Factors influencing the decision to become a supervisor: A qualitative study of early-career general practitioners and rural generalists

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Background and objective
General practitioner (GP) training in Australia relies on accredited GP supervisors facilitating workplace-based training for GP registrars. There is a shortage of supervisors that is likely to worsen. This research aimed to elucidate the perspectives of early-career GPs and rural generalists (RGs) about the barriers, motivators and enablers to becoming a GP supervisor.

Methods
Qualitative descriptive methodology was used in the study. Transcripts from three focus groups and six semistructured interviews with 11 RGs (four registrars and seven new Fellows) and 13 GPs (all new Fellows) were analysed thematically.

Results
The following key themes were identified: being a good supervisor; motivated by past experiences of supervision; financial implications of being a supervisor; factors unique to rural settings; new models of supervision; and becoming a supervisor – how and when?

Discussion
The findings highlighted personal and professional barriers to becoming a GP supervisor and some enabling strategies to mitigate these barriers.

GENERAL PRACTITIONER (GP) training in Australia largely follows an apprenticeship model where accredited GP supervisors facilitate 18 months (full-time equivalent) of workplace-based training for GP registrars.[1,2] GP supervisors (a voluntary role) are responsible for supporting the clinical, professional and personal development of GP registrars while ensuring the safety of both patients and registrars.[3] Both general practice professional colleges – The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) – stipulate GP supervisors' minimum qualifications and experience and provide oversight of supervisor accreditation.[4,5]

The Australian Government recognises the GP workforce as critical to the delivery of high-quality primary care[6,7] and provides funding for payment to registrars, GP supervisors and accredited training practices. However, Australian general practice is currently in crisis, with GPs feeling that their work is unsustainable and financially unviable.[8] The decreasing numbers of GPs, the lack of GPs in rural and regional areas and the impending retirement of older GP supervisors are coalescing into a shortage of supervisors that is likely to worsen.[9]

The worsening shortage of GP supervisors creates an imperative to understand the factors that influence GPs to take on this role. The limited extant research has predominantly focused on current supervisors, who report supervision of registrars as intellectually stimulating, professionally and psychologically fulfilling, a means to stay up to date with clinical advancements and guidelines, a source of personal and professional satisfaction, and a strategy to address local workforce issues and succession planning.[2,10–12] Current GP supervisors have also reported barriers to taking on this role, such as time constraints due to existing workload, a lack of confidence in their ability to teach, concerns about registrar competence,[2,10] stage of life (either early- or late-career GPs)[10,11] and a lack of remuneration commensurate with the time impost of supervision.[13]

Research investigating the perspectives of the next generation of supervisors is needed to ensure they, too, become supervisors. Therefore, this research aimed to elucidate the perspectives of early-career GPs and rural generalists (RGs) about the barriers, motivators and enablers to becoming a GP supervisor.

Methods

Qualitative approach

This research employed a pragmatic qualitative research approach,[14] which sought to understand participants' perspectives and subjective experiences.[15,16] It was used here to provide a rich description of participants' perspectives that remain grounded in their viewpoints and experiences.[16]

Reflexivity

The research team included GP/RG medical educators, GP/RG supervisors, an academic researcher, a medical student and a research officer. Team members had a mixture of experience in GP vocational training and/or qualitative research and brought these different perspectives to all aspects of the project.

Sampling and recruitment

Eligible participants were new RACGP or ACRRM Fellows (ie those having attained Fellowship within the past five years) and final-year GP/RG registrars; Fellowship is a specialist general practice qualification accredited with the Australian Medical Council.

Participants were recruited by email invitation sent from the two regional training organisations (RTOs) in Queensland at that time: General Practice Training Queensland (GPTQ) and James Cook University General Practice Training (JCUGPT). The RTOs had email lists of all current and past registrars. Since this research was undertaken, GP registrar training has transitioned from a geographically dispersed model overseen by RTOs to a centralised one overseen by the RACGP and ACCRM.

A brief demographic survey attached to the consent form enabled purposive sampling to ensure diversity among participants with respect to age, sex, training pathway (ACRRM or RACGP), time since Fellowship (if applicable), type of practice and affiliated RTO.[17] Participants received a gift card up to the value of $150 as a thank you for their contribution to the research.

Data collection

Focus groups (FGs) were the preferred data collection strategy due to being cost-effective and social in nature, and the capacity to generate interaction between group members. Semistructured interviews (SSIs) were conducted with participants who could not attend an FG. FGs, lasting one hour, and SSIs, lasting between 30 and 60 minutes, were all conducted by one team member (MS) between May and July 2022. Various other team members (DA, PH, RL) attended the FGs. An interview schedule informed by the study's aim, relevant literature and the research team's expertise was used for the FGs and the SSIs. The interview schedule explored participants' interest in becoming a supervisor and their perceptions of the benefits, barriers and potential enablers to being a GP supervisor.

FGs and SSIs were conducted using Zoom's online video-conferencing platform, audio recorded and professionally transcribed. MS de-identified the transcripts and then shared them with the other research team members for analysis.

Data analysis

Data analysis proceeded inductively, informed by the principles of thematic analysis[18] and centred on identifying factors influencing early-career GPs/RGs' intentions to supervise. All team members read some transcripts, and five team members (RL, DA, MS, CJ, KDL) independently read and re-read all transcripts.

These five members met and discussed the key issues and concepts. They developed an initial coding framework, which was then discussed with the entire team before finalisation. MS coded all transcripts using NVivo (Release 1.5.2). Team members then reviewed the coding summaries to identify themes and succinctly describe participants' perspectives.

Ethics

This research was approved by the University of Queensland Medicine Low and Negligible Risk Sub-Committee (2021/HE002656) and ratified by the JCU Human Research Ethics Committee (H8728).

Results

Participants

Twenty-four participants were recruited: 11 RGs and 13 GPs. No respondents were excluded, although some respondents did not participate due to scheduling difficulties. Three FGs with 18 participants, and six SSIs were held. Participant characteristics are presented in Table 1.

Six key themes were identified:

- Being a good supervisor.
- Motivated by past experiences of supervision.
- Financial implications of being a supervisor.
- Factors unique to rural settings.
- New models of supervision.
- Becoming a supervisor – how and when?

Being a good supervisor

Participants identified that a good supervisor was an experienced GP with sound clinical reasoning and good teaching skills, who demonstrated person-centred care and emotional intelligence.

> *So I can separate it out and appreciate the ones that are truly very skilled and genius with their management of patients, their understanding of medicine … someone who has the emotional intelligence to deal humanely with individuals as a base, and then the combination of clinical skills developed over a long period of time and that means both bookish knowledge and on-the-ground knowledge, merged together.* (New Fellow [NF], semistructured interview [SSI], rural generalist [RG])

Being a good supervisor meant taking the inherent responsibilities of supervision seriously and providing sufficient support when necessary. Participants were acutely conscious that they would be medically and legally responsible for a registrar's mistakes, as well as have influence over their future career.

> *I think it would also worry me if I had one that was clearly maybe not up to scratch and you had to deal with remediating them or maybe being responsible because they're not continuing in their career … I think that would be very, very difficult.* (NF, Focus Group [FG])

Motivation to become a supervisor

All but one participant assumed they would become a supervisor. They considered that teaching was an expected part of being a doctor, with one new Fellow reflecting that:

> *Throughout your career as a doctor, even as a student, you are told that your job is to teach.* (NF, SSI)

Participants spoke of teaching as a useful mechanism for increasing their knowledge, considering that:

> *When I teach someone, it's teaching* (my)*self as well … the more you teach, the more you learn.* (NF, SSI)

Others felt a sense of responsibility to teach the next generation.

> *And that is how we pass on all the stuff that we've learnt, and we've had passed on to us from other supervisors.* (NF, SSI)

Although teaching was an expected part of being a doctor, participants recognised the flawed logic in this medical education model. Teaching is a skill that participants did not feel they had been taught, and teaching does not come naturally to everyone, as one participant reflected:

> *And in the end it's not a great model because not all people are good teachers, but doctors are forced to do it even if you're not good at it.* (NF, SSI)

Participants recounted varying experiences of being supervised – some excellent, some bordering on non-existent. Those with good experiences were motivated to become a supervisor to inspire the next generation of GPs, just as their supervisors had inspired them. For those working in rural areas, this was also perceived as a means of addressing workforce issues, as the registrar who has had a good experience is more likely to want to stay at that practice.

> *I've had such a great GP supervisor as a mentor, it really just makes me want to be part of that. If there's one person I can inspire as much as he has inspired me, then that's good for our town.* (NF, FG, RG)

Conversely, others with poor supervisory experiences were motivated by the desire to ensure that new registrars did not have similarly poor experiences.

> *A bad supervisor is actually a really good motivation to not be a bad supervisor.*

> *So you see what was done wrong, then you try and do the right thing.* (NF, FG)

Financial implications

Participants understood the inextricable link between time spent supervising and lost income.

Table 1. Selected sociodemographic characteristics of participants (N=24)

	RGs (n=11)		GPs (n=13)		Total (N=24)	
	n	%	n	%	n	%
Career stage						
New Fellow	7	64	13	100	20	83
Registrar	4	36	0	0	4	17
RTO						
James Cook University General Practice Training	6	55	3	23	9	38
General Practice Training Queensland	5	45	10	77	15	63
Age (years)						
20–29	2	18	1	8	3	13
30–39	7	64	11	85	18	75
40–49	2	18	1	8	3	13
Sex						
Female	7	64	7	54	14	58
Male	4	36	6	46	10	42
Geographical location of current practice						
Urban/metropolitan	1	9	9	69	10	42
Regional	2	18	4	31	6	25
Rural	6	55	0	0	6	25
Remote	2	18	0	0	2	8
Type of practice						
Non-corporate private practice	6	55	11	85	17	71
Corporate private practice	1	9	1	8	2	8
Aboriginal Medical Service	0	0	1	8	1	4
Other	4	36	0	0	4	17
Years post Fellowship (n=20)[A]						
0–2 years	6	86	3	23	9	45
3–4 years	1	14	7	54	8	40
>4 years	0	0	3	23	3	15

[A]20 Fellows participated.

GP, general practitioner; RG, rural generalist, RTO, regional training organisation.

> *If you're spending time supervising, you're seeing less patients yourself, which means less billing and less income.* (NF, FG)

Some participants spoke of resentment towards the system where Medicare (Australia's universal health insurance scheme) rebates had not increased, but GPs were expected to give their time to teaching. This was particularly galling for participants in relation to supervising second-year registrars, which is currently not financially remunerated. Additionally, participants were aware that payments made to the practice for supervising first-year registrars do not reflect the time taken to prepare educational materials or the informal supervision and teaching. Furthermore, GPs who were contractors or employees were not always guaranteed to receive any payment for supervision, as the payments are made to the practice rather than the individual who has the formal supervision role.

Participants suggested that GP/RG supervisors should receive sufficient financial remuneration to at least offset the reduced income from not seeing patients. Other incentives were identified as attractive incentives for early-career GPs/RGs to become supervisors, including discounted college membership fees; access to or subsidisation of professional subscriptions, such as Therapeutic Guidelines and UpToDate; and subsidised attendance at professional development and networking events.

Factors unique to rural settings

RGs reflected on some of the unique elements of supervision in rural settings. They considered that some RGs would be more confident teaching in their advanced procedural skill area rather than in general practice. Another RG, reflecting on the reality of rural general practice where solo GPs are common, commented:

> *If I was a GP supervisor … I'd be supervising the only other doctor in town which makes it a very tricky situation if you have disagreements, or you want a second opinion, or just other questions.* (Registrar [REG], FG, RG)

Medical workforce shortages in rural areas affect rural hospitals and general practices, leading to employment of locums, junior doctors and registrars. Participants in these situations sometimes relied on a remote supervision model, but generally found it less than satisfactory as the supervisor lacked familiarity of the specific contextual factors experienced by the registrar. Other logistical issues explored by RGs included that rural practices are generally smaller than urban ones, and therefore there is less physical space to accommodate registrars. Additionally, a smaller practice means a smaller supervisory team so there is less capacity to get supervisory cover for leave. Concerns were also raised about the lack of registrars and perceived poorer quality of registrars going into rural general practice.

> *Often the rural centres are … the least wanted and so you tend to get registrars who are more difficult to teach and difficult to engage … that's a barrier* (to becoming a supervisor). (NF, FG, RG)

New models of supervision

Role flexibility, shared supervision models and a culture of supervision and teaching within the practice where multiple GPs are committed to supporting and teaching the registrars, as opposed to the responsibility falling on only one GP, were suggested. These suggestions were identified as a way of managing self-identified clinical weaknesses and overcoming a preference to work part time, secondary to family responsibilities and other competing interests, both professional and personal. One participant stated:

> *If there was to be … a contingency plan for when I'm not around, then I'd be much happier to engage in that as a collective … Why not teach us all how to educate new doctors and sort it through that, as a collective supervision,* (rather) *than a sole responsibility on one doctor. I think also in that sense, gives you an ability, if it's not your strong area or if someone else does it better, then you can defer to them.* (REG, FG, RG)

Becoming a supervisor – How and when?

Participants did not know how to become a supervisor. They were not aware of any training for taking on this role, neither were they aware of when in their career they could become a supervisor. One new Fellow commented that they are:

> *… In that boat of* (being) *completely naive to what the process is to become a supervisor.* (NF, SSI, RG)

Another Fellow said:

> *I just thought you said, 'Yes, I'll be one (*a supervisor*)' and they said, 'Right, here's your registrar'.* (NF, SSI)

Participants were unsure about the best stage of their GP career to become a supervisor. Many spoke of feeling insufficiently experienced or knowledgeable to take on the responsibility of registrar supervision. Conversely, some participants reflected that as new Fellows, although they lacked years of clinical experience, they had recently passed all their college exams and therefore could be of most assistance in supporting registrars with their own exam preparation.

> *When you first Fellow, you've just passed your exam. So, you're very up to date with your knowledge base … The further you go away, the less up to date you are but the more experienced you are, so there's a bit of a play there. When's the right time, I guess, to do it, that's a general question that I have.* (NF, SSI, RG)

When it came to promoting the opportunity to become a GP supervisor, a mixture of responses suggested a multifaceted approach was needed to ensure maximum reach and conversion. It was felt that targeting not only GPs themselves, but also practice owners and practice managers was important. Some participants suggested promotional events where interested GPs could hear from those already in a supervisor role.

> *A meet-and-greet … where you've got some experienced supervisors. You get some personal stories and then you say what you get the benefits of it.* (NF, SSI, RG)

Participants also reflected on the need to increase the understanding of the role of a supervisor, what it entails and what the incentives are.

> *If all of us are new Fellows, and we don't know what's involved and how much you get paid and stuff like that, it's probably not going to get much interest.* (NF, FG, RG)

> *I think what we're saying for recruitment is it needs to be clear, it needs to be one home* (that) *recruits everybody and it needs to be a really clear process and maybe they actively recruit, rather than leaving it up to the GPs themselves.* (NF, FG)

Discussion

This qualitative study has highlighted that these early-career GPs have enormous respect for good supervisors and are motivated to become supervisors by a professional sense of responsibility, the rewards of giving back and a belief that supervision can add diversity into their own GP consulting. Supervision was also considered to be a mechanism for the long-term building of a sustainable clinical workforce from within, particularly in rural contexts. However, a range of personal, professional and systemic barriers to becoming a GP supervisor were identified, including the potential negative impact on work-life balance, incomplete professional identity formation and lack of knowledge on how to become a supervisor.

Various enabling strategies were suggested, including being part of an established training environment, team supervision arrangements, clear contractor agreements and remuneration. Shared models of supervision could provide flexibility to match learner to supervisor, utilising collegial peer support. Using available resources to share the load appears more critical in smaller practices and rural training environments.

Mentorship and teaching are core competencies in the RACGP and ACRRM curriculums.[19,20] Thus, participants' reflections on the inevitability of becoming a supervisor were grounded in the professional responsibility of being a GP. The notion of giving back through teaching is inherent in the social contract that all doctors have with society[21,22] and most were already providing informal supervision to registrars and medical students.

GP supervisors' professional identities include both their clinical and supervisory roles.[13]

Our findings suggest that early-career GPs were still developing their clinical identities and might lack the confidence and capacity to take on a supervision role at this stage of their careers. Similar to previous research,[11] participants were uneasy about being personally, professionally and medicolegally responsible for registrars. To overcome these challenges, early-career GPs need detailed information on, and personalised recruitment to, the supervisor role, and continuing professional development once in that role. Furthermore, new models of supervision are required that reflect GPs' desire for more flexible working arrangements.[23]

Limitations

All but one participant in this research intended to become a supervisor, raising the possibility that our recruitment strategy attracted those with the most interest in the topic. Only four RG registrars participated and no International Medical Graduates (IMGs), and therefore our reporting of barriers and enablers to becoming supervisors should not be considered representative of all early-career GPs. Despite potential self-selection bias in recruitment, the barriers and enablers to becoming a GP/RG supervisor identified in our research resonated with previous national and international research.[2,11–13,24,25]

Conclusion

These early-career GPs identified several strategies to improve and incentivise recruitment of the next generation of GP supervisors. These included establishing clear pathways to becoming a GP supervisor, nationally consistent (mandatory) training modules and paid continuing professional development, flexibility in supervisory models, and remuneration that reflects both the importance and time commitment of the role.

With the shift of Australian GP training to the ACRRM and RACGP's college-led training in 2023, the incorporation of a national GP supervisor curriculum, implementation of nationally consistent GP supervisor professional development framework and future enhanced professional recognition for the role of GP supervisor is pivotal. Investment in enablers for becoming a GP supervisor is a strategic imperative to build the pipeline for a sustainable GP workforce and further research will be needed to evaluate the effectiveness of initiatives to enable GPs to become – and continue to work as – GP supervisors.

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