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Effective Leadership and Followership Theories for Healthcare Organizations: A Systematic Review

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ABSTRACT

This systematic review synthesized global evidence for leadership and followership theories in healthcare, with specific applicability to the UK National Health Service (NHS). It follows PRISMA guidelines to synthesize 40 studies published from 1990-2024. The transformational leadership model emerged as the most researched model with consistently improved associations to staff outcomes; however, its effectiveness is mediated by contextual elements like empowerment. Relational models, particularly Leader-Member Exchange, strikingly demonstrated strong links to personal job satisfaction and safety. This review identified a crucial followership gap, highlighting its role as an active, courageous form of followership that is of immense importance to team safety and effectiveness; however, it remains understudied. The synthesis highlights that NHS leadership development must incorporate an integrated, multi-level strategy which is mindful of relational competencies, intentionally promoting followership at all levels and strengthening structures for implementing a more distributed leadership.

INTRODUCTION

Effective leadership is a cornerstone determinant of organizational performance, patient safety, and systemic resilience in global healthcare (Restivo *et al.,* 2022). In an era defined by digital transformation, demographic shifts, persistent workforce shortages, and the enduring impacts of global health crises like the COVID-19 pandemic, the capacity to guide, inspire, and coordinate multidisciplinary teams has never been more vital (Singh *et al.,* 2024). Leadership directly influences clinical outcomes, staff engagement, and the sustainability of systems under immense strain. The significance of appropriate leadership styles is now intensively scrutinized, especially in light of the unprecedented challenges presented to healthcare management during the pandemic (Wu *et al.,* 2024). The conceptualization of leadership has evolved significantly from early, simplistic models. Foundational theories like the "Great Man" and Trait theories posited that leaders were born with inherent, unchangeable qualities such as charisma and intelligence. While these perspectives were influential, modern scholarship has largely discredited the notion that leadership is an innate trait possessed by only a select few. The field subsequently shifted toward Behavioral theories, focusing on learnable actions and skills, and later to more sophisticated contingency and relational frameworks.

Today, the understanding of leadership in healthcare recognizes it not merely as a function of position or personality, but as a dynamic process of social influence. This shift is particularly pertinent in healthcare, where traditional hierarchies are increasingly challenged by the need for collaborative, patient-centered care. Integral to this contemporary view is the critical role of followership. A growing consensus acknowledges that followers are active, critical agents who shape leadership outcomes and organizational success (Oc *et al.,* 2023). As noted in recent analyses, leadership is often an amalgamation of different behaviors, and the Followership model productively switches the focus from the leader to the follower, positing that high-quality followership is foundational to high-quality leadership (Gallegos *et al.,* 2024). Professionals fluidly oscillate between leading and following based on situational demands, highlighting that these are dynamic roles rather than fixed positions (Barry, 2024). This reciprocal relationship underscores the need for adaptive, context-sensitive models that reflect the fluid reality of complex clinical environments.

Healthcare organizations worldwide, regardless of their economic or geographic context, operate under a converging set of intensifying pressures (Braithwaite *et al.,* 2017). Workforce shortages, clinician burnout, and challenges in staff retention threaten operational stability and care quality (Wu *et al.,* 2024). Simultaneously, rising patient acuity, the growing burden of multimorbidity, and escalating financial constraints demand models of care that are both highly efficient and deeply compassionate (Singh *et al.,* 2024). These systemic pressures are compounded by rapid technological advancements, evolving healthcare policies, and persistent calls for greater equity, diversity, and inclusion within leadership structures themselves. Within this pressurized ecosystem, the traditional, rigid demarcation between "leaders" and "followers" is not only blurred but often counterproductive. Hierarchical structures with significant power distance can stifle communication, potentially jeopardizing patient safety through errors and miscommunication (Alanazi *et al.,*

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2023). Instead, contemporary healthcare requires models where professionals at all levels are empowered to exercise leadership within their sphere of competence, contributing to decision-making and quality improvement. This reality necessitates a decisive move away from command-and-control hierarchies toward more distributed, shared, and enabling forms of leadership that can mobilize the collective expertise of the entire workforce (Barry, 2024; Wu *et al.,* 2024).

Despite a vast and growing corpus of leadership theory, a significant evidence-practice gap persists. Numerous leadership frameworks from transformational and servant leadership to situational and shared leadership models have been proposed and studied (Restivo *et al.,* 2022; Wu *et al.,* 2024). Transformational leadership, for instance, has emerged as the most extensively discussed style in the healthcare literature, linked to driving organizational change and enhancing team performance (Wu *et al.,* 2024). However, the comparative utility, contextual suitability, and measurable impact of these various models on definitive healthcare outcomes remain inadequately synthesized and often discordant (Restivo *et al.,* 2022). Crucially, the dimension of followership represents a profound gap in both research and practice. Although followers outnumber leaders four to one in most organizations, scholarly and developmental attention remains disproportionately focused on those in formal leadership roles (Alanazi *et al.,* 2023). A recent systematic review of health-professions education literature found that while 75% of articles discussed leadership qualities, only 57% discussed followership qualities, and empirical research on the topic is particularly sparse (Gallegos *et al.,* 2024). This omission creates an incomplete and potentially flawed picture of the relational dynamics that underpin team performance, safety, and organizational health.

This systematic review aims to identify, evaluate, and synthesise the existing evidence on leadership and followership theories within healthcare organisations, with a dedicated emphasis on their application and relevance to the UK National Health Service (NHS).

The review is guided by the following primary and secondary objectives:

Primary Objective

To evaluate the evidence for various leadership and followership models in healthcare settings and assess their applicability to the challenges and context of the NHS.

Secondary Objectives

- To compare the empirical impact of predominant leadership models (e.g., transformational, transactional, servant, authentic, and distributed leadership) and followership theories on measurable healthcare outcomes, including staff well-being, team collaboration, organizational resilience, and patient care quality.
- To examine the role of followership as an active, complementary component of effective team dynamics and leadership processes in healthcare.
- To synthesize findings into evidence-informed insights regarding the transferability and implementation of effective leadership and followership approaches within the NHS.

MATERIALS AND METHODS

A systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Adhering to these research standards, existing evidence on leadership and followership theories within healthcare organizations was evaluated and synthesized.

Eligibility Criteria

A PICOS framework was employed for article selection in accordance with the PRISMA statement. The target population was any healthcare professional working within any healthcare system (Population); concept included any defined leadership model or followership theory applied specifically in a healthcare context (Intervention/Concept); for comparison, absence of a formal leadership style/model or standard practice (Comparison); distinct characteristics exhibited by staff, team, organization, and patient were identified, along with contextual factors with applicability/transferability to NHS context (Outcomes); and environments in which study was conducted included any global healthcare organization, or particularly relevant to UK National Health Service (NHS) (Settings). The selected study designs were theoretical and empirical studies, qualitative studies, and mixed-method studies published in English. The detailed inclusion/exclusion criteria are presented in Appendix I.

Information Sources and Search Strategy

Literature search was conducted across five academic databases, including PubMed, MEDLINE, CINAHL, SCOPUS, and Web of Science Direct. The search covered the period from 1990 to 2024. The syntax was modified according to each database for search strings, which included controlled vocabulary terms (e.g., MeSH terms/PubMed) and free-text keywords. To refine the search results, Boolean operators (AND, OR) were used. The search string used for PubMed is provided in Appendix II. Keywords included "Leadership Models/Theories," "Followership Models/Theories," "Healthcare Systems," "Healthcare Organizations," "National Health Service," "NHS," etc. The reference list of selected studies was hand-searched to identify any potential articles missed during the database search.

Study Selection

The process of study selection adhered to PRISMA guidelines to ensure a transparent and systematic approach in identifying and including relevant studies. Initial database searches yielded a total of 1500 studies based on predefined keywords. After removing duplicate

records, 1050 unique studies remained for further review. Screening for title and abstract followed by two independent reviewers, who verified alignment with predefined eligibility criteria. Full-text articles were assessed for 140 records for eligibility by the independent reviewers. At this stage, any disagreement was resolved through discussion and mutual consensus; however, a third reviewer mediated if the conflict was not resolved. Following a detailed review, 38 studies met all inclusion criteria and were selected for the systematic review. A visualization of the study selection process is presented in the PRISMA Flowchart in Figure 1.

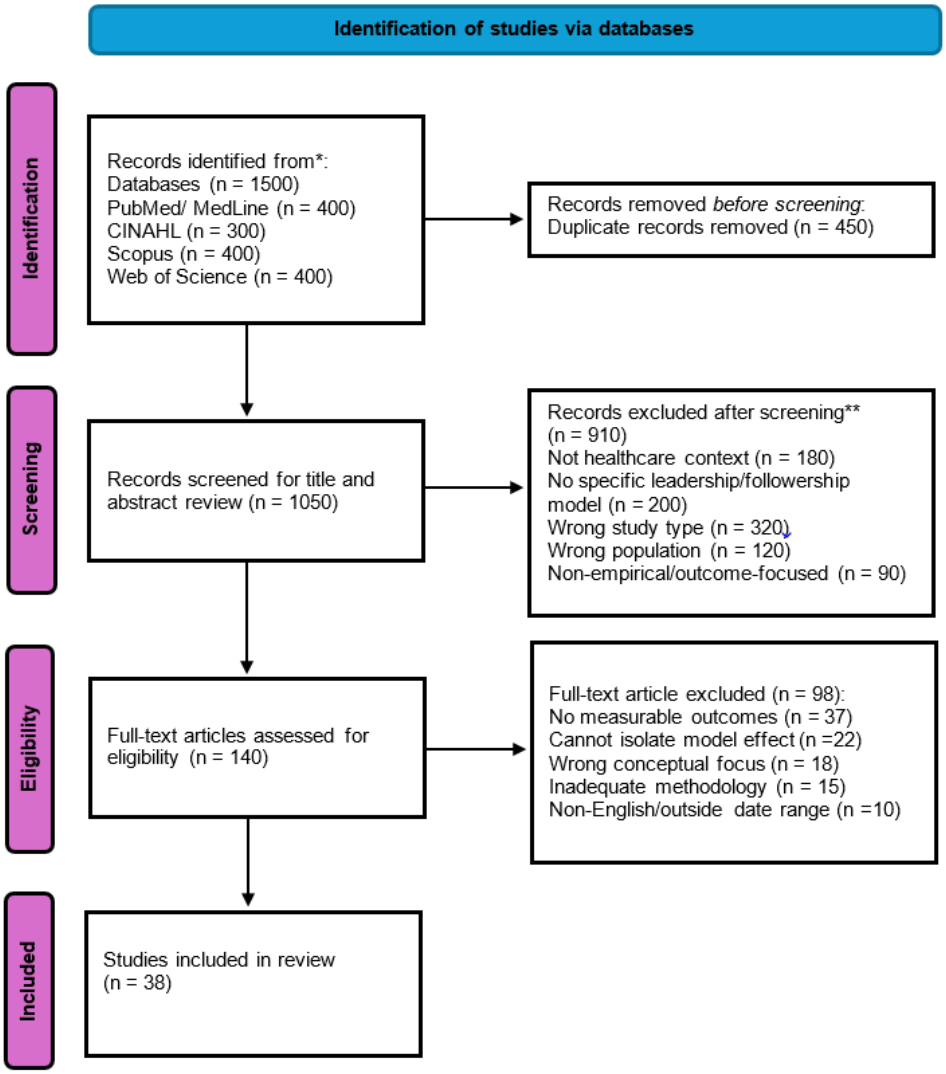

Figure 1: PRISMA Flowchart for Study Selection

Data Extraction

Using a tailored extraction form, data extracted from selected studies included study and participant characteristics, concept details such as specific leadership/followership model investigated, context, primary and secondary outcomes, measurement tools, key quantitative results or qualitative themes, and author's conclusion regarding the leadership effectiveness in their study. The data was handled through Microsoft Excel for clarity and completeness. The data extraction criterion is presented in Appendix III. Studies were divided between two reviewers for data extraction, and each reviewer cross-checked the information extracted by the other reviewer. In case of disagreements, mediation of a third reviewer and mutual consensus were adopted.

Synthesis Methods

Given the anticipated heterogeneity in study designs, interventions, and outcome measures, a narrative synthesis approach was employed, guided by the framework proposed by Popay *et al.* (2006). The synthesis proceeded in three stages as described below, informing the reporting of results and the evidence-based conclusion in the discussion:

- Evidence mapping, where studies were grouped by theoretical model and key characteristics
- Exploring relationships, involving within- and between-model analysis to identify patterns, mechanisms, and contextual moderators
- Assessing the robustness of the synthesis where the findings were critically evaluated in light of the methodological quality of the contributing studies.

Quality Appraisal

All of the selected studies were evaluated for their methodological strengths and weaknesses. Specific critical appraisal tools from the Joanna Briggs Institute (JBI) were selected based on the study designs of articles. The tools employed included JBI Checklist for Analytical Cross-Sectional Studies (8-items), JBI Checklist for Cohort Studies to appraise longitudinal and cohort studies across 11-items, and JBI Checklist for Qualitative Research (9-items). Based on individual ratings and methodological strengths and limitations, a ranking system of "High, Moderate, or Low" was devised based on overall judgement. This ranking was used for critically evaluating the evidence for narrative synthesis, where high-rated studies were given more weight in the synthesis. The consolidated quality appraisal table is present in Appendix IV.

RESULTS AND DISCUSSION

Evidence Mapping

The evidence base consisted of 38 studies in total. Studies were based on diverse geographical context mainly from Asia (n = 14), Europe and North America (n = 10 respectively), and the Middle East (n = 4). Only 3 NHS-based studies were included. A methodological limitation was observed where the majority of the studies were of a quantitative cross-sectional nature (n = 31), followed by qualitative studies (n = 5), and quantitative longitudinal studies (n = 2). The professional focus of the studies was dominated by nurses only (n = 24), mixed healthcare staff (n = 11), physicians (02), and allied health professionals (n = 11). In terms of the primary leadership/followership model, transformational leadership emerged as the most commonly followed model (n = 13). 29 studies assessed staff outcomes only, while 4 examined team and patient outcomes respectively, and only one study explored patient outcomes in addition to staff and team focus. Furthermore, the majority of the studies were situated within the country's public healthcare system. Detailed evidence mapping is presented in Appendix V.

Thematic and Model-Based Findings

Within-Model Analysis

Transformational Leadership

Majority of the studies focused on examining transformational leadership (TL) and reported positive relationships with major staff outcomes including job satisfaction (Othman & Khrais, 2022; Wang *et al.,* 2012), organizational commitment (Cheng *et al.,* 2016; Top *et al.,* 2013), reduced burnout (Bosak *et al.,* 2021; Lewis & Cunningham, 2016) and low turnover expectation (Kim & Yi, 2019). However, TL's impact is not direct and often incorporates robust mechanisms that mediate these findings. For example, empowerment emerged as a strong mediator among TL and staff outcomes (job satisfaction, performance) and patient safety (Asif *et al.,* 2019; Boamah *et al.,* 2018; Choi *et al.,* 2016). TL was also associated with enhancing team climate and lower burnout by strengthening employees' social identities with their teams (Cheng *et al.,* 2016). This was further facilitated by growing attractiveness to the organizational mission ("mission valence") (Bosak *et al.,* 2021). Areas of work life, such as workload, control, reward, community, fairness, and values, were found to be improved by TL's impact on reducing burnout and engagement via staff's person-job matches across the earlier-mentioned areas (Lewis & Cunningham, 2016). The positive impact of TL on job satisfaction and well-being is enabled by enhancing employees' belief in not just their job abilities but also the team's collective abilities (Nielsen *et al.,* 2009).

According to the higher-quality evidence, TL also serves as a protective buffer, which mediates between adverse work-family conflict on nurse engagement and subsequently patient safety outcomes (Labrague & Obeidat, 2022). Despite these findings, another study reported that organizational commitment was rarely influenced by TL and had no direct impact on factors like job satisfaction or intent to stay. This indicates that the TL is more responsible for enabling conditions than directly impacting key outcomes. Moreover, several moderating factors were also reported, such as span of control over TL's effectiveness (which gets weaker with a larger span) or managerial experiences (higher impact on less experienced managers) (Jankelová & Joniaková, 2021).

Authentic Leadership

Following TL, Authentic Leadership (AL) also demonstrated positive effects on job satisfaction and well-being; however, these were constantly mediated through empowerment and work environment factors. In acute care, structural empowerment fostered through AL was responsible for enhancements in job satisfaction and self-rated performance (Wong & Laschinger, 2013). Similarly, in the case of new graduates, empowerment led to relational social capital (i.e., a sense of community), which exhibits positive outcomes for mental health and job satisfaction (Read & Laschinger, 2015). AL's effect in long-term care reported enhanced job satisfaction via better person-job fit in the Areas of Worklife, which led to a reduction in emotional exhaustion (Wong *et al.,* 2020). A notable finding was the contextual mediator, where this positive impact of AL on job satisfaction was reduced significantly in nurses with long tenure (> 20 years) (Baek *et al.,* 2019).

Relational Models

Leader-Member Exchange (LMX) was examined in several studies where high-quality evidence suggested increased job-satisfaction, organizational commitment, and reduced turnover intentions. While this positive influence of LMX that majorly mediated job satisfaction (Han & Jekel, 2011; Portoghese *et al.,* 2015), it also served as a cross-level moderator for positive job characteristics (e.g., autonomy and significance) on job satisfaction (Portoghese *et al.,* 2015). High-quality LMX is essential for nurse managers themselves, where enhanced empowerment and job satisfaction are experienced with

their own supervisors, underscoring the cascading impact of relational quality (Laschinger *et al.,* 2007). Another model examined was Team-Member Exchange (TMX), which had positive effects on job satisfaction; however did not demonstrate any significant outcome to lower turnover intention, highlighting the role of vertical dyad (Kim & Yi, 2019).

Servant leadership prominently exhibited employee and patient satisfaction (McCann *et al.,* 2014), where high-quality LMX encompassing empowerment, humility, and stewardship was strengthened through it (Hanse *et al.,* 2016). Servant leadership was reported to lower burnout rates through improved psychological safety amid a crisis, which was further improved if the trust in the leader was high (Ahmed *et al.,* 2023). Other predictors elevating employee job satisfaction included "developing others" and "caring for others" dimensions (Farrington & Lillah, 2019).

Followership

Across the evidence base, only four studies reported the impacts of the followership model, which were also qualitative in nature. It highlighted that followership encompasses an active, skilled role instead of mere passive obedience. This model thrives on trust in leaders, which is built via mutual load bearing exhibited through knowledge and clear communication (Honan *et al.,* 2023). However, the contextual and cultural moderators of the followership model are distinct. The nature of the followership, particularly in power-distance cultures (Saudi Arabia, Pakistan), is reported to be of a pragmatic and conformist kind, where the followers constantly feel undervalued or barred from decision-making (Alanazi *et al.,* 2024; Urooj *et al.,* 2020). Contrary to these findings, studies conducted in Japan and the USA healthcare context reported that "flattening hierarchy" and "speaking up" were the most critical elements of the followership model; they are more complicated in hierarchical contexts (Akamine *et al.,* 2021).

Distribute/Shared Leadership in the NHS

A significant disconnect between policy aspiration and practice was observed within both NHS context studies concerning the distributed leadership model (Gordon *et al.,* 2015; Martin *et al.,* 2015). Despite advocacy, static hierarchical relationships are still ingrained and reinforced through professional tribalism, power imbalance, systemic barriers, inflexible protocols, etc. There was a significant "disconnect" in power, distance, and values between managerial and clinical staff. While leadership is considered to be of fluid identity, emergent leadership rarely demonstrates this attribute and is suppressed within an organizational context.

Full Range Leadership

Only one study examining full range leadership was included, which reported higher job satisfaction as correlated with transformational and transactional styles. While laissez-faire leadership exhibited an unconventional positive association in the Saudi primary care context, this is contradictory to broader literature, highlighting a unique local managerial environment (Alqahtani *et al.,* 2021).

Between-Model Comparisons

The synthesis of between-model comparisons revealed convergent and distinctive pathways. Shared mediating pathways were fostered through transformational, authentic, and servant leadership models, all of which demonstrated significant positive impacts on staff well-being. This pathway encompassed empowering work structures and enhancing psychological states. These insights underscore that, irrespective of the leadership model, any betterment in staff's well-being is dependent on altering the perceived work environment and resources. The distinguishing factor within these models is their locus of effect. For example, LMX is unique for its dyadic, reciprocal nature, exhibiting a direct or fully mediated (via satisfaction) impact on retention outcomes. Servant leadership is distinct with its focus on ethical stewardship and follower-centricity, which is evident through its stronger links to factors like patient satisfaction and crisis resilience, enhanced through psychological safety. In the case of transactional leadership, which is more based on inspiring towards a vision, servant leadership flows from humility and service.

While limited to qualitative studies and a lack of scholarship, NHS studies highlighted the importance of organizational and professional context as the driving factors of strengthening or limiting leadership models. However, models like TL, AL, or servant leadership, despite being aspirational and empowering, are prone to consistent systemic "reality checks" (e.g., legacy hierarchies, resource constraints) that limit distributed leadership from taking place in the NHS.

Followership as a Complementary Component

The evidence regarding followership models exhibits a unique characteristic, which is to complement leadership literature through its reciprocal nature of influence. In relational models (LMX, servant), the effectiveness of leadership rests upon fostering active, trusting followership. Similarly, followership styles are the principal contextual moderators that are inspired by national culture and power dynamics. Collectively, these demonstrate how the leadership behaviors are received and followed.

NHS-Specific Synthesis

The three studies within the NHS context provide critical insights, along with highlighting a stark lack of evidence. These studies report a consistent theme of challenges faced during the implementation of empowering hierarchical leadership models (Gordon *et al.,* 2015; Martin *et al.,* 2015). Furthermore, in these studies, it has been established that moving from authentic leadership to well-being requires relational security elements (reduced attachment anxiety) (Cartmell, 2020). There is variability reported within

transformational leadership behaviors across professions, mainly due to professional culture ("situational strength") and leadership training (Wylie & Gallagher, 2009).

Assessing Robustness

As presented in the methodological appraisal of the included studies (Appendix IV), there are some limitations observed in the strength of findings. Initially, over-reliance on cross-sectional, self-reported data underscores that the discussed relationships are more supportive of correlation than causation. The limited number of longitudinal studies (Ahmed *et al.,* 2023; Bosak *et al.,* 2021), while providing high-quality evidence, is limited in their temporal precedence. Furthermore, most of the studies were staff self-reported attitudes, which not only pose a risk of method bias but highlight a critical gap in providing objective patient care or organizational performance. Only five studies reported patient-related measures. The specific focus on the NHS, while highly relevant, is also constricted methodologically. Since all three included NHS-specific studies were qualitative, they provided exploratory insights but were limited in quantifying these contextual barriers via effects or predictive models. Moreover, there was variability in cultural contexts, healthcare systems, and professional groups that challenge the direct comparisons. While this heterogeneity is explained in terms of identified moderators (culture, trust, span of control, tenure), it also highlights the limited generalizability of findings.

Discussion

This systematic review synthesized the existing scholarship on the leadership/followership models implemented within global healthcare systems and their outcomes. The evidence base was dominated by scholarship of transformational Leadership (TL), highlighting its importance in healthcare leadership research. While consistent, it exhibited moderate, positive relationships among TL and staff outcomes, particularly job satisfaction and lowered burnout rates. These insights are parallel with broader literature that situates TL as an influencer of employee well-being (Restivo *et al.,* 2022). A striking observation emerged from the narrative synthesis that this positive impact of TL is not direct. The effectiveness of TL is often mediated or moderated by factors like psychological empowerment, structural support, and the quality of team climate. This positions TL to extend beyond an isolated solution, but more as an enabler. The success of TL within challenging NHS settings is often due to legacy hierarchies or systemic pressures, which may rely on increased focus on flattening power structures through allowing teams with more autonomy and resources. Working on the contextual limitations instead of training leaders via inspirational motivation pose serious risk of creating a "leadership fantasy," which was suggested in the NHS context study by Martin *et al.* (2015), which demonstrated the clash between distributed rhetoric and concentrated power.

Our findings highlight a shift towards the relational model, especially Leader-Member Exchange (LMX) and, to a smaller extent, also observed in Servant Leadership, which were the strongest predictors of individual-level outcomes that point towards a shift in understanding. These findings underscore that the quality of the dyadic relationship existing between a professional and their immediate supervisor powerfully determines personal job satisfaction and psychological safety in comparison to a more general leadership style. These insights have significance for the NHS, which often experiences workload and transient rotations that ultimately impact relationship building. Arguably, leadership development is more dependent on relational skills, fairness, and trust-building, simply at the ward and department level, which provides actionable recommendations for impactful betterment in staff retention and well-being instead of the organization-wide TL programs.

One of the most important contributions of this review is the followership gap. While the evidence has been synthesized from very few studies, they still demonstrate the potential in breaking the passive follower stereotype. The insights highlight followership to be an active practice that is inspired by critical thinking, proactive communication, and courageous challenge. These findings highlight their alignment with the literature that followers are co-producers of leadership and safety (Gallegos *et al.,* 2024; Oc *et al.,* 2023). These behaviors were more explicitly discussed and linked to better team decision-making and safety climate (Alanazi *et al.,* 2024; Honan *et al.,* 2023). This is contradictory to traditional NHS hierarchies, where there is a disconnect between power distance and upward communication. This review suggests that improving patient safety and team resilience is more dependent on cultivating "courageous followership" at all levels of hierarchy, just as it is for senior leaders. Leadership development program solely based on formal positions, based on our findings, is deemed inherently incomplete.

There is limited scholarship on distributed/shared leadership within NHS settings, which signifies a contrast between theory and practice. NHS is presented as a multidisciplinary care setting, but implementing these criteria is cut short by deeply rooted institutional logics and conflicting accountabilities. These findings highlight that implementation of such models within the NHS, without reforming structures, incentives, governance, and professional identities, will likely exhibit superficial results instead of long-term care outcomes. Hence, it is important in the NHS context to adopt a distributed leadership where, in addition to skills and training, more concentrated efforts are required, targeted at structural and cultural barriers to overcome the hardships faced in the NHS.

This review has several implications for the NHS. Initially, the findings underscore the importance of a balanced, multi-level leadership strategy. While organization-wide TL is instrumental for a positive vision, it must

be strengthened by mandated support for relational leadership (LMX), especially at the line-manager level, and intentional followership development for all of the concerned staff. Moving beyond this recommendation, the lack of evidence is striking. Many models are investigated in relation to staff attitudes; there is a scarcity of literature connecting them to objectively measured patient outcomes or organizational performance. Future research must focus on outcome-based NHS literature. Moreover, the context is non-negotiable. The findings point towards the applicability of leadership models not being universally effective; however, it is moderated through factors like cultural norms, resource availability, and team stability. In light of these findings, it is recommended that the NHS adopt a diagnostic approach coupled with tailoring leadership and followership interventions based on their local challenges, which often include mid-staff retention, interdisciplinary collaboration, or safety culture, instead of following a single "best" model.

This review has several limitations. Clausal claims cannot be made due to the heavy reliance on cross-sectional evidence. The heterogeneity of measurement tools utilized within these studies and their outcomes makes a direct comparison difficult. The literature was dominated by nurse perspectives, lacking solid evidence from medical or allied health leadership dynamics. Comprehensiveness was the goal of this search; however, the cultural specificity of leadership must be acknowledged and adapted according to the ground realities, especially in the UK context.

CONCLUSION

This review highlights that for effective leadership, it is important that it is contextualized as a relational system, instead of adopting a single theory. According to this view for the NHS, the workforce and safety crises demand integrated strategies that extend beyond mere executive training. Achieving this requires strengthening transformational vision with relational leadership at all levels of hierarchies and not just the formal positions. This approach will ensure more skilled, proactive followership across the team. To install a distributed model, ingrained structural and cultural barriers must be addressed first. In the future, a shift is required to target the implementation of these theoretical models not only at the top levels of hierarchy but empowering them for a collective leadership strategy that is for the entire workforce.

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Appendix

Appendix I – Eligibility Criteria

Population	Healthcare professionals, leaders, managers, and clinical staff (e.g., doctors, nurses, allied health) within formal healthcare organizational settings.	Studies focused exclusively on students, non-healthcare professionals, or populations in non-organizational settings (e.g., community-only studies without organizational context).
Intervention/ Concept	Leadership Models: Formal, defined theories or models (e.g., Transformational, Transactional, Servant, Situational, Leader-Member Exchange, Shared/Distributed). Followership Theories: Formal, defined concepts or frameworks (e.g., Kelley's model, Chaleff's model, or emergent grounded theories).	General management practices, unspecified "good leadership," or studies where a specific leadership/followership model cannot be identified or isolated.
Comparator	Other distinct leadership/followership models, absence of a formal model (standard practice), or measurement of change from baseline.	Studies with no comparator or outcome measurement (purely descriptive or theoretical).
Outcomes	At least one of the following: • Staff: job satisfaction, burnout, engagement, psychological safety, turnover intention. • Team: collaboration, communication, safety climate. • Organization: efficiency, resilience, implementation success. • Patient: safety metrics, clinical outcomes, patient experience.	Studies that do not report on any staff, team, organizational, or patient outcome.
Context/ Setting	Primary Interest: Healthcare organizations globally. Special Emphasis: Studies conducted within or explicitly discussing the UK National Health Service (NHS) are of particular relevance, but all healthcare settings are included to build a comprehensive evidence base for comparative analysis and transferability assessment.	Studies conducted in non-healthcare settings (e.g., corporate, military, education-only).
Study Type	Primary empirical studies that evaluate the association or impact of leadership/followership concepts on healthcare-relevant outcomes. This includes: • Experimental & quasi-experimental studies (e.g., RCTs, non-randomized trials) of leadership development programs or organizational interventions, provided they assess staff, team, organizational, or patient outcomes. • Observational studies (e.g., cohort, longitudinal, cross-sectional). • Qualitative studies and mixed-methods studies.	• Systematic reviews, meta-analyses. • Studies of leadership development that report only on learner satisfaction, knowledge, or self-efficacy without measurement of subsequent work-based outcomes. • Theoretical papers, narrative/ scoping reviews, editorials, opinion pieces, theses, conference abstracts.

Appendix II – PubMed Search String

The search strategy combined key terms for Leadership/ Followership, Healthcare, and the UK National Health Service (NHS), using Boolean operators and field tags.

Core Search String

("Leadership"[Mesh] OR "Leadership"[tiab] OR leader*[tiab] OR "Followership"[tiab] OR follow*[tiab]) AND
("Health Personnel"[Mesh] OR "Hospitals"[Mesh] OR healthcare[tiab] OR hospital*[tiab] OR nurs*[tiab] OR clinician*[tiab] OR "allied health"[tiab]) AND
("State Medicine"[Mesh] OR "National Health Services"[tiab] OR NHS[tiab] OR "United Kingdom"[Mesh] OR UK[tiab] OR Britain[tiab] OR England[tiab] OR Scotland[tiab] OR Wales[tiab])

Applied Limits

• Date: 1990-2024
• Language: English
• Article Type: Excluded "Review", "Systematic Review", "Meta-Analysis"

This strategy was adapted for syntax in CINAHL, Scopus, Web of Science, and EMBASE.

Appendix III – Summarized Data Extraction Variables

Extraction Category	Variables Extracted
Study Identification & Context	Full citation; NHS status (Primary/Comparative/Non-NHS); Country; Healthcare system type; Setting details; Primary aim. (For grouping by context and assessing transferability to NHS)

Methodological Characteristics	Study design; Sample size/profession/seniority; Data collection methods; Measurement instruments with psychometrics. (For quality appraisal and understanding methodological diversity.)
Theoretical Framework	Primary leadership/followership model; Key measured constructs; Operational definitions. (For grouping studies by theoretical model and comparing constructs.)
Key Findings & Outcomes	Outcome categories addressed (Staff/Team/Org/Patient); Quantitative results (effects, p-values, CIs); Qualitative themes; Mediators/Moderators identified; Author's conclusions. (For comparing model effectiveness and understanding mechanisms.)
Quality & Applicability	Methodological strengths/limitations; Contextual factors; Applicability to NHS (Relevance, Transferability, Implementation factors); Reviewer synthesis notes. (For assessing evidence robustness and making NHS-specific recommendations.)

Appendix IV – Summary of Critical Appraisal

Study ID (Author, Year)	**Type of Study**	**Appraisal Tool Used**	**Individual Rating (Score)**	**Overall Quality**
Alanazi *et al.* (2024)	Qualitative (Thematic)	JBI Checklist for Qualitative Research	5/9	Low-Moderate
Notarnicola *et al.* (2024)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	4/8	Low
Urooj *et al.* (2024)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate
Jaaffar & Samy (2023)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	7/8	Moderate-High
Ahmed *et al.* (2023)	Longitudinal Cohort	JBI Checklist for Cohort Studies	8/11	High
Honan *et al.* (2023)	Qualitative (Grounded Theory)	JBI Checklist for Qualitative Research	8/9	Moderate-High
Wahyudin *et al.* (2022)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	4/8	Low-Moderate
Labrague & Obeidat (2022)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate-High
Othman & Khrais (2022)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Bosak *et al.* (2022)	Longitudinal (Time-lagged)	JBI Checklist for Cohort Studies	7/11	Moderate-High
Jankelová & Joniaková (2021)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Alqahtani *et al.* (2021)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Akamine *et al.* (2021)	Qualitative (Cross-cultural)	JBI Checklist for Qualitative Research	7/9	Moderate-High
Cartmell (2020)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Wong *et al.* (2020)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	4/8	Moderate-Low
Kim & Yi (2019)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate-High
Asif *et al.* (2019)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Baek *et al.* (2019)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate-High
Farrington & Lillah (2018)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Boamah *et al.* (2017)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	7/8	Moderate-High

Hanse *et al.* (2016)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Cheng *et al.* (2016)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Brewer *et al.* (2016)	Quantitative Cross-Sectional (Longitudinal Panel)	JBI Checklist for Cohort Studies	9/11	High
Lewis & Cunningham (2016)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate-High
Choi *et al.* (2016)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Portoghese *et al.* (2015)	Quantitative Cross-Sectional (Multilevel)	JBI Checklist for Analytical Cross-Sectional Studies	7/8	High
Martin *et al.* (2015)	Qualitative (Organisational)	JBI Checklist for Qualitative Research	8/9	High
Read & Laschinger (2015)	Quantitative Longitudinal	JBI Checklist for Cohort Studies	7/11	Moderate-High
Gordon *et al.* (2015)	Qualitative (Narrative)	JBI Checklist for Qualitative Research	8/9	High
McCann *et al.* (2014)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	3/8	Low
Top *et al.* (2014)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Wong & Laschinger (2013)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate-High
Top *et al.* (2013)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Wang *et al.* (2012)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Han & Jekel (2011)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Wylie & Gallagher (2009)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	7/8	High
Nielsen *et al.* (2009)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	5/8	Moderate
Laschinger *et al.* (2007)	Quantitative Cross-Sectional	JBI Checklist for Analytical Cross-Sectional Studies	6/8	Moderate-High

Appendix V – Evidence Mapping

Study ID (Author, Year)	Country	Setting	Healthcare System	Study Design	Sample	Primary Leadership/ Followership Model & Theory	Key Constructs/ Measures	Outcomes (S/T/O/P)
Alanazi *et al.* (2024)	Saudi Arabia	Public Ministry of Health hospitals; mixed departments	Saudi Arabian Public Healthcare System (Ministry of Health)	Qualitative (Thematic Analysis)	n=7 RNs (staff/head nurses)	Followership (Kelley's Followership Typology; Chaleff's Courageous Followership)	Understanding of followership, involvement in decision-making, barriers/facilitators	S: Job satisfaction, role valuation; T: Collaboration, decision-making; P: Clinical safety (narratives)

Wahyudin *et al.* (2022)	Honan *et al.* (2023)	Ahmed *et al.* (2023)	Jaaffar & Samy (2023)	Urooj *et al.* (2024)	Notarnicola *et al.* (2024)
Indonesia	Canada	China	Malaysia	Pakistan	Italy
5 Level II Public Hospitals	Tertiary care hospital; acute care units	27 hospitals across provinces (COVID-19 frontline)	7 large public hospitals (Klang Valley)	8 teaching hospitals (military & civil) across provinces	Public & private hospitals (national)
Indonesian Public Healthcare System	Canadian Public Healthcare System (Alberta Health Services)	Chinese Public Healthcare System	Malaysian Public Healthcare System (government-funded)	Pakistani Mixed Public & Military Healthcare System	Italian National Health Service (public) & Private Sector
Quantitative Cross-sectional (SEM)	Qualitative (Constructivist Grounded Theory)	Longitudinal (3-wave)	Quantitative Cross-sectional (PLS-SEM)	Quantitative Cross-sectional	Quantitative Cross-sectional
n=362 Nurses	n=11 Registered Nurses	n=1,204 Frontline Nurses	n=366 Registered Nurses	n=281 Medical Residents	n=37 Nursing Leaders (coordinators/managers)
Transformational Leadership & Psychological Empowerment (Bass's TL theory; Spreitzer's Psychological Empowerment)	Followership (Emergent "Followership as Trust" model; Carsten *et al.*'s constructivist model)	Servant Leadership (Liden *et al.*'s Global Servant Leadership Scale)	Empowering Leadership & Leader-Member Exchange (LMX) (Social Exchange Theory)	Followership (Kelley's Followership Typology)	Transformational Leadership (Full Range Leadership Model – Bass & Avolio)
TL, psychological empowerment, job satisfaction, organizational commitment	Trust, role clarity, knowledge demonstration, communication, willingness to engage	Servant leadership, psychological safety, trust in leader, burnout (MBI-GS)	Empowering leadership, LMX, psychological safety, intrinsic motivation, voice behavior	Independent critical thinking, active engagement, followership styles (Effective, Pragmatist, etc.)	MLQ-6S (Idealized Influence, Inspirational Motivation, etc.), job satisfaction, personal mastery
S: Job satisfaction, organizational commitment	S: Willingness to engage; T: Team cohesion, communication, safety climate	S: Burnout, psychological safety	S: Voice behavior	S: Followership style distribution	S: Job satisfaction, personal mastery

Akamine *et al.* (2021)	Alqahtani *et al.* (2021)	Jankelová & Joniaková (2021)	Bosak *et al.* (2022)	Othman & Khrais (2022)	Labrague & Obeidat (2022)
Japan & USA	Saudi Arabia	Slovakia	Canada	Jordan	Philippines
Academic/tertiary hospitals; resuscitation teams	25 Primary Health Care Centers (PHCCs)	5 public university hospitals	General hospital (consultancy project)	Two government teaching hospitals	10 acute care hospitals (public & private)
Japanese Universal Health Insurance & US Mixed Healthcare System	Saudi Arabian Public Healthcare System (Ministry of Health)	Slovak Public Healthcare System	Canadian Public Healthcare System (provincial)	Jordanian Public Healthcare System	Philippine Mixed Public & Private Healthcare System
Qualitative (Reflexive Thematic Analysis)	Quantitative Cross-sectional	Quantitative Cross-sectional (Moderation)	Quantitative Time-lagged (2-wave)	Quantitative Cross-sectional	Quantitative Cross-sectional
n=18 Physicians (Emergency & Critical Care)	n=325 (managers & providers) Mixed professionals	n=132 FLNMs, n=1,120 subordinate nurses	n=185 Mixed hospital staff	n=253 Registered Nurses	n=754 Clinical Nurses
Followership (Kelley's Followership Theory)	Full Range Leadership Model (Transformational, Transactional, Laissez-faire – Bass & Avolio)	Transformational Leadership (Multifactor Leadership Questionnaire – Bass & Avolio)	Transformational Leadership (Bass & Avolio's Full Range Model)	Transformational Leadership (Global Transformational Leadership Scale)	Transformational Leadership (Global Transformational Leadership Scale – Carless *et al.*)
Technical skills, non-technical skills (role-taking, communication, hierarchy flattening)	MLQ6S, Job Satisfaction Survey (9 domains)	Communication skills, TL, job satisfaction, psychosocial work factors, span of control, management practice	TL (MLQ), mission valence, burnout (emotional exhaustion, depersonalization)	TL, job satisfaction, organizational commitment	TL, work-family conflict, job engagement, nurse-reported quality of care, adverse patient events
T: Communication, role clarity, hierarchy management; P: Patient safety (implied)	S: Job satisfaction	S: Job satisfaction of nurses	S: Burnout	S: Job satisfaction, organizational commitment	S: Job engagement; P: Nurse-reported quality of care, adverse events

Farrington & Lillah (2018)	Baek *et al.* (2019)	Kim & Yi (2019)	Asif *et al.* (2019)	Wong *et al.* (2020)	Cartmell (2020)
South Africa	South Korea	South Korea	Pakistan	Canada	UK
Private owner-operated healthcare practices	6 hospitals (teaching & non-teaching)	3 general hospitals	17 government hospitals (Punjab)	Long-term care facilities (national sample)	NHS (nationwide; various settings)
South African Private Healthcare Sector	Korean Mixed Healthcare System	Korean Mixed Healthcare System (public/private insurance)	Pakistani Public Healthcare System	Canadian Public Healthcare System	UK National Health Service (NHS)
Quantitative Cross-sectional	Quantitative Cross-sectional	Quantitative Cross-sectional (Multi-source)	Quantitative Cross-sectional (SEM)	Quantitative Cross-sectional (Secondary analysis)	Quantitative Cross-sectional
n=241 (practitioners & employees) Mixed	n=1,118 Staff Nurses	n=40 head nurses, n=284 clinical nurses	n=386 Female Registered Nurses	n=78 Registered Nurses (LTC)	n=207 Clinical Psychologists
Servant Leadership (Page & Wong's Servant Leadership framework)	Authentic Leadership (Authentic Leadership Theory – Avolio *et al.*)	Leader-Member Exchange (LMX) & Team-Member Exchange (TMX) (Graen & Uhl-Bien's LMX theory)	Transformational Leadership (Bass's model)	Authentic Leadership (Authentic Leadership Theory – Avolio *et al.*)	Authentic Leadership (Authentic Leadership Theory – Avolio *et al.*)
Humility, servanthood, caring for others, developing others, job satisfaction	ALQ (4 factors), job satisfaction, organizational commitment, nurse tenure	L-LMX, M-LMX, TMX, job satisfaction, turnover intention	TL, structural empowerment, job satisfaction, nurse-assessed adverse patient outcomes, quality of care	ALQ, Areas of Worklife Scale, emotional exhaustion, job satisfaction	Authentic Leadership Inventory, workplace wellbeing, attachment insecurity
S: Job satisfaction	S: Job satisfaction, organizational commitment	S: Job satisfaction, turnover intention	S: Job satisfaction; P: Adverse patient outcomes, quality of care	S: Job satisfaction, emotional exhaustion	S: Workplace wellbeing

Portoghese *et al.* (2015)	Lewis & Cunningham (2016)	Brewer *et al.* (2016)	Cheng *et al.* (2016)	Choi *et al.* (2016)	Hanse *et al.* (2016)	Boamah *et al.* (2017)
Italy	USA	USA	Australia	Malaysia	Sweden	Canada
4 public hospitals	Hospital(s) (local & network)	National sample; multiple settings	Large metropolitan public hospital (Victoria)	One public & one private hospital	Four units in two not-for-profit hospitals	Acute care hospitals (Ontario)
Italian National Health Service (public)	US Private Healthcare System (predominantly)	US Mixed Healthcare System (public/private)	Australian Public Healthcare System (state-based)	Malaysian Mixed Healthcare System	Swedish Public Healthcare System (not-for-profit)	Canadian Public Healthcare System (provincial)
Quantitative Cross-sectional (Multilevel)	Quantitative Cross-sectional	Quantitative Cross-sectional (Probit)	Quantitative Cross-sectional (SEM)	Quantitative Cross-sectional (PLS-SEM)	Quantitative Cross-sectional	Quantitative Cross-sectional (SEM)
n=935 Registered Nurses (74 teams)	n=120 Registered Nurses	n=1,037 Early-career Registered Nurses	n=201 Registered Nurses	n=200 Nursing staff	n=240 Mixed healthcare staff	n=378 Registered Nurses
Leader-Member Exchange (LMX) (Graen & Uhl-Bien's LMX theory)	Transformational Leadership (Rafferty & Griffin's Transformational Leadership Model)	Transformational Leadership (Bass & Steidlmeier's Transformational Leadership Theory)	Transformational Leadership (Bass & Avolio's Full Range Model)	Transformational Leadership (Bass's Transformational Leadership Theory)	Servant Leadership (van Dierendonck & Nuijten's Servant Leadership model)	Transformational Leadership (Bass's Transformational Leadership Theory)
LMX scale, job characteristics, job satisfaction, turnover intention	TL, Areas of Worklife (6 domains), burnout, work engagement	TL, intent to stay, job satisfaction, organizational commitment, autonomy, MD-RN collaboration, etc.	TL (MLQ 5X), social identity, team climate, burnout, perceived quality of care, turnover intention	TL, empowerment, job satisfaction (recognition & pay)	Servant Leadership Survey (5 dimensions), LMX scale	TL (MLQ-5X), structural empowerment, job satisfaction, nurse-assessed adverse patient outcomes
S: Job satisfaction, turnover intention	S: Burnout, work engagement	S: Intent to stay, job satisfaction, organizational commitment	S: Burnout, turnover intention; T: Team climate; P: Perceived quality of care	S: Job satisfaction	S: Leader-member exchange (relational)	S: Job satisfaction; P: Adverse patient outcomes

Wong & Laschinger (2013)	Top *et al.* (2014)	McCann *et al.* (2014)	Read & Laschinger (2015)	Gordon *et al.* (2015)	Martin *et al.* (2015)
Canada	Turkey	USA	Canada	UK	UK
Acute care teaching & community hospitals	Two large government hospitals	10 rural community hospitals	Acute care hospitals (Ontario)	NHS hospitals & GP practices	3 co-located NHS organisations
Canadian Public Healthcare System (Ontario)	Turkish Socialized Public Healthcare System	US Private Healthcare System (rural)	Canadian Public Healthcare System (provincial)	UK National Health Service (NHS)	UK National Health Service (NHS)
Quantitative Cross-sectional (SEM)	Quantitative Cross-sectional	Quantitative Cross-sectional	Longitudinal (2-wave)	Qualitative (Narrative Inquiry)	Qualitative (Multi-method)
n=280 Registered Nurses	n=804 Mixed staff (public & outsourced)	n=219 Hospital employees (mixed)	n=191 New graduate nurses	n=65 Medical Trainees	n=127 Mixed staff
Authentic Leadership (Authentic Leadership Theory – Avolio *et al.*)	Transformational Leadership (Podsakoff *et al.*'s Transformational Leadership Inventory)	Servant Leadership (Barbuto & Wheeler's Servant Leadership Questionnaire)	Authentic Leadership (Authentic Leadership Theory – Avolio *et al.*)	Distributed/Shared Leadership (Distributed Leadership Theory)	Distributed Leadership (Gronn's Distributed Leadership Theory)
ALQ, structural empowerment (CWEQ-II), job satisfaction, self-rated performance	TLI (6 dimensions), job satisfaction (JSS), organizational commitment, organizational trust	SLQ (5 subscales), employee satisfaction (MSQ), HCAHPS scores	ALQ, structural empowerment, relational social capital, mental health, job satisfaction	Static vs. emergent leadership, identity construction, power dynamics	Disconnections (power, distance, values), institutional logics, leadership fantasy
S: Job satisfaction, self-rated performance	S: Job satisfaction, organizational commitment, organizational trust	S: Employee satisfaction; P: Patient satisfaction (HCAHPS)	S: Job satisfaction, mental health	S: Professional identity, morale; T: Interprofessional collaboration, conflict	S: Empowerment, engagement; T: Collaboration; O: Implementation disconnect

Laschinger *et al.* (2007)	Nielsen *et al.* (2009)	Wylie & Gallagher (2009)	Han & Jekel (2011)	Wang *et al.* (2012)	Top *et al.* (2013)
Canada	Denmark	UK (Scotland)	USA	China	Turkey
Acute care hospitals (provincial)	Elderly care centres	NHS Scotland (primary & secondary care)	Large non-profit Catholic healthcare system	Single tertiary care hospital (Harbin)	Two public general hospitals
Canadian Public Healthcare System	Danish Public Healthcare System	UK National Health Service (NHS Scotland)	US Private Non-profit Healthcare System	Chinese Public Healthcare System	Turkish Socialized Public Healthcare System
Quantitative Cross-sectional (SEM)	Quantitative Cross-sectional	Quantitative Cross-sectional	Quantitative Cross-sectional (Mediation)	Quantitative Cross-sectional	Quantitative Cross-sectional
n=141 Nurse Managers	n=274 Mixed healthcare staff	n=753 Allied Health Professionals	n=181 Nurses	n=238 Registered Nurses	n=804 Mixed staff
Leader-Member Exchange (LMX) & Empowerment (Kanter's Structural Empowerment Theory)	Transformational Leadership (Global Transformational Leadership Scale)	Transformational Leadership (Bass & Avolio's Full Range Model)	Leader-Member Exchange (LMX) (Graen & Uhl-Bien's LMX theory)	Transformational Leadership (Kouzes & Posner's Leadership Practice Model)	Transformational Leadership (Podsakoff *et al.*'s Transformational Leadership Inventory)
LMX-MDM, structural empowerment (CWEQ-II), psychological empowerment, core self-evaluation, job satisfaction	TL, self-efficacy, team efficacy, job satisfaction, psychological well-being	MLQ Form 5X (self-rated transformational behaviors)	LMX quality, job satisfaction, turnover intentions	LPI (5 dimensions), Nurse Job Satisfaction Scale (9 subscales)	TLI, job satisfaction (JSS), organizational commitment, organizational trust
S: Job satisfaction (of managers)	S: Job satisfaction, psychological well-being	S: Self-reported leadership behaviors	S: Job satisfaction, turnover intentions	S: Job satisfaction	S: Job satisfaction, organizational commitment, organizational trust