# UK trainee perspectives on leadership in the COVID-19 pandemic

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## Introduction

There has been redeployment, 'up-skilling', halted rotations and an earlier than planned start to work for many new foundation year-1 (F1) doctors, to name just a few of the events impacting trainees in the UK during these 'unprecedented times'. At times of crisis we look to leaders for guidance and support; but it is not only in these times that leadership plays a pivotal role – note the General Medical Council (GMC) leadership and management guidance. This snapshot survey was designed to explore trainee experience of leadership during the COVID-19 pandemic in the UK.

## Materials and methods

An online survey was designed and emailed out to trainees across a UK hospital trust, over a 2-week period in June 2020. Trainees were asked to list up to three examples of 'good leadership' they had observed during the COVID-19 pandemic, and for each, list the skills and qualities of the leader they felt underpinned them. In addition, they were asked the demographics of each of the leaders in question including gender, ethnicity (using the format taken from hospital trust equality and diversity monitoring forms), and stage of training, plus their own. Qualitative data analysis occurred via identification of common themes.

## Results and discussion

20 responses were obtained. Trainee grades ranged from interim F1 doctor, to senior specialist registrar. Respondents were primarily female (85%; n=17), and of Caucasian ethnicity (80%; n=16). Most were working in general medical specialties (60%; n=12), redeployed due to the pandemic in over half of cases (60%; n=12).

There were 55 examples of 'good leadership'. These good leaders were described commonly as 'leading by example', showing kindness and empathy, with clear communication. They were primarily male (55%; n=30), and of Caucasian ethnicity (76%; n=42). These good leaders were mostly of consultant grade (56%; n=31), with junior trainees (foundation year and 'senior house officer' grades) comprising 15% (n=8) of responses, and senior nurses 9% (n=5).

Approximately a third of respondents (35%; n=7) had had to 'act up' (practising at a level senior to the one officially achieved) in their current posts, while the majority (80%; n=16) reported no prior leadership training.

This survey highlights a potential disconnect between the focus on medical leadership promoted by bodies such as the GMC and seen frequently in job person specifications, and trainee perceptions in day-to-day practice. The survey responses show that trainees are 'stepping up' into roles requiring leadership without – in the majority of cases – prior leadership training to adequately prepare themselves. With leaders typically described as senior, male, and Caucasian, this survey (though limited by a small sample size) suggests more may be needed to encourage diversity, and to empower trainees to recognise and put leadership theory into practice.

## Conclusion

The preparation for the pandemic brought with it much innovation in the NHS. This is an opportunity to make real and lasting change to current medical leadership teaching and practice; one we owe to ourselves, our clinical teams and our patients. ■

## Conflicts of interest

None declared.

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