PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	New graduate doctors' preparedness for practice: A multi-stakeholder, multi-centre narrative study
AUTHORS	Monrouxe, Lynn V; Bullock, Alison; Gormley, Gerard; Kaufhold, Kathrin; Kelly, Narcie; Roberts, Camille; Mattick, Karen; Rees, Charlotte

VERSION 1 – REVIEW

REVIEWER	Kamran Ali Plymouth University Peninsula Schools of Medicine & Dentistry, United Kingdom
REVIEW RETURNED	09-Apr-2018

GENERAL COMMENTS	It is a well written paper and provides useful insights into the preparedness of medical graduates entering foundation training. The authors may be able to respond to the following points to enhance clarity and value of the paper: Results Explicit conceptualisations of preparedness for practice The results are somewhat superficial and do not seem to add significantly to what is already known. It would be helpful if this section can be elaborated a bit more to identify any differences in the perceptions of different stakeholder groups Preparedness for communicating effectively with patients and colleagues Given that communication skills of professionals play a key role in shaping the public and patients' perceptions about the competency of a doctor, this section could be improved by including narratives from the PPRs to gauge their expectations and experiences Similarly, the perspectives and experiences of PPRs are generally scant throughout the manuscript. Given that public and patients represent a key stakeholder group and PPRs were included in the study, including their narratives would help articulate their expectations and add value to the paper. Discussion The authors state " .. to our knowledge our study is the first time preparedness for practice has included behavioural and emotional aspects that this is the first study"

	However, this claim may not be factually correct as several studies have explored and reported on these attributes previously. Some examples are given below Mason S, O'Keeffe C, Carter A, O'Hara R, Stride C. An evaluation of foundation doctor training: a mixed-methods study of the impact on workforce well-being and patient care [the Evaluating the Impact of Doctors in Training (EDiT) study]. Southampton (UK): NIHR Journals Library; 2013 Dec. O'Connor P, Lydon S, O'Dea A, Hehir L, Offiah G, Vellinga A, Byrne D. A longitudinal and multicentre study of burnout and error in Irish junior doctors. Postgrad Med J. 2017 Nov;93(1105):660-664. It may be best to rephrase this sentence. Also there is some repetition regarding the skills and attributes of preparedness of medical graduates in the introduction and discussion, it may be best to restrict this to the discussion section. Minor typo: Page 17 Box 3 Excerpt 6: Rhesus should be resusc

REVIEWER	Nancy Sturman Primary Care Clinical Unit, University of Queensland, Australia
REVIEW RETURNED	11-Apr-2018

GENERAL COMMENTS	Thank you for inviting me to review this paper. In their introduction, the authors present a convincing case for a deeper and more nuanced understanding of what it might mean (to a range of stakeholders) to be prepared for the junior doctor workplace. Their methodology is interesting and compelling, especially the use of foundation year doctor audio-diaries over a 3 month period, and the diverse range of stakeholders interviewed. The point that being prepared to 'hit the ground running', and being prepared for long term careers in medicine, are different aspects of preparedness is well made (although I am not sure I understand the author's claim that emotional preparedness for practice has been previously ignored - surely the resilience, medical humanism and doctor well-being medical education literature is relevant here). Interestingly, as I read the paper, I felt any concept of preparedness almost slipping through my fingers. This is not necessarily a criticism of the paper, although I would have liked more emphasis on Theme One in the results section, perhaps revisiting in the Discussion section how the Theme Two findings using GMC outcomes might further address the first research question. I would also have found it interesting if the authors had compared and contrasted more explicitly the understandings of the different stakeholders about the concept of preparedness, and how the short term and longer term aspects may inter-relate. Does experiencing a situation as challenging or difficult indicate unpreparedness, as the authors seem to imply? Perhaps quite the contrary, if the situations do call for advanced skills, or if they remain difficult and emotional throughout a medical career (such as work-life balance, self-care, time management, situational awareness, domestic violence and death of a child, arguably). Allegations that junior doctors have a poor understanding of the financial implications of their prescribing may be unwarranted, especially as junior doctors are known to emulate senior doctors' prescribing practices for a

	range of reasons (as the authors also mention); consulting the BNF before prescribing strikes me as indicating awareness and professionalism as much as unpreparedness .No-one except perhaps the patient themselves is ever likely to fully understand the psycho-social and spiritual meaning of health-care predicaments and decisions, so this expectation seems unrealistic. The authors acknowledge the inevitability (and effectiveness) of learning on the job, the importance of realistic expectations of job readiness, and the unpredictability of real life interactions. These suggest that some level of abruptness and challenge ("unpreparedness"?) in the transition and indeed beyond is inevitable, irrespective of at which stage of medical education meaningful participation in workplace activities is introduced (and surely there is a case against introducing such participation prematurely) . What are reasonable expectations of medical education in terms of both preparing graduates for work and preparing them for life-long work-based learning? Certainly simplistic checkbox approaches are inadequate, as the authors intimate. It may be important to acknowledge that learning and becoming also unfold in other worlds of 'growing up' outside the two worlds of undergraduate medical education and junior doctor workplaces. The literature on supervision and clinical oversight is of obvious importance here, in terms of ensuring that learning is compatible with patient safety. Perhaps the authors might comment on any specific implications of their findings for oversight and supervision? I am not convinced that the authors have produced strong arguments to support their recommendation for students to spend more time in workplace multi-professional teams (although few would actively disagree with this rather general recommendation). However the authors' other two conclusions seem well supported and convincing: their recommendation for developing a shared understanding and realistic expectations of new medical graduates' preparedness, and their findings of complexity and nuance in both concepts and assessments of preparedness for practice. Thank you for this stimulating and well written paper.

VERSION 1 – AUTHOR RESPONSE

REVIEWER: 1

Results: Explicit conceptualisations of preparedness for practice

The results are somewhat superficial and do not seem to add significantly to what is already known. It would be helpful if this section can be elaborated a bit more to identify any differences in the perceptions of different stakeholder groups.

REVIEWER: 2

I would also have found it interesting if the authors had compared and contrasted more explicitly the understandings of the different stakeholders about the concept of preparedness, and how the short term and longer term aspects may inter-relate.

OUR RESPONSE

Both reviewers are calling for identification and comparison of different stakeholders' conceptions of preparedness, so we deal with them together in our response here. We politely disagree with the point made by reviewer 1; that the results do not take us beyond what is already known.

Unfortunately, the reviewer did not cite any research when they assert this case, so we are unable to ascertain where this information comes from. However, our assertion is derived from our own rapid review of the literature (published previously in BMJ Open), in which we analysed 87 studies examining medical students' preparedness for practice. As we reference in this manuscript, there is

lack of clarity around the concept and very few studies (of the 87 reviewed) defined the construct: "The majority of manuscripts did not define the concept of preparedness, but tended to focus on knowledge and skills required immediately on graduation rather than researching longer term preparedness for becoming a doctor, or behaviours and patient outcomes" (Original manuscript referring to Page 15 of Monrouxe LV, Grundy L, Mann M, et al. How prepared are UK medical graduates for practice? A rapid review of the literature 2009–2014. BMJ Open 2017;7(1) doi: 10.1136/bmjopen-2016-013656).

As such we retain our statement in the introduction.

Both reviewers requested that we elaborate a bit more to identify any differences in the perceptions of different stakeholder groups. Therefore, we have gone back to the coded data in Atlas.ti to explore this further. A table of sub-themes, participant groups and number of mentions can be seen below. As you will see from Table 1, excepting the final 'code' "Preparedness for practice on registration", all participant groups mentioned all key factors to some degree or another.

This final "preparedness for practice on registration" code refers to the situation in the UK whereby on graduation, students are not fully registered as doctors. This particular PGY1 (postgraduate year 1) year currently acts as a safeguard, with trainees having to wait the year before they can be fully registered for practice (although this might change in the future, see Ref 27 in our manuscript). In our description of this theme, we only briefly touch on this specific issue as only 4 mentions were coded across the 3 participant groups. Thus, in our original version we use the vague quantifier 'some' to indicate that not all participant groups talked about this issue:

"When they did begin to define the term, however, some focused on how preparedness meant passing exams in order to become a doctor, whereas others made a distinction between passing exams and actually being prepared to work as a new graduate doctor" (original version).

In terms of the Table below and what the data mean, this is not a simple matter. Firstly, this is a qualitative study, so we asked open questions and thus we did not seek everyone's opinion on all aspects of preparedness (like you would do with a questionnaire). As such, these numbers do not represent any kind of agreement that the constructs are important or correct. They merely represent the number of times our researcher identified that particular construct in the talk of the different groups.

Secondly, the numbers are absolute. However, we did not have the same number of participants in each group. As such, we cannot say that just because we have coded a response more times in one group than another, that it represents a genuine difference between groups.

Thirdly, we undertook a narrative approach to our interviews. This means that we asked deeper questions that tried to elicit narratives of events. As such, a single coded excerpt might contain one individual's narrative or it might have multiple individuals interacting to co-create a story. So each number in the table does not necessarily represent a single participant, nor do the numbers necessarily exclude the possibility that one person was coded twice or more (if they reiterated what they said at a later point in the interview). As such, it is not a simple matter of dividing the numbers in the table by participant numbers.

Table 1. Number of times talk from participant groups were coded to different sub-themes relating to conceptualisations of preparedness

Sub-themes PGY1 PGY2 CEs DTPLs HCPs EMPs PPRs POLs Totals
Hesitations 25 11 13 18 8 5 4 6 90

Preparedness to work as a doctor on day 1 29 24 17 13 12 3 5 10 113
Prepared in terms of skills and knowledge 12 10 16 16 11 6 2 8 81
Prepared in terms of confidence, maturity, resilience 7 7 16 10 5 5 6 10 66
Longer-term preparedness to practice as a doctor over time 1 9 14 11 1 6 1 7 50
Preparedness for practice on registration 0 0 2 1 0 0 0 1 4

There are two ways forward with this. One way is to replace the numbers in the tables with X's and Π's to represent the presence or absence of codes associated with that group. However, as you will see, this will result in a table of just Π's (excepting the final code). Alternatively, we could add a sentence to say that all groups mentioned all aspects except for one. Again, this feels a little unhelpful. Therefore, what we have decided to do is to add a few additional comments to this section where appropriate. We hope this will suffice:
"Some participants across all stakeholder groups struggled to conceptualise 'preparedness for practice', as evidenced by their faltering talk (Excerpt 1, Box 1). When they did begin to define the term, however, the majority focused on how preparedness meant passing exams in order to become a doctor, whereas a minority (from the CE, DPL and POL groups) made a distinction between passing exams and actually being prepared to work as a new graduate doctor. Participants from all stakeholder groups highlighted that performing as a new graduate doctor included possessing the knowledge, skills and behaviours expected of them, but also included knowing limitations, prioritisation, managing stress, engendering patient trust and generally being a safe doctor (Excerpts 2 & 3, Box 1). Temporal aspects of preparedness also featured heavily in participants' talk across stakeholder groups."

REVIEWER: 1
Preparedness for communicating effectively with patients and colleagues: Given that communication skills of professionals play a key role in shaping the public and patients' perceptions about the competency of a doctor, this section could be improved by including narratives from the PPRs to gauge their expectations and experiences
OUR RESPONSE
We thank the referee for her suggestion. We have now added a narrative excerpt, Excerpt 12, Box 3 to our revised paper (being mindful that we are trying to keep the paper to a readable length) and have summarised patients' perspectives in more detail as follows:
"Finally, patients variously narrated events concerning junior doctors' preparedness for communication. The general consensus was that communication skills were lacking in junior doctors, but that these skills were also lacking in their seniors too. Thus, we had multiple narratives from patient groups in which they focussed on more senior consultants and the issue of abruptly breaking bad news, leading to patient distress. Some participants felt that such role models had a significant influence on the development of junior doctors' communication skills, especially those early on in their careers. Others discussed the issue of individual differences in people, rather than this being a training issue (Excerpt 13, Box 3). However, it was noted that the patient group, more than other stakeholder groups, tended to refer to a range of sources (e.g. their friends, family and media) when presenting their opinions, rather than just first-hand experiences.28 Furthermore, patient participants' first-hand experiences were generally more positive than when they discussed these second-hand stories."

REVIEWER: 1
Similarly, the perspectives and experiences of PPRs are generally scant throughout the manuscript. Given that public and patients represent a key stakeholder group and PPRs were included in the study, including their narratives would help articulate their expectations and add value to the paper.
OUR RESPONSE
We thank the reviewer for making this suggestion. In fact, due to patients not being able to comment directly on many technical aspects of preparedness, we are unable to provide a PPR quotation for all

sub-themes. Indeed, this led us to presenting the PPR data in greater detail in another publication [Kostov C, Gormley G, Rees CE, Monrouxe LV (2018) "I did try and point out about his dignity": A qualitative narrative study of patients' and carers' experiences and expectations of junior doctors. BMJ Open. 8:e017738. doi: 10.1136/bmjopen-2017-017738]. However, we have gone back to the 'Outcomes for Graduates' themes and added further PPR perspectives where these were originally omitted. Please note that we have been very mindful not to include any data that has already been published previously. Thus, we have made the following changes (we present the additional sentences/paragraphs here, not the entire narrative, for brevity):

"However, from the perspective of patients, one PPR participant reported that his experience with "very, very junior doctors" was positive, but added the caveat that these junior doctors had the benefit of having "a lot of time to do it", suggesting that they were probably undergraduate medical students learning without the pressures of work (Excerpt 5, Box 3)."

"The PPR group empathised with the difficulties that new graduates faced in terms of their juggling many different demands and linked this with junior doctors developing mechanisms to block out patients' demands (Excerpt 6, Box 4)."

"Healthcare improvements also work at a more interpersonal level. Consider the interaction between members of one of our patient groups (Excerpt 11, Box 4) in which they discuss the issue of junior doctors and nurses who witness poor patient care. Here, they highlight the issue that junior doctors are more closely aligned with patients' perspectives than their seniors, due to them also being in an 'alien environment', yet it is often their seniors who they witness breaching patients' safety or dignity. For junior doctors, this creates a dilemma around whistle-blowing (in the words of the PPR participant, although the GMC prefer the term 'raising concerns'). The conclusion that these patients come to is that, provided with the necessary support, junior doctors can make sense of what they see and subsequently make informed decisions around whether or not to whistle-blow."

"Some of the PPR group participants also highlighted this issue, although their focus was more around how junior doctors were so overworked that their brains were not alert, which was deemed detrimental to patient care".

REVIEWER: 1
Discussion: The authors state "... to our knowledge our study is the first time preparedness for practice has included behavioural and emotional aspects that this is the first study." However, this claim may not be factually correct as several studies have explored and reported on these attributes previously. Some examples are given below
Mason S, O'Keeffe C, Carter A, O'Hara R, Stride C. An evaluation of foundation doctor training: a mixed-methods study of the impact on workforce well-being and patient care [the Evaluating the Impact of Doctors in Training (EDiT) study]. Southampton (UK): NIHR Journals Library; 2013 Dec.
O'Connor P, Lydon S, O'Dea A, Hehir L, Offiah G, Vellinga A, Byrne D. A
longitudinal and multicentre study of burnout and error in Irish junior doctors.
Postgrad Med J. 2017 Nov;93(1105):660-664.
It may be best to rephrase this sentence.
OUR RESPONSE
We thank the reviewer for bringing this issue to our attention. We are fully aware that other research has examined issues of junior doctors' wellbeing (indeed, we already cite such research and have undertaken some of this work ourselves). What we were trying to say is that this is the first time that a study focussing on the issue of graduates' preparedness for practice has highlighted behavioural and emotional aspects. We hope the following revised sentence has greater clarity:
"Although previous research has explored preparedness in terms of clinical skills and procedures (e.g. communication skills, examination skills and practical procedures), and other studies have considered

issues around junior doctors' wellbeing,13 32 to our knowledge our study is the first time that research focussing on the issue of whether graduates are prepared for practice has included behavioural and emotional aspects."

REVIEWER: 1
Also there is some repetition regarding the skills and attributes of preparedness of medical graduates in the introduction and discussion, it may be best to restrict this to the discussion section.
OUR RESPONSE
We have now deleted this section:
"Recent graduate junior doctors typically reported feeling prepared for history taking, performing physical examinations, some procedural skills (e.g. venepuncture), communication with patients and colleagues, and understanding their own limitations.10 However, they typically felt less prepared for prescribing, clinical reasoning, early management of acutely unwell patients, some procedural skills (e.g. wound suturing), multi-disciplinary team-working and handover, reporting and dealing with error and safety incidents, understanding how the clinical environment works, time management, and ethical and legal issues.10"

REVIEWER: 1
Minor typo: Page 17 Box 3 Excerpt 6: Rhesus should be resusc
OUR RESPONSE
Thank you for pointing this out – we have now amended it to 'resus' (we think the 'c' is not needed).

REVIEWER: 2
Thank you for inviting me to review this paper. In their introduction, the authors present a convincing case for a deeper and more nuanced understanding of what it might mean (to a range of stakeholders) to be prepared for the junior doctor workplace. Their methodology is interesting and compelling, especially the use of foundation year doctor audio-diaries over a 3 month period, and the diverse range of stakeholders interviewed. The point that being prepared to 'hit the ground running', and being prepared for long term careers in medicine, are different aspects of preparedness is well made (although I am not sure I understand the author's claim that emotional preparedness for practice has been previously ignored - surely the resilience, medical humanism and doctor well-being medical education literature is relevant here).
OUR RESPONSE
Thank you for your positive comments. We apologise for not being clear in terms of our claims around emotional preparedness and have amended this as per Reviewer 1's comments above.

REVIEWER: 2
Interestingly, as I read the paper, I felt any concept of preparedness almost slipping through my fingers. This is not necessarily a criticism of the paper, although I would have liked more emphasis on Theme One in the results section, perhaps revisiting in the Discussion section how the Theme Two findings using GMC outcomes might further address the first research question.
OUR RESPONSE
We have responded to this comment in two ways. Firstly, we have amended our introductory paragraph to include the distinction between explicit and implicit conceptualisations – the first being as a direct response to the request for participants to define the construct and the second being implicit (i.e. unsolicited comments alluding to their conceptualisations) in their narratives around preparedness, as follows:

"This paper set out to address two research questions. In relation to the first question focusing on stakeholders' conceptualisations of preparedness for practice, participants sometimes struggled to articulate this when specifically asked to define the concept. When they did, their understandings

varied by the constituent aspects of preparedness (e.g. knowledge, skills, behaviours and emotional aspects) and time (e.g. short-term versus longer-term). Furthermore, throughout the remainder of the interviews, participants' implicit conceptualisations of preparedness for practice also reflected these factors as they narrated their own experiences of observing and interacting with newly graduated doctors. Although previous research has explored preparedness in terms of clinical skills and procedures (e.g. communication skills, examination skills and practical procedures), and other studies have considered issues around junior doctors' wellbeing,13 32 to our knowledge our study is the first time that research focussing on the issue of whether graduates are prepared for practice has included behavioural and emotional aspects. Furthermore, since the primary focus of current research is around new graduates' short-term preparedness (i.e. preparedness for their role as PGY1 doctor) it appears that in general, researchers' understandings of this concept are more limited than those of our participants.16-20 This is also echoed in the GMC's outcomes for graduates document that focuses on knowledge, skills and behaviours,31 despite them recognising the importance of resilience for doctors."

We have also further addressed this within the discussion section where we expand on our references to conceptualisations of preparedness as follows:
"An understanding of these nuances enables a more sophisticated appreciation of the concept of preparedness, which recognises that preparedness is not binary, an aspect that was not specifically highlighted when participants were asked to define the concept."

"Additionally, the issue of situational awareness further expands on our conceptualisation of preparedness for practice, pointing to the necessity for this to be facilitated during students' undergraduate years."

REVIEWER: 2
Does experiencing a situation as challenging or difficult indicate unpreparedness, as the authors seem to imply? Perhaps quite the contrary, if the situations do call for advanced skills, or if they remain difficult and emotional throughout a medical career (such as work-life balance, self-care, time management, situational awareness, domestic violence and death of a child, arguably). Allegations that junior doctors have a poor understanding of the financial implications of their prescribing may be unwarranted, especially as junior doctors are known to emulate senior doctors' prescribing practices for a range of reasons (as the authors also mention); consulting the BNF before prescribing strikes me as indicating awareness and professionalism as much as unpreparedness.
OUR RESPONSE
We agree with the reviewer on this issue. As we highlight in our methods section, we "classified the narratives according to how the narrators constructed the events (e.g. explicitly saying something such as 'a time when I felt prepared…')". Therefore, we have done our best to remain true to narrators' perspectives of preparedness. We have added this clarification in our strengths and weaknesses section of the Discussion:
"Finally, we classified participants' narratives in terms of relative preparedness according to how they constructed the events. Thus, what we present here is an accurate picture of stakeholders' perceptions of newly graduated doctors' preparedness rather than objective assessments or our classifications. Indeed, there might be instances where a situation was narrated as one of unpreparedness but when seen through the eyes of another reveals a level of preparedness. For example, that newly graduated doctors narrated referring to the BNF during their ward-based prescribing as them feeling unprepared for prescribing – double-checking their drug selection and dose calculations – could be constructed by others as evidence of preparedness in terms of awareness and professionalism. This disparity of interpretation is worth noting in order to evaluate the utility of our results."

REVIEWER: 2
No-one except perhaps the patient themselves is ever likely to fully understand the psycho-social and spiritual meaning of health-care predicaments and decisions, so this expectation seems unrealistic.
OUR RESPONSE
While we appreciate the reviewer's comment, at no point do we mention "the psycho-social and spiritual meaning of health-care predicaments and decisions" as an outcome in our paper. We do, however, talk about applying psychological principles to medical practice. Here, it is the GMC, not the authors, who specify this as a learning outcome: (Learning outcome 9 "Apply psychological principles, method and knowledge to medical practice." Alongside seven specified aspects [General Medical Council. Outcomes for Graduates (Tomorrow's Doctors). http://wwwgmc-ukorg/Outcomes_for_graduates_Jul_15pdf_61408029pdf 2015 page 9).

REVIEWER: 2
The authors acknowledge the inevitability (and effectiveness) of learning on the job, the importance of realistic expectations of job readiness, and the unpredictability of real life interactions. These suggest that some level of abruptness and challenge ("unpreparedness"?) in the transition and indeed beyond is inevitable, irrespective of at which stage of medical education meaningful participation in workplace activities is introduced (and surely there is a case against introducing such participation prematurely)… I am not convinced that the authors have produced strong arguments to support their recommendation for students to spend more time in workplace multi-professional teams (although few would actively disagree with this rather general recommendation).
OUR RESPONSE
We thank the reviewer for their opinion but we respectfully disagree that we have not presented sufficient evidence in our analysis for workplace learning and participation in multi-disciplinary teams earlier in the curricula. Note, we do say that given the data we have, that it is our belief that students learning will improve if additional workplace learning early in the curricula were given. Further, there is wide evidence that early vocational learning is beneficial: the following paper in BMJ Open expounds the benefits of interprofessional student-clinician interactions as part of informal workplace learning for pre-registration learners, and we now cite it [see Rees et al. (2018) Understanding students' and clinicians' experiences of informal interprofessional workplace learning: an Australian qualitative study. BMJ Open 8, e021238]. Therefore, we do not change this section of our discussion.

REVIEWER: 2
What are reasonable expectations of medical education in terms of both preparing graduates for work and preparing them for life-long work-based learning? Certainly simplistic checkbox approaches are inadequate, as the authors intimate. It may be important to acknowledge that learning and becoming also unfold in other worlds of 'growing up' outside the two worlds of undergraduate medical education and junior doctor workplaces.
OUR RESPONSE
We wholeheartedly agree with this comment. We have added the following to the discussion section: "Additionally, the issue of situational awareness further expands on our conceptualisation of preparedness for practice, pointing to the necessity for this to be facilitated during students' undergraduate years. However, it is worth noting that while medical students mature as they go through their undergraduate medical education, their development is not constrained to this environment, but necessarily interacts with their personal world outwith their studies. And it is within and between these two worlds that the emotional and psychological aspects of themselves develop. Thus, merely adding 'situational awareness' to the check-box is not the answer."

REVIEWER: 2
The literature on supervision and clinical oversight is of obvious importance here, in terms of ensuring that learning is compatible with patient safety. Perhaps the authors might comment on any specific implications of their findings for oversight and supervision?

OUR RESPONSE
We thank the reviewer for their comment on oversight and supervision. We have discussed this at length and added the following under our 'implications' section:
"Secondly, as trainees, junior doctors are supervised. With this understanding of preparedness as an on-going process, our study holds implications for supervisors as guardians of patient safety. Junior doctors require the right balance of supervision (to safeguard patient safety) and autonomy (to facilitate their development). This balance develops with supervisory experience and can benefit from appropriate training.55".

REVIEWER: 2
I am not convinced that the authors have produced strong arguments to support their recommendation for students to spend more time in workplace multi-professional teams (although few would actively disagree with this rather general recommendation).
OUR RESPONSE
On re-reading, we agree with the reviewer that in the discussion we could provide stronger arguments for our recommendations. We have therefore added the following to enhance our stance on this issue:
"Furthermore, across a range of factors reported in our results – including communication in the workplace, prescribing, learning and working effectively in multi-professional teams – our participants narrated a range of problematic situations leading to feelings of unpreparedness."

REVIEWER: 2
However the authors' other two conclusions seem well supported and convincing: their recommendation for developing a shared understanding and realistic expectations of new medical graduates' preparedness, and their findings of complexity and nuance in both concepts and assessments of preparedness for practice. Thank you for this stimulating and well written paper.
OUR RESPONSE
We thank the reviewer for their positive comments and hope we have addressed the shortcomings they have highlighted appropriately.

VERSION 2 – REVIEW

REVIEWER	Kamran Ali University of Plymouth, Faculty of Medicine and Dentistry, UK
REVIEW RETURNED	06-Jun-2018

GENERAL COMMENTS	Following the amendments, I am happy to recommend publication.

REVIEWER	Nancy Sturman The University of Queensland, Australia
REVIEW RETURNED	14-Jun-2018

GENERAL COMMENTS	No further comments, thank you for these revisions.. The authors may also be interested in a study (Sturman N, Tan Z, Turner J. "A steep learning curve": junior doctor perspectives on the transition from medical student to the health-care workplace. BMC Med Educ. 2017 May 26;17(1):92) in which Australian medical students interviewed junior doctors about their transition from medical school to the junior doctor workplace, which has some similar findings in terms of emotional, psychological and inter-professional aspects of preparedness.