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REVIEW

Conceptualisations of Leadership and Relevance to Health and Human Service Workforce Development: A Scoping Review

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Purpose: This scoping review was undertaken to determine leadership definitions and approaches relevant to health and human service (H&HS) workforce development. This review provides a preliminary analysis of the potential size and scope of available research literature to inform ongoing research with the ultimate aim to inform a future systematic review in relation to leadership development interventions.

Methods: Following the methodology proposed by Arksey and O'Malley and using PRISMA-ScR, a systematic search was conducted using seven databases (PubMed, Health Business Elite, Medline, CINAHL, Ovid, Scopus, and Web of Science). Articles were screened and assessed for eligibility. From eligible studies, data were extracted to summarize, collate, and make a narrative account of the findings.

Results: Employing pre-selected criteria, a total of 424 records were identified and 171 full-text articles were assessed. The majority of the papers were studies undertaken by researchers based in North America. Leadership in the H&HS sector was addressed in 35% of the articles. The narrow disciplinary or workforce fields of the nursing and medical professions in hospitals and acute care settings dominated the literature.

Conclusion: The findings suggest that while leadership has been studied extensively in the health system, there is a paucity of leadership development research specific to the broader H&HS sector. This review emphasises the need for further research, including a more critical examination of leadership development interventions and their application to the H&HS sector.

Keywords: leadership, development, health and human services, workforce development, scoping review

Introduction

There is widespread recognition of the importance of leadership and leadership development in the health and human service (H&HS) sectors.[1–3] This is particularly relevant for workforce development in these sectors with leadership development being a major strategic focus related to capacity-building initiatives and strategies.[4–8] Leadership development is a ubiquitous yet ambiguous focus of H&HS workforce development.[9–11]

"Leadership is like the abominable snowman whose footprints are everywhere but who is nowhere to be seen".[12] Leadership has been defined by many and yet there does not appear to be a universally accepted definition, and the term has different meanings to different people and different contexts.[13–20] Most leadership

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theories and definitions have stemmed from a business context and are then adapted to the H&HS sector.[21–23] This lack of a specific definition of leadership in the H&HS sector was identified by Berghout et al[24] in a systematic review of medical leadership in which they acknowledged that the lack of conceptual understanding and commonly used terminology hampers empirical developments in leadership research for this sector. Thus, there is a need for more research of leadership development specific to the H&HS sector.

Developing a working definition of leadership as it relates to the H&HS sector is the key starting point to add precision to this research by removing the multiplicity of meaning that can be attributed to this concept.[25] Suddaby[26] argues that a good definition is needed to capture the essential properties and characteristics of the concept under consideration. Definitions of the human services continue to be difficult and contested because this workforce is responsible for a broad variety of functions and tasks, with roles performed by a diverse array of people from different disciplines, with various qualifications, and with a variety of knowledge bases and approaches in diverse environments.[27] Human Services is not a single service delivery system, but a complex network of organisations whose primary goal is to help people in need. It encompasses, but is not limited to, disability services; aged services; child, youth, and family services; corrections; social housing; crisis intervention; and education.[28] In contrast, the health system has been clearly defined as all organizations, people and actions whose primary intent is to promote, restore or maintain health.[29]

This scoping review was conducted with three objectives: (a) to identify a definition of leadership applicable to the H&HS sector (b) to identify and describe the theories and approaches to leadership and the relevance to H&HS sector workforce development with a view to informing a future predetermined systematic review in relation to leadership development interventions and (c) to provide a preliminary analysis of the potential size and scope of available research literature to inform ongoing research.[30–33]

Methodology

The scoping review methodology developed by Arksey and O'Malley[34] refined by Levac et al[35] with enhanced guidance from the Joanna Briggs Institute Manual[33] informed this review. Scoping reviews are exploratory and descriptive with one of the key values being the ability to incorporate various types of the literature that are not limited to research studies.[36–38]

Search Strategy and Criteria

Search terms were derived from the research question and included "leadership", "leadership theory", "leadership definition", "health sector", "human services", and "health and human services". These were used both alone and in combination. In an iterative process, various combinations of the key words were tested in keeping with the scoping review methodology.[34] The final search string was as follows: "leadership", "leadership AND definition", "leadership AND theory" "leadership AND definition AND theory", limit to English, AND "health and human services". The identification of key words and the selection of search strings using Boolean logic is important to determine what material you retrieve.[39,40] The search included journal articles, dissertations, book chapters, and conference proceedings as identified in each database.

Seven databases were searched: PubMED, Health Business Elite, Medline, CINAHL, Ovid, Scopus and Web of Science. These databases were identified for their relevance to H&HS sector leadership. The initial search was conducted in September 2020 and repeated in April 2021.

The inclusion and exclusion criteria for each phase of the review are detailed in Table 1. Articles were excluded if they did not meet all inclusion criteria. If the information provided in either the title and/or the abstract was insufficient for a justified decision, the articles were included in the full-text screening phase. Screening of reference lists and hand searching of known journals for newly published articles was also undertaken.

In accordance with the standard approach to conducting scoping reviews, a quality appraisal was not performed.[37,38]

Results

The initial search yielded 424 articles. After removal of duplicates and application of the exclusion criteria, there were 73 articles remaining to analyze. The research has also been informed by seminal works and by examining the bibliographies of resources identified through the screening process, which provided further 47 articles or books. A total of 171 articles met the eligibility criteria and were reviewed. The PRISMA flowchart (see Figure 1) illustrates the screening process that resulted in articles to be included in the scoping review.[36,41,42]

Table 1 Inclusion and Exclusion Criteria

Phase of Review	Inclusion Criteria	Exclusion Criteria
Title and Abstract Screening	Peer reviewed articles with leadership definition and theory in the title and/or abstract	Not peer reviewed or did not contain the word leadership in the title and/or abstract Opinion papers Articles based on theories not concerned with leadership
	English language	Not published in English
Full Text Screening	Studies focused on; • Leadership • Leadership definition • Leadership theory • Leadership approaches • Health and human services	Studies focused on; • Clinical Care • Children and adolescents • Training • Organizational factors and processes (eg, Job satisfaction, integrity) • Health policy • Project management • Trauma • Gender/Cultural studies • Sectors not concerned with health and/or human services

Characteristics of the Included Papers

Initial examination of the papers resulted in the following observations. The largest share of the papers reviewed was review articles (38%) followed by qualitative studies (22%). Literature reviews (7%), books (7%) and systematic review (3%) papers were the next most common. Only 4 quantitative studies were located. The geographical distribution of the publications by author/s was predominantly USA (56%) followed by the UK (10%), Canada (5%) and Australia (3%). Of the 171 papers reviewed only 61 (35%) specifically addressed leadership in the H&HS sector.

Evolution of the Definition of Leadership

This review of the literature demonstrates the diversity and variety of opinions that exist when one attempts to define leadership. This review demonstrates that definitions of leadership have evolved over time (refer Table 2). Leadership has moved from power "over" people to working "with" people to achieve the desired outcomes. In most health settings, old practices such as command and control have become obsolete and are unsustainable. Key components that have been identified as pivotal are that leadership is a process, it involves influence, occurs between people, and involves attainment of goals (which may be individual, group or organizational).[43–45]

Leadership Theories and Approaches: Historical Overview

Historically, the concept of leadership has been extensively studied and analyzed by researchers, resulting in an evolving succession of theories and approaches. This historical overview, based on the findings of this scoping review, demonstrates that the early theories focused on the traits or innate qualities of the leaders with later theories expanding to include the context in which leadership takes place. Whilst it is difficult to divide the theories and approaches into specific timeframes, it is possible to demonstrate the evolutionary development, as identified in this scoping review, and potential applicability to the H&HS sector (refer Table 3,).

The earlier theories and approaches considered that there was one factor that determined leadership be they innate traits,[44,47,54–60] a set of skills,[44,61–63] certain behaviours,[44,47,64] or a certain style.[13,44,47,65–68] Particular traits and characteristics that have been shown to promote leadership are openness, extroversion, self-confidence, energy, inclusiveness, and motivation to manage.[47,55–57] The strength of the skills approach was that it categorized leadership as an identifiable set of skills, which can be learned, developed and improved, instead of being a concept reserved for the select few born with the ability.[44] Researchers then identified two general types of leadership behaviours: task behaviours and relationship

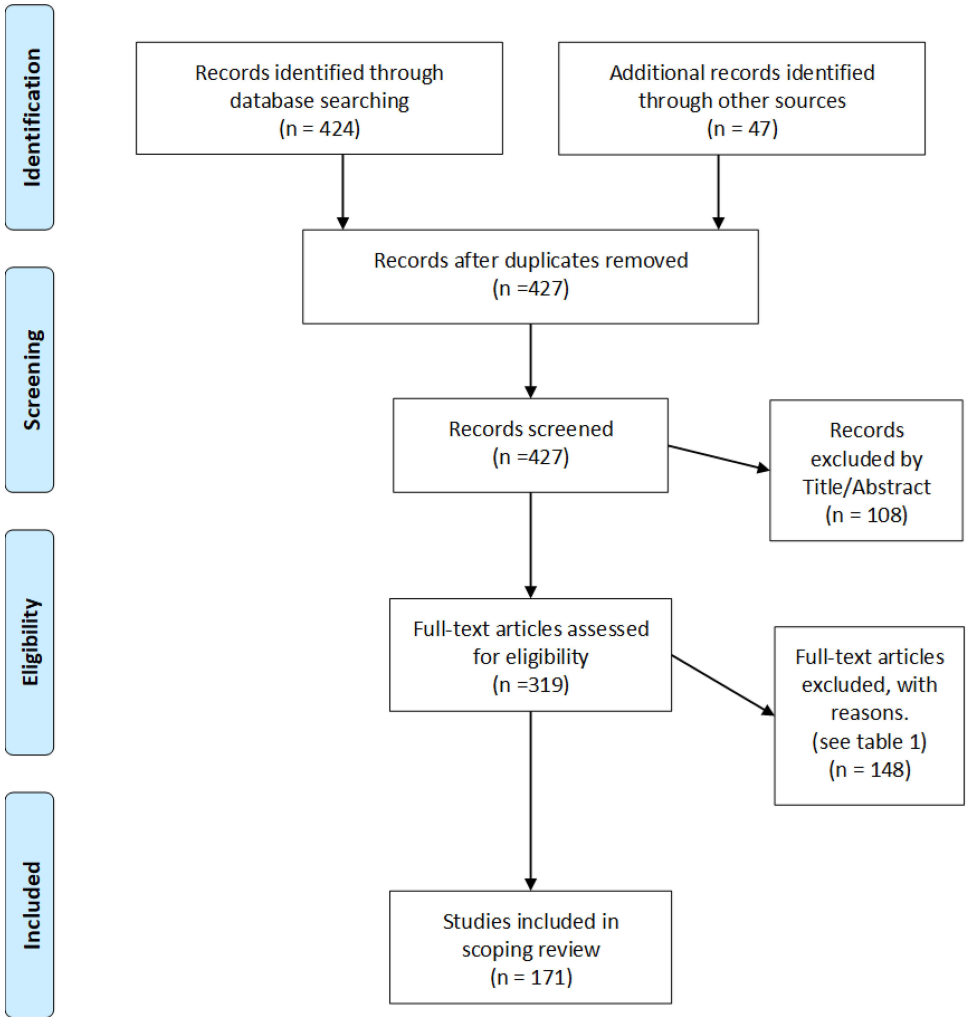

Figure 1 PRISMA flow diagram for the scoping review process.
Note: Adapted from Moher D, Liberati A, Tetzlaff J, Altman DG; The PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the prisma statement. PLoS Med. 2009;6(7):e1000097. doi:10.1371/journal.pmed.1000097.[42]

behaviours, and this approach aimed to explain how leaders made decisions and identified their primary areas of concern.[44] The styles approach emphasized patterns of leadership that are categorized as democratic, autocratic, and laissez-faire.[44,47]

Understanding that these leader-centric theories and approaches had many shortcomings, researchers started to combine factors resulting in the emergence of the Situational Approach. This approach asserted that effective leaders adapt their leadership style to the context and to meet the needs and abilities of their followers, and includes life-cycle theory, contingency theory, and path-goal theory.[13,44,47,50,53,69–74] Whilst these theories have a strong history of use in the marketplace, there has been limited research to justify the assumptions and propositions set forth with critics highlighting conceptual weaknesses, ambiguous constructs, oversimplification, and lack of intervening explanatory processes, as well as the fact that the approach does not address the issue of individual versus group leadership.[13,44,47,60]

Leader-Member Exchange (LMX) theory is based on the nature and quality of the relationship between the leader and followers. The theory asserts that the more positive the interactions, the better organizational outcomes.[44] In LMX, followers are divided into "in group" or "out group" based on their relationships with leadership. "In" group members are those with whom the leader has a high-quality relationship with trust, communication, respect, and commitment as identifying features.[44,75,76] "Out" group members are those with whom the leader has a low-quality relationship

Table 2 Evolution of the Definitions of Leadership

Author	Date	Definition of Leadership
Burns[46]	1978	"Leadership over human beings is exercised when persons with certain motives and purposes mobilize, in competition or conflict with others, institutional, political, psychological, and other resources so as to arouse, engage, and satisfy the motives of followers"
Yukl[47]	1989	"Leadership is defined broadly in this article to include influencing task objectives and strategies, influencing commitment and compliance in task behaviour to achieve these objectives, influencing group maintenance and identification, and influencing the culture of an organization".
Bass[48]	1990	"An interaction between two or more members of a group that often involves a structuring or restructuring of the situation and the perceptions and expectations of the members".
Rost[49]	1991	"Leadership is an influence relationship among leaders and followers who intend real changes and reflect their mutual purposes"
Vroom and Jago[50]	2007	A process of motivating people to work together collaboratively to accomplish great things
Yukl[43]	2012	A process whereby intentional influence is exerted by one person over other people to guide, structure and facilitate activities and relationships in a group or organization
Branchini[51]	2012	A complex emerging process in which the content, context and characteristics of agency are orchestrated in dynamic interplay with the environments in which they function, to result in achievement of a desired outcome
Smith and Cockburn[52]	2014	"A process of continuous optimization and adaption, where the next leadership action is based on what is happening now. In other words, leadership is emergent, and is co-developed with the context in which the leadership is taking place"
Northouse[44]	2018	A process whereby an individual influences a group of individuals to achieve a common goal
Belrhiti et al[53]	2018	A behaviour or set of behaviours that emerges from the interaction among individuals and groups in organizations occurring throughout the whole organisation, and not a role or function formally assigned to an individual
Van Dick and Monzani[45]	2020	An interactive process of reciprocal influence where social actors interact with each other and their context

characterised by limited trust, formal communication based on formalized organizational roles and transactional interactions.[44,75,76] With more than 35 years of research, including evidence from multiple cultures, the theory has been demonstrated to provide potential in the area of health information management.[76] Criticisms of the theory cite the appearance of being unfair and discriminatory;[44,47] how it does not identify a specific guide to the process of relationship building, which is central to the theory;[47,76] and there is limited evidence of actual practical applications of the LMX model.[13] An extensive body of research undertaken by Gottfredson et al uncovered numerous issues leading to the conclusion that LMX is not a valid construct and therefore incapable of serving the needs of the theories it has traditionally served and is unlikely to advance leadership theory and practice in significant or meaningful ways.[77]

Transactional leadership theories are based on the premise that the leader attempts to motivate followers behaviour through the promise of rewards.[14,44,78] While Burns[46] saw transactional and transformational as two distinct styles of leadership, Bass[14] identified that both these elements are required and that leaders will use them in varying amounts. Transactional leadership involves both the leader and follower getting something for their efforts. Transactional leadership is task-oriented, and reward driven with an underlying assumption that team members have no self-motivation.[44,79] It has been argued that transactional leadership is more about management and is really only appropriate in selected situations.[20,80,81]

Transformational theories have been widely studied, researched, and advocated for many years.[13,44,53,82,83] These theories focus on how leaders can "transform" their followers and elevate, empower and develop teams.[46,47] There is an emphasis on vision, innovation, motivation, empowerment, inspiration, and communication.[12,14,44,80,83–86] Kouzes and Posner argue that anyone can become a leader and that leadership is

not reserved for those with special talent but can be learned and mastered through education and practice.[86]

Transformational leadership is intuitively appealing, places a strong emphasis on the empowerment of others and has been purported to be an effective form of leadership.[44,79,82,85] Criticisms of transformational leadership include lack of conceptual clarity with an overlap between the key constructs, treating leadership as a personality trait, bias toward executive and heroic notions of leadership, lack of a causal link between transformational leaders and changes in organizations or their teams and that it has

Table 3 Synopsis of Leadership Theories and Approaches

Theory	Date	Description	Strengths/Weaknesses	Relevance to H&HS
Great Man Theory[160]	1840s	Rare individuals were born with unique characteristics that predisposed them to take command and lead others. Based on the idea that leaders were born to rule.	The heroic leader as an influential person that comes to prominence when needed. Key weakness is the lack of scientific evidence for the theory.	Outdated theory providing little value to H&HS leadership.
Trait Approach[44,58,161]	1930s	This approach asserted that leaders demonstrate certain physical, social, and personal characteristics that make them better suited to leadership. Whilst great man theory contends that traits are inherited, trait theory does not specify where they come from.	Particular traits shown to promote leadership are openness, extroversion, self-confidence, energy, inclusiveness, and motivation to manage. Conversely, there is no consensus on a definitive list of leadership traits that are consistently associated with great leaders.	Pure trait theory fails to identify all variables for H&HS leadership.
Skills Approach[44,61–63,162]	1940s	This leader-centric approach focussed on the acquired skills that the leader requires to perform rather than on personality traits with the implication that these skills can be learned.	Key strength is that this approach categorised leadership as an identifiable set of skills which can be learned, developed, and improved. Weakness is the lack of precision and inability to identify how variations in the skills will lead to positive leadership performance.	A pure skills approach also fails to identify all variables for H&HS leadership.
Styles Approach[67,68,81,163,164]	1940s	This approach asserts that different styles of leadership may be more appropriate for different types of decision-making and ultimately influence the success of an organization. Leadership styles are categorized as democratic, autocratic, or laissez-faire.	Similar to the Behavioural Approach this is easy to understand and has been validated through research. Key Weakness with this approach is that no one style have been identified as suitable for all situations or contexts.	A pure styles approach also fails to identify all variables for H&HS leadership.
Behavioural Approach[44,64,115,165]	1950s	This approach focussed on what leaders do. The theories assert that different patterns of behaviour are observed in successful leaders with leaders being either task-oriented or people-orientated.	Strengths are that it is easy to understand and has been validated by a broad range of studies. Weakness is that despite a substantial research base the results have been contradictory and inconclusive and has not identified universal behaviours associated with effective leadership.	A pure behavioural approach also fails to identify all variables for H&HS leadership.

(*Continued*)

Table 3 (Continued).

Theory	Date	Description	Strengths/Weaknesses	Relevance to H&HS
Situational/Contingency Approaches[50,69,71–74,166]	1960s	This approach asserted that effective leaders use a combination of styles that are contingent upon the particular situation, the personalities involved, the task, and the organizational context. These approaches demonstrate the evolution of leadership theory from the one-dimensional leader-centric approaches discussed above.	Key strength of this approach is that it allows the leader to be more flexible in their approach as it also considers the situation or context. Identified weaknesses are the lack of a strong body of research, the ambiguous conceptualisation of the followers developmental levels and the fact that the approach does not address the issue of individual versus group leadership.	The inclusion of multiple variables provides potential for informing H&HS leadership, but the indistinct concepts make these difficult to implement.
Leader Member Exchange (LMX)[44,76,167,168]	1970s	This theory focuses on the relationship between leaders and followers and the psychological effect of leaders building positive or negative relationships with employees. LMX theory explains that in any organization, there are in-group members and out-group members.	A key strength of this theory is that it validates how people within organizations relate to each other and directs our attention to the importance of communication in the leader-follower relationship. Weaknesses are that it does not identify a specific guide to the process of relationship building and there is limited evidence of actual practical applications.	Demonstrated potential in health information management
Transactional Theories[14,46,48]	1970s	In this theory the focus is on the exchange of value between employee performance and the leader's response to it. Based on systems of reinforcement and punishment this theory is task orientated. Also known as management theories.	Strength is the simplicity of the theory. Transactional leaders set goals and standards for employees and provide rewards in return for them being met. Biggest weakness is the assumption that everyone can be motivated by reward and punishment.	Limited value in H&HS leadership with applicability in selected situations.
Transformational Theories[12,14,46,78,84,86,127,128,131–134]	1980s	Transformational leadership encompasses idealised influence (charisma), inspirational motivation, individualized consideration and intellectual stimulation, with the leader maintaining a continuous challenge to followers by espousing new and innovative ideas and approaches. This theory is one of the most studied, researched and advocated theories, and were seen as an improvement over earlier theories.	Theory is intuitively appealing, places a strong emphasis on the empowerment of others and has been purported to be an effective form of leadership. Criticisms of transformational leadership include lack of conceptual clarity with an overlap between the key constructs, treating leadership as a personality trait, bias toward executive and heroic notions of leadership, lack of a causal link between transformational leaders and changes in organizations/ teams and that it has the potential to be abused as it is concerned with changing people's values	Potential to inform H&HS leadership has been identified in numerous studies across multiple settings.

(*Continued*)

Table 3 (Continued).

Theory	Date	Description	Strengths/Weaknesses	Relevance to H&HS
Authentic Leadership Theory[88–92,135–139]	1980s	Emphasizes the values system of the leader and its role in leading from a base of self-awareness, integrity, compassion, interconnectedness, and self-discipline. Builds on from Transformational theory and includes charismatic leadership theory.	Take the positives from Transformational theory and add a values orientation. Weaknesses identified include that the theory has not been substantiated, over-emphasis on person-centred factors and perpetuation of the 'heroic leader'.	Demonstrated applicability in healthcare settings but needs to be tested in a variety of populations and settings.
Servant Leadership Theory[93–96]	1990s	A multidimensional leadership theory that starts with a desire to serve followed by the intent to lead and develop others. first priority should be to serve others, not to promote their own agendas over the good of their followers	This intuitively appealing theory take the positives from Transformational theory, adds a values orientation, and places a strong emphasis on teamwork. Key weakness is that it is largely atheoretical, highly altruistic, and not supported by empirical data.	Aligns with healthcare and professional ethics but does not suit situations where quick decisions are required.
Collective/Shared/ Distributed Leadership Approaches[97–103,140–142,169]	2000s	This approach argues the no one individual is the ideal leader in all situations or circumstances and that leadership is diffuse throughout the organisation. Includes dispersed, collaborative, collective, devolved, relational, democratic, concurrent, and co-operative approaches. Boundaries have been somewhat blurred by the range of different terms employed by these plural forms of leadership.	Shared leadership has been positively correlated with increased team effectiveness and organizational performance. Critics of this approach cite the lack of empirical methodological rigour, measurement issues with the construct and the transferability or application in different cultural settings	Demonstrated applicability in healthcare settings and has been adopted by the NHS in the UK. Needs further exploration in the wider H&HS context.
Complexity Theory[98,104–106]	2000s	This theory focusses on leadership as part of a complex system and the inter-relationships between patterns of behaviour, power structures and networks of relationships.	Strength is that complexity theory provides a framework in which effective leadership can thrive in dynamic environments. Weakness is that there is little consensus on when and in which situations complex leadership should be applied.	Potential to inform due to the complex and unpredictable nature of H&HS leadership but requires further research

the potential to be abused as it is concerned with changing people's values.[44,78,87]

Authentic leadership theory, building on from transformational leadership theory, is based on the premise of being true to oneself and one's values and the leader acting from a position of high ethical standards and self-regulation to make a positive contribution in the world.[13,88,89] Self-regulation has been described as the process through which authentic leaders align their values with their intentions and actions.[90] Critics of authentic leadership theory cite that the theory is still formative and has not been substantiated; there is an overemphasis on person-centred factors and a lack of attention to context results in the continuation of the concept of an "ideal or heroic leader" and the perpetuation of bias in favour of white males for promotion to power positions in organizations.[44,91,92]

Servant leadership, which originated in the seminal work of Greenleaf, is based on the premise that power is distributed to the followers and that leaders work to serve their followers for the purpose of achieving organizational goals.[13,44,65,93]

This theory is intuitively appealing with a people-orientated approach that places a strong emphasis on integrity, teamwork and building relationships.[65,94] A strong criticism of servant leadership is that it is largely atheoretical restricted by its own limitations in research design and not supported by empirical data despite being promoted within a broad range of organizations.[13,44,90,94–96]

Since the 2000s, there has been a distinct shift away from the heroic models of leadership. The collective, distributed, or shared leadership approaches argue that no one individual is the ideal leader in all situations or circumstances and that leadership is diffuse throughout the organization.[82,97–99] The locus of leadership is separated from the organizational hierarchy, and all team members, not just those with an overt management function, can take a leadership role.[82,100–102] This approach seems counter-intuitive to many of the leader-centric leadership theories previously discussed. With changing organizational structures, increased levels of complexity and diversity, and changing patterns of work, the limitations of traditional leadership models with their individualistic understanding of leadership are being questioned.[82,100,102,103] Critics of this approach cite the lack of empirical methodological rigour, measurement issues with the construct and the transferability or application in different cultures.[100,101]

The application of complexity theory to leadership has moved the focus of research from an emphasis on the leader as an individual or the leader–follower relationship to a focus on leadership as part of a complex system and the interrelationships between patterns of behaviour, power structures and networks of relationships.[13,86,104–106] The viability of this theory is still uncertain as some authors argue it is only a philosophical lens for exploring leadership in organizational studies.[104,106] Belrhiti et al[53] in their scoping review found that there is little consensus on when and in which situation complex leadership should be applied and the relationship between complexity leadership and organizational performance is an area where more empirical research is required.

Examining the historical evolution of leadership theories does provide some context in which to conceptualize leadership, but we should also look at other approaches to truly appreciate the complexity of these phenomena.

Leadership vs Management: Same or Different?

Another approach when trying to conceptualise leadership is to compare and contrast the practices of management and leadership. The terms leadership and management are often used interchangeably, which can lead to confusion, and there are calls from some researchers for making an important distinction between the two terms.[13,44,82,86,107–109]

Azad et al[110] argue that leadership and management are a continuum of a single construct, but the majority of the papers in this scoping review assert that they are distinct concepts. Zaleznik[111] in his seminal article argues there is a clear distinction between managers and leaders. Managers focus on process interacting to establish strategies and make decisions, whereas leaders work in the opposite direction. He went on to identify that managers act to limit choices in the workplace, leaders develop new and fresh approaches to long-standing problems and open issues to new options.[111] Katz[61] asserts that management is unidirectional, whereas leadership is multidirectional. This argument is supported by Kotter[112] and Leonard,[17] who say management is a set of well-known processes, like planning, budgeting, structuring jobs, staffing jobs, measuring performance and problem-solving, which help an organization to predictably do what it knows how to do well. Leadership, by contrast, is about setting the direction, aligning and motivating people, and creating the right culture for success. Management produces a degree of predictability and order. Leadership produces change. Marion and Uhl-Bien in their discussion of leadership in complex organizations differentiated the constructs as leadership being focussed on growth, fitness, innovation, and the future of organizations, whereas management is focussed on the nuts and bolts of detailed day-to-day operations.[104]

Jandaghi et al[85] assert that leadership and management are not identical. Management is dependent on formal power to influence others, while leadership is a result of a social influence process. This view is supported by several authors who assert that leadership is a series of interaction processes where people influence one another and that leaders are identified by their acts not by an appointed position.[55,107]

Some authors argue that both are important for success, and the separation of the two functions – management without leadership and leadership without management – may be seen as misleading and potentially harmful in practice.[82,113–115] Each concept has some unique features; however, I would argue that leadership and management are distinct but complementary activities, but both are required for successful organizations.

Power, Influence and Leadership

Another approach to conceptualizing leadership is to examine the concept of power and its relationship to

leadership and organizational outcomes.[116–118] Early definitions of leadership focused on power "over" people, whereas later definitions focused on the ability to influence others. The "Five Forms of Power" research conducted by French and Raven in 1959 is one of the most influential theories of power that has been used to explain many of the phenomena of social influence and determine the sources of power that leaders use to influence others.[119] The five forms of power have stood the test of time and remained constant for the study of power in organizations.[118,120]

Reward power is the most common type of power and is defined as power whose basis is the ability to reward.[119] The assumption is that if you have the ability to reward team members with things like bonuses or promotions, you have the ability to command their attention. Coercive Power is the opposite of reward power and is based on the ability to take things away or punish. The assumption is that team members are willing to comply with the leaders directive for fear of punishment. As stated by Joullie et al[121] coercion is not cooperation and is associated with resentment and negative organizational outcomes.[118,122,123] Legitimate or Position Power comes from being appointed to a specific position. Within an organization, the leader occupies a particular position with the right to influence team members.[118,119] Referent Power is the ability to influence others because they like and respect the individual and desire to become closely associated with them.[118,119] This type of power is borne out of admiration of another and is associated with charismatic leadership.[118] Expert power is achieved when a person finds themselves in a position of expertise based on their knowledge, skills, and experience. Credibility is acquired by having the right credentials.[118,119] Most leaders use a combination of these types of power, depending on the leadership style used and the context in which leadership occurs.

Leader versus Leadership

When describing leadership, the terms leader and leadership are often used interchangeably, but it is important to make a clear distinction as this influences the approach the researcher may take. The leader is the individual person; leadership is the function this individual performs or an influential process. Leader development is one aspect of leadership development.

Leader development is intrapersonal with a focus on individual leaders and is often associated with formal roles within an organization.[13] Leader development results as a function of purposeful investment in human capital. Specific examples of the type of intrapersonal competence associated with leader development initiatives include self-awareness (eg, emotional awareness, self-confidence), self-regulation (eg, self-control, trustworthiness, adaptability), and self-motivation (eg, commitment, initiative, optimism).[124] Leaders are individuals or groups that influence the direction of a system or organization.[89]

In contrast, leadership development is interpersonal and focused on enhancing leadership capacity associated with both formal and informal roles within groups and organizations.[13] The primary emphasis in leadership development is on building social capital. Specific components of interpersonal competence include social awareness (eg, empathy, service orientation, and developing others) and social skills (eg, collaboration and cooperation, building bonds, and conflict management).[124] Leadership is a complex process of influencing the creation, destruction, transformation, and distribution of information throughout the system, and enabling action in response to this information in a complex environment.[89]

The development of the intrapersonal capabilities serves as a foundation for the interpersonal capabilities, which also encompasses the interactions with team members and the context in which leadership occurs, and both are required to address leadership using a workforce development lens in the H&HS sector.

Discussion

The first objective of this review was to identify a definition of leadership applicable to the H&HS sector. The lack of a universal definition should not be a deterrent to proposing a definition. Some key components central to understanding this phenomenon are identified in this review, but to address the complexity of the sector, these components need to be bought together into one cohesive definition that can be used to advance empirical research and evaluation of leadership development pertinent to the H&HS sector. Thus, the proposed definition of leadership in the context of H&HS is a dynamic process that influences outcomes in specific contexts and stimulates and inspires others, through respectful two-way relationships, towards the achievement of desired goals.

This definition implies that:

1. Leadership is a dynamic process, not a personal quality.[43,44,47,49,51]

2. Leadership is characterised by the ability to influence outcomes, not authority or power.[43,44,49,116–118,120–122]
3. Leadership is not management, but they are complementary processes.[61,85,104,112]
4. Leadership occurs in specific contexts. If the context changes, the process will be different.[50,70,125]
5. Leadership requires respectful relationships with others – one leading the other, or both mutually leading one another – it is not a solo pursuit.[44,60,86,108,126]
6. Leadership involves the achievement of goals.[44,50]

The second objective of this review was to identify and describe the theories and approaches to leadership and the relevance to H&HS sector workforce development. The results from this review demonstrate overwhelmingly that the majority of research in the field of leadership has been conducted in business settings in Western contexts, and mainstream leadership theories offer mixed results for the H&HS sector. Despite the extensive research into leadership in healthcare, a central problem is that much of this research is predominantly focused on the narrow disciplinary or workforce fields of the nursing and medical professions in hospitals and acute care settings. Relatively little scholarship has focused on the broader H&HS sector.

Of the theories presented, three are cited as showing the potential to inform leadership in the H&HS sector. Transformational leadership features heavily in healthcare leadership[87,98,114] and has been associated with high performing teams and improved patient care;[127,128] Magnet nursing organizations;[129] and a reduction in nursing staff turnover.[130] There is some evidence that transformational leadership has been shown to be effective in the human and social services sector[131,132] and in particular with the social work profession.[133,134]

Authentic leadership with its focus on ethical behaviour and trusting leader–follower relationships has been cited as being particularly applicable to healthcare settings by a number of studies.[135,136] Shirey[137] found a positive correlation between authentic leadership and health work environments in acute care hospitals. Coxen et al[138] found that authentic leadership had a significant influence on trust in public healthcare organizations. Malila et al[139] revealed that whilst the theory demonstrates potential in the healthcare setting, the current research has not been comprehensive and identified a number of research gaps including the need to test in a variety of populations, settings and cultures.

While collective or shared leadership was adopted as a key strand of policy by the National Health Service in the UK, the focus has been on the medical and nursing professions in acute care settings.[140–143] Antecedents for successful shared leadership have been identified as employee commitment, staff autonomy, managerial guidance, collaborative decision-making, a culture of innovation and a shared organizational vision.[103] Whilst collective or shared leadership has been found unsuitable where tasks are routine or employees have low levels of autonomy, this is not the case in healthcare, which recognises that care and support are provided in complex systems.[82,98,103] The review could not identify evidence of this leadership approach being explored in the broader H&HS sector.

Exploration of the use of power and leadership in the H&HS sector reveals again that the medical profession and hospitals dominate the research.[116,117] Gabel[117] identifies the bases of power available to medical professionals and discusses the application in medical practice but fails to consider the broader system or other professions. A quantitative study undertaken by Havold and Havold[144] found that legitimate, referent and reward power had a positive influence on trust whilst coercive power had a negative influence in hospitals. Saxena et al[116] acknowledge that healthcare requires collaborative leadership but still sees physician leaders as those who will lead diverse groups of healthcare workers.

The focus on the medical profession was evident from Bottles,[145] who stated that healthcare leadership has failed miserably when judged by the production of intended effects and that "physician executives must provide leadership"[145] and Swanwick and McKimm,[82] who argue that leadership is the responsibility of doctors. Berghout et al[24] conducted a systematic review focussed exclusively on medical leadership in hospital settings. Keijser et al[146] also focused on medical professionals in developing their leadership competency framework. Gordon et al[147] conducted a qualitative study purported to focus on healthcare leadership but interviews were only conducted with medical trainees resulting in a strong medical emphasis. The authors did acknowledge that future research should consider broadening the approach to include the wider interprofessional team but failed to discuss the broader H&HS sector.

A significant number of papers examined leadership as a fundamental skill of nursing practice,[11,55,79,148–152] while Kan and Parry[153] used grounded theory to generate a theory to explain nursing leadership in New Zealand hospital settings. Malila et al,[139] in undertaking a scoping review of authentic leadership in healthcare, identified nurses as the most common study population, while hospitals and acute healthcare settings were most frequent. The authors identified the need for greater diversity in study population, setting, organization and geographical origins. Mianda and Voce[154] limited their literature review to clinical leadership for frontline healthcare workers. Nelson-Brantley and Ford[155] argue that nurses should be leading change and redesign in health systems. None of these authors consider the broader H&HS sector.

Professions that have identified a paucity of research related to leadership includes radiography;[113] social work;[23] psychology[156] and pharmacy[157] irrespective of the practice setting. The lack of a robust empirical foundation for leadership in the human service sector is an identifying challenge.[27,158] Smith et al[3] noted that there are significant structural and cultural differences that need to be acknowledged between health and social care organizations.

The final objective of this scoping review was to provide a preliminary analysis of the potential size and scope of available research literature to inform ongoing research. This review demonstrates that there is limited high-quality research available regarding leadership approaches that inform broader H&HS sector workforce development and identifies prominent gaps in our understanding of leadership in the sector. This review demonstrates that there is a significant body of research dedicated to healthcare leadership, predominantly undertaken by the medical and nursing professions in acute care settings, but there is a lack of evidence that any of these approaches may be transferrable to other H&HS contexts and professions.

The review raises more questions that need to be answered. We need to understand how leadership is developed within the broader H&HS sector. We need to understand what should be included (the interventions or initiatives) in leadership development programs to enhance workforce capacity in the H&HS sector. We need to understand how we know what is taught is effective and transferable to the workplace.

Limitations

Acknowledgement must be given to the inherent limitations specific to a scoping review, including the absence of quality appraisal, potential interpretation bias and the balance between comprehensiveness and feasibility.[30,33,36] Only one person conducted the literature review, so the conclusions, including themes and definitions of leadership, were not subject to any additional assessment. In order to at least partially validate the results, an additional analysis or review by one or more individuals is warranted.[23]

Conclusion

This review demonstrates that leadership is a multifaceted, multi-contextual phenomenon that can be defined in multiple ways. Despite prolific volumes of the literature on leadership, no theory or approach so far has provided a satisfactory explanation of leadership in the health and human service sector. This review has provided a definition of leadership for the H&HS sector.

The need for rigorous research on leadership to inform workforce development in the broad H&HS sector is evident. This review demonstrates that there is a paucity of leadership development research specific to the broader H&HS sector. One way to investigate leadership development is through the lens of workforce development. We need to understand what are the knowledge, skills and capabilities that enable individual health and human service practitioners to develop as more effective leaders in the diverse environments of the sector.[159] The definition of leadership proposed in this review may inform further research in this area.

Data Sharing Statement

The data that support this study will be shared upon reasonable request to the corresponding author.

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Disclosure

The author declares that there are no competing interests in this work.

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