to its perceived inflexibility.

From the results, supervision is dynamic, and influenced by the diverse interpretations, identities, roles and expectations of GP trainees and their supervisors. Where clarity is lacking with respect to these aspects, confusion or suspicion may arise, which can threaten trainee openness.

Supervision: Expectations and experiences

Within **Chapter 3**, I discussed the influence of structure within the Figured World, and the way in which institutional messages can impact the situated understandings of participants within a social group (Goodenough, 1994). Such structural discourses can shape what we expect and 'know' about particular normative categories, to the extent where things can become entrenched and 'normal'. Participants may take on set roles, whilst environments are laid out in set fashions, without question or critique (Kuper et al., 2013). It has been suggested that these taken for granted assumptions are evident within the field of medical education, related to universal, a-contextual and a-historical 'truths', about matters such as the doctor-patient relationship, professionalism, and the political and social roles of doctors (Bligh, 2003, Hodges, 2005, Bennett et al., 2017). Without questioning and critique in the context of postgraduate GP training, we risk a casual acceptance of what 'successful' professional development is, or what constitutes a 'good' GP trainee (Kuper et al., 2013, Bennett et al., 2017).

There were particular areas that emerged from within the data where the expectations of the supervisors (outlined from within the interviews with experienced educators and the documentary analysis) were at odds with the lived experience of the GP trainees. These related to 'taken-for-granted' expectations that the trainee would be an 'adult learner', 'legitimate participant, and 'reflective learner'. These areas of dissonance (between what the supervisor may expect, and what the trainee may experience) are particularly important when we consider Bordin's model of the supervisory working alliance, as they represent particular areas where disagreement may occur.

Within the next section, I have developed the discussion to highlight each of these areas in turn.

The 'good' trainee is an adult learner

Within the documentary analysis, the trainee as an 'adult learner' was frequently discussed, and emerged as the most frequently coded construct related to trainees. This related to a commitment to lifelong learning, but also to being proactive, engaged and responsible for self-directed learning within the context of postgraduate GP training. These concepts relate to Knowles' 'andragogy', where adult learners were highlighted to be different to children in a cluster of ways, including their motivation to learn, sense of self-concept and personal responsibility for learning and readiness to learn (Knowles et al., 2005). Knowles also refers to the role of the learner's experiences within adult learning, which are valued by the learner, and which educators should respect (Taylor and Hamdy, 2013, Knowles et al., 2005).

Conceptualising the trainee as an 'adult learner' could be perceived as a universal 'truth' within postgraduate GP training. Within the documentation, there appeared to be a casual acceptance of respect for the GP trainee's experiences and opinion, and a taken-for-granted assumption within the terminology suggested a personalised approach to learning. However, through exploring the areas of dissonance within the research analysis, particularly with respect to the ways in which work is scheduled, this assumption is called into question.

Work scheduling and adult learning

As outlined within the results from the documentary analysis, GP trainees are considered to be 'adult learners', and personalised and tailored approaches to their education are advocated. Guidance related to the implementation of the European Working Time Directive (EWTD) appears to be deliberately non-prescriptive in an attempt to enable development of a personalised working schedule, with sufficient flexibility and negotiation between the GP trainee and their supervisor (Health Education England West Midlands, date unknown-d). However, the results suggested a number of irregularities.

The first relates to the degree in which work scheduling is 'personalised'. There was a sense from the various stages of the research that trainee's did not have a considerable voice in contributing to discussions on their working schedule, making it 'enforced' rather than 'personalised'. For example, one of the experienced supervisors described her approach to work scheduling, which was based on her own beliefs regarding workload progression throughout the training year, rather than taking account of the trainee's learning needs or preferences.

Similar experiences were recounted by some of the GP trainees within their narratives, where (in contrast to the personalised approach), they felt pushed by their supervisor to work in certain ways, frequently without prior discussion or negotiation.

The 'good' trainee is a legitimate participant

Learning within a community of practice emerged within the results of the systematic review, and participation within communities of practice (based on Lave and Wenger's theory) was frequently alluded to by the literature on postgraduate GP supervision (Lave and Wenger, 1991). It was also a construct that frequently emerged within the documentary analysis. Participation in this regard relates to growing levels of participation and legitimacy within the workplace (or Community of

Practice), as the training progresses, towards full participation within the community (Lave and Wenger, 1991).

However, despite its prominence, the lived experiences of the GP trainees, and the meaning ascribed to this concept by the trainees, suggested particular irregularities. Not every trainee shared the profession's view of 'legitimate participation', and some trainees did not appear to be afforded sufficient opportunities to participate. I will discuss each of these in turn within this section.

The GP trainee's perception of 'participation'

Some of the trainees did refer to their pursuit to move towards greater autonomy, with increasing responsibility and legitimate participation in practice life as their training progressed. Conversely, their aim was to rely on the support of their supervisor less as their training progressed. This was particularly apparent in George, Stephen's and Ayesha's narratives, where increasing workloads and responsibilities, and decreased supervisory support were perceived to be inherent to the training trajectory. These experiences did appear to support the wider profession's view of the 'good' trainee as a legitimate participant (Lave and Wenger, 1991).

However, not all the trainees shared the view that 'being' a GP trainee involved a progression from peripheral to full (and autonomous) participation within the community of practice. 'Being' a GP trainee for Sarah meant still having access to the support and input from her supervisor, right up until the point of qualification. Taking this further still, both Nadia and Esther rejected the idea that autonomous practice was ubiquitous with 'becoming' a GP upon qualification. Both trainees were actively seeking employment upon qualification that would provide ongoing support through the community of practice, and a shared sense of responsibility for complexity and risk.

Within the General Practice literature, the phrase 'preparedness for practice' is often used to describe the trainee's confidence upon qualification, and ability to manage complexity and risk autonomously (Sabey and Hardy, 2015, Wiener-Ogilvie et al., 2014). In one sense, reluctance to

practice autonomously could be viewed as lacking 'preparedness'. However, the narratives

suggested a more complex view of preparedness and participation, related to accumulation of the

skills of ongoing interdependence within the practice team, rather than pursuing a career as an

independent practitioner.   Such a view may have important implications for the expectations,

motivations and identity formation of current trainees, where the end goal may differ to that of their

supervisors and peers. A deeper exploration of this concept, and its meaning for trainees and their

supervisors, may be required, particularly with respect to the degree of autonomy, legitimacy and

participation expected.

Positioning within the community of practice

Fundamental to Lave and Wenger's theory is the socio-cultural context provided by the community

of practice, and the means by which the trainee is transformed and encouraged to greater

participation within it. Within postgraduate GP training, it can be argued that trainees are afforded

(or offered) subject positions by the culture itself: in the way they are spoken to, the opportunities

they are given and the outcomes that are celebrated (Davies and Harre, 1990). Applying this to the

culture of the community of practice, the members have a role in positioning the trainee, particularly

through affordances such as access and discourse (Holland et al., 1998). By extension, through this

positioning, the members of the community of practice have a role in the extent to which a trainee

remains peripheral, or enters into greater degrees of participation.

The contrast of Stephen's 'insider' position and Seema's 'outsider' position provides a powerful

illustration of the ways in which trainees can be positioned by the practice team. Seema's 'outsider'

position appears to run contrary to the aims of participation set out within the expectations of the

wider profession. Participation in Seema's case appeared closely tied to the affordances and access

offered by her supervisor and the training practice, rather than the taken-for-granted linear

trajectory from peripheral to more full participation suggested within the training documents.

Positioning within the practice team was not the only threat to legitimate participation. Nat's

narrative highlighted the constraints she experienced with respect to legitimate participation in the

on-call duties in her practice, when she was denied the opportunity to 'step up' towards the end of

her training due fears related to the contractual boundaries imposed by the Junior Doctors contract.

Within their writing, Lave and Wenger discuss the influence of 'hegemony over resources and

alienation from full participation' in relation to legitimacy (Lave and Wenger, 1991 p.42). Concepts of

legitimacy, participation and the community of practice are frequently alluded to within the

documents on postgraduate training. However, what is less frequently discussed (if at all) are the

responsibilities of the supervisor and the wider community of practice to make the relevant

affordances of access and discourse, or how to mediate those relationships which may threaten

legitimacy. This may be particularly important in situations where the trainee is 'different' to what

the supervisor expects, where the training trajectory is non-linear, or where unanticipated difficulties

arise within training.

The 'good' GP trainee as a reflective learner

The trainee's electronic training portfolio was frequently referred to within the results of the

documentary analysis: as a formative learning tool, and also as a place to record written reflection,

workplace based assessment and educational meetings. Although the assessment and summative

function of the portfolio is acknowledged, there are a number of areas in which its formative use is

highlighted, particularly the reflective component. A systematic review exploring the use of

portfolios within medical education found that portfolios were more often considered as

bureaucratic tools when the content was highly prescribed, and that they were more appreciated

when learners were given a degree of freedom to develop the content (Driessen et al., 2007). For

success at Annual Review of Competency Progression (ARCP), the Royal College of GPs (RCGP) is

deliberately non-prescriptive on the minimum requirement of written reflective entries, and this contributes to the formative element of the GP training E-portfolio.

However, there are a number of irregularities in the 'truths' regarding the reflective and formative functions of the E-portfolio. Seema's references to the portfolio and learning log requirements appear to relate to a more bureaucratic perspective, and the prescriptive requirements (of roughly *'50 learning log entries every 6 months'*) outlined within local training guidance appeared to reinforce this perspective for many of the trainees (Palmar, 2014)

However, both the trainees and supervisors referred to an additional function of the portfolio, which I have termed its 'defensive' function. In many ways, it appeared that documentation and 'evidence' became areas where battles of position were fought, lost and won between trainees and their supervisors (or the training system).

The results suggest that the bureaucratic and defensive functions of the E-portfolio may override its reflective and formative purpose in context of postgraduate GP training. Whilst supervisors may expect the portfolio to be used primarily as a learning tool, there appeared to be an emerging perspective where trainees recognised (and at times wielded) the power of the Portfolio in battles of positioning and judgement of performance, in addition to its formative function.

The Royal College of General Practitioners (RCGP) provide some opportunity and guidance for discussion of expectations for trainee and trainer in the supervisory interaction, such as learning plans, personal development plans and educational supervisor reviews (Royal College of General Practitioners, 2013, Royal College of General Practitioners, 2016a, Royal College of General Practitioners, date unknown). However, they do not provide explicit guidance on how the relationship should navigate the inherent tensions in supervision (influenced by the local and wider educational environments), the multiple and diverse identities (of both trainee and supervisor) and the areas of potential dissonance between expectations and lived experiences. It is possible that

trainee and trainer may co-exist in relationship for three years, each believing 'truths' about

supervision and professional development, with neither fully comprehending the tacit values, beliefs

and expectations of the other.

RQ4: How do lived experiences of trainees and their supervisors relate to the expectations of the wider profession?

There appears to be an expectation within the profession that GP trainees will be adult learners,

legitimate participants and reflective learners. However, the lived experience of the trainees and

supervisors suggests that we should exercise caution in making these casual assumptions. Rigid and

enforced scheduling of workload runs contrary to the expectation that the trainee will 'be' an adult

learner. Collation of evidence and an emphasis on documentation threaten the formative aspects of

training for the trainee as a 'reflective learner'. In addition, it appears that further exploration is

required to understand the range of perspectives regarding participation and preparedness. These

areas of dissonance were particularly evident within this research, and have been highlighted within

the thesis. However, they illuminate the possibility that multiple 'truths' and expectations may exist

regarding aspects of postgraduate supervision, where both the trainee and their supervisor may vary

in their expectations and perspectives.

Implications for postgraduate GP training: Developing the model

Based on the results from the systematic review of the literature on GP supervision, I introduced a model of the supervisory alliance, which was influenced by Bordin's working alliance based model of supervision (Bordin, 1983, Jackson et al., 2019) (See **Figure 11: Returning to the Model of General Practice Supervision**, presented below). Within this section, I will develop this model and the associated discussion in light of the findings from my research.

Figure 11: Returning to the Model of General Practice Supervision
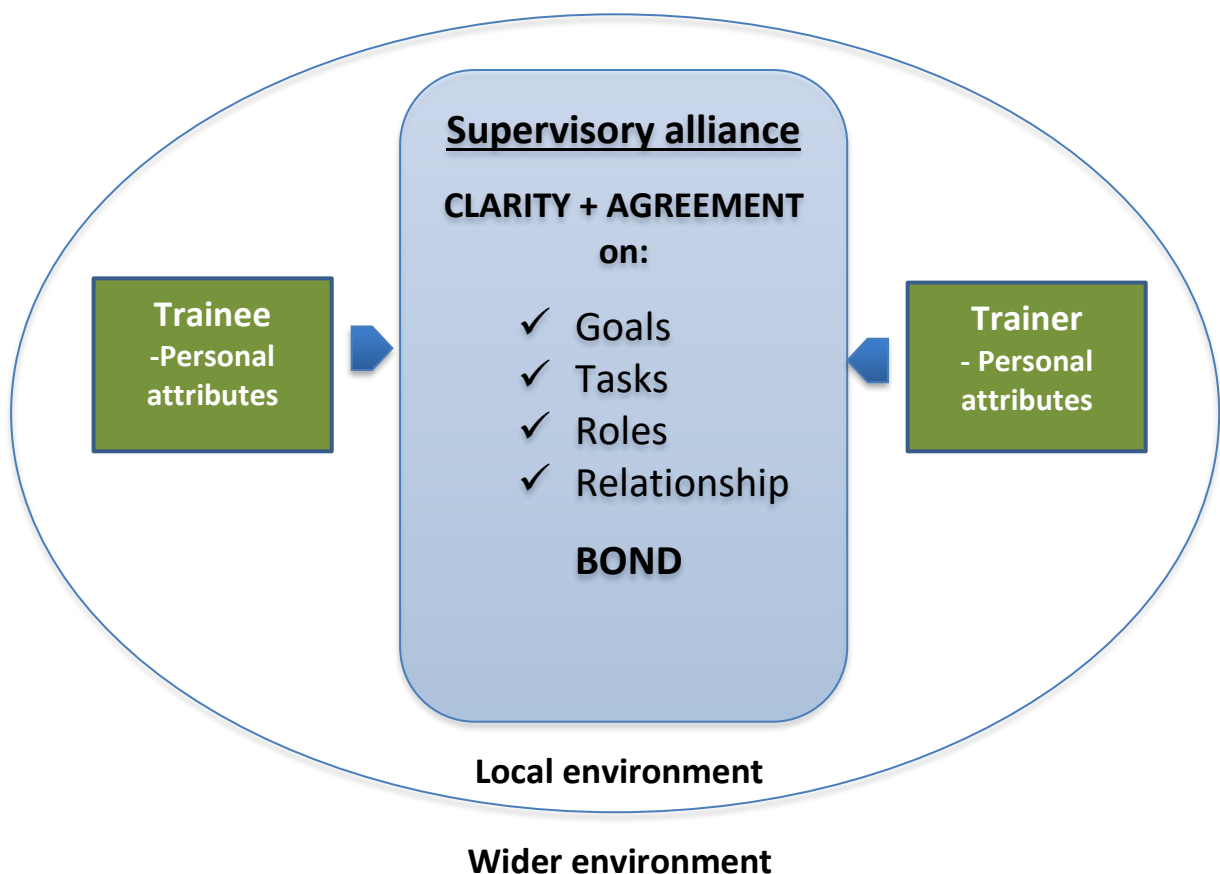
Currently, supervisory discussions within GP training are framed to explore the trainee's learning needs, reflect on their performance and develop action plans for development (Royal College of General Practitioners, date unknown). However, probing beneath the surface to consider the expectations and experiences that influence observed behaviours or values is not articulated within

training guidance. Producing a 'model' to facilitate these discussions for trainees and supervisors may assist in making explicit the tacit and taken-for-granted assumptions about training, supervision and the community of practice.

Development of a model in the context of socio-cultural approach risks an oversimplification of the dynamism that unpins the social world. However, the 'model' proposed within this section is intended as a springboard for exploration and discussion, rather than a prescriptive approach to supervision and training.

Clarity

Clarity on goals and tasks was described by Bordin as an important element of agreement (Bordin, 1983, Wood, 2005, Jackson et al., 2019). Within the systematic review, we suggested that this related to sufficient openness on the part of the trainee regarding their particular learning needs, and explicit discussion from the supervisor on their particular agenda and role (Jackson et al., 2019). We also highlighted 'clarity' within our model of supervision to facilitate greater focus on the trainee's perspective, with respect to the goals and tasks of supervision, and to encourage greater openness and negotiation between trainee and supervisor.

The results of this research, and the subsequent exploration of the mechanisms and irregularities surrounding the taken-for-granted 'truths' within postgraduate GP training, suggest that 'clarity' extends to the implicit and tacit assumptions within postgraduate GP training (Kuper et al., 2013). Tacit messages from this research included the unintended messages from within the profession regarding collation of evidence, and not complaining.

Particular areas of dissonance and irregularity from the results of this research lie in the terms 'adult learner', 'legitimate participant', 'reflective learner', the multiple (and potentially conflicting) identities of trainee and supervisor, and the recommended trainee attributes of 'insight' and

'engagement'. Each of these represents a site of significant complexity, tension and socio-cultural context that may remain ignored or only superficially explored within supervision, or by the profession as a whole. These may be pertinent areas to explore in discussions between trainees and their supervisors, and relate to the 'roles' within supervision.

It is likely that there are areas of dissonance or irregularity within the experience of training or supervision that extend beyond the scope of the universal 'truths' illuminated within this research. Exploring how trainees and their supervisors can develop an approach to clarity that incorporates the questioning and critique of their assumptions about these 'truths' may be an useful mechanism to enhance clarity within supervision. Exposing implicit assumptions regarding the particular way things are done within supervision and the community of practice may also be required. For example, 'norms' within the culture of a particular training practice (such as the preferred ways to access support for ad hoc questions or the 'rules' for booking appointments on the electronic surgery timetable) may not be immediately obvious to the neophyte trainee, but their legitimacy and positioning within the practice may partly hinge on getting this 'right'.

Clarity and agreement on the goals and tasks of supervision

Workload scheduling and the extent to which the trainee participated within the community of practice appeared to be additional sources of irregularity within the results, and therefore particular areas where clarity may be lacking. These observations relate to Bordin's reference to the 'goals and tasks' of supervision within his working alliance based model of supervision (Bordin, 1983).

Clarity and negotiation on the task of work scheduling appears to be an important area for discussion. Supervisor concerns relating to preparedness for practice, and training practices' interpretation and implementation of contractual guidance, appeared to drive an imposition of a working schedule that (at times) was incongruent with the trainee's preferred approach to education and learning. De-bunking myths for training practices around EWTD and contractual arrangements

may create space for negotiation between trainees and supervisors with respect to greater legitimacy and authenticity in their workload. Recognition by supervisors of the potential for multiple (and potentially conflicting) demands of other responsibilities and identities for the trainee may also be important within these negotiations.

There was variability amongst trainees and supervisors regarding the goal and extent of trainee participation within the community of practice. These variabilities were most evident in their perceptions of legitimacy, their goals for autonomous practice and their position in the community of practice. As discussed within the systematic review, the supervisor may have an important role in brokering the trainee's inclusion in the community of practice (Wearne et al., 2012). This includes influencing constraints that may impact their learning, and facilitating their inclusion and legitimacy in the practice life. Raising awareness for trainees on the potential benefits of participation for motivation and learning may also serve as a useful tool for discussion. Brokering, in the context of this research, may also involve supporting the trainee to develop mastery of particular artefacts, such as the surgery electronic timetable, E-Portfolio or navigation of access to supervisors for ad hoc questions (particularly when surgery doors are often closed).

An additional area to consider, which appears to require further exploration beyond this thesis, was the finding that some of the trainees were particularly apprehensive about becoming independent practitioners after qualification. Some were actively seeking employment that would provide a support network, and share the responsibilities related to complexity and risk in clinical care. In a small study such as this, it is difficult to draw significant conclusions based on the aspirations of a small number of trainees. However, these stories raised questions about whether GP training (in its current format) is supporting the identity development of trainees as capable independent practitioners.

Clarity and agreement on the roles in supervision

The multiple roles of the supervisor (including their role in assessment) were also suggested within the results, and offering clarity of these within supervisory dialogues remains a recommendation within the model (above). Results from the interviews with experienced educators would suggest that this should also extend to providing clarity on the 'locus of control' within the supervisory alliance: 'who' is expected to be driving or initiating the various aspects of the supervisory interaction.

Recognition of the multiple and (at times) conflicting identities of the trainees, extending to their lives outside of work, was an important finding. Any discussion to clarify and negotiate roles within supervision should also include the multiple roles, identities, responsibilities and priorities of the trainee. There was some evidence of recognising the preferences and priorities of the trainee in the national guidance on work scheduling and reflective log requirements, which appeared to be deliberately non-prescriptive. However, local reiterations of this guidance appeared to have added additional prescriptions (explicit or implicit) for training practices and supervisors, which may serve as constraints for trainee agency. Training documents (and local training documents in particular) may require review to ensure they enable sufficient tailoring to the adult learning preferences of the trainee, their circumstances and the socio-cultural context of their training.

Agreement: Power and positioning

Alongside the concept of clarity, the model from within the systematic review also referred to Bordin's concept of 'agreement' between trainee and supervisor on the goals, tasks, roles and power within the supervisory relationship (Bordin, 1983). In **Figure 12** (**Model of the Supervisory Alliance in Postgraduate GP Training: A springboard for discussion**), I have developed the original model to include 'power' and 'positioning'.

Within the literature, non-hierarchical relationships were recommended to minimise the risk of power imbalance (Ingham, 2012, Ingham et al., 2015a, Wearne et al., 2015). However, the results from this research were equivocal regarding the extent to which non-hierarchical relationships should be pursued. Certainly, there were a number of positive supervisory experiences in the context of relatively hierarchical relationships.

However, in areas of disagreement, the issue of power imbalance did appear prominent. This seemed to relate to a lack of affordances for the trainee to challenge or raise concerns, and also to a consideration of positioning and vantage point when making judgements about the trainee. Creating safety within the relationship may go some way to reduce this imbalance, and encourage trainee openness (Giroldi et al., 2017). The experienced educators described techniques such as getting the know the trainee as an individual, sharing stories of their own lives and preparing to learn from the trainee as additional methods to 'flatten' the hierarchy and invite the trainee's voice.

The results also indicated that power relationships within supervision are also related to positioning and vantage point. The supervisor and community of practice appeared to hold significant power to position the trainee within the context of postgraduate training, through a number of means. Those trainees who appeared to be 'insiders' within their community of practice (and with respect to their supervisors) also appeared to have a trajectory of growing participation and legitimacy in the life of the practice. However, this was not the experience for every trainee, particularly in stories of supervisory relationship or training problems. The results suggest that, for a supervisor questioning their trainee's engagement, insight or participation, they may need to question the extent to which that trainee is afforded access within the practice (and to their supervisor). Understanding the tacit rules of 'how things are done around here' may be challenging to navigate for those trainees who lack access to the knowledge of the rules of the game. In some situations, it may require a reflection

on the role of the supervisor as a broker with the community of practice, a phenomenon described elsewhere within the literature (Wearne et al., 2012).

Bond and creating safety

An additional consideration within the model from our systematic review was Bordin's concept of 'bond'. This related to knowing one another as individuals, as liking one another, and appeared to overlap with the notion of trust within the supervisory relationship (Bordin, 1983, Jackson et al., 2019). I have developed the original model to also contain 'safety'.

There was a suggestion from the literature that trainees needed to be able to count on (or trust) their supervisor to provide the support they required (Sagasser et al., 2017). However, the results from this research suggested that, when supervisors were perceived as agents of structure (or the 'system'), distrust and suspicion arose. This suspicion appeared to relate to the supervisors' assessment, gatekeeping and monitoring roles. It was most marked when the trainees perceived these functions to predominate over the educational and supportive roles of the supervisor.

As discussed by the experienced educators, taking steps to know the trainee as an individual (and also to be known by the trainee) suggested a means to mediate this tension. Seeking openness and clarity (particularly on the multiple roles of supervisor and trainee), reducing the power imbalance, and inviting the trainee's voice to shape their workload and training may also offer means to mediate the threats to bond.

The local training environment

The explicit influence of the training practice was evident in stories of workload scheduling, the support from practice staff in trainee supervision and assessment, and the provision (or lack of provision) of time and resources to support supervision. However, it is also important to recognise the influence of the training practice on the culture of education and supervision, and its role in

affording the trainee legitimacy and opportunities to participate through positioning. In the West

Midlands, evaluation and assessment of the quality of training practices is undertaken through a

process of self-assessment. However, the forms used focus largely on the explicit elements of

practice influence, such as workload, induction and resources (Committee of General Practice

Education Directors, 2014). These go some way to illuminate the culture of the practice, but in a

somewhat simplistic fashion. The re-introduction of HEEWM monitoring visits to practices, or

meetings with the local training region and practice staff, may go further to explore and develop the

implicit local influences from the training practice.

The wider training environment

The results from this research suggested the important role of the wider profession in the

irregularities and dissonances observed in the lived experiences of supervision. This was particularly

poignant when considering the emphasis on collation of evidence within postgraduate GP training

and supervision, and also within the processes for trainees to raise concerns.

The results indicated an over-emphasis of collation of evidence as a bureaucratic exercise, rather

than using it as a tool to improve quality. The E-Portfolio, in particular, risked becoming a tool used

defensively by both trainees and supervisors. Supervisory discussions may benefit from exploring

trainee and supervisor expectations from the E-Portfolio, and may require a degree of

personalisation and flexibility in the approach.

Revisiting the model

In light of these discussions, I have developed the original model (See **Figure 12: Model of the**

Supervisory Alliance in Postgraduate GP Training: A springboard for discussion). It remains a

springboard for discussion for trainees and supervisors, and for educators within the wider

profession, and therefore I have attempted to avoid being overly descriptive in directing these

discussions. However, the term 'relationship' has been replaced by 'power' and 'positioning' to place

a greater emphasis and clarity on their influence within GP training and supervision. Although

'safety' within the supervisory alliance is perhaps assumed within the concept of 'bond', it has been

highlighted as a distinct element within the revised model. This is because of the explicit attempts

that have been described by supervisors to create safety (both within the literature and the

interviews with experienced educators), and the risks to the alliance (particularly the extent of

trainee openness and engagement) when suspicion or confusion arise.

Figure 12: Model of the Supervisory Alliance in Postgraduate GP Training: A springboard for discussion
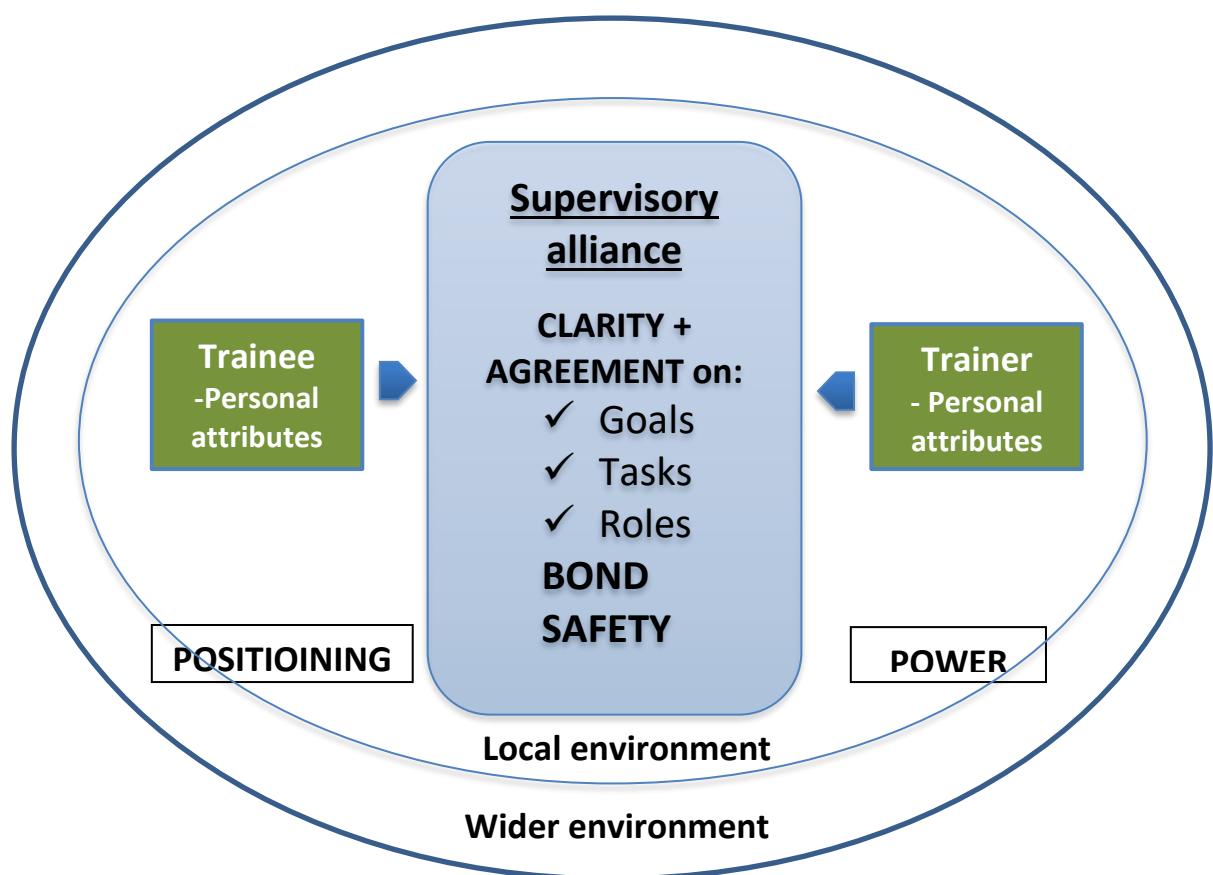
Implications beyond the supervisory relationship

Through this research, the wider profession has emerged as a key area of influence on supervision.

Although the focus of this research and the model (outlined above) was at the interpersonal level of

the supervisory relationship, the mutuality of the community plane on the trainee's professional development suggests that we must look beyond the supervisory interaction (Rogoff, 1995). I have highlighted this with respect to 'evidence collation', 'raising concerns' and 'the role supervisor as an agent of the 'system''.

Evidence collation

Making training guidance less prescriptive with respect to minimum requirements for evidence collation may serve to reduce the bureaucratic perception of training documentation, and there appeared to be some evidence of this already within national training guidance. Extending this to local training documentation, which (at times) offered a more prescriptive approach, may offer one means to facilitate negotiation (and personalisation) of the use of evidence, and reduce the associated bureaucratic perceptions.

Raising concerns as a valued and useful process for GP trainees

There appeared to be a number of deterrents to raising concerns for the GP trainees. These included the complexity of the process, the risk of being labelled as a 'problem trainee' and stories where the consequences of raising concerns had been unsatisfactory. Development of a local system to raise concerns could remove the hierarchical and complex approach. This could include the development of a local 'Freedom to Speak Up Guardian'. These are roles in development with the National Guardian's Office, an independent, non-statutory body. The aim of this organisation is to make raising concerns a matter of 'business as usual', with easily accessible, independent individuals to address the issue of raising concerns both proactively and reactively (Francis, 2015, Care Quality Commission, 2019).

Taking steps to remove the stigma of raising concerns within training may also offer an area for consideration. This could be in collaboration with the proactive 'Freedom to Speak Up Guardian

role', or through local steps in signposting routes for support with greater clarity, and communicating positive actions taken as a result of raising concerns.

The role of the supervisor as an agent of the 'system'

An additional observation from within the research related to the perception of the supervisor as an agent of the 'system'. The trainees described feelings of suspicion regarding the supervisors' functions of assessment and monitoring, which (for some trainees) appeared more prominent than their role in educational support, advocacy or protection.

Within this research, the experienced educator's feelings of being 'vulnerable' in situations where trainees were experiencing difficulty, and the theme of 'failure to fail', suggest that the supervisor as an agent of the 'system' is complex. These responses highlight the potential power of the training system to sanction supervisors who may be perceived to be underperforming, and also suggest that the supervisors identify with their assessment and 'system' roles to variable extents.

At the wider training environment level, there may be a case to consider the utility of the multiple (and potentially conflicting) roles of the educational supervisor. Certainly, within the literature, the assessment burden of supervision has been perceived by supervisors as a threat to their educational role, and to trainee openness as a result (Wearne and Brown, 2014, Ferguson et al., 2014).

Plans for further research

Whilst the interviews with the experienced educators gave important historical insights into the postgraduate GP training context, contemporary reflections were limited, and their stories frequently drew on negative experiences, rather than the day-to-day lived experience of being supervisors in General Practice. Knowledge of the lived experiences of postgraduate GP supervision is limited without the voices and perspectives of current educational supervisors, who observe and work within the socio-cultural complexity of postgraduate supervision.

I sought to illuminate the voices of current educational supervisors at the outset of my research design. However, as the research evolved, it became apparent that significant further exploration was required to provide sufficient understanding of this important voice. I have designed the next phase of the study (the implementation of which sits outside the scope of this thesis) to enhance the understanding of the supervisor perspective.

Exploring areas of dissonance through the voices of GP supervisors

Within the discussion of my research findings, several areas of dissonance and irregularity emerged. The next phase of my research explores these areas of irregularity from a different perspective; that of the supervisor. I was particularly interested in the supervisors' reactions and responses to the voices of the trainees, and saw this as a means to explore the dialogical voices and perspectives within the socio-cultural world of postgraduate GP training (Bhaskar, 1975, Bakhtin, 1992). In light of this, a design evolved that would enable a presentation of the trainee's voices to focus groups of supervisors, focusing on the observed areas of irregularly and dissonance within this research.

Ten focus groups are intended, with 8-12 supervisors in each. Each group is anticipated to last between 45 minutes to one hour, and to be scheduled during various trainers' workshops. These are regional training evenings for GP supervisors, and attendance is recommended as part of Continuing Professional Development and ongoing recognition and approval as a GP supervisor. Running the

focus groups at such an event such is likely to capture the views of a breath of GP supervisors, potentially from various subgroups, currently active in supervision on a daily basis (Cohen et al, 2007). Furthermore, trainers' workshops are often opportunities for supervisors to discuss their experiences of supervision with peers, and the peer-discussion planned within the focus group design would likely not be out of place in this collegial context (Neighbour, 2006).

Building on the data from the narrative interviews with GP trainees, short audio-recorded vignettes will be designed and presented to each focus group. The reactions and responses of the supervisors will be video-recorded. The focus groups will be facilitated by myself and members of a research team, and each group will be invited to share their collective view as part of a plenary at the end of the session. Due to the educational setting of the focus groups (within a trainer's CPD workshop), the educational impact of the focus groups will be gauged using a written feedback form, and by taking verbal feedback from the supervisors (within their focus group) before the final plenary. Concerns with this approach include the risk of dominance of the discussion by a few individuals within the group, and also in ensuring that participants address the area of interest in sufficient depth (Cohen et al, 2007). However, through careful facilitation, it is hoped that these risks will be mediated.

Construction of vignettes

The vignettes will be constructed to illuminate particular areas of irregularity and dissonance from my research findings. This may include areas of training and supervision such as work scheduling, the trainee as an adult learner, legitimate participation and the community of practice, collation of evidence and raising concerns. Relevant excerpts across the trainee narratives will be used within the construction, with potentially identifying information removed to preserve trainee anonymity. It is likely that each vignette will represent the stories of a number of GP trainees, partly to represent the multiplicity of voices within the Figured World, and partly to preserve anonymity.

The use of vignettes has been incorporated within empirical research in postgraduate GP education, to explore supervisors' experiences of the supervisory interaction (Wearne, 2003). The focus group method has been observed to facilitate interaction between participants (Cohen et al., 2007). Its ability to provoke discussion between participants (and therefore to invite and provoke alternative points of view) is particularly appealing in light of the socio-cultural approach to this research (Lincoln and Guba, 1985).

A further rationale for the use of vignettes was to focus the discussion on particular irregularities and dissonances within GP training and supervision, to facilitate a greater depth of insight into the various perspectives on these areas of interest.

The experienced educators in the Stage 2 interviews had frequently chosen to discuss negative accounts of relationship breakdown, which had often not resolved, and had caused considerable emotional distress. A final consideration in the use of vignettes was the desire to move the supervisors' discussion beyond the 'problems' in supervision, to considering stories of success, remediation and the realities of daily supervision.

Beyond GP training

The exploration of the multiple voices within the socio-cultural world of medical education offers an exciting avenue for researchers, both within and outside of the context of GP training. The Listening Guide applied to the narrative interviews in this research offered a useful lens to multiple voices in the Figured World of my own professional context. This is an emerging analytic method and, to date, is not commonplace within medical education or GP training. However, studies in healthcare, social work education and disability have benefitted from the application of this approach (Taylor et al., 2013, Corby et al., 2018, Bright et al., 2018a). Increasing recognition of its ability to attend to the various dialogic voices within complex social interactions, such as those within medical education, is likely to prove fruitful.

Final Thoughts

This thesis contributes to the understanding of the professional identity development of GP trainees, and the contribution of supervision to this development, in a number of ways. It demonstrates that GP trainees are exposed to multiple (and potentially conflicting) structural messages regarding supervision and the 'good' GP trainee, and highlights areas of dissonance between these messages and the lived experience of the trainees with respect to being adult learners, reflective learners and legitimate participants. By considering the intersection of the Figured World of GP training alongside the responsibilities and socio-cultural worlds of the trainees outside of the training context, the multiple identities, perspectives and vantage points of the trainees are illuminated. Supervision, within this context, appears to undulate between an agent of structure and an environment where trainee agency can be facilitated and developed, through the affordances of access, and through brokering inclusion in the wider community of practice.

Currently, supervisory discussions within GP training are framed to explore the trainee's learning needs, reflect on their performance and develop action plans for development. However, probing beneath the surface to consider the factors and expectations that influence observed behaviours or values is not articulated within training guidance.

Frequently under-utilised within postgraduate GP research, this thesis displays the potential for stories to illuminate the multiple voices within the socio-cultural world, and highlights the benefits of mixed methods approaches to attend to the mutuality of the individual and their environment.

This study offers a model (**Figure 12**) to serve as a springboard for discussion for trainees and their supervisors. The goal is to establish a platform for greater clarity and negotiation of the inherent complexities within postgraduate GP training, and to assist in making explicit the tacit and taken-for-granted assumptions about training and supervision.

I am aware (as a GP myself) that a pragmatic message from research is particularly welcomed by GPs. This thesis offers some practical suggestions for GP trainees, supervisors and educators from within the wider profession, and my concluding remarks reflect this pragmatism. It is important that the profession is aware of the areas in postgraduate training where expectations of the 'good' GP trainee appear in contrast to the reality of the lived experience. Appreciation of these areas in particular, alongside an understanding of the threats to the intentions of the profession, helps to direct resources and efforts to improve postgraduate GP training and supervision. Within my research, particular areas of dissonance included the trainee as an 'adult learner', 'legitimate participant' and 'reflective learner'. I have therefore outlined a series of recommendations that relate to these areas:

- **The 'good' trainee is an adult learner**: However fixed impositions of work scheduling (by the supervisor or training practice) can threaten a personalised approach to learning. Furthermore, myths appear to exist amongst some training practices regarding the application of the European Working Time Directive (EWTD), leading to overly rigid approaches to work scheduling in fear of 'breaching' the EWTD.

- **The 'good' trainee is a legitimate participant (is 'engaged')**: However trainees differ in their perceptions of what 'participation' means. Some expect ongoing guidance from their supervisors up to the point of qualification, whilst others expect to use their supervisor less and less as their training progresses. A trainee and their supervisor may have very different views about what 'participation' should involve, and openness and clarity may be needed. Participation in the life of the practice (engagement) also involves an appreciation of 'how things are done around here'. Trainees who are not afforded meaningful access to their supervisor or the practice team may struggle to understand how they can participate legitimately, and this may be interpreted as disengagement.

- **The 'good' trainee is a reflective learner**: However, the E-portfolio (as a platform for reflective learning) is frequently used by trainees and supervisors for other purposes. Some

perceive it as having a defensive function, where claims can be made (to the profession) that they are a 'good' trainee, or a 'good' supervisor. This threatens the quality of written reflection contained within the portfolio.

The results also suggest some unintended messages from the profession, which appear to have emerged as universal 'truths' for the GP trainees:

- **The 'good' GP trainee collects evidence**: There is a sense that collation of *quantity* of evidence is valued more than the *quality* of the evidence. Local training documents that offer suggestions for the minimum number of log entries appear more prescriptive than the more general guidance from within national training documentation.

- **The 'good' GP trainee doesn't complain**: The complexity of the process to raise concerns, and the potential consequence of being labelled as a 'problem' trainee serve as a deterrent.

The supervisory relationship may offer a number of ways to mediate these irregularities. However, to do this effectively, the dialogues between trainees and their supervisors need to move beyond the current frameworks used for educational supervision meetings. This includes offering greater clarity on the goals, tasks and roles within supervision. Supervisors can facilitate engagement and participation by creating a safe environment, by recognising that the trainee (like their supervisor) has multiple roles and responsibilities outside of GP training, by inviting their opinion on matters of work scheduling, and by helping them feel included in the training practice. Assisting the trainee to master the surgery electronic timetable, and suggesting feasible ways to access assistance when required (rather than simply knocking on a closed door) are also important to facilitate the trainee's sense of inclusion and engagement.

The research journey

To assist readers of this thesis in following the main lines of reasoning and discovery, I presented the results from each stage of the research process in line with Rogoff's 3 planes of analysis (Rogoff, 1995). The thesis foregrounds trainee development within the 'community' plane in **Chapter 5**, the 'interpersonal' plane in **Chaper 6**, and the 'personal' plane in **Chapers 7-8**. However, the chronology of the project differed somewhat from the thesis structure. As discussed within **Chapter 4**, the design of this research project was emergent and iterative. New approaches to observation and approach were employed based on important discoveries made in the earlier stages of data analysis (Lincoln and Guba, 1985). Within this section, I will outline the research journey taken.

Refining the research focus

At the outset of this research, I was a GP trainee, having recently entered my final clinical placement within GP training. Aware of stories of peers and colleagues who had experienced failure in this high stakes examination, I was struck by the considerable personal and finanicial cost. The focus on supervision emerged early within the project planning, motivated by a desire to consider support for trainee development to 'meet the mark' of examination success before the 'cost' of failure was realised. The initial approach to the research began with a desire to explore supervisory support for success in summative examination.

I was particularly mindful of my limited insight into the supervisor's perspective, my relative inexperience in qualitiative research and the potential risk of bias. In an attempt to mediate these concerns, it became an early priority to explore the perspectives of GP supervisors. Feasibility, practicality and familiarity governed the approach to this stage, which enabled a timely thematic analysis of semi-structured interviews that would facilitate clarification of the research questions and set the scene for in-depth methodological considerations for later stages of the research.

Although presented as **Chapter 6** within the thesis, exploring the supervisor perspective in semi-structured interviews was undertaken as the first stage in the project. The results that emerged that informed the research design in some crucial and unanticipated ways:

1. Trainee 'problems' also related to issues of professionalism and personal difficulty, suggesting that a focus on 'examination failure' and summative assessment was too narrow. This turned the focus towards professional identiy development in GP trainees (RQ1)

2. Tensions within the supervisor role, and variable supervisor perspectives regarding the goals, tasks and locus of supervision, suggested significant complexity to the supervisory alliance, requiring further exploration (RQ2, and systematic review of the literature).

3. Reliance of the supervisors on the training practice team, and references to documentation and evidence suggested influence beyond the trainee-supervisor interaction (RQ3).

Chapter 5 (analysis of the training documentation) highlights the dynamic nature of supervision, with changing messages and emphases from the profession on various elements of supervision, and tensions regarding the roles of supervisor and trainee. I began to question how the expectations from the profession related to the lived experiences of trainees and their supervisors, particularly in light of these 'moving goalposts'. This stage of the research set the scene for an exploration of the lived experiences of trainees through narrative interviews, and a particular focus on the expectations and experiences of supervision (RQ4).

Originally, I had anticipated a fourth stage to the research, which would explore the discursive practices of supervisors through focus groups, using trainee case vignettes as springboards for discussion. However, as the latter stages of the research progressed, it became apparent that sufficient study at this stage would require resources and timescles outside the scope of this PhD project. As a result, it has been included as a plan for future research.

Original contributions made by this research

Reflecting on the journey taken within this thesis also requires a consideration of its contribution. Alongside the research outcomes (discussed earlier in this chapter), the research processes in this study have made original contributions to the medical education research community in the following areas:

Integration of Figured Worlds theory within a methodological approach aligned to Rogoff's 3 planes of development

Focusing only on the trainee's personal development, or on the interpersonal interaction between trainee and supervisor, risks an incomplete understanding of the socio-cultural context and its influence on supervision (Ajjawi and Bearman, 2012). The research design incorporated three distinct stages, foregrounding each of Rogoff's 3 planes, to enable a consideration of the mutuality of the individual (the trainee) and their environment (Rogoff, 1995). This mutuality was also addressed through the introduction of Figured Worlds theory, described in the literature as a contextual identity theory (Dornan et al., 2015). Figured Worlds theory offered a means to consider the individual trainee's identity development (personal plane), and also to attend to the influences of interpersonal and supervisory relationships (interpersonal plane) and the institutional messages of the wider profession (community plane) through a consideration of power, agency, artefacts and positioning. Rogoff's socio-cultural stance has been discussed within Lave and Wenger's work on situated learning and communities of practice, but its association with Figured Worlds theory is novel in the context of postgraduate medical education (Lave and Wenger, 1991).

Adapation of Brown and Gilligan's 'Listening Guide' to include positioning

Bamberg's conceptualisation of positioning (**Chapter 3**) offered a useful lens to consider position, access and vantage point within the Figured World of postgraduate GP supervision (Bamberg, 1997; Bamberg and Georgakopoulou, 2008). The levels of positioning (of characters within the narrative,

to the audience and to oneself) resonate with the levels of 'listening' described within Brown and

Gilligan's Listening Guide (1991). In light of this, I adapted the Listening Guide to include analysis

that attended to positioning within the trainee narratives. **Chapter 4** outlines the novel way in which

the guide has been adapted, and offers an avenue for researchers to consider position when

attending to the multiplicity of voices within this type of anaylsis.

Exploring professional identity development within postgraduate GP training

General Practice offers a rich environment to explore professional identity development, but

research in this area is limited (Johnston and Reid, 2019). This thesis provides a comprehensive

consideration of the trainee's professional identitiy development within supervision, and adds to the

literature in an under-researched area. Furthermore, it offers a series of approaches and methods

that could be incorporated or adapted by others with an interest in professional identity

development in GP trainees, which may have implications for recruitment, training and workforce.

Highlighting changing messages and emphases from within the profession

The documentary analysis stage of this research **(Chapter 5)** underlined several ways in which both

explicit and implicit messages from national bodies (such as the GMC and RCGP) can be explored and

considered. The 'mapping' stage of analysis **(Appendix 9)** enabled a visual representation of the

documents across time, political events, audience and origins.

Illuminating the trainee voice

A noteworthy finding from the systematic review (**Chapter 2**) was the relative absence of the trainee

voice within the published literature. Through the narratives of 13 GP trainees within the West

Midlands region, the trainee voice is illuminated. Their lived experiences are explored in light of the

messages from supervisors and the profession, and foregrounded within a key stage of the research

process. On my own journey as a researcher and clinician throughout the PhD, beginning as a trainee

and ending as a GP partner, I view this final contribution as my greatest.

Appendix 1: Medline Search

1. ("General practice" or "family practice" or "primary care" or "primary health care").mp. [mp=tx, bt, ti, ab, ct, sh, hw, tn, ot, dm, mf, dv, kw, nm, kf, px, rx, an, ui, id, cc, tc, tm, pt]

2. limit 1 to english language

3. limit 2 to human

4. limit 3 to yr="2011 -Current"

5. limit 4 to humans

6. limit 5 to english language

7. limit 6 to human

8. limit 7 to yr="2011 -Current"

9. limit 8 to humans

10. (Supervis* or train* or registrar or intern* or teach* or educat* or residen*).mp. [mp=tx, bt, ti, ab, ct, sh, hw, tn, ot, dm, mf, dv, kw, nm, kf, px, rx, an, ui, id, cc, tc, tm, pt]

11. limit 10 to english language

12. limit 11 to human

13. limit 12 to yr="2011 -Current"

14. limit 13 to humans

15. 9 and 14

16. (attribut* or characteristic* or qualit* or trait* or feature* or aspect*).mp. [mp=tx, bt, ti, ab, ct, sh, hw, tn, ot, dm, mf, dv, kw, nm, kf, px, rx, an, ui, id, cc, tc, tm, pt]

17. limit 16 to english language

18. limit 17 to human

19. limit 18 to yr="2011 -Current"

20. limit 19 to humans

21. 15 and 20

22. ("General practice" or "family practice" or "primary care" or "primary health care").m_titl.

23. limit 22 to english language

24. limit 23 to human

25. limit 24 to yr="2011 -Current"

26. limit 25 to humans

27. 21 and 26

28. limit 27 to (learning resource or practice example or practice guidance or research or "research review" or statistical publication or "systematic review")

29. limit 28 to (female or humans or male)

30. limit 29 to english language

31. limit 30 to (adult <18 to 64 years> or aged <65+ years>)

32. limit 31 to humans

33. limit 32 to (fringe to psychology: questionable or general public or psychology: professional & research)

34. limit 33 to health professions

35. limit 34 to English

36. limit 35 to (human or male or female)

37. limit 36 to yr="2011 -Current"

38. limit 37 to (education or evidence-based medicine or family medicine or health or medical education or medical research or "primary care/family medicine/general practice" or sociology)

39. limit 38 to humans

Appendix 2: Paper Quality Assessment

Research question:

What are the attributes of the supervisory relationship in General Practice?

Aims

1. To better understand the interaction between GP trainee and GP trainer within the GP postgraduate supervisory relationship
2. To describe the facilitators and barriers to the interaction of GP trainee and GP trainer within the GP postgraduate supervisory relationship
3. To develop a narrative account and model to explain key elements of the interaction in postgraduate GP supervision

1.Study Details

Study Details *(surname of first author and year first full report of study was published)*

Title of paper
Other papers relating to this study *(e.g. duplicate publications, follow-up studies)*
Remaining citation details *(Journal, volume, issue, pages)*

2. General Information

Date form completed *(dd/mm/yyyy)*	
Name/ID of person extracting data	
Country of origin *(specify)*	
Publication type *(e.g. full report, abstract, letter)*	
Study funding source *(including role of funders)*	

Possible conflicts of interest *(for study authors)*	

3.Eligibility

	Type of study	**Yes/ No / Unclear**	**Location in text** *(pg & ¶/fig/table)*
	Observation of supervision in action	**…**	
	Video-observation	**…**	
	Survey	**…**	
	Interviews	**…**	
	Focus groups	**…**	
	Mixed methods	**…**	
	Case reports	**…**	
	Personal opinion (IN THIS INSTANCE, PLEASE GO TO SECTION 8 FOR SUMAMRY OF PAPER)	**…**	
	Magazine articles, literature review, institutional guidance documents, newspaper articles *(exclusion criteria)*	**…**	
	Other design (specify):	**…**	
Participants		**…**	
Types of intervention *(if applicable)*		**…**	
Types of outcome measures (if intervention) *(if applicable)*		**…**	

4.Population and setting

	Description *Include comparative information for each group (i.e. intervention and controls) if available*	**Location in text** *(pg & ¶/fig/table)*
Population description *(from which study participants are drawn)*		
Setting *(including location and social context)*		
Inclusion criteria		
Exclusion criteria		
Method/s of recruitment of participants		
Sampling of participants		
Notes:		

5. Methods

	Descriptions as stated in report/paper	**Location in text***(pg & ¶/fig/table)*
Aim of study		
Design		
Start date		
End date		
Duration of participation *(recruitment to last follow-up)*		

6. Area(s) of supervision addressed

Domain	Yes/No/ Unclear	Support for judgement	Location in text *(pg & ¶/fig/table)*	What is the key domain of interest in this paper? (choose one)
Clinical supervision *(relating to patient safety/ gatekeeping)*	...			...
Educational supervision *(related to educational development of the trainee(s)*	...			...
Support in supervision *(personal /professional support)*	...			...
Assessment in supervision	...			...
Structural issues in supervision:local *(practice context)*	...			...
Structural issues in supervision:institutional *(wider structure, governing bodies)*	...			...
Doctors in difficulty (trainees)	...			...
International medical graduates (trainees)	...			...
Variable experience (novice – expert) (trainees)	...			...
Highly performing (trainees)	...			...
Remote supervisors	...			...
Variable experience (novice- expert) (supervisors)	...			...
Other (please specify)				
Notes:				

7.Participants

Provide overall data and, if available, comparative data for each intervention or comparison group.

	Description as stated in report/paper	Location in text (pg & ¶/fig/table)
Total no. participants *(if applicable, no. of people per group)*		
Baseline imbalances		
Withdrawals and exclusions		
Age		
Sex		
Race/Ethnicity		
Other relevant sociodemographics		
Subgroups measured		
Subgroups reported		
Notes:		

8. Results – summary of main findings.

PLEASE USE THIS SECTION FOR A SUMMARY OF NON-RESEARCH ARTICLES
Where qualitative work has resulted in themes or similar, please outline the main themes and findings:

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Findings relevant to this review (brief summary)		
Person measuring/ reporting		
If qualitative, method of qualitative analysis e.g. thematic, using software etc.		
Is outcome/tool validated? *(specify how)*	... *Yes/No/Unclear*		

References to other relevant studies	
Correspondence required for further study information *(what and from whom – if applicable)*	
Further study information requested *(from whom, what and when)*	
Correspondence received *(from whom, what and when)*	
Notes:	

IF THE PAPER IS NOT RESEARCH, PLEASE PROCEED TO SECTION 12: OVERALL CONFIDENCE IN THE STUDY FINDINGS

9.Quality assessment of quantitative/survey research (if applicable)

	Response to question:	Rationale for response given where "no" or "unclear"
Did the study address a clearly focused question / issue?	... *Yes/No/Unclear*	
Is the research method (study design) appropriate for *answering the research question?*	... *Yes/No/Unclear*	
Is the method of selection of the subjects (employees, teams, *divisions, organizations) clearly described?*	... *Yes/No/Unclear*	
Could the way the sample was obtained introduce *(selection)bias?*	... *Yes/No/Unclear*	
Was the sample of subjects representative with regard to the *population to which the findings will be referred?*	... *Yes/No/Unclear*	
Was the sample size based on pre-study considerations of *statistical power?*	... *Yes/No/Unclear*	
Was a satisfactory response rate achieved?	... *Yes/No/Unclear*	
Are the measurements (questionnaires) likely to be valid and *reliable?*	... *Yes/No/Unclear*	
Was the statistical significance assessed?	... *Yes/No/Unclear*	
Are confidence intervals given for the main results?	... *Yes/No/Unclear*	
Could there be confounding factors that haven't been *accounted for?*	... *Yes/No/Unclear*	
Was the survey tool validated? *If so, how?*	... *Yes/No/Unclear*	
Did they account for missing data?	... *Yes/No/Unclear*	
Notes:		

10.Quality assessment of qualitative research (if applicable)

	Yes/No/Unclear	If "no", "unclear", please specify
Was there a clear statement of the aims of the research? *HINT: Consider* *▢ What was the goal of the research?* *▢ Why it was thought important?* *▢ Its relevance*	... *Yes/No/Unclear*	
Is a qualitative methodology appropriate? *HINT: Consider* *▢ If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* *▢ Is qualitative research the right methodology for addressing the research goal?*	... *Yes/No/Unclear*	
Was the recruitment strategy appropriate to the aims of the research? *HINT:Consider* *▢ If the researcher has explained how the participants were selected* *▢ If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* *▢ If there are any discussions around recruitment (e.g. why some people chose not to take part)*	... *Yes/No/Unclear*	
Was the research design appropriate to address the aims of the research? *HINT: Consider* *▢ If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?*	... *Yes/No/Unclear*	
Was the data collected in a way that addressed the research issue? *HINT: Consider* *▢ If the setting for data collection was justified* *▢ If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* *▢ If the researcher has justified the methods chosen* *▢ If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?* *▢ If methods were modified during the study. If so, has the researcher explained how and why?* *▢ If the form of data is clear (e.g. tape recordings, video material, notes etc)* *▢ If the researcher has discussed saturation of data*	... *Yes/No/Unclear*	

Has the relationship between researcher and participants been adequately considered? *HINT: Consider* *⬜ If the researcher critically examined their own role, potential bias and influence during* *(a) Formulation of the research questions* *(b) Data collection, including sample recruitment and choice of location* *⬜ How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	... *Yes/No/Unclear*	
Have ethical issues been taken into consideration? *HINT: Consider* *⬜ If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* *⬜ If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* *⬜ If approval has been sought from the ethics committee*	... *Yes/No/Unclear*	
Was the data analysis sufficiently rigorous? *HINT: Consider* *⬜ If there is an in-depth description of the analysis process* *⬜ If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?* *⬜ Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* *⬜ If sufficient data are presented to support the findings* *⬜ To what extent contradictory data are taken into account* *⬜ Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation* *⬜ To what extent others are involved in the analysis*	... *Yes/No/Unclear*	
Is there a clear statement of findings? *HINT: Consider* *⬜ If the findings are explicit* *⬜ If there is adequate discussion of the evidence both for and against the researchers arguments* *⬜ If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* *⬜ If the findings are discussed in relation to the original research question*	... *Yes/No/Unclear*	

Notes:		

11.Applicability

Have important populations been excluded from the study? *(consider disadvantaged populations, and possible differences in the intervention effect)*	... *Yes/No/Unclear*	
Is the intervention likely to be aimed at disadvantaged groups? *(e.g. lower socioeconomic groups)*	... *Yes/No/Unclear*	
Does the study directly address the review question? *(any issues of partial or indirect applicability)*	... *Yes/No/Unclear*	
Is the research valuable? *HINT: Consider* *☐ If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g.* *do they consider the findings in relation to current practice or policy?, or relevant research-based literature?* *☐ If they identify new areas where research is necessary* *☐ If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	... *Yes/No/Unclear*	WHY: (please explain rationale for yes, no and unclear responses)
Notes:		

12. Overall confidence in study's findings

	Please select one	Please expand on why this choice has been made
Empirical research 1 *Research article, confident appraisal of trustworthiness*	... *Yes*	
Empirical research 2 *Research article. Some elements found to be lacking in terms of design, description or relevance; but an overall suggestion of trustworthiness*	... *Yes*	
Empirical research 3 *Research article. Elements of study found to be lacking, which cause significant doubt about the trustworthiness*	... *Yes*	
Opinion piece 1 *Confident appraisal of trustworthiness: informed through a breadth and depth of their observed or personal experiences, and clarity in relation to our research aim*	... *Yes*	
Opinion piece 2 *Elements of the opinion presented cause significant doubt about the trustworthiness: lacking breadth, depth or clarity regarding source material/relevance to our research aim*	... *Yes*	
Notes:		

1. Effective Practice and Organisation of Care (EPOC). (2013) Data collection form. EPOC Resources for review authors. Oslo: Norwegian Knowledge Centre for the Health Services. Retrieved (3rd April, 2017) from: http://epoc.cochrane.org/epoc-specific-resources-review-authors
2. Center for Evidence Based Management (July, 2014), Critical Appraisal Checklist for Cross-Sectional Study. Retrieved (30th March, 2017) from https://www.cebma.org
3. Critical Appraisal Skills Programme (CASP) (May, 2013), Qualitative Research Checklist. Retrieved (1st September, 2016) http://www.casp-uk.net/checklists

Appendix 3: Summary of E1, E2 and O1 papers

KEY:

Code	Participant	Code	Country of Origin
AD	*Area Director*	AU	*Australia*
GPR	*GP registrars/trainees*	CA	*Canada*
GPS	*GP supervisors*	NL	*The Netherlands*
IMG	*International Medical Graduate*	CH	*Switzerland*
TPD	*Training Programme Director*	UK	*United Kingdom*
Y1, Y2	*Year 1, Year 2*	US	*United States*

E1

PAPER	GEOGRAPHICAL LOCATION, SETTING	AREA(S) OF SUPERVISION	PARTICIPANTS	STUDY DESIGN	THEORETICAL PROPOSITONS
E1 Papers providing evidence/observation of supervision					
Clement et al. (2016)	AU, 1 practice	clinical, educational supervsion and assessment	5 training pairs (GPS and GPR), focuses on a single training pair	secondary analysis (analytic expansion) of audio-recorded ad hoc encounters, reflections, interviews	Applying Wenger's social theory of learning to a supervisory interaction
Junod Perron et al. (2013)	CH. 1 hospital, 2 settings (inpatient medicine, outpatient primary care)	educational supervision	GPSs, hospital Ss (n=51) (intervention group n=28, control group n=20)	intervention (6m training programme on feedback) and control. Outcome measures: survey and objective assessment of feedback	Learner-centred design
Morgan, Wearne, Tapley et al. (2015)	AU, 4 training regions	educational supervision, clinical supervision	GPRs (n=645): 84723 consultations, 131583 problems.	Caseload, trainee diaries (cross sectional and simple/multiple regression analysis of data)	
Pelgrim et al. (2014)	NL, 3 training institutes	support in supervision	GPS/GPR training pairs (n=62)	survey (bivariate and multiple regression analysis)	
Sagasser et al. (2017)	NL, 7 general practices	educational supervision	GPS/GPR training pairs (n=7)	Observation, interviews (phenomenological analytic method)	Situated learning, legitimate participation, self-regulated learning

PAPER	GEOGRAPHICAL LOCATION, SETTING	AREA(S) OF SUPERVISION	PARTICIPANTS	STUDY DESIGN	THEORETICAL PROPOSITONS
E2 Papers providing evidence/observation of supervision					
Ahern et al. (2013)	AU, 1 region	vertical learning	GPSs, GPRs, med students, practice managers (n=33), across 9 practices	interviews (thematic analysis)	
Allan et al. (2012)	CA, 1 training programme, 5 teaching centres	educational supervision	Y1 and Y2 trainees (n=38) Addressing 25 questions over 114 clinical half-day session (420 patient contacts)	observer observation of questions. Descriptive analysis, unpaired t tests between groups	
Ferguson et al. (2014)	Scotland, UK	structural issues in supervision:institutional	ADs (n=6), TPDs (n=19), GPSs (n=93), across 11 focus groups	interviews, focus groups (thematic anaylsis)	
Foulkes et al. (2013)	UK, 1 training region	assessment in supervision, workload of supervision	GPSs (n=212) (70% response rate)	survey (descriptive analysis)	
Garth et al. (2016)	AU, 3 Regions (urban,remote)	educational supervision	GPRs n=35, GPSs (n=16), med educators (n=17), NQGP's (n=12).	interviews, focus groups, review of trainee learning plans (template analysis)	Situated learning, Socio-material approach
Giroldi et al. (2017)	NL, 1 training institute	educational supervision	GPSs (n=25, n=11), GPRs (n=11, n=5)	interviews, focus groups, observtion of training sessions (thematic analysis)	
Ingham et al. (2014)	AU, 1 training region (urban,remote)	educational supervision	GPSs (n=84) (90% response rate)	survey (descriptive and Chi-square analysis)	
Ingham, Fry, O'Meara et al. (2015)	AU, 1 training region, (remote)	remote supervision, educational supervision	GPSs, rural (n=20)	interviews (framework analysis)	Adult learning theory, situated learning
Ingham, Morgan, Kinsman et al. (2015)	AU, 1 training region (urban,remote)	clinical supervision	GPSs (n=91) (91 - 97.8% response rate)	survey (Pearson correlation, ANOVA, t-test)	
Jochemsen-van der Leeuw et al. (2014)	NL, 4 training institutes	clinical trainer as a role model	Y1 and Y3 GPRs (n=279)	survey (descriptive analysis, principal component analysis)	
Longman and Temple-Smith (2013)	AU, 1 training region	educational supervision	GPRs (n=8) and GPSs(n=8)	interviews (thematic analysis)	adult learning theory (and challenges of implementation)
McLaren et al. (2013)	UK, 1 training region	doctors in difficulty (emphasis on trainers)	GPSs (n=11)	interviews (thematic analysis)	
Meijer et al. (2016)	NL, 1 training region	educational supervision (role models)	GPRs (n=6), STs (n=6)	interviews (thematic analysis)	
Morgan, Ingham, Kinsman et al. (2015)	AU, 1 training region	clinical supervision,educational supervision	GPSs (n=66)	evaluation (pre- and post workshop survey) (descriptive statistics, one sample t-test)	
Morgan et al. (2016)	AU, 1 training region	clinical supervision	GPSs (n=54)	evaluation (pre- and post workshop survey) (descriptive statistics)	
Oerlemans et al. (2017)	NL, 1 training programme	educational supervision	GPSs (n=18)	interviews (Constant Comparative Method)	
Patterson et al. (2013)	UK, 1 training region	educational supervision	GPSs (n=12), training support staff (n=8). GPRs (n=32)	interviews and focus groups (content analysis)	
Sagasser et al. (2012)	NL, 2 training institutes	educational supervision	GPRs (n=21)	interviews (phenomenological analytic method)	Self-regulated learning
Sagasser et al. (2015)	NL, 2 training institutes	educational supervision	GPSs (n=20)	interviews (phenomenological analytic method)	Self-regulated learning, sociocognitive perspective, situated learning
Saucier et al. (2012)	CA, 1 training institution, French-speaking	educational supervision	GPSs (n=11), GPRs (n=6)	Observation, survey, focus groups (thematic analysis)	Cognitive apprenticeship
Stolper et al (2015)	NL, all 8 training institutes	clinical supervision	GPS/GPR training pairs (n=16), tutorial dialogues (n=17)	video-observation (content and coding analysis)	
Triscott et al. (2016)	CA, 2 training institutes	IMG's	GPs (n=10), 'home' GPRs (n=2), IMGs (n=2), AHPs (n=13)	interviews, focus groups (thematic anaylsis)	
Walters et al. (2015)	Au, 1 rural training pathway, 3 training regions	support in supervision	GPRs (n=18)	interviews (thematic analysis)	
Warwick (2014)	UK, 1 training region	IMG's	IMGs (n=12)	Focus groups (framework analysis)	Legitimate peripheral participation
Wearne et al. (2015)	AU, multiple training regions. CA, 1 rural training program	remote supervision	GPSs, remote (n=16)	interviews (template analysis, constant comparative method)	
Wiener-Ogilvie et al. (2014)	Scotland, UK	educational supervision	NQGP's (n=15) GPRs (n=12)	interviews (Constant Comparative Method)	Situated learning
Zwart et al. (2011)	NL, 1 training institute	clinical supervision	Y1 and Y3 GPRs (n=79)	mixed methods- interviews, doc analysis (root cause analysis)	

O1

PAPER	GEOGRAPHICAL LOCATION, SETTING	AREA(S) OF SUPERVISION	PARTICIPANTS	STUDY DESIGN	THEORETICAL PROPOSITONS
O1 Papers providing opinion/commentary on supervision					
Bowen et al. (2015)	US, multiple regions. 7 authors	educational supervision		opinion	
Ingham (2012)	AU, 1 author	clinical supervision		opinion	
Morgan, Ingham, Wearne et al. (2015)	AU, 6 authors across 4 training areas	training of trainers		opinion	Educational alliance
Wearne and Brown (2014)	AU, 2 authors	assessment in supervision		opinion	

Appendix 4: Application for ethical review, and request for

amendments

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UNIVERSITY OF BIRMINGHAM
APPLICATION FOR ETHICAL REVIEW –
REQUEST FOR AMENDMENTS

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Who should use this form:

➢ This form is to be completed by PIs or supervisors (for PGR student research) who are requesting ethical approval for amendments to research projects that have previously received ethical approval from the University of Birmingham.

Please be aware that all new research projects undertaken by postgraduate research (PGR) students <u>first registered as from 1st September 2008</u> will be subject to the University's Ethical Review Process. PGR students first registered before 1st September 2008 should refer to their Department/School/College for further advice.

➢ What constitutes an amendment?

Amendments requiring approval may include, but are not limited to, additions to the research protocol, study population, recruitment of participants, access to personal records, research instruments, or participant information and consent documentation. Amendments must be approved before they are implemented.

NOTES:

➢ Answers to questions must be entered in the space provided
➢ An electronic version of the completed form should be submitted to the Research Ethics Officer, at the following email address: aer-ethics@contacts.bham.ac.uk. Please **do not** submit paper copies.
➢ If, in any section, you find that you have insufficient space, or you wish to supply additional material not specifically requested by the form, please submit it in a separate file, clearly marked and attached to the submission email.
➢ If you have any queries about the form, please address them to the Research Ethics Team.

UNIVERSITY OF BIRMINGHAM APPLICATION FOR ETHICAL REVIEW - REQUEST FOR AMENDMENTS	*OFFICE USE ONLY:* Application No: Date Received:

1. **TITLE OF PROJECT**

> New title (as per amendment on this form) : What's Happening in the GP trainee-trainer supervisory relationship?
> Previous title: How can we meet the training needs of the GP trainee within the GP trainee-trainer relationship, before it's "too late"?

2. **APPROVAL DETAILS**
   What is the Ethical Review Number (ERN) for the project?

> ERN_14-0957

3. **THIS PROJECT IS:**
   University of Birmingham Staff Research project ☐
   University of Birmingham Postgraduate Research (PGR) student project **YES**
   Other ☐ (Please specify):

4. **INVESTIGATORS**

   a) **PLEASE GIVE DETAILS OF THE PRINCIPAL INVESTIGATORS OR SUPERVISORS (FOR PGR STUDENT PROJECTS)**

Name: Title / first name / family	Dr Ian Davison
Highest qualification & position	PhD Lecturer
School/Department	School of Education, Centre of Medical and Dental Education
Telephone:	0121 414 4808
Email address:	i.w.davison@bham.ac.uk

Name: Title / first name / family name	Dr Josephine Brady
Highest qualification & position held:	Lecturer
School/Department	School of Education
Telephone:	0121 415 8226
Email address:	j.a.brady@bham.ac.uk

   b) **PLEASE GIVE DETAILS OF ANY CO-INVESTIGATORS OR CO-SUPERVISORS (FOR PGR STUDENT PROJECTS)**

Name: Title / first name / family name	
Highest qualification & position held:	
School/Department	
Telephone:	
Email address:	

c) **In the case of PGR student projects, please give details of the student**

Name of student:	Dr Dawn Jackson	Student No:	1016482
Course of study:	PhD		
Principal supervisor:	Dr Ian Davison		

5. **ESTIMATED START OF PROJECT**   Date: 1/8/16

   ESTIMATED END OF PROJECT   Date: 1/11/2020

ORIGINAL APPLICATION FOR ETHICAL REVIEW AND ANY SUBSEQUENT APPROVED AMENDMENTS:

Please complete the section below for the original application and any subsequent amendments submitted:

Title and reference number of application or amendment

Original application (ERN_14-0957)

How can we meet the training needs of the GP trainee within the GP trainee-trainer relationship, before it's "too late"?

Key points of application and/or changes made by amendment (include: aims of study, participant details, how participants were recruited and methodology)

Originally submitted for the first stage of the PhD project. Aim was to explore the views of key educators in General Practice regarding the General Practice training relationship (between a GP trainee and their trainer).

Participants were 4 experienced GP educators within the West Midlands, who were purposively sampled for their educator role, gender and geographical region.

Semi-structured interviews were conducted by the researcher, recorded by Dictaphone and transcribed verbatim.

Ethical considerations arising from these key points (e.g. gaining consent, risks to participants and/or researcher, points raised by Ethical Review Committee during review)

Participants were introduced to the researcher and area of study at a training day for experienced educators. The e-mails of potential participants were obtained by the researcher as part of this training day (this was addressed in response to a point raised by the Ethics Committee).

The sample of potential participants was then invited for interview by e-mail invite, with an attached participant information sheet (which was corrected for typographical errors, as per Ethics committee advice, and also indicated that the study was part of a PhD thesis).

How were the ethical considerations addressed? (e.g. consent form, participant information, adhering to relevant procedures/clearance required)

Consent form, participant information sheet, "text" used for the e-mail invite and interview schedule was all submitted for ethical review, and adhered to during the execution of this stage of research.

7 potential participants were invited to participate. 5 out of 7 invitees responded to the first e-mail invite. 2 invitees did not respond to a first or second e-mail invite. One did respond with a positive interest in the study after the first invite, but did not respond to a follow-up e-mail suggesting potential times and venues to conduct the interview. As a result, they were not contacted further. 4 participants were therefore interviewed.

It was anticipated that interviews would last around 30 minutes. The interviews lasted between 35 and 41 minutes when undertaken.

No respondents chose to withdraw from the study at any stage (however, they were offered an opportunity to do this at any point up to 2 weeks after participation, as per ethical review).

There was a potential risk as the participants may have had to recount difficult experiences, which may have caused distress. In addition, there was a risk to anonymity of the trainee. This was minimised by the semi-structured interview schedule, which gave the participant a degree of choice over the experiences disclosed. Participants were advised as the voluntary nature of the study and their right to withdraw.

Participants were also asked to ensure that details which may identify a trainee were not disclosed, and all participants adhered to this. During the writing of the thesis, care has been taken to ensure this anonymity is preserved when using quotes verbatim and , when appropriate, the gender of the particular trainee has been change to "gender neutral" to further ensure anonymity.

The data from the project continues to be stored on a password-protected laptop, and will be stored for 10 years duration from the time of collection (as per ethical review). The transcribed data files are password-protected.

DETAILS OF PROPOSED <u>NEW AMENDMENT</u>

Provide details of the proposed new amendment, and clearly and explicitly state how the proposed new

amendment will differ from the details of the study as already approved (see Q6 above).

The subsequent PhD study has been informed by the results from the first stage of the study (as per

Ethical Review ERN_14-0957).

NEW TITLE:

WHAT'S HAPPENING IN THE GP TRAINEE-TRAINER SUPERVISORY RELATIONSHIP?

The key results of the first stage research (as above):

The results indicated that difficulties in training relationships appeared to be associated with a lack

of agreement (or correspondence) between trainee and trainer. Trainees in these instances were

felt to demonstrate a "lack of engagement" with the educators' expectations of trainee behaviour

and attitude. These findings relate somewhat to Bordin's (1983) model of the supervisory working

alliance, whereby a lack of "agreement" in the tasks and goals of supervision can adversely affect

the working alliance. The educators themselves appeared to differ in some cases as to their

expectation of trainee attitude and behaviour. "Role theories", particularly "anticipatory role

theory" (Biddle, 1986) may go some way to explaining this finding, where participants in the

supervisory relationship may hold differing understandings or expectations of their "role" in the

relationship, and that of the other party. Some educators demonstrated elements of the supervisor

as the "guide", by setting an environment and conditions for learning that were tailored to the

trainee. Others demonstrated the opinion that the trainee should drive the process of supervision,

and suggested a series of prescribed behaviours that should be expected for all trainees. Rotter's

(1954) social learning theory, and the "locus" of control in the supervisory relationship has been

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considered, as the responses suggested that the educators occupied varying positions on the spectrum of "locus of control".

If there is variability in the views of experienced educators with regards to "roles", "expectations" and "locus" in the supervisory relationship, it follows that this variability could also exist within GP trainers and GP trainees. The scene could be set for a mismatch in expectations from trainee and trainer in the supervisory alliance, which could have bearing on "agreement" and ultimately "alliance".

This PhD study ultimately wants to examine these concepts in the context of the GP supervisory relationship, to consider their importance and impact, and to determine if steps to address mismatch of "roles" and "expecations" would be of value.

These results provide additional questions for further study:

AIM: To understand what is happening in the GP trainee-trainer relationship.

1. How are the respective "roles" performed in the GP supervisory relationship?

2. What are the expectations about "roles" within the supervisory relationship?

3. What influences are considered to shape the expectations of "roles" within the supervisory relationship?

4. Is there consensus of "role" beliefs and expectations between GP trainers and GP trainees?

5. Is there is sense that consensus of "role expectations" relates to working alliance?

6. Is there is sense that consensus of "role expectations" relates to performance at examination?

Proposed methodology

An evaluation approach is suggested to best address these research questions, comprising of a 3

or 4 stage approach. It is intended that the results from each stage will inform the ongoing design

for the subsequent stage.

Stage 2 ("Stage 1" is the project already completed as per ERN_14-0957 - scoping interviews with

4 experienced educators).

Documentation review: review of relevant Royal College of General Practitioner (RCGP) and West

Midlands Deanery (also termed Health Education England, West Midlands) statutes and

documentation. Access to these statutes will be obtained via online searching (for public

documents), and also by written request to Health Education England (West Midlands) GP

education staff. The researcher (Dr Dawn Jackson) is presently a GP trainee, and has access to

general practice trainee documentation through access to her own training E-portfolio. This will

also be reviewed.

It is anticipated that a review of such documentation would give a contextual picture of General

Practice training. The documentation would relate to training and statutes, and therefore would

not relate to personal or sensitive information.

Stage 3

Interviews with GP trainees.

It is intended that 6-8 GP trainees would be interviewed over the course of their third and final

year of training. It is anticipated that 2-3 interviews with each trainee would be undertaken. The

first in the first 3 months of the third (and final) year of training, the second in the last 3-4 months

of training, and a third follow-up interview (if required for clarification or expansion of relevant data). The interviews should last between 45-60 minutes.

The initial recruitment of participants was planned for August 2016. This is when the population of interest (ST3 GP trainees) would begin their third and final year of training. However, it is likely that ethics application and HRA approval will be incompatible with this schedule. Therefore, a pilot phase of interviews with ST3 trainees as they come to the end of their training is planned for May 2017. Recruitment of GP trainees after this pilot would then take place in August 2017.

Pilot phase:

This will consist of a single interview with 4 GP trainees in the final 4-month period of their training in General Practice. This is anticipated to be in May-August 2017, and will involve recruitment of ST3 trainees.

Trainees would be recruited through verbal invite (by the PhD student), and this invitation would take place at one of their weekly training sessions. Interested students would be offered the opportunity to submit their e-mail address to the researcher, and would be contacted with a participant information sheet. Those who are interested in taking part can then contact the researcher directly via e-mail.

It is anticipated that the researcher will attend weekly teaching at 2 different locations within the West Midlands Deanery, to recruit potential pilot participants from 2 different vocational training schemes (VTS). They will not recruit from VTS training at South Birmingham VTS, as this is where the researcher is a current trainee (until October 2016).

It is anticipated that the interviews would take a narrative approach, with participants encouraged to reflect upon their experiences of supervision within General Practice training. The interviews should last between 45-60 minutes. For the purposes of the pilot, enquiry about the trainee's

outcome at ARCP will not be undertaken. The nature of the interviews (narrative approach) may

lead to circumstances in which this becomes known. However, this would be at the discretion of

the participant, and if they choose to share this information as part of their story of supervision.

The aim of the pilot is to gain an appreciation of recruitment of potential participants, and for the

PhD student to gain experience of narrative interviewing within this population of interest. The

data from the pilot will form part of the PhD thesis. The results from the pilot stage will not be

used in the construction of "case vignettes" (this is discussed in further detail in the next section).

A participant information sheet and interview schedule for the pilot phase is attached. The same

consent form will be used for all GP trainees (both those taking part in the series of interviews, and

those in the pilot).

Moving beyond the pilot stage:

August 2017 – August 2018: Series of interviews with ST3 GP trainees

It is anticipated that the interviews would take a narrative approach, with participants encouraged

to share their stories of professional training and GP supervision. This has been chosen as a

means to capture data which is deemed "significant" to the participant. It has been proposed that

a focus on story-telling within an interview can allow a more natural and "everyday" form of

discourse (Coffey and Atkinson, 1996, p. 56). Furthermore, the authors state that this form of

interviewing has the ability to capture information relating to culture, significant events (which

may relate to tales of success or challenge), and has been well-documented in medical literature

(Coffey and Atkinson, 1996). An interview schedule has been designed (see attached), with the

view that this should serve as a guide for discussion, whilst ensuring that the participant has a

significant degree of choice, flexibility and openness as to the experiences and stories recounted.

Interview 1 (August 2017 – October 2017) will focus on the trainee's experiences of professional training (throughout their career).

Interview 2 (April 2018-May 2018) will focus on the trainee's reflections of their GP training in their third and final year.

Potentially, a third interview may be required for clarification or expansion of points raised in the 2 previous interviews (June 2018- August 2018).

Interviews will be undertaken by the PhD researcher (Dr Dawn Jackson), recorded by Dictaphone and transcribed verbatim.

It is anticipated that narrative analysis will be undertaken. It is difficult at this stage to outline the exact means by which this will take place. Reissman, (1993) outlines the fact that there are a variety of narrative styles (generating various forms of narrative) and a variety of analytical methods, which often relate to the story that has been told.

However, the researcher has considered a number of analytical methods which may be appropriate. For example Labov, (1972, 1982) has suggested that narratives have "formal, structural properties" (Coffey and Atkinson, 1996 p.57), and suggests that a participant's story can be analysed by identifying elementary units within the tale (such as an 'abstract' which relates to the main point of the story, 'orientation' which relates to contextual information and 'evaluation' which relates to the participants meaning of the importance of the story).

However, other authors within this field have considered narratives based on their 'function', and the social actions which are implied in the text (which may be 'intended or unintended', 'explicit or implicit') (Coffey and Atkinson, 1996 p. 62). Stories which relate to success or those which are moralistic (and relate to 'what not to do'), may benefit from this type of analysis. Information

constructed in this way may relate to important information about the participant, and also to the way in which they have chosen to develop and construct their particular story (Coffey and Atkinson, 1996). The authors have actually given excerpts from participant's stories of PhD supervision to illustrate how functional analysis may apply, and this suggests that this type of analysis could relate to a study of GP supervision.

A third consideration is that of narratives as a 'chronicle'. Certainly narratives which discuss career, and reflect retrospectively on career development, have been analysed in this way (Coffey and Atkinson, 1996). It has been argued that the sequencing of events is important within the story, and gives an insight into contextual and central experiences of the participant (for example, the people they chose to discuss, and the events of importance). Furthermore, this method may give additional insights about individual perspectives, and the wider cultural and social setting (Coffey and Atkinson, 1996) These are of particular interest in this study of GP trainees.

The choice of analytic method will depend on the interview data which is collected, and the analytic method to which it best relates. The issue of participant anonymity will also be considered when choosing a method of analysis, to ensure that participant anonymity is preserved.

In addition, analysis of the interview accounts will be used to generate short, structured vignettes. It is intended that each vignette will represent a particular trainee experience or perspective relating to the 'roles' within GP supervision. These vignettes will be used to summarize trainee experiences of supervision, which will subsequently be presented to GP trainers for discussion. Data from the pilot stage of interviews with GP trainees will not be used in the construction of the case vignettes. The vignettes will be discussed in greater detail in the next section.

The interview methods (as outlined above) relate somewhat to the original ethics application (ERN_14-0957). However, the schedule will differ somewhat in its attempt to draw out stories of professional training. The analysis will also differ from previous content and coding methods, to use a narrative approach instead. Most noteworthy is the use of GP trainees as research participants (in contrast to the experienced educator participants in the original application). The participants will be discussed in the next section.

Stage 4

Focus groups with GP trainers

It is anticipated that a series of focus groups will be undertaken with GP trainers. 10 focus groups are anticipated, with 8-12 trainers in each. Each focus group should last between 45 minutes to one hour (with the entire education session lasting 90 minutes).

Vignettes which relate to the results of Stage 3 of this research (trainee interviews) will be presented to the focus groups.

Construction of vignettes:

The vignettes will be based upon data collected in Stage 3 of the research. Anonymity of trainee responses will be preserved by ensuring that personal-identifying information (such as training practice, geographical location or names) is removed. It may be the case that some of the vignettes are constructed to represent a number of experiences (i.e. an amalgamation of accounts) for research purposes, or to better preserve the anonymity of the trainees.

The vignettes will be chosen and designed to represent a breadth of trainee perspective. They may therefore relate to both frequently and infrequently occurring themes. They may therefore also consist of contrasting statements, noteworthy or thought-provoking information.GP Trainer

participants will be encouraged to discuss their reactions to each vignette, and "problem-solving" solutions where appropriate.

Focus groups will be facilitated by the researcher, and recorded by Dictaphone and boundary microphone. They will be transcribed by the researcher verbatim.

Thematic analysis will be undertaken using content and coding methods.

Each group will be invited to report their collective view as part of a plenary at the end of the session. Feedback relating to the session will also be invited as part of this group discussion for 5 minutes at the end of the session.

A focus group method has been chosen to capture the collective view of the GP trainers in each group, and the interaction of the participants with one another. The researcher is a GP trainee. This method has been chosen as it was thought that the interaction of GP trainers with their peers (rather than with a GP trainee as an "interviewer") may result in a more informal and natural discussion. This method also has the ability to gather data on attitudes, values and opinions (Cohen et al, 2007), and can do this from various subgroups of a particular population. It therefore offers the opportunity to yield insights from subgroups such as 'experienced' and 'inexperienced' trainers, various training regions and genders.

The triangulation of participants (GP trainees and GP trainers) has been proposed to provide data which relates to both parties in the training relationship, in an attempt to better understand the interaction from various viewpoints.

Possible: Stage 5

It is anticipated that surveys to trainees and trainers may be undertaken to provide a means to generalize responses from Stages 3 and 4 of this research.

It is anticipated that a further amendment to this ethics application would be submitted should surveys constitute a part of this research design. It therefore has not been explored in greater detail here, as it may ultimately not be included.

Participants

GP trainees (for interviews, Stage 3)

Participants will be sampled from all ST3 (final year) GP trainees who are training within the West Midlands General Practice Vocational Training Programme.

Potential participants will be purposively sampled to ensure a breadth of gender and geographical training region. There are 5 training regions in the West Midlands:

1. Birmingham and Solihull

2. Coventry and Warwickshire

3. Black Country

4. Stafford and Shropshire

5. Hereford and Worcester

It is intended that trainees will also be sampled to ensure a breadth of trainee performance at Annual Preview of Competency Progression (ARCP).

GP trainees are assessed annually at an Annual Review of Competence Progression (ARCP). In this review, trainee performance in workplace-based assessment, summative assessment and written reflection is assessed by a panel of GP educators, and the trainee is allocated an 'outcome' denoted by a number. Potential outcomes are shown below:

Outcome 1: Satisfactory Progress

Outcome 2: Unsatisfactory progress - additional training time not required.

Outcome 3: Unsatisfactory Progress - additional training required.

Outcome 4: Released from the scheme

Outcome 5: Insufficient evidence presented.

Outcome 6: Gained all competencies required

Outcome 7: Fixed Term Speciality Trainee

Outcome 8: Out of programme for research approved clinical training or Career Break

It is intended that GP trainees will be sampled to include those trainees who have attained an 'Outcome 1' at both their first and second year of training in General Practice, and those who have been deemed as Outcome 2 or 3 in either (or both) their first or second year of General Practice training(ST1 or ST2). This would ensure that the interview sample includes those trainees who have been successful at all ARCPs (outcome 1 in both ST1 and ST2), and those who have had adverse outcomes at ARCP (outcomes 2 or 3).

Inclusion criteria

• ST3 GP trainee

• Full time or less than full time trainee

• ARCP outcome 1,2 or 3 at any point during their ST1 and ST2 years of training

Exclusion criteria

- ST1 or ST2 GP trainee

- ARCP outcome 4,6,7 at any point in GP training

- ARCP outcome 8 at their most recent ARCP (suggesting that they are currently 'out of programme', and not currently training e.g. due to maternity leave).

Participants- trainers (for focus groups, stage 4)

Participants will be GP trainers in the West Midlands GP Vocational Training Programme.

Participants will be sampled from those in attendance at regional GP trainer's workshops.

Trainers' workshops are regular training events held within training regions in the West Midlands, and it is advised that all GP trainers should attend (though attendance is not mandatory).

It is intended that focus groups will be run at trainers' workshops across 3 to 4 training regions.

There are 5 training regions in the West Midlands:

1. Birmingham and Solihull

2. Coventry and Warwickshire

3. Black Country

4. Stafford and Shropshire

5. Hereford and Worcester

GP trainer participants exclusion criteria:

Those trainers who are not in attendance at the regional Trainers' workshop where the focus group is taking place.

All GP trainers at the workshop will participate in the vignette and problem-solving activity. Those who consent to taking part in the study will be asked to sit in groups of 8-12, at a table with a

Dictaphone recording device and boundary microphone. Those who do not wish to take part will

be seated in a group with the same discussion activity, but which is not recorded.

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Recruitment

Stage 3 (interviews with trainees)

The researcher (Dr Dawn Jackson) is also a GP trainee at the time of this ethics application. (The

researcher is anticipated to qualify as a GP on 4th October 2016, but this is subject to success at

her own ARCP). She will therefore receive administrative help from Health Education England,

West Midlands with the sampling process, in order to ensure that sensitive trainee information is

not disclosed to the researcher without prior consent from the potential participant.

An administrator already responsible for processing and notifying ARCP outcomes will send out an

e-mail invite to all West Midlands GP trainees to inform them of the study. The administrator

already has access to the e-mail addresses of all trainees through their role. Potential participants

will be informed that the researcher is a GP trainee (until October 2016, when it is anticipated that

she will qualify as a GP). They will also be informed that research participants will be chosen based

on their training region, gender and outcomes at ARCP, to ensure a breadth of response in the

interview sample. They will be informed that, by replying to the e-mail and expressing their

interest, they are also consenting to this information being used by the researcher to recruit

potential participants. GP trainees who are interested in participating in the study will be invited

to respond to the researcher directly.

The training administrator will send out the initial e-mail invite with a 2-week deadline to respond.

In the event of under-recruitment at this stage, a second e-mail will be sent, with a 1-week

deadline to respond (3 weeks total from the sending of the initial invite).

If recruitment is low, the researcher may also attend weekly training sessions (which all GP

trainees are expected to attend), to advertise the study (Microsoft PowerPoint slide for this is

attached).

The researcher will then compile a list of all GP trainees who have expressed interest in the study

(and therefore have implied their consent for their outcome at ARCP and training region to be

made known to the research team). The administrator from Health Education England, West

Midlands will complete the ARCP outcome and training region information for all responding

trainees, and submit this to the research team. Of those responding positively to the initial invite

e-mail, 10 participants will be sampled. The researcher will undertake a process of stratified

sampling of the respondents. Firstly they will be separated into the desired homogenous groups

(to ensure a breadth of "outcome at ARCP", "training region" and "gender"), and then using simple

randomisation to select from within each group if required. The simple randomisation element

will involve drawing names from a hat until each area of interest (ARCP outcome, gender, training

region) is adequately filled.

The researcher will then send out a formal invite to the study for the sampled participants, including a participant information sheet (see attached for formal e-mail invite and participant information sheet). Those who are interested will be advised to reply directly to the researcher.

In the event of under-recruitment from the identified sample (particularly of a particular ARCP outcome of interest), follow-up e-mails will be sent by the researcher. In the event of continued under-recruitment, the researcher will review the list of trainees showing initial interest, and determine if additional e-mail invites can be sent based on the sampling criteria.

Those who respond favourably to participate will be contacted by the researcher to arrange a convenient time and location for the interview. The researcher will offer to travel to the participants preferred location. For example, the place of work of the trainee, or at the location of their weekly teaching session (where a private room could be identified). Alternatively, the researcher will offer to meet the trainee at a pre-booked room at the University of Birmingham. The participant will be offered the opportunity to re-review the participant information sheet at the time of interview, and will be asked to complete the written consent form.

The researcher has a presence on "Twitter", and will advertise Stage 3 of the study (interviews with GP trainees) on her "Twitter" account during the period of recruitment. This will include a link to a document which contains the same information as the "e-mail invite to GP trainees", and the researcher's e-mail address should they wish to find out more (attached).

Recruitment - Stage 4 (focus groups with trainers)

It is intended that the focus groups will run as a workshop within the education programme for GP trainers in a particular training area (within the West Midlands region). There are 5 training areas within the West Midlands:

1. Birmingham and Solihull

2. Coventry and Warwickshire

3. Black Country

4. Stafford and Shropshire

5. Hereford and Worcester

It is anticipated that the workshop will run at training sessions for GP trainers in 3 or 4 of these training regions.

At the beginning of the workshop, all GP trainers attending the workshop will be verbally invited (by the researcher) to take place in the study. Each workshop participant will be given a participant information sheet and consent form at the beginning of the workshop.

Those who do not wish to participate will be seated at a table which does not have a recording device. Those who do wish to participate will be seated at a table which does have a recording device. Those who do wish to participate will also be asked to complete a written consent form.

Research site:

Following discussion with Alastair Mobley (CRN Research Support facilitator), the project will take place at a single NHS host site in the West Midlands. This is because the GP trainees and trainers are NHS staff, within Primary Care.

Host details:

Solihull PCT
Friars Gate
1011 Stratford Road
Shirley
B90 4BN

6.   **JUSTIFICATION FOR PROPOSED <u>NEW AMENDMENT</u>**

It is felt that the additional trainee perspective (not collected in the study outlined in the initial

ethics application) is required to provide adequate insight to the trainee-trainer relationship.

Presenting the results of the trainee interviews (in the form of vignettes) to GP trainers, is

intended to achieve further insights into trainer perspectives in the training relationship, and to

create a platform for dialogue and problem-solving. This approach has been chosen as the

researcher ultimately wants to consider options to improve the training relationship. It is felt

this stage of the research may generate data which relates to this.

7. **ETHICAL CONSIDERATIONS**

What ethical considerations, if any, are raised by the proposed <u>new amendment</u>?

Informed Consent:

Potential participants will be informed of the nature of the study by e-mail. Trainee participants will receive this from an administrator (from Health Education England, West Midlands). The e-mail will include information outlining the study in the form of a participant information sheet, and will outline the researcher's position as a GP trainee.

Interested parties will then have the opportunity to enquire further about the study, or to express interest to participate in the study.

Participants will be given another chance to read the Participant Information sheet prior to interview, and will complete a written consent form prior to beginning the interview.

GP trainee participants will be informed (via participant information sheet, and at the time of interview) that their interview data will be used for analysis within the PhD thesis, and also to construct anonymized "vignettes" which will be presented to GP trainers to stimulate focus group discussion.

Confidentiality:

It is anticipated that trainee participants will be sampled based on their "outcome" at Annual Review of Competence Progression (ARCP) (and annual assessment of progression towards attainment of the professional qualification "MRCGP"). This is potentially sensitive information, and will require permission from the GP trainee to be released to the research team. It is planned

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that an e-mail will be sent from an administrator from Health Education West Midlands to introduce the study, and invite interested participants to respond. This administrator is already involved in processing the ARCP outcomes of trainees. The e-mail invite will advise trainees that the lead researcher is also a GP trainee, and that data relating to their ARCP will be used by the researcher for sampling. They will be informed that, by responding favourably to the e-mail, they are consenting to their ARCP outcome being made known to the researcher for sampling purposes.

All GP trainee participants will be assigned a number. This will be used throughout all interview recordings, interview transcripts and analysis.

Anonymity:

The anonymity of the participants will be preserved in the presentation of the data.

Participants (both GP trainees and GP trainers) will be asked to withhold any identifying information, should they wish to recount stories of particular GP trainees or trainers during the interview or focus groups.

The researcher will not have access to information relating to trainee outcome at ARCP until the respondent has expressed their consent for this information to be shared with the researcher. This consent will be collected as an e-mail response to an administrator (working for Health Education England, West Midlands). The administrator already has access to this information as part of their job role.

Trainee anonymity in the generation of "case vignettes" (which will be presented to GP trainers)

will be preserved. Methods to ensure this include removing identifying information such as personal identifiers, training region and gender. It may be the case that some of the vignettes are constructed to represent a number of experiences (i.e. an amalgamation of accounts) for research purposes, or to better preserve the anonymity of the GP trainees. Vignettes which highlight a unique or rare experience (which could lead to identification of a particular trainee) may be significantly altered to preserve anonymity, or not included.

Personal identifying information will not be included in the PhD thesis or any published work.

Anonymity of participants will also be considered in the presentation of the results (within the PhD thesis and any material submitted for publication):

The method of analysis of the GP trainee interview transcripts is likely to involve narrative analysis. The particular type of narrative analysis will be chosen based on the interview data. However, the anonymity of participants will also be considered in the presentation of the data. For example, if a "chronicle" method of analysis could lead to identification of participants, the risks of this would be considered and an alternative method of analysis would be considered.

Thematic analysis is intended for the focus group data from GP trainers.

For both sets of data (interviews and focus groups), personal identifying information will be removed. Accounts which may lead to identification of the respondent will be presented in a way which limits this (such as presenting only excerpts, removing gender, removing training region).

Focus group participants will be asked that all discussions within the group remain confidential,

and that they do not disclose the identities of the other participants to anyone outside of their group.

Feedback:

All participants will be offered the opportunity to be informed about publications which may arise from the whole study (including the PhD thesis).

Participants (GP trainees) will also be offered the opportunity to receive their interview transcript to amend if they wish, as a form of "member checking".

Right to Withdraw:

This will be extended to the GP trainee participants in the study (those who will be interviewed).

The GP trainee participant information sheet will include details of the participant's right to withdraw up to 14 days after taking part in the research.

The GP trainee consent form will also include information of the participant's right to withdraw up to 14 days after taking part in the research.

The researcher will verbally inform the participant (GP trainee) of their right to withdraw after 14 days after taking part in the research.

There will be no consequences for the participants upon withdrawal from the study.

Participants will be asked about their reasons for withdrawal, if they choose to disclose these. This is to help inform the research team for further interviews and recruitment.

Upon withdrawal, all data collected from the GP trainee participants will be destroyed.

The right to withdraw after data has been collected will not be offered to the GP trainer participants (as it may be difficult to identify particular individuals on the focus group recordings).

Compensation:

All participants will be advised that participating in research is an opportunity for reflective practice within the trainee and revalidation E-portfolio (as it would provide an event which could subsequently be reflected upon by the participant in their personal written reflective log). The researcher does not have access to these reflective logs.

Payment, financial incentives or gifts will not be offered for any participants in the study.

Storage of information:

Dictaphone recordings will be stored in a locking filing cabinet, within the locked office of the PGR student.

A single Excel document (password-protected) will exist to hold the names, e-mail addresses and region of training of participants during the recruitment and interview process. The spreadsheet of GP trainers will also include their "years of training experience". The spreadsheet of trainees will include their ARCP outcome. This will be stored on the laptop of the PGR student, which is encrypted and password protected. A back-up file of this information will be stored in the PGR's personal area within the university network, also password protected.

A single member of staff from Health Education West midlands will have a list of all eligible GP

trainees to invite for interview, and this will be stored within a password protected computer. This member of staff already has access to this information as part of their job role.

The PGR Student and both PhD supervisors only will have access to the data.

Interview transcripts and analysis will be labelled with the participant's number, and no names or contact information will be displayed on these files.

The ARCP outcome, if present, for the GP trainees will also be displayed within their interview transcript.

They will be stored on the laptop of the PGR student, which is encrypted and password protected.

The contact details for participants will be destroyed upon completion of the PhD project. This is expected to be in November 2020. At this point, the computer files with their details will be deleted.

The interview data and any e-mail correspondence relating to interview data will be stored for 10 years past the completion date for the PhD. This is expected to be 10 years after November 2020. At this point, all computer files will be deleted and tapes will be manually destroyed.

NB: the original application for ethics for this project (ERN_14-0957) advised that data files would be held until December 2029 (which, at that time, was 10 years after the anticipated completion of the PhD). Since then, the researcher has had an official leave of absence of 11 months, which therefore has extended her PhD programme until November 2020.

Potential risks to participants

GP trainee participants:

Those who wish to participate in the research will be asked that their ARCP outcome (annual review of competency progression) be disclosed to the researcher and research team for sampling purposes. This is a voluntary disclosure, but may cause discomfort for the potential participant if they have received an unfavourable outcome at this assessment. Participants will be informed that disclosure of this is voluntary, and that any personal identifying information will be anonymised. The outcome at ARCP will not be shared beyond the research team.

Intrusion - GP trainee

GP trainees will be invited to participate in a series of interviews, which could require up to 3 hours of their time across their final (ST3) stage of training.

This is a year where high stakes examinations are sat, and the trainee has many training demands.

The interviews could therefore intrude in an already busy schedule, and add additional stress.

The researcher will work with the GP trainee to ensure that a time for interview is arranged that is mutually convenient, and does not contribute to additional pressure for the trainee. It is anticipated that the first interview will take place at the beginning of this the final year of training, when deadlines and examinations are not pressing. The second interview will take place after the trainee's high stakes examination, to avoid intrusion prior to this. A third interview may or may not be required, and will be discussed with the participant to ensure a mutually

convenient time.

The planned schedule for interview is designed to allow flexibility for the participant and to minimise disruption, with a 3-4 month window at the beginning and end of this stage of training (ST3) to ensure a convenient time.

It is anticipated that all interviews with GP trainees will be face-to-face. However, an option of a telephone interview as the second or third in the series of interviews may be considered if this were to be deemed as preferable by the participant.

Discomfort within the interview with a GP trainee:

The trainee may have experienced difficulties within GP training, which could cause discomfort or distress if they are recounted.

All trainee participants are advised of these right to withdraw (without reason) at any point during the study. This will be advised via the participant information sheet, consent form and prior to each interview.

The narrative style of interview that is planned allows the participant to have significant control over the information that is shared. If they do not wish to disclose or discuss particular events, this does not need to be expressed.

The interviewer will be the chief investigator. If a participant appears to be distressed during the interview, they will be offered the opportunity to pause, or to stop the interview, without reason. The interviewer, in her job as a GP trainee, is skilled in detecting and responding to expressed emotion. Participants will be offered space and opportunity in the event that time is required

for the participant to express distress.

GP Trainers:

All GP Trainers at the particular workshop will be taking part in the discussion relating to the GP training relationship, and the vignettes will be provided to all GP trainers for discussion (therefore, the educational task will be available for both research participants, and for those who are not participating).

Change to education programme for GP trainers:

It could be perceived that the planned discussion activity (using vignettes) may distract from other planned educational activities. However, a discussion with the Head of School for General Practice training has agreed that the training relationship is an important area within a trainer's role, and therefore discussion and peer-support as a means of peer-education in this area would be a welcome addition to the education programme.

Potential distress/discomfort to GP trainers

GP trainers may also have experienced difficult or distressing experiences in their own training, or in their role as a GP trainer. These could be raised within the focus groups.

The focus groups invite voluntary participation. Furthermore, the responses given by participants to the vignettes will also be voluntary. In this way, disclosing information which may be sensitive will be on a voluntary basis.

Potential risks to the researcher

There is a potential risk that stories raised in the interviews or focus groups could be distressing for the researcher (who is also a GP trainee at the time of this ethics application, and will have personal experiences of training).

It is hoped that these will be minimised though the researcher's self-awareness, and an ongoing process of reflexivity. Through her role as a GP trainee, she is trained and familiar in listening to accounts which may be distressing or upsetting, and in managing her own response and reaction. She also has personal and professional support within General Practice and University of Birmingham supervisory arrangements. De-briefing will take place in the event of an upsetting or difficult interview experience, with the PhD student's supervisor. The researcher will undertake a maximum of 3 interviews in one week to allow adequate time between interviews. No more than one interview will be undertaken in a single day.

8. **DECLARATION BY APPLICANTS**

I make this application on the basis that the information it contains is confidential and will be used by the University of Birmingham for the purposes of ethical review and monitoring of the research project described herein, and to satisfy reporting requirements to regulatory bodies. The information will not be used for any other purpose without my prior consent.

I declare that:

- The information in this form together with any accompanying information is complete and correct to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to abide by University Code of Conduct for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) alongside any other relevant professional bodies' codes of conduct and/or ethical guidelines.
- I will report any changes affecting the ethical aspects of the project to the University of Birmingham Research Ethics Officer.
- I will report any adverse or unforeseen events which occur to the relevant Ethics Committee project to the University of Birmingham Research Ethics Officer.

Signature of Principal investigator/project supervisor:	
Date:	

Appendix 5: Participant Information Sheets

UNIVERSITY OF BIRMINGHAM

NHS

Health Education West Midlands

> # What's happening in the GP trainee-trainer supervisory relationship?

> *Participation in this research WILL HELP INFORM the deanery's approach to providing support for GP training*

WHO ARE WE?

We are a team from the Schools of Education and Primary Care at the University of Bimingham. This research has been funded by the Primary Care Research Trust and approved by Dr Martin Wilkinson of Health Education West Midlands. The research has ethical approval from the University of Birmingham.

The lead researcher, Dr Dawn Jackson, is a GP trainee (ST3) at South Birmingham VTS, and the project is part of her PhD thesis.

WHY ARE WE DOING THIS RESEARCH?

We are looking to improve General Practice Training in the West Midlands.

We know that trainees who face difficulty in their GP training programme, such as exam failure or failure at ARCP (annual review of competence progression), are at risk of requiring additional support and possibly extension to their training. Exam failure or extension to training at this late stage of the training programme can be very

distressing for the trainee, and costly to both the trainee and the Deanery.

A key component of General Practice training is the role of the GP trainer, who is responsible for "oversight of the educational process" (RCGP, 2008). The trainer role comes to the fore in the final year of training, when the trainee works within the trainer's practice, and therefore is directly supervised by the trainer in their clinical work. For numerous reasons, trainees' progression may be suboptimal, and they may face difficulties with exam failure or failure at appraisal. We want to understand the contribution of the training relationship to a

> *We want to hear the views of GP educators within the West*

trainees' progress. This is a pilot study that will help to inform the design of a larger-scale study.

WHO DO WE WANT TO HEAR FROM?

We are particularly interested in their views of GP educators about the trainee-trainer relationship. You have been invited to participate because you have an interest and experience in supporting GP trainees who face difficulty in their training, and also of the GP training relationship.

WHAT DOES IT INVOLVE?

You will be invited to participate in 1 interview, which will be audio-recorded and should last around 30 minutes.

The interviewer will aim to fit in with your schedule to arrange a time for interview.

CONFIDENTIALITY

We are collecting information to give a broader sense of the GP training relationship, and therefore are not collecting information that is about a GP trainee or GP trainer individually.

Your information will be stored confidentially and no identifiable personal data will be published.

IS PARTICIPATION VOLUNTARY?

Your participation in this study is entirely voluntary.

Funding for this study unfortunately cannot provide financial reimbursement for your participation. However, a small token of appreciation for your participation will be given on the day of interview.

You are free to withdraw up to 14 days after giving the interview, without giving any reason.

WHAT WILL WE DO WITH THE RESULTS?

The results from this pilot study will be used to help develop further research to look at the GP trainee-trainer relationship

WHAT NEXT?

If you wish to be involved in the study, please e-mail Dr Dawn Jackson to express your interest.
dvjackson@doctors.org.uk
She will then contact you to arrange a time that is convenient for you to complete the interview.

WANT TO KNOW MORE?

If you may be interested, but want to know more, please e-mail Dr Dawn Jackson to ask any questions, or to arrange a telephone call to discuss further.
dvjackson@doctors.org.uk
Supervisor: Dr Ian Davison: I.W.Davison@bham.ac.uk
Thank you for taking the time to read this participant information sheet

Royal College of General Practitioners (2008) **Standards for GP Speciality training: guidance for deaneries.** (online) [accessed 19/8/14]. URL: http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Information%20for%20deaneries%20trainers%20supervisors/Guidance-for-deaneries-on-standards-for-GP-training-Jan-2014.ashx

UNIVERSITY OF BIRMINGHAM

NHS
Health Education England

> ### What's happening in the GP trainee-trainer relationship?

PARTICIPANT INFORMATION SHEET (GP Trainees)

WHO ARE WE?

We are a team from the Schools of Education and Primary Care at the University of Bimingham. This research has been funded by the Primary Care Research Trust and approved by Dr Martin Wilkinson of Health Education England, West Midlands. The research has ethical approval from the University of Birmingham.

The lead researcher, Dr Dawn Jackson, is a recently-qualified GP in south Birmingham, and the project is part of her PhD thesis.

WHY ARE WE DOING THIS RESEARCH?

We are looking to improve General Practice Training in the West Midlands.

We know that trainees who face difficulty in their GP training programme, such as exam failure or being unsuccessful at ARCP (annual review of competence progression), are at risk of requiring additional support and possibly extension to their training. Exam failure or extension to training at this late stage of the training programme can be very distressing for the trainee, and costly to both the trainee and those involved in supporting them.

A key component of General Practice training is the role of the GP trainer, who is responsible for "oversight of the educational process" (RCGP, 2008). The trainer role comes to the fore in the final year of training, when the trainee works within the trainer's practice, and therefore is directly supervised by the trainer in their clinical work. We want to understand the contribution of the training relationship to a trainees' progress. It is hoped the results from this study will shape future training and support for GP trainees and GP trainers.

> *We want to hear the views of GP trainees within the West Midlands.*

WHO DO WE WANT TO HEAR FROM?

We are interested in the views of GP trainees about the trainee-trainer relationship. This may include trainees who have experienced difficulties such as lack of success in exams or ARCP, and also those who have not had these experiences. You have been invited to participate because you are a GP trainee, and therefore you have first-hand experience of this training relationship.

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WHAT DOES IT INVOLVE?

You will be invited to participate in 2 or 3 face-to-face interviews, throughout the course of your final year of training (ST3), which will be audio-recorded and should last around 45 minutes. The first is expected to be at the beginning of ST3, with the second planned for after the Clinical Skills Assessment examination (CSA). A third and final interview may be needed to clarify information.

The interviewer will aim to fit in with your schedule to arrange a time and place for interview.

CONFIDENTIALITY

Information will be stored confidentially and no identifiable personal data will be published.

You are free to withdraw up to 14 days after giving any of the interviews, without giving any reason. The data obtained will be stored for 10 years after the research, in a password-protected file and computer.

IS PARTICIPATION VOLUNTARY?

Participation in this study is entirely voluntary. Funding for this study unfortunately cannot provide financial reimbursement for your participation. However, it may serve as an example of "Academic Activity" for your learning log.

WHAT WILL WE DO WITH THE RESULTS?

The results from this study will be used to construct short "vignettes", to represent some of the experiences faced by GP trainees. These will be presented to GP trainers for discussion. All personal identifable data will be removed from the vignettes to preserve trainee anonymity. Ultimately, the study will consider how we can better train and provide support within the GP training relationship. Results will be published as a PhD thesis, and submitted for relevant journal and conference presentation.

WHAT NEXT?
If you wish to be involved in the study, please e-mail Dr Dawn Jackson to express your interest.
dvjackson@doctors.org.uk
She will then contact you to arrange a time and place that is convenient for you to complete the interview.

WANT TO KNOW MORE?
If you may be interested, but want to know more, please e-mail Dr Dawn Jackson to ask any questions, or to arrange a telephone call to discuss further.
dvjackson@doctors.org.uk
Supervisor: Dr Ian Davison: I.W.Davison@bham.ac.uk

Thank you for taking the time to read this participant information sheet

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Royal College of General Practitioners (2008) **Standards for GP Speciality training: guidance for deaneries.** [online] [accessed 19/8/14]. URL: http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Information%20for%20deaneries%20trainers%20supervisors/Guidance-for-deaneries-on-standards-for-GP-training-Jan-2014.ashx

Appendix 6: Participant Consent forms

> How can we meet the training needs of the GP trainee within the GP trainee-trainer
> relationship, before it's "too late"?

CONSENT FORM (Experienced Educators)

This information is being collected as part of a PhD research project concerned with improving General Practice Training in the West Midlands. It is being conducted by the Centre of Medical and Dental Education in the University of Birmingham, and the PhD is funded by the Primary Care Research Trust.

The information which you supply and that which may be collected as part of the research project will be entered into a database and will only be accessed by authorised personnel involved in the project. The information will be retained by the University of Birmingham and will only be used for the purpose of research, and statistical and audit purposes. By supplying this information you are consenting to the University storing your information for the purposes stated above. The information will be processed by the University of Birmingham in accordance with the provisions of the Data Protection Act 1998. No identifiable personal data will be published.

Statements of understanding/consent

- I confirm that I have read and understood the participant information leaflet for this study. I have had the opportunity to ask questions and these have been answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw up to 14 days after taking part, without giving any reason. If I withdraw, my data will be removed from the study and will be destroyed.
- I understand that my personal data will be processed for the purposes detailed above, in accordance with the Data Protection Act 1998.

- Based on the above, I agree to take part in this study

Name of participant…………………………………… Date…………… Signature……………………………

Name of researcher…………………………………… Date…………… Signature……………………………

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What's happening in the GP trainee-trainer supervisory relationship?

</div>

CONSENT FORM (GP Trainees)

This information is being collected as part of a PhD research project concerned with improving General Practice Training in the West Midlands. It is being conducted by the School of Education in the University of Birmingham, and the PhD is funded by the Primary Care Research Trust.

The information which you supply and that which may be collected as part of the research project will be entered into a database and will only be accessed by authorised personnel involved in the project. This information will also be used to help inform short "vignettes", which will be presented to groups of GP trainers to discuss. Identifiable personal data will not be used in the construction of these vignettes. The information will be retained by the University of Birmingham and will only be used for the purpose of research, and statistical and audit purposes. By supplying this information you are consenting to the University storing your information for the purposes stated above. The information will be processed by the University of Birmingham in accordance with the provisions of the Data Protection Act 1998. No identifiable personal data will be published.

Statements of understanding/consent   *Please tick to confirm*

- I confirm that I have read and understood the participant information leaflet for this study. I have had the opportunity to ask questions and these have been answered satisfactorily.   ☐
- I understand that my participation is voluntary and that I am free to withdraw up to 14 days after taking part, without giving any reason. If I withdraw, my data will be removed from the study and will be destroyed.   ☐
- I understand that the interview will be recorded.   ☐
- I understand that my personal data will be processed for the purposes detailed above, in accordance with the Data Protection Act 1998.   ☐
- I understand that my interview will be recorded for the purposes detailed above, and that all recorded media will be deleted 10 years after the completion of this study (expected November 2030).   ☐
- I understand that data from my interview will be treated as confidential, and will be anonymized in the outputs of the research.   ☐
- I understand that data from my interview (in pseudonomised form) may be shared for publication at a later date, or may be added to an archive.   ☐

- Based on the above, I agree to take part in this study   ☐

Name of participant……………………………………… Date…………… Signature………………………….

Name of researcher……………………………………… Date…………… Signature………………………….

Appendix 7: Interview Schedule for Interviews with Experienced Educators

INTERVIEW SCHEDULE:

Egan's model Stage 1: Current Scenario:

1. *What do you think are the important elements of the GP trainee-trainer relationship?*

2. *What are your thoughts about the role of the GP trainer in identifying trainees at risk of failing their Clinical Skills Assessment (CSA: high stakes summative assessment)?*

3. *Do you think that GP trainees need help from trainers or others to identify their training needs?*
   a. *Does this differ between those "typical" trainees, and those at risk of failing the CSA?*

Egan's model Stage 2: Preferred Scenario:

4. *What are your thoughts about the training needs of a typical GP trainee?*

5. *Do you think the training needs differ between those expected to pass CSA, and those at risk of failing?*

Egan's model Stage 3: Strategy:

6. *What are your thoughts about the role of the GP trainer in intervening to help GP trainees at risk of failing the CSA?*

7. *What, in your opinion, what should they be doing to intervene?*

Bordin's Model: Supervisory Working Alliance:

8. *How important is it that the trainee and their trainer get along?*

9. *The (working) title of this research is :*

   How can we meet the training needs of the GP trainee within the GP trainee-trainer

   relationship, before it's "too late"? Do you have any views or comments relating to this title?

10. *Do you have any final comments or questions?*

Appendix 8: Data form for Documentary Scrutiny

DATA FORM FOR DOCUMENTS

Name of document:

Date:

Author:

Interests of the author:

Overall aim and interests: (from their website):

Origins and intentions (highlight)		Comments
Formal?	Informal?	
Public?	Private?	
Local?	National?	
One?	Many?	
Anonymous?	Attributable?	
Opinions/beliefs?	Factual?	
Lay?	Professional?	
For circulation	Not for circulation?	

Original intention of document:

Audience (original) for the document:

What is taken for granted about the audience? (Pre-knowledge they need to have)

Additional influences at the time (context):

What documents does it build upon?

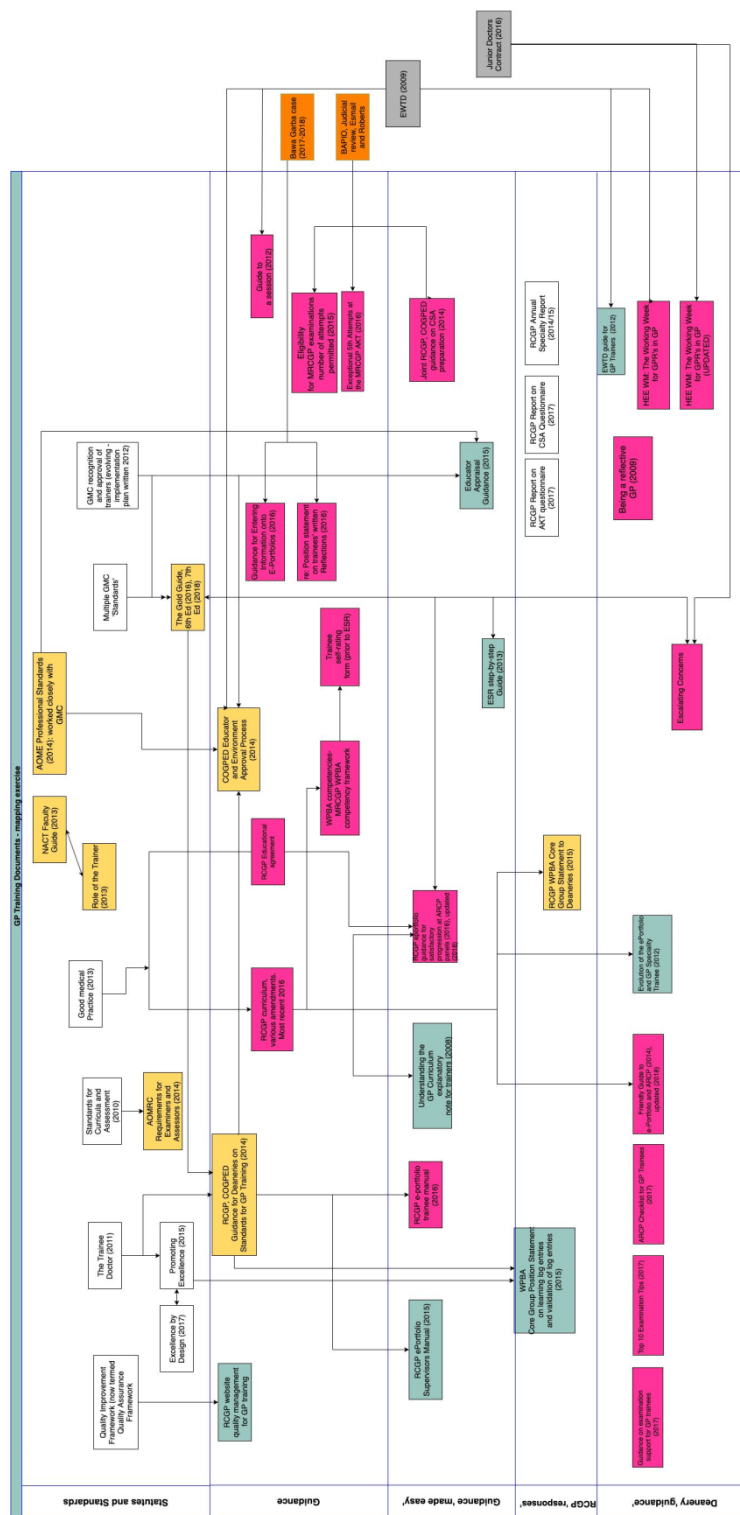Comments on style:

Comments on language:

Obvious omissions?

How was it circulated?

Anything about the timing of its release?

Press response? (Union response)

Appendix 9: Mapping of Documents

GP Training Documents - mapping exercise

Vertical category labels (left side):
- Statutes and Standards
- Guidance
- Guidance 'made easy'
- RCGP 'responses'
- Deanery 'guidance'

Diagram boxes (labels):

- Junior Doctors Contract (2016)
- EWTD (2009)
- Bawa Garba case (2017-2018)
- BAPIO judicial review, Esmail and Roberts
- Guide to a session (2012)
- Eligibility for MRCGP examinations number of attempts permitted (2015)
- Exceptional 5th Attempt at the MRCGP AKT (2016)
- Joint RCGP COGPED guidance on CSA preparation (2014)
- RCGP Annual Specialty Report (2014/15)
- EWTD guide for GP Trainees (2012)
- HEE WM: The Working Week for GPR's in GP
- HEE WM: The Working Week for GPR's in GP (UPDATED)
- GMC recognition and approval of trainers (evolving - implementation plan written 2012)
- RCGP Report on CSA Questionnaire (2017)
- Educator Appraisal Guidance (2015)
- RCGP Report on AKT questionnaire (2017)
- Being a reflective GP (2009)
- Multiple GMC 'Standards'
- ADME Professional Standards (2014) worked closely with GMC
- The Gold Guide, 6th Ed (2016), 7th Ed (2018)
- Guidance for Entering Information onto E-Portfolio (2016)
- Re: Position statement on trainees' written Reflections (2018)
- NACT Faculty Guide (2013)
- COGPED Educator and Environment Approval Process (2014)
- Trainee self-rating form (prior to ESR)
- ESR step-by-step Guide (2013)
- Escalating Concerns
- Role of the Trainer (2015)
- RCGP Educational agreement
- WPBA competences - MRCGP WPBA competency framework
- Good medical Practice (2013)
- RCGP curriculum, various amendments. Most recent 2016
- RCGP Approval guidance for satisfactory progression at ARCP panels (2016), updated 2018
- RCGP WPBA Core Group Statement to Deaneries (2015)
- Evolution of the ePortfolio and GP Specialty Trainee (2012)
- Standards for Curricula and Assessment (2010)
- ADMC Requirements for Examiners and Assessors (2014)
- Understanding the GP Curriculum explanatory note for trainees (2008)
- Friendly Guide to e-Portfolio and ARCP (2014), updated 2018
- RCGP e-portfolio trainee manual (2016)
- The Trainee Doctor (2011)
- Promoting Excellence (2015)
- RCGP COGPED Guidance for Deaneries on Standards for GP Training (2014)
- ARCP Checklist for GP Trainees (2017)
- Quality Improvement Framework (now termed Quality Assurance Framework)
- Excellence by Design (2017)
- RCGP ePortfolio Supervisors Manual (2015)
- WPBA Core Group Position Statement on learning log entries and validation of log entries (2015)
- Top 10 Examination Tips (2017)
- RCGP website quality management for GP training
- Guidance on examination support for GP trainees (2017)

KEY:

Colour of box	Type of document
White	Documents written mainly for RCGP and other Royal Colleges within medical education
Yellow	Documents written mainly for Health Education England, and regional training bodies
Blue	Documents written mainly for Educational supervisors
Pink	Documents written mainly for GP trainees
Orange	Guidance written in response to political events
Grey	Contractual documents

Appendix 10: Interview schedule for Narrative Interviews with GP Trainees

INTERVIEW SCHEDULE – summarizing the series of interviews

What's Happening in the GP Trainee-Trainer Supervisory Relationship?

Beginning:

Short questions to determine where participant is in their training:

Just to clarify before we begin – where are you up to in your training? (i.e. regular run-through. FT/LTFT? Extension/out of sync).

Introduction

Thank you for agreeing to take part in this interview.

The study aims to explore the GP trainee-trainer relationship, and how it addresses the training needs of GP trainees, particularly in their ST 3 year.

You've been asked to take part because you are a GP trainee, who therefore has experience of the GP trainee-trainer relationship, and the training needs of GP trainees.

If regular training:

The series of interviews hopes to explore your experiences. (It's aimed that I'll talk to you today, and again after you've sat your CSA). It may be that I contact you a final time to check things with you, or ask for some clarification if that's needed.

OR (if towards the end of their training)

In the initial invitation, I'd discussed the plan to have a second interview after CSA. In your case, this isn't relevant, as you've already sat your CSA and are coming towards the end of training. As a result, the interview today will be the only one that we will do.

Each (the) interview should last around 45minutes.

Opportunity to ask questions

Opportunity to review Participant Information Sheet

Signing of consent

INTERVIEW ONE

Today's interview is to focus on your experiences of medicine and training before becoming an ST3

GP trainee.

It involves some looking back to the past, so take time to think where you need it. I'll give you a pen

and paper too, as I know some people think better with a pen in their hand!

This type of interviewing is very different to the way we take histories in General Practice, so please

do talk freely. It is also different to a typical interview, as I don't have a predefined list of questions

to ask. I am much more interested in hearing your story and the things that you think are important.

 You may notice me scribbling here and there – that's just to jog my memory in case I need to come

back to something you've said later.

<u>OPENING QUESTION</u>

- Please can you tell me the story of your supervision experience from medical school until
  now? Start however you like, and consider the experiences, events and people that have
  shaped that story, and which you think are important to share.

OR *(if coming to the end of ST3):*

- Option to start from ST1 if too difficult to go back in terms of time.

It is likely that much of the interview will be based on the given response to this question.

Should the respondent require additional prompting, the following may be considered:

What happened then?

Is there anything else that you think is important to tell me about your training? (Encourage

expansion of the narrative).

If more prompting needed:

Consider: are there particularly important events in your training experience?

Are there particularly important people in your training experience?

If struggling to construct in entirety, consider:

Story of medical school

Foundation years

Becoming a GP trainee

GP training so far

The context: family, culture, past experience, the "personal", institution/external factors

Exploration of expectations of supervision

Exploration of supervision experiences in training –good, bad, best, worst

Agreement in supervision

Roles in the relationship

Working alliance

Relation to performance

Appendix 11 Exemplar of Narrative Analysis Summary

Seema: Analysis Summary (researcher reflections in red)

<u>**Seema: Participant 10 Summary**</u> 72 mins

Story Caption: I'm a problem trainee, what's wrong with me?

Brief Synopsis

The participant in this narrative is an older trainee, single mother and an International Graduate. She has spent a number of years training within a hospital speciality, but changes to General Practice training later in her career.

Her training journey appears fraught with difficulties (including hospital posts outside of General Practice). These include supervisors raising concerns related to her timekeeping, rota commitments and competence. Later, in GP training, she has a breakdown in relationship with her trainer, fails her AKT and is referred for Professional Support.

Main stories (First reading)

The courtroom: a victim	The trainee describes a training journey fraught with difficulties. In this narrative, she is defending her position as the victim, with the training culture as the protagonist (and various supervisors seen as agents of the training culture).
What's wrong with me?	The quieter, vulnerable voice: In this narrative, the trainee appears to be questioning why

	these difficulties have occurred, and is asking herself, 'What is wrong with me'? The narrative appears to be a place where she is working out her sense of self within a culture which has positioned her as an outsider.
Seeking acceptance	Trainee tries to adapt to behave 'appropriately' for her supervisor
A new vantage point	In her new practice, she is learning how to work in the identity of a 'problem-trainee' and move forwards, with support

WHO is telling the stories? (First reading)

The trainee describes herself as a 'problem trainee'. Certainly, her training journey has not been smooth.

There appears to be a catalogue of misunderstandings: smaller stories woven throughout the narrative.

Positioning to me (as the researcher)

Protagonist. In her eyes, supervisors have misinterpreted her intentions, and she has struggled to articulate a response.

It appears that she views me (the researcher) as a potential advocate, and someone who can listen to her 'side of the story'. Her 'side' relates to her identity as 'not a typical trainee'. Within this sense of

'self', she has the responsibility of motherhood (and being a single mother), which she must balance with the demands and expectations of GP training.

<div align="center">

I-poem "I am a single mother"
I started GP training
I was moving from Coventry
I was living in Coventry
I made him sit the exam
First choice was Birmingham
Which I never got

I had a few issues
I couldn't be there bang on time at 8 o'clock
I have to drop my kids
I made it very clear
I moved into hospital
I never needed to go at 8
I went there at half 8
I was always bang on half 8

I-poem "I'm not a typical trainee"
I'm less than full-time
I'm part time
I'm quite an experienced doctor
I'm not training at the level of the trainees that come out just out of medical school
I've done *surgery (speciality changed to preserve anonymity)
I know what the training in the hospital is like in *surgery
I training in India
I'm very experienced

</div>

Vantage point:

Outsider: seeking acceptance and inclusion

She perceives the institution and training culture as the antagonist, and many of her supervisors as agents of this.

Through her experiences, there is a sense she has come to expect judgement and scrutiny from the prevailing training culture and its agents.

She perceives the institution as having particular expectations of her (as a 'good trainee'): Humble, teachable, engaged, and motivated

'Insider': The narrative ends with the trainee at a new practice, with a new supervisor. She explicitly contrasts her current experience:

I'm still doing the same things. I haven't changed anything since I've come here. Um, but I feel better. I feel better. I feel supported. I don't know if it's from the deanery. They have said you have to be supportive. Sometimes when I'm feeling under-confident. Or when I'm feeling like, "ok, no, I'm not a great person", maybe that makes me think maybe it's not me. Maybe it's the deanery said that to them, that she has to go gently.

Here, she describes her tentative journey to a different position – taking up more of an 'insider' position, but battling with her sense of self related to her previous experiences.

Me as the listener:

As the listener, I frequently find myself reacting to the defensive voice within the narrative. Not only is she attempting to defend herself to me, but she also recounts examples where she has defended herself to supervisors. As the listener, such defensiveness is jarring, and filled with a sense of frustration and almost aggression from the trainee. It creates feelings of empathy in me towards the supervisors involved. I wonder if, related to this defensiveness, she may well have 'blind spots' within her learning and professional development, and thus efforts of the part of supervisors to 'teach' or 'support' may not have been well-received. The defensiveness displayed, exam failure and instances of lateness or perceived lack of commitment, create in my own mind a picture of a 'problem trainee'.

However, when I attend to the quieter, vulnerable voice, I feel a deep sense of sympathy for the trainee. From the outset, her identity of 'not a typical trainee' appears to have positioned her as an

Expanding on the narratives (First and Second Readings, including relevant I Poems)

Narrative 1 – The courtroom. A victim.

<u>Supervisor as the antagonist</u>

The starkest example of a supervisor as an antagonist within the narrative is her ST2 GP placement

supervisor. The following excerpt is an example of this:

"And then this meeting that happened it was very frustrating I would say, because somebody telling

you that you don't have a clinical knowledge, um, because you telling me to read everything. It's very

difficult to read everything. You are a GP, and I thought in my head, there's nothing, there is no way

you know 100% everything. Such a wide, you tell me what are the areas I should be focusing more

than others. I can't overnight in 6 months cover everything, If I'm not being very well educated.

So he said, first he fumbled.

Then I said, "No. You need to give me an example of a patient which I've done wrong. Because the

way the meeting is happening, it's really looking like I've done something wrong, so I need to know

which patient has been neglected, mishandled".

Within this excerpt, the trainee's 'case' is built and a defensive voice is paramount; rejecting the

assumption of the trainer that she is a 'bad' trainee, and wanting to be understood as a 'good

trainee'. It is interesting that much of her 'defence' occurs 'in her head', suggesting that her voice is

somewhat silenced in her interaction with her trainer. If the discussion did in fact play out as it is

described, the supervisor would have simply heard her rejection of his diagnosis and her defensive

call for 'proof'. However, her search for more specific feedback from the supervisor is not expressed

to him directly.

Narrative 2 – What's wrong with me?

However, listening to the voice within the I-poems in the subsequent dialogue following this episode,

a different perspective is offered, where the trainee's vulnerable voice is apparent.

<div align="center">

I-poems – vulnerable voice

I'll sort that out
I swapped it
Now I know that
I said
I didn't think of that
I shouldn't have
I said
I didn't know that
I've discussed that
I didn't know
I had opted

</div>

This quieter voice provides a window to the second story within the narrative; a vulnerable voice. It

appears that within the narrative, she is attempting to work out her identity and position, and is

asking the question (of herself), "What is wrong with me"? The story here is a questioning of her

sense of 'self' within postgraduate GP training, and in relation to her 'bad' experiences within

training. It appears that, through the difficult experiences within training, she feels pushed into a

position which is not aligned to the sense of self she desires. She refers to herself as a 'problem

trainee', and positioned as an outsider within the Figured World of GP training.

Narrative 3 – Search for acceptance

Searching for acceptance –trainee agency

As the listener, the defensive voice is loud in this narrative, and the trainees describes occasions where this 'defensive voice' has been used to challenge her supervisor. As the listener, the sense of protest and defence is louder that I would expect, and I find myself quite jarred by the intensity and volume of the protest. I could also imagine that a supervisor may well feel the same – and conclude that their feedback and guidance is falling on 'deaf' ears.

Positioning

However, attending to the issue of positioning within the narrative, alternative perspectives are important.

The trainer is intending to direct and to guide, expecting humility and engagement from the trainee. However, the trainee expects acceptance and validation from the trainer, and perceives the trainer's 'guidance' as judgement and rejection (thus positioning her as an 'outsider'). Her response, often expressed defensively, is an attempt to gain the acceptance she craves (by rejecting the trainer's claims of 'bad' trainee, and defending her desired position of 'good' trainee). Perhaps the trainee must defend so 'loudly' on the few occasions she describes, because of the degree by which she is positioned as an outsider, and frequency by which she is silenced within this position.

Sadly, as the listener, I wonder if this defensiveness may reinforce her outsider position, due to the way in which it is received by the trainer.

Search for acceptance- the olive branch

At a turning point in the story, it seems that the trainee begins to realise this. She describes an attempt to display the attributes of a 'good trainee', changing tack on her quest for acceptance:

And then, I thought there is something wrong here. Something I've not done right [choking up]. Like that's when I mentioned about anaesthetics. Like also a personality issue. But there is was opposite. In the beginning it used to be, but in the end it used to settle down. In fact they used to prefer me over, there were many examples. They used to prefer me over any other anaesthetists. Because that was a personality issue there. So I thought it was a personality issue. What I did was, maybe I'm too senior. I'm not coming across of kind of humble trainee. I've got a bit of a kind of a laid back attitude as well. So I thought I might show that I'm learning or something. Ask questions. When I don't need to ask questions [laughs]. So what I started doing was, I wrote a letter.

*A referral letter and I said, "Dr K*****, I wrote a letter, a referral letter, Can I show it to you"?*

He came, he said "leave it on my desk then, when I've read it, I'll let you know". So, after he read it, towards the end of the day, he came to my room and said, "This is the letter you've written. Any damn F1 can write a letter".

In this, we see the trainee question herself, and question what is 'wrong' with her. In this example, she is questioning how she might position herself differently in the eyes of her supervisor – considering what his expectations of her might be (humble, teachable, motivated, engaged), and taking a step to meet these expectations.

As the listener, I sense the 'olive branch' in this example –the action of writing the referral letter representing a move on her part to be positioned differently, accepted as an 'insider'. And in the trainer's response, I feel the trainee's sense of disappointment and further rejection.

Relationships with Supervisor (s) (Third Reading)

ST2 supervisor: Feels rejected and inadequate. Relationship breakdown. Defensive voice on the part of the trainee.

Agency and expectations: She has particular expectations of her supervisor. These include listening to her, detecting unconscious incompetence, and guiding her. She instead perceives significant monitoring and gatekeeping from her supervisor (which might relate to her vantage point of suspicion). The following except also suggests a feeling of being silenced, and thus misunderstood.

"The other way I felt I discriminated was the um, in fact, sending to PSU, it should have been addressed by them I feel. I feel they should have addressed it and seen that ok, there was a problem. Golden Minute silence. In the beginning that should have been corrected. Second patient, blood in urine. They should have listened to me, why. I said, but because she was having periods, we know coincidence there. But nobody listens, they just talk over you. So, maybe discussing in detail with the trainee where you were lacking and whether you know it or not. In the tutorials is a good opportunity to discuss that. In tutorials, they did discuss, it was like a rapid fire questions I used to get. They, because they couldn't pick up anything there, so they just referred to PSU.

ST3 supervisor: a change of vantage point and experience occurs with a move of practice. See 'vantage point'. She is moving to a more insider position, and appreciating the world through her supervisor's eyes.

<div align="center">

I poem- a different perspective
I can't complain
I can understand
I could send a text
I can sit in my room
If I was a GP supervisor
I would do that
I wouldn't take anything in my hands
If I don't know the trainee
I wouldn't
I would see
I can't complain

</div>

Relationships with wider practice (Third Reading)

The above example serves as an illustration of the trainee's cultural position as an 'outsider' in her ST2 practice. It appears that she is positioned:

Through a lack of access – to the supervisor and the community of practice (with the 'door' as the artefact)

"after I've finished seeing patients I used to keep my door open so that they don't have to barge through the door. They used to sometimes just barge into the room, "what are you doing still"? Kind of thing.

And that made me wonder, because all that's going on, I used to think, "Are they thinking that I'm watching some movie or something on the computer". So I used to keep the door open so that they don't have to just barge in without knocking on the door. So, those kind of things. Once I had left the door open, even then supervisor would pass through and the door opposite was the ST3,

*She said, "*Amy, have you had your lunch"?*

[ST3] "Yeah",

[Supervisor] "I want you guys to have your lunch before you see the next lot of patients" and all.

But it's in a loud voice to tell that 'I'm more concerned about trainees, but not about you".

Societal/cultural messages (Fourth Reading)

Artefact – the consulting room door

Within a GP practice, the doctor works in their own room, and therefore with a door to the room (usually closed when interacting with a patient to protect their confidentiality). Within the narrative,

the 'door' serves as an artefact to signify the notion of access; both to the supervisor as also to the community of practice. The trainee refers to the 'door' in two instances:

1. She is expected to discuss every patient she sees with her supervisor, who is also concurrently in clinic with patients of his own. To gain access to her supervisor (and thus his subsequent feedback, guidance and opportunity for learning), she must wait outside his door until he is available. The closed door in this instance represents the difficulty in gaining access to the supervisor, and emphasizes the feeling of 'outsider'.

"Before I was taking my half an hour time and waiting outside their rooms and discussing it, the patient. Then we had another meeting after another month and they said, "You're still on half an hour and you haven't done anything about it and your clinical knowledge is poor".

And I said, "Ok, about half an hour I'll try and do. But I must admit to it, the waiting outside your room sometimes takes 10 minutes and then discussing for another 5 minutes, so 15 minutes you can just put for every patient".

So, they said "no, who said I see patients in 10 minutes. I don't see patients in more than 10minutes. I see patients very quickly

I said you might be, but I still have to wait outside"

2. The trainee uses to the door (keeping it open) to prevent perceived suspicion from practice staff. In contrast, she perceives that the other trainees in the practice are afforded access and a status of 'insider' that she is not – observing these trainees to have access to the supervisors beyond the formal 'educational' interaction, and privy to the relaxed corridor and lunchroom culture of the practice. As the listener, I therefore wonder if the 'door' in this example serves two purposes for the trainee: firstly to avoid arousing suspicion, but secondly

to attempt to gain access to the 'insider' position that she perceives afforded to the other trainees:

"After I've finished seeing patients I used to keep my door open so that they don't have to barge through the door. They used to sometimes just barge into the room, "what are you doing still"? Kind of thing.

And that made me wonder, because all that's going on, I used to think, "Are they thinking that I'm watching some movie or something on the computer". So I used to keep the door open so that they don't have to just barge in without knocking on the door. So, those kind of things. Once I had left the door open, even then supervisor would pass through and the door opposite was the ST3,

*She said, "*Amy, have you had your lunch"?*

[ST3] "Yeah",

[Supervisor] "I want you guys to have your lunch before you see the next lot of patients" and all.

But it's in a loud voice to tell that 'I'm more concerned about trainees, but not about you".

The 'system'

Within the trainee's 'courtroom' she appears to be defending herself to me (as the researcher). Although most of the narrative discusses her experiences with supervisors and the practice directly, she also alludes to a wider structural influence, and it appears that her defence also relates to this 'system' (with myself viewed to be an agent of that 'system'). This influence is interwoven throughout the narrative, and is a subtle yet consistent presence.

Seema first discusses the 'system' as influencing the geographical location of her placements, leading to difficulties in juggling her son's school commitments with travelling to and from work:

"There were issues with the other things, nothing to do with supervision. Like I was moving from

*Wolverhampton to, I was living in *Wolverhampton. Applied for Birmingham because at

Birmingham hospital I was based in *surgery so I was already applying for it. So my son, I made him

sit the exam for grammar schools in Birmingham so that we'll finally relocate there. In between

change of mind. Got the GP training, and then I got *Coventry. So the first choice was Birmingham,

*which I never got. **So there was an issue with travelling**."*

Her training duration, in the form of an extension, was also set by the 'system', without discussion,
and without her input. Through her use of the phrase 'an issue I would like to be corrected', I felt
that she may have viewed me as someone who could influence her 'case' within the 'system':

*"and then I had an extension after that, **which was never discussed with me**. This was again an issue*

***I would like to be corrected**. Because it was discussed that this 6 months will not be counted. I had a*

*meeting with *the head of training. This 6 months will never be counted, so I have to do it again. **But***

***I didn't realise**. There will be an extension of 6 months. **I didn't realise** it would be equivalent of full*

time, so it will be more than 6 months. It sinked in afterwards, I think."

In various points within the narrative, Seema also refers to the use of documentation (in the form of
'educator's notes, made by supervisors within her electronic training portfolio), which is
subsequently used as evidence for training decisions by 'panel'. The 'panel' refers to an annual
review of a trainee's progression within their training, and determines if they are competent to
proceed to the next stage:

"For a new trainee, I didn't know there was an educator note gone on the system until I got called on

for the panel. And then they said "there is an educator's note on your system"

So the educator note said, "She's very unprofessional and she doesn't have, she's never punctual. There is an issue with punctuality and she's very unprofessional and she could do better if she could improve on that". Something like...And they said, "so you have anything to say about this?"

"So they're trying to find out where I had problems in the past, because they are raising issues now. So they contacted him [the educational supervisor] and said put it on the educators note. So he's putting the educator's note in the month of sept about what happened in June/July'

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