

# The tacit rules of the game in the GP trainee–trainer supervisory relationship

Jackson, Dawn; Davison, Ian; Brady, Josephine

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**THE TACIT RULES OF THE GAME IN THE GP TRAINEE - TRAINER  
SUPERVISORY RELATIONSHIP**

**Authors:**

Dr Dawn Jackson<sup>1</sup> GP, Senior Clinical Tutor, PhD Student. University of Birmingham

Dr Ian Davison<sup>2</sup> Lecturer, School of Education. University of Birmingham

Dr Josephine Brady<sup>3</sup> Lecturer, School of Education. University of Birmingham

## **ABSTRACT**

**Introduction** A key aspect of support in UK General Practice training is the trainee-trainer supervisory relationship. A small but significant number of trainees struggle in training, and relationship 'breakdown' can result. This study aims to better understand the nature of the supervisory interaction when a trainee faces difficulty.

**Methods** Using Bordin's 'Supervisory Working Alliance' [1] and Egan's 'Skilled Helper Model' [2] as a conceptual framework, semi-structured interviews were undertaken with GP educators all experienced with trainees in difficulty, purposively sampled based on geography and gender. Interviews were transcribed verbatim, and content and coding analysis undertaken to identify key themes.

**Results** Four interviews took place. Trainee factors (insight, engagement, GP as 'best fit' career and difficulties in training) and trainer factors (failure to fail, tensions in role) were perceived as contributing to relationship breakdown. A lack of agreement in the goals and tasks of supervision was described when relationships broke down. It is proposed that both trainee and trainer may hold differing expectations, particularly relating to the goals and tasks of supervision. This relates to Bordin's model [1].

**Conclusion** Making expectations more explicit could be part of the solution to an improved supervisory working alliance. Further study on the influence of structure and agency is required to better understand the relationship in context.

## **INTRODUCTION**

A key aspect of educational support for trainees within UK General Practice (GP) training is the role of their educational supervisor, or 'trainer': a qualified General Practitioner responsible for the oversight of the educational process[3]. For a small but significant number of trainees, the supervisory relationship with their trainer can 'break down'. This is often in situations of trainee difficulty, such as examination failure, and leads to distress for both trainee and trainer [4]. Much of the literature focuses on remediation of trainees in these circumstances, or evaluation of the assessments themselves [5, 6, 7]. Consideration of the supervisory relationship as a tool for detection and mitigation of trainee difficulty, long before the experience of failure in summative assessment, appears to have been overlooked. An impetus for further study in this area is that it has been argued that the supervisory relationship is probably the 'single most important factor in the effectiveness of supervision' [8].

## **CONCEPTUAL FRAMEWORK**

The 'therapeutic alliance' between counsellor and client has been found to be the strongest predictor of positive outcome in counselling [9]. Bordin, in the 'Supervisory Working Alliance' model, extends 'therapeutic alliance' to introduce the 'educational alliance', or supervisory relationship, as central to successful supervision [1]. 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)[10]. In a 2012 integrative review on GP supervision, 'educational alliance' and Egan's model are viewed as important theories in GP supervision, and

a definition of a GP supervisor, which relates to these theoretical models, was proposed:

*'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. [9]*

This paper focuses on the trainee and trainer supervisory interaction. However, proponents of sociocultural learning theory argue that the learner 's development is mediated by the wider environment in which they learn [11]. It has been argued that to ignore the influence of this environment risks a misattribution of 'control' to either trainee or supervisor for elements of supervision[12]. Thus, the influence of the wider team will be considered.

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 [13], alongside the additional time, resource and emotional impact to the trainer [4, 14]. In such cases, 'relationship breakdown' may result, with some trainees requiring a costly move (both financially and emotionally) to an alternative training practice [15]. Whilst this is often a last resort, it raises the question of whether such 'breakdown' can be avoided in earlier stages of the supervisory relationship. The extensive literature on supervision interaction, both inside and outside clinical supervision, intimates complexity, variability and dynamism, with the sense that 'breakdown' of relationship is likely to be multifactorial and complex in nature [8, 16]. This study aims to better understand the dynamics of the supervisory interaction, from the educators' point of view, when a trainee faces difficulty in GP training. The research questions guiding the design are as follows:

1. Are there particular theories or models of supervision which relate to GP educators' experiences of General Practice Supervision?
2. In the view of experienced educators, how is the supervisory interaction impacted when a trainee faces difficulty?

## **METHODS**

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. TPDs and ADs who had roles in supporting trainees in difficulty in the West Midlands region of the UK attended a training day on supporting such trainees in September 2014. At the time of the study, this 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[7, 17]. A number of individual training schemes exist within the region, formed on a geographical basis, and thus participants were purposively sampled from this group to allow for a geographical, and also a gender spread. Due to their duration of experience as a trainer, a final participant was recruited based on recommendations from the training day participants. In addition to TPD and AD roles, all had considerable experience of being a GP trainer.

## **DATA COLLECTION**

Individual semi-structured interviews were conducted by one researcher (DJ) from October to December 2014. 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[18]. The participants were chosen based on considerable experience in supporting trainees in difficulty. An interview guide, based on Egan's Skilled Helper Model and Bordin's Supervisory Working Alliance, was constructed (Appendix 1) [1, 2]. 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 [2,10]. The guide was

used flexibly enabling the interviewer to respond to the participant's agenda. 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

Content analysis was undertaken. Following familiarisation with the data, each interview transcript was coded by the lead researcher using sentences or phrases within the text as sampling units [19]. Initially, an inductive approach was taken to formulate areas for interrogation and interpretation [20]. 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 [21]. 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 identified codes and text which linked to pre-defined theories of supervision. 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 Midlands Medical Education conference further helped to clarify and develop the themes [22].



## RESULTS

Four educators took part in interview; 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 trainers, in addition to their TPD roles. The participants shared over 60 years of combined experience. The interviews ranged in length from 35 to 41 minutes.

### Focus on 'break down'

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 'break down' that the perspectives and themes were identified.

**Figure 1: Key themes and perspectives in the breakdown of the supervisory relationship**

	<u>Sub-Theme</u>	<u>Theme</u>
1	<b>Academic, personal and/or professional difficulties</b>	<b>Trainee factors</b>
2	<b>Engagement</b>	
3	<b>Insight</b>	
4	<b>GP as 'best fit career'</b>	
5	<b>Tensions in trainer role</b>	<b>Trainer factors</b>

6	<b>Failure to fail</b>	
7	<b>Goals of supervision</b>	<b>Lack of agreement on expectations for supervision</b>
8	<b>Tasks of supervision</b>	
9	<b>Locus of control</b>	
10	<b>Effect on the trainer</b>	<b>Effects of breakdown</b>
11	<b>Effect on the trainee</b>	
12		<b>Dynamic relationship</b>

### **Trainee factors**

#### 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 behavior 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.

#### 2. 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.'*(Participant 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.

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'

*'There 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.'*(Participant 3)

#### 4. GP as 'best fit' career

All participants described trainees where GP was not the best fit career for them. In these cases, the trainee experienced multiple failures at high stakes examinations and/or subsequent relationship breakdowns with future trainers:

*'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'. (Participant 3)*

## Trainer factors

### 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 protect the safety of patients and the profession (*gatekeeper*), whilst trying to support and develop the trainee:

*‘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...’*(Participant 3)

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’* (Participant 1)

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.

### 6. Failure to fail

Two participants had experienced hesitancy of trainers 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.'*(Participant 4)

## **Lack of Agreement on expectations for supervision**

### 7. 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* (Participant 1)

It was frequently suggested that the trainee's lack of 'insight' contributed in these cases.

### 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'* (Participant 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.

### **Effects of Breakdown**

#### **10. Effect on the trainee:**

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.'* (Participant 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.

#### **11. Effect on the trainer**

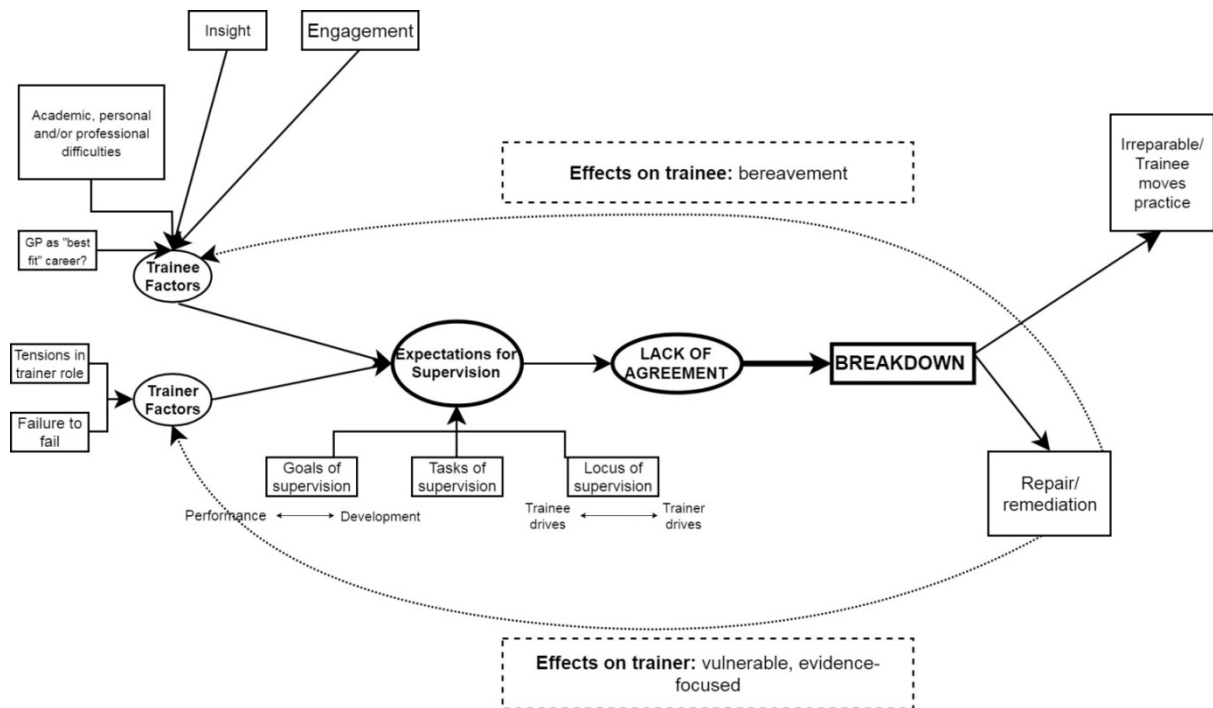
Three participants described feeling 'vulnerable' following relationship breakdown. This was expressed most frequently in terms of concern about subsequent complaints from the trainee. However, the educators also discussed feeling like a 'failure' themselves, with significant emotional distress. It is in the context of this 'cost' to the trainer that 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'.*

## 12. Dynamic relationship

Reviewing the responses in their entirety, the 'pathway' to breakdown is 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. Furthermore, not every 'breakdown' resulted in an end to the relationship, and the experience of 'breakdown' subsequently appeared to affect both trainee and trainer. The model below summarizes the perspectives and themes above, incorporating this dynamism and suggesting that Bordin's concept of 'agreement' is also central in the educator accounts in this study [1]. It will be elaborated in further detail within the discussion.

**Figure 2: The dynamic course to breakdown, and its effects**





## DISCUSSION

The first research question considers which theories or models of supervision relate to the educators' experiences. The participants spoke frequently of a lack of trainee engagement and insight. 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 [2, 10]. 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 are examples within the results where relationship breakdown appears 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 [1]. 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 supervisory relationship. What is perceived as an 'insight problem' in the trainee may in fact point towards 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 is most striking in two respects.

The first relates to the limited focus on the supervisory relationship within these models. The participants in the study suggested a context for training much wider in

scope than the interaction between trainee and trainer. 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. The models above suggest that the quality of the supervisory relationship is central to achieving the eventual goals or 'help' required by the trainee. However, the reluctance of some of the trainees to seek pastoral support from their trainer suggests this is not always the case. Furthermore, the reference by the trainers to provide evidence and documentation suggests an accountability to the institution (and profession), 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.

The second research question considered the educators' perspective on the way in which the supervisory relationship was impacted when the trainee faced difficulty. Beyond simply 'trainee difficulty' in isolation, the results indicate particular trainee and trainer factors which may contribute to varying expectations of the goals and tasks of supervision, and also the locus of supervision ('who' should be driving the supervisory relationship). Using Bordin's notion of 'agreement', the model in Figure two 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. Sharing expectations, and the factors which shape them, may well highlight areas of disagreement, and thus offer a platform for these to be remediated long before

relationship breakdown. The model thus offers a tool for the trainee and trainer to consider in their discussions regarding the supervisory process, in attempt to make their expectations of supervision explicit, and potentially avoid disagreement or breakdown within the relationship

## LIMITATIONS

A striking observation at the outset was the choice of the respondents to focus largely on relationship breakdown in their responses, despite a relatively open interview schedule. This could be attributed to the recruitment method, during training in supporting Doctors in Difficulty. Participants may have presumed a focus on problems in supervisory relationships. Alternatively, it may simply reflect human nature, where the 'bad' is often remembered more vividly than the 'good'[23].

At the time of the study, the lead author was a GP trainee within the West Midlands region which may have influenced the participants' responses or altered the subsequent analysis. However, insider research can be beneficial [24, 25]. The sample size is small. The participants represent 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. The cumulative experience of over 60 years of the participants provides an important voice. This research team is now involved in further work to gauge perceptions of wider groups of trainers, with varying experience, and those of trainees, to better understand the dynamics of the supervisor interaction.

## CONCLUSION

The findings in this study appear to support Bordin's view of 'agreement' as a central component in the GP supervisory relationship, and raise 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 suggest that viewing the supervisory relationship in isolation may fail to appreciate its complexity; for example, this study suggests that institutional context has a critical role.

The Royal College of General Practitioners (RCGP) provide some opportunity and guidance for discussion of expectations for trainee and trainer in the supervisory interaction [26, 27, 28]. However, they do not provide explicit guidance on how the relationship should navigate the inherent tensions in roles, or who should be driving the relationship. It is possible that trainee and trainer may co-exist in relationship for three years, with neither fully comprehending the values, beliefs and expectations of the other. Each may be involved in the process of supervision, never fully knowing the other's expectations for the 'rules of the game'. This study proposes that such implicit expectations, if not shared, could risk a lack of agreement between trainee and trainer, and potentially subsequent relationship breakdown; risking long-term affective impact for both trainee and trainer. In a dynamic interaction such as this, we would recommend that training pairs ensure that expectations about the supervisory process are shared on a regular and ongoing basis. In the UK setting, the six-monthly review meeting could provide an opportunity for this. Further research is needed to make recommendations on the nature of this discussion, but the results indicate that trainees and their trainers should consider a discussion on the potential for tensions and variability in trainee and trainer role, and the expectation of who

should be driving the supervisory interaction. The model highlighted in Figure 2 may provide a framework for such a discussion.

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## **DECLARATION OF INTEREST**

At the time of the interviews, DJ was a GP trainee in the West Midlands region.

## **DISCLOSURE STATEMENT**

The authors report no potential conflict of interest.

## **ETHICAL APPROVAL**

This study was approved by the University of Birmingham Ethics Committee

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