Institutional influences on the supervision of GP trainees

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Institutional influences on the supervision of GP trainees: a documentary analysis

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Abstract

Introduction

The supervisory relationship is a key source of support for postgraduate GP trainees in the United Kingdom. This article focuses on the institutional influences on GP supervision through an analysis of training documentation.

Methods

Training documents were identified through a search of key sources of institutional influence: General Medical Council, Royal College of General Practitioners, Health Education West Midlands and a local university's supervisor-training material. Searches were run from September 2016 until February 2019, and 60 documents identified. Content analysis was undertaken, and documents were considered based on audience, context, language and purpose.

Results

Institutional expectations regarding the functions of trainees and supervisors were identified, and supervisory relationships appeared entangled within the broader contexts of the training practice, wider profession and political events. Collation of evidence, quality assurance and patient safety were prominent messages within the documents. The institutional hierarchy was accentuated through these messages, and through processes for trainees to raise concerns. Moving down this hierarchy, messages from within the profession changed in emphasis and content.

Conclusion

With patient safety paramount, and high quality training and supervision expected, the hierarchical system outlined by the documents is perhaps unsurprising. However, unintended messages may result; collation of evidence may be prized above quality and trainees may feel unable to raise legitimate concerns. Furthermore, conflicting messages from different institutions illustrate the

tensions and complexities of GP supervision. For trainees and supervisors, these inconsistencies could lead to different perspectives and expectations as they interact within the supervisory relationship.

Keywords

General Practice

Supervision

Postgraduate

INTRODUCTION

A key aspect of educational support for trainees within General Practice (GP) training in the United Kingdom (UK) is the role of their educational supervisor, or 'trainer'; a qualified GP responsible for the oversight of the educational process[1]. The supervisory relationship has been described the 'single most important factor in the effectiveness of supervision' [2p827]. Rather than existing in isolation, the supervisory relationship is situated within a historical, political and cultural context. Influences such as the training practice, local training region and wider profession suggest that a focus solely on the interpersonal interaction between trainee and trainer may fail to comprehensively provide solutions to support trainees in their educational, clinical and professional development [3].

CONCEPTUAL FRAMEWORK

Proponents of sociocultural learning theory argue that the learner's development is mediated by the wider environment in which they learn [4]. GP training occurs in a complex system where patient care, public accountability and trainee development co-exist. Each element may be valued and perceived differently by various groups, and perhaps (at times) at odds with one another. 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. 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 [5,6]. Each plane can become the focus of analysis at various times, but with an acute awareness of the other planes remaining behind the scenes. Therefore, each plane is not separate or hierarchical, but rather offers a different lens by which to study socio-cultural development as a whole.

In our context, the GP trainee (a postgraduate learner) is the individual ('personal plane'), within the 'interpersonal' relationships of supervision and the training practice. Beyond this sits the 'community'; the sociocultural environment within which supervision occurs and where multiple interconnections exist between both trainee and supervisor [19]. In the UK, such interconnections could include the regional GP vocational training scheme (which coordinates learning opportunities for trainees), professional bodies (such as the General Medical Council) and the wider professional and political context of postgraduate GP training. Supervisory relationships can be conceptualised as entangled in this environment, which influences the way in which they develop [19].

A systematic review of the literature on postgraduate GP supervision highlighted tensions in developing quality supervisory relationships, related to rising clinical workloads, service delivery and documentation burden. These observations suggest a structural influence on supervision, potentially outside the control of the supervisor or trainee, and building a complex picture of supervision, laden with expectations, competing roles, power imbalances and risk of disagreement [3]. A critical lens was applied at various stages of the research to provide greater insight into these complexities [20].

Whilst institutional influences are a facet of the wider 'community plane' in which GP supervision sits, it is important to attend to this area to appreciate the complexities of the development of the GP trainee-trainer relationship. Within a sociocultural perspective, institutional texts can be considered to have the potential to contribute to the discourse on GP supervision, directing and mediating supervision. In his work on identity, Gee refers to this as the notion of "Big 'D' Discourse", in which the 'conversations' amongst different social groups set out the expectations for the 'kinds of people' that we should 'be' [21]. In this research, we examine the messages from institutional

texts to consider the conversations framing GP supervision, and the expectations for trainees and their supervisors in this context [22].

METHODS

The following areas of institutional influence were considered:

1. General Medical Council (GMC): sets standards for postgraduate GP training and supervision. The professional regulator of doctors, responsible for ensuring that GP trainees are fit to hold their medical licence, and that training programmes are of sufficient quality [8,23].
2. Royal College of General Practitioners (RCGP): sets the curriculum and assessment for GP training.
3. A regional education team (Health Education England, West Midlands (HEEWM), also referred to as the 'deanery'): responsible for the delivery and quality assurance of local training and supervision.
4. A linked regional university, responsible for delivering 'Training the Trainers' courses (TtT)

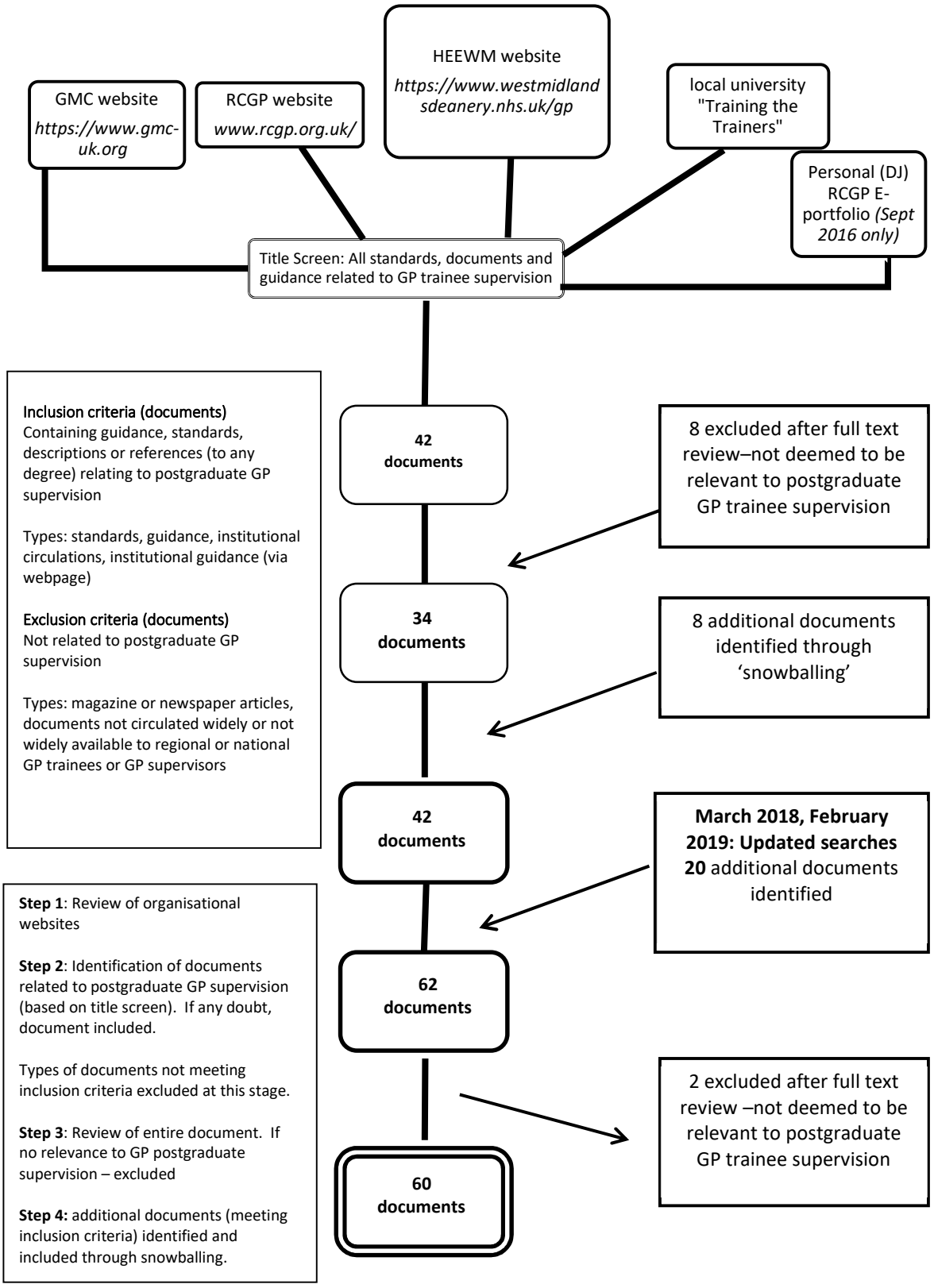
To varying degrees, these organisations are responsible for setting the standards and guidance for postgraduate GP supervision, and for the implementation and monitoring of those standards. They were chosen as they constitute the organisations responsible for the development of a GP trainee to become qualified, and represent sources of information that are likely to influence GP supervision. A relatively narrow focus was taken initially to ensure the exploration of key sources of institutional influence for trainees and their supervisors. However, additional relevant sources that were referenced by these organisations were later included as part of the analysis.

Document search

The search strategy is outlined in **Figure 1 (Document Search Strategy).** In September 2016, each organisation's website was reviewed. Based on title screen, all relevant documents to postgraduate

training and supervision were included. Upon request, a university within the West Midlands region provided an outline of their 'Training the Trainers' course. At the time of the study, the lead author (DJ) was a GP trainee. Her electronic training portfolio was reviewed to identify additional RCGP guidance documents circulated to GP trainees and supervisors on this platform. Further documents were identified from snowballing (i.e. looking at the documents' references), and the search was updated again to identify new documents in March 2018 and February 2019.

Figure 1: Document search strategy



Analysis of the documents:

The documents were analysed in 3 stages, using a form of discourse analysis; considering the explicit messages from the institutional texts, and also the implicit messages that may infer and illuminate the way in which trainees, supervisors and the supervisory relationship are framed [24]. Coding was used at an early stage of analysis to explore patterns and broader messages within the data, and to build a picture of the predominant explicit messages from the institutional texts. Following this, the texts were re-examined in context to consider the intentions and functions of the documents, and the relationships between them 'mapped', to appreciate the 'conversation' between various institutional groups [24-26].

1. Content analysis

Content analysis was applied initially due to the advantage of data reduction, whilst still respecting the quality, detail and context of the qualitative data [25,27,28].

All documents were uploaded to QSR NVivo Version 11. Passages or phrases of text relating to GP supervision were identified and coded [29] . The list was continually added to while reading the documents, and codes were re-visited, refined and grouped into subcategories. These were reviewed in turn for agreements, contradictions and paradoxes and grouped to create overarching categories. The software enabled a 'count' of the frequency of each particular code, giving a sense of the predominant messages.

2. Analysis for meaning: scrutiny

In this separate stage of analysis, each document was considered in context. A pro forma was developed to facilitate reflection on the audience for each document, its purpose, political or external influences, omissions within each document and the style and language used [30,31] **[appendix 1].** This information formed the basis for a mapping exercise, exploring the chronology, audience and purpose of the documents, and the ways these related to one another. The TtT guidance was excluded from this stage, as it was not sufficiently detailed to appreciate the origins or intentions in its design.

3. Analysis for overarching institutional messages

Texts were re-examined in light of the results from content analysis, and in context, to consider broader messages (both explicit and implicit).

Reflexivity

The complex contribution of the researcher to the research process was considered, reflecting on personal elements of reflexivity, the methodological approach and the way in which the discipline of interest (GP supervision) has formed and developed [32]. Field notes and a reflective diary were kept by the lead researcher, who also independently coded and reviewed each document (DJ). At the outset of the research, the lead researcher (DJ) was a GP trainee, and subsequently qualified as a GP, working as a GP partner at the time the research was concluded. This provided benefits of insider research and *a priori* knowledge of GP supervision [33]. However, invitation of an 'outsider' perspective was also invited through team discussion, which informed the overarching messages and relationships between the documents (DJ, ID and JB). Insights from ID and JB (experienced in school-based education and research) offered an important disciplinary breadth of perspective, facilitating additional vantage points and interpretations [34,35].

RESULTS

Figure 2 outlines the 60 documents which were included in the analysis:

Figure 2: Documents identified for analysis

Source of documents	Number of documents	Documents
General Medical Council (GMC)	11	**GMC**, 2010b. Standards for curricula and assessment systems. Manchester: General Medical Council[36]
		GMC, 2011. The Trainee Doctor. London: General Medical Council [37]
		GMC, 2013. Good Medical Practice. London: General Medical Council [38]
		GMC, 2013b. Role of the Trainer; Promoting, supporting and enabling training excellence[39]
		GMC, 2015. Promoting excellence: standards for medical education and training [12]
		GMC, 2016a. Our Role [40]
		GMC, 2016b. Recognition and Approval of Trainers [41]
		NACT UK, 2013. Faculty Guide;The Workplace Learning Environment in Postgraduate Medical Training General Medical Council [42]
		GMC, 2010. Workplace Based Assessment: A guide for Implementation [43]
		GMC, 2017. Excellence by Design: Standards for Postgraduate Curricula [44]
		GMC, 2019**.** How we Quality Assure [16]
AoMRC **(via GMC website)**	1	**ACADEMY OF MEDICAL ROYAL COLLEGES,** 2014. Requirements for Colleges and Faculties in relation to Examiners and Assessors[45]
AoMRC **(via their website)**	3	**ACADEMY OF MEDICAL ROYAL COLLEGES,** 2016. Guidance for Entering Information onto E-Portfolios [46]
		ACADEMY OF MEDICAL ROYAL COLLEGES, 2016. Improving assessment: Further Guidance and Recommendations [47]
		MacLeod, S. 2016**.** RE: Position Statement on Trainees' Written Reflections[48]
COGPED **(Deanery Assessment**	2	**DEANERY ASSESSMENT REFERENCE GROUP (COGPED),** 2016. GP Specialty Trainee (GPST) ePortfolio: Guidance for Satisfactory Progression at ARCP Panels. COGPED [49]

Reference Group)		**DEANERY ASSESSMENT REFERENCE GROUP (COGPED),** 2018. GP Specialty Trainee (GPST) ePortfolio: Guidance for Satisfactory Progression at ARCP Panels. COGPED [50]
RCGP website: trainer information	10	**RCGP & COGPED,** 2014. Standards for GP Speciality Training: guidance for deaneries [1]
		RCGP, 2008. Understanding the RCGP Curriculum :An explanatory note for GP trainers[51]
		RCGP, 2013. Educational Supervisor's Review – A step-by-step guide[52]
		RCGP, 2014b. The e Portfolio for GP Specialty Training A Guide for Trainers/Clinical supervisors plus additional functionality for educational supervisors[53]
		RCGP, 2015a. Annual Specialty Report to the GMC [54]
		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 [55]
		RCGP, 2015d. RCGP WPBA Core Group Statement to Deaneries [17]
		RCGP, Date Unknown. Quality management of GP training [56]
		RCGP, 2014b. Joint RCGP and COGPED Guidance on CSA preparation [57]
		RCGP, 2015b. Eligibility for MRCGP examinations number of attempts permitted and consideration of mitigating circumstances [58]
RCGP website/E-portfolio: trainee information **RCGP website/E-portfolio: trainee information (continued)**	10	**RCGP**, 2016a. The E-Portfolio for GP Speciality Training (Including WPBA Guidance). A Guide for Trainees [59]
		RCGP, 2016b. The RCGP Curriculum: Core Curriculum Statement. Being a GP [10]
		RCGP, 2016c. The RCGP Curriculum: Professional & Clinical Modules. 2.01–3.21 Curriculum Modules [60]
		RCGP, date unknown-a. Educational Agreement and Probity Declaration [61]
		RCGP, date unknown-b. MRCGP Workplace Based Assessment (WPBA) [62]
		RCGP, date unknown-c. Trainee Self-Rating form, Educational Supervisors Review [63]

		RCGP, date unknown – d. WPBA competencies- MRCGP WPBA competency framework [62]
		RCGP, 2017**.** Report on AKT Questionnaire [64]
		Williams, N., 2017. Report on CSA Questionnaire [65]
		RCGP, 2016**.** Exceptional fifth attempts at the MRCGP Applied Knowledge Test (AKT) and Clinical Skills Assessment (CSA)
Health Education England, West Midlands website: **Information for trainers and trainees**	18	**ACADEMY OF MEDICAL EDUCATORS.** 2014. Professional Standards for medical, dental and veterinary educators. *3rd Edition* [14]
		BMA & COGPED , 2012. Guide to a session for GP trainees and trainers [66]
		COMMITTEE OF GENERAL PRACTICE EDUCATION DIRECTORS, 2014. Educator and Environment Approval Form [13]
		COPMED, 2016. A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide). 6th Edition [9]
		COPMED, 2018. A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide). 7th Edition [18]
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, 2015. Educator Appraisal Guidance [67]
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-a. European Working Time Directive: Guide for GP Trainers [68]
Health Education England, West Midlands website: **Information for trainers and trainees (continued)**		**HEALTH EDUCATION ENGLAND WEST MIDLANDS**, date unknown-b. The Working Week for GP Registrars in General Practice [69]
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-c. The Working Week for GP Registrars in General Practice (updated) [70]
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-d. The Role of the GP Trainer [71]
		HEALTH EDUCATION ENGLAND WEST MIDLANDS, date unknown-e. Escalating Concerns [72]
		HIBBLE, A, 2009. Being a Reflective GP. Health Education East of England [73]

		PALMER, D, 2012. Guide for Educational Supervisors - Evolution of the E-Portfolio and the GP Speciality Trainee [74]
		PALMER, D, 2014. Friendly Guide to the E-Portfolio and MRCGP [11]
		PALMER, D, 2018. Friendly Guide to the E-Portfolio and MRCGP [75]
		PALMER, D, 2017. ARCP Checklist for GP Trainees [76]
		GOODYEAR, H, 2017. Top Ten Examination Tips [77]
		GOODYEAR, H, 2017**.** Guidance on Examination Support for GP Trainees [78]
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 [79]
		GIBSON, C, LOVATT, T, 2015b. Intended Learning Outcomes – Day 2 TtT [80]
		GIBSON, C, LOVATT, T, 2015c. Intended Learning Outcomes – TtT update course [81]
		GIBSON, C, LOVATT, T, 2015d. Keele University School of Medicine. Teach the Teachers course – Mapping Exercise [82]
		GIBSON, C, LOVATT, T, 2015e. Lesson Plan: Training the Trainers [83]

Content analysis

From the 60 included documents, 224 codes were identified on initial analysis, and were subsequently reviewed, modified and grouped into subcategories. The following 4 main overarching categories emerged from within the content analysis:

1. Functions of the supervisor
2. Functions and expected attributes of the trainee
3. The local training environment (training practice)
4. Structural Hierarchy

These categories are presented (with the associated subcategories and illustrative quotes) within **Figure 3 (Content analysis and subcategories).** Each section of the table has been constructed based on the relative frequencies of occurrence of each sub-category (within and between sources). The final results section, 'moving goalposts', relates to implicit and dynamic messages from the documentation.

Figure 3: Content Analysis and subcategories

Subcategory	Illustrative quote from text	Aggregate number of codes	Aggregate number of sources
	FUNCTIONS AND EXPECTED ATTRIBUTES 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" [7]*	*67*	*14*
Trainees are regulated (GMC regulates trainees to ensure they are up to date, and permitted to continue to hold their medical licence) [8]	*"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" [9]*	*19*	*10*
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" [10]*	*49*	*9*
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)" [9]*	*13*	*7*
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" [11]*	*19*	*6*
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" [10]*	*15*	*3*
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" [10]*	*13*	*2*
	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" [12]*	*133*	*21*
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" [1]*	*55*	*17*
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" [9]*	*52*	*15*

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" [13]*	*18*	*9*
Protector	*"Standard: Ensures that trainees receive the necessary instruction and protection in situations that might expose them to risk" [13]*	*26*	*8*
Role Model	*"Standard: A supervisor provides a positive role model, through demonstration of exemplary clinical skills, professional behaviours and relationships" [13]*	*12*	*5*
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" [9]*	*6*	*3*
Broker with community of practice	*"Standard: Trainees must have the opportunity to learn with, and from, other healthcare professionals. (standard 6.17) [13]*	*2*	*2*
THE LOCAL TRAINING ENVIRONMENT (TRAINING 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 judgements about the trainee's abilities, performance and progress" [1]*	*80*	*12*
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" [10]*	*13*	*2*
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" [13]*	*9*	*2*
STRUCTURAL HIERARCHY			
Quality Assurance of trainees (Regulation)	*"It may be necessary for the TPD [training programme director] 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" [9]*	11	21
Quality assurance of supervisors	*"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" [9]*	5	6

Patient safety paramount	*"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" [9]*	11	26
Evidence	*"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"[11]* *"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" [14-16]* *"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" [17]*	14	49
Supervisor raising concerns (about trainee)	*"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…* *…Trainees also need to be aware that any such discussions should be reported as part of the required self-declaration for revalidation"* [18]	6	12
Trainee raising concerns (about supervisor)	*"Whistle blowing is the popular term applied to reporting such concerns about malpractice, wrongdoing or fraud. Such concerns should usually be raised by the trainee to their employer or an appropriate regulator. However, HEE, NES, the Wales Deanery and NIMDTA recognise that a trainee may feel it is not appropriate for them to raise a concern with their employer, or may be concerned that they will suffer detriment from their employer or others as a result of raising such concerns. In these circumstances, HEE, NES, the Wales Deanery or NIMDTA will offer appropriate guidance and signposting to support any trainee wishing to raise concerns" [18]*	5	7

Functions of the supervisor, trainee and training practice

Akin to Rogoff's three interdependent planes of development, there was significant overlap within the documents between the expected functions of trainee (personal plane), and the supervisor and training practice (interpersonal plane). The documents were clear about the importance of the supervisory relationship, describing it as a 'key relationship' in postgraduate training in General Practice [7]. 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 cited, and the potential for tension between these roles is discussed later within this results section.

Trainee functions included the expectation 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.

Training practice functions: It was expected that the training practice would facilitate trainee participation within the community of practice, through the interpersonal relationships with the wider team. This included timetabling an induction programme and the trainee's working week; balancing the intensity of work to provide sufficient 'educational value' for the trainee and sufficient exposure to the multidisciplinary team, whilst adhering to the European Working Time Directive (EWTD) [13,66]. 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 [7].

Hierarchy

Hierarchy and gathering evidence

Much of the evidence on trainee performance was expected to be collated within their electronic learning portfolio. This included evidence of formal supervision reviews, assessments and records of significant and adverse events involving the trainee [9,18,46]. This written evidence was then available for use by regional training bodies (for educational support), the RCGP (towards the trainee's accreditation as a Member of the RCGP) and the GMC (for trainee regulation). The drive for evidence also extended to regulate the quality of education provided by their supervisor, and was collected by the GMC in the form of data from trainees in their annual National Trainee Survey [15]. Further evidence on both the supervisor's and training practice's eligibility to provide training was collated at deanery level [13,67].

Hierarchical relationships within postgraduate GP supervision were evident through the processes for trainees to raise concerns, and also through emphases on quality assurance, patient safety and accumulating evidence. These are outlined in **Figure 3: Content Analysis and Subcategories.**

Hierarchy and patient safety

A number of documents emphasised patient safety as paramount (26 codes across 11 sources), mandating that supervisors and local education teams share information and concerns about poorly performing trainees. Trainees themselves were expected to report any concerns that had been raised about their performance through an annual self-declaration as part of GMC regulation.

Hierarchy and raising concerns

For a trainee experiencing concerns about the quality of supervision, the guidance was fragmented. A review of 4 separate documents was required to put together a pathway by which to raise concerns about a supervisor [9,12,69,72]. Reporting a concern appeared to require formal escalation to the head of the regional training body, or to a generic email address (without clarity on who would read the email or the timescales for responding). There did not appear to be a more local, accessible step available to the trainee. This was in contrast to more local routes of support

for a supervisor with concerns about a trainee; such as referral to training support groups or the local training programme director [9].

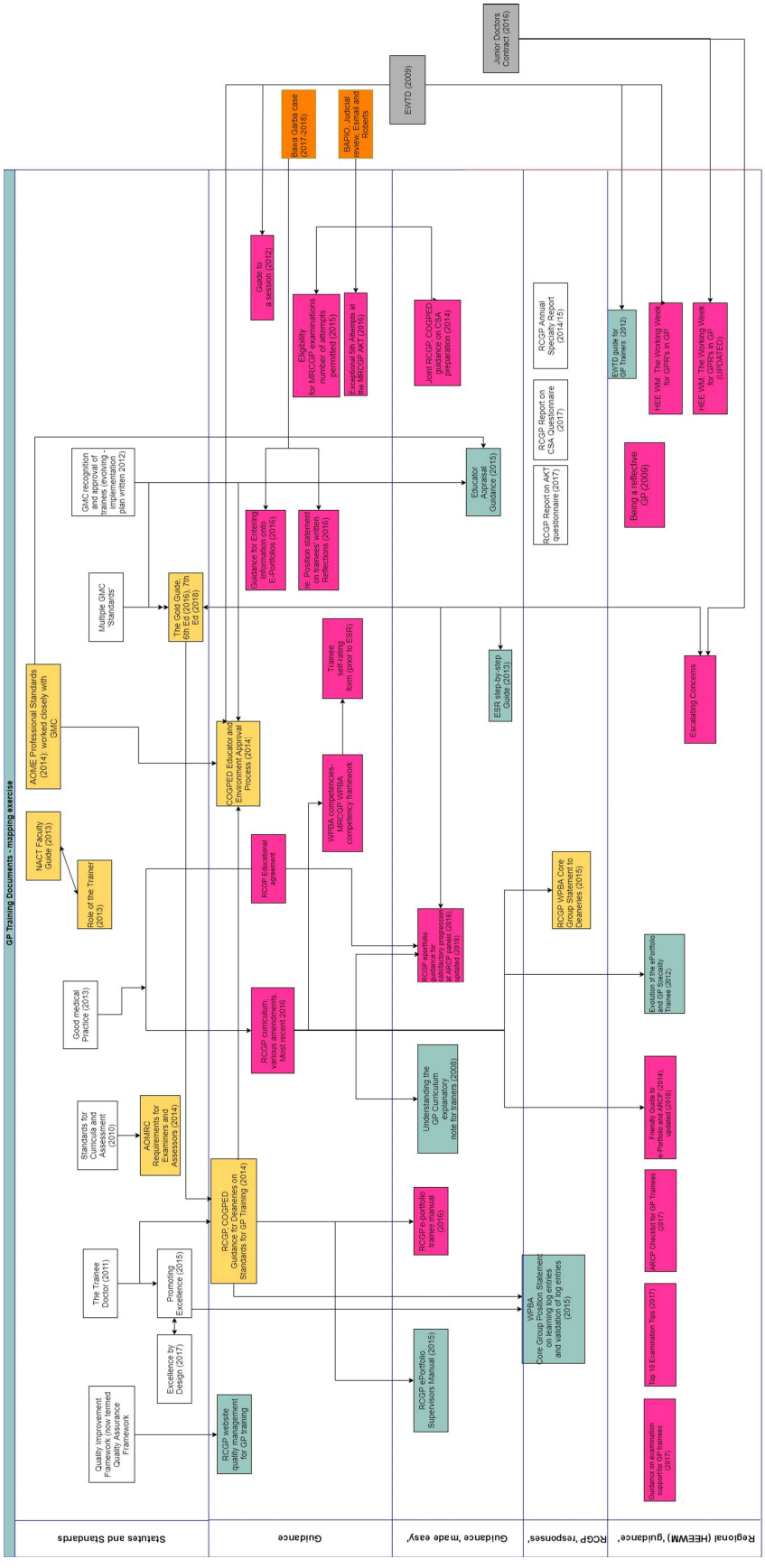
Hierarchy and quality assurance

Quality assurance was a prominent message within the organisational hierarchy. Quality assurance represents a dedicated section with the GMC website; relating to both patient safety and training quality [16]. Processes were embedded to monitor the quality of both supervisors (as educators) and trainees.

Hierarchical pathways and the relationships between documents

Figure 4: Mapping of Documents illustrates the way the documents were mapped to one another, flowing from the General Medical Council (GMC) to the Royal College of General Practitioners (RCGP), then the regional training body (HEEWM) and finally the practice. It considers the authors, audience, key messages of each document, timing of release and political events. These have been summarised (in the left column) as 'statutes and standards', 'guidance', guidance made easy', 'RCGP responses' and 'regional guidance' (referring to HEEWM guidance).

Figure 4: 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

Figure 4 highlights the way in which the institutional messages (or 'conversation') on supervision flowed and developed between each of the various institutional groups. For example, standards for postgraduate training (denoted by white boxes) informed RCGP guidance on curriculum and assessment design. In general, standards from the GMC were written in a formal style, outlining mandatory expectations for training. However, there were examples where organisations further down the hierarchy attempted to 'translate' the formal language of these standards into more user-friendly and accessible documents. In one such instance, the GMC's 'Good Medical Practice' informed the design of the RCGP's curriculum. HEEWM later produced a 'friendly guide' (favouring the word 'should', as opposed to 'must') for trainees with information on how to document curriculum coverage, and an additional document for supervisors on the 'evolution of the ePortfolio and GP Speciality Trainee' [11,75] .

The mapping exercise and scrutiny of the documents highlighted differences in the institutional messages within the training hierarchy, which ranged from subtle shifts of emphasis between various organisations, to more overt differences in guidance.

Moving goalposts and mixed messages

The change in language between the documents has been discussed above. Observations were also made where two different institutional groups published differing opinions. At times, this appeared to relate to guidance that was deliberately open to interpretation. However, additional examples were noted where one institutional group appeared to have a difference of opinion to another.

1. Guidance open to interpretation

There were instances where organisational standards and statutes (written by the GMC or RCGP) appeared to be deliberately open to interpretation by trainee and trainer, but were later 'translated' by local training regions to be overtly more prescriptive. Learning logs (and maintaining a regular learning log) contribute to the evidence available to supervisors when completing reviews on their

trainee's capability progression [84]. When outlining the number of learning entries required, the RCGP guidance stated that:

*'There is **no minimum number of learning log entries** required for completion of training'.* [59]

However, in a later 'translation' of this document by local training region HEEWM, explicit standards were introduced, removing this option of interpretation:

*"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**"*

[11]

2. Differing opinions

When considering revalidation and accreditation, it appeared that different organisations had differing opinions regarding the consequences of failing to comply with completion of various documents (over and above those within the E-Portfolio) for the GMC purpose of revalidation:

The following statement is taken from the 'Gold Guide' (published by Health Education England):

*'**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'***

[9]

However, messages from RCGP guidance were 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'* [17]

Moving goalposts and inherent tensions

Inherent tensions were frequently acknowledged within postgraduate GP training, such as the tension between avoiding a 'clocking off' approach to workload, whilst also avoiding becoming overworked:

"A typical day is hard to define. ***To be too precise about the working week and 'clocking-off' at 5pm calls into question the suitability of a trainee for General Practice. Overworking is also considered poor practice****… [70].*

Supervisors were expected to facilitate their trainee's growing autonomy in service delivery and patient care.

"Trainees are employed to provide a clinical service and they learn from making decisions and taking responsibility – this is an essential part of postgraduate training. Trainees do not learn when they are "supernumerary". All members of faculty have a responsibility ***to allow and encourage trainees to take an active part in service provision whilst ensuring patient safety*** *at all times" [42]*

However, they also had a duty to the profession and to patient safety if quality of care was threatened by the trainee working autonomously.

"Account should be taken of all relevant factors that might affect performance (e.g. health or domestic circumstances) and ***these should be recorded in writing****…*

*…****If concerns are considered serious at the outset, persist or increase, further action should be taken…"*** *[18]*

Furthermore, the supervisor's roles as judge, gatekeeper and assessor appeared to be in tension with the need to provide educational and pastoral support. As outlined in the quote above, the supervisor was expected to record concerns about the trainee in writing, and to escalate concerns

where appropriate. However, despite the risk that their personal health or domestic concerns could be recorded, trainees were encouraged to open up to supervisors about their struggles and difficulties.

*"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"*

[1]

Moving goalposts and responding to political events

A number of documents were released in response to, and in line with, political events or policy. For example, the 2016 Junior Doctors Contract prompted the update of documents pertaining to the working week for GP trainees, allocating a dedicated proportion of time for supervision meetings (and related activities) within the weekly timetable [70]:

"Most GP-trainees within the WM region will be subject to the provisions of the JDC 2016 from August 2017…

…Your 40-hour working week will divided up as follows:

…30% educational hours, with two structured educational periods: which may include (but not restricted to) …educational supervisor meetings, activities relating to workplace based assessment, e-portfolio entries and other engagement with the Annual Review of Competence Progression process" [70]

Changes such as this indicate the need for the profession to respond dynamically and flexibly to government policy, and highlights influences beyond medical institutions on the conditions expected to facilitate the delivery of supervision and training.

Discussion

As outlined in **Figure 3: Content analysis and subcategories**, the results outline a series of explicit expectations for the GP trainee and supervisor within postgraduate GP training. They begin to frame a discussion on the expected professional identity for trainees and their supervisors; the 'kind of people' they're expected to be. Put differently, the institutional texts appear to recognise certain characteristics and behaviours as 'right' for the 'good' GP trainee or the 'good' supervisor [21,24].

These have been presented as a short narrative summary of findings in **Figure 5** (**Short Summary of Explicit Institutional Expectations).** The words in bold relate to the particular subcategories (pertaining to the functions of the trainee and the GP supervisor) that emerged within the analysis.

Figure 5: Short Summary of Explicit Institutional Expectations

A GP trainee learns within the training practice, **engages** with **workplace-based** learning, and **participates legitimately** within the **community of practice**. They are considered to be an **adult learner**, and regular **reflection** on their performance is expected, with sufficient **insight** into their areas of weakness for educational development. GMC **Regulation** of trainees is a key element of the **quality assurance** process, mainly conducted through review of **documentary evidence** contained within their electronic portfolio). The quality assurance process also extends to **supervision**, with contracts in place to direct safe working hours and conditions for trainees.

A GP supervisor has a role in both **assessment** and **educational support** of the GP trainee. With patient safety paramount, they are a **gatekeeper** for patients and the profession, whilst also providing **protection** to the trainees in situations that might expose them to risk, and **personal and pastoral support**. Supervisors are expected to be **role models**. They hold **roles outside the supervisory relationship**, including within the multidisciplinary team at the training practice, enabling them to support the trainee by acting as a **broker with the community of practice.**

There was significant overlap within the documents between the expected personal responsibilities of the trainee and supervisor, and their interpersonal relationships between another and with members of the training practice team. This overlap reflects the interdependence of Rogoff's 3 planes of development, and highlights the importance of attending to each plane of influence when considering development [5].

With a critical lens, it is also important to consider the context in which institutional texts are produced, their purposes and their consequences [85]. The results also suggest a series of implicit messages for those involved in GP supervision, some of which may be unintended, and which may lead to confusion, ambiguity or challenges for supervisory relationships.

It can be argued that the 'good' trainee must meet sufficient quality standards to practise autonomously, and be held to account to meet these standards. Similarly, the supervisor and local training region responsible for providing this education should perform their roles to sufficient quality, and also be held to account. In this regard, the hierarchical structures related to the delivery and monitoring of training and supervision are unsurprising.

However, there are potential unintended consequences of this hierarchical structure to the supervisory relationship. Quality assurance, patient safety and collation of evidence are prominent messages within the documents. This is particularly important when considering the role of the supervisor, who must provide educational support, but must also be a gatekeeper and assessor. For a trainee, there may be questions about the supervisor's commitment to their educational and pastoral roles, when (as an agent of the 'institution') they have roles in gatekeeping and assessment. Such ambiguity may impact the trust and openness at this 'interpersonal' relationship level, and this concern has been raised elsewhere within the literature [3,86-88].

The formality and complexity of the routes for trainees to raise concerns about their supervisors is noteworthy. On the one hand, escalation of concerns to the head of the regional training body (or to a single email address) creates a simple pathway for trainees, suggestive of ease and accessibility. However, with this relative logistical 'ease' comes a pathway where formal escalation is the only

option, potentially reducing trainee agency within the supervisory relationship. Within the regional documents, trainees who raised concerns risked being labelled 'defensive' or being questioned about their suitability for work in General Practice [69,73]. A trainee with legitimate concerns may therefore keep quiet.

A further observation relates to the differing messages, emphases and language from the various institutional levels. Our observations of hierarchy suggest that those organisations at the 'top' should dominate the practice of trainees and their supervisors. However, further study is required to determine if this is the lived experience. It is unclear which messages (and under which circumstances) are more fully embraced within training and supervision.

Collation of evidence to support the quality assurance of supervision can be considered as beneficial to training, and ultimately to patient care. However, other than the TtT documents, the reviewed documents rarely mentioned methods to enhance the quality of supervisory interactions. For example, 'surrogate' markers, such as evidence of written reports from formal meetings, were used to determine evidence of supervision quality [17,82]. A potential unintended message is that the recording of a supervisory activity (such as documenting that a supervision meeting has 'happened') is emphasized by trainees and supervisors, rather than a consideration of the quality of interpersonal supervisory interactions. With this in mind, those involved in GP supervision may focus on particular 'recordable' or 'formal' aspects of supervision.

The inherent tensions of the messages within the training documents highlight the complexities that require negotiation within postgraduate GP supervision. Supervisor roles as judge, gatekeeper and assessor appeared to be in tension with the need to provide educational and pastoral support. This tension of 'looking after' the trainee, or 'looking over their shoulder', is discussed within the literature on postgraduate GP supervision, and suggests interpersonal complexities that must be navigated by supervisors with their trainees within the relationship [89]. Particularly striking within the results were the sections of institutional texts that were deliberately open to interpretation, or

sections that led to contrasting opinions between organisations. For trainees and supervisors tasked with implementation of guidance, these inconsistencies could lead to very different perspectives and expectations for supervision, and future difficulties in negotiation and navigation if these expectations are not shared or understood. In our review of the literature on postgraduate GP supervision, we discussed the importance for these expectations to be shared in quality supervisory relationships, providing clarity for trainees and their supervisors on their perspectives of the roles, goals and tasks in supervision [3].

At the outset of this research, we discussed the importance of considering supervision in 3 planes, and their interdependence, which is suggested within our results. The analysis brings the influence of institutional messages into focus, and highlights the importance of both the explicit and implicit messages that may direct and mediate supervisory relationships. However, further research is needed to explore the lived experiences of postgraduate GP supervision, foregrounding the personal and interpersonal planes.

Limitations

Secondary data is produced with a specific purpose in mind, which may run contrary to the research interests of this study [90,91]. The use of content analysis in isolation could further compound these limitations due to the risk that important contextual information could be overlooked, particular issues overstated (or understated), or complexities oversimplified during data reduction [25,92]. However, this analytic approach offered the benefit of reducing large amounts of textual data to outline the predominant institutional messages, and to explore these messages in detail [11]. A form of discourse analysis in the latter steps of analysis enabled a consideration of the purpose and context of the release of the institutional texts, in an attempt to minimise these sources of bias [90].

It is likely that the list of documents within this analysis is not exhaustive. Furthermore, multiple sources of interpretation exist within this review of secondary data, and inference was key to the analytic approach. Unwitting evidence may have been inferred, yet not intended by the authors [93]. However, it is important to consider the possible inferences that can be made when looking across institutional texts, as these may well be shared by those reading the documents, even if not intended by those who authored them. The documents included represent UK national standards for GP training, frequently authored by knowledgeable and experienced teams, however further research is needed to explore whether the findings in this study relate to the lived experiences of supervision.

Conclusion

Supervisory relationships occur in a complex socio-cultural environment, and where structural influences from the wider profession have the potential to direct and mediate their development [5]. Our results illuminate the institutional messages that shape the context for GP supervision, and which suggest several institutional expectations for the 'good' trainee and supervisor, which must be navigated as these relationships develop [94]. However, to fully appreciate the Discourse around GP supervision, we must also acknowledge the implicit messages that permeate, and the interplay between them. Hierarchical arrangements within the profession may create an environment that hinders trainee agency, particularly in instances where they may have legitimate concerns about their training or supervision. Despite being a profession committed to excellence, implicit messages within its documentation may suggest that collation of evidence is valued above its quality. These are important areas of caution for those involved in writing professional standards and guidance at all levels.

Alongside the inherent tensions that must be navigated in the supervisor role, goalposts appear to move between institutions, with regional requirements being more stringent than the national regulations on which they were based. These mixed messages risk mismatched expectations and

differing perspectives regarding supervision. Greater clarity on these requirements may help trainees and their supervisors navigate potentially conflicting expectations of supervision.

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REFERENCES

1. RCGP, COGPED. Standards for GP Speciality Training: guidance for deaneries.
2. Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: a literature review. Medical Education. 2000;34(10):827-840.
3. Jackson D, Davison I, Adams R, et al. A systematic review of supervisory relationships in general practitioner training. Medical Education. 2019;53:874-885.
4. Vygotsky LS. Mind in society: The development of higher psychological processes. Cambridge, MA: Harvard University Press; 1978. (Book, Whole).
5. Rogoff B. Observing sociocultural activity on three planes: participatory appropriation, guided participation and apprenticeship. In: Wertsch J, del Rio P, Alvarez A, editors. Sociocultural Studies of Mind. New York: Cambridge University Press; 1995. p. 139-164.
6. Ajjawi R, Bearman M. Sociomateriality matters to family practitioners as supervisors [Article]. Medical Education. 2012;46:1145-1147.
7. RCGP. The RCGP Curriculum: Core Curriculum Statement 1.00: Being a General Practitioner 2016. Available from: http://www.rcgp.org.uk/training-exams/gp-curriculum-overview/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-1-Being-a-GP.ashx
8. General Medical Council. What is revalidation? United Kingdom: General Medical Council; 2020 [cited 2021 4th January]. Available from: https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/introduction-to-revalidation
9. COPMeD. A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide). 6th Edition. United Kingdom: Health Education England.
10. Royal College of General Practitioners. The RCGP Curriculum: Core Curriculum Statement. Being a GP. United Kingdom: Royal College of General Practitioners; 2016.
11. Palmer D. Friendly Guide to the E-Portfolio and MRCGP. United Kingdom: Health Education England, West Midlands; 2014.
12. General Medical Council. Promoting excellence: standards for medical education and training. United Kingdom: General Medical Council; 2015.
13. Committee of General Practice Education Directors. Educator and Environment Approval Form. 2014.
14. Academy Of Medical Educators. Professional Standards for medical, dental and veterinary educators. 3rd Edition. Cardiff: Academy of Medical Educators; 2014.
15. General Medical Council. Recognition and approval of trainers UK: General Medical Council; 2019 [cited 2019 16th September]. Available from: https://www.gmc-uk.org/education/how-we-quality-assure/local-education-providers/recognition-and-approval-of-trainers
16. General Medical Council. How we quality assure UK: GMC; 2019 [cited 2019 5th Feb]. Available from: https://www.gmc-uk.org/education/how-we-quality-assure
17. Royal College of General Practitioners. RCGP WPBA Core Group Statement to Deaneries. United Kingdom: Royal College of General Practitioners.
18. COPMeD. A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide). 7th Edition. United Kingdom: Health Education England.
19. Ajjawi R, Bearman M. Sociomateriality matters to family practitioners as supervisors. United Kingdom2012. p. 1145-1147.
20. Illing J. Thinking about research: frameworks, ethics and scholarship. Edinburgh: Association for the Study of Medical Education; 2007.
21. Gee JP. Discourse, Small d, Big D. In: Sandel T.T., Ilie C, editors. The International Encyclopedia of Language and Social Interaction. New Jersey: Wiley; 2015. p. 1-5.
22. Lemke JL. Articulating communities: Sociocultural perspectives on science education. Journal of Research in Science Teaching. 2001;38(3):296-316.

23. General Medical Council. Recognition and approval of GP trainers United Kingdom: General Medical Council; 2016 [cited 2016 1st November]; Outlines purpose of approval of GP trainers, and hw to access the list of approved GP trainers. only around 10.7% of GP's are trainers.]. Available from: http://www.gmc-uk.org/education/approval_trainers.asp
24. Gee JP. Chapter 3: Tools of inquiry and discourses. In: Gee JP, editor. An Introduction to Discourse Analysis: Theory and Method. Oxon: Routledge; 1999. p. 27-42.
25. Cohen L, Manion L, Morrison K. Research Methods in Education. 6th ed. London: Routledge; 2007.
26. Parker I. Discourse dynamics: Critical analysis for social and individual psychology. London: Routledge; 1992.
27. Thomas G. How to do your research project: A guide for students in education and applied social sciences. London: Sage Publications; 2009.
28. Krippendorp K. Content Analysis: An Introduction to its Methodology. Thousand Oaks, CA: Sage; 2004.
29. Miles M, Huberman A. Qualitative Data Analysis. London: Sage; 1994.
30. Bowen GA. Document Analysis as a Qualitative Research Method. Qualitative Research Journal. 2009;9(2):27-40.
31. Hammersley M, Atkinson P. Ethnography: Principles in Practice. London: Routledge; 1983.
32. Wilkinson S. The role of reflexivity in feminist psychology. Women's Studies International Forum. 1988 1988/01/01/;11(5):493-502.
33. Greene MJ. On the Inside Looking In: Methodological Insights and Challenges in Conducting Qualitative Insider Research. The Qualitative Report. 2014;19.
34. Adler PA, Adler P. Membership roles in field research. Beverley Hills, CA: Sage; 1987.
35. Maykut P, Morehouse R. Beginning qualitative researchers: A philosophical and practical guide. DC: Falmer; 1994.
36. General Medical Council. Standards for curricula and assessment systems. Manchester: General Medical Council; 2010.
37. General Medical Council. The Trainee Doctor. London: General Medical Council; 2011.
38. General Medical Council. Good Medical Practice. London: General Medical Council; 2013.
39. General Medical Council. Role of the Trainer; Promoting, supporting and enabling training excellence United Kingdom2013 [cited 2016 21st September]. Available from: http://www.gmc-uk.org/Role_of_the_trainer.pdf_53816777.pdf.
40. General Medical Council. Our Role United Kingdom2016 [cited 2016 21st September]. Available from: http://www.gmc-uk.org/about/role.asp
41. General Medical Council. Recognition and Approval of Trainers United Kingdom2016 [cited 2016 15th March]. Available from: http://www.gmc-uk.org/education/10264.asp
42. NACT UK. Faculty Guide;The Workplace Learning Environment in Postgraduate Medical Training: General Medical Council; 2013 [cited 2016 21st September]. Available from: http://www.gmc-uk.org/Faculty_Guide_Oct13.pdf_53817349.pdf.
43. General Medical Council. Workplace Based Assessment: a guide for implementation. United Kingdom: General Medical Council; 2010.
44. General Medical Council. Excellence By Design: Standards for postgraduate curricula. United Kingdom: General Medical Council; 2017.
45. Academy of Medical Royal Colleges. Requirements for Colleges and Faculties in relation to Examiners and Assessors.
46. Academy of Medical Royal Colleges. Guidance for Entering Information onto E-Portfolios.
47. Academy of Medical Royal Colleges. Improving assessment: Further Guidance and Recommendations.
48. MacLeod S. RE: Position Statement on Trainees' Written Reflections. United Kingdom: Health Education England; 2016.

49. Deanery Assessment Reference Group (COGPED). GP Specialty Trainee (GPST) ePortfolio: Guidance for Satisfactory Progression at ARCP Panels. United Kingdom: COGPED; 2016. p. 1-23.
50. Deanery Assessment Reference Group (COGPED). GP Specialty Trainee (GPST) ePortfolio: Guidance for Satisfactory Progression at ARCP Panels. United Kingdom: COGPED; 2018. p. 1-23.
51. Royal College of General Practitioners. Understanding the RCGP Curriculum :An explanatory note for GP trainers. United Kingdom: Royal College of General Practitioners; 2008. p. 1-2.
52. Royal College of General Practitioners. Educational Supervisor's Review – A step-by-step guide United Kingdom: RCGP; 2013 [cited 2016 22nd November]. Available from: ESR-step-by-step-Guide-November-2013-v4_2
53. Royal College of General Practitioners. The e Portfolio for GP Specialty Training A Guide for Trainers/Clinical supervisors plus additional functionality for educational supervisors. London: Royal College of General Practitioners; 2014.
54. Royal College of General Practitioners. Annual Specialty Report to the GMC. United Kingdom: Royal College of General Practitioners; 2015. p. 1-42.
55. Royal College of General Practitioners. 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. United Kingdom: Royal College of General Practitioners; 2015.
56. Royal College of General Practitioners. Quality management of GP training United Kingdom: Royal College of General Practitioners; Unknown [cited 2016 21st September]. Available from: http://www.rcgp.org.uk/training-exams/quality-management-of-gp-training.aspx
57. Royal College of General Practitioners. Joint RCGP and COGPED Guidance on CSA preparation. United Kingdom: COGPED; 2014.
58. Royal College of General Practitioners. Eligibility for MRCGP examinations number of attempts permitted and consideration of mitigating circumstances. United Kingdom: Royal College of General Practitioners.
59. Royal College of General Practitioners. The E-Portfolio for GP Speciality Training (Including WPBA Guidance). United Kingdom: Royal College of General Practitioners.
60. Royal College of General Practitioners. The RCGP Curriculum: Professional & Clinical Modules 2.01–3.21 Curriculum Modules United Kingdom: Royal College of General Practitioners; 2016.
61. Royal College of General Practitioners. Educational Agreement and Probity Declaration. United Kingdom: Royal College of General Practitioners; date unknown.
62. Royal College of General Practitioners. MRCGP Workplace Based Assessment (WPBA) United Kingdom: Royal College of General Practitioners; date unknown [cited 2016 21st September]. Available from: http://www.rcgp.org.uk/training-exams/mrcgp-workplace-based-assessment-wpba.aspx
63. Royal College of General Practitioners. Trainee Self-Rating form, Educational Supervisors Review. United Kingdom: Royal College of General Practitioners; date unknown.
64. Royal College of General Practitioners. Report on AKT Questionnaire. United Kingdom: Royal College of General Practitioners; 2017.
65. Williams N. Report on CSA Questionnaire. United Kingdom: Royal College of General Practitioners; 2017.
66. BMA, COGPED. Guide to a session for GP trainees and trainers.
67. Health Education England West Midlands. Educator Appraisal Guidance. United Kingdom: Health Education England West Midlands; 2015.
68. Health Education England West Midlands. European Working Time Directive: Guide for GP Trainers. United Kingdom: Health Education England, West Midlands; date unknown.

69. Health Education England West Midlands. The Working Week for GP Registrars in General Practice United Kingdom: Health Education England West Midlands; date unknown [cited 2016 21st September]. Available from: https://www.westmidlandsdeanery.nhs.uk/GP/Trainees/Working-Week
70. Health Education England West Midlands. The Working Week for GP Registrars in General Practice United Kingdom: Health Education England West Midlands; date unknown [cited 2019 5th February]; [updated version]:[Available from: https://www.westmidlandsdeanery.nhs.uk/gp/trainees/working-week
71. Health Education England West Midlands. Role of the GP Trainer Uniter Kingdom: Health Education England West Midlands; date unknown [cited 2016 16 September]. Available from: https://www.westmidlandsdeanery.nhs.uk/gp/trainers/role-of-the-gp-trainer
72. Health Education England West Midlands. Escalating Concerns United Kingdom: Health Education England West Midlands; date unknown [cited 2019 5th February]. Available from: https://www.westmidlandsdeanery.nhs.uk/support/escalating-concernspathway-for-learners
73. Hibble A. Being a Reflective GP Health Education East of England2009 [cited 2016 21st September]. Available from: https://www.gp-training.net/training/gpstr/being_a_reflective_gp_(2009)_.pdf
74. Palmer D. Guide for Educational Supervisors - Evolution of the e-Portfolio and the GP Speciality Trainee. United Kingdom: Health Education England, West Midlands; 2012.
75. Palmer D. Friendly Guide to the E-Portfolio and MRCGP. United Kingdom: Health Education England, West Midlands; 2018.
76. Palmer D. ARCP checklist for GP trainees. United Kingdom: Health Education England West Midlands; 2017.
77. Goodyear H. Top Ten Examination Tips. United Kingdom: Health Education England West Midlands; 2017.
78. Goodyear H. Guidance on Examination Support for GP Trainees. United Kingdom: Health Education England West Midlands; 2017.
79. Gibson C, Lovatt T. Intended Learning Outcomes – Day 1 TtT. United Kingdom: Keele University School of Medicine; 2015.
80. Gibson C, Lovatt T. Intended Learning Outcomes – Day 2 TtT. United Kingdom: Keele University School of Medicine; 2015.
81. Gibson C, Lovatt T. Intended Learning Outcomes – TtT update course. United Kingdom: Keele University School of Medicine; 2015.
82. Gibson C, Lovatt T. Keele University School of Medicine. Teach the Teachers course – Mapping Exercise. United Kingdom: Keele University School of Medicine; 2015.
83. Gibson C, Lovatt T. Lesson Plan: Training the Trainers. United Kingdom: Keele University School of Medicine; 2015.
84. Practitioners RCoG. Learning Log - old WPBA programme: RCGP; 2020 [cited 2021 4th January]. Available from: https://www.rcgp.org.uk/training-exams/training/mrcgp-workplace-based-assessment-wpba/learning-log.aspx
85. Habermas J. Toward a theory of human competence. Inquiry. 1970 (13):360-375.
86. Sagasser M, Kramer A, Weel C, et al. GP supervisors' experience in supporting self-regulated learning: a balancing act [Article]. Advances in Health Sciences Education. 2015;20(3):727-744.
87. Sagasser MH, Kramer AWM, Fluit C, et al. Self-entrustment: how trainees' self-regulated learning supports participation in the workplace. Advances in Health Sciences Education. 2017 Oct;22(4):931-949.
88. Sagasser MH, Kramer AWM, van der Vleuten CPM. How do postgraduate GP trainees regulate their learning and what helps and hinders them? A qualitative study. BMC medical education. 2012;12:67.

89. Launer J. Supervision, Mentoring and Coaching. In: Swanwick T, editor. Understanding Medical Education: Evidence, Theory and Practice. Chichester, United Kingdom: Wiley-Blackwell; 2010. p. 111-123.
90. Stewart DW, Kamins MA. Secondary research: Information, sources and methods. 2nd edition. Vol. 4. London: SAGE; 1993. (Applied Social Research Methods Series).
91. Reichmann WJ. Use and abuse of statistics. New York: Oxford University Press; 1962.
92. Weber RP. Basic content analysis. 2nd ed. Thousand Oaks, CA: Sage; 1990.
93. Robson C. Real world research. Oxford: Blackwell; 1993.
94. Giddens A. Modernity and self-identity. Cambridge, England: Polity Press; 1991.

Appendix 1: PRO FORMA FOR DOCUMENTS

1. Name of document:
2. Date of release:
3. Author:
4. Interests of the author:

Circulation and audience information (please freetext response, and add comments if necessary)		
Formal?	Informal?	
Public?	Private?	
Local?	National?	
One? (author)	Many? (author)	
Anonymous?	Attributable?	
Opinions/beliefs?	Factual?	
Lay?	Professional?	
For circulation	Not for circulation?	

5. Original intention of document (where possible, based on the document contents. If researcher impression, please indicate):

6. Audience (original) for the document:

7. What is taken for granted about the audience? (pre-knowledge they need to have)

8. Additional influences at the time (context):

9. What documents does it build upon?

10. Comments on style:

11. Comments on language:

12. Obvious omissions?

13. How was it circulated?

14. Anything about the timing of its release?

15. Press response? (Union response)