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Becoming a clinician: Trainee identity formation within the GP supervisory relationship

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Abstract

Objectives

Becoming a clinician is a trajectory of identity formation in the context of supervised practice. This is a social process where the supervisory relationship is key. Therefore, to know how to support identity formation of clinical trainees, it is necessary to understand how this happens within the supervisory relationship. Our aim was to develop a conceptualisation of trainee identity formation within the general practice(GP) supervisory relationship to aid its support.

Methods

We took a critical realist approach using case study design and 'cultural worlds' theory as a conceptual frame. Each case comprised a GP trainee/supervisor pair. Our data were weekly audio-recordings of interactions between trainee, supervisor and a patient over 12-weeks augmented by post-interaction reflections and sequential interviews. We undertook interpretive analysis using dialogic methods focusing on the doing of language and the cultural Discourses expressed.

Results

We identified three social Discourses centring on: clinical responsibility; ownership of clinical knowledge; and, measures of trainee competency. Versions of these Discourses defined four trainee/supervisor relational arrangements within which trainee and supervisor assumed reciprocal identities. We labelled these: *junior learner/expert clinician*; *apprentice assistant/master coach*; *co-clinicians*; and, *lead clinician/advisor*. We found a trajectory across these identity arrangements. Behind this trajectory was an invitation by the supervisor to the trainee into the social space of clinician and a readiness of the trainee to accept this invitation. Congruence in supervisor and trainee positioning was important.

Conclusions

In the supervisory relationship, trainee and supervisor adopted reciprocal identities. For trainees to progress to identity of *lead clinician*, supervisors needed to invite their trainee into this space and vacate it themselves. Congruence between supervisor positioning of their trainee and trainee authorship of themselves was important and was aided by explicit dialogue and common purpose. We offer a model and language for trainees, supervisors and faculty to facilitate this.

Introduction

General Practice(GP) trainees transition from nascent to fully credentialed general practitioners by being involved in clinical care under supervision(1). It is now clear that becoming a clinician is not

just the acquisition of knowledge and skills, it is a trajectory of identity formation(2, 3) much of which is a tacit process(4). To meet the call for a more purposeful approach to addressing issues of clinician identity formation(5) we need to understand how this occurs.

Social theories of learning have led medical education researchers to examine the social dynamics of identity formation(5, 6). From this perspective, identity formation occurs in the context of participation in shared activities with others(7, 8) where participants are positioned socially by each other(9, 10). This occurs within cultural frameworks which also sustain structures of authority and power(11). The identity an individual can claim depends on the identity they are granted(10). Language is fundamental for forming and framing identities(12, 13). This happens through the enactment of cultural Discourses with which a social group defines how things are done and what is and isn't acceptable(13). A trajectory of joining a social group involves an individual appropriating the language and Discourses of that group which is then re-used in their own internal and external dialogues as expressions of their emerging identity in that group(11, 13).

To understand clinical trainee identity formation, we need to examine the dynamics of their workplace relationships, social frameworks and Discourses. Both primary(14) and secondary(15) research have identified the supervisory relationship as fundamental to trainee identity development. Research into GP supervision has confirmed that relational factors influence identity formation for the trainees(16) and the supervisors(17).

Research on clinicians' identity formation has largely used post-event data from interviews(18, 19) and reflective diaries(10). To understand the social dynamics of identity formation, contemporaneous naturalistic data is needed(20). Kennedy et al(21) and Clement et al(22) have used naturalistic data, with a focus on dialogue, to examine trainee identity in supervised practice. They showed that trainees do indeed conform to cultural norms because of hierarchical power structures. Their findings, however, were based on data from single moments in trainee identity trajectories. Identity formation is a longitudinal process and so research using sequential data points over time is needed to deepen understanding.

We therefore sought to explore clinical trainees' dynamically evolving identity formation within supervised practice using naturalistic data collected over time. Our aim was to develop a conceptualisation of trainee identity formation within the GP supervisory relationship to aid its support. We asked two questions:

1. What shapes the clinical trainee's identity in the context of GP supervised practice?
2. How does the clinical trainee's identity change over time within GP supervised practice?

Methods

Overview

Conceptual orientation

We took a critical realist approach. That is, there is a real world that can be understood; that there are real outcomes that have causal processes; and that we can act purposefully through understandings gained from constructed perceptions(23).

Holland et al's theoretical framework(11) was used, taking a socio-historic approach to identity, viewing it as personal and social, historic and emergent. Identities are formed and enacted in figured worlds which are culturally structured (worlds) with ways of doing and interacting organised around positions of status and power. Medicine can be viewed as a figured world. Key constructs from Holland's theorising are summarised in Figure 1. This framework has been drawn on by others for examining identity formation in medical education(10, 24).

Figure 1: Key theoretical constructs from Holland et al(11)

Setting

This study was undertaken in Victoria, Australia, with trainees in twelve-week GP intern placements as the sample. These trainees were in their first post-graduate training year as provisionally registered junior doctors. This year is a period of significant transition between completion of medical school and entering a medical specialist pathway with the trainee completing 10-12 week rotations through a range of disciplines. In a GP rotation, trainees work in community-based clinics and attend primary-care patients who book to see the trainee. The trainee is required to check-in with their supervisor before completing each patient consultation. This is often the trainee's first extended period in the role of a doctor making significant contributions to clinical decisions. The structure also provides the basis of a substantial supervisory relationship.

Study design

Case study design(25) was used with trainee/supervisor pairs as the cases, each situated in a different community based general practice. Case study design provided for a deep examination of supervisory relationships as contexts for identity formation. From a realist perspective(23), this is necessary for understanding causal processes. Sullivan's dialogic methods were used to approach the data(13). This methodology takes a social perspective on identity and its enactment through dialogue. It focuses on the 'doing' of language and uses discrete speech acts as the unit of analysis. Speech acts are characterised by their readiness for a reply or reaction(13).

Participants and recruitment processes

An open invitation was sent to supervisors and trainees from a pool of eleven potential trainee/supervisor pairs within a GP training program. In five of the pairs, both the intern and supervisor expressed interest in participating. Following detailed explanation of the project, the invitees from these pairs all provided informed consent to participate.

Study procedures

We collected three types of data:

- 1) Audio recordings of the dialogue from weekly supervisory encounters in the presence of a patient
- 2) Audio recorded reflections on these supervisory encounters by both the trainee and the supervisor directed by a prompt sheet (Appendix 1)
- 3) Four sequential recorded semi-structured interviews with each supervisor and trainee from before, at two points during, and then following the twelve-week placement - using topic guides (Appendix 2). The interviews were informed by an initial analysis of preceding data for the purposes of theory development and member checking.

Before recording an encounter, informed consent was established with the patient(s). Written consent was sought prior to the consultation by reception staff at patient check in and, if provided, confirmed verbally by the intern prior to switching on the recording device.

The interviews were conducted by two employed researchers and by JB. In most instances, the interviewers were not known to the research participants.

31 hours of audio data were collected. These were transcribed verbatim and anonymised.

Data analysis

Analysis was done iteratively, moving between the data and conceptualisation; and between the particular and the global. Memoing was used as an analytic tool. JB led the analysis and analysed all data in depth. The remainder of the team familiarised themselves with the full data set and analysed one or two of the cases in depth. JB met regularly with each team member for case-focused interpretative checking and development. The whole team met for three extended meetings for cross-case analysis and over-arching conceptual development. These discussions were theoretically framed and drew on the different perspectives that each of the research team brought. Our research team included two members native to GP supervisory environments (JB and HR), one member native to clinical supervision but from another field of medicine (TD) and one member a

sociologist/educationalist and hence an outsider to the research context but an insider to the theoretical and methodological approaches(DN). Two were based in Australia and two in the United Kingdom. This mix of insider and outsider perspectives was important to both analytical rigour and depth(13, 26).

The supervisory encounter data were taken as the primary view on the supervisory relationship in action. The data from the interviews and reflections were used for checking and deepening the understanding of what was happening in the encounters(26, 27); and, as a view on the meaning-making by the participants(11, 13).

In analysing the data, a focus was taken on the 'doing' of the talk(13) identifying its social actions. These social actions were categorised both inductively and deductively using Holland et al's theoretical constructs (figure 1). From this, an interpretative framework with top level themes arranged hierarchically was developed and applied back to the data. This analytic hierarchy of themes is illustrated in figure 2.

Figure 2: Hierarchy of top-level themes

Key 'sound bites'(13), which exemplified the social actions, were identified. These were used to scaffold a narrative summary for each case. The narrative summaries were used for cross case analysis.

One case, with a strong trajectory of trainee identity change, was chosen for further examination to explore causal processes underlying identity change. Identified causal process were tested against the other four cases. This approach is consistent with critical realist methods for this purpose(23).

Ethics

Ethics approval was gained from Monash University Human Research Ethics Committee – project number CF14/2058 – 2014001069. Participation was voluntary. All trainees, supervisors and patients provided informed consent prior to participating.

Findings

The findings are divided into two parts. The first part concerns the way the trainee and supervisor identities were paired in a relational way and enacted through their shared Discourses. The second part concerns how the trainee and supervisor paired identities could change over time.

Part 1 – Trainee and supervisor paired identities

We found that the trainee and supervisor assumed identities that were paired with each other in a relational and reciprocal way. We identified four distinct pairings of identities. These distinct pairings were not peculiar to any particular trainee/supervisor relationship as each trainee/supervisor relationship could change in the way they interacted and thus assume different paired identities at different times. We have labelled these four pairings of reciprocal identities as: 1) *junior learner* and *expert clinician*; 2) *apprentice assistant* and *master coach*; 3) *co-clinicians*; 4) *lead clinician* and *advisor*. These paired reciprocal identities are represented in figure 3.

Figure 3: Trainee/supervisor paired reciprocal identities

The trainee and the supervisor enacted these paired identities through using different versions of three identifiable social Discourses to author and position each other. These three social Discourses were:

1. Discourse on attribution of clinical authority
2. Discourse on the ownership of medical knowledge
3. Discourse on the measure of trainee competency

The Discourse on clinical authority might attribute responsibility for the care of the patient to the supervisor, to the trainee or to both. The Discourse on ownership of medical knowledge positioned knowledge either as a commodity owned by a person and a mark of their authority or positioned knowledge as a communal asset to be shared. The Discourse on the measure of trainee competency valorised different things by which to judge the trainee's performance.

We now describe each of the four sets of paired identities describing how they were framed by different use of the three social discourses and the consequent positioning and authoring that occurred between the trainee and supervisor within their relationship.

1. Trainee as *junior learner*, supervisor as *expert clinician*

In this pairing of identities, the Discourse on clinical authority assigned authority for patient care to the supervisor who made the clinical decisions with the trainee assisting. The Discourse on ownership of medical knowledge identified medical knowledge as a personal asset for the trainee to seek and for the supervisor to dispense.

...you've got a guy who's got thirty...years' experience telling you stuff, you[the trainee] should be listening. (Supervisor C pre-placement interview)

The Discourse on the measure of trainee competency gave value to the trainee's factual knowledge and their ability to collect and deliver a complete history and examination for the supervisor to then use for making a diagnosis.

He hadn't mentioned to me issues such as family history. He hadn't mentioned to me any exploration of past psychological issues with depression, et cetera. (supervisor C reflection 3)

These versions of the three Discourses positioned the trainee as a learner to report to the supervisor and to be taught. The supervisor was positioned reciprocally as lead clinician and expert. In the following extract from an encounter, we see this evident in the way that the supervisor interrogates the trainee in the presence of the patient:

Supervisor: What about constitutional symptoms. Anything there?

Trainee: The cold, sort of feeling hot and cold but that's really all.

Supervisor: Appetite, that sort of stuff.

Trainee: Appetite? I didn't ask. (Pair C Encounter 1)

This hierarchical positioning was paralleled with concordant hierarchical authoring by both the trainee and the supervisor.

I think that reinforces that, as a junior doctor, that you are in fact learning things, and retaining things... (Trainee C reflection 1)

2. Trainee as apprentice assistant, supervisor as master coach

In this pairing of identities, the Discourses on clinical authority and ownership of medical knowledge positioned the trainee as an assistant who made clinical suggestions; however, final responsibility and authority lay with the supervisor.

Rather than me having to make decisions about management, more lik, suggestions of what I think I would do. (Trainee C interview week 9)

The trainee competency Discourse valued trainee clinical reasoning and their ability to offer credible differential diagnoses and management options for the supervisor to consider.

What worked well was that I had formulated a bit of an impression of what I thought was going on. (Trainee C reflection 5)

The trainee and supervisor played 'let's pretend the trainee is in charge' where the trainee either made clinical propositions that the supervisor could accept or decline; or, the trainee was coached by the supervisor to come to a supervisor determined conclusion using questions and prompts. In

this way, the trainee could appear to be making decisions however the consultation was actually controlled by the supervisor.

Supervisor: Yep... What do you think?

Trainee: It doesn't have any major concerning features, I suppose, to have a look at.

Supervisor: Yeah.

Trainee: It is irregular but that's really the only concerning feature. In terms of colour, it's reasonably uniform, you know, it's got some pigment through it but in a uniform distribution almost.

Supervisor: I think that's right. (Pair B encounter3)

The trainee and the supervisor authored themselves and each other in a way that aligned with the positioning of the trainee as the assistant and the supervisor as the leader:

[Supervisor] allowed me to present, you know, differentials and investigations that I might want to do, and then even lead me a little in terms of other things that he thought that I was missing, allowed me to sort of, go through the process of discovery. (Trainee A reflection 1)

3. Trainee and supervisor as *co-clinicians*

In this pairing of identities, the Discourse on clinical authority shared responsibility for clinical care between trainee and supervisor. The Discourse on the ownership of medical knowledge positioned knowledge as a shared asset with both contributing knowledge to solve a clinical problem. Trainee and supervisor were positioned as *co-clinicians* with both contributing to the development of the plan in a non-hierarchical way.

There was a good exchange of information and conversation between myself, [trainee A] and the patient, and we formed a collaborative plan as to how to deal with the situation.

(Supervisor A reflection 7)

The trainee competency Discourse valued the ability of the trainee to adopt the role of the GP clinician. Authoring by both trainee and supervisor was congruent with the non-hierarchical positioning:

I get the impression from [supervisor] that he thinks of me as a colleague and values what I have to say and has a reasonable degree of trust in my clinical judgement. (Trainee E interview 2)

4. Trainee as *lead clinician* and supervisor as *advisor*

In this pairing of identities, the clinical responsibility Discourse assigned clinical responsibility to the trainee with the supervisor providing support as far as was requested by the trainee. The ownership of knowledge Discourse positioned knowledge as a resource to be sourced and shared. With this version of the knowledge Discourse, the trainee called on the supervisor as an information source for the trainee to manage the consultation themselves. The competency Discourse gave value to the trainee's capacity to assume the role of the *lead clinician* for the patient.

...if what he has formulated from the consult appears to be appropriate and the patient interaction with him appears normal then by inference, I can presume that the consult has gone perfectly okay. (Supervisor A interview week 10)

The trainee was positioned as *lead clinician* developing and delivering a diagnostic formulation and the management plan for the patient while the supervisor was positioned as an advisory resource for the trainee to utilise in order to complete the consultation. This might be as a resource for additional information, an opinion or affirmation. *...the questions that I needed answered, [supervisor D] was there to assist me in answering them myself. (Trainee D reflection 3)*

Authoring by trainee and supervisor was consistent with the positioning of the trainee as the *lead clinician* and the supervisor as an *advisor*.

Part 2: Change in identity over time

In this section, we describe how the pairing of identity might change within a particular trainee/supervisor relationship. We then explore the features within the supervisory relationship that facilitated this change.

A trajectory of change in identity

Across the placements, we identified a trajectory of paired reciprocal identities. The participants talked about this trajectory and it was evident in changes in the predominant reciprocal identities each case adopted. The start and finish points were different across cases; however, overall the trajectory went from *junior learner/expert clinician*, to *apprentice assistant/master coach*, to *co-clinicians*, to *lead clinician/advisor*. While this trajectory usually tended forwards, it could halt or go backwards. One case did not have a clear trajectory.

We use case B to exemplify this trajectory. At the start of the placement, the trainee and supervisor adopted the reciprocal identities of *junior learner/expert clinician*. This was expressed in the way the supervisor quizzed the trainee in encounter 1:

Supervisor: *Okay, so what options have you got?*

Trainee: *What options have we got? I think, given there's no evidence of fluid overload. There's no need to treat as for that at the moment. There's no oedema in the legs, there's nothing no sound in the chest.*

Supervisor: *But he's short of breath.*

Trainee: *But he's symptomatic. Could we increase the Lasix[a diuretic]?*

Supervisor: *Yes.*

Early authorship by trainee and supervisor identified the trainee as a *junior* and a *learner*, and the supervisor as the *expert clinician* in a hierarchical world.

...we have very hierarchical in that, you know, he's the GP and I'm the junior and he's providing some education as we go. (Trainee interview week 3)

The trainee competency Discourse was about the trainee's ability to collect the information required for a comprehensive presentation.

I felt a little bit embarrassed that I hadn't completed an extensive examination. You know, I'm eager to impress and will certainly remember that for next time. (Trainee reflection 2)

Further into the placement, they tended to adopt the reciprocal identities of *apprentice assistant/master coach*. In encounter 3:

Supervisor to patient: *So [trainee] can just run through what medications you may need,*

Later in the placement positioning, authorship and the trainee competency Discourse shifted to reflect the reciprocal identities of *co-clinicians*. In encounter 7, trainee and supervisor together work towards a diagnosis for a patient's joint pain:

Trainee: *...given we've got no crystals on microscopy[of the joint fluid], unlikely gout or pseudo gout, certainly not a good history for it really, there's a few key features. No microbes, no polymorphs so, and certainly not a septic type picture.*

Supervisor: *He'd be unwell.*

Trainee: *Well exactly, and so I suppose my best thought here is that there's some osteoarthritic change that we know is there.*

Supervisor: *Yeah.*

Trainee: *And that for whatever reason we've had some joint...*

Supervisor: *It's flared up...*

Trainee: Inflammation following some, just irritation.

Both trainee and supervisor now also author the trainee as a *co-clinician*:

...the patient certainly saw me as a doctor with the knowledge to manage her conditions, that sort of thing. (Trainee reflection 9)

[on the trainee's involvement] it's good to have a second opinion and review. (Supervisor reflection 9)

The trainee competency social Discourse has become about the trainee's ability to make clinical decisions:

...[trainee] is comfortable making decisions...ordering tests. (Supervisor interview week 9)

Features within the supervisory relationship that facilitated the progression of identity change

Alongside the trajectory of reciprocal identities over time, we identified features about a supervisory pair that facilitated this trajectory. These features were particularly apparent on a deeper examination of pair E where there was a clear transition during the placement to the reciprocal identity of trainee as *lead clinician* and supervisor as *advisor*. Data from the other cases were used to refine this theorising. In summary, the facilitating features were:

- 1) The supervisor offering the trainee the possibility of *clinician* identity
- 2) The trainee being ready to accept the offered identity
- 3) Time for the trainee to learn how to assume a new identity
- 4) The supervisor safety-netting as the trainee learned the new identity
- 5) Congruence in the trainee's and supervisor's authorship of their relationship
- 6) A strong relationship with mutual respect and goodwill

1. Supervisor offering the trainee the possibility of *clinician* identity

In this pair, from the start supervisor E imagined, authored and enacted an intention to position the trainee and himself as *co-clinicians* and then the trainee as *lead clinician* and himself as *an advisor*. He was also deliberate in supporting the trainee's position in the eyes of the patient.

with supervision it's about empowering the learners to use the knowledge they have...to make decisions...I always remain standing in the consultation...I don't take their bed, chair or the computer. (Supervisor pre-placement interview)

As the placement progressed, this supervisor moved towards the position of *'advisor'* and thus enabled the trainee to occupy the position of *'lead clinician'*. He did this by occupying a more marginal social space in their shared clinical encounters. His input progressively reduced to verbal fillers such as *'mmm'* and *'yep'* and he progressively relinquished ownership clinical decisions by initially giving trainee E options to choose from themselves and then later accepting trainee decisions that might be different to his own:

...even if it may not be necessarily the one that I would actually use, if it's still appropriate I won't interfere (Supervisor in joint reflection 3)

By the end of the placement, his usual input to management decisions became a simple affirmation of the trainee's decisions.

In one of the closing joint reflections, he invites a reversal of the position of expertise by seeking the trainee's judgment of his own supervisory role.

In contrast, in another pair, the supervisor retained the position of lead clinician through persistent positioning of patients as his own and positioning of the trainee as a junior through quizzing, correcting and over-riding the trainee during the encounters. That pair did not progress beyond the reciprocal identities of *apprentice assistant/master coach*.

2. Trainee being ready to accept the offered identity

Prior to commencing the placement, trainee E imagined himself taking greater clinical responsibility:

being an intern in the hospital you're as much doctor as you sort of are unit secretary... It's that movement from here's the information, what's the plan boss? to here's the information, this is my plan... (Trainee pre-placement interview)

When positioned as *clinician* by his supervisor, this trainee embraced the position.

In contrast another trainee did not express a readiness to accept the position of decision maker.

That trainee did not progress beyond the position of *apprentice assistant*:

Trainee: ...every patient needs to be seen by a GP which is, I feel quite good about...

Interviewer: what are you least confident about?

Trainee: Making management decisions...like I will ...rarely make decisions (Other trainee pre-placement interview)

Readiness also required the trainee to have the requisite competencies for the offered identity. Trainee E expressed confidence that he had sufficient knowledge and skills to assume the identity of *lead clinician*.

I'm reasonably comfortable with my medical knowledge in a lot of areas and I'm happy with my ability to ... make the right sort of management choices (Trainee interview week 7)

3. Time for the trainee to learn how to assume a new identity

Adopting a new identity took time. Learning new skills and a new disposition took practice.

Confidence required familiarity through experience.

Early in the placement, trainee E exhibited a lack of confidence in adopting the offered identity of *co-clinician* by heavy use of hedging in giving his opinion. "*Sort of*" appears three times in this statement given during a clinical encounter:

dental treatment is sort of the, the primary sort of management... I sort of thought ... (Trainee in encounter 2)

As the placement progressed, he authored himself as clinician with increasing strength, both within the consultations and in the way he spoke about himself:

saying, okay..., here is the problem and this is what we should do, rather than saying, oh, this is sort of what I think, maybe we should try this. (Trainee reflection 7)

4. The supervisor safety-netting as the trainee learned the new identity

We have identified that it takes time between the trainee being offered a new identity and the trainee becoming confident in the skills and disposition of that identity. This means that there is a period when the new identity may be beyond the trainee's capacity. Supervisor E was aware of this and watched for evidence that the trainee was floundering in which case he would reposition himself and their reciprocal identities:

a couple of times I sort of started to talk and then let you continue, ... it lets you take over and be responsible... I'm watching the way you respond and hopefully if you need some assistance we'd try and do it in a way that doesn't sort of compromise too much the relationship you have with the patient. (Supervisor in joint reflection 3)

Early in the placement, supervisor E could provide scaffolding to enable the trainee to make clinical decisions by offering a range of diagnostic options or treatment pathways which the trainee could choose from. This provided a safety-netting 'retreat' to the *apprentice assistant/master coach* reciprocal identity.

5. Congruence in the trainee's and supervisor's authorship of their relationship

This pair had a high level of congruence in the way they each authored their relationship and their approach to patients. They talked about this explicitly thereby facilitating congruence. There was congruence in the way that they addressed and answered each other and congruence in the way they talked about the doctor patient relationship. Trainee E adopted some of supervisor E's language. Supervisor E said in a joint reflection:

the role of a GP isn't as director of patients, it's really to be empowerer of patients, you know, try to help them identify what their needs are. (Supervisor in joint reflection 4)

Trainee E adopts the supervisor's talk four weeks later:

If you can empower somebody (the patient) to say, I have these health problems... (Trainee reflection 8)

Another pair were not congruent in positioning, authoring and addressing. In that pair the supervisor positioned their trainee as an *apprentice assistant* while the trainee authored themselves as *lead clinician*. This led to tension about who was in charge within the encounter and a sense of one being diminished when the other took the lead position. This other pair did not have a clear trajectory in their relational arrangement over the placement.

6. A strong relationship with mutual respect and goodwill

A notable feature of pair E was the strength of their relationship. This was evident in frequent expressions of mutual respect and goodwill and by the increasing ease of interaction between the two.

Discussion

We found that the trainee's identity was shaped by their supervisory relationship as trainee and supervisor enacted reciprocal identities in the context of engaging together in managing patients. These reciprocal identities were framed by three social Discourses with which the trainee and supervisor authored and positioned themselves and each other. There was a trajectory of change in these reciprocal identities. This trajectory is represented in figure 4:

Figure 4: Trajectory of trainee and supervisor reciprocal identities with associated positioning and versions of three social Discourses

We found key facilitators of this trajectory that were particular to each of the supervisor, the trainee and the supervisory relationship. This has important implications for supervisors, trainees and training programs if they are to act purposefully to support trainee identity development towards that of *lead clinician*.

The supervisor occupies a position of power in authoring the supervisory relationship; therefore, for the trainee to progress towards the identity of the *lead clinician*, the supervisor needs to invite the trainee into that space and withdraw from it themselves. This is a staged invitation and withdrawal with each stage marked by a different positioning by the supervisor. The first transition requires the supervisor to 'play as if the trainee is the *lead clinician*' while the supervisor remains in indirect control. The second transition requires the supervisor to share the role of clinician with the trainee. The third transition requires the supervisor to position themselves as an advisory resource for the trainee as the trainee leads the clinical encounter. As well as this staged invitation and withdrawal, the supervisor needs to ensure that the trainee is not positioned beyond their capacity.

For the trainee to progress in response to the supervisor's invitation, they need to be ready to accept the offered identity. This requires first imagining themselves as clinician and then authoring themselves as clinician. It also requires acquiring the competencies needed for each stage of the trajectory. The trainee competency Discourse suggests that first the trainee requires sufficient clinical knowledge; then they require the ability to collect and deliver a clinical presentation; then they require the ability to use clinical reasoning to form a credible diagnosis and management option; and finally, they require the disposition and ability to project themselves as a clinician.

Three features of the supervisory relationship are important for enabling the trainee to develop the identity of lead clinician. The first feature is sufficient time for the trainee to play the role of clinician for them to project the identity of clinician with confidence. The second feature is congruence in the way the supervisor and trainee position and author each other. This is assisted by overt articulation about how they are authoring their relationship. The third feature is mutual respect and goodwill.

Figure 5 provides a visual representation of the trainee and supervisor actions and the features of their relationship that support the trajectory of the trainee towards *lead clinician*.

Figure 5: Diagram of reciprocal trajectory of trainee and supervisor identities and associated actions and facilitators.

Supervisors and trainees need training program support to deliberately engage with the actions that achieve this trajectory. For supervisors to relinquish the position of *lead clinician* to the trainee, they

need to be enabled to recognise the position of power they hold; and, learn how this might be transferred in a staged way depending on the trainee readiness. For trainees to adopt the position of *lead clinician*, they need to know the skills and knowledge required; and, to have the means to achieve these. They also need to know how to claim the position of *lead clinician*. This can be taught. This research also provides evidence in support of training structures that enable longitudinal supervisory relationships as change within a supervisory relationship requires time.

Our findings and theorising resonate with other work in this field. In an earlier companion paper, three patterns of supervisory encounter were identified: 'managing for'; 'managing through'; 'managing with' (16). These reflect the enactment of this paper's first three relational arrangements. Billett also identifies the relational interdependence of work-place learning and the importance of the invitation by the workplace to the trainee and their response to this (28, 29). Our finding that a trajectory of identity development is supported by congruence in positioning and mutual respect parallels Telio's et al's (30) features of a strong educational alliance – mutual understanding, respect and goodwill. Our trajectory of competencies that are part of a trainee's readiness to progress is consistent with ideas of staged competency development and associated entrustment that feature in the Competency Based Education and the Entrustment literature (31, 32). The importance of supervisory support and scaffolding as the trainee develops the identity of clinician aligns with Vygotsky's 'Zone of Proximal Development' (12).

This research provides an exploration of the social dynamics of trainee identity development and the reciprocal nature of trainee and supervisor clinical identities. Holland et al and Sullivan describe identity as a contested space (11, 13). Our findings support this, indicating the importance of the supervisor inviting the trainee into the space of clinician while vacating that space themselves as an act of relinquishing power. To achieve this, we suggest that it is important for supervisors and trainees to find congruity in their authorship of their relationship by being explicit about these things and our model provides a language for this. What aren't clear are the personal, relational and social factors that impact on this transfer of power. This is an important area for further research.

Strengths and limitations

The strength of this work is that it gives a dynamic view of identity by using naturalistic data collected over time. This research was based on five supervisory relationships in a GP internship program in rural Victoria Australia over a limited time. While this enabled depth to our investigation, it meant that the research was highly contextual. However, we believe that supervision in this context has much in common with supervision in many other clinical contexts. Our use of Holland's theoretical frame gives both rigour and relevance beyond the field of enquiry. Our research team

brought different perspectives which enhances the credibility of our findings. As qualitative research, we made interpretative judgments in deciding what data spoke to our questions, what that data was saying and what this meant for identity formation within a supervisory relationship. We see our interpretative direction with this data as one among many justifiable directions. Our emphasis was on the trainee/supervisor relationship rather than the trainee/patient relationship. The trainee/patient relationship is an important context for trainee identity development and warrants investigation in its own right.

Conclusion

The formation of the identity of clinician by trainees in the context of the supervisory relationship is a reciprocal process. It requires invitation by the supervisor to the trainee into the space of clinician identity, a willingness for the supervisor to withdraw from that space and for the trainee to be willing and capable to assume the identity of clinician. As the more powerful person in the supervisory relationship, the supervisor has a critical role enabling the trainee to form the identity of clinician by providing the space, invitation and support. Congruence between the supervisor's positioning of the trainee and the trainee's authoring of themselves is important and is aided by explicit dialogue and common purpose.

Contributors

JB and DN, together with a colleague and a researcher, conducted the initial project development and data collection. JB, DN, HR and TD undertook the analysis including the theorising and development of the conceptual framework. JB led the writing of the manuscript and the other authors contributed through iterative cycles of revision. All authors approved the final version of the manuscript.

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Conflicts of interest

JB is a PhD candidate and a GP supervisor. He was also employed by the training organisation that received the grant for this research and from where the supervisors and trainees were recruited. Funding for this project contributed to remuneration for DN as a senior academic consultant.

Ethics approval

This study was approved by Monash University Human Research Ethics Committee, project number CF14/2058 – 2014001069.

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Appendices

1. Prompt sheets for post-supervisory encounter reflections
2. Interview topic guide examples

Appendix 1

Prompt sheets for post-supervisory encounter reflections

Trainee post-supervisory encounter prompt sheet

Introduction

After each recorded consultation, we would like you to make a short audio-recording as soon as possible. This should take just a couple of minutes.

Remember that the consultation has been recorded, so we do not need you to describe what happened.

For each reflection please record your answers to the following

1. Your name
2. Date and approximate time of encounter
3. Please consider the following questions:
 - a) How do you think the supervision encounter went?
 - b) What worked well with the supervision?
 - c) What could have been improved in the supervision?
 - d) How do you think the patient saw you as a doctor?

- e) Was there anything from the encounter which made you feel that your practice was good?
 - f) Was there anything that you think made you feel more developed as a doctor?
 - g) Was there anything that left you questioning your practice?
 - h) Was there anything that left you questioning your identity as a doctor?
4. Anything else you think important or significant?

Supervisor post-supervisory encounter prompt sheet

Introduction

After each recorded consultation, we would like you to make a short audio-recording as soon as possible. This should take just a couple of minutes.

Remember that the consultation has been recorded, so we do not need you to describe what happened. We are interested in how you decided on your response to the intern's practice and how you judge the outcome of the supervision.

For each reflection please record your answers to the following

1. Your name
2. Date and approximate time of encounter
3. Please describe:
 - a) How do you think the supervision went?
 - b) What worked well in the supervision?
 - c) What could have been improved in the supervision?
 - d) Was there anything that you think was affirming for the intern in terms of advancing their practice?
 - e) Was there anything that you think left the intern questioning their practice?
 - f) Anything else you think important or significant?

Thank you

Appendix 2

Interview topic guide examples

Topic guide for trainee pre-placement interview

Preamble:

Thanks [name of intern] for agreeing to participate in our research.

The aim of our research is to explore what happens during intern supervision, about which there has been little research. Through this, we hope to understand the impact on the intern, what works well and why. We are especially interested in the development of their professional identity. By this we mean the process by which interns assume the identity of a doctor over the period of your studies, training and practice.

Before we start the interview, I want to reiterate a couple of things regarding your consent to participate. Any information or data that we gather from you will be de-identified. This means that you, your input, and the practice will not be identified in reports, papers, education resources or any other outputs which arise from this research. The interview questions are grouped around four categories, which are: *questions about your background and interests; questions regarding your expectations of your general practice placement; questions regarding supervision and questions about your perceptions of professional identity development.* Any questions so far?

BACKGROUND DETAILS

We'll start off talking about you as an intern...

1. Can you briefly tell me about your journey to becoming a doctor?
 - *[Did you study straight from school, or come to medicine by way of another profession? Did you do your medical studies in a graduate-entry medical course? Where did you study medicine? How was it? When did you graduate?]*
2. What experiences of general practice did you have as a medical student?
3. What are your perceptions of living and practicing in a non-metropolitan or rural area?
4. What other placements have you done during your intern year? *[How have they been? Can you tell me about your experiences?]*
5. How have the other placements influenced how you see yourself as a doctor?

EXPECTATIONS OF THE GENERAL PRACTICE PLACEMENT

1. How are you feeling about this placement? *[Did you choose to do this placement? Here?]*
2. What are you expecting from the placement? *[If not answered under 6].*
3. What do you think your responsibilities will be in the placement?

4. What expectations do you have with respect to clinical decision-making in the placement?
5. How confident do you feel about consulting with patients in this placement? What are you most confident about? What are you least confident about?

SUPERVISION

I'd like to ask some questions about your thoughts on clinical supervision.

1. In your experience, what makes a good clinical supervisor?
 - *What are the elements of supervision?*
 - *What is their responsibility?*
 - *Do you think there are specific personality/personal characteristics of a good supervisor or teacher?*
2. Have you found that there are some ways of learning which are more effective for you?
 - *In terms of retaining knowledge, feeling confidence in your new knowledge and practice, etc?*
 - *In terms of skills, demonstration, learning by doing etc?*
3. What has supervision been like in your internship so far? Has it differed between different placements?
4. What expectations do you have of the supervision you will receive in this placement? Anything you are looking forward to? Anything you are concerned about?
5. When you were a medical student, what sort of supervision did you have in general practice?

PROFESSIONAL IDENTITY

Let's talk about you as a developing doctor...

1. Were there any stand out experiences during medical school that really helped you feel as though you were becoming a doctor?
2. Has the internship influenced how you see yourself as a doctor?
 - *[Can you think of any examples of where you have really felt like a doctor? What happened? What factors contributed to this feeling? What else might contribute to it?]*
3. How did you feel as you entered your first placement as an intern? How are you feeling now?
4. Can you think of any examples where you felt you were a long way from being a doctor? Can you describe?

5. What sort of doctor do you want to be?
 - *Thinking about the ideal role for you?*
 - *How would you like people to see you – your peers and your patients?*

ANY QUESTIONS OR COMMENTS?

Thank you

Topic guide for supervisor pre-placement interview

Thanks [name of supervisor] for agreeing to participate in our research.

We want to find out what happens during intern supervision, about which there has been little research. Through this, we hope to understand the impact on the intern, what works well and why. We are especially interested if (and how) the supervision influences the development of professional identity of interns. By this we mean the process by which individuals assume the identity of a doctor over the period of studies, training and practice [White, Borges, Geiger 2011].

Before we start, I want to reiterate a couple of things regarding your consent to participate in this interview. Any information or data that we gather from your participation will be de-identified. This means that you, your input, and the practice will not be identifiable in reports, papers, education resources or any other outputs that arise from this research.

The interview questions are grouped around four categories, which are: *background about you as a GP and supervisor, the context in which you are a supervisor, intern supervision and your perceptions of professional identity development*. So, if you're happy to continue....

BACKGROUND

We'll start off talking about you as GP and supervisor...

1. As briefly as you can, tell me about your 'journey' to becoming a GP.
 - *Optional probe: Did you study straight from school, or come to medicine by way of another profession, or study in a post-graduate medical course?*
2. So that means you've been a GP for how long.....?
3. And how long have you been a supervisor?
4. What level of learners do you supervise in general practice (that is, medical students, interns, registrars, anyone else)?
5. What motivates you to take on supervision?

6. In a few sentences, how would you describe your approach to supervising?
7. So, what skills and qualities do you think a supervisor needs? Have you attended any workshops or other events that you've found useful in your role as supervisor? Do you have any formal qualification in teaching/supervision?

CONTEXT

The context in which you work is of interest, so the next couple of questions explore your perception of the practice and attitudes to supervision...

1. How would you describe the culture that exists in your practice?
 - *Optional probes: Is it team oriented? Individualistic? Interdisciplinary? Supportive?*
2. You've explained your approach to supervising. How is supervision viewed more broadly within the practice?
 - *Optional probes: Is it encouraged? Ongoing? Is there any interdisciplinary supervision for the interns? E.g. allied health, nurses?*
3. What impact do you think the supervision has on the day-to-day running of the practice?
 - *Optional probes: Anything specific about intern supervision?*

INTERN SUPERVISION

Now we'll turn our attention specifically to intern supervision. The questions consider your supervision practice across the whole clinical placement as well as specific supervision events. I'll offer prompts as we go.

1. Can you describe how you supervise interns – first, across the clinical placement and second, in a typical day?
 - *Optional probes: Can you talk me through what happens in a typical intern supervision consultation (WAVE consultation)? What are the logistics for WAVE consulting? Do you think your approach to supervision of the intern changes over the course of the placement?*
2. Do you orientate the intern to this supervision process? If so, how?
3. Now that you've described how intern supervision works. What do you see as being really important when supervising interns?
4. What are your expectations of interns with respect to supervision?
5. What do you hope interns will achieve over the clinical placement period?

6. What level of responsibility do you hope they achieve?
7. Thinking about a specific intern, can you describe supervision that worked really well?
What made it successful? Why was it successful?
8. Again, thinking about a specific intern, can you describe supervision that was not a success? Why do you think it was not successful? What factors contributed to it not working?
9. When the intern calls you into the consulting room, what considerations do you have for your relationship with the patient? And the intern's relationship with the patient?
10. When you are participating in the consultation, what impact does the supervision have on the intern/patient relationship? How do you balance the need to get things right, without undermining the intern?
11. How do you introduce interns to patients (or is it the other way round)?
12. How do interns generally address you in general practice?
13. How do you address the interns during the consultation?
14. Is there anything else you would like to say about supervisor-intern relationship over the placement? Do you think it is important? If so, how do you build and maintain the relationship in the work environment? How do you handle conflict or differences?
15. Do you think the supervisory relationship influences intern engagement in GP?
16. Have you noticed what happens to interns' perspectives on general practice across the placement?

DO YOU HAVE ANY QUESTIONS?

Thank you

Figure 1: Key theoretical constructs from Holland et al(11)

Figured world	A <i>figured world</i> is a shared culturally structured world that is both historic and in a state of change as it is enacted when we undertake a shared cultural activity. A <i>figured world</i> provides us with language and <i>artefacts</i> to participate and to make meaning through <i>authoring</i> ourselves and that world.
Positioning and addressing	<i>Positioning</i> is the way we are placed and place others in relation to each other within a <i>figured world</i> . <i>Positioning</i> is framed by hierarchies of power, entitlement and <i>identity</i> . <i>Positioning</i> is enacted by the way we <i>address</i> each other.
Authoring, answering	We use <i>dialogue</i> to <i>author</i> ourselves, our world and our place in it. This is a process of <i>meaning making</i> . In <i>answering</i> the way the world <i>addresses</i> us, we enact our <i>authorship</i> .
A 'Social Discourse'	A <i>Social Discourse</i> is socio-historical framed talk that expresses and enacts a particular social arrangement within a <i>figured world</i> . They are about who we are and what we do in relation to each other.
Identity	<i>Identities</i> are ways we tell others and ourselves who we are. The context of an <i>identity</i> is its <i>position</i> in a <i>figured world</i> and the way we <i>author</i> ourselves in response to that <i>positioning</i> .
Imagining	<i>Imagining</i> is using inner speech to conceive a future identity in a <i>figured world</i> .
Play	<i>Play</i> is acting as if we are an <i>identity</i> in a <i>figured world</i> as a precursor to being that <i>identity</i> . Play is a means of mastery and of creation.

Figure 2: Hierarchy of top-level themes

Figure 3: Trainee/supervisor paired reciprocal identities

Figure 4: Trajectory of trainee and supervisor reciprocal identities with associated positioning and versions of three social Discourses

Reciprocal identities	Three social Discourses		
	Attribution of clinical authority	Ownership of medical knowledge	Measures of trainee competency
1. <i>Junior learner and expert clinician</i>	Supervisor manages, trainee assists	Knowledge is a resource that trainee seeks and supervisor dispenses	Factual knowledge. Ability to collect and deliver a clinical presentation.
2. <i>Apprentice assistant and master coach</i>	Trainee proposes or is coached to clinical conclusions that supervisor may or may not accept	Knowledge is a resource that supervisor has authority in	Clinical reasoning. Ability to form credible diagnostic and management options.
3. <i>Co-clinicians</i>	Trainee and supervisor share responsibility	Knowledge is a shared asset to be brought to a common purpose	Functioning as a clinician.
4. <i>Lead-clinician and advisor</i>	Trainee manages, supervisor provides advice	Knowledge is a resource to be sourced	Functioning as a lead clinician.

Figure 5: Diagram of reciprocal trajectory of trainee and supervisor identities and associated actions and facilitators.

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