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Leadership skills training needs of early career doctors: a European survey

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Abstract

Introduction: This study aims to investigate the access to leadership development opportunities among European psychiatric trainees and early career psychiatrists (ECPs) and their perceptions and needs related to leadership skills training.

Materials and methods: This is a cross-sectional study using an online survey. The collected data was statistically analyzed using Stata 13, including an ordered probit regression to study the impact of five demographic characteristics of participants on the prioritization of 18 variables of leadership skills and 12 variables of management skills.

Results: A total of 119 psychiatry trainees from 31 European countries responded to the study, of which 80 (67.2%) were female. Additionally, 48.7% of participants (n = 58) were general adult psychiatric trainees, and 29.4% (n = 35) were ECPs. Our results show that 63.0% (n = 75) had no access to leadership skills training within their training program. Also, respondents tended to be unsatisfied with the training received. More than half (n = 62, 52.1%) of trainees sought additional leadership and management training outside their program. All the participants recommended that training in leadership skills should be included in a psychiatric training program. The top three most important skills to trainees were "communication", "teamwork", and "empathy and cultural sensitivity" regarding leadership skills; and "stress management", "time management", and "crisis management" concerning management skills.

Conclusions: Our study provides an overview of important gaps in the need, availability, and access to leadership skills training amongst psychiatric trainees and ECPs across Europe. We hope this study will help inform future developments and improvements in leadership skills training for trainees and ECPs across Europe.

Keywords: *leadership, medical education, leadership skills training, early career*

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1. Introduction

In contemporary medical practice, leadership and management skills are as vital as biomedical knowledge. While often used interchangeably, these terms represent two distinct yet complementary disciplines essential for organizational success, including in medicine.

Management is primarily focused on the effective and efficient execution of established organizational goals through systemic processes. Its core functions (planning, organizing, leading, and controlling) aim to maintain stability, administer policy, and ensure smooth operations by adhering strictly to existing

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procedures, budgets, and schedules. Management is crucial for order and productivity. On the other hand, leadership operates on a transformative and visionary plane. It is defined as the process of influencing, inspiring, and motivating others to adopt the work behaviors necessary to achieve organizational goals. This capacity involves two key aspects: the interaction between leader and follower that fosters followership, and the direction toward which the leader guides [1, 2].

The fundamental difference lies in their focus: management centers on efficiency and procedure, while leadership prioritizes vision and influence. Both are critically important and must work together for any organization (including medical systems) to thrive. As such, comprehensive training in these domains must be readily accessible to all medical professionals (including trainees), as they frequently lead and manage multidisciplinary teams in clinical practice, even if they do not hold formal managerial positions, a fundamental aspect of their daily work that is frequently understated or overlooked [3–5]. These leadership roles include, among others, leading a treatment team, acting as chief resident, acting as unit or service coordinator, serving as chairmen of advisory groups, chairing an academic department, acting as the Chief Executive Officer of a hospital or organization, participating in utilization reviews, responding to complaints, and working with community-based or other complex systems of care.

The unprecedented challenges posed by the COVID-19 pandemic served as a profound global demonstration of this fact, firmly establishing effective management and leadership capabilities as being just as critical to the physician's professional identity as scientific expertise [6].

Investing in leadership skills training yields substantial benefits for medical practice, medical professionals, and the broader healthcare system. Such education equips professionals with the necessary tools to navigate the increasingly intricate and demanding healthcare environment. It significantly enhances their ability to resolve interpersonal and systemic conflicts, fosters effective collaboration within multidisciplinary teams, and ensures preparedness for the diverse and often rapidly changing work settings encountered in modern medicine. Ultimately, this enhanced capacity for effective team management directly translates into heightened patient safety and improved clinical outcomes [1, 5, 7]. Furthermore, leadership and management training is a catalyst for personal and professional growth, cultivating higher levels of emotional intelligence and refined communication skills. This contributes to continuous quality improvement and innovation in healthcare and increases personal and professional development, thus resulting in the delivery of high-quality, effective, and compassionate care and higher patient satisfaction [1, 7]. Beyond the clinical impact, effective leadership is also strongly linked to improved job satisfaction, greater professional loyalty, and increased productivity among staff [8].

While these skills are crucial across all medical disciplines, psychiatrists possess a distinctive set of interpersonal skills, self-awareness, and unique perspectives, stemming from their training and expertise in mental health, that are particularly valuable in leadership positions [1, 2, 5, 8–10]. These unique attributes include exceptional competence in conflict resolution, a sophisticated understanding of group dynamics, and a strong capacity for rapport-building [1, 11]. In effect, psychiatrists are habitually at the forefront of leading multidisciplinary mental health teams, and there is a rapidly growing international recognition of the importance of physicians, and specifically psychiatrists, in leadership positions within healthcare organizations [1, 2, 12, 13]. Psychiatrist-led leadership is essential to address emerging mental health challenges, as psychiatrists are particularly well equipped to inspire, motivate, and empower teams [2, 9, 14]. As such, there is an internationally acknowledged and urgent mandate to provide robust leadership and management training to psychiatrists and psychiatric trainees, in order to equip them for the multifaceted demands of current clinical practice [2, 15]. This imperative is formally recognized by authoritative bodies, with the Union Européenne des Médecins Spécialistes (UEMS) explicitly mandating that all psychiatric trainees must acquire and continuously maintain leadership skills to effectively lead the mental health team in their work setting [16, 17].

Despite this clear necessity and formal endorsement, leadership and management skills training has been historically neglected in medical curricula worldwide; only recently have efforts begun to address this long-standing gap. Current postgraduate training programs, in many instances, either entirely lack or offer only limited and unstructured opportunities for trainees to learn and develop these skills [18, 19]. Access to substantive leadership training is often dependent solely on individual initiative, rather than being a standardized and integrated part of the educational process. This traditional lack of emphasis on leadership and management during medical education leaves future practitioners poorly prepared for the responsibilities they will inevitably face and, as a result, fosters reluctance to actively embrace or pursue formal leadership roles [20–22].

Significant disparities exist among countries and medical specialties regarding access to leadership training during residency programs, as well as the pedagogical models employed, and specific training content [19]. Within the field of psychiatry, the varying emphasis on leadership training during residency is evident when comparing international curricula. While some countries (such as the United Kingdom, United States of America, Canada, Australia, and New Zealand) have successfully integrated comprehensive leadership training into their programs, many others have yet to formally acknowledge its importance [19]. Moreover, there are few studies analyzing this matter. To our knowledge, only one study using a similar methodology and aims was conducted on this topic. This study by van Zeist-Jongman [20] assessed how Australian and New Zealand early career psychiatrists valued leadership skills education in their training to become psychiatrists. A smaller study, using a different methodology—a survey of early career psychiatrists' (ECPs) representatives, spanning 35 world countries—found that only a small minority (eight out of 40 respondents) reported having access to any form of leadership and/or management training during their residency [23].

The European Federation of Psychiatric Trainees (EFPT), an independent federation founded in 1992, represents psychiatric trainee organizations from over 30 European countries. It works in close collaboration with major bodies like the European Psychiatric Association (EPA) and UEMS, dedicating its mission to continuously enhancing and harmonizing psychiatric training standards across Europe. The federation is composed of several working groups (WGs), including the Leadership WG. This specific group aims to empower European psychiatric trainees, by not only providing them with direct opportunities for leadership skill development, but also by advocating for the formal inclusion of

comprehensive leadership training within all national psychiatric curricula.

Given the existing limited and fragmented data concerning the actual availability and structure of leadership training within European psychiatric training programs, and in direct alignment with its core mission to improve training quality, the EFPT Leadership WG intends to conduct an exploratory study on this subject. The goals of this study are to assess the current availability and integration of leadership training across various European countries; to evaluate the perceived impact of this training on the trainees and early career psychiatrists' (ECPs) professional practice and development, and to capture the specific, current leadership training needs of psychiatric trainees and ECPs and their perspectives on the topic. The findings from this EFPT-led study are anticipated to provide empirical evidence necessary to support further studies on this issue, inform policy, harmonize training standards, and ultimately ensure that the next generation of European psychiatrists is fully equipped to assume the essential leadership roles required of them in modern healthcare.

2. Materials and methods

2.1. Study design

This cross-sectional study was conducted between July and December of 2021.

2.2. Study instrument

For this purpose, we designed a survey for European psychiatric trainees and early career psychiatrists by iterative consensus discussion, based on relevant literature review on leadership training and our group's experience on this topic. The decision to create a novel survey for use in our study stemmed from a lack of standardized questionnaires to evaluate this topic, as well as the need to synthesize in a single survey the widespread literature and knowledge. The questionnaire included multiple-choice, free-text, checkbox, and Likert-scale questions. The complete survey is found in Supplementary material S1.

2.3. Eligibility criteria

Early career psychiatrists were defined as doctors within the first 5 years after finishing training or over 5 years after finishing training but less than 40 years of age.

2.4. Data collection

The survey dissemination followed a multilevel distribution strategy, leveraging existing organizational structures to reach the target audience. The process unfolded in several levels: (1) the survey was disseminated and promoted through the European Federation of Psychiatric Trainees (EFPT) network, via newsletters, emails, and social media platforms; (2) EFPT sent the survey and the request for dissemination to the National Trainee Associations (NTAs) of each member European country; (3) the NTAs were responsible for actively disseminating the survey to their members, specifically psychiatric trainees/early career psychiatrists nationally; (4) to increase the reach of the survey, the survey was also disseminated via social media platforms and newsletters of other associations identified to have relevant representation within European early career psychiatrists (World Network of Psychiatric Trainees, European Psychiatric Association, and World Psychiatric Association). The survey was sent out and promoted on several occasions throughout the data collection period via reminders and subsequent shares. The survey was administered via SurveyMonkey (Momentive, San Mateo, CA, USA). Informed consent was obtained from all respondents.

The questionnaire and study design were submitted and approved by the ethics committee of Hospital Prof. Doutor Fernando Fonseca, in Portugal (protocol code CES 112/2021; approved on 17 November 2021).

2.5. Data analysis

Data were analyzed using Stata 13 (StataCorp LP, College Station, TX, USA). Descriptive statistics were employed to examine sample characteristics. To study the impact of participants' characteristics on the prioritization of 18 leadership skills and 12 management skills in leadership training (each answer is measured through a 5-point Likert scale), we used regression analysis. Specifically, we analyzed whether participants' experience with leadership skills in psychiatric training, additional leadership training, or being psychiatrists influenced their prioritization of each aspect of management and leadership skills.

Given the perceived value of each aspect of leadership and management skills is an ordinal variable, a linear regression model was unsuitable due to violations of its assumptions for ordinal dependent variables. Thus, we employed an ordered probit model, which accounts for ceiling and floor effects and avoids subjectively chosen scores assigned to the categories. In this model, the ordinal dependent variable, V, is viewed as the discrete realization of an underlying latent continuous variable, V^*. The categories are envisaged as contiguous intervals on the continuous scale. The unobservable V^* satisfies the following linear regression model:

$$V_i^* = X_i \times \beta + C_i \times \gamma + \varepsilon_i \quad (1)$$

where V_i^* is the unobservable continuous variable for individual i, X_i is an array of the explanatory variables of individual i described earlier, C_i is an array of socio-demographic control variables of individual i, β and γ are the vectors of parameters to be estimated, and ε_i is the error term. The observable categorical variable, V_i, arises from V_i^* as follows:

$$V_i = j \quad if\, \alpha_{j-1} \leq V_i^* \leq \alpha_j, \qquad j = 1, 2, \ldots, J \quad (2)$$

where α are unknown cut-off points in the distribution of V_i^*, with $\alpha_0 = -Inf$ and $\alpha_J = Inf$. As stated above, each aspect of leadership and management skills is an ordinal variable comprising five categories, that is, $J = 5$.

3. Results

Among the sample studied (N = 119), most participants were female (n = 80, 67.2%), with an average age of 32 years. The sample was mainly composed of trainees (n = 84, 70.6%), most of whom worked in general adult psychiatry (n = 58, 48.7%). The most common workplace setting in the sample studied was the Psychiatric Hospital (n = 62, 39.5%). Full information is reported in **Table 1**.

Table 1 • Demographic and work setting information, N = 119.

Variable	N (%)
Gender	N = 119
Male	39 (32.8%)
Female	80 (67.2%)
Age	N = 119
Mean	32.3
Standard Deviation	5.0
Immigrant	N = 119
Yes	14 (11.8%)
No	105 (88.2%)
Workplace	N = 157 [a]
General Hospital	50 (31.8%)
Psychiatric Hospital	62 (39.5%)
Psychiatric Outpatient Clinic	31 (19.7%)
Community Unit	6 (3.8%)
Private Practice	8 (5.1%)
Current work	N = 119
General adult psychiatric trainee	58 (48.7%)
Child and adolescent psychiatric trainee	15 (12.6%)
Other psychiatric trainees (e.g., forensic psychiatric trainees)	11 (9.2%)
Early career psychiatrist (within the first five years after finishing training)	26 (21.8%)
Early career psychiatrist (>five years after finishing training, but <40 years of age)	9 (7.6%)

[a] Participants were able to select more than one option for this question, accounting for the difference in N.

Supplementary material S2 (Figure S1) fully assesses the distribution of respondents by country (total of 31 countries). The countries with the most respondents were Portugal (n = 23, 19.3%), the United Kingdom (n = 12, 10.1%), and Ireland (n = 10, 8.4%).

Most participants (n = 91, 76.5%) believed leadership could be taught formally. However, a few (n = 22, 18.5%) reported being unsure about this statement, and a small minority (n = 6, 5.0%) opposed it.

When asked if their psychiatric training program included leadership skills training, most participants reported that it did not (n = 75, 63.0%), with a minority of individuals having access to mandatory (n = 25, 21.0%) or optional (n = 14, 11.8%) leadership skills training.

Among those individuals with access as part of their psychiatric training program, 39.0% (n = 16) had access to theoretical training, 14.6% (n = 6) to practical training, and 46.3% (n = 19) to both theoretical and practical leadership skills training.

The participants reported being dissatisfied with the leadership skills training received in their psychiatric training program (average rating of 2.41 points on a Likert scale from 1—very dissatisfied to 5—very satisfied; 95% CI, 2.23–2.59). This result was not associated with a higher likelihood of engaging in further training (the average difference in satisfaction towards training between those who sought out additional training and those who did not is 0.15; 95% CI, −0.21–0.51). The majority of the participants (n = 62, 52.1%) stated that they had sought out additional leadership skills training outside of their psychiatric training program, either theoretical (n = 15, 12.6%), practical (n = 10, 8.4%), both theoretical and practical training (n = 35, 29.4%), or in other formats (n = 2, 1.7%). The source of additional training was not assessed. Additionally, all participants expressed that leadership skills training should be included in a psychiatric training program, with 59.1% (n = 68) stating it should be mandatory and 40.9% (n = 47) stating it should be optional.

The results shown in **Figure 1** represent the distribution of leadership skills included in the training that the respondents had accessed.

Respondents were asked to rate the importance of learning specific leadership and management skills using a Likert scale from 1—completely unimportant to 5—very important. The results can be observed in **Figure 2** and **Figure 3**, respectively.

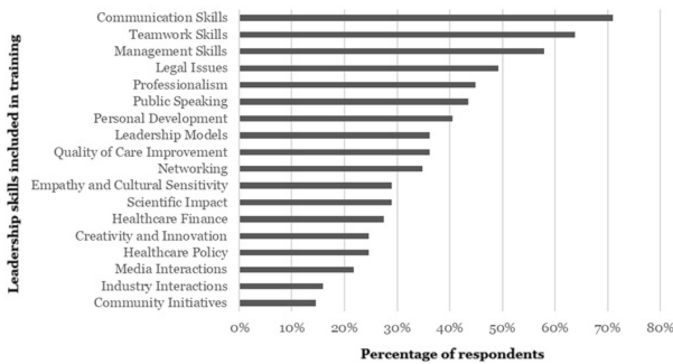

Figure 1 • Distribution of skills included in the leadership skills training accessed by the respondents, $N = 119$.

Figure 2 • Rating of the importance of specific leadership skills according to the respondents, $N = 119$. The vertical grey line represents the overall mean across all items. Error bars indicate 95% confidence intervals.

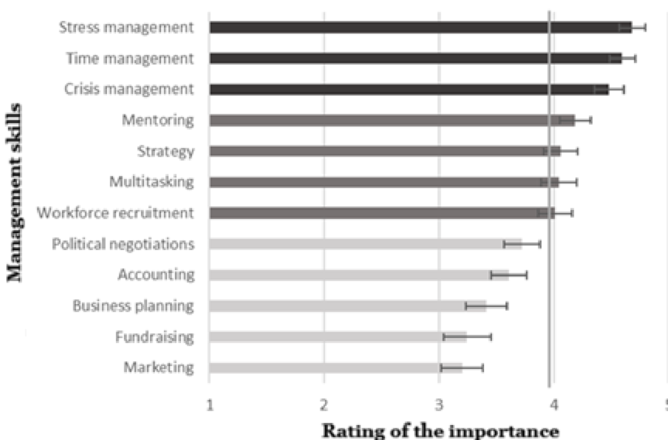

Figure 3 • Rating of the importance of specific management skills according to the respondents, $N = 119$. Different shades of grey added to facilitate visualization of clustering of skills. The vertical grey line represents the overall mean across all items. Error bars indicate 95% confidence intervals.

A secondary analysis using an ordered probit regression was made to study the distribution of the variables shown in **Figure 2** and **Figure 3** against different subsets of the participants (participants with leadership skills training included in their psychiatric training program, $n = 39$, 32.8%; participants who had sought out additional leadership skills training outside of their psychiatric training program, $n = 62$, 52.1%; early career psychiatrists, $n = 35$, 29.4%), with age and gender acting as controlling variables. The results can be seen in **Table 2** and **Table 3**, respectively.

Looking at the relevance participants attributed to different leadership skills (**Table 2**), results varied according to their background training. When compared with other participants, individuals who received leadership training in the context of their residency program attributed a significantly lower value to "personal development" ($p < 0.05$), "community initiatives" ($p < 0.01$), "networking" ($p < 0.05$), and "public speaking" ($p < 0.05$) than to the other leadership skills listed. On the other hand, participants who sought additional leadership skills training outside of their residency curriculum gave a significantly lower rating to "professionalism" ($p < 0.05$), "teamwork" ($p < 0.05$), and "legal issues" ($p < 0.05$) skills, and attributed a significantly higher relevance to "networking" ($p < 0.01$) skills, in comparison to their counterparts. Finally, ECPs gave a higher rating to "legal issues" ($p < 0.01$) and "media interactions" ($p < 0.05$), and a lower value to "creativity and innovation" ($p < 0.1$) than other leadership skills in comparison to psychiatry trainees.

When asked to rate specific management skills according to their importance (**Table 3**), participants' opinions varied according to their background training. When compared to other participants, those who had access to leadership skills training as part of their residency program attributed a lower value to "marketing" ($p < 0.05$) and "fundraising" ($p < 0.1$) skills than to the other management skills listed. Moreover, in comparison to their counterparts, individuals who sought additional leadership skills training outside of their residency curriculum rated "fundraising" ($p < 0.05$), "accounting" ($p < 0.05$), and "multitasking" ($p < 0.1$) skills higher, and gave "crisis management" ($p < 0.05$) and "stress management" ($p < 0.01$) skills a lower score than to the other management skills listed. Finally, ECPs gave a higher rating to "marketing" ($p < 0.1$), "time management" ($p < 0.1$), and "stress management" ($p < 0.1$) skills, and a lower value to "political negotiations" ($p < 0.05$) than other leadership skills, in comparison to psychiatry trainees.

Table 2 • Ordered probit regression estimations of 18 leadership skills, $N = 119$ [a,b].

Variables	Professionalism (1)	Empathy and cultural sensitivity (2)	Creativity and innovation (3)	Teamwork skills (4)	Communication skills (5)	Management skills (6)	Quality of care improvement (7)	Personal development (8)	Community initiatives (9)
Leadership skills in psychiatric training	0.2087 (0.92)	−0.0211 (−0.09)	−0.1421 (−0.64)	0.0083 (0.03)	−0.0272 (−0.11)	0.2030 (0.85)	−0.0875 (−0.37)	−0.5764 ** (−2.45)	−0.7533 *** (−3.20)
Additional leadership skills	−0.4768 ** (−2.16)	−0.2965 (−1.35)	0.1388 (0.65)	−0.5642 ** (−2.43)	−0.3402 (−1.48)	−0.0569 (−0.25)	−0.2034 (−0.91)	0.0660 (0.30)	−0.1646 (−0.75)
Psychiatrist	0.1019 (0.43)	−0.2660 (−1.10)	−0.4197 * (−1.79)	−0.0957 (−0.38)	0.3018 (1.19)	−0.1923 (−0.76)	0.1864 (0.75)	0.1959 (0.80)	0.0490 (0.20)
Control variables									
Age	−0.0097 (−0.44)	−0.0083 (−0.37)	0.0421 * (1.91)	0.0153 (0.65)	0.0259 (1.09)	0.0246 (1.04)	0.0512 ** (2.18)	−0.0160 (−0.70)	−0.0286 (−1.28)
Gender	−0.4220 * (−1.88)	−0.1244 (−0.56)	0.0283 (0.13)	−0.0066 (−0.03)	0.3959 * (1.68)	0.2009 (0.86)	0.6156 *** (2.64)	−0.3342 (−1.47)	−0.2625 (−1.18)
Statistics									
Log-likelihood	−113.55	−113.66	−125.37	−95.57	−94.03	−93.64	−102.08	−108.32	−110.65
Pseudo R2	0.0362	0.0211	0.0238	0.0336	0.0376	0.0152	0.0581	0.0418	0.0700
Sample size	119	119	119	119	119	119	119	119	119

Variables	Legal issues (10)	Healthcare policy (11)	Healthcare finance (12)	Leadership models (13)	Networking (14)	Media interactions (15)	Industry interactions (16)	Scientific impact (17)	Public speaking (18)
Leadership skills in psychiatric training	0.0056 (0.02)	0.0132 (0.06)	0.2489 (1.11)	0.0740 (0.31)	−0.4684 ** (−2.06)	−0.2369 (−1.06)	−0.1952 (−0.85)	−0.1952 (−0.85)	−0.4907 ** (−2.09)
Additional leadership skills	−0.4691 ** (−2.13)	0.2145 (1.00)	0.0780 (0.37)	0.1915 (0.84)	0.6405 *** (2.88)	0.1329 (0.62)	0.2544 (1.14)	0.2544 (1.14)	0.2951 (1.32)
Psychiatrist	0.8503 *** (3.44)	0.2763 (1.17)	0.1117 (0.47)	0.3562 (1.40)	−0.0058 (−0.02)	0.5524 ** (2.29)	−0.3627 (−1.50)	−0.3627 (−1.50)	−0.1261 (−0.52)
Control variables									
Age	−0.0145 (−0.64)	0.0346 (1.58)	0.0339 (1.50)	0.0296 (1.24)	0.0023 (0.10)	−0.0104 (−0.48)	−0.0034 (−0.15)	−0.0034 (−0.15)	−0.0048 (−0.21)
Gender	0.2367 (1.07)	−0.0505 (−0.23)	−0.0383 (−0.18)	0.1783 (0.77)	0.0875 (0.40)	0.1894 (0.86)	0.1401 (0.62)	0.1401 (0.62)	0.2833 (1.24)
Statistics									
Log-likelihood	−114.97	−120.77	−125.61	−98.78	−119.59	−122.74	−110.97	−110.97	−109.84
Pseudo R2	0.0662	0.0309	0.0225	0.0374	0.0448	0.0304	0.0181	0.0181	0.0299
Sample size	119	119	119	119	119	119	119	119	119

Note. [a] Robust z-statistics in brackets. [b] *, **, and *** correspond to the 10%, 5%, and 1% significance levels, respectively.

Table 3 • Ordered probit regression estimations of 12 management skills, N = 119 [a,b].

Variables	Strategy (1)	Marketing (2)	Fundraising (3)	Accounting (4)	Business planning (5)	Multitasking (6)
Leadership skills in psychiatric training	−0.0266 (−0.12)	−0.4825 ** (−2.15)	−0.4018 * (−1.83)	0.3560 (1.56)	−0.2240 (−1.02)	0.0007 (0.00)
Additional leadership skills	0.1152 (0.53)	0.3386 (1.58)	0.4901 ** (2.32)	0.4734 ** (2.14)	0.2614 (1.23)	0.3970 * (1.89)
Psychiatrist	−0.1161 (−0.48)	0.3983 * (1.67)	0.0779 (0.34)	−0.2932 (−1.23)	−0.0949 (−0.41)	0.1330 (0.58)
Control variables						
Age	0.0354 (1.58)	−0.0435 ** (−1.97)	−0.0439 ** (−2.04)	−0.0055 (−0.25)	0.0003 (0.02)	−0.0291 (−1.35)
Gender	0.1513 (0.68)	−0.4011 * (−1.84)	−0.2958 (−1.39)	0.2292 (1.03)	0.1453 (0.67)	−0.6423 *** (−2.95)
Statistics						
Log-likelihood	−110.26	−124.36	−138.08	−113.64	−129.61	−136.85
Pseudo R2	0.0151	0.0549	0.0431	0.0434	0.0099	0.0456
Sample size	119	119	119	119	119	119
Variables	**Mentoring (7)**	**Political negotiations (8)**	**Crisis management (9)**	**Stress management (10)**	**Workforce recruitment (11)**	**Time management (12)**
Leadership skills in psychiatric training	0.2012 (0.91)	−0.2098 (−0.93)	0.3426 (1.47)	0.0938 (0.41)	0.1537 (0.70)	0.2473 (1.11)
Additional leadership skills	−0.0006 (−0.00)	−0.0564 (−0.26)	−0.4890 ** (−2.17)	−0.7026 *** (−3.12)	−0.1715 (−0.80)	−0.1703 (−0.80)
Psychiatrist	−0.0696 (−0.30)	−0.5763 ** (−2.40)	0.2717 (1.11)	0.4665 * (1.92)	0.3696 (1.56)	0.4582 * (1.94)
Control variables						
Age	0.0150 (0.68)	0.0272 (1.24)	−0.0046 (−0.20)	−0.0027 (−0.12)	0.0156 (0.73)	−0.0472 ** (−2.12)
Gender	−0.0689 (−0.32)	0.1804 (0.81)	−0.2106 (−0.93)	0.0011 (0.00)	0.0786 (0.36)	−0.2070 (−0.95)
Statistics						
Log-likelihood	−127.73	−118.08	−106.66	−110.84	−125.52	−123.62
Pseudo R2	0.0062	0.0315	0.0330	0.0525	0.0180	0.0329
Sample size	119	119	119	119	119	119

Note. [a] Robust z-statistics in brackets. [b] *, **, and *** correspond to the 10%, 5%, and 1% significance levels, respectively.

4. Discussion

This study produced some interesting findings. In total, 63.0% reported that their psychiatric training program did not include leadership skills training, and more than half (52.1%) stated that they sought additional leadership skills training outside their psychiatric training program. Also, all the participants expressed that leadership skills training should be included in a psychiatric training program.

When asked which leadership skills were addressed in their leadership skills training, only three skills were addressed for more than half of trainings: "communication skills", "teamwork skills", and "management skills". At the same time, the leadership skills rated as most important are, in order, "communication skills", "teamwork skills", "empathy and cultural sensitivity", "professionalism", "management skills", "quality of care improvement", "legal issues", and "personal development". However, the results varied according to their background training. Regarding management skills, "stress management", "time management", and "crisis management" were distinctly rated as important. Again, the results varied according to their background training.

There is a paucity of studies analyzing this topic that can stem from various reasons, including prioritization of other topics within training or cultural reasons (it seems that countries influenced by Anglo-Saxon tradition are more likely to introduce this topic within their training programs) [19]. We envision that some barriers may exist that hinder the implementation of leadership skills training, including pressure for high productivity in clinical settings and a lack of funding. Considering that the present study comprises 119 respondents from 31 European countries, it can provide an important snapshot of the opportunities and gaps in leadership training among early career psychiatrists, especially in Europe, while shedding some light on a relevant field outside this specific cohort.

More than three-quarters of the participants believed leadership could be taught formally, aligning themselves with various key literature like the Medical Leadership Competency Framework, jointly developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement [24]. However, only a minority of respondents had access to any leadership skills training, opposing the results found among Australian and New Zealand early career psychiatrists [20] and the growing literature and expert consensus [1, 3, 7, 19, 24–27], which supports the systematic integration of essential leadership development for all doctors throughout postgraduate medical training. This result illustrates the gap in this type of training throughout most of Europe and that there is an excellent margin for development to catch up with the best practices and evidence available. In this regard, it is important to highlight some initiatives. The United Kingdom stands out as a prominent example of a country with established and proactive programs, including the RCPsych Leadership and Management Fellow Scheme (established in 2017, combining national development training with a local apprenticeship model) [28], the NHS Leadership Academy, and the Faculty of Medical Leadership and Management (both of which were established in 2011 and provide extensive resources and training) [26]. On the international stage, other notable initiatives include the European Psychiatric Association's Leadership Academy (launched in September 2025) [29] and the highly influential, long-standing Leadership and Professional Skills courses pioneered by Professor Norman Sartorius [30, 31]. Also the European Board Examination in Psychiatry (which had its first sitting in February 2025) bases its syllabus on the UEMS European Training Requirements, which states that all psychiatric trainees must acquire and continuously maintain leadership skills [16, 32]. Despite these efforts, the general scarcity of publications on this topic in most European nations suggests a widespread lack of formal, structured leadership training programs across the continent. Among the same group of respondents, less than half had received training that included both theoretical and practical leadership skills. While there is a lack of robust evidence of the effectiveness of specific training programs, a blend of different modalities for developing these skills appears to be favored by the literature, experts, and early career professionals [3, 7, 19, 20, 24–26]. Considering these results, it is no surprise that participants were, on average, dissatisfied with the leadership skills training received in their psychiatric training program. The overwhelming majority think leadership skills training should be included in the psychiatric training program.

As doctors progressively need to get more involved in planning, delivering, and transforming health services [24], trainees and early career professionals need to realize and accept leadership responsibility [26]. There is also a need to create more advanced opportunities for aspiring medical leaders to complement more basic training and they should be offered as part of their core specialization training [26]. In our sample, most participants indicated that they had sought additional leadership skills training outside of their psychiatric training program.

When asked which leadership skills were addressed in the leadership skills training, respondents noted that only three skills were addressed for more than half of them: "communication skills", "teamwork skills", and "management skills". "Legal issues", "professionalism", "public speaking", and "personal development" were also featured in more than 40% of respondents, but they were distant from the first three. While these are among the skills highlighted in the literature [24, 33], it is fair to say that a relevant portion of skills has not been adequately represented/addressed in training opportunities. This shows that even if a significant part of the respondents has partaken in some leadership skills training, there is a good chance that this training was not comprehensive in scope and lacked several important topics.

This study also elicited some data on the perspectives of psychiatric trainees and ECPs regarding the different leadership and management skills. In effect, our results suggest that the importance attributed to the different skills varies according to the participants' degree of training in this area as well as their professional experience of working in psychiatry. We propose that this may be secondary to the increase in responsibility and awareness about limitations after transitioning from trainee to consultant psychiatrist, which has also been reported in the literature as an important factor fueling leadership competency development [34].

Moreover, our data suggest that there may be differences between the leadership/management skills training received as part of the residency curriculum and the training procured outside of this setting. This is evidenced by the fact that individuals in the latter group express distinct perspectives on the importance of certain management and leadership skills, and may even oppose the views

of the former group. This is the case for "networking" leadership skills (regarded as significantly less important by participants who received leadership training in the context of their residency program and as one of the most important leadership skills by those who sought additional training) and "fundraising" management skills (given a lower importance score by individuals who had access to leadership skills training as part of their residency program, and considered amongst the most important management skills by participants who received additional training).

These results suggest that the type and context of leadership training may have an impact on psychiatrists' views of leadership and management practices and the skills required to implement them. Other studies have supported this view, with evidence of gains in leadership knowledge and skills after participation in leadership training programs [35].

In addition, our results also indicate variations in attitudes and interest in leadership among individuals pursuing extra training outside of their residency program, as compared to their counterparts. It has been noted that individuals who recognize their leadership potential tend to pursue skill development opportunities actively [34].

Some limitations were identified regarding this study. Some seem to stem from many of the issues already pointed out in this text. The paucity of leadership skills training opportunities likely contributed to the low response rate. After reviewing some of the available programs in leadership skills in Europe (most prevalent in the United Kingdom) and presented in the introduction to this paper, we do not believe training availability conditioned the response rate and it was not a major driver of respondent distribution discrepancy by country. The response rates depended greatly on the survey delivery methods. Firstly, the countries with the most answers were those where the main study authors live/work, resulting from increased email and social network posts asking participants to answer the survey. Secondly, the low response rates could be due to the limited reach of the survey in some countries, depending on the willingness and capability of the NTAs to contact their psychiatric trainees/early career psychiatrists. Thirdly, despite our best efforts to minimize it, we recognize that responses might have been limited due to "survey fatigue", which has particularly increased after the COVID-19 pandemic [36]. This might have led to a smaller than expected number of respondents. At the same time, there is a risk for selection bias, as participants who responded to our survey could be more predisposed to the topic of leadership skills versus trainees and career psychiatrists who did not answer our survey. Additionally, a smaller number of respondents could specially limit the subsample analyses as they can be constrained by low subsample sizes. Despite this, this study delivers a relevant snapshot regarding this important topic and provides avenues for further research.

This study provides an exploratory picture of the current gaps in leadership skills training in European psychiatry. Despite some limitations, it can provide some worthwhile knowledge to design new training initiatives and push for widespread inclusion of leadership skills training in national psychiatric training curricula. More research into this topic, using broader and greater samples, might prove worthwhile in improving general knowledge about the subject and current and future training opportunities, as well as in supporting the implementation of new initiatives.

5. Conclusions

Addressing the current gaps in leadership skills training will be challenging, but it seems possible to meet this challenge adequately. Leadership skills training provides opportunities for professional and personal growth and seems to affect people's perception of these skills. New training initiatives and lobbying for inclusion in national training curricula are part of the path forward, as well as further research to increase knowledge and support these initiatives.

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Author contributions

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Conflict of interest

The authors declare that they have no competing interests.

Data availability statement

The data supporting the findings of this publication can be made available upon request.

Institutional review board statement

The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Ethics Committee of Hospital Prof. Doutor Fernando Fonseca, in Portugal (protocol code CES 112/2021, approved on 17 November 2021).

Informed consent statement

Informed consent for participation was obtained from all subjects involved in the study.

Supplementary materials

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