

Remote leadership in health care: a scoping review

Abstract

Purpose – The degree of remote working has increased in the health care sector, but remote leadership in health care contexts has not been systematically studied. Thus, the purpose of this review was to map existing literature and research themes of remote leadership in health care, then identify potential research gaps to guide future studies.

Design/methodology/approach – A scoping review with narrative synthesis was conducted, covering all published literature addressing remote, virtual, online or distance leadership practices. The ABI/INFORM Collection, CINALH, PsycArticles, Scopus and Web of Science, MedNar, Open Grey and PQDT Open databases were searched electronically, and Finnish Journal of eHealth and eWelfare manually.

Findings – In total 15 articles were included in the review. Most literature concerning remote leadership in health care has been published during the last three decades. The main themes discerned in this research stream are related to interactions, work environments, leadership in practice, use of technology, and needs for more study of remote leadership and guidance for remote leaders.

Research limitations/implications – Research on remote leadership in health care is limited, patchy, and associated concepts vary substantially. More comprehensive research on the phenomenon is needed, with more systematic attention to, and coverage of, relevant populations, concepts, contexts and the identified themes.

Originality/value – This appears to be the first review to map research on remote leadership in health care and identify research gaps, which is important as its prevalence has rapidly increased.

Keywords leadership, remote, virtual, distance, health care, scoping review

Paper type Literature review

1 Background

Modern health care faces diverse, complex global challenges (Figueroa *et al.*, 2019). The Covid-19 pandemic of 2020 is one such challenge. This global public health threat has led to the largest workforce experiment in history. Due to the threat the virus posed to workers and customers in all industries and sectors, organisations quickly transformed how they work, specifically by moving to remote or virtual work. Traditionally remote working has been possible for knowledge workers, known as individuals who may work from anywhere and anytime through their laptops, tablets and smartphones (Maitland and Thomson, 2014). For example, remote working has been common amongst IT workers (El-Sofany *et al.*, 2014) and in global business (Glikson and Erez, 2020). Remote working and leadership in other sectors than health care has been scrutinized for example from the viewpoints of well-being (Charalampous *et al.*, 2017) and work performance (Bartsch *et al.*, 2020). Within health care remote working and leadership has been less scrutinized probably because prior to the spread of Covid-19 remote working was not very common amongst health care workers. The research concerning remote working prior to the spread of Covid-19 mostly focused on health care taking place in rural and remote communities (MacLeod *et al.*, 2017).

In health care organisations there have been greater investments in technology and remote work as a result of recent reforms and decentralization of some organisations. Telemedicine was already introduced in the 1990s, although it's acceptance by health care providers and patients had been slow (Stanberry, 2001; Wootton, 2001). The 2020 pandemic accelerated the need for remote work. For example, mental health services confronted a major transformation into a telemedicine service (Uscher-Pines *et al.*, 2020). Proposed solutions to the complex problems facing global health care systems include reforms and decentralisation of organisations (Braithwaite *et al.*, 2019), with greater investment in information technology and remote working (Clancy *et al.*, 2009). To achieve these goals new leadership practices and competencies, such as information technology skills and ability to build trust, are required, to effectively address and harness the changes in dynamics that occur in remotely working teams (Gil *et al.*, 2011; Saarinen, 2016; Eikenberry and Turmel, 2018).

In attempts to define remote leadership, researchers have used concepts such as distance (Connaughton and Daly, 2005) and virtuality (Hertel *et al.*, 2005), as well as remoteness (Kelloway *et al.*, 2003) of leaders. In an early contribution, Bass (1990) discussed leadership and distance but stressed the importance of physical proximity.

Geographical distance refers to spatial dispersion of team members in this context (O'Leary and Cummings, 2007). However, in addition to physical distance and dispersion, Connaughton and Daly (2005) recognized that temporal separation may be involved, and distance may not only occur in geographically dispersed organisations. Virtual leadership refers to leadership in geographically and/or temporally dispersed work environments, mediated via information and communication technologies (ICT) such as e-mail and videoconferencing (Cascio, 2000; Hertel *et al.*, 2005; Schmidt, 2014).

High-quality leadership is required in health care to deliver appropriate transformative responses to rapid ongoing social, technological and medical changes (Dickson, 2009). The increasing multi-professionality of health care workforces is also changing the team dynamics involved, and engendering needs for different leadership practices, such as greater creativity and innovation, communication, and team-building skills (Smith *et al.*, 2018). The complexity of health care and increasing prevalence of remote working are raising urgent needs for systematic analysis of remote leadership. In this review, which is intended to help meet this need, remote leadership refers to leadership in contexts where positional leaders and employees are spatially and/or temporally dispersed, encompassing related concepts, such as virtual and distance leadership. Thus, we adopted the definition of remote leadership by Kelloway *et al.* (2003), according to whom remote leadership can be understood as “leadership interactions that are characterized by electronically-mediated communication between geographically and physically isolated leaders and followers.” Thus, their definition includes leadership practices involving virtual communication and distance elements. We also recognize that remote leadership may occur although there is no spatial distance, for example remote leaders may have responsibilities associated with the activities, relations and/or welfare of teams dispersed in two or more departments in a large health care organisation.

No previous reviews of studies concerning remote leadership in health care were identified in a preliminary search of the CINAHL, PubMed, Scopus, Google Scholar and PROSPERO International databases, Joanna Briggs Institute (JBI) Database of Systematic Reviews and Implementation Reports, or Cochrane Database of Systematic Reviews. Moreover, Stanley and Stanley (2019) noted a lack of studies on clinical leadership in rural and remote contexts. Thus, there has been no comprehensive analysis of remote leadership, including aspects related to geographical distance, or systematic review of relevant current knowledge, despite the rapid increase in extent of remote working in health care. Therefore, purpose of this review was to map existing literature and research

themes of remote leadership in health care, then identify potential research gaps to guide future studies.

2 Methods

Scoping reviews are used to increase knowledge of a research topic (Mays *et al.*, 2001), map the literature and identify characteristics of available research (Peters, Marnie *et al.*, 2020). To meet the objectives stated above, scoping review methodology was applied, following updated JBI guidance (Peters, Marnie *et al.*, 2020).

2.1 Inclusion criteria

To aid identification of relevant articles, and exclusion of irrelevant articles, we first stipulated PCC (Population, Concept and Context) criteria for inclusion (Peters, Marnie *et al.*, 2020). Participants deemed to be relevant included health care leaders or any health care professionals working remotely, for example in tele-, virtual, online, remote, or distributed working environments. Articles addressing health care students were excluded. The focal concepts in this scoping review were remote leadership and related concepts, such as virtual or distance leadership, which originate from health care literature and other sectors as well. Articles not related to remote leadership were excluded. Articles describing studies focused on health care sectors in any geographic locations, including virtual locations, were eligible for inclusion, but articles not related to health care were excluded. Studies with quantitative, qualitative, and mixed methods designs were eligible. Unpublished studies and grey literature (e.g. dissertations) and anecdotal articles, such as opinion papers, were also considered, as a scoping review should consider all types of available evidence (Peters, Marnie *et al.*, 2020). If the full text of an article was not available, or it was written in any language other than English, Finnish or Swedish, it was excluded.

2.2 Search strategy

The search strategy was designed to locate relevant entries in databases specified in a pre-established, three-step plan constructed following consultation with an information specialist about the search terms and strategy. The first step involved an initial limited search of CINAHL and Scopus databases, in September 2020, followed by analysis and

indexation of terms in the title, abstract or keywords. The search terms “remote”, “distance”, “distant”, “virtual” and “telework” were combined with the terms “leadership” and “management” using the Boolean operator OR. The resulting search phrases were then combined with the search terms “health”, “nursing” and “clinic” using the Boolean operator AND.

In the second search step, the identified keywords and index terms were used to search the ABI/INFORM Collection, CINAHL, PsycARTICLES, Scopus and Web of Science databases, and grey literature compiled in the MedNar, Open Grey and PQDT Open databases. We also searched the Finnish Journal of eHealth and eWelfare, manually, since the journal is not indexed. No publication date restrictions were set, to enable detection of early research on remote leadership. Articles published in English, Finnish or Swedish were considered. Searches were conducted in October and November 2020. In the third step, reference lists of all included articles were searched for additional relevant studies.

2.3 *Article selection process*

The article selection process and reasons for excluding articles are presented in the PRISMA flow diagram shown in Figure 1. All the identified records (n=2677) and six articles found in the preliminary, manual and citation searches) were collated, uploaded into the Covidence (version 2.0) bibliographic management system, and duplicates (n=672) were removed, leaving a set of 2005 articles. Screening of titles and abstracts of this set by two independent reviewers, using the PCC, framework resulted in exclusion of a further 1959 articles, and screening of full texts of the remaining 47 left a set of just 15. Any disagreements arising between the reviewers were resolved through mutual discussion or with a third reviewer. The reported studies’ quality was not an inclusion criterion, because the methodological quality of included material is not usually formally assessed in scoping reviews (Peters, Godfrey *et al.*, 2020).

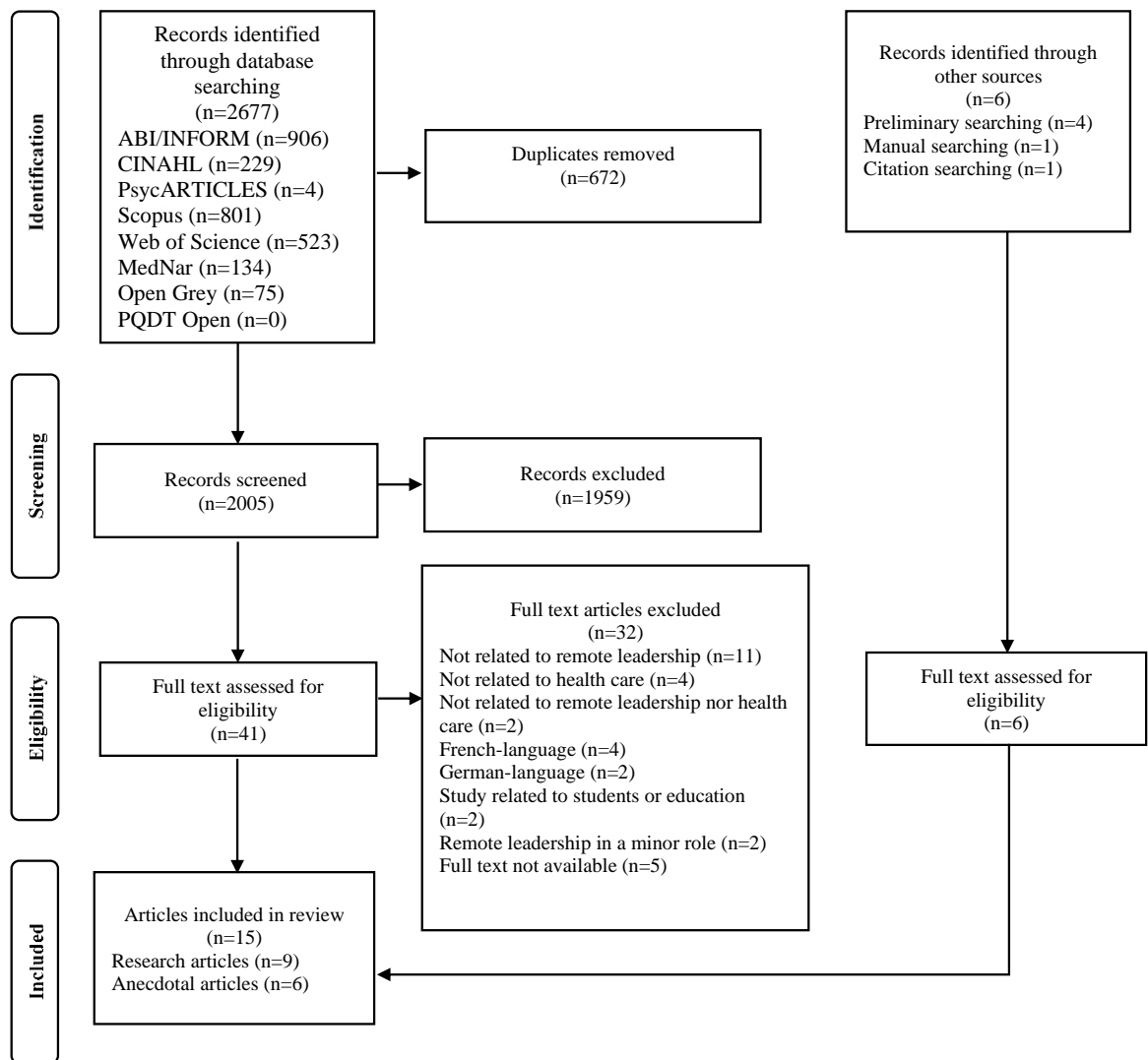


Figure 1. PRISMA flow diagram adapted for the scoping review

2.4 Data extraction, analysis, and presentation of results

Data concerning the studies reported in selected research articles, and their findings, were extracted by two reviewers, and corresponding data (except, for obvious reasons, information on the study design, methodology and empirical findings) from anecdotal articles using the JBI guidelines for scoping reviews (Peters, Godfrey *et al.*, 2020). The extracted information is summarised in Tables I and II. When encountering difficulties with data extraction, the third reviewer was consulted.

The extracted data were presented in visual maps reflecting the key findings, in accordance with the JBI guidelines (Peters, Godfrey *et al.*, 2020). Narrative synthesis was then applied to summarize and explain key findings of the review and their implications,

in a coherent manner (Moola *et al.*, 2020). To present the narrative synthesis, the key findings of the articles were carefully read through and emerged themes were grouped to form subthemes and further main themes based on their similarity.

Table I

Table II

3 Results

3.1 Characteristics of included articles

The current review included 15 relevant publications. One of the included articles was published in 1988, and the other 14 between 2007 and 2020. Slightly more than half originated from the USA (n=8), while others originated from The Netherlands (n=2), Sweden (n=1), Norway (n=1), Finland (n=1), Australia (n=1), and Philippines (n=1). One of the articles was written in Finnish, and all of the others (n=14) in English. In studies reported in four (of nine) research articles quantitative data were collected in either single or two-wave surveys and analysed with various statistical methods. Qualitative methods were applied in studies described in three of the research articles, including interviews and observations, then acquired data were subjected to thematic, descriptive, narrative, or inductive analysis. The same data were employed in two of the three qualitative studies. Mixed methods were applied in studies described in two research articles: one single survey and one two-wave survey. In addition, there were six anecdotal articles: three opinion articles, one editorial, one commentary and one perspective paper. Tables I and II summarise the included articles' main characteristics.

Employees' perspectives were addressed in eight research studies, and participants were most commonly nursing assistants and registered nurses, followed by physicians, employees in a health care consulting firm and employees of various health care organisations. Perspectives of leaders (including head nurses, nurse managers, a service line director, health care executives and leaders of the health care consulting firm) were also addressed in seven of the research articles. All included anecdotal articles considered leaders' perspectives, but employees' perspectives were also addressed in one of them. Concepts used to represent remote leadership in articles included indirect leadership (n=1), e-leadership (n=3), virtual leadership (n=6), remote management (n=1) and distance management (n=5). Both e-leadership and virtual leadership concepts were applied

in one of the articles. The remote management concept was only applied in the Finnish language article. Research articles focused on all health care sectors, including primary, secondary, and tertiary care. Three of the reported studies were conducted in hospitals, while others assessed remote leadership in a health care consulting firm, nursing homes, home help services and remote health care services. Although all the anecdotal articles concerned health care, they did not specify which health care sector they were discussing of.

3.2 Themes of the articles

Four main themes in the included articles were identified: interactions, work environment, leadership in practice and use of technology (Figure 2).

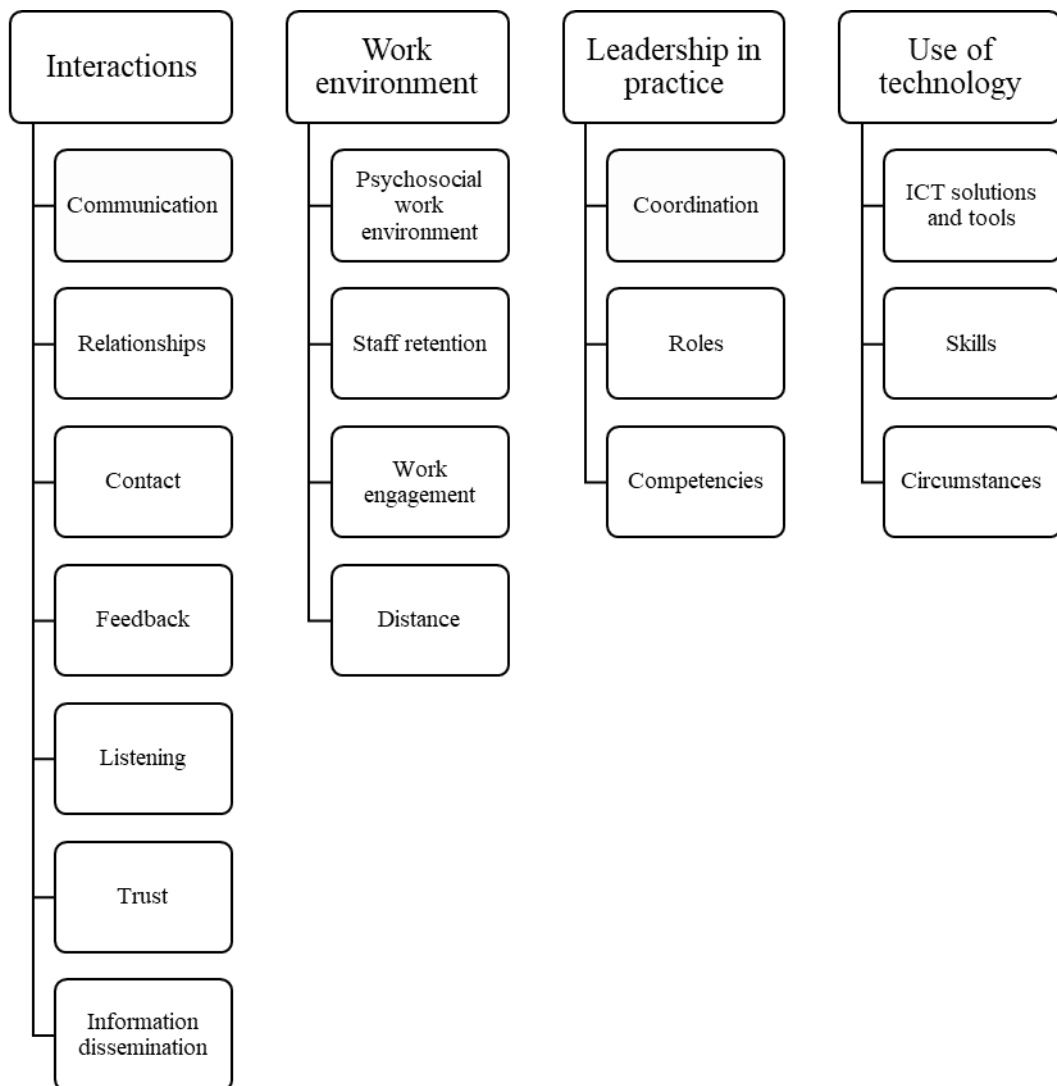


Figure 2. Themes of the included articles

3.2.1 Interactions

Most of the articles addressed interactions in remotely led teams. Considered aspects included: communication (Rich, 1988; Weymouth *et al.*, 2007; Holland *et al.*, 2009; Stoopendaal, 2009; Kerfoot, 2010; Cowan, 2014; Stoopendaal, 2015; Kligler, 2017; Sharpp *et al.*, 2019; Hunt, 2020; Ristolainen *et al.*, 2020), relationships (Weymouth *et al.*, 2007; Holland *et al.*, 2009; Cowan, 2014; Sebastian and Hess, 2019; Sharpp *et al.*, 2019; Hunt, 2020; Solstad *et al.*, 2020), contact (Rich, 1988; Weymouth *et al.*, 2007; Stoopendaal, 2009; Holland *et al.*, 2009; Cowan, 2014; Stoopendaal, 2015; Lundgren *et al.*, 2016; Ristolainen *et al.*, 2020; Hunt, 2020), feedback (Weymouth *et al.*, 2007; Cowan, 2014), listening (Rich, 1988; Kerfoot, 2010), trust (Holland *et al.*, 2009; Cowan, 2014; Kligler, 2017; Ristolainen *et al.*, 2020; Hunt, 2020) and dissemination of information (Weymouth *et al.*, 2007; Stoopendaal, 2009; Cowan, 2014; Kligler, 2017; Solstad *et al.*, 2020; Hunt, 2020). Needs for good communication in remote leadership (Weymouth *et al.*, 2007) and leaders' involvement in creation of effective communication channels (Holland *et al.*, 2009) have been recognised. In addition, Ristolainen *et al.* (2020) found that leaders' and employees' assessments of communication in remote leadership were similar. Leaders' availability (Holland *et al.*, 2009), personal connections, and familiarity between leaders and employees were found to be desirable (Holland *et al.*, 2009; Cowan, 2014; Ristolainen *et al.*, 2020). However, Weymouth *et al.* (2007) found that nurses' perceptions of remote leadership arrangements included deficiencies in accessibility of leaders, general leadership and support from management. In contrast, employees have expressed antipathy to overly frequent personal visits to workplaces by leaders, and desires for appropriate distance (Stoopendaal, 2009). Several authors, in both the previous century and more recently, also highlighted the importance of remote leaders listening to, and informing, members of teams they lead for open communication (Rich, 1988; Kerfoot, 2010; Hunt, 2020). When information is transferred from top to bottom, leaders can be seen as translators (Stoopendaal, 2015), but only relevant information should be reportedly communicated (Cowan, 2014).

A theme in several articles was the need to build and maintain trust (Holland *et al.*, 2009; Cowan, 2014; Kligler, 2017; Ristolainen *et al.*, 2020; Hunt, 2020), particularly in order to foster better and more natural communication among team members (Cowan, 2014; Ristolainen *et al.*, 2020). However, differences in the ways required to build trust in remote and traditional leadership arrangements have been noted and considered (Kligler, 2017). Trust is reportedly important for both remote team cohesiveness (Cowan,

2014) and ‘natural’ remote communication (Ristolainen *et al.*, 2020). In addition, employees’ positive perceptions of their relationship with leaders can outweigh the possible negative effects of large geographical distances between employees and leaders, according to (Solstad *et al.*, 2020).

3.2.2 *Work environment*

Various aspects of the work environment have been addressed in relation to remote leadership, such as psychosocial work environment factors (Lundgren *et al.*, 2016) staff retention (Weymouth *et al.*, 2007), work engagement (Sebastian and Hess, 2019), and distance (Rich, 1988; Solstad *et al.*, 2020). Effects of overall organisational structure were considered in several research articles (Weymouth *et al.*, 2007; Stoopendaal, 2009; Stoopendaal, 2015; Lundgren *et al.*, 2016; Solstad *et al.*, 2020). One addressed psychosocial environmental factors in workplaces and the difference in this respect between traditional and remote leadership settings (Lundgren *et al.*, 2016). The results included findings that employees working closely together with co-workers and leaders rated control of the work pacing, support from co-workers and challenges at work more positively than employees working generally alone with large physical distances from their leaders. In addition, (Weymouth *et al.*, 2007) found a negative correlation between nurse retention and dysfunctional management, including (*inter alia*) excessive expectations, low management stability and poor communication. Significant correlations between leaders’ emotional intelligence and employees’ work engagement, vigour and dedication were also recorded in one study (Sebastian and Hess, 2019).

3.2.3 *Leadership in practice*

Aspects of leadership in practice addressed include coordination (Solstad *et al.*, 2020), roles (Weymouth *et al.*, 2007; Stoopendaal, 2009; Stoopendaal, 2015), and competencies in practice when leading remotely (Weymouth *et al.*, 2007; Holland *et al.*, 2009; Kerfoot, 2010; Cowan, 2014; Hunt, 2020). Participants in the study by (Solstad *et al.*, 2020) regarded large geographical distance as a barrier to daily cooperation between different hospital units, and participating leaders even associated distance with a sense of disenfranchisement. Stoopendaal (2009) found that health care leaders regarded their roles as interested outsiders, trying to maintain contact between two different worlds, without being too tied to either of them, and (Weymouth *et al.*, 2007) detected a need for clear

communication of management teams' roles to employees in remote contexts. Several articles also discussed leadership styles and traits preferred by the nurses (Orte and Diño, 2019), ways of coping with the distance (Stoopendaal, 2009; Stoopendaal, 2015; Solstad *et al.*, 2020) and creation of virtual presence (Cowan, 2014). Moreover, the importance of not only employees' perceived support from leaders (Weymouth *et al.*, 2007) and co-workers (Lundgren *et al.*, 2016), but also support that leaders receive, has been highlighted (Weymouth *et al.*, 2007).

3.2.4 Use of technology

Several articles addressed technological aspects (Rich, 1988; Holland *et al.*, 2009; Cowan, 2014; Kligler, 2017; Sharpp *et al.*, 2019; Ristolainen *et al.*, 2020; Solstad *et al.*, 2020; Hunt, 2020), particularly information and communication (ICT) solutions (Holland *et al.*, 2009; Sharpp *et al.*, 2019; Hunt, 2020), skills (Sharpp *et al.*, 2019; Ristolainen *et al.*, 2020) and the circumstances in which technology is used (Sharpp *et al.*, 2019; Solstad *et al.*, 2020). ICT solutions were regarded simply as tools to improve communication in several articles (Holland *et al.*, 2009; Cowan, 2014; Kligler, 2017; Sharpp *et al.*, 2019; Hunt, 2020). However, some articles identified difficulties when using ICT solutions (Sharpp *et al.*, 2019; Ristolainen *et al.*, 2020; Solstad *et al.*, 2020), including variation in skills (Sharpp *et al.*, 2019; Ristolainen *et al.*, 2020), lack of time (Solstad *et al.*, 2020), excessive pervasiveness of ICT, and poor guidance in its use (Sharpp *et al.*, 2019). In addition, despite requirements for good electronic communication tools and robust virtual communication channels in remote leadership, needs for face-to-face meetings have also been recognized (Holland *et al.*, 2009; Ristolainen *et al.*, 2020), as well as appropriate situational and contextual use of technology (Holland *et al.*, 2009; Cowan, 2014; Kligler, 2017; Sharpp *et al.*, 2019; Ristolainen *et al.*, 2020).

4 Discussion

The purpose of this scoping review was to provide an overview of available literature on remote leadership in the context of health care and the main associated research themes. Nine research articles and six anecdotal articles that met specified criteria regarding remote leadership in health care were identified. These articles scrutinized various aspects of the phenomenon of remote leadership, which were grouped into four themes: interactions, work environment, leadership in practice and use of technology. Most of the

literature concerning remote leadership in health care has been published during the last 24 years (2007-2020), and more than the half of the articles were published after 2015. This indicates that remote leadership in health care has attracted limited but increasing interest. Similarly, Shore (2019) found limited literature but growing interest in managing virtual teams in psychiatric care contexts. Most of the articles considered in this review addressed remote leadership from nurses' perspectives, and there are particularly urgent needs to acquire more knowledge of other health professionals' views of the phenomenon and associated issues.

Concepts used in literature on remote leadership in health care vary, and there is not even a universally applied term for it. The most frequently used concepts are virtual leadership and distance management. Our analysis indicates that e-leadership is applied in association with virtual leadership, underlining the reliance on ICT. The term indirect leadership is also used, in contrast to the direct leadership prevailing in traditional arrangements. The multitude of concepts demonstrates the complexity of remote leadership in the context of health care. The diversity of concepts applied in analyses of health care leadership in digital contexts and needs for more rigorous definition and standardisation of terms have been previously recognised (Laukka *et al.*, 2021). Also, the concept analysis of the remote leadership in health care would be needed.

Remote leadership in health care has received limited research attention. Only nine relevant research articles were identified, which focused on various challenges associated with leading remotely in health care. None of the articles focused on benefits of that effective remote leadership may provide in health care contexts. This is despite claims that decentralisation may help efforts to meet global challenges facing health care systems (Braithwaite *et al.*, 2019), and the increasing use of teleservices and other ICT systems in both health and social care. Thus, there are clearly needs to study possibilities offered by remote leadership for the emerging organisations in health care systems.

The aspects of remote leadership in health care most commonly addressed in the examined literature are the interactions involved, particularly in relation to communication, contact and trust. Previous studies have found that virtual work limits opportunities to communicate (Saarinen, 2016), and various forms of communication are required to enhance task performance in other settings with remote leadership (Hafermalz and Riemer, 2016). He *et al.* (2020) also found that investment in communication is one of the key practices to combat challenges in remote e-work. Teamwork in health care is interprofessional, so both communication and team building skills are important for effective

leadership (Smith *et al.*, 2018). Trust in virtual teams is also important, as it reportedly enhances (*inter alia*) coordination and cooperation (Choi and Cho, 2019). Thus, the significance and roles of trust in remote leadership practices warrant more attention in future research.

It should be noted that, despite clear differences in environments, remote and traditional leaders face many similar challenges. Articles included in this review reported the importance of leadership in matters such as staff retention and work engagement (Weymouth *et al.*, 2007; Lundgren *et al.*, 2016; Sebastian and Hess, 2019), and the negative impact of lack of professional support (Weymouth *et al.*, 2007). Other studies have shown that leadership is related to perceptions of work environments, and perceptions of organisational support affect staff retention in health care settings (Liss-Levinson *et al.*, 2015; Pourshaban *et al.*, 2015; Kloutsiniotis and Mihail, 2017). A fifth of health care workers participating in the studies by (Liss-Levinson *et al.*, 2015; Pourshaban *et al.*, 2015) were reportedly considering leaving their workplaces, so further analysis of perceived organisational support and leadership practices that foster support in remote leadership contexts is needed.

Variety of skills using technological tools in health care, and difficulties in use of relevant technological solutions, were described. According to other researchers, leaders are key agents in the development of a digital culture in organisations (Cortellazzo *et al.*, 2019), people working in remote teams need to handle virtuality through effective technology-mediated communication (Chudoba *et al.*, 2005), which is essential for developing successful leadership in emerging work environments (Avolio and Kahai, 2003). Elucidation of primary roots of the challenges, solutions and practices associated with use of ICT in leadership in future studies may be essential for development of optimal use of ICT in remote leadership in health care.

The opinion papers proposed and discussed various guidelines for remote leadership. In addition, the anecdotal articles discussed new ways of leading in remote contexts (Holland *et al.*, 2009; Kerfoot, 2010; Cowan, 2014; Kligler, 2017; Hunt, 2020), which is important as working remotely changes team dynamics (Gil *et al.*, 2011; Saarinen, 2016). However, none of the research articles focused on the competencies needed for effective remote leadership in health care contexts, so more research on these competencies is required.

Also, when comparing to other fields of business, it seems that several unequally researched phenomena exist within health care. For example, none of the included articles

concerned remote working or leadership and wellbeing (Charalampous *et al.* 2019). Thus, it seems that remote leadership and working are a rising research phenomena within health care that might benefit from the more advanced studies made in other sectors. In their recent study Ravelin *et al.* (2021) stated that the digital work culture of health care has come here to stay due to Covid-19. Thus, it may be expected that also the necessity of remote working and leadership are going to increase in the upcoming years.

4.1 Strengths and limitations

Few studies have addressed remote leadership in health care, so a scoping review covering both research articles and grey literature was deemed essential for mapping gaps in knowledge of the phenomenon. However, only articles published in English, Finnish or Swedish were included in the final set, so relevant articles in other languages may have been missed. Another limitation is that the quality of included studies is not assessed in a scoping review (Peters, Godfrey *et al.*, 2020). This may have led to bias in the interpretations and perceptions of associated issues, but two independent reviewers engaged in the selection of articles in an attempt to reduce such bias. Moreover, one of the main objectives of a scoping review is to acquire indications of the full spectrum of opinions regarding a subject, regardless of their veracity, which can be assessed in later, more targeted reviews.

5 Conclusions

In conclusion, remote leadership and distributed organisations are becoming increasingly prevalent, but literature on remote leadership in health care is limited and scattered, there are no universally agreed definitions of the concepts, and diverse terms are used to describe it. Thus, future studies should include analysis of concepts associated with remote leadership and seek to establish consensus regarding appropriate terms. Empirical qualitative research on key aspects is also required for further elucidation of the phenomena. Based on the research gaps identified in this review, future studies should focus on the opportunities and possibilities offered by remote leadership, and the integration of technology and remote leadership practices in health care settings. Moreover, as there are numerous health care contexts with diverse organisational structures, more comprehensive research on the optimal leadership practices in specific settings and health care professions is needed.

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