

A Strategy for Retaining General Practitioners:

A pilot and feasibility study of group supervision for improving the wellbeing of Year Two General Practitioner Registrars in Waitaha Canterbury



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This pilot and feasibility evaluation of group supervision for Year Two GP (GPEP2) registrars was undertaken through a collaboration between the Canterbury Faculty of the Royal New Zealand College of General Practitioners (RNZCGP) and the Canterbury Primary Care Taskforce (PCTF). The Taskforce is a collaborative of health system and community leaders working to improve access to care by addressing the capacity pressures in primary care.

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EXECUTIVE SUMMARY

General practitioners (GPs) in New Zealand continue to experience high levels of stress and burnout, with GPs in training and early-career practitioners particularly at risk. Burnout has well-documented implications for the quality of patient care, clinician wellbeing, and the sustainability of the general practice workforce.

Professional reflective supervision (supervision) is an emerging intervention with evidence of benefits, including clinician wellbeing, reduced stress, improved interpersonal skills, and decreased professional isolation. Despite these reported benefits, supervision is not routinely accessed by GPs. Delivering supervision in a group format may also offer a scalable and cost-effective approach.

GP registrars are recognised as being at greater risk of reduced wellbeing as they transition to near-full GP workloads. This pilot and feasibility study examined:

- whether a gap exists in the professional and wellbeing supports available to Year Two GP (GPEP2) registrars in Canterbury,
- the extent to which Year Two GP (GPEP2) registrars would engage in supervision,
- early signals that group supervision may contribute to reducing work-related stress and burnout,
- the acceptability, and perceived value of incorporating group supervision within the GPEP2 programme, and
- the utility of the survey tool used.

Ten of 25 eligible GPEP2 registrars self-selected to participate in six online small-group supervision sessions delivered between June and November 2025. Participation occurred in the evenings and was additional to the GPEP2s' clinical and structured learning commitments.

Quantitative and qualitative data were collected through pre- and post-intervention surveys, attendance logs, and semi-structured interviews. Work-related burnout was assessed using the validated Copenhagen Burnout Inventory work-related subscale.

The findings offer early insights and guide future research. They include:

- Group professional supervision is both feasible and acceptable for GPEP2 registrars, with 71% average attendance, 89% (8/9) of respondents satisfied or very satisfied with the programme, and 100% recommending the programme to future GPEP2 registrars.
- There are early signals of benefit for GPEP2 registrars' wellbeing and work-related stress, with 55% (5/9) showing reduced burnout, and 89% (8/9) reporting improved wellbeing. Participants also reported feeling less isolated and benefiting from increased collegial support.
- Results also highlight the marked reduction in structured training, reflective learning, and clinical supervision as registrars transition from Year One to Year Two. Group supervision may provide GPEP2s with valuable additional support through this period.
- Participants recommended integrating group supervision into protected or paid time to reduce barriers to participation.

We recommend that further studies move beyond the pilot study design, provide group supervision within protected or paid time; expand the number of participants and explore the longer-term impacts on participants wellbeing, and workforce retention.

Overall, findings suggest that group supervision is a promising and scalable way to enhance GP Year Two registrar wellbeing. Furthermore, integrating such supports into the GPEP2 programme may be an evidence-based strategy to strengthen the wellbeing and sustainability of the GP workforce.

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INTRODUCTION

Background

About levels of stress, burnout and leaving profession

Recent evidence highlights the high and persistent levels of burnout among general practitioners (GPs). In the 2024 Royal New Zealand College of General Practitioners (RNZCGP) survey, 70% of GPs rated themselves as moderately to highly burnt out.¹ GPs in training, and early to mid-career GPs appear more at risk.^{2,3} New Zealand GPs under 55 years of age reported significantly higher rates of burnout (57%), compared with those 55 years of age and older (40%).⁴ International evidence is consistent with these findings. A 2019 assessment of 503 current and future GPs in Switzerland identified that residents intending to enter general practice had significantly lower levels of mental health than qualified GPs, with 20% meeting the criteria for being at risk of burnout.²

Burnout among doctors has been described as a ‘public health crisis’ given its impact on patient care, workforce wellbeing, and the productivity of health organisations and systems.^{5,6}

High levels of stress and burnout within the health workforce are well documented,⁷⁻⁹ with burnout defined as “a state of physical, emotional and mental exhaustion that results from long term involvement in work situations that are emotionally demanding”.^{10(p501)}

Contributors and solutions: what is known

GP burnout arises from a complex interplay of system, organisation and individual factors including insufficient system capacity, low-value administrative burden, high workload, workforce shortages, reduced sense of purpose, increasing patient complexity and expectations, professional isolation and fear of making mistakes.¹¹⁻¹³ While long-term system-level reforms are required to address structural contributors, more immediate organisational and individual-level interventions can play a critical role in mitigating the risk of burnout and supporting the retention and sustainability of the GP workforce.

Evidence-based organisational strategies include reducing GP workloads, streamlining systems and processes, organisational promotion of wellbeing and peer support, and fostering a sense of community and collegiality.^{13,14}

Individual-level strategies shown to support GP wellbeing include mindfulness, stress management and communication training, self-care practices, and participation in small-group programmes that encourage collegiality and connectedness.^{6,11,13-16}

Professional reflective supervision

Emerging evidence suggests that professional supervision may help prevent or alleviate burnout. Reported benefits include improved GP to patient relationships, enhanced clinician wellbeing, protection against work-related stress and burnout, improved morale and, in some cases improvement in clinical skills.¹⁷⁻²⁰ When delivered in a group format it may also reduce GPs sense of isolation, improve feelings of empowerment and collaboration, and provide GPs with a regular source of support.^{21,22}

Additional evidence from a randomised clinical trial involving 79 internal medicine physicians found that both small groups and one to one professional coaching (which included professional supervision-like elements), were associated with reduced burnout. The study concluded that small group coaching may be a more cost effective and scalable approach.⁵

Definitions of supervision vary, with Rothwell et al. (2021) describing professional supervision as “an event that involves an ongoing professional relationship between two or more people to support professional development, enhance knowledge, and skills”.^{23(p1)} For the purposes of this evaluation professional reflective supervision is defined as a structured, and intentional reflective process that supports health practitioners to critically examine their work. Key features include:

- a relationship involving a supervisor (or facilitator) and a supervisee (or a group of supervisees),
- independence of the supervisor from the group or organisation,
- a focus on interpersonal work-related issues, and
- the use of reflective practice to enhance self-awareness in professional relationships.

Through this document the term ‘supervision’ refers specifically to professional reflective supervision.

Despite the potential benefits, supervision is not embedded as a form of professional support available to, or routinely accessed by, GPs. Barriers to access include professional culture and norms, competing workloads and limited time.²⁴

Supervision is, however, a well-established requirement in several other health professions.¹⁸

Context: Local access to professional education and wellbeing supports

Given the evidence that small-group interventions and professional supervision may reduce burnout risk, a scan of the Canterbury environment was undertaken to identify the professional and educational supports currently available to GPs. A summary is provided in Figure 1.

In addition to the group-based supports, a small number of GPs self-fund or access externally funded individual supervision. Some Canterbury Primary Health Organisations (PHOs) offer pastoral care that may include a limited number of funded supervision sessions per annum.

Peer Groups: A forum for GPs to review cases and reflect on their clinical practice.

Clinical Connect – Peer Education Programme: Provides education for primary care health professionals.

Continuous Improvement Peer Group*: Provides general practice staff with the opportunity to share ideas, innovations and challenges that support efficiency and sustainability of general practice.

Pastoral Care*: Individualised confidential support to help GPs stay safe and provide excellent care. May include counselling, business sustainability and audits of patient records.

*Pegasus PHO only

Figure 1: Scan of Professional educational and wellbeing supports in Canterbury, Jan. 2026.

GPs in training in Canterbury: Existing local resources and context

In addition to the professional supports described in Figure 1, the following is available to GP registrars in Canterbury.

The training schedule of Year One GP (GPEP1) registrars is typically four days per week in general practice and one day per week as a group seminar day. On most (30 of 40) seminar days GPEP1 registrars participate in a small-group reflective practice session that focuses on the non-biomedical aspects of working as a GP and utilises the features of supervision described in this report.

The frequency of the reflective practice and group learning sessions reduce substantially as GP registrars transition from Year One to Year Two of training. Year Two (GPEP2) and Year Three (GPEP3) GP registrars are provided with eight two-hour facilitated learning groups annually. The focus of these sessions also expands to include biomedical issues.

The other structured learning provided to GP registrars includes clinical supervision from a nominated GP supervisor within the practice and visits from one of the RNZCGP Canterbury Medical Educators.

Overall, the total volume of structured training and peer-supported learning reduces markedly between Year One and Year Two of GP registrar training. While a phased reduction in formal training and support would be expected within a specialist vocational pathway, it is unclear whether the current level and type of support provided to GPEP2 registrars adequately meets their needs and is sufficient to maintain wellbeing during their transition to a near full GP workload.

Table 1 summarises the structured training and support provided to GPEP1 and GPEP2&3 registrars in Canterbury.

Structured Training and Support Inputs		
Training / support type	GPEP 1	GPEP 2 & 3
Structured learning	40 x 8-hour seminar days per annum. Reflective practice sessions are included in 30 of the 40 seminar days. Total = 275 hours /annum (excl. reflective sessions)	Self-directed
Group learning	1.5-hour x 30 reflective practice sessions. Total = 45 hours / annum	2-hour x 8 facilitated learning groups Total = 16 hours / annum
Clinical supervision / mentoring	Typically, GPEP1 registrars are employed by the RNZCGP for 46 weeks practice placement. Within the placement: <ul style="list-style-type: none"> • Patient appointments transition from 30→20→15-minutes duration during the year. • Registrars receive 1.5 hours/week teaching and 2.5 hours/week support. Total = 184 hours/annum	GPEP2 & GPEP3 registrars are employed by general practices for a minimum of four sessions/week. This typically includes: <ul style="list-style-type: none"> • 15-minute appointments • A minimum of 8 hours direct supervision per annum Total = 8 hours / annum
RNZCGP Medical Educator coaching	Two visits per annum	One visit per annum
TOTAL	504 hours of structured learning and support + 2 visits	24 hours of structured learning and support + 1 visit

Table 1: Structured training and support provided to GPEP registrars

The Gap

A high performing and sustainable GP workforce is dependent on addressing the significant levels of stress and burnout experienced by GPs. GP registrars are recognised as being at greater risk of reduced wellbeing as they transition to near-full GP workloads.² Ensuring that the professional supports available adequately meet GP registrars' mental health and wellbeing needs is therefore important for retaining early career GPs and supporting their progression into the future GP workforce.

Supervision is emerging as an intervention that can improve wellbeing, reduce stress and strengthen interpersonal relationships. When delivered in a group format it may also reduce professional isolation and build collegiality. Despite these potential benefits, supervision is not routinely accessed by GPs nor is it a standard component of the GPEP2 training programme.

It remains unknown whether providing group supervision for New Zealand GPEP2 registrars is feasible or effective and whether it could address any gaps in the existing wellbeing supports.

This research, therefore, examines whether a gap exists in the professional supports currently available to GPEP2 registrars, particularly those designed to address stress and wellbeing. It investigates whether group supervision may help address this gap, by identifying signals of impact on stress and burnout, and explores its feasibility, acceptability and potential value as part of the GPEP2 programme in New Zealand. This study's results will also contribute to evidence on strategies that promote wellbeing and retention of GPs by supporting clinicians early in their careers and normalising their use of structured wellbeing supports over time.

OBJECTIVES

Specifically, the study aims to:

1. understand in more detail the gap in professional wellbeing supports available to GPEP2 registrars in Canterbury,
2. determine whether GPEP2 registrars will engage in group supervision designed as a strategy to address this gap,
3. explore whether group supervision helps address the gap by surveying for signals of effectiveness, including changes in work related stress and burnout indicators,
4. investigate how satisfactory the GPEP2 registrars' experience of group supervision was, including perceived value and barriers to participation, and
5. assess the usefulness of the survey tools.

METHODS

Study Design

We conducted a pilot and feasibility study to assess the intervention's feasibility, acceptability, and early signals of effectiveness. Elements of the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework were applied and informed the selection of outcome measures.^{25,26} A mixed method approach enabled the collection and integration of qualitative and quantitative data that informed the findings.

Study setting and population:

The study was conducted in Canterbury, New Zealand. The study population comprised of the GPEP2 registrars (n=25), who were eligible¹ and invited to participate. With two supervision groups planned, a target sample of 12-14 participants was sought to enable workable group sizes while retaining a small-group supervision format. GPEP2 registrars self-selected to participate in the group supervision and contribute to the research through participation in the study activities.

¹ Canterbury based GPEP1 registrars in 2024 that were continuing as GPEP2 registrars in Canterbury in 2025.

Recruitment process

Recruitment occurred in the following three stages:

1. November 2024: Communication about the pilot and invitation for expressions of interest.
2. March - April 2025: Follow-up with those who expressed interest to confirm participation.
3. May – June 2025: Participation offered again to eligible GPEP2 registrars.
Registrars self-selected into the intervention.

INTERVENTION

The Canterbury Faculty of the RNZCGP collaborated with the Primary Care Taskforce (a collective of clinical and community leaders across the Canterbury health system), to deliver and evaluate the pilot and feasibility study. The RNZCGP Canterbury GPEP1 Lead Medical Educator, managed the recruitment of the GPEP2 registrars, engagement of the supervisors, coordination of the delivery of the group supervision, and communication between the PCTF and the GPEP2s. The Primary Care Taskforce (PCTF) led the evaluation including the study design, data collection and analysis, and completion of the report with input from the GPEP1 Lead Medical Educator.

The supervisors were engaged to deliver six supervision sessions and were responsible for setting the session schedule (day/time/frequency). These details, along with the names of the supervisors were provided to the registrars before they selected which group to join.

Group A met monthly (Monday 7:00-9:00 pm) and Group B met fortnightly (Tuesday 7:30 – 9:00 pm). The different schedules reflected supervisors' availability. The sessions were conducted via videoconferencing, except for Group A's final session which was held in person.

Delivery parameters and participant numbers are summarised in Table 2.

	No. of participants	Duration	Time of day	Frequency	Timeframe
Group & Supervisor A	6	2 hours	Mon. 7:00 - 9:00 pm	Monthly	June – Nov. 2025
Group & Supervisor B	4	1.5 hours	Tues. 7:30 - 9:00 pm	Fortnightly	June – Sept. 2025

Table 2: Delivery parameters and participant numbers

Supervisors

Both supervisors delivered this pilot in addition to clinical and/or supervision roles. They were engaged part time by the RNZCGP to facilitate GPEP1 registrars reflective practice sessions and were known to the GPEP2 registrars. Both supervisors had extensive experience as GP clinicians, acted as practice preceptors for GP trainees, and had undertaken professional supervision training. Supervisor A's formal training included one year of psychotherapy training and completion of a Balint Group Leader qualification. Supervisor B's training included a three-day supervision workshop and listening skills training, complemented by extensive self-directed learning.

While each supervisor applied a slightly different supervision framework, both followed a reflective registrar-led approach in which participants nominated two cases or issues per session and facilitated a structured reflection

and group discussion. Both supervisors prioritised the establishment of a safe environment and considered this as foundational to GPEP2 registrars’ participation and openness.

Data collection

Quantitative and qualitative data were gathered through:

- pre- and post-intervention surveys that included a validated burnout measure,
- attendance logs, and
- semi-structured interviews with supervisors and the GPEP1 Lead Medical Educator.

Data sources were selected to assess the feasibility, acceptability and early signals of effectiveness. We note the pilot design does not support causal inference.

The data sources are mapped to the research questions in Table 3.

Research question	What seeking to understand	Tool utilised
1. Gap Analysis: Understand in detail any gap that may exist	The professional supports GPEP2 registrars were accessing and their perceptions of whether the existing supports were sufficient. What GPEP2 registrars wanted from the intervention.	Pre and post intervention survey items Semi-structured interviews with the GPEP1 Lead Medical Educator.
2. Engagement in professional reflective supervision	Registrar interest in, and attendance at, the group supervision sessions.	Supervisor completed attendance log.
3. Signals of effectiveness	Changes in work-related burnout scores. Change in perceived wellbeing and level of stress associated with the intervention.	Copenhagen Burnout Inventory (work-related subscale) in pre and post intervention surveys Post-intervention survey quantitative and qualitative data items
4. Satisfaction	Registrar satisfaction with the programme including what worked and areas for improvements.	Post-intervention survey quantitative and qualitative data items
5. Usefulness of the survey tools	Clarity, ease of understanding and length of the survey tool.	Post-intervention survey quantitative and qualitative data items

Table 3: Mapping of research questions to measures and data sources.

Tools utilised in evaluation

Pre-and post-intervention surveys

Surveys were developed in Microsoft Forms in conjunction with the GPEP1 Lead Medical Educator. Desk piloting with a small group of GPs was undertaken to refine wording, content, and usability. Surveys included a combination of categorical quantitative items and free-text responses. Respondents were asked to enter the same Unique Identifier in both surveys to enable matching of the pre-and post-survey responses while maintaining anonymity.

The pre-intervention survey comprised 17 items and took an average of 2 minutes 57 seconds to complete. It included three sections: professional education and wellbeing supports (5 items), work-related stress and wellbeing (8 items), demographics and the Unique Identifier (4 items).

The post-intervention survey comprised 34 items and took an average of 10 minutes 07 seconds to complete. It included four sections: professional education and wellbeing supports, (4 items), work-related stress and wellbeing (18 items), satisfaction with the GPEP2 group supervision (6 items), general information and the Unique Identifier (6 items).

The complete survey instruments are provided in Appendix One.

Distribution and completion

The pre-intervention survey was distributed on 30 June 2025 by the GPEP1 Lead Medical Educator, with participants asked to complete it prior of their first supervision session. Supervisors reminded participants to complete the survey, and where required, enabled this to occur at the start of the first supervision session.

The post intervention survey was distributed on the day of the programme completion with participants asked to complete it within a week. Additional reminders included a group reminder approximately two weeks after programme completion and reminders to non-responders in early December.

A timeline of key milestones in the intervention is provided in Figure 2.

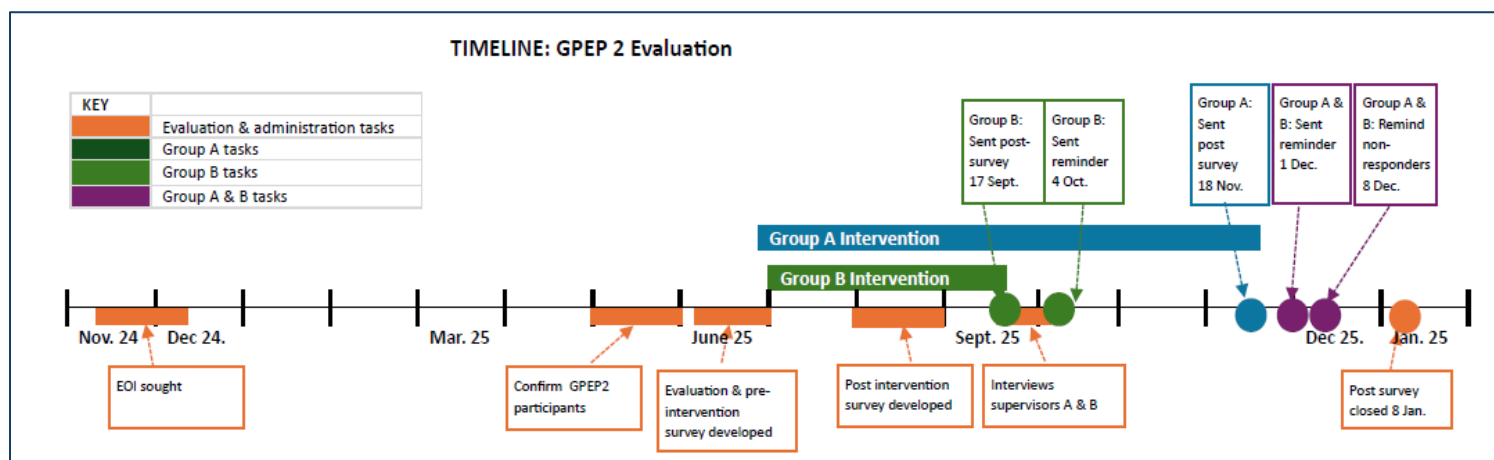


Figure 2: Timeline of key milestones

Confidentiality

Confidentiality of participants was maintained through the following procedures:

- surveys were anonymous; participants entered a Unique Identifier to enable pre/post matching without recording names,
- the GPEP1 Lead Medical Educator communicated with participants and did not have access to any dataset linking Unique Identifiers to individual responses, and
- where participants used inconsistent Unique Identifiers across surveys, limited correspondence occurred to confirm matching. In some cases, demographic information was used to aid confirmation.

Evaluating burnout

The Copenhagen Burnout Inventory (CBI) was used to assess burnout pre- and post-intervention. The CBI is a widely used validated tool, that has been applied in studies of employee burnout across the service sector, including with healthcare workers.²⁷ It consists of three scales: personal burnout, work-related burnout, and client-related burnout; with each scale having high internal validity. Selection of the CBI was informed by its high response rate, length, the internal validity of each scale, and its capacity to detect change over time. The core of burnout in the CBI is exhaustion and fatigue.²⁷

Given the focus of this evaluation, the seven-item CBI work-related scale was used. Work-related burnout is defined by Kristensen et al. as “the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work”.^{27(p196)} One item from the client-related burnout scale (“Do you sometimes wonder how long you will be able to continue working with patients”),^{27(p196)} was included due to its relevance to workforce retention. However, the inclusion of a single item from a multi-item scale limits the interpretability and validity for any client-related burnout construct; results from this stand-alone item were therefore be treated as exploratory.

Scoring and Interpretation

CBI items are rated on a five-point response scale scored from 0 – 100, (Always=100 points, Often=75, Sometimes=50, Seldom=25, and Never/almost never=0). Scale scores are calculated as the mean of item scores.²⁸

In the work-related burnout scale a mean score change of five mean score points is generally considered an indicative threshold for meaningful difference. However, interpretation should consider sample size, and the pilot nature of this study.^{9,27}

Because burnout scores exist on a continuum, categorical cut-off points have limitations. Nevertheless, the following commonly used bands are included to aid understanding.⁹

- 0–49 (Low): normal levels of fatigue or stress
- 50–74 (Moderate): likely burnout symptoms present
- 75–99 (High): serious physical and psychological exhaustion
- 100 (Severe): total exhaustion

FEASIBILITY

Feasibility criteria were determined as a priori thresholds across five domains using seven measures addressing:

- perceived gap in supports,
- engagement,
- signals of effectiveness,
- satisfaction, and
- usefulness of the survey tool.

A priori thresholds are provided in Appendix Two.

ANALYSIS

Quantitative responses were analysed using simple counts and proportions in Microsoft Excel. Free-text responses were synthesised using thematic analysis by the researcher and discussed with the research team.

Pseudonyms are used when participant comments are included to illustrate a finding.

RESULTS

Survey response rate

All ten participants completed the pre-intervention survey (10/10, 100%), and nine participants completed the post-intervention survey (9/10, 90%). The reason for the single non-completion of the post-intervention survey is unknown. Where survey results relied on paired pre- and post-survey responses, (e.g., CBI work-related burnout scores), only participants with matched survey responses were included (paired sample = 9).

Most survey items were mandatory. The pre-intervention survey contained no missing data (all respondents provided complete responses).

The post-intervention survey contained some missing item-level responses, as detailed below.

- Where a respondent selected 'no effect' for the perceived influence of supervision on stress (n=4) or wellbeing (n=1), no additional explanatory comment was provided.
- Free-text response rates were low for some items: only 2/9 respondents provided insights to guide future decisions regarding a supervision programme for GPEP2 registrars, and 2/9 provided comments on the survey tool. Non-response rates for these open-ended questions should be considered when interpreting the qualitative findings.

Participant uptake and demographics

Ten registrars participated in the pilot, representing 40% of the eligible GPEP2 cohort (10/25). A comparison of pilot participant demographics with the full GPEP2 cohort identified no differences in gender or ethnicity distribution. However, pilot participants were more likely to be aged 30–34 years (7/10; 70%) than in the overall cohort (9/25; 36%). The age distribution is presented in Table 4.

Age Band	Pilot	All GPEP2 registrars
25-29	2 (25%)	13 (52%)
30-34	7 (70%)	9 (36%)
35-39	1 (10%)	3 (12%)

Table 4: Age distribution of pilot participants compared with all Canterbury GPEP2 registrars

Gap in Professional Supports

The pre-intervention survey asked participants what regular professional supports they engaged in that were additional to the formal GPEP2 training, and whether these were sufficient to help manage wellbeing and work-related stress.

Participants reported accessing a mean of two additional professional supports (range 1-4). The most frequent professional supports accessed were peer groups (n=7), professional supervision (n=6), and Clinical Connect (n=5).

Two participants (2/10, 20%) indicated that the available supports were 'not sufficient'; a further two (2/10, 20%) responded 'maybe sufficient' and six (6/10, 60%) reported the supports 'were sufficient'. The two participants who reported that the supports were not sufficient, were each only accessing one additional professional support regularly and described limited time and level of stress as barriers to accessing further supports. Results are summarised in Table 5.

Are the professional supports you regularly engage in sufficient	No. of respondents	Average no. of professional supports being accessed
Not sufficient	2	1
May be sufficient	2	3
Were sufficient	6	2

Table 5: Perceived sufficiency of professional supports at baseline

All respondents to the post-intervention survey (9/9; 100%) reported no change in the additional professional supports they were accessing.

What participants wanted out of the programme

Participants were asked what they hoped to gain from group supervision. Thematic analysis identified three primary expectations:

- Emotional and peer support and an ability to debrief/vent (n=4).
- Reflection on their own practice and continued development of clinical skills (n=3).
- To learn more about the Balint process and its application (n=3).

Engagement in professional reflective supervision programme

Participation and attendance data were used to assess engagement in the group supervision programme.

Attendance

Average attendance across both groups was 71%, equating to a mean of 6.8 attendees per session out of a possible ten. One participant attended all six sessions, while most participants missed one to two sessions. Attendance ranged from two sessions (n=1 participant) to five sessions (n=3 participants). Attendance results are presented in Table 6.

	Participant no.	Average attendance
Group A	6	58% (3.5 of a possible 6 attendees) per session
Group B	4	83% (3.3 of a possible 4 attendees) per session.
Combined	10	71% (6.8 of a possible 10 attendees) per session.

Table 6: Number of participants and average attendance by supervision groups

Effectiveness: Signals of impact of group professional reflective supervision on GPEP2 Registrars

Signals that the group supervision intervention influenced GPEP2 registrars' wellbeing and work-related stress were assessed using three data sources:

- pre- and post-intervention survey responses to the CBI work-related scale,
- post-intervention survey responses on whether group supervision influenced perceived stress and wellbeing, as well as any other perceived benefits, and
- post-intervention responses regarding intentions to continue accessing supervision and to recommend the programme to future GPEP2 registrars.

Copenhagen Burnout Inventory: Work-related burnout scale

Comparison of pre- and post-intervention CBI work-related mean scores among participants with matched surveys (n=9) suggested a reduction in work-related burnout for most participants:

- Five participants (5/9, 55%) had decreases in mean scores ranging from 7 to 39 points.
- Three participants (3/9, 33%) had no change in mean scores.
- One participant (1/9, 11%) had an increase in mean score of 57 points.

Across all paired participants, the mean CBI work-related score decreased by 6.3 points (11%), from 56.7 pre-intervention to 50.4 post-intervention, indicating a small overall improvement in work-related burnout within this pilot cohort.

This pattern was also evident in movement between the CBI interpretive categories used in this report where:

- the number of registrars classified as experiencing moderate-or-higher burnout decreased from 6/9 (67%) pre-intervention to 4/9 (44%),
- the number classified as no/low burnout increased from 3/9 to 5/9, and

Two participants were classified as experiencing high or severe burnout in both the pre and post intervention surveys; however, only one was the same individual across both surveys. One participant showed an improvement by moving from the high/severe burnout category to the moderate burnout category, while another participant showed a marked deterioration, moving from the no/low burnout category to the high/severe burnout category. This notable increase in mean burnout score for a single participant diverges from the overall trend suggesting factors unrelated to the intervention may have influenced this participant's post-intervention score.

See Table 7 for a comparison of CBI work-related scale mean scores and burnout categories.
 Note: Demographic data have been removed from the table to maintain participants anonymity.

Participant	PRE-INTERVENTION		POST-INTERVENTION		CHANGE		
	Mean score CBI	Category of burnout	Mean Score for CBI	Category of burnout	Change in mean score	% change in mean score	Change in category of burnout
1.	57.1	Moderate	60.7	Moderate	+3.6*	6%	No change
2.	89.3	High	89.3	High	0	0%	No change
3.	14.3	No /low	14.3	No /low	0	0%	No change
4.	32.1	No /low	89.3	High	+57.2	178%	Increased
5.	60.7	Moderate	21.4	No /low	-39.3	-65%	Decreased
6.	60.7	Moderate	39.3	No /low	-21.4	-35%	Decreased
7.	100	Severe	67.9	Moderate	-32.1	-32%	Decreased
8.	60.7	Moderate	42.9	No /low	-17.8	-29%	Decreased
9.	35.7	No /low	28.6	No /low	-7.1	-20%	No change
Mean	56.7		50.4		-6.3	-11%	
Range	14 - 100		14 – 89				
Median	60.7		42.9		-17.8	-29%	

Table 7: Comparison of CBI work-related scale mean scores and burnout category
 *A difference of 5 points is considered significant

Change in CBI work-related scale items

Item-level analysis of the seven CBI work-related questions indicated:

- Mean scores decreased for all items except: Q4: 'Do you have enough energy for family and friends during leisure time', which was relatively low in both the pre- and post-intervention survey,
- At baseline, the highest mean scores related to questions about feeling worn out, emotionally exhausted, and frustrated. The largest reductions were observed for:
 - Q6: 'Does your work frustrate you?', which decreased from a mean of 61.1 to 44.4 points (-16.7 points; -27%); and
 - Q3: 'Do you feel that every working hour is tiring for you?', which decreased from a mean of 55.6 to 41.7 points (-13.9 points; -25%).
- Overall, the mean of all item scores decreased from 56.7 to 48.4 points (-8.3 points; -15%), and the median score decreased from 60.7 to 42.9 points (-17.8 points, -29%).

Pre- and post-intervention item level means scores are presented in Table 8.

QUESTIONS: CBI work related burnout scale	PRE-INTERVENTION	POST-INTERVENTION	CHANGE	
	Mean Score CBI of all participants	Mean Score CBI of all participants	Change in mean score	% change in mean score
Q1: Do you feel worn out at the end of the working day?	72.2	66.7	-5.6	-8%
Q2: Are you exhausted in the morning at the thought of another day at work?	55.6	50.0	-5.6	-10%
Q3: Do you feel that every working hour is tiring for you?	55.6	41.7	-13.9	-25%
Q4: Do you have enough energy for family and friends during leisure time?*reverse scored*	36.1	36.1	0.0	0%
Q5: Is your work emotionally exhausting?	69.4	58.3	-11.1	-16%
Q6: Does your work frustrate you?	61.1	44.4	-16.7	-27%
Q7: Do you feel burnt out because of your work?	47.2	41.7	-5.6	-12%
Mean of all question scores	56.7	48.4	-8.3	-15%

Table 8: Pre and post intervention item level means scores

Attribution: Perceived influence of group supervision on wellbeing and stress

While the pre–post design cannot determine causality, the post-intervention survey asked participants whether the group supervision influenced their wellbeing and level of stress in relation to their GPEP2 work and whether they experienced other benefits. Responses used a five-point scale ranging from “always/to a high degree” to “never/almost never/to a very low degree.”

Analysis of responses indicated:

- Eight of nine respondents (8/9; 89%) reported that participation in group supervision improved their wellbeing, while one (1/9; 11%) reported no effect. Among those reporting improved wellbeing, six rated the influence as ‘somewhat’ and two as ‘to a high degree’.
- Five of nine respondents (5/9; 56%) reported that participation in group supervision reduced their stress, while four (4/9; 44%) reported no effect. Among those reporting reduced stress, two rated the influence as ‘to a low degree’, two as ‘somewhat’, and one as ‘to a high degree’.
- Seven of nine respondents (7/9; 78%) reported other benefits, most commonly: reduced isolation, collegial support, and professional development.

Participants’ perception of the influence of group supervision on their wellbeing and stress are summarised in Table 9.

	Improved	Decreased	No effect	To what degree did group supervision influence the change
Influence on wellbeing	8 (89%)	0	1 (11%)	<ul style="list-style-type: none"> • 6 (75%) somewhat • 2 (25%) to a high degree
Influence on level of stress	5 (56%)	0	4 (44%)	<ul style="list-style-type: none"> • 2 (40%) to a low degree • 2 (40%) somewhat • 1 (20%) to a high degree

Table 9: Perceived influence of group supervision on wellbeing and stress

“Helped overcome relative isolation of GPEP2 compared with GPEP1, from seeing peers weekly to 6 weekly is a big change.” Edmund, 30-34-year-old male

“Sense of collegiality.” Murray, 30–34-year-old male

Maintenance: Intention to continue accessing supervision

Participants were asked whether they intended to continue with supervision and why.

The pre-intervention survey did not explore the type of supervision being accessed. Where respondents recorded ‘supervision’ it was assumed to be individual supervision, unless specified further. The post intervention survey sought additional details about the type of supervision they intended to access, (i.e. individual or group). The assumptions made interpreting the pre-intervention findings impact the conclusions drawn on any change in the type of supervision accessed pre- and post-intervention.

Prior to the intervention

- Six participants with paired responses (6/9, 66%) reported accessing some form of supervision.
- Three (3/9, 33%) were not accessing any supervision.

Post-intervention:

Eight participants with paired responses (8/9, 89%) indicated an intention to continue with supervision. Of those intending to continue supervision:

- Five intend to continue with group supervision. This included:
 - one previously not accessing any supervision,
 - four assumed to have been accessing individual supervision pre-intervention, and
 - one accessing group supervision pre-intervention.
- Three planned to continue with individual supervision. This included:
 - two who were assumed to be accessing individual supervision pre-intervention, and
 - one previously not accessing any supervision.

One respondent (1/9, 11%) who had not accessed supervision prior to the intervention indicated that they did not intend to access supervision after the intervention.

Respondents access, and/or intent to access supervision, are displayed in Table 10.

“I find it helpful for me to have someone else look at challenging situations and offer advice/give their opinion”. Lydia, 30–34-year-old female

	Pre-intervention: Participants regularly accessing supervision*	Post-intervention: Participant intentions to continue accessing supervision
1.	Yes: individual	Yes: group
2.	No	Yes: individual
3.	Yes: group	Yes: group
4.	Yes: individual	Yes: group
5.	No	No
6.	Yes: individual	Yes: group
7.	No	Yes: group
8.	Yes: individual	Yes: individual
9.	Yes: individual	Yes: individual

Table 10: Access / intent to access supervision

*Where participants indicated they attended supervision in the pre-intervention survey it was assumed to be individual supervision, unless stated otherwise.

Acceptability: Participant Satisfaction with the programme

The post-intervention survey assessed overall satisfaction with the group supervision, access barriers, and perceived positive and negative aspects of the programme.

Overall satisfaction

Eight of nine respondents (8/9; 89%) reported being satisfied (n=6) or very satisfied (n=2). One respondent reported being neither satisfied nor dissatisfied.

Barriers to access

Participants were asked about barriers to accessing the programme, with the following identified:

- Evening scheduling (n=3).
- Energy levels (n=1).
- The fortnightly sessions were too frequent (n=1).

One participant suggested that the group supervision be scheduled in paid work time.

“It would be great if group supervision going forward was free or in paid time rather than an additional thing in the evening that is self-funded”. Freda, 25–29-year-old female

Participants expressed mixed views regarding the value of online versus in-person delivery. Some identified online delivery as reducing access barriers (e.g., travel/time), while others preferred in-person interaction despite potential additional barriers.

“Little barrier as it was done on zoom. However, I prefer in person group which can bring the barrier of time and transport”. Gary, 35–39-year-old male

Positive and negative aspects of intervention

Perceived positive aspects of the programme included a supportive atmosphere, peer interaction/collegiality, practical case discussion focused on patient interactions, and the supervisors' experience. Negative aspects included the need for it to be provided in protected/paid time, insufficient time, and the frequency of sessions, with fortnightly sessions perceived as too frequent.

“Evening time so I missed them when work overran. Sometimes hard to keep talking about work in your own time”. Jane, 30–34-year-old female

Recommending to future GPEP2 registrars

All respondents to the post-intervention survey indicated they would recommend the programme to future GPEP2 registrars (9/9, 100%). Comments emphasised peer support, reduced isolation, maintaining connection, and the value of hearing different perspectives.

“GPEP2 can feel very isolated - this helps stay connected” Tom, 25–29-year-old male

Survey tool feedback

Feedback on the survey tools was sought to inform future refinement. Most respondents agreed or strongly agreed that the surveys were clear, easy to understand, relevant, and of reasonable length. One respondent noted that questions about positive and negative aspects of the programme felt repetitive.

Feedback on the survey tools is displayed in Table 11.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Clarity and easy to understand	2 (22%)	6 (67%)	1 (11%)	0	0
Length	1 (11%)	7 (78%)	1 (11%)	0	0
Covered relevant topics	2 (22%)	6 (67%)	1 (11%)	0	0

Table 11: Survey tool feedback (clarity, length, and relevance)

FEASIBILITY CRITERIA

This pilot assessed the feasibility of group supervision for GPEP2s to inform decisions about continuation of the intervention and/or refinement of the GPEP2 programme structure. A priori feasibility criteria were agreed before the intervention. The results are summarised in Table 12 and indicate that the pre-specified feasibility criteria were met.

	Criteria	Result	Achieved / not achieved
1. Survey respondents perceive there is a gap in the professional supports available			
	Gap identified by 10%	Gap identified by 20% and a further 20% unsure.	Achieved
2. GPEP2 registrar level of engagement in group professional reflective supervision			
Uptake	Initial uptake of > 20%	Uptake of 40% (10/25) of all GPEP2 registrars.	Achieved
Attendance over time	Attendance of 50% retained	71% (average of 6.8 attendees per session)	Achieved
Continued access to professional reflective supervision	% participants that intend to continue accessing supervision	89% (8/9) intend to continue supervision*. Of the eight: <ul style="list-style-type: none"> • five intend continuing with group supervision, and • three of eight continuing with individual supervision. Of the three not engaged in any form of supervision prior to the intervention: <ul style="list-style-type: none"> • one indicated they intend to continue with group supervision, and • one to continue with individual supervision. 	Achieved While no target was set, the increased uptake in supervision by two participants suggests this has been achieved
3. Does this address the gap			
Signal of effectiveness	Negative change in levels of burnout	Analysis of the paired CBI scores indicated that: <ul style="list-style-type: none"> • 56% (5/9) participants had a decrease in burnout, • 33% (3/9) were unchanged, and • 11% (1/9) had an increase. Furthermore, 89% (8/9) attributed supervision to an increase in wellbeing, while 55% (5/9) attributed supervision to an improved level of stress.	Achieved
4. Level of satisfaction of GPEP2 registrars' experience of professional reflective supervision			
Level of overall satisfaction	Positive overall satisfaction	89% (8/9) identified they were satisfied (n=6) or very satisfied (n=2).	Achieved
5. Usefulness of survey tool			
Usefulness of survey tool	50% agreed the survey tool statements on clarity and understanding	89% (8/9) of respondents either agreed (n=6) or strongly agreed (n=2) that the survey tool was clear and easy to understand, the right length and relevant.	Achieved While no target was set results suggest this was achieved with improvements identified.

Table 12: Results against feasibility thresholds established a priori

*Six participants were accessing individual supervision prior to the intervention.

DISCUSSION

The results from this pilot and feasibility study suggest that some GPEP2 registrars experience a gap in available professional wellbeing supports and that group supervision may be a feasible and acceptable intervention that contributes to improved wellbeing and reduced risk of work-related burnout.

A moderate proportion of eligible GPEP2 registrars (40%) enrolled in the programme, indicating reasonable uptake for an optional intervention delivered outside usual work hours. Participants expected it would support their self-management and wellbeing and/or build their clinical skills.

Most participants (n=7/10) missed only one to two sessions of the six-session programme. High levels of satisfaction and universal willingness to recommend the programme suggest that non-attendance was more likely due to practical constraints (e.g., workload, fatigue, running late) than perceived lack of value.

Although the overall attendance rate across both groups was reasonable (71%), Group B attendance (83%) was higher than Group A (58%). Because of the small sample, it is not possible to determine whether this difference was attributable to frequency, group size, session length, session timing, or other factors. Nevertheless, when attendance patterns are considered alongside participants' feedback on barriers (evening scheduling, energy levels, clinical workload), the findings support testing the delivery of group supervision within paid work time or the formal training schedule, if operationally feasible.

The pre-intervention CBI scores indicated that 67% of participants (6/9) were experiencing moderate-to-high levels of work-related burnout, with a mean score of 57. This provides an initial signal that this cohort may be experiencing substantial work-related exhaustion.

To contextualise the study's findings, the results were compared with other studies on GP burnout that used the CBI or involved New Zealand GPs.

Of the estimated 88 studies across different countries and occupational groups that have used the CBI, two explored burnout levels in the GP workforce.²⁹ A 2021 study exploring 548 GP's level of satisfaction, happiness and prevalence of burnout in Germany, found a CBI work-related mean score of 37;³⁰ while a study assessing physician burnout and the COVID-19 pandemic in Austria found a CBI work-related mean score of 36 among 252 GPs.³¹ While comparisons with these two studies are limited by differences in study populations, setting, and period, both suggest this study's GPEP2 population is experiencing high levels of burnout.

Of the 1,374 GP respondents to the RNZCGP workforce survey (2024), 70% rated themselves as moderately to highly burnt out.¹ New Zealand GP responses to the 2022 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (n=377) indicate that 49% were burnt out; this percentage increases to 57% for GPs under 55 years of age only.⁴ The Commonwealth Fund survey also indicates that New Zealand primary care physicians were experiencing the highest levels of burnout of the ten high income countries surveyed.

Although differences in survey tools and study populations limit direct comparisons, this study's pre-intervention indication that 67% were experiencing moderate to high burnout, appears broadly consistent with burnout levels reported among early-career GPs in New Zealand.

Exploratory patterns were observed in this pilot, with the two participants categorised as experiencing high or severe burnout being 30 – 34-year-old females who accessed fewer additional supports. By comparison the participants categorised as experiencing no to low levels of burnout were male, with no pattern in the number of professional supports they were regularly engaged in. These findings regarding burnout and gender, are reinforced by a study that assessed the mental wellbeing of 503 next generation general practitioners in Switzerland, which found women had lower levels of wellbeing than men;² and a study of 548 GPs in Germany that concluded “being female and working as an employed physician is associated with a higher prevalence of personal burnout symptoms”.^{30(p1)} However, due to the small numbers of this study the findings are not robust, and any interpretation of subgroup patterns should be treated as hypothesis-generating only.

Changes in individual CBI scores and participants’ attribution of benefits provide a signal that group supervision may positively influence wellbeing. Participants also reported reduced isolation, collegial support, and assistance in managing difficult situations. This is consistent with literature describing professional reflective supervision as supportive for clinician wellbeing and professional relationships.

Alternative explanations for changes in burnout should be considered. For example, GPEP2 registrars may experience changing contributors to stress over the second half of the training year (e.g., increasing familiarity and competence, fluctuating workload, or reduced peer contact). The design of this pilot does not allow separation of these factors from the intervention effects.

One participant demonstrated a marked increase in burnout score from the no/low category pre-intervention to high burnout post-intervention. As this diverges from the overall trend it is suggested that circumstances outside the intervention may have had a substantial impact on this individual’s scores. Future studies could include the full CBI (personal and client-related scales), or additional contextual measures, to better understand drivers of change in CBI scores.

Item-level shifts across the CBI work-related questions suggest that frustration, being worn out, and emotional exhaustion may be significant contributors to burnout in this cohort. While these findings are exploratory, they could be considered in future support strategies within the GPEP training or professional reflective supervision.

Where the greatest shift in CBI item scores occurred “Does your work frustrate you”, it is plausible to consider that the group supervision contributed to the changes given the evidence that supervision offers benefits that include improved interpersonal relationships.

Overall, participants appear satisfied and recommend the programme to future GPEP2 registrars. A consistent improvement suggested was to deliver group supervision in paid time or within GPEP2 registrars work schedules. Given workload and fatigue were barriers to attendance, implementation options that reduce the time burden (e.g., aligning with GP registrar training sessions, paid time) warrant exploration.

Prior to the pilot, six participants were accessing supervision, while post-intervention, eight of nine respondents reported an intention to continue with some form of supervision. Of these, five of the eight planned to continue with group supervision. While there is an increase in the number of participants accessing any form of supervision, determining if there is a shift from accessing individual to group supervision is limited by the construct of the pre-intervention survey. Addressing this in future studies would reinforce the value of increasing forms of group-based support within GPEP2 to strengthen collegiality and reduce a sense of isolation.

Limitations and Considerations

This study was designed as a pilot and feasibility evaluation in a single regional context. While the small participant numbers and lack of a control group limit the conclusions that can be drawn from the findings, it provides early signals that group supervision may contribute to reducing the risk of burnout among GPEP2 registrars.

Self-selection into the pilot introduces the potential for volunteer bias. Registrars with greater perceived need for support may have been more likely to participate, whereas those experiencing lower levels of burnout may have had greater capacity to enrol. Both possibilities may have influenced the study cohort's baseline burnout levels and should be considered when interpreting the pre-intervention estimates of burnout.

The intervention was delivered in the second half of the year, when GPEP2 registrars may be experiencing an increase in familiarity with registrar role alongside a reduction in structured support. This timing may have contributed to the reduction in levels of burnout observed and participants' perceptions of benefit.

Limitations in the survey design affected the ability to interpret some findings.

- The pre-intervention item exploring professional supports GPEP2s were accessing, did not distinguish between types of supervision (e.g., individual versus group), constraining the ability to assess changes in supervision formats over time.
- The post-intervention item on the influence of group supervision on stress was also ambiguously worded, which may affect measurement validity. While cross-checking participant responses against their direction of change in the CBI scores provides some reassurance, future surveys should refine these items to improve clarity and measurement validity.

Implementation considerations

In addition to the time contributed by GPEP2 registrars to participate in the pilot programme, the two supervisors were each engaged for twelve hours to deliver the supervision and undertake associated administrative tasks.

Implications

These findings provide early support for strengthening the wellbeing-focused group-based professional supports available to GP registrars during the transition into GPEP2. If replicated in larger studies, structured group supervision may represent a feasible and evidence-informed strategy to enhance support and potentially reduce the risk of work-related burnout in this cohort. These results have implications for programme design and for funding models that enable sustainable delivery of such interventions, including the provision of protected time to participate.

Future research

This pilot supports the value of further research on group supervision for GPEP2 registrars. In addition to improvements in the survey design, future studies could:

- Integrate professional supervision within GPEP2 training time.
- Expand the number of participants.
- Consider including a comparator group.
- Use all three subscales of the CBI to provide more context on the contributors to GPEP2 levels of burnout.
- Explore longer-term outcomes, including retention and ongoing engagement with wellbeing supports among participants.

CONCLUSIONS

Given the ageing GP workforce and levels of stress and burnout being experienced by general practitioners, strategies that strengthen GP registrar wellbeing and retention are essential for sustaining the future GP workforce.

In this pilot, group supervision was feasible to deliver and acceptable to participants, with high levels of satisfaction and universal recommendations for continuation.

While causal conclusions cannot be drawn, early signals from this study suggest that group supervision which involves reflective learning on non-biomedical aspects of practice, may contribute to improved wellbeing and reduced burnout risk among GPEP2 registrars. Delivering supervision in a group format may also reduce isolation and strengthen collegial support. These benefits appear especially relevant in the second year of GP training where reduced structured training time and less frequent peer contact may contribute to feelings of isolation and diminished collegial support.

Future research could build on this study's learnings to further inform decisions about design of the GPEP2 registrars' programme by evaluating delivery models that reduce access barriers (e.g., integrating sessions into protected or paid time), strengthen the study design, involve larger samples, and evaluate short term and longer impact on GP registrar wellbeing and retention.

Addressing the high levels of burnout among GP registrars remains critical to ensuring they can thrive and progress to Specialist GPs who are a critical part of a sustainable and resilient health system.

RECOMMENDATIONS

It is recommended that:

- Group supervision continues as a standard support option for GPEP2 registrars.
- Future programmes test and refine delivery models to optimise engagement, e.g., frequency, duration.
- Group supervision is delivered within protected or paid GPEP2 registrar time to reduce barriers to participation.
- Evaluation design is strengthened as the programmes scales up, including by exploring long term outcomes and comparator benefits.

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APPENDICES

Appendix One: Pre Intervention and Post Intervention surveys

PRE INTERVENTION SURVEY

Thank you for taking part in the pilot of group supervision for Year Two GP Registrars (GPEP 2). We are assessing the feasibility of the pilot through short pre- and post-programme surveys.

This survey takes five minutes to complete and comprises of three sections that gather information on:

- Professional education and wellbeing supports
- Level of wellbeing and stress related to your work
- Demographics

We also ask for a unique identifier to link responses between the pre and post programme surveys.

Thank you for contributing to the evaluation through completing this survey.

If you have any questions, please contact Linda Wensley linda.wensley@pegasus.health.nz

Section One: Professional and wellbeing supports

1. In addition to the GPEP two training what other regular professional education and wellbeing supports do you currently engage in
 - Clinical Connect – Pegasus small group education
 - GP Peer group
 - Supervision
 - Counselling
 - Other Professional education and wellbeing
2. If you answered 'Other' to Question 1, please identify what other professional education and wellbeing supports you access.

3. Are the professional supports you regularly access sufficient in helping you manage your wellbeing and work-related stress?
 - Yes / No / Maybe

4. Please comment

5. What are you hoping to gain from participating in this group supervision programme

Section Two: Work related wellbeing and stress

This section asks about your wellbeing and stress as it relates to your work as a GPEP 2. **Please read each question carefully and select the response that best reflects your experience.**

6. Do you feel worn out at the end of the working day

Always	often	sometimes	seldom	Never/almost never
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7. Are you exhausted in the morning at the thought of another day at work

Always	often	sometimes	seldom	Never/almost never
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8. Do you feel that every working hour is tiring for you?

Always	often	sometimes	seldom	Never/almost never
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9. Do you have enough energy for family, and friends during leisure time

Always	often	sometimes	seldom	Never/ almost never
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10. Is your work emotionally exhausting

To a very high degree	To a high degree	somewhat	To a low degree	To a very low degree
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11. Does your work frustrate you

To a very high degree	To a high degree	somewhat	To a low degree	To a very low degree
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12. Do you feel burnt out because of your work

To a very high degree	To a high degree	somewhat	To a low degree	To a very low degree
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13. Do you sometimes wonder how long you will be able to continue working with patients

Always	often	sometimes	seldom	Never/ almost never
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Section Three: Demographic Information

This information is requested to better understand cohorts that will benefit from supervision.

14. Please indicate your age

- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55 or over

15. What is your gender

- Male
- Female
- Another gender

16. Which ethnic group do you belong to? Please select the ethnic group or groups which apply to you.

- New Zealand
- Māori
- Samoan

- Cook Island Māori
- Tongan
- Niuean
- Chinese
- Indian
- Other

17. If you answered 'Other' to the question above, please state the other ethnic group(s) you belong to.

Unique Identifier

Please provide an identifier that you will also use on the post programme survey to enable the comparison of results

e.g., first two letters of your middle name and number of your address JA07

POST INTERVENTION SURVEY

Evaluation of GPEP 2 Group Supervision - Participant Survey

Thank you for participating in the pilot of group supervision for Year Two GP Registrars (GPEP 2).

Data from the pre- and post-programme surveys will be used to assess any benefit you gain, gather your feedback on the programme, and evaluate the feasibility of ongoing provision of group supervision to GPEP2s.

The survey takes six minutes to complete and comprises of four sections that gather information on:

- Professional education and wellbeing support
- Wellbeing and stress related to your work
- Satisfaction with the GPEP 2 Group Supervision
- General information

You will be asked to add your same unique identifier (you included in the first survey) to enable us to link responses between the pre and post surveys.

Please contact linda.wensley@pegasus.health.nz with any questions

Section One: Professional and wellbeing supports

1. In addition to the GPEP two training what other regular professional education and wellbeing supports do you currently engage in?
 - Clinical Connect – Pegasus small group education
 - GP Peer group
 - Supervision
 - Counselling
 - Other Professional education and wellbeing supports
 - None
2. If you answered 'Other' to Question 1, please identify the other supports you are accessing
3. Since commencing the GPEP 2 Group Supervision have you started or stopped any of the regular professional education and wellbeing supports you were accessing?

Yes

No

4. If yes, please tell us which professional supports you have started or stopped and why.

Enter your answer

Section Two: Work related wellbeing and stress

This section asks about your wellbeing and stress as it relates to your work as a GPEP 2.

Please read each question carefully and select the response that best reflects your experience.

5. Do you feel worn out at the end of the working day? Required to answer. Likert.

Always	Often	Sometimes	Seldom	Never/ almost never
--------	-------	-----------	--------	---------------------

6. Are you exhausted in the morning at the thought of another day at work?

Always	Often	Sometimes	Seldom	Never/ almost never
--------	-------	-----------	--------	---------------------

7. Do you feel that every working hour is tiring for you?

Always	Often	Sometimes	Seldom	Never/ almost never
--------	-------	-----------	--------	---------------------

8. Do you have enough energy for family and friends during leisure time?

Always	Often	Sometimes	Seldom	Never/ almost never
--------	-------	-----------	--------	---------------------

9. Is your work emotionally exhausting?

To a very high degree	To a high degree	Somewhat	To a low degree	To a very low degree
-----------------------	------------------	----------	-----------------	----------------------

10. Does your work frustrate you?

To a very high degree	to a high degree	somewhat	to a low degree	to a very low degree
-----------------------	------------------	----------	-----------------	----------------------

11. Do you feel burnt out because of your work?

To a very high degree	to a high degree	somewhat	to a low degree	to a very low degree
-----------------------	------------------	----------	-----------------	----------------------

12. Do you sometimes wonder how long you will be able to continue working with patients?

Always	Often	Sometimes	Seldom	Never/ almost never
--------	-------	-----------	--------	---------------------

13. How has your participation in the GPEP 2 Group Supervision influenced your wellbeing as it relates to your GPEP 2 work?

- Improved
- Decreased
- No effect

If answer improved or decreased link through to

14. Please indicate too what degree it has Improved or decreased your wellbeing

To a very high degree	To a high degree	Somewhat	To a low degree	To a very low degree
-----------------------	------------------	----------	-----------------	----------------------

15. Please comment

Enter your answer

16. How has your participation in the GPEP 2 Group Supervision influenced your level of stress as it relates to your GPEP 2 work?

- Improved
- Decreased
- No Effect

17. If answer improved or decreased please indicate too what degree it has increased or decreased your level of stress

To a very high degree	To a high degree	Somewhat	To a low degree	To a very low degree
-----------------------	------------------	----------	-----------------	----------------------

18. Please comment

Enter your answer

19. Have you gained any other benefits from participating the GPEP 2 Group Supervision?

- Yes
- No

20. If you answered yes, please comment on these benefits

21. Do you intend to continue accessing supervision because of this programme.

- Yes – group,
- yes – individual
- No

11. Please comment on why / why not you will continue to access supervision

Enter your answer

12. Please comment on any barriers to accessing this year’s GPEP 2 Group Supervision programme or accessing supervision in the future.

13. Would you recommend the programme to a colleague starting GPEP 2 in 2026.

- Yes
- No

14. Please comment on why / why not

Enter your answer

Section Three: Satisfaction with the GPEP 2 Group Supervision

This section explores your satisfaction with the GPEP 2 Group Supervision provided, for example how it was offered, delivered, cost, timing

15. Comment on up to three things that were positive about what was provided

Enter your answer

16. Comment on up to three things that were negative about what was provided

Enter your answer

17. Comment on anything that could be improved about what was provided

Enter your answer

18. Please rate your overall satisfaction with the GPEP 2 Group Supervision programme provide

Very satisfied	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied	Very unsatisfied
----------------	-----------	-----------------------------------	-------------	------------------

Please share any further insights or comments that may help guide future decisions regarding supervision for GPEP 2.

Enter your answer

Section Four: Additional Information

This additional information will be used to guide future work to support GPEP 2 with managing work related stress and wellbeing

19. Please indicate who facilitated your group

- Brett
- Zoe

About this survey tool: Please indicate how much you agree or disagree with the following statements

- The survey questions were clear and easy to understand
- The length of the survey was good
- The survey covered all the relevant topics

Strongly agree	Agree	Neither agree nor disagree	Strongly disagree	Disagree
----------------	-------	----------------------------	-------------------	----------

About this survey tool: Please provide any additional comments

Enter your answer

In the pre-programme survey, you added a unique identifier to your response.

Please add this same unique identifier in the free text box below.

In the pre-programme survey, it was suggested you use the first two letters of your middle name and number of your address JA07. If you cannot remember your identifier, please contact linda.wensley@pegasus.health.nz or phone 0275126168. In the pre-programme survey, it was suggested you use the first two letters of your middle name and number of your address JA07.

Are you willing to be contacted to discuss your responses?

- Yes
- No

20. If you answered yes, please enter your email below

Appendix Two: A priori thresholds

DOMAIN	CRITERIA
1. Survey respondents perceive there is a gap in the professional supports available	
	Gap identified by 10%
2. GPEP2 registrars' level of engagement in professional reflective supervision	
Uptake	Initial uptake of > 20% (5)
Attendance over time	Attendance of 50% retained
Continued access to supervision	% participants intend to continue accessing professional supervision
3. Does this address this gap	
Signal of effectiveness	Negative change in levels of burnout *
4. Level of satisfaction of GPEP2 registrars experience of professional reflective supervision	
	Positive overall satisfaction
5. Usefulness of survey tool	
	50% level of agreement

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