Authentic leadership embedded in a social capital framework: A theory in Nursing Science

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Thesis submitted for the degree Doctor of Philosophy at the Potchefstroom Campus of the North-West University

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DECLARATION

I, Petra Bester, student number 11311738, declare that:

- *A THEORY FOR AUTHENTIC LEADERSHIP EMBEDDED IN A SOCIAL CAPITAL FRAMEWORK : A THEORY IN NURSING SCIENCE,* is my own work and that all the sources that I used or quoted are indicated or acknowledged in the bibliography.

- This study has been approved by the Ethics Committee of the Institutional Office of the North-West University (Potchefstroom Campus).

- This study complies with the research ethical standards of the North-West University (Potchefstroom Campus).

Petra Bester

November 2008

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1 The Leader of all leaders

Soli Deo Gratia, Soli Deo Gloria.

2 The authentic leader

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3 My personal leaders

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9 To the memory of a great leader

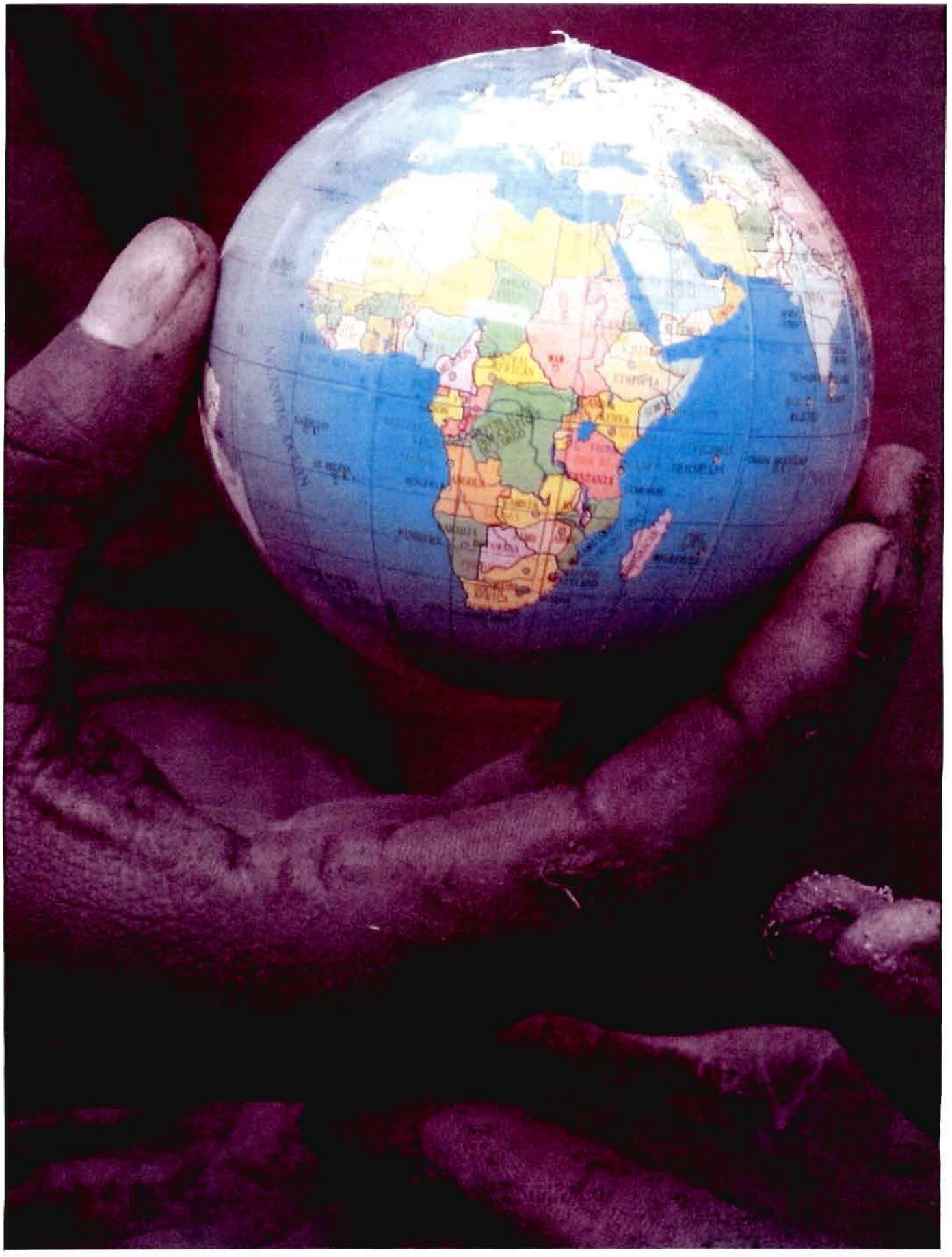
To my late father – who bestowed in me a scholarly heart – how I wish that we could share this moment.....

Dedicated to Tertius....the water is becoming wine....

They [the religious leaders] do all their deeds to be noticed by men; for they broaden their phylacteries, and lengthen the tassels of their garments. And they love the place of honour at banquets, and the chief seats in the synagogues, and respectful greetings in the market places, and being called by men, Rabbi.

And do not be called leaders; for One is your Leader, that is, Christ. But the greatest among you shall be your servant. And whoever exalts himself shall be humbled; and whoever humbles himself shall be exalted.

Matthew 23:5-12



OPSOMMING

Die oorgang van 'n industriële - na 'n inligtingsera het 'n snel-groeiende verandering van 'n wêreldfokus en 'n mededingende ekonomie meegebring. Die verpleegprofesie as deel van die groter ekonomie word direk deur uitdagings kenmerkend van die 21ste eeu beïnvloed. Hierdie uitdagings kan opgesom word as globalisering, internasionalisering, kapitalisme met 'n verbruikersmark, 'n veranderende werksmag met personeeltekorte, internasionale migrasie en gevorderde tegnologie. Hierdie uitdagings beïnvloed egter ook die verpleegetos deurdat die balans tussen die diepliggende waardes van verpleging, naamlik omgee en vertroue, deur 'n wins-georiënteerdheid versteur word. Die bestaande bestuurstrategieë in verpleging word as onvoldoende beskou om die verpleegprofessie te begelei. Klem word op die leiers in verpleging geplaas om as belangrike rolspelers, rigting vir die verpleegprofessie te bied 'n Dringende beroep is gedoen vir nuwe leiers om die verpleegprofessie wat onder druk verkeer, internasionaal te lei. Sosiale kapitaal, alhoewel 'n abstrakte en komplekse konsep word as 'n moontlike raamwerk voorgestel om met die bogenoemde krisis te help. Daar is beperkte literatuur beskikbaar oor die gebruik van sosiale kapitaal in die ontwikkeling van leiers in verpleging.

Die vraag en uiteindelike doel met hierdie navorsing was om te bepaal hoe 'n teorie in verpleging vir unieke leierskap gebaseer op 'n sosiale kapitaal raamwerk, gegenereer kan word. Die generering van 'n middel-vlak teorie was in drie fases behartig. Fase Een het die identifisering, beskrywing, definiëring en analise van konsepte behels. In Fase Twee is die teorie vir unieke leierskap gebasser op 'n sosiale kapitaal raamwerk vir Verpleegkunde gegenereer. Gedurende die Derde Fase is die teorie deur 'n paneel kundiges geëvalueer, is die teorie daarvolgens verfyn en riglyne vir die operasionalisering daarvan geformuleer. Hoof- en verwante konsepte was geïdentifieer as agent, ontvanger, konteks, prosedure, doel en dinamika. Data insameling was gedoen deur middel van 'n omvattende literatuur soektog van alle beskikbare nasionale en internasionale bronne wat teorieë, handboeke, artikels en ander tipes inligting soos verslae en voordragte ingesluit het. Data versadiging was bereik nadat geen nuwe inligting gevind is nie, N=425.

Die twee hoofkonsepte naamlik unieke leierskap in verpleging (agent) en sosiale kapitaal (prosedure) is omvattend geanaliseer. 'n Literatuur analise is vir die verwante konsepte die

professionele verpleegkundige (ontvanger), Suid-Afrikaanse hospitale (konteks), positiewe impak op die "triple bottom line" (doel) asook vertroue (dinamika) uitgevoer. Die resultate van konsep identifisering, beskrywing, definiëring en analise is gebruik in die formulering van aannames – en vir teorie sintese.

'n Visuele voorstelling is aangewend om die beskrywing van die teorie te fasiliteer. Die teorie is voorgelê aan 'n paneel kundiges (n=6). Die paneellede was deur middel van 'n doelgerigte steekproef en aan die hand van insluitingskriteria geselekteer. Die insluitingskriteria het onder andere vereis dat paneellede kundiges ten opsigte van sosiale kapitaal en/of leierskap en/of teorie generering moes wees. Die evaluering van die teorie was gedoen aan die hand van 'n kritiese reflekteringsraamwerk. Nadat die teorie verfyn is, is riglyne vir die operasionalisering van die teorie op 'n makro-, meso- en mikrovlak geformuleer. Die finale stappe van hierdie navorsing het die evaluering daarvan behels asook die formulering van aanbeveling vir Verpleegkunde, navorsing en die verpleegpraktyk.

[**Sleutelterme**: unieke leierskap, sosiale kapitaal, teorie generering, Verpleegkunde]

ABSTRACT

The transformation from an industrial to a knowledge age has brought about a fast-changing world-focus and a competitive economy. The nursing profession, as part of the larger economy, is challenged by this transformation due to globalisation, internationalisation, capitalism within a consumer society, an ageing workforce, staff shortages, international migration and advanced technology. It is argued that these challenges are impacting directly on the nursing profession as a part of the global economy. This impact is intensified due to the ethos of nursing that is evaluated from a profit perspective and does not value the core values of nursing, that of caring and trust. The managerial strategies that are applied in nursing does not sufficiently harness and direct nurses. Focus is placed on nurse leaders as crucial role players in directing the nursing profession in peril. A call was made by followers for a different type of nurse leaders to lead this challenged profession, in an international arena. Social capital, being an abstract and multi-facet concept is presented as a possible framework to assist with the above crisis. Extremely limited literature was found on the utilisation of social capital to develop nurse leadership amongst these challenges.

The research question, and later comprehensive aim, was formulated to examine how a theory in Nursing Science for authentic leadership embedded in a social capital framework, can be constructed. Theory construction of a middle-range theory was conducted in three phases. Phase One implied concept identification, descriptions, definitions and analysis. The actual theory construction was achieved in Phase Two, whilst Phase Three detailed the theory evaluation and guidelines for operationalisation. Main and related concepts were identified as agent, recipient, context, procedure, goal and dynamics. Data collection was conducted by means of a comprehensive literature search of all available national and international literature and included theories, textbooks and articles. Data saturation was achieved after no new information surfaced, n=188.

The main concepts, authentic leadership (agent) and social capital (procedure) underwent a comprehensive concept analysis. Related concepts, namely the professional nurse (recipient), South African hospitals (context), positive impact on the triple bottom line (goal) and trust (dynamics) underwent a literature analysis. The results of the concept

The theory was graphically portrayed and described by means of a model. The theory was submitted to a panel of experts (n=6). The panel was selected following purposive sampling due to specific inclusion criteria for expertise in social capital, and/or leadership and/or theory construction. The evaluation of the theory was conducted according to a specific framework for critical reflection. Guidelines for the operationalisation of the theory were formulated on a macro-, meso- and micro-level. The final step was the evaluation of the research and recommendations were made.

[Key words: authentic leadership; social capital; theory construction, Nursing Science.]

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CHAPTER ONE

OVERVIEW OF RESEARCH AND PHILOSOPHICAL POSITIONING

1.1 INTRODUCTION

This study challenges the construction of a Nursing Science theory for authentic leadership embedded in a social capital framework. The abstract and complex concept of social capital is explored as a possible framework to assist authentic leaders in leading a challenged nursing profession.

During Chapter One the reader is introduced to an overview of the planned research. The take-off is a background to this study, followed by the problem statement and consequent research questions, aim and objectives. These discussions sketch the underlying rationale for this research. Thereafter the leading concepts 'authentic leadership' and 'social capital' are explored. However, a detailed concept analysis follows later in this thesis (please refer to Chapters Three and Four). This ensures that the reader and the researcher share similar information on these concepts in the progressing chapters. The researcher's philosophical assumptions and the ethical considerations in this research are formulated. The chapter ends with an outline of the structure of this thesis.

Note: Although this research pertains to authentic leadership within the nursing profession, the term authentic leadership and the authentic leader will be used in general. The utilisation of these concepts refers to both leaders and leadership in nursing.

1.2 BACKGROUND TO THIS RESEARCH

As the world is moving at an ever progressive and exponential pace, various technological, socio-economic and political changes have crystallized (Borthwick & Galbally, 2001:75; Herdman, 2004:237). In his book "Business at the speed of thought", Bill Gates (2008) accentuated the rapid changes of information technology into a fast pacing business reality. In addition, Crow (2002:1, 5) called it a transformation from an industrial to an information age where "business sectors are discovering that their industrial age hierarchies were not robust or nimble enough to effectively interact with a fast-changing and destabilized 'world-focused' competitive economy". Crow is supported by various authors (Austin, 2001:1-2; Bargagliotti, 2006:1) who characterize this "flat world" with *globalisation* and

internationalisation; advanced technology (Borthwick & Galbally, 2001:79; Crow, 2002:2); capitalism with associated individualism (Borthwick & Galbally, 2001:75; Herdman, 2004:237); a consumer society (Crow, 2002:2) as well as an ageing workforce (Ehlers, 2003:64; Emerson & Records, 2005:10). The phrase "flat world", coined by Friedman, refers to the 21st century reality wherein globalisation and advanced technology networks are deleting boundaries, making all the people next-door neighbours (Bass, 2005:1). In this "flat" world, Crow (2002:6) informed readers that since healthcare systems function within the broader economy and society, international changing trends are also visible in this sector. Additionally, Borthwick and Galbally (2001:76) accentuate Crow's statement and claim that the above changes have called for the need for health realignment, health system reform and professional realignment.

Considering international authors' seemingly congruent opinion that universal changes are affecting the healthcare sector, literature was found that directly associated the effect of these changes with the nursing profession – as an integral part of the healthcare sector. Whilst Herdman (2004:237) and Murray (2006:158) warned that *globalisation* and *internationalisation* affect nursing directly. Borthwick and Galbally (2001:75) stated that *economic changes* have led to an international market for nursing. In this international arena, migration of nurses and nurse shortages are major concerns (Buerhaus, Donelan, Ulrich, Norman and Dittus, 2006:6-12; Emerson & Records, 2005:9) with an increased focus on the complexity of nursing staff recruitment and retention (Kingma, 2004:196; Powe, 2005:2319) influenced by the supply and demand economy of *capitalism*. Buerhaus *et al.* (2006:6-9) and Ehlers (2003:63-65) discussed the increased international shortage of nurses against the background of a worldwide increase in *ageing* baby boomers who are entering retirement from 2005-2020, whilst Herdman (2004:238) and Kingma (2004:196) warn that the above-mentioned dynamics may cause nurses to be exploited. Furthermore, Kerfoot (2006:116), Borthwick and Galbally (2001:8) and Crow (2002:2) identified the effect of advanced *technology* in nursing and refer to it as an information economy in nursing. Finally Hofmeyer (2003:1) added that the effect of perpetual changing in the corporative healthcare workplace influence not only the nurses' morale, work choices and quality of work-life but also the well being of patients.

While the nursing profession is directly affected by international changes, Emerson and Records (2005:10) warned that these changes are placing nursing faculty in jeopardy. Nursing shortages, international staff migration and an ageing workforce can cause depleting and efflux of nurse leaders. The importance of nurse leaders in nursing during a time of change is accentuated by Crow (2002:9) who stated that nursing should not only be

managed but also be lead. This statement is supported by Buerhaus *et al.* (2006:6), who urged that the state of the registered nurse workforce should be managed and should form the backbone of nurse leaders' strategic plans. To corroborate this statement, Kerfoot (2006:115) viewed the successful nurse leader's challenge as recognising and anticipating current and future trends. Kerfoot (2006:118) continued and defined such an emerging trend as the 'end of hierarchical leadership and the beginning of a distributed, shared networks where becoming a real human being really is the primary leadership issue of our time'. Crow (2002:2), reinforced the above notion in a colourful manner and suggested that trends in the nursing profession can be seen as an unfamiliar language where the nurse leader can perform the duties by being both translator and teacher.

From the literature provided in the above paragraphs, it seems to crystallise that leaders are placed in a central position to lead the challenged nursing profession. The logical starting point would be to construct a theory for authentic leadership that could enable nurse leaders with the above-mentioned realities. Regarding leadership theories, Covey (2004:259) confirmed that leadership, in general, is a theme that has been researched and acclaimed in literature for over a century. Covey conducted an intense literature review on available literature on leadership theories and condensed the literature into twenty-four theories of leadership. Although leadership has been a concept greatly explored in literature, there was a shortage of literature that explores the association between social capital and leadership. Social capital in return, is greatly reported in literature when one acknowledges that a key word search on social capital via EbscoHost provided 51 419 results. Although social capital research is internationally progressive, the researcher found very little evidence of social capital as a potential mechanism to assist the leader within the nursing profession. Therefore, the researcher selected a unique approach whereby a framework of social capital serves as the departure point from where theory construction will be activated.

1.3 OVERVIEW OF SOCIAL CAPITAL AND AUTHENTIC LEADERSHIP

Social capital and authentic leadership are two concepts central to this research. An overview of each concept follows below:

1.3.1 Social capital

Originally an educational term, there is evidence that social capital roots from the work of Marx (Lin, 1999:28). The term 'social capital' was first used by Hanifan in 1916 (Smith, 2006;

Koniordos, 2005:3) who studied schools in rural communities and referred to the 'tangible substances that count for most in the daily lives of people'. The awareness of this phenomenon increased when the concept was used in the work of Putnam (Smith, 2006:1; Policy Research Initiative, 2005:3). For the past decades the term social capital has predominantly been used in an economic perspective, due to the presence of the word "capital" (Fin *in* van Schaick, 2002:4). The World Bank (2008:1) refers to social capital as a 'useful organising idea' whilst Cohen and Prusak (2001:6) were forerunners in viewing the organizational maintenance and development potential of social capital. Today, social capital is a buzzword and researchers from several subject fields claim their interest in this concept (Policy Research Initiative, 2005:3, Poortinga, 2005:1; Thomas, 2003:18-19).

Defining social capital is difficult and not without critique. As Poortinga (2005:2), Thomas (2003:19) and van Schaick (2002:5, 8-10) state, social capital is a complex and multi-faceted term that remains abstract, despite various definitions. In short, social capital can be defined in three attempts. The first is to distinguish social capital from physical capital as well as human capital. Where physical capital refers to physical objects and human capital to human properties (knowledge, skills and experience), social capital refers to the connections amongst individuals (Smith, 2006:2), or in other words, the 'glue that holds everything together' (Hopper, 2003:1; The World Bank, 2008:1). Secondly, social capital could be defined as the connections between individuals and social networks with the norms of reciprocity (Fukuyama, 1999:1) and trustworthiness that arise from this connectedness (Fukuyama *in* van Schaick, 2002:6; Thomas, 2003:20) which facilitates co-ordination and co-operation for mutual benefit (Putnam, 1998). And thirdly, with a focus on social networks, social capital can be defined as the networks of social relations that may provide individuals and groups with access to resources (Policy Research Initiative, 2005:6). For the purpose of this research the definition of social capital formulated by The World Bank (2008:1) is utilised, namely "*the institutions, relations and norms that shape the quality and quantity of a society's social interactions. Social capital is not just the sum of the institutions which underpin a society; it is the glue that holds them together.*"

Authors on social capital (Koniordos, 2005:148; Strathdee, 2005:65-67; Woolcock, 1998:158) identified three types of social capital. These include: bonding, bridging and linking social capital. Bonding social capital is the glue that holds similar social groups together whilst bridging social capital involves those types of horizontal social interaction that stretch across social structures. Lastly, linking social capital is the networks and institutionalised relationships between unequal agents that operate vertically between agents with dissimilar access to resources and power. It is argued that all three types of social capital are

necessary to enhance social mobility, advance coping with social adversary, provide opportunity for social development and to provide a responsibility to authority to create social capital. The presence of all three types of social capital is the ideal.

Another debate on social capital is the concept's importance. What are the benefits of social capital and why all this interest? As Schuller (*in* Strathdee, 2005:64) stated, social capital provides a heuristic device for people to question and critically reflect the human race and human relationships. Various benefits have been listed, due to the presence of social capital. According to the Policy Research Initiative in Canada (2005:9-10), the benefits of social capital is in direct proportion to the value of the flow of resources that can be drawn from, and activation of social networks and listed material goods and services/information; reduced transaction costs; emotional support; reinforcement of positive behaviour and service brokerage.

More benefits of social capital are to provide a sense of belonging; to build communities and to commit oneself to a closer knitted social structure; concrete experience of social networks and trusting and tolerant relationships (Hopper, 2003:93, Smith, 2006:2); lower crime rates, higher educational achievements, more economic growth (also in Strathdee, 2005:53) as well as increased levels of health and better coping mechanisms with trauma, to list a few. In addition, Winck (*in* Strathdee, 2005:63) remarked that social capital research could benefit policy making that contributes towards industrial democracy whilst Strathdee (2005:66-67) stated that effective competing in the global economy requires a social capital rich society.

However, social capital could also have negative implications, especially when close bonding ties are considered. This might lead to exclusion from groups or using social capital for criminal purposes as seen in terrorist networks, corruption (Hooghe & Stolle, 2003:172; Smith, 2006:2; Koniordos, 2005:28; Policy Research Initiative, 2005:11; Rose, 2006:8); cronyism (Narayan & Cassidy, 2001:60); parochialism, nepotism and bribery (Koniordos, 2005:28).

Although the literature listed above confirms that high levels of social capital implicate various benefits, it does not imply the spontaneous possession of social capital in connections. On the contrary Hofmeyer (2002) who conducted a critical philosophical inquiry into the relationship between nursing and the concept of social capital urged that nurse leadership plays a crucial part in "crafting high social capital and ethical workplaces". She concluded that nurse leaders should become crucial social and political activists to develop sustainable services and policies for the common good. Taking the above into account, it is

argued that positive social capital in the form of bonding, bridging and linking social capital, may be an advantage to various practices but needs to be driven and supported by leadership.

1.3.2 Authentic leadership

Discussions on authentic leadership start by focusing on leadership in general. Thereafter a condensed discussion on the concept authentic leadership follows. Please refer to the theoretical assumptions in this chapter (see 1.7.3.3.2) for an extensive outline of the supported leadership theories that sculpted the definitions selected. In Chapter Three (see 3.4); a concept analysis of authentic leadership is conducted to gain an in-depth insight into this phenomenon.

Contrary to the comprehensive and abstract meaning of social capital, the researcher found that the definition of leadership enjoyed more simplicity and congruence amongst authors. A challenge to this research is the large amount of literature available on both social capital and leadership in general, versus the limited amount of literature on authentic leadership. According to Covey (2004:100) the importance of leadership is portrayed when realizing the existence of thousands of leadership articles and research. Covey's (2004:100) comprehensive investigation on the types of literature available on leadership in general summarised twenty-four leadership theories that have been constructed over a course of a century (please refer to Annexure A). These leadership theories, listed by Covey, confirm the depth of the exploration into leadership and confirm two realities. Firstly, leadership as an enabling art, and secondly there is an inseparable connection between leadership and management (Covey, 2004:99). For the purpose of this research the researcher combined Covey (2004:98-99) and Collins' (2001:20) independent works on leadership with the work of George and Sims (2007), and Goffee and Jones (2005) who explored authentic leadership.

An overview of leadership according to Covey highlights the difference between leadership in the industrial age versus leadership in the information age. Covey (2004:112) referred to leadership in the industrial age as a position rather than a skill. People were regressed to "things" or "objects" to be managed by means of rules, control and efficiency. Leadership in the information age is apprehensible within the context of global seismic changes of globalisation of markets and technologies; permanent changing environments; free agency; emergence of universal connectivity, the move of wealth creation from financial capital to intellectual and social capital; democratisation of information and the exponential increase in competition (Covey, 2004:103-104). Industrial age leadership by means of rules, control and

efficiency will lead to increased mistrust, misalignment and disempowerment. Although the arena in which leadership happens is changing, the importance of management and leadership should remain essential and equal. An over led and under managed organisation is just as ineffective as an over managed and under led organisation will be.

It is essential to understand the proactive principle of man's responsibility of choice that forms part of Covey's seven habits of highly effective people (2004:152). Covey (2004:303) stated that leadership is a *choice* rather than a *position.* When referring to leadership as a choice, it can be described as the *moral authority* of a person rather than a formal authority granted to a person by means of *position.* The following table portrays the contrast between leadership as a position versus leadership as a choice.

Table 1.1 Leadership as a position versus leadership as a choice (Covey, 2004:303)

LEADERSHIP AS A.....	
POSITION (formal authority)	**CHOICE (moral authority)**
Might makes right	Right makes might
Loyalty above integrity	Integrity is loyalty
To get along, go along	Stubborn refusal
The "wrong" is in getting caught	The "wrong" is in doing wrong
The top people don't buy it	Ethos, pathos, logos
The top people don't live it	Be a model, not a critic
Image is everything	"To be rather than to seem"
"No one told me"	Ask; recommend
I did what you told me to do; it didn't work. Now what?	"I intend to"
There is only so much	There is enough and to spare

Covey (2004:98) defined leadership as an *enabling art* where a leader *"...communicates to people their worth and potential so clearly that they come to see it in themselves".* A leader within the information age should exercise the four roles of leadership. These are path finding, modelling, aligning and empowering. As Covey (2004:113) referred to people as body, heart, mind and spirit, these roles are positive manifestations of the whole person and act in response to the chronic organisational problems found in the information age. The first role that of path finding sets of a common vision and values when these are absent. In the event of low trust, modelling of trustworthiness creates trust. Goals, structures, systems and processes that nurture and encourage the people and the culture, to serve the common

vision and values, are aligned should misalignment occur. Empowerment becomes the focus on projects at job level, should disempowerment be present. Please refer to 1.7.3, for a more in-depth discussion of Covey's theory of leadership.

In conjunction with Covey, Collins' (1991:20) definition of leadership is utilised. Collins' conclusions in his book 'Good to great', which researched what catapults an organisation from good to really great, urged new views on traditional leadership. He distinguished between effective leaders and a Level 5 Executive, where a Level 5 Executive is the highest ranked leader. Collins' definition of an effective leader is one that "*catalyses commitment to and vigorous pursuit of a clear and compelling vision, stimulates the group to high performance standards*". Collins' (1991:20) level 5 hierarchy is graphically portrayed as follows:

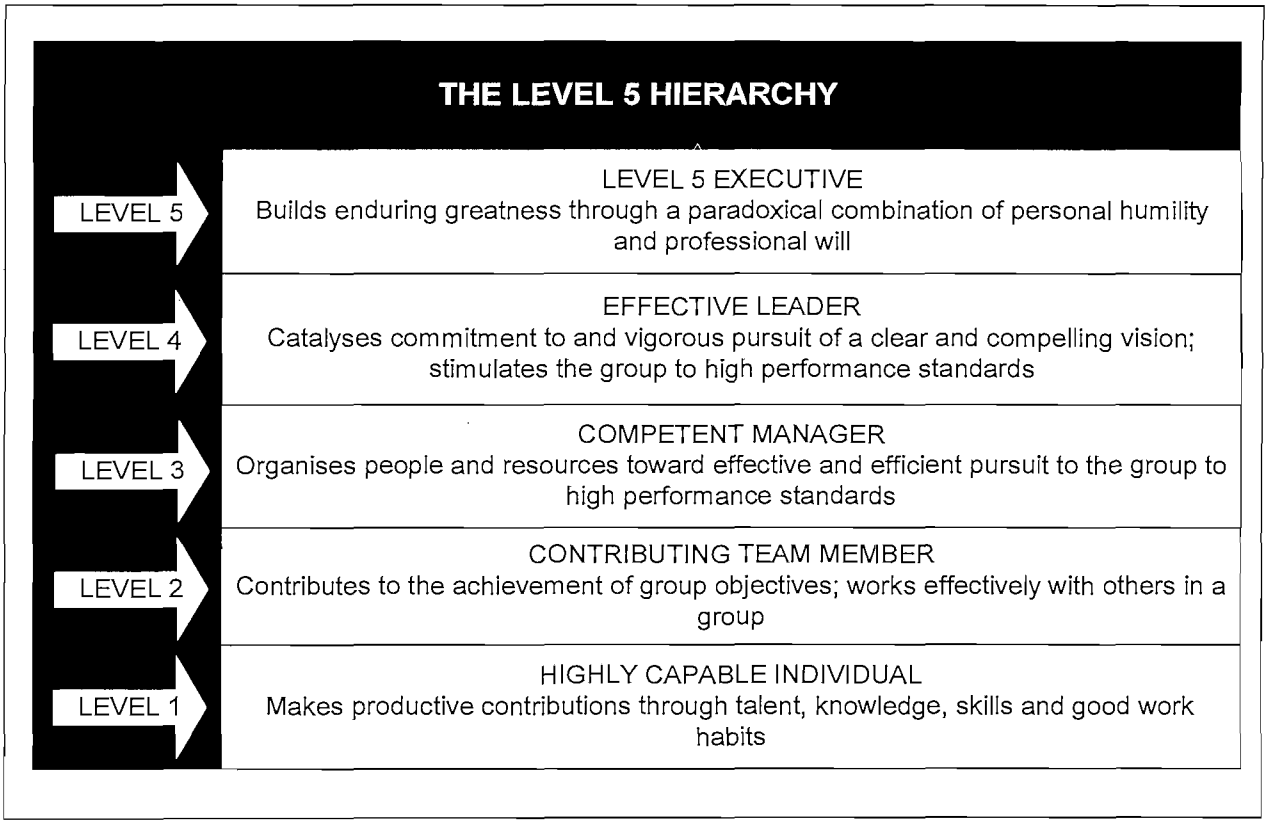

Figure 1.1 The level 5 hierarchy of leadership (Collins & Porras, 2000:20)

An effective leader can be described as the secondary greatness against that of a Level 5 Executive. Collins stated that when a person in a formal position utilises his/her position only as a final resort, will it increase such a leader's moral authority (Collins, 1991:22). This increase in moral authority is due to the visible subordination of the leader's ego and position

power and by using reasoning, persuasion, kindness, empathy and trustworthiness. Collins' definition of leadership acknowledges leaders' moral authority with the paradox of servant leadership. Thus, this definition has a strong correlation with leadership as viewed by Covey as it places leadership on a moral and formal continuum. A comprehensive discussion of Collins' theory of leadership is provided, in the theoretical assumptions of this research.

With a specific reference to the United States of America, George (2007:2) referred to the presence of a leadership crisis. The crisis is has manifested because the confidence and trust that followers have in leaders are at an all time low due to an array of detrimental effects that leaders have had on various industries. He argued that leaders are guilty of abusing power to serve themselves and not the people whom they should lead. The emerging definition of leadership by George (2007:3) is also situated in a current time frame within a western, capitalistic economic and political sphere. In this sphere, the leader is inseparable from both the human and the financial responsibilities that need to communicate trust to the followers. Followers refer to employees, investors and customers. George (2007:8) stated that leadership should change from the industrial organisational reality into the new century where people within organisations have changed into a more knowledgeable reality. Therefore, George notes a definition for 21st century leaders - a new definition referred to as authentic leaders.

George (2007:5) as well as Goffee and Jones (2006:8) welcomed authentic leadership into the arena of leadership studies. According to George (2007:5), leadership cannot be defined by traits or characteristics, but is embroidered into the highly complexity of human beings. Therefore, leadership emerges with a narrative nature that is sculptured from your life story. Where the crucibles lived directs a leader to understand leadership as a service and empowerment of people rather than gratification or success. The definition of authentic leadership (George and Sims, 2007:xxxi) is to "*...bring people together around a shared mission and values and empower them to lead, in order to serve their customers while creating value for all their stakeholders.*" In addition, George and Sims (2007:12) conducted comprehensive interviews with 125 leaders and found that the most challenging person to lead would be yourself. It is only when you are able to lead yourself through difficulties and challenges, that you will be enabled to lead others. The leading of oneself can only be conducted through the principles of gaining self-awareness; i.e. (i) practicing values and principles when under pressure; (ii) balancing of extrinsic and intrinsic motivations; (iii) building a support team; (iv) staying grounded by integrating your life and (v) understanding your passions and the purpose of leadership.

The above authors (Covey, 2004; Collins, 1991; George, 2007; George and Sims, 2007; Goffee & Jones, 2006) argued uniformly that the arrival of the information age has seen the emergence of a different type of leader. This is clustered by some as the authentic leader. Authentic leadership as part of this research's theoretical assumptions is discussed in point 1.7.2.

1.4 PROBLEM STATEMENT

Assimilating the information expounded above, it is clear that progressive and universal worldwide changes impact directly on the nursing profession that serves as an integral part of the broader healthcare industry and world economy. These changes that are evidenced in the reality of *globalisation* and *internationalisation*; *advancing technology*; *capitalism* with an evolving *consumer society*; an *ageing workforce*; *nursing shortages* and *international nursing migration*, poses a challenge to the nursing profession and leaders in nursing. This latter deduction is affirmed by Muller, Bezuidenhout and Jooste (2006:394). They confirmed that leaders in nursing as much as nurse managers are placed in a central position, where they are required to both lead and manage the nursing profession amidst inevitable worldwide changes.

In addition, Hofmeyer (2002:14) stated that nursing can no longer be viewed as healthcare only but needs to be placed in a larger system with reference to both healthcare **and** society. These universal challenges focus on building economic capital whilst nursing should be defined beyond the indicators of profit (Hofmeyer, 2002:14). The ethics and ethos of nursing are based on the core value of caring and are in direct conflict with a profit-focused society. Therefore, the need to re-evaluate trust and social values, as the core values of nursing is essential (Hofmeyer, 2002:15) with significant emphasis on leaders in nursing who are required to apply the above.

Although much has been written on contemporary nursing challenges, managers and leaders in nursing, the researcher found limited literature that proposes the utilisation of a social capital framework to develop leadership in nursing amidst this plethora of changes. Social capital is a concept subjected to considerable debate (Lauder, Reel, Farmer & Griggs, 2006:73), although social capital theory embraces the possibility of operationalisation due to its multidimensional, complex structure. In the article "The relationship between trust, social capital and organizational success", Crow (2002:1-11) stated that social capital could be viewed as a valuable framework to leaders in nursing, affected by globalisation, internationalisation, advanced technology and an ageing workforce. When focusing on

nursing specifically, Crow moved from the assumption that change from an industrial to an information age have changed the context and the nature of how people trust. In turn, this influences peoples' shared values and the potential towards social capital. Adding to the work of Crow, Hofmeyer (2003:1) successfully investigated the utilization of a social capital framework to meet the triple bottom line.

The researcher argues firstly that a different type of leader is needed to tackle the challenges that face the nursing profession and secondly, the viability of using a social capital framework to equip leaders in nursing to lead the challenged nursing profession.

1.5 RESEARCH QUESTIONS

From the above problem statement, the researcher isolated specific research questions and aims to address this problem statement during the research project. As the theme of authentic leadership embedded in a social capital framework in relation to Nursing Science, particularly in South Africa, has not been investigated in any depth the following central question emerges:

How can a theory for authentic leadership embedded in a social capital framework, in Nursing Science be constructed?

In order to answer this question, the following sub-questions need to be addressed:

- What are the concepts and the relationships between these concepts (in other words, statements) in constructing a theory for authentic leadership embedded in a social capital framework in Nursing Science?
- How can a theory for authentic leadership embedded in a social capital framework in Nursing Science be operationalised?

1.6 AIM AND OBJECTIVES

The overall aim of this study is to construct a theory for authentic leadership embedded in a social capital framework in Nursing Science. To achieve this aim, the following objectives are stipulated:

1. To identify, define, describe and analyse the main and related concepts of a theory for authentic leadership embedded in a social capital framework in Nursing Science.

2. To describe the relationships between the main and related concepts in order to construct a theory for authentic leadership embedded in a social capital framework in Nursing Science.
3. To describe the theory with reference to concepts, statements, structure and process for authentic leadership embedded in a social capital framework in Nursing Science.
4. To evaluate and refine the theory for authentic leadership embedded a social capital framework in Nursing Science.
5. To formulate guidelines for the operationalisation of the theory for authentic leadership embedded in a social capital framework in Nursing Science.

1.7 PHILOSOPHICAL POSITIONING

The researcher agrees that no research is free of values and therefore views a proclaimed philosophical position as important (Botes, 1995:9, Burns & Grove, 2005:12). This implies that the researcher's assumptions directly influence the selected research problem, methodology and the interpretation of research findings. For this rationale the reader will now be introduced to the researcher's philosophical positioning also referred to as paradigmatic perspective. The paradigmatic perspective is divided into meta-theoretical, theoretical and methodological assumptions. These assumptions are discussed using the Botes research model (1995).

1.7.1 The Botes research model

The researcher utilises Botes' research model (1995:5) as a framework to guide the research decisions. Botes' research model for Nursing Science is derived from the work of Mouton and Marais (1994:3-27) and focuses on research in the social sciences. The Botes model is embedded in the post-modern science view and the functional approach.

Please refer to a graphic proposal of the Botes research model applied to this research (Figure 1.2). Botes' model portrays three independent orders of activities that stand in a

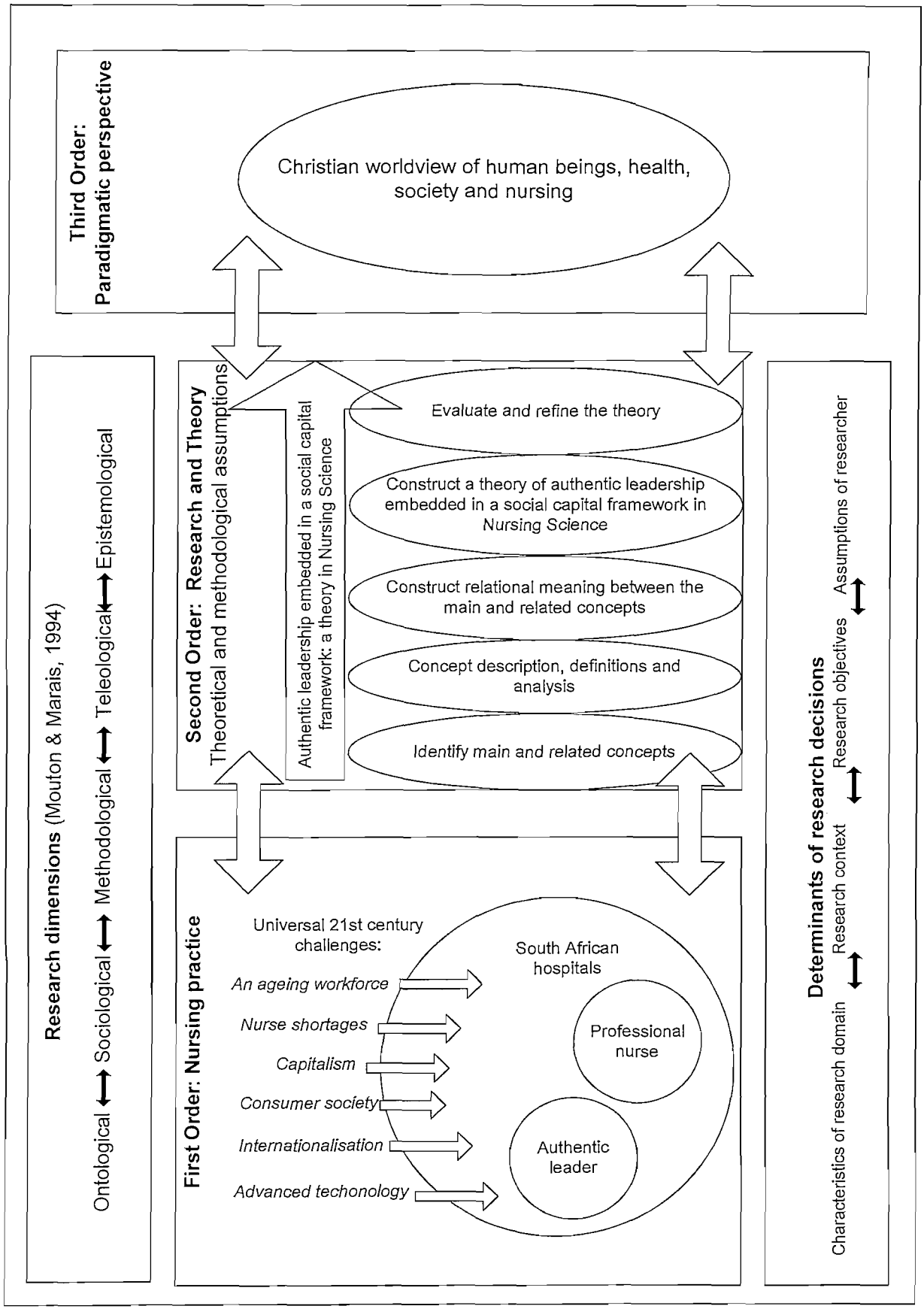

Figure 1.2 Research model by Botes applied to this research

specific relationship one another other. These orders are the nursing practice, nursing theory and the presence of a paradigmatic perspective.

The **practice** is viewed as the first order in this research model. This level is the pre-scientific level and directs the research questions (Botes, 1995:6). In this research the nurse leader and the professional nurse employed in hospitals in South Africa, are embedded in the first order as the research domain.

The second order in the Botes research model is the level where **research and theory construction** are conducted. These actions are performed through rational decision-making within a framework of research determinants (Botes, 1995:6) that guides the researcher's decisions. This research's planned design and method is discussed under points 8 and 9.

The researcher's **paradigmatic perspective** is viewed as the third order in the research model. The researcher's paradigmatic perspective refers to assumptions that continuously influence the first and second levels (Botes, 1995:6). The researcher's paradigmatic perspective has been outlined in 1.7.2.1-1.7.2.3.

In solidarity with the Botes model, the researcher adheres to the **post-modern science view** as a prominent position in this research. Postmodernism is collective of a group of philosophies (Higgs & Smith, 2006:111) that originated in Europe after the publication by Jean-François Lyotard in 1983, titled "The post-modern condition: A report on knowledge". These philosophies challenged truth after people had experienced disillusions with science and rationalism, or as accurately stated by Higgs and Smith (2006:111), postmodernism is the "rage against reason". The Eurocentric reference of postmodernism does not portray a period after modernism but rather a voice for a new discontinuity (Rossouw, 1995:7) and expresses the limitations captured in the Eurocentric references of the term "modernism".

Postmodernism challenges a broader rationality and anthropology (Rossouw, 1995:76) that excels the mere acceptance of scientific results a mere truth of falsity (Higgs & Smith, 2006:110). Society is not viewed as an oiled system that runs smoothly due to specific social structures (Higgs & Smith, 2006:116). Nor are symbols of language the only means of functioning within a social structure (Higgs & Smith, 2006:110). Post-modern thought seeks recognition of the existence of multiple perspectives and the plurality of the comprehension of social reality rather than a tunnel vision search to universal, essential truths. If post-modern thought stimulates man to think of reality in a reflexive manner, it implies that there might be various representations of the reality that is in question (Cheek, 2000:20).

In this research a theory for authentic leadership embedded in a social capital framework, was constructed. Postmodernism therefore warns the researcher to have an increased awareness of meta-narratives used in the healthcare industry that may justify cultural authority of natural sciences (Rossouw, 1995:125). Furthermore, the context in which this research is conducted is described in detail. On the contrary, the researcher explored the main and related concepts that formed the building blocks in theory construction, to widen the researcher's perspective and deepen the researcher's outlook regarding authentic leadership and social capital.

This research was conducted from a narrative approach whereby the researcher acknowledged the progressive learning and awareness that is locked beyond the doors of immediate expectation.

Another position congruent with the researcher's is the adherence to a **functional approach** as presented by Botes (1991). A functional approach emphasises the practice-orientated character of nursing science (Botes, 1991:1). It can be described as a partnership between theory and practice where the researcher wants to conduct research, for utilisation in the nursing practice, in a science where the boundaries between theory and practice are dimming. Botes' model (1991 and 1995) indicates interdependent actions between practice and theory by describing nursing activities and theory within three orders. The first order is that of the nursing practice – the reality in which the nursing interventions are rendered. The nursing practice serves as the field of research and has specific attributes to direct the decisions made for research problems. Many nursing interventions within the nursing practice are conducted in accordance to pre-scientific confirmations and lay interpretations. Due to the constant interdependent relationship between the researcher's paradigmatic perspective, research and theory as well as the nursing practice, a functional approach to this research was executable.

1.7.2 Meta-theoretical assumptions

The researcher's meta-theoretical assumptions originate from the following views and philosophies that are congruent with the researcher's personal philosophy.

1.7.2.1 Assumptions

The researcher's paradigmatic perspective originates from a Christian Worldview as well as a purpose-driven life. A **human being** is viewed as a unique, spiritual and God-created

being that functions in a unit with body, mind and spirit within a mortal, earthly life. Although God creates a human being, the person is conceived and born in sin. Only God can transform man's mortal life to spiritual immortality through the process of conversion and faith in Jesus Christ. The process of salvation through conversion and faith is achieved by mercy from God as well as the choice given by God to man.

In this research, the leader in nursing is viewed as a unique, spiritual and God-created human being that functions in a specific relationship towards God and fellow men. The leader is subjective to the sinful nature of a mortal life that can only be converted through repentance. A leader leads a purpose-driven life and acts on the choice to be a leader rather than being appointed as a leader due to formal position. Finally, a leader is also subjected to the mercy from God and therefore has a unique life narrative that may direct his/her leadership.

Society is viewed as the internal and external environments in which human beings function. The internal environment contains the psychological; spiritual and physical body of a human being. The external environment groups the social; external spiritual and the physical world together. Although a human being functions as an independent unit, it remains in an interdependent relationship towards fellow men according to a specific social structure.

Society in this research refers to the environment in which the leader in nursing functions. This environment is a complex structure of formal and informal relationships that are interdependent in nature. Leadership in nursing can only be performed in an environment where there is the presence of a group (followers). The leader in nursing therefore stands in direct relationship with her-/himself and social others and can be categorised as intra-personal, socio-familial and professional. Intra-personal relationships refer to the leaders' relationship with the self within a social context. The socio-familial relationships are the informal and family relationships and can also be outlined in a specific social structure. Finally, the leader in nursing functions in a professional relationship towards others that is occupied with work-related aspects and that acts in the capacity of stakeholders of the healthcare industry and members of the nursing profession.

Health is the balance between body, mind and spirit and not necessarily the absence of illness. Health is dynamic, unique and sensitive and needs conscious input to be maintained and enhanced.

Health in this research refers to the employees' wellness in the workplace. This wellness is a state of being that characterises a balance amongst employees' body, mind and spirit and implies an active attempt by employees to maintain it.

Nursing is the purposive and comprehensive service to patients in order to promote and maintain health as well as the caring for and prevention of illness.

In this research, the leader in nursing provides a purposive and comprehensive service towards his/her followers. The goal of this service is to enhance and maintain wellness in the workplace of the followers and significant others to prevent and address aspects that are challenging their level of wellness.

Nursing Science: The body of knowledge pertaining to the discipline of nursing, which is continuously developed and composed through research findings and tested theories.

In this research, Nursing Science is the directed receiving discipline in which the theory for authentic leadership embedded in a social capital framework, is constructed. This discipline is characterised by a current body of knowledge that is being grown and developed dynamically through research output and by testing of theory. This theory is planned to be beneficial to Nursing Science, research and the nursing practice.

In addition to the researcher's meta-theoretical assumptions with regard to man, society, health, nursing and Nursing Science, the researcher is also a partisan of existentialism and critical social theory. The researcher found that these two philosophical departure points did not only influence the research direction, but were also applicable. An overview of existentialism and critical social theory follows with indicators of where these philosophical positions apply to this research.

1.7.2.2 Existentialism

Existentialism is best understood under the background of the cultural, literary and art development characterised predominantly in Europe between the nineteenth to the twentieth centuries. The reality during which existentialism developed, was the grim European wars and associated suffering which explains the absurdity and radical-nature (Wyatt, 2008:1) thereof. According to Crowell (2004:1), existentialism was characterised by various philosophers of whom Sarte, Kiekergaard, Heidegger and Nietzsche are known. These philosophers activated a philosophical discourse of existentialism. This discourse impacted

on the twenty-first century philosophical inquiries into the subject fields of psychology (Victor Frankl, Boss, Rank, Laing) and theology (Bultmann, Tillich, Barth).

Existentialism refers to man's experiences of life and world, which implies that man has the freedom of choice accompanied by responsibilities and consequences (Anon A, 2006:1). Thus, man is responsible for what he makes of himself (Anon B, 2005:1). Consequently, existentialism is opposed to rationalism and empiricism, stating that man's experience cannot be tabled to scientific fact only (Dictionary.com Unabridged, 2006:1). It is warned that with the freedom of choice and amidst experience, man is directed towards the experience of dread and anguish (Anon B, 2005:1).

Sarte used the "existence precedes essence" slogan in his discourse on existentialism (Banach, 2006:1). This slogan means that man does not have a predetermined essence (nature) that controls his doing and being, but is radically free for independent determination from external influences. Free choices cause man to create his own human nature and values. Existentialism becomes clearer from the philosophical view with regard to the work of Heidegger. Heidegger (*in* Lopez & Willis, 2004:279) evolved the classical existentialism view and added that the relation of an individual to his life-world had to be that of phenomenological inquiry. Therefore, man cannot abstract himself from a living-world, but is embedded into a world that cannot be separated from the social, cultural and political context. Heidegger referred to these phenomena as 'being in the world' and 'situated-freedom'. These important landmarks drawn by Heidegger, Michel Foucault (Stahl & McBride, 2005:3-6) introduced structuralism and post-modernism to existentialism. He stated that the specific underlying conditions of truth that constituted what are applicable and what is not, is present in each distinctive period in history. Crowell (2004:9-10) referred to the notion of authenticity that progressively emerged from existentialism. Authenticity in existentialism refers to the integration of man's freedom by man himself, in the attempt to attain meaning and to direct value and morality.

As with the progressive attempts of many philosophies, existentialism's origin and development was initially associated with atheism and later underwent a theistic phase (Banach, 2006:01). The researcher's meta-theoretic assumptions are directed from a Christianity world-view and therefore, existentialism is viewed from a Christian-perspective, where God is central to essence and existence.

The authentic leader in nursing and the professional nurse are two concepts central to this research and therefore existentialism is argued to be an appropriate philosophical departure

point. The authentic leader in nursing and the professional nurse are people with a purpose-driven life and can exert freedom of choice with the associated responsibilities and consequences. Therefore, investigations into the authentic leader in nursing (also referred to as the authentic leaders in nursing) and the professional nurse should be comprehensive and in-depth. The concept analysis of the authentic leader will portray an in-depth investigation. In addition to the above, the work of Covey (2004), Collins (2001) and George and Sims (2007) on leadership share an existentialistic view on man and organisation. It is therefore argued that the researcher's meta-theoretical assumptions could be correlated with existentialism and with the view of man as depicted by the theories utilised as a framework for concept analysis.

1.7.2.3 Critical social theory

Critical social theory is a prominent philosophy in qualitative research methodologies (Burns & Grove, 2005:62-63). The main focus of critical social theory is to view the content of social phenomena within a specific context, and considering the history of that context. These social phenomena manifest in societies that function as closed systems and portray specific patterns. It is believed that critical philosophy could provide critique that could be applied to address the limitations of knowledge, to enhance moral autonomy (Robinson, 2008:1).

After Marx and Kant, Habermas (Ali-Hassan, 2005:1) evolved as a renowned philosopher on critical social theory. He explored the epistemological discussions of the critical social theory by promoting the real purpose thereof – to understand the symbolic meaning of people. Most people might be unaware of these symbolic meanings until they start to question the legitimacy thereof. When challenging the legitimacy of these symbols, insight is gained. This insight indicates that order within society is only maintained through dominion relations. According to Habermas, critical social theory research could uncover these 'invisible' structures within society and enhance free, unforced and equal societal participation. These place researchers in the driver seat to liberate humans from oppressive structures and to facilitate actualisation of their potential. Change can only be facilitated through research and by criticizing the negative societal order.

The motivation for support of critical social theory in this research is multiple. Firstly, Karl Marx played a fundamental role in critical social theory, and therefore social theory can also be associated with social capital in its early and underdeveloped era. Secondly, critical social theory's focus is reflected on social phenomena. As social capital also refers to networks and groups within society, it serves as the second association to the

appropriateness of critical social theory. Thirdly, critical social theory warns the researcher that 'invisible' social structures may play a dominant role within society and this could influence moral autonomy. This philosophical critique of social phenomena to address the risks of dominions, oppression and exploitation is warned of in social capital. Within the study of social capital there is a distinction between positive and negative social capital. Positive social capital refers to the benefit it has, whilst negative social capital might lead to unlawful events. A fourth motivation and application of critical social theory with this research is the acknowledgment of society that contains specific social structures. This view is not only synonymous with the researcher's paradigmatic perspective of society, but is also applicable to social capital. Social capital refers to specific social structures and reveals that the different forms of obtaining social capital are bridging, bonding and linking networks or ties. This indicates that different types of social capital and processes to obtain different types of social capital can be identified.

The final motivation for the use of critical social theory within this research is the underlying goal of critical social theory that is stipulated in the liberation of humans from oppressive structures to facilitate the actualisation of their potential. It can be viewed that social capital has been introduced to investigate the equal and appropriate division of resources, the focus of positive social capital, the damasking of negative social capital to ultimately enhance the health of the individuals in the greater community. Social capital can serve as a tool to help humans in the process of self-actualisation of their potential.

1.7.3 Theoretical assumptions

Theoretical statements are the testable statements that provide epistemic findings about the research domain (Botes, 1995:10). The theoretical assumptions utilised in this research are categorised into the central theoretic statement, conceptual descriptions central to this study and theories and models of social capital and authentic leadership that will be used as departure point.

1.7.3.1 Central theoretical statement

The 21st century is characterised by fast pacing change brought about by the information era. Nursing, as part of the greater socio-economic sphere, has also been warned of challenges brought about by this change. Factors such as an ageing workforce, capitalism and a consumer society, internationalisation and nurse shortages as well as the effect of advanced technology, pose challenges to the nursing profession. There is an international call to develop a new type of leader, authentic leaders in nursing, to lead the nursing profession

through these new challenges. Social capital has been distinguished as a useful managerial tool to assist with 21st century challenges. This leads to an argument that a theory in Nursing Science, about authentic leadership that is embedded in a social capital framework, might be beneficial to address the above problem.

Based on above background, this research's central theoretic statement is as follows:

It is argued that a comprehensive literature review may lead to the identification of main and related concepts that, in turn, could develop into concept identification, description, definitions and analysis. After main and related concepts have been analysed, relational meaning can be constructed between these concepts, which could be used to construct a theory of authentic leadership embedded in social capital, in Nursing Science. With a panel of experts' input, this constructed theory can be evaluated and refined into a valuable contribution. Such a contribution would be a theory to assist authentic leaders in nursing to lead the challenged nursing profession, utilising this theory.

1.7.3.2 Conceptual descriptions

The following concepts are central to this research and will be described shortly:

Theory: A set of integrated and defined concepts and relational statements that sketch a phenomenon. A theory can be used to describe, predict, explain and/or control the phenomenon (Chinn & Kramer, 1991:79; Walker & Avant, 2005:28).

Authentic leadership: Due to the ill-defined critique that George's definition received (Pai, 2001:2); the definition of authentic leadership will combine Collins (1991:20), Covey (2004:89) and George's (2007:11) definitions. Leadership is both the communication to people, of their value and potential, in such a clear way that they come to see it, in themselves and to catalyse commitment to and vigorous pursuit of a clear and compelling vision and to stimulate the group to high performance standards. Leadership is a choice of moral authority that exceeds formal position. Authentic leadership focuses on being you rather than focusing on style.

This definition serves as the conceptual description before the concept analysis of authentic leadership is conducted. The researcher acknowledges that this description might change after a comprehensive concept analysis is completed.

Embedded: When an essential part or characteristic(s) is incorporated or contained in something else (Dictionary.com Unabridged, 2006:1)

Social capital: For the purpose of this research the definition of social capital by the World Bank will apply: "*...the institutions, relations, and norms that shape the quality and quantity of a society's social interactions. Social capital is not just the sum of the institutions which underpin a society; it is the glue that holds them together*" (The World Bank, 2008:1).

The conceptual description for social capital as provided by the World Bank, used in this research, is subject to change following concept analysis thereof.

Framework: A structure or a frame that is composed by different parts, fitted and joined together (Dictionary.com Unabridged, 2006:1).

Nursing Science: The body of knowledge that is composed of research findings and tested theories, pertaining specifically to the discipline of nursing. Nursing Science is a continuous process that contains research products (Burns & Grove, 2005:8).

1.7.3.3 Models and theories of social capital and authentic leadership

The following paragraphs outline the selected social capital and authentic leadership theories that direct this research's central concepts.

1.7.3.3.1 Model and theories of social capital

The social capital models and theories supported in this research can be summarised as follows:

- Dimensions of social capital
    - Trust (Coleman, 1988; Fukuyama, 2001:7-20; Putnam, 1993) as well as Covey and Merrill (2006).
    - Rules and norms governing social interaction (Coleman, 1988, Fukuyama, 2001:7-20; Portes and Sensenbrenner, 1993:1320-1350).
    - Types of social interaction (Snijder, 1999:27-44).
    - Group characteristics, generalised norms, togetherness, everyday sociability, neighbourhood connections, volunteerism and trust (Narayan & Cassidy, 2001:59-102).
    - Views of social capital by Woolcock (1998).

- Theories of capital (Lin, 1999:28-51).
- Types of social capital (Claridge, 2004:1).

1.7.3.3.2 Theories of leadership

Investigations into leadership have received great attention in the literature, if one acknowledges the amount of information available about this concept. After investigating a large amount of leadership theories, the researcher selected to support the following leadership theories in this research:

- authentic leadership (George, 2007:1-15; George and Sims, 2007; Goffee & Jones, 2005);
- inspiring others to find their voice (Covey, 2004:99-121, 352-359); and
- effective leadership and a Level 5 Executive (Collins, 1991:20).

1.7.4 Methodological assumptions

The final assumptions for discussion are the researcher's methodological assumptions. Botes' (1995) research model for Nursing Science enjoyed the majority of attention. Attention is also granted to the assimilation of epistemology.

1.7.4.1 Epistemology

The researcher strives to produce research results that approximate the true reality as far as possible. Therefore, epistemology will serve as the starting block for discussion. *Epistemology refers to the reliable and valid understanding of a reality that exceeds the mere* understanding of the research phenomenon (Mouton & Marais, 1994:8). The focus of epistemology rests on truth, belief and the standards of justification of knowledge claims (Dictionary.com Unabridged, 2006:1). Through the development of science, the epistemological ideal of the quest for truth can only be appreciated in a retrospective manner. The development of social sciences and social science research has pressed towards the development of a greater epistemological appreciation. When entering social science research, the researcher does not have take a position that is in total opposition to the positivism. On the contrary, Mouton and Marais (1994:15) have already proclaimed that the "complexity of the research domain of the social sciences, and the inherent inaccuracy and fallibility or research it is necessary to accept that complete certainty is unattainable". To the researcher, this implies clear warning that a continuous awareness and strive to obtain the 'truth' in this research, should enjoy an important position in the comprehensive research

process. This motivates why the researcher submits continuous reference to strategies that will ensure validity.

This research's overall aim is to construct an authentic leadership theory that is embedded in a social capital framework in Nursing Science. The derived concepts, that will be the building blocks of the theory constructing process, will be the product of extensive literature searches. It is therefore extremely important that the researcher maintains the highest quality of rigor in this research process. This is especially important when one is reminded of the complexity of social capital's meaning it's relation to authentic leadership in nursing.

1.8 RESEARCH DESIGN

The purpose of this research is to construct a theory of authentic leadership embedded in a social capital framework in Nursing Science. This purpose can be most effectively reached through a qualitative research design that is theory-constructive; qualitative; explorative; descriptive and contextual (Burns & Grove, 2005:55, 238). In the following paragraphs a condensed description of each of these components are provided, accompanied by the reasons for and applications thereof, in this research. The research design is discussed in detail in Chapter Two.

1.8.1 Theory-constructive

According to Chinn and Kramer (1991:26) theory construction is a multi-step process, where empirical evidence is used in "an interrelated system of ideas" (Walker & Avant, 2005:135). During theory construction the focus is on the constructs of research (concepts; statements and conceptual frameworks), followed by the systematisation of statements, in order to classify, describe or explain typologies, models or theories (Klopper, 1994:31). The process of theory construction is based on indirect observation and literature searches. It is a continuous written discourse that depends on deductive and inductive logic, concept analysis and statement synthesis. The main and related concepts to a theory for authentic leadership, embedded in a social capital framework, will be identified and analysed. Thereafter, statements will be synthesised between the analysed concepts, and a theory will be constructed. The process of theory construction will be detailed in Chapter Two (refer to 2.3.2).

1.8.2 Qualitative research

Qualitative research refers to an interpretive and naturalistic approach whereby things are studied in their natural settings, in an attempt to interpret phenomena or to make sense thereof (Denzin & Lincoln, 2000:3). Qualitative research applies a holistic approach, with underlying principles, and considers that there is not one reality but rather multiple perceptions. These perceptions are also contextual in nature (Burns & Grove, 2006:23). The goal of qualitative research is to understand the meaning through a process of structural reasoning. In this research, the aim is to construct a theory of authentic leadership embedded in a social capital framework in Nursing Science. The qualitative inquiry nature of this research is discussed in detail in Chapter Two, point 2.3.3.

1.8.3 Explorative

The aim of exploratory research is to explore the full nature of a phenomenon with regard to the manner in which the phenomena exists and manifests as well as any other related factors, by means of a formally documented exploration (Burns & Grove, 2005). Through this exploration, the researcher gains more knowledge about the phenomena that is explored. This research aims to explore authentic leadership and social capital as part of theory construction.

1.8.4 Descriptive

According to Mouton & Marais (1996:43), the aims of a descriptive study are to discover new facts about a phenomenon and to provide in-depth feedback of the phenomenon's characteristics. This research will launch an in-depth study into ideas that will be structured into concepts using symbols and words (Chinn & Kramer, 1991:72-73). Literature searches will be used to gain all available information about main and related concepts. Literature searches will be utilised in the form of concept identification, descriptions, definitions and analysis. In Chapter Two, point 2.3.4, discusses the descriptive design follows.

1.8.5 Contextual

A context can be defined as the "circumstances and conditions that 'surround'" as well as the background stimuli that accompany foreground events (Dictionary.com Unabridged, 2006:1). As qualitative research aims to understand perceptions rather than reality, these perceptions will be specific in a specific context (Burns & Grove, 2005:54). According to the research model by Botes (1995:6) the research context refers to its universal or contextual nature

whereas Mouton and Marais (1994:11) distinguished the ontological dimension in order to answer, "What is the reality of the research domain?" Due to this study's qualitative nature and the direction provided by Botes (1995) and Mouton and Marais (1994), the context of this study is sketched in detail in Chapter Two number 2.3.5.

1.9 RESEARCH METHOD

The research method refers to the steps in the research process that the researcher followed to obtain the stated aim and objectives. The steps in this process can be listed as the methods of data collection; the population and sampling procedure; data analysis and description of research results and finally ensuring rigor.

The purpose of this research is to construct a theory for authentic leadership embedded in social capital in Nursing Science. An overview of the research methods that is planned for this study is outlined in Table 1.2.

1.10 ETHICAL CONSIDERATIONS

The researcher acknowledges the importance of approved ethical guidelines when conducting any research. To ensure optimal ethical conduct, the researcher followed the code of ethics of the North-West University (Potchefstroom Campus) as adhered to in the Belmont Report (1979) on ethical principles and guidelines for the protection of human research subjects. Based on these principles, the researcher strived to ensure the principles of respect for others, beneficence and justice in the following manner:

- A research proposal was submitted to the Ethical Committee of the North-West University (Potchefstroom Campus). The Ethical Committee has granted consent (Certificate nr: 07K01). (Please refer to Annexure B to view this certificate).
- The researcher utilised the North-West University's (Potchefstroom Campus) principles on the prevention of plagiarism.
- The researcher maintained the anonymity and confidentiality of participants.

Please refer to point 4.6 in Chapter Two for a detailed discussion on the ethical considerations adhered to in this research.

1.11 STRUCTURE OF THIS THESIS

The outline of the chapters in this thesis is as follows:

- Chapter One: Overview of research and philosophical positioning.
- Chapter Two: Scientific justification of the research design and research method.
- Chapter Three: Conceptual framework: agent, recipient and context.
- Chapter Four: Conceptual framework: procedure, goal and dynamics.
- Chapter Five: Theory description, - evaluation, - refinement and guidelines for operationalisation.
- Chapter Six: Evaluation of the study, limitations and recommendations for Nursing Science, -practice and –research.

1.12 SUMMARY

In Chapter One the researcher provided an overview of the planned research. The relevant concepts were defined and the research design and method was outlined. Attention was granted to the ethical considerations in this research. Chapter Two details the research design and method.

Table 1.2 Overview of the research methods planned for this research

Aim of this research is to construct a theory of authentic leadership embedded in a social capital framework in Nursing Science				
Research Objectives	**Data Collection**	**Population & Sampling**	**Data Analysis**	**Rigor**
PHASE 1: CONCEPT IDENTIFICATION, DESCRIPTION, DEFINITION AND ANALYSIS				
STEP 1: **To identify main and related concepts**	Literature searches (Walker & Avant, 2005:67)	**Population:** All available national and international sources of data (Walker & Avant, 2005:67). **Sampling:** Purposive sampling (Denzin & Lincoln, 1994:228), N=425 due to data saturation (Denzin & Lincoln, 1994:230).	Survey list of Dickoff, James & Wiedenbach (1968:415-435)	Guba's model (Lincoln & Guba, 1985)
STEP 2: **Concept descriptions, definitions and analysis**	Literature searches (Walker & Avant, 2005:67)	**Population:** All available national and international sources of data (Walker & Avant, 2005:67). **Sampling:** Purposive sampling (Denzin & Lincoln, 1994:228). N = 425, data saturation (Denzin & Lincoln, 1994:230).	Content analysis (Walker and Avant, 2005; Wilson, 1987).	Deductive logic Guba's model (Lincoln & Guba, 1985)

Table 1.2 continues

PHASE 2: THEORY CONSTRUCTION				
Research Objectives	**Data Collection**	**Population & Sampling**	**Data Analysis**	**Rigor**
STEP 1: **To construct relational meaning of main and related concepts**	Results of Phase 1: Step 1 and 2	**Population:** All available national and international sources of data (Walker & Avant, 2005:67). Formulated conclusion statements of the main and related concepts. **Sampling:** Conclusion statements n=36	Statement synthesis (Walker & Avant, 2005:85-108)	Deductive logic and strategies to enhance trustworthiness by Guba and Lincoln (1985:290)
Step 2: **Theory construction through theory synthesis**	Results of Phase 2: Step 1		Theory construction process through theory synthesis (Walker & Avant, 2005:135-147)	Deductive and inductive logic, strategies to enhance trustworthiness by Guba and Lincoln (1985:290)

Table 1.2 continues

PHASE 3: THEORY EVALUATION, REFINEMENT AND GUIDELINES FOR OPERATIONALISATION				
Research Objectives	**Data Collection**	**Population & Sampling**	**Data Analysis**	**Rigor**
STEP 1: **To evaluate and refine the theory of authentic leadership embedded in a social capital framework in Nursing Science**	Results of Phase 2: Step 2 and an evaluation report compiled according to points for critical reflection of a theory (Chinn & Kramer, 1991)	Evaluation of the theory by a panel of experts (Chinn & Kramer, 1991). **Population:** Experts in the area of theory construction and/or authentic leadership and/or social capital. **Sampling:** Purposive sampling according to inclusion criteria (Denzin & Lincoln, 1994:228), (n = 6).		Strategies to enhance trustworthiness by Guba and Lincoln (1985:290)
STEP 2: **To formulate guidelines for operationalisation of the theory**	Results of Phase 2: Step 1		Inductive and deductive logic	Strategies to enhance trustworthiness by Guba and Lincoln (1985:290)

CHAPTER TWO

SCIENTIFIC JUSTIFICATION OF THE RESEARCH DESIGN AND RESEARCH METHOD

2.1 ORIENTATION TO THE CHAPTER

Before activating this research project, the researcher decided to endeavour the creative journey of theory construction. As a junior researcher, the question was predominantly on the 'why' rather than on the 'how'. Harnessed with great supervision, flowing creativity and the discipline to learn, the researcher started with the end picture in mind: to construct a theory in order to better understand the phenomenon under investigation. The researcher's motivation to investigate theory construction is synonymous with that of Walker and Avant (2005:25), who warns beginner researchers of the complexity and sometimes-abstractive nature of theory construction.

At the end of Chapter One an overview of the research method was provided. Chapter Two aims to deliver an extensive discussion of the research design and -methods that will serve as the blueprint to obtain the stated research aim. The planned format for Chapter Two is to organise the content of the research methods in accordance to the research aim and -objectives. As stated in Chapter One, the overall aim of this research is to construct a theory for authentic leadership embedded in a social capital framework in Nursing Science. This aim has been divided into five consecutive objectives that are exerted to discuss the research methods selected. Strategies employed to optimise trustworthiness are discussed and attention is given to the research's ethical considerations.

2.2 AIMS AND OBJECTIVES

The researcher acknowledges that the research question(s) directs the research aims and objective(s). In this research the question "How can a theory of authentic leadership embedded in a social capital framework in Nursing Science be constructed?" serve as indicator for the research aim and objectives. Therefore, discussions on the selected research methods applied in this research are categorised in accordance to the sequential research objectives to be obtained through this research (please refer to Figure 2.1 on the following page).

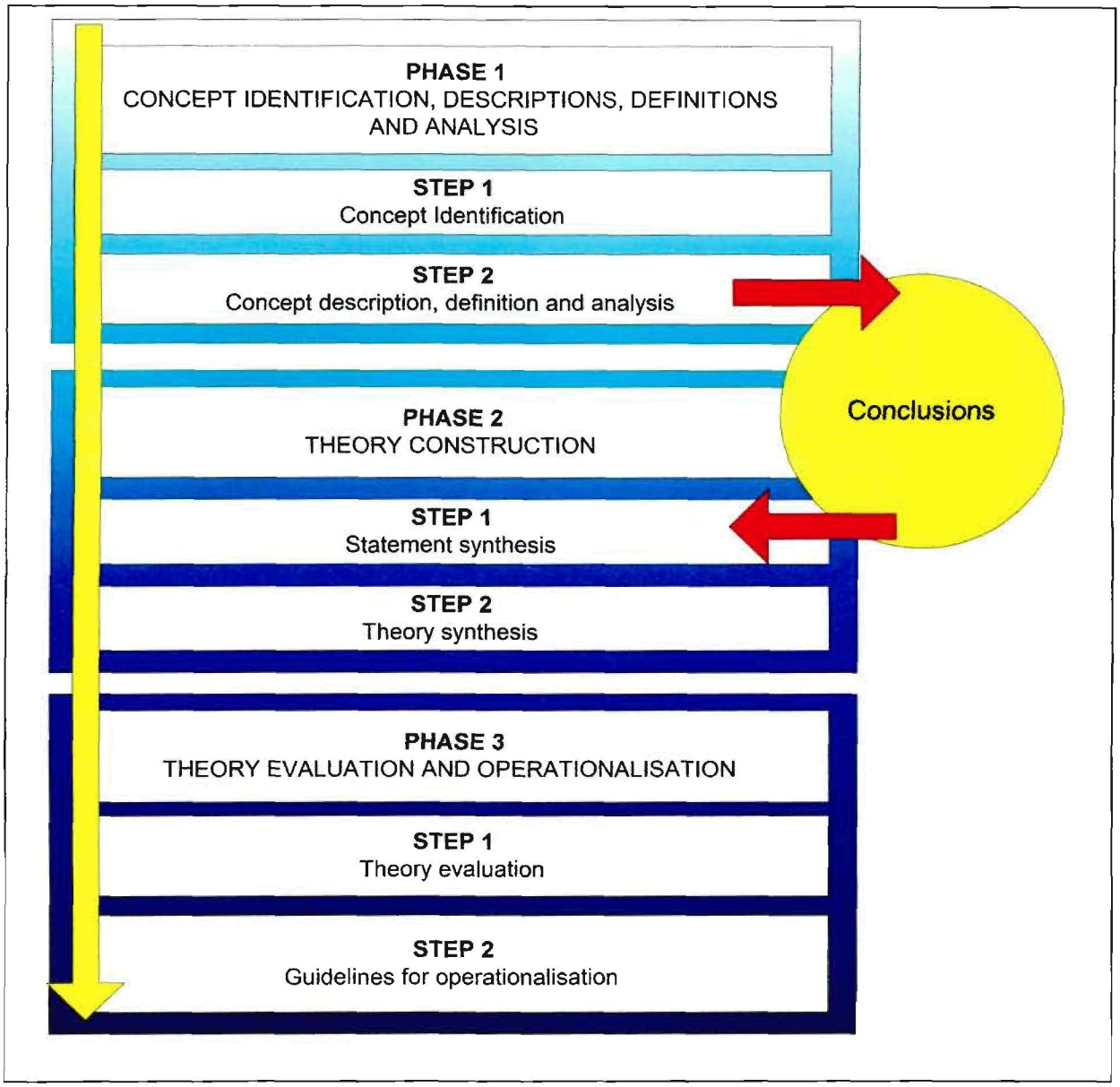

Figure 2.1 Flow of this research process

2.3 RESEARCH DESIGN

The purpose of this research is to construct a theory for authentic leadership embedded in a social capital framework in Nursing Science. A qualitative research design is used, it is theory-constructive, qualitative, explorative, descriptive and contextual (Burns & Grove, 2005:55) in nature.

2.3.1 Theory-constructive

The term 'theory' derives from the Greek work *theorio*, which means to consider, assess or think through (Hunink, 1995:73). This study has selected to utilise Kerlinger's (1973:9) definition of theory. According to Kerlinger a theory is "...a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations between variables, with the purpose of *explaining* and *predicting* phenomena". Added to Kerlinger's definition, Walker and Avant (2005:28) referred to the *describing* and *prescription* or *control* purposes of theories.

The process of theory construction is a qualitative research approach and thus dependent on inductive reasoning to explain, describe, predict or control the phenomena that is studied. Through the process of theory construction, the researcher gains greater understanding of how social capital can be used as a framework for authentic leadership in Nursing Science.

Theory construction is a continuous process that commences in the background and problem statement components of the research project (Chinn & Kramer, 1991) and directs the research method accordingly. Theory construction focuses on the constructs of research and the relationship between these constructs that leads one to classify, describe and/or explain. In this research, the main and related concepts are identified as the first step in the research objectives. After classifying and defining concepts, the relational statements and the theory are synthesised. The following paragraphs discuss unfolds the classification and elements of theory construction. This discussion aims to provide literature about theory construction in order to justify this study with scientifically.

2.3.1.1 Classification of theory

Literature on theory construction provides various categories into which theories can be classified. Theories can be classified in terms of the function of the theories, the levels thereof or the scope/range of the theories (Hunink, 1995:27-30). After short description of each type of classification is given, the application of these classifications in this research is described.

2.3.1.1.1 Function classification

Functional types of theories are classified according to how these theories relate to reality. Some theories aim only to *describe* and/or *explain* existing phenomena. Furthermore, theories that can describe and explain can be developed in order to *predict* a phenomenon. A fourth type of function theories is *prescriptive* theories that aim to provide propositions with

the focus on changing an existing situation. The following graphic presentation provides an example of function-oriented theories (Hunink, 1995:28).

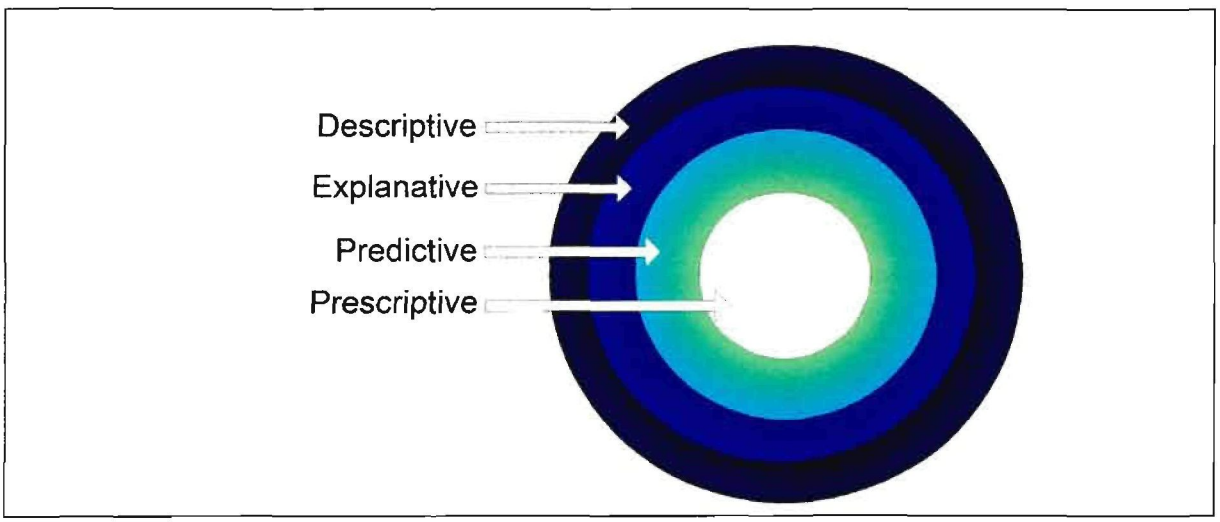

Figure 2.2 Functional classification of theories (Hunink, 1995:27-30)

The functional classification of theories implies a progressive relationship. In other words, in order to have a theory that can prescribe the predictive nature of the phenomena should be clear. This is only possible if the phenomena is comprehensively explained and described. In this research the aim is to construct a theory of authentic leadership embedded in a social capital framework in Nursing Science. This implies that a platform should be established during theory construction to describe and explain the main and related concepts. Once concepts have been analysed and relational meanings formulated, a theory for authentic leadership embedded in a social capital framework, could be constructed. In this research the process of theory construction, formulated by Walker and Avant (2005:32) enables the researcher to select, identify and analyse the central and related concepts.

2.3.1.1.2 Level classification

According to Dickoff, James and Wiedenbach (1968:419-420), a theory should be goal-directed and value driven. Dickoff *et al.* classified theories into four distinctive levels that are listed as follows:

- the first level of theories is *factor-isolating* theories that involves the classification or naming of phenomena;
- the second level is *factor-relating* theories, this implies associating or correlating factors in a manner that ensures that it forms part of a larger unit that can meaningfully depict a situation;

- the third level of theories is *situation-relating* which explains and predicts how situations are related, whilst
- the fourth level of theories is that of *situation-producing*, this requires sufficient knowledge about how and why situations are related.

The level classification of theories according to Dickoff *et al.* is depicted in the following figure:

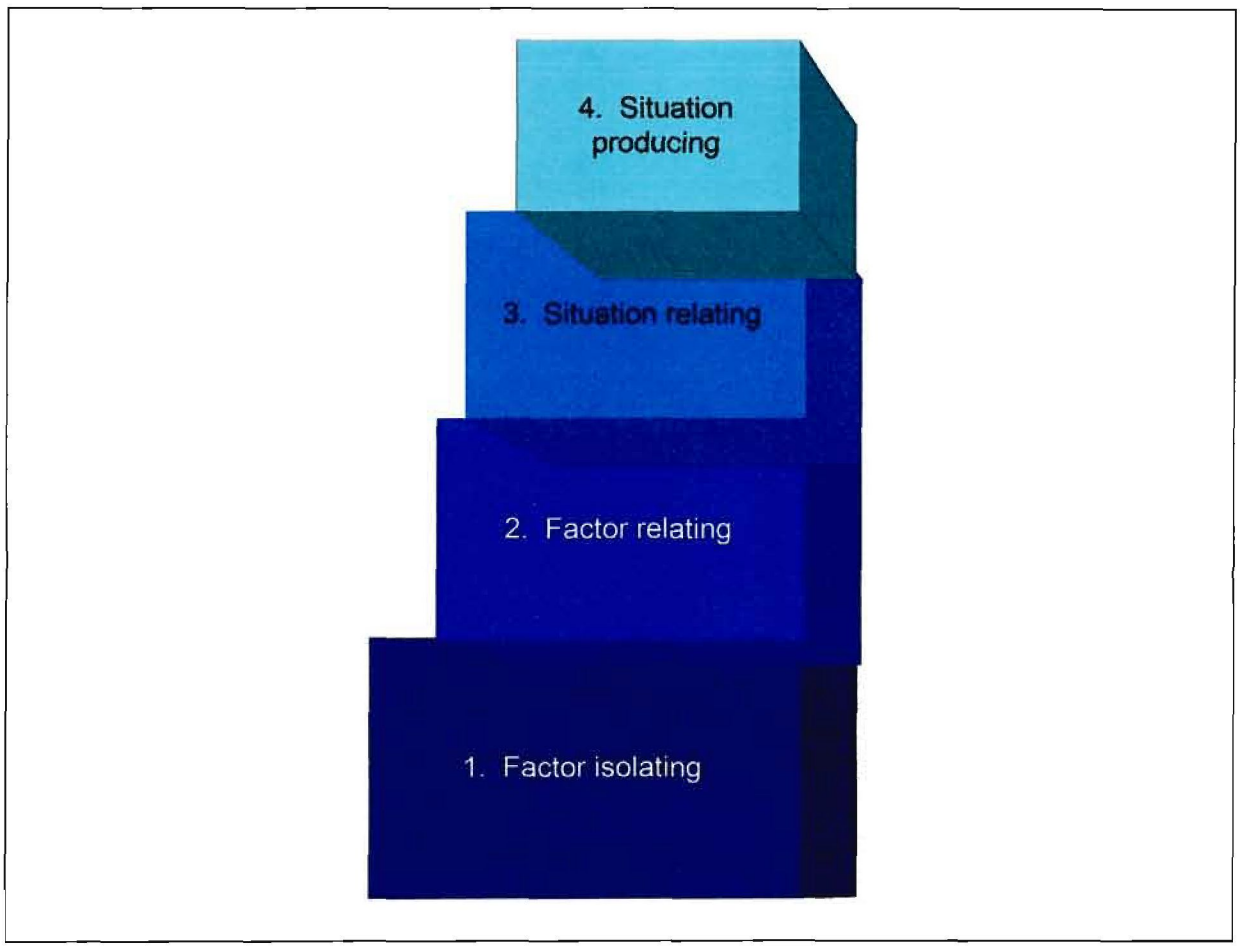

Figure 2.3 Level classification of a theory (adapted from Dickoff *et al., 1968:419-420)*

In this research the process of concept identification is conducted according to Dickoff *et al.*'s (1986:417) survey list. Although these authors' directed theory classification towards practice level theory, they explained that there is an important and interdependent dynamic between theory and practice. Therefore, it is argued that the survey list could be applied to this research.

2.3.1.1.3 Scope of range classification

The third classification of theories is done according to the theory's scope of range (Walker & Avant, 2005:16). The range or scope refers to the means in which the theory covers different areas of reality (Hunink, 1995:29) or the different levels of abstraction. Micro-level theory relates to a single phenomenon and is also referred to as *practice-theory* or single-domain theory. *The middle-range* theory is concerned with various related phenomena. A *grand theory* refers to the wide-ranging and most abstract type of theory that presents with a broad framework and broad perspectives. Finally a *meta-theory* is described as the epistemology and methodology of developing theories. Please refer to the graphic presentation (Figure 2.4) of the different ranges or scopes of theories, below:

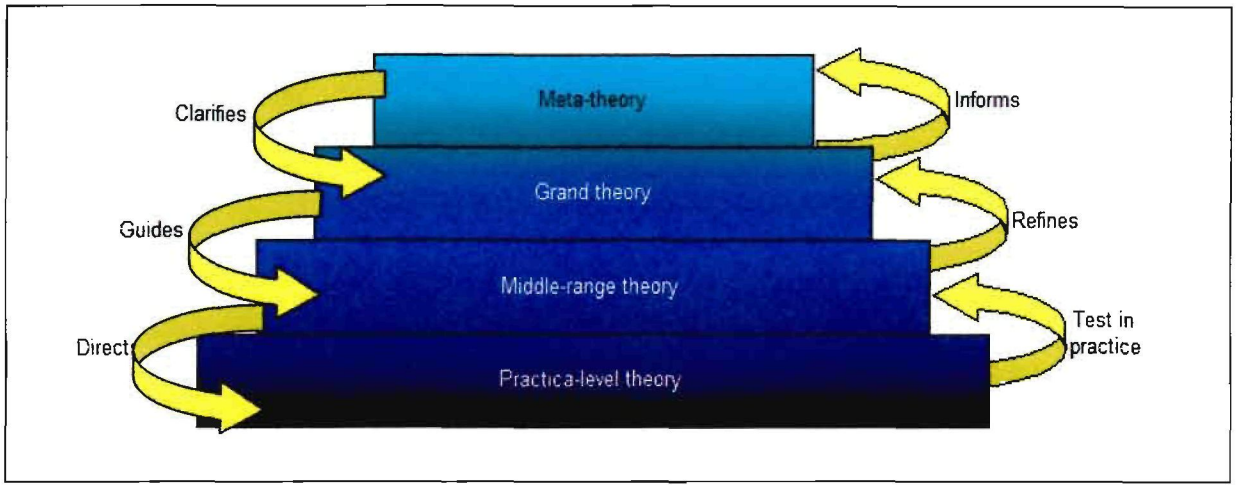

Figure 2.4 Scope of range classification of theories (Walker & Avant, 2005:16)

In this research, the classification of theories and theory construction are supported as referred to by Walker and Avant (2005:16). Walker and Avant acknowledge that theory construction cannot only be classified by function, scope or level. The question asked in return is 'do the levels of theory development relate to each other?' In this research, according to the classification of theories, a theory of the middle-range will be constructed. This implies restricted variables that might be limited in scope (Walker & Avant, 2005:13) but, it is envisaged that the constructed theory could be testable. The application of the theory classifications regarding function, level and scope is summarised in the following table:

Table 2.1 Applied theory classification criteria in this research

Classification criteria	Application in a theory for authentic leadership embedded in a social capital framework in Nursing Science, constructed according to Walker and Avant (2005:16)
Functional classification	Describe, explore, predict
Level classification	Situation-producing
Scope classification	Middle-range theory

This research aims to construct a theory for authentic leadership embedded in a social capital framework in Nursing Science. The above table portrays how the different classification criteria for theories apply to this research. Concerning functional classification, the researcher describes, explains and predicts the main and related concepts. With regard to level classification, a situation-producing level is present. Relating to the scope classification of theories, this constructed theory could be classified as a middle-range theory.

2.3.1.2 Elements and strategies of theory construction

The following elements form part of the process of theory construction: concepts, statements and a theory. According to Hunink (1995:74) a concept can be defined as the term or label that is used to describe a basic phenomenon or group phenomena as a means to understand reality (Mouton & Marais, 1994:126). Although concepts are used to classify experiences in a meaningful manner, it may be even more efficient to describe the relationship between concepts (Walker & Avant, 2005:27). Therefore, concepts could be regarded as the building blocks of a theory. The relationships between concepts are referred to as statements. The theory generative elements in this research are the *concepts* that are selected and identified from a literature study. The concepts are identified according to the survey list by Dickoff *et al.* (1968:419-420). After the concept(s) are identified, described, defined and analysed, *statements* are developed. By developing statements in relational meaning, the *theory* for authentic leadership embedded in a social capital framework in Nursing Science is described.

Walker and Avant (2005:32) proposed nine strategies towards theory construction by using the elements of theory. By utilising of the elements of theory (concept/statement/theory) three approaches to theory construction are isolated: synthesis; derivation and analysis. The selection of a theory building strategy is subjective to the availability of literature; the researcher's area of interest; whether the focus rests upon the concepts statements of an

overall theory as well as the quality of these elements. In the following schematic outline, the various strategies for theory construction as cross-classified by Walker & Avant (2005:32) are demonstrated. The applicable strategy selected for this research is highlighted and it is followed by motivation for the selection of this strategy.

ELEMENTS OF A THEORY	APPROACHES TO THEORY CONSTRUCTION		
CONCEPT	**Concept synthesis:** to extract concept(s) from a body of data	**Concept derivation:** shift/redefine concepts from one field to another	**Concept analysis:** clarify/redefine an existing concept
STATEMENT	**Statement synthesis:** to extract state-ment(s) from a body of data	**Statement derivation:** shift/reformulate the content/structure of statements from one field to another	**Statement analysis:** clarify/refine an existing body of statements
THEORY	**Theory synthesis:** to build a theory from a body of data	**Theory derivation:** Shift/reformulate the content/structure of theories from one field to another	**Theory analysis:** Clarify/refine an existing theory

Figure 2.5 Cross-classification of theory construction strategies (Walker & Avant, 2005:32)

For the purpose of this research, **concept analysis; statement synthesis** and **theory synthesis** have been identified as the most effective strategies to obtain the stated research aim. Concept analysis implies the process of concept identification according to the survey list of Dickoff *et al.* (1968:420). As an initial step towards theory construction, concept identification is viewed as an important intervention as it directs the rest of the theory construction process. Extensive literature studies are conducted prior to and during the process of theory construction. To select concepts that are highly abstract in order to retain meaning, even when the term is removed from a specific situation, is the primary challenge that surrounds concept identification. Yet, the concept should remain identifiable and have clear boundaries (Walker & Avant, 2005:66). The next challenge is to avoid primitive terms that can only be defined by providing examples as well as umbrella terms. The latter refers

to concepts that are so broad that they can encompass a variety of meanings and lead to confusion. The selected concept(s) should be important and significant to the research problem and should further theoretical development (Walker & Avant, 2005:63).

For the purpose of this research, two concepts were selected during the initial literature study. These concepts are *social capital* and *authentic leadership.* These listed concepts were selected for the following reasons:

- these concepts represent the core interest in this research;
- these concepts reflected the researcher's interest;
- the analysis of social capital and authentic leadership may further theoretical development in nursing; and
- it may assist the researcher in attempting to clarify social capital and authentic leadership that lack consensus in definition from the literature. As social capital and authentic leadership can be viewed as abstract – and umbrella terms, this may complicate the concept analysis process.

2.3.2 Qualitative inquiry

A qualitative inquiry refers to an investigation into phenomena in order to gain a better understanding thereof. According to Denzin and Lincoln (2000:3), the term "qualitative research" implies an interpretive and naturalistic approach where things are studied in their natural settings in an attempt to interpret phenomena or to make sense thereof. Considering the above, it is argued that this research's overall aim can be obtained, predominantly through a qualitative research design. Due to the human responses and processes that are present in constructing a theory for authentic leadership embedded in a social capital framework in Nursing Science, a qualitative research design would enable the researcher to conduct concept identification and analysis as well as statement synthesis and theory construction. Selecting a qualitative research design, paves the way to both see the 'picture' (that of a theory for authentic leadership embedded in a social capital framework in Nursing Science) and to portray this 'picture' by assigning meaning to it.

2.3.3 Explorative

Exploratory research aims to gain more knowledge of phenomena by exploring its full nature while documenting this exploration formally (Burns & Grove, 2005). In this research the main and related concepts are explored through the process of concept identification and – concept analysis. The extensive exploration of all available national and international

literature sources (Walker & Avant, 2005:67) was conducted to describe the main and related concepts and to analyse social capital and authentic leadership.

2.3.4 Descriptive

The aims of a descriptive study are to discover new facts about a phenomenon and to provide in-depth feedback on its characteristics (Mouton & Marais, 1996:43). In this research literature searches were completed to obtain all available national and international information about main and related concepts. Furthermore, an in-depth study was conducted to identify, describe, define and analyse the main concepts. The related concepts were identified and their content analysed by means of a literature review (Walker & Avant, 2005:67). The formulation of conclusion statements and relational statements serve as another descriptive intervention in this research. All of these descriptive actions are structured into a theory, applying symbols and words (Chinn & Kramer, 1991:72-73).

2.3.5 Contextual

The specific contextual nature that is central to qualitative research (Burns & Grove, 2005:54) also serves as an integral aspect towards enhancing trustworthiness. The construction of a theory for authentic leadership embedded in a social capital framework in Nursing Science was conducted within a context specific to this research. This context is discussed in terms of the micro-, meso- and macro levels. An in-depth discussion of the context in this research is done in Chapter Three point 3.6. Please refer to Figure 2.6 for a graphic depiction of this research's context. A summary of the research context is outlined as follows:

Micro-level: South African hospitals

- Both public and private hospitals;
- high patient turnover within a business model with a profit focus in the private sector;
- remuneration dissatisfaction;
- staff shortages and brain drain;
- HIV/AIDS, TB;
- crime, poverty, unemployment, cultural diversity;
- medical schemes and private patients versus public patients; and
- prescribed minimum benefits.

Meso-level: The Republic of South Africa

- South African Constitution and the Bill of Rights;
- National Health Act nr 67 of 2003;
- 1994 democracy and post apartheid inequality;
- Department of Health;
- nine provinces;
- approximately 45 million South African citizens;
- poverty, crime;
- unemployment versus brain drain and skills shortages;
- HIV/AIDS and TB;
- National health plan with a primary healthcare focus;
- cultural diversity and Xenophobia;
- free healthcare to 80% of population;
- private healthcare to 18% of population and the private/public healthcare dichotomy;
- Council for Medical Schemes and the Medical Schemes Act (131 of 1998);
- Health Professions Council;
- South African Nursing Council; and
- political and economic instability.

Macro-level: International arena

- 21st century information age;
- advanced technology;
- globalisation and internationalisation;
- capitalism and a consumer society;
- ageing workforce; and
- nurse shortages.

2.5 RESEARCH METHODS

In the following paragraphs the research methods conducted in this research, are described. The discussion is sequenced according to the research objectives as stipulated in Figure 2.1. During the description of each phase and step in the research process, specific reference is made to the research objective, the data collection, population and sampling, the data analysis and applicable rigor.

2.5.1 PHASE 1: Concept identification, description, definitions and analysis

STEP 1: Concept identification

A concept is defined as a "complex mental formulation of experience" (Chinn & Kramer, 1991:58) and is categorised on a continuum that runs from empiric to abstract. Empiric concepts are concepts that are experienced more directly; whereas abstract concepts are constructed mentally. Simultaneously, abstract concepts are less likely to be directly measurable and are less concrete. Highly abstract concepts are referred to as *constructs* (Chinn & Kramer, 1991:60). The first step towards theory construction is concept identification.

Authors (Chinn & Kramer, 1991:58; Walker & Avant, 2005:66) noted that concept identification might be progressive and is initiated by the purposive review of literature and the awareness of various uses of similar words. It also entails examining a concept's significance in various contexts. After literature was studied in-depth, the survey list by Dickoff *et al.* (1968:420) was selected as a framework to assist the researcher in concept identification. The research method planned for Phase 1: Step 1 is provided in Table 2.2.

Table 2.2 Research process in Phase 1: Step 1 (Concept identification)

Steps in research process	Discussion and application in this research
Data collection	The method of data collection should support the purpose of this research (Chinn & Kramer, 1991:153), which is the constructing of a theory for authentic leadership embedded in a social capital framework in Nursing Science. The data collection process included a review of all data available nationally and internationally.
Population	The population in this study refers to all available national and international data obtained through a comprehensive and advanced literature searches.

Table 2.2 continues

Steps in research process	Discussion and application in this research
Sampling	Purposive sampling was achieved by means of literature searches (Chinn & Kramer, 1991:154). Polit, Beck and Hungler (2001:231) stated that the quality of research is subjective to the method of sampling. Both the adequacy and the appropriateness of a sample influence the quality of the research. In order to establish trustworthiness, data collection continued until data become saturated and when no new information was identified. Please refer to Chapter Three, point 3.2 and Chapter Four, point 4.2 for a discussion on the realisation of data collection in accordance with the search engines utlised for data collection of authentic leadership and social capital.
Sample size	The sample size was established when data saturation was reached. Data saturation refers to the repeated pattern of information that is established during the process of data-analysis (Denzin & Lincoln, 1994:230; Lo-Biondo-Wood & Haber, 1994:302). N = 106.
Data analysis	With regard to data analysis, Walker and Avant (2005:66) warned that the selection of concepts is an integral part of the theory constructing process and should be done with great care. They urged that concepts that are most critical to the research process and that would assist in achieving the research aim and objectives should be selected. The risk of identifying concepts that are not manageable and directly related to the research topic might lead to the termination of concept analysis, reverting to the very beginning of concept selection. The researcher acknowledged the importance of accurate identification of the main and related concepts and for this reason the survey list by Dickoff *et al.*, (1968:415-423) was used.

Table 2.2 continues

Data analysis (continues)	Although Dickoff *et al.* (1968:415-416) focused on the practice theories; they voiced the importance of the "practice to the problem to the theory" association. Furthermore, Dickoff and James (*in* Chinn & Kramer, 1991:68-69) stated that theory construction would unfold in a manner related to the study's purpose and therefore theory needs to be created deliberately, to obtain a specific purpose. Therefore, the survey list is an empirically grounded and organised guide that assists in achieving the purpose of theory construction. The survey list consists of the following elements: • the ***agent*** that refers to the who or what that performs the activity; • the ***recipient***, which is the who or what that stands at the receiving point of this activity; • a framework, that refers to the ***context*** in which the activity is performed; • the ***procedure*** – the guiding technique, procedure or protocol of the activity; • the ***goal***, which refers to the final result of the activity; and • the ***dynamic***, namely what is the energy source for the activity. The survey list by Dickoff *et al.* (1968:415-416) was selected due to the functionality thereof in the process of concept identification.

The survey list by Dickoff *et al.* (1968:415-420) was applied to this research in the process of concept identification and is illustrated in Table 2.3 (below). Please refer to Chapter Three, point 3.2, for a discussion on the realisation of concept identification.

2.5.2 PHASE 1: Concept identification, description, definitions and analysis

STEP 2: Description, definitions and analysis of main and related concepts

The process of concept analysis is a formal, linguistic exercise (Walker & Avant, 2005:63) that aims to determine a concept's characteristics. It starts off as a precise and rigorous process that terminates into a tentative final product. Concepts are compiled by defining characteristics and the description of these characteristics, enabling the researcher to list the elements that best describe the concept (Walker & Avant, 2005:64). Through concept

definitions, a concept is formulated in a manner that decreases vagueness and ensures that reference to a specific concept will be similar to the defined concept. This is essential should little be known about a concept, in a specific discipline.

Table 2.3 Applied survey list of Dickoff *et al.* (1968:415-423) for concept identification in this research

MAIN CONCEPTS	SURVEY LIST	RELATED CONCEPTS
Authentic leader in nursing	**Agent** The agent is the one who performs the activity.	
	Recipient Refers to the "who" or "what" that is at the receiving point from the activities of the agent.	Professional nurse
	Context The context refers to the framework in which the activity by the agent to the recipient is performed.	South African hospitals
Social capital	**Procedure** Procedure refers to the guiding technique, the protocol of the procedure of the activity conducted by the agent.	
	Goal Refers to the final result of the agent's activity.	Positive impact on triple bottom line
	Dynamics The dynamics imply the energy source; the impetus for the agent's performing activity.	Trust

The purpose of concept analysis is to clarify the meaning of a concept, to refine concepts in a theory that might be ambiguous and to clarify overused or vague concepts used frequently in the nursing practice (Walker & Avant, 2005:63). The main and related concepts identified in Phase 1, Step 1, serve as the building blocks for concept analysis (Walker & Avant, 2005:139) as the researcher anticipates that more than one concept may surface. Please refer to Table 2.4 for a description of the research process applied for concept description, definition and analysis.

Table 2.4 Research process for Phase 1: Step 2 (Descriptions, definitions and analysis of main and related concepts)

Steps in the research process	Discussion and application in this research
Data Collection	Extensive literature searches are conducted of all available national and international sources (Walker & Avant, 2005:64).
Population	The population is the selected main and related concepts that were identified in Phase 1.
Sampling	Purposive sampling was done in the form of literature searches (Chinn & Kramer, 1991:154).
Sample size	The sample size was established when data saturation was reached. Data saturation refers to the repeated pattern of information that is established during the process of concept description, concept definition and concept analysis (Denzin & Lincoln, 1994:230; Lo-Biondo-Wood & Haber, 1994:302). **N = 425**
Data analysis	After the processes of concept identification, related concepts were described and defined and main concepts analysed according to the guidelines by Walker and Avant (2005). This analysis process can be listed as follows: • Concept identification. • Determine the aims and objectives of the analysis. • Identification of all the uses of the concept that can be discovered. • Determine the defining attributes of the concept(s). • Definition of the concept(s). • Description a model case. • Identify antecedents and consequences. • Define empirical referents.

The comprehensive process of concept analysis of the main – and related concepts is described in Chapters Three and Four.

2.5.3 PHASE 2: Theory construction

STEP 1: Statement synthesis

Phase 2's first step is constructing relational meaning between the identified, described, defined and analysed concepts. It implies a process in which the researcher moves from research findings to general statements, during the process of statement synthesis. According to Walker and Avant (2005:87) "if concepts synthesised from practice or research are the building blocks of theory, then theoretical statements are the mortar that glues each block to its neighbour". During statement synthesis the researcher is urged to move from evidence to inferences, followed by the generalisation from specific inferences to more abstract ones.

Table 2.5 Research process for Phase 2: Step 1 (Statement synthesis)

Steps in the research process	Discussion and application in this research
Data Collection	The data collection during Phase 2 (Step 1) is the results from Phase 1, Step 1 and 2. Specifically, the identified, described, defined and analysed main and related concepts are utilised.
Population	The conclusion statements of the main and related concepts are used for the population.
Sampling	Purposive sampling (Burns & Grove, 2005:353) was conducted whereby all conclusion statements were included into the sample.
Sample size	This includes all the conclusions drawn from the analysed concepts. N=39, according to data saturation (Denzin & Lincoln, 1994:230).
Data analysis	The process of statement synthesis was conducted in this research (Walker & Avant, 2005:91-99) as guided by the research design. As the process of theory construction is based on a qualitative research design, qualitative statement synthesis was done (Walker & Avant, 2005:90).

2.5.4 PHASE 2: Theory construction

STEP 2: Theory synthesis

The aim of theory synthesis is to portray a specific phenomenon by means of the analysed concepts and synthesised statements. After all possible relational statements regarding the focal concepts were made, these concepts are organised according to the relationships between the variables (Walker & Avant, 2005:140). In this research, the relational statements between the main concepts, namely social capital and authentic leadership and the related concepts, the professional nurse, South African hospitals, positive impact on the triple bottom line and trust, are formulated and thereafter, graphically portrayed in a model. Please refer to Table 2.6 where the process for theory synthesis is described.

Table 2.6 Research process for Phase 2: Step 2 (Theory synthesis)

Steps in the research process	Discussion and application in this research
Data Collection	The theory is synthesised using the statements synthesised in Phase 2 (Step 1).
Data analysis	The process of analysis followed during theory synthesis is that of Walker and Avant (2005:139). The main concepts (authentic leadership and social capital) and related concepts are specified as well as the relations between these concepts. A model as a means of an integrated representation is constructed to describe the theory for authentic leadership embedded in a social capital framework.

2.5.5 PHASE 3: Theory evaluation and operationalisation

STEP 1: Evaluate and refinement of the theory

The overall aim of this research is to construct a theory for authentic leadership embedded in a social capital framework in Nursing Science. It is also stated that the theory needs to be operationalised or tested in order to be evaluated. Due to the intensive nature of theory construction, the theory is submitted to a panel of experts for evaluation. The panel's critical evaluation feedback is utilised to refine the theory. Please refer to Table 2.7 for a description of Phase 3, Step 1.

Table 2.7 Research process for Phase 3: Step 1 (Evaluate and refinement of theory)

Steps in the research process	Discussion and application in this research
Data Collection	The research data utilised in this phase is derived from Phase 2 (Step 2) – the constructed theory for authentic leadership embedded in a social capital framework in Nursing Science.
Population	The population deployed in this phase was a panel of experts. After the theory has been presented, it was submitted for evaluation by a panel of experts. The members of the panel matched the following inclusion criteria: • Should have obtained at least a doctoral degree as a minimum qualification. • Must have at least two years experience in social capital and/or leadership and/or theory construction. • Possible candidates must be willing to act on the panel of experts and provide written consent for voluntary participation
Sampling	A purposive sampling was done according to inclusion criteria of the panel of experts.
Sampling size	The sampling size of the panel of experts was 6 (N = 6) and the representation of the panel members' expertise was as followed: • Expertise in leadership: n=2. • Expertise in theory construction: n=4. Please refer to Chapter Five, Table 5.3 for an outline of the panel of experts that participated in this research.
Data collection	Chinn and Kramer (1995:135-136) provided guidelines for the critical reflection of a constructed theory. These guidelines were submitted to the panel of experts during the process of theory evaluation. Please view Table 2.8 for a summary of the critical reflections utilised by the panel of experts for the evaluation of the theory.

The evaluation of a theory for authentic leadership, embedded in a social capital framework is conducted according to the following critical reflections:

Table 2.8 Critical reflections for the evaluation of a theory for authentic leadership embedded in a social capital framework

Critical reflection	Criteria	Application in this study
Is this theory clear?	• Semantic clarity • Semantic consistency • Structural clarity • Structural consistency	• The main and related concepts are clearly defined • The definitions are both general and portray specific traits. • Clarity and consistency are enhanced by describing all available relationships between the main and related concepts, with congruent uses of diagrammatic portrayals throughout the research
Is this theory simple?	Is the amount of theoretical relationships utilised in the theory complex or simple?	The theory is user-friendly, written in an effective, comprehensible linguistic manner. Definitions of concepts are used congruently throughout the research.
Is this theory general?	To whom does this theory apply and what is the breadth of this theory?	Nurse leaders, professional nurses, all levels of nurses and healthcare members in the healthcare industry. The theory is applicable to other disciplines.
Is this theory accessible?	How attainable is the projected outcomes of this theory? What is the extend to which empiric indicators can be identified for concepts within the theory?	Empirical indicators were formulated for the main and the related concepts.

Table 2.8 continues

Is this theory important?	Does the theory create a reality that is important to nursing?	The theory is future-directed, useful and valued for creating a future in nursing. The importance of the theory depends on the person who is addressing the question's professional and personal values.

Please refer to Chapter Five for a detailed discussion on the panel of experts' evaluation and refinement of the constructed theory.

2.5.6 PHASE 3: Theory evaluation and operationalisation

STEP 2: Guidelines for the operationalisation

The final step in this research is to formulate guidelines for the operationalisation of the theory. The guidelines for operationalisation are provided on a macro-level, meso-level and a micro-level. These guidelines serve as a description of the factors that are necessary to enhance the effectiveness of this theory.

2.6 INDUCTIVE AND DEDUCTIVE REASONING

Both inductive and deductive reasoning were used during the course of this research. Inductive and deductive reason refers to the point of view that the researcher took from the initial start of the research problem right through the research process and in this event, also during the formulation of guidelines. Inductive logic refers to the reasoning from the particular to general principles (Denzin & Lincoln, 1994:431). Deductive logic entails is the reasoning from the general to the particular (Denzin & Lincoln, 1994:431). According to Walker and Avant (2005:163–171), it is important to know if a theory started from an inductive or deductive reason as this impacts on the theory. An inductive theory will always remain logically inclusive.

The reasons why both inductive and deductive reasoning are motivated as follows:

- Inductive reasoning: the researcher was unfamiliar with the concepts social capital and authentic leadership, viewed these concepts to be complex and multifaceted and wanted to explore and describe these concepts during the process of concept analysis (Denzin & Lincoln, 1994:431).

- Deductive reasoning: the main concepts underwent concept analysis followed by a literature control, an extensive literature analysis was done with the related concepts and the researcher wanted to describe, explore and explain the relations between the relevant concepts.

2.7 ETHICAL CONSIDERATIONS

Specific ethical considerations were made during the course of this research and these considerations are described in the following paragraphs.

2.7.1 Code of ethics adhered to

The researcher selected and abided to specific codes of ethics as stipulated by weight bearing local, national and international bodies. This was a conscious decision and definite awareness of ethical considerations was maintained during the entire research process.

2.7.2 University's code of ethics

The researcher functioned within the scientific domain as a PhD-candidate, registered as a student at the North-West University (Potchefstroom Campus). In this research, the student proclaimed adherence to the University's code of ethics as stipulated by the Statute. A comprehensive research proposal was submitted to the University's Ethical Committee and research was conducted only after the Ethical Committee has granted its consent (Guidelines for postgraduate studies, North-West University, 2005:29). Please refer to Annexure A for a copy of the ethical consent certificate.

2.7.3 National ethical governance

The researcher submitted to the Constitution of the Republic of South Africa (Act 108 of 1996). As the Constitution serves as the 'South African DNA' for human rights, the researcher wished to add this law as national body that has directed the formulation of research ethics in South Africa. On a national level the researcher adhered to the code of ethics as governed by the Medical Research Council (Guidelines for postgraduate studies, North-West University, 2005:31) as well as the South African Department of Health (Ethics Committee: North-West University, 2006:1) and of the Democratic Nursing Association of South Africa (DENOSA, 1998).

2.7.4 International codes of ethics

From an international perspective, the researcher chose to adhere to the code of ethics by the International Council of Nurses (ICN) (2008:1-2) as well as the ethical principles and guidelines for the protection of human research subjects as stipulated in the Belmont Report, World Medical Association Declaration of Helsinki's ethical principles for medical research that involves human subjects and the Nuremberg Code (Guidelines for postgraduate studies, North-West University, 2005:33-34).

2.7.5 Prevention of plagiarism

The researcher acknowledged the North-West University's policy to prevent plagiarism (Guidelines for postgraduate studies, North-West University, 2005:28-29) and declared to adhere to this policy.

2.7.6 Ethical principles ensured

The following ethical principles received attention in this research and strategies for their assurance are stipulated in the consecutive paragraphs. Although the researcher's primary form of data collection was literature, the researcher maintained adherence to the general ethical principles.

2.7.6.1 Respect for others

The principle of respect for others rests upon the autonomy of others (Guidelines for postgraduate studies, North-West University, 2005:29) and therefore emphasises each person's right for existence. The researcher utilised members of the panel of experts' right for respect by first confirming members' availability to participate voluntary. In the event that a member either refused or terminated participation, it was accepted without discrimination.

2.7.6.2 Benevolence

The principle of benevolence refers to the panel of experts' right to maintained well-being during the course of the research (Guidelines for postgraduate studies, North-West University, 2005:29). Besides maintaining their well-being, any form of emotional discomfort should be avoided or minimalised. Therefore the researcher submitted a research proposal and written request for consent to the North-West University's (Potchefstroom Campus) Ethical Committee. Members of the panel of experts were informed of the intensity of the evaluation of the theory, within a specific timeframe, amidst their workload.

2.7.6.3 Justice

The principle of justice (Guidelines for postgraduate studies, North-West University, 2005:29) refers to the participants' right to a fair selection as well as their right to privacy and anonymity. After purposive sampling of the members of the panel of experts was conducted, members were requested to complete an informed letter of consent, agreeing to participate in this research voluntary. Members were informed of the reason(s) why they were included in the sample, with specific reference to their academic qualifications and expertise in social capital, and/or theory construction, and/or leadership. The theory evaluation reports conducted by the panel of experts were anonymous and all measures possible were taken to ensure privacy during the data collection process, data analysis and the publication of the research results.

2.8 RIGOUR

Rigour is defined as striving for excellence in research that can only be obtained by the use of discipline and the scrupulous adherence to accuracy (Burns & Grove, 2005:779). Various authors (Brink, 1993:35; Guba & Lincoln, 1989:290; Rolfe, 2004:304) refer to rigour in qualitative research as trustworthiness. Trustworthiness according to Guba and Lincoln (1985:290) implies that the researcher should answer the following question to him/herself and to the readers of the research: "*Is the findings of this research worthwhile to pay attention to and to take account thereof*?" For the purpose of this research, trustworthiness can be established according to Guba and Lincoln's (1989:236-243) strategies. Four questions should be answered in the pursuit of trustworthiness, as outlined in Table 2.9. Please refer to Table 2.10 for a depiction of the strategies taken to ensure trustworthiness in this research.

2.9 SUMMARY

The aim of Chapter Two was to debate the selected research methodologies utilised in this research. The reasons for selecting a qualitative research design were stated. The research methods were described according to each research objective. A broad discussion on the ethical considerations ensured by the researcher followed as well as the strategies to enhance trustworthiness. Finally, a summary strategies of to enhance rigor in this research, was provided. In Chapter Three, the process of theory construction will be activated.

Table 2.9 Questions and associated criteria for trustworthiness in qualitative research

Question asked by Guba and Lincoln (1985:290):	The answer/criteria to each question by Guba and Lincoln (1985:290-305):
How can the researcher establish if the research findings in this research's specific context and participants are really the true findings?	Seek for the "truth value" of the research and refers to the confidence that one have in the research findings. Truth-value is established through *credibility*.
How do you determine if the research findings are applicable to another research context or other participants?	The applicability of the research when the research can be applied to other participants and contexts. The strategy of *transferability* is used to establish applicability.
How do you determine if the research findings can be repeated, and if the research is repeated with the same participants, in the same context?	The consistency of the research is when the research is repeated and the same research findings surfaced. A strategy to establish consistency is through *dependability*.
How do you know if the participants and not the researcher's bias determined the research findings?	The neutrality of the researcher during the research process and the description of the research findings are the fourth criteria. Neutrality can be established through *conformability*.

Table 2.10 Strategies to enhance trustworthiness in this research (Guba & Lincoln, 1989:236-243)

Criteria for trustworthiness	Threats to the trustworthiness	Strategies to establish trustworthiness
Truth		**Credibility**
This criterion refers to the degree that the research results are an actual portrayal of literature.	• Researcher incompetence and bias (Brink, 1993:35) • Insufficient extend of literature utilised in a review that doesn't portray all the necessary information. • Insufficient data inclusion criteria that may lead to insufficient data collection.	• Declare the researcher's paradigmatic perspective for readers to consider during the evaluation and reading of this research as well a clear declaration of the researcher's interest into this specific research (Brink, 1996:38). • Formulate a research question from a problem statement and select the appropriate research methodology. • Utilise the services of international acknowledged search engines as endorsed by the Ferdinand Postma Library of the North-West University (Potchefstroom Campus) for the process of literature searches during data collection. Data collection needs to represent national and international sources and cross searches to be conducted. • Use various search engines as well as various search options and do not be limited to only one type of literature (journal articles for example), but seek to search about all available types of information. • Conduct literature searches until the point of data saturation (Denzin & Lincoln, 1994:230) is reached. • Start with literature searches with key words found in all available text that are narrowed towards key words only applicable to the main and related concepts in this research.

Table 2.10 continues

		• Study all available national and international information thoroughly and strive to study all the relevant literature sources. • Conduct a comprehensive literature review during the process of data analysis. • Conduct accurate concept analysis according to the process of concept analysis by Walker and Avant (2005). • Ensure that defined concepts are not ambiguous, circular, too narrow or broad, don't portray core characteristics and don't use figurative language. • Keep continuous, accurate and detailed field notes (Brink, 1993:36). • Have regular consensus discussions between the researcher and an independent theory construction specialist.
Applicability →		**Transferability** →
The degree to which this research may be applied to another context/participants, and to found similar research results	• The researcher worked alone on this research project and might become biased. • Holistic fallacy (Miles & Huberman 1994:437-439).	• Provide a detailed description about the broader spatio-temporal factors (historical, socio-political and economic factors) as well as the research setting that is specific to this research (Mouton, 1996:90). • Conduct literature searches according to specific criteria as part of purposive sampling.

Table 2.10 continues

		• Provide an accurate outline and detailed description of the research methodology that was used in this research. • Provide the criteria for the evaluation of the theory as indicated by Chinn and Kramer (1991) and submit these criteria to the panel of experts. • Stipulate the inclusion criteria of the panel of experts for the evaluation of the research. • As stated above, continue with data collection until you reach the point of data saturation (Denzin & Lincoln, 1994:230). • Provide a detailed description of the realisation of data collection (Brink, 1993:38). • All administrative tools that portrayed the process of data collection and analysis should be kept available (Brink, 1993:38).
Consistency →		**Dependability** →
This criterion refers to the stable repeatability of this study over a time period and the manner in which this research can be audited.	• The researcher worked alone on this research project and might become biased. • Holistic fallacy (Miles & Huberman, 437-439).	• A detailed description about the broader spatio-temporal factors (historical, socio-political and economic factors) as well as the research setting that is specific to this research (Mouton, 1996:90). • Seek for representativeness in literature by purposively seeking for information from every possible source.

Table 2.10 continues

		• Subjecting the constructed theory to a panel of experts in order to control holistic fallacy. • Keep all administrative tools used in the documenting of data collection and analysis available for review.
Neutrality →		**Confirmability** →
This criterion refers to the neutrality of this research versus the extend to which this research might be influenced by situations.		• Keep field notes during the course of the research. • Invest in regular consensus discussions to reach a point of inter-subjectivity that refers to subjectivity of the research in an aimed objectivity of the research data. Pursue with peer group interaction. • Do acknowledge that overzealous and uncritical uses of research methodology may be counterproductive (The British Medical Journal, 2001:6) and therefore the researcher is to strive to follow rigour strategies accurately but never loose the importance of logic argumentation.

CHAPTER THREE

CONCEPT FRAMEWORK: AGENT, RECIPIENT AND CONTEXT

3.1 INTRODUCTION

The aim of Chapter Three is to conduct concept identification, description, definitions and when needed, analysis of the relevant concepts. During this Chapter the realisation of data is discussed with reference to data collection and – analysis. Conclusive statements with regard to these concepts are formulated.

3.2 REALISATION OF DATA

The research design and - method was discussed in Chapter Two with specific reference to the process of concept identification, description, definitions and analysis. The method by Walker and Avant (2005:65-80) serves as the theoretical guideline for concept analysis in this research. Walker and Avant's procedure for concept analysis is a simplified modification of the classic concept analysis procedure by Wilson. The original 1963 Wilsonian method of concept analysis contained eleven steps that were lessened by Walker and Avant whilst ensuring that the essence of efficient concept analysis remained intact (Walker & Avant, 2005:65). The following iterative steps in the process of concept analysis by Walker and Avant (2005:65), is conducted in this research:

- Step 1: identification of main – and related concepts.
- Step 2: the aims or purposes of analysis.
- Step 3: identify all available uses of the concept.
- Step 4: determine the defining attributes (connotations).
- Step 5: construct a model case.
- Step 6: define empirical indicators (denotations).

The two main concepts, authentic leadership in nursing and social capital were analysed according to Walker and Avant's (2005:65) method of concept analysis. A literature analysis was conducted for the related concepts, namely the recipient (the professional nurse), the context (South African hospitals) and the goal (positive impact on the triple bottom line) and dynamic (trust).

The population was national and international sources of data. A purposive sampling according to selection criteria was done in the form of an extensive literature search. Search engines were operated in the process of literature searches through advanced search options. Search options were done electronically and close documentation was done of the process of literature searches. Five (5) international search engines were accessed, namely EbscoHost; Biblioline; Science Direct; Emerald and ISI Web of Knowledge. Thereafter SABINET was accessed for national searches. The North-West University's (Potchefstroom and Vaal Triangle Campus) alphabetical list of journals was accessed as well as book catalogues. Please refer to Table 3.1 for a list of the databases accessed within each search engine. These search engines were selected because of the accessibility, user-friendliness and the vast amount of databases that were listed.

The following search techniques were used: Boolean Searching; OR; AND; Match All and URL searches. In the event of large search results advanced search options were used. Searches were conducted in three phases (Please refer to Table 3.2) as advanced search options were activated in the event of large search results. The phases of searching are summarised as follows:

- *Phase 1: concepts searched by key words*

During the first phase the following concepts were searched as key words as part of an initial broad search. The results of the first search indicated if advanced search options had to be activated. Searches were done with the following key words:

  - authentic lead*;
  - professional nurs*; and
  - South African hospital*.

- *Phase 2: advanced search options activated*

Advanced search options were activated in the second phase of data collection. In the event of large search results, searches were changed from key word searches in all literature sources and limited to data source titles. Due to large search results search options were changed from key words to title searches. The following searches were changed:

  - authentic leader* limited to title;

- authentic lead* & nurs*;
- professional nurs* limited to title; and
- South African hospital* limited to title.

- *Phase 3: advanced search options increased*

The third phase of literature searchers were only done in the event of large search results that didn't respond significantly to title limitations. During this phase of searching, various key words were combined in AND/OR options. The following advanced search options were activated during the third phase:

- authentic lead* limited to title;
- authentic lead* & nurs* &/OR health*;

Various forms of literature were searched to ensure optimal scrutiny of all available literature and included dictionaries; subject dictionaries; thesauri; encyclopediae; journal articles, textbooks; theories and other types of data. Other types of data used referred to fact sheets, reports; Micro Soft Power Point Presentations; presentation papers; information by governing bodies/councils; press releases; press conferences; position statements; working papers; support documents; manuals; discussion papers; web-based articles or chapters; statistical reports; minutes from committee meetings and unspecified documents. Please refer to Table 3.3 for a summary of the types of data used and Table 3.4 for a summary of data listed as "other".

The amount of literature found was documented and first assessed for both applicability to this research and availability before it was added to the using list. Please refer to Table 3.5 for the amount of literature found against the actual amount of literature used for the agent, recipient and context. A total of 221 sources (n=221) of literature were used.

Table 3.1 Databases accessed through international and national search engines

EBSCO HOST	BIBLIOLINE	SCIENCE DIRECT	EMERALD	ISI WEB OF KNOWLEDGE	SABINET (RSAT/ISAP)	LIBRARY CATALOGUE
ATLA Eric Business Source Premier Chinahl EconLit HealthSource (Nursing/Academic ed) MasterFile Premier Medline Newspaper Source PsychINFO Academic Search Complete SocIndex	Africa-Wide: NiPad (Incorporating South African studies, AIDSearch, Child Abuse, Child Welfare & Adoption)	Life Sciences Health Sciences Social Sciences & Humanities	Emerald	Web of Science, Biological Abstracts BIOSIS, Preview	Book Data (Expanded) Current & completed research, ASArticleFirst, FS WorldCat, Government Gazettes ISAP by the National library of South Africa Kovsidex, NDLTD (Thesis & dissertations NWU Catalogue) Provincial Gazettes SA Media SA e-Publications SA Cat SANB Subsidie UCTD	Libraries of the Potchefstroom – and the Vanderbijlpark Campuses of the NWU, included books and journals

Table 3.2 Summary of phases in literature searches for articles and theories: agent, recipient and context

Main and related concepts	Phase 1 Title search done		Phase 2	Phase 3	Literature found per search engine
	Key word(s) used	Literature found	Concepts specified in title search	Advanced search conducted	
AUTHENTIC LEADERSHIP IN NURSING	Authentic leader*	**EbscoHost:** 67 **BiblioLine:** 6 **Science Direct:** 154 **Emerald:** 1100 **ISI:** 32 **Sabinet:** 367 **Library cat.** 7	Authentic leader* Authentic leader & nurs*	Limited search to title Authentic leader* Authentic leader* & nurs Authentic leader* & health*	**EbscoHost:** 67 **BiblioLine:** 6 **Science Direct:** 14 **Emerald:** 121 **ISI:** 32 **Sabinet:** 41 **Library cat.** :7
-PROFESSIONAL NURSE	Professional nurse	**EbscoHost:** 561 **BiblioLine:** 55 **Science Direct:** 4530 **Emerald:** 31 **ISI:** 119 **Sabinet:** 1789 **Library cat.** : 7	**Limited search to title** Professional nurse	Limited search to title: EbscoHost, Sabinet, ISI, Science Direct	**EbscoHost:** 32 **BiblioLine:** 55 **Science Direct:** 35 **Emerald:** 31 **ISI:** 21 **Sabinet:** 86 **Library cat.** : 7
SOUTH AFRICAN HOSPITALS	South African hospitals	**EbscoHost:** 26 **BiblioLine:** 40 **Science Direct:** 181 **Emerald:** 2 **ISI:** 19 **Sabinet:** 4143 **Library cat.** :0	**Limited search to title** South African hospitals	Limited search to title: Sabinet "South Africa" & hospital: Library Catalogue	**EbscoHost:** 26 **BiblioLine:** 40 **Science Direct:** 181 **Emerald:** 2 **ISI:** 19 **Sabinet:** 95 **Library cat.** :0

Table 3.3 Summary of the types of data used for agent, recipient and context (N=425)

Main and related concepts	Dictio-naries	Thesauri	Subject diction-naries	Encyclo-pediae	Journal articles	Textbooks	Theories	Other	Total used
Authentic leadership in nursing	11	7	6	5	63	4		20	116
Professional nurse					2			16	18
South African Hospitals					6	3		78	87
TOTAL AMOUNT OF LITERATURE USED									n=221

Table 3.4 Summary of data used listed as "other"

Data type	Authentic leadership in nursing	Professional nurse	South African hospitals	Total amount of other sources of data
Report	2		10	12
Fact sheet			2	2
Power point presentation		1	2	3
Presentation paper	1		1	2
Information of governing body/council		9	14	23
Press release / press conference / Position statement		3	3	6
Working paper/ Support document/ Manual/ discussion paper	4	2	3	9
Web-based article / chapter	11		26	37
Unspecified document	2		4	6
Statistics report		1	8	9
Minutes from committee meeting			5	5
Total data used per concept	20	16	78	**114**

Table 3.5 Summary of all literature searches with literature used for agent, recipient and context (n=221)

Search engines used	EBSCO HOST		BIBLIO-LINE		SCIENCE DIRECT		EMERALD		ISI		SABINET		LIBRARY CAT.		OTHER	Sub-total	Dictio-naries	Total amount of literature used
	F	U	F	U	F	U	F	U	F	U	F	U	F	U	U			
Authentic leadership in nursing	67	12	6	1	14	12	121	25	32	8	41	5	7	4	20	87	29	116
Professional nurse	32	1	55	-	35	-	31	1	21	-	86	-	7	-	16	18		18
South African hospitals	26	2	40	3	181	-	2	1	19	2	95	1	-	-	78	87		87
Total	125	15	101	4	230	-	154	27	72	10	222	6	14	4	182	192	29	**221**

F = literature found during literate search

U = actual literature used

3.3 CONCEPT ANALYSIS: AGENT AND LITERATURE ANALYSIS: RECIPIENT AND CONTEXT

In the following section of Chapter Three, the concept analysis of the main concept, the authentic leadership in nursing is conducted. Thereafter, the literature analysis of the related concepts, the recipient (professional nurse) and the context (South African hospitals) follow.

STEP 1: IDENTIFICATION OF MAIN- AND RELATED CONCEPTS

3.3.1 Identification of main- and related concepts in this research

As stated in Chapter Two (refer to point 2.5.3), the main and related concepts in this research have been identified through the survey list of Dickoff *et al.* (1968:415-423). These concepts can be summarised as follows (also refers to Table 2.3):

Table 3.6 Application of the survey list in this research (Dickoff *et al.*, 1968:415-423)

SURVEY LIST	MAIN CONCEPT(S)	RELATED CONCEPT(S)
AGENT	Authentic leadership in nursing	
RECIPIENT		Professional nurse
CONTEXT		South African hospitals
PROCEDURE	Social capital	
GOAL		Positive impact on the triple bottom line
DYNAMICS		Trust

The process of concept analysis is activated by the identification of the concept(s) central to this research and was conducted with caution. The concepts that were identified according to the survey list (Dickoff *et al., 1968:415-423)* were divided into main- and related concepts. The main concepts were selected as authentic leadership in nursing as the agent and social capital as the procedure. Authentic leadership in nursing and social capital is the two concepts central to this research. These concepts directed this research from the initial stage of a problem statement and the researcher argues that the research aim, namely to construct a theory for authentic leadership embedded on a social capital framework in Nursing Science, would be best achieved by an in-depth investigation of authentic leadership in nursing and social capital. The motivation for this decision was due to the realisation that the current definitions of authentic leadership in nursing and social capital are vague and not

specific to Nursing Science. The recipient, context, goal and dynamics were indicated as related concepts. Conclusion statements were formulated for the main and related concepts followed by the process of theory construction through statement synthesis.

3.4 CONCEPT DESCRIPTION, DEFINITION AND ANALYSIS: THE AGENT [AUTHENTIC LEADERSHIP IN NURSING]

Authentic leadership in nursing is the first main concept to undergo the process of concept description, definition and analysis. When referring to authentic leadership in nursing, it is inclusive of the authentic leader in nursing.

STEP 2: AIMS AND PURPOSES OF THE CONCEPT ANALYSIS

3.4.1 The aim and purpose of concept description, definition and analysis of authentic leadership in nursing

The aim of the concept description, definition and analysis of authentic leadership in nursing is to provide a definition of this concept for Nursing Science. In addition, the purpose for a concept analysis of authentic leadership in nursing in this research is three fold. Firstly, it is to clarify the meaning thereof. Secondly, the concept authentic leadership in nursing is analysed to gain more insight into this concept. Thirdly, increased insight into the concept authentic leadership in nursing is essential towards the provision of an operationalised *definition for authentic leadership in nursing as part of theory construction.*

STEP 3: IDENTIFY ALL AVAILABLE USES OF THE CONCEPT

3.4.2 Identify all the available uses of the concept authentic leadership in nursing

All the available uses of the concept authentic leadership in nursing were searched in dictionaries, thesauruses and encyclopedias. Please refer to Table 3.7, for an outlay of authentic leadership's uses in these sources. Due to the relative newness of the concept authentic leadership in nursing, this concept wasn't richly represented in literature sources. This supports the aim of this concept description, definition and analysis, to provide a definition for authentic leadership in Nursing Science.

3.4.2.1 Textbook definitions of authentic leadership in nursing

The first step in the process of concept description, definition and analysis of authentic leadership in nursing is to list all definitions of the concept as found in dictionaries, thesauruses and encyclopaedias. As Table 3.4 indicates, the concept authentic leadership in nursing is not well represented in dictionaries, thesauruses, subject dictionaries and encyclopediae. Therefore, textbooks and articles were investigated in addition. The available uses of authentic leadership in nursing as found in articles and textbooks are now listed with specific reference to the origin thereof, various definitions of authentic leadership in nursing according to different authors and the characteristics of an authentic leader in nursing.

Table 3.7 Summary of the uses of authentic leadership in dictionaries, thesauri, subject dictionaries and encyclopediae

DATA SOURCE	SEARCH RESULTS
DICTIONARIES	
Cambridge Advanced Learner's Dictionary (2008)	No results found for the search on "authentic leadership"
Cambridge Dictionary of American English (2008)	No results found for the search on "authentic leadership"
Your Dictionary.com (2008)	No results found for the search on "authentic leadership"
The DUCT Development Group (2008)	No results found for the search on "authentic leadership"
Encarta Dictionary (2007)	No results found for the search on "authentic leadership"
Shorter Oxford Dictionary (2008)	No results found for the search on "authentic leadership"
Merriam-Webster Online Dictionary (2007)	No results found for the search on "authentic leadership"
Reference.com Dictionary (2008)	No results found for the search on "authentic leadership"
The Oxford Dictionary (1989)	No results found for the search on "authentic leadership"
THESAURI	
ıcarta Thesaurus (2008)	No results found for the search on "authentic leadership"
Merriam-Webster Online Search (2007)	No results found for the search on "authentic leadership"
Roget's Thesauri (2008)	No results found for the search on "authentic leadership"
The New Oxford American Dictionary (2006)	Prove or show (something, a claim or an artistic work) to be true or genuine: they were invited to authenticate artefacts from the Italian Renaissance, validate: the nationalist statements authenticated their leadership
Wordsmyth Thesaurus (2002)	No results found for the search on "authentic leadership"
Canadian Oxford Dictionary (2005)	No results found for the search on "authentic leadership"
Oxford Paperback Thesaurus (2006)	No results found for the search on "authentic leadership"
Thesaurus.com (2008)	No results found for the search on "authentic leadership"
Australian Oxford Dictionary (2004)	No results found for the search on "authentic leadership"

Table 3.7 continues

SUBJECT DICTIONARIES	
A Dictionary of Scientists (2003)	No results found for the search on "authentic leadership"
A Dictionary of Nursing (2008)	No results found for the search on "authentic leadership"
A Dictionary of Psychology (2006)	No results found for the search on "authentic leadership"
A Dictionary of Public Health (2007)	No results found for the search on "authentic leadership"
Science, Technology, and Society (2005)	No results found for the search on "authentic leadership"
Dictionary of the Social Sciences (2002)	No results found for the search on "authentic leadership"
A Dictionary of Sociology (2005)	No results found for the search on "authentic leadership"
ENCYCLOPEDIA	
Encarta encyclopaedia (2008)	No results found for the search on "authentic leadership"
Encyclopedia Britannica (2008)	No results found for the search on "authentic leadership"
Columbia Encyclopedia (2008)	No results found for the search on "authentic leadership"
Oxford Reference Online Encyclopedia (2008)	No results found for the search on "authentic leadership"
World Encyclopedia (2008)	No results found for the search on "authentic leadership"

Table 3.8 Textbook definitions of authentic leadership by various authors

UTHOR(S)	DEFINITION(S) OF AUTHENTIC LEADERSHIP
Goffee and Jones (2006:8-10)	Goffee and Jones can be ascribed as early writers on the theme of authentic leadership. They noted that **real leaders** are in fact authentic leaders. In defining authentic leadership, Goffee and Jones revealed three fundamental leadership truths as central to the definition thereof. Firstly leadership is **situational** - the situation will indicate what the leader requires. Secondly, leadership is **non-hierarchical**. This implies that great leaders are at all the levels in an organisation and great leaders aren't necessary in top positions. Thirdly, leadership is **relational** – this implies that relationships are central in leadership. Or as excellently described by Goffee and Jones (2006:8) as a "**web of relations** that is fragile and requires constant re-creation." It is argued that final outcomes for authentic leadership are all about **results**. These results are not only external performance but also the potential to **excite followers towards extraordinary levels of achievement**. Or shortly stated, authentic leadership is all about **meaning**, about the ability of the leader to **make performance meaningful** and to motivate both with mission and meaning. Being a leader is about becoming an **integrated human being** that implies that you are in touch with and understand **yourself** mentally, physically, emotionally and spiritually. Goffee and Jones (2006:10) summarised authentic leadership as **being you with skill**.

Table 3.8 continues

	There is a short supply of authentic leaders in organisations. Organisations suppress leadership because they encourage conformists and role players. Authentic leaders aren't stimulated within organisations due to the cracked fundamental understanding about leadership. People want to be led by a **person** and **not by a position**. There aren't universal leadership traits that can be listed. There is a strong psychological bias in the mainstream leadership literature that focuses on leaders' characteristics. Leadership should be perceived as "what we do ***together with*** other people" and not as "what we do *to* other people". This is an important approach differentiation. When one views leadership as "what we do *with* others", then the **relationships-focus** surfaces. When leadership is viewed by what qualities this person have, then leadership is viewed predominantly from and **individual perspective**. An authentic leader doesn't have to truly know thyself. The focus should remain on the authentic leader to have an **intense passion** that can be combined with **sufficient self-knowledge** of one's potential leadership assets. An authentic leader builds and maintains **enduring relationships** with followers. This might seem as a weakness and risky for the leader. The authentic leader has **tough empathy**. This is when authentic leaders publicly displays emotions for others and portrays personal vulnerability. **Real display** of **honest emotions** can be very powerful in authentic leadership as it can stretch the performance of followers.
George (2006:1-3), George and Sims (2007:5)	**21st century** has brought about specific global challenges. Leaders in general cannot handle these challenges and therefore there is an outcry for a **new/different leader**. This leader is not judged by style or image but rather by **substance and integrity**. The time has arrived to give to followers a leader that can **inspire** the led. Authentic leaders are **believable**, **trustworthy**, **reliable** and **genuine** and have been placed in a **responsible position**.

Table 3.8 continues

	The authentic leader doesn't have to impress others because this person is **being his/her unique self** and **know who he/she is**. George refers to authentic leaders as people that know their **true north**. This is their **moral compass** that keeps an authentic leader on course even in the event of disappointments and challenges. Leadership is part of the highly complexities of human beings and cannot be defined by traits or characteristics. It has a **narrative nature** that is sculptured from life stories. Crucibles lived directs a leader to understand leadership as a **service** and **empowerment of people** rather than gratification or success. Authentic leadership can therefore be defined as "*...bring people together around a shared mission and values and empower them to lead, in order to serve their customers while creating value for all their stakeholders.*" Leaders are enabled to lead others only after they could **lead themselves** through challenges and hardships. The leading of oneself can only be conducted through the principles of gaining **self-awareness**; practicing of your **values** and your **principles** when under pressure; **balancing** of your extrinsic and your intrinsic **motivations**; by building a **support** team; staying grounded by **integrating** your life and to understand your **passions** and **your purpose** of your leadership. Both George (2006:2) and Goffee and Jones (2008:10) stated that authentic leaders are not supernatural beings that have outcome and solutions to everything and all. Authentic leaders are also subject to mistakes and **human weakness**. It is not a question if authentic leaders can escape error, but rather the demand of authentic leadership to admit these errors and to **acknowledge frailties**. Through this **honest expression** of human weakness, the authentic leader connects with followers and thereby stimulates followers to take risks. The characteristics of authentic leadership are listed as follows: • Pursuing your purpose with passion. An authentic leader first needs to discover his/her purpose for their leadership. This is only possible if an authentic leader understands him/her self as well as the passions that sketch his/her **life stories.**

Table 3.8 continues

	• Practicing **solid values.** An authentic leader is tested how he **acts under pressure** and if the leader can remain true to his values; it will enhance the trust relationship between the leader and followers. When an authentic leader isn't true to the **values** that he proclaims, then it will have the detrimental effect of mistrust. An authentic leader's **values** are **sculpted** through experience, through consultation with others as well as through introspection. It is also shaped by the authentic leader's personal beliefs. • Leading with their **hearts as well as their heads**. An authentic leader *should have **passion** for the work she does and simultaneously have* **compassion** and **empathy** for your followers even though you have to make tough calls. • Establishing **connected relationships**. It is a requirement of followers to have a relationship with leaders on a **personal level** before followers are willing to give themselves fully for the work. • Demonstrates **self-discipline**. Authentic leaders need to display consistent high-levels of **self-discipline** that is applicable to all areas of life.
American Association of Critical Care Nurses (AACN) (2008:1)	Authentic leaders are people that **speak the truth** and **conform to fact** and therefore, they are **worthy of trust**, **reliance** and **belief**.
Kerfoot (2006:1)	Kerfoot (2006:1) wrote about authentic leadership in the workplace with specific reference to nursing. She states that authentic leadership **inspires excellence** in the workplace and **brings hope**, **love**, **inspiration** as well as **relationship-centered principles** into this workplace. A leader himself cannot label authenticity. Only the followers can **ascribe** authenticity to a leader, as it is perceived by others that a leader is **honest**, having **integrity** is **sincere** and **real**. People hunger for a leader that can **inspire** them; that **speaks** from his/her **heart**; and that can lead a group to accomplish things that the followers never **dreamt** that they had the capability of accomplishing.

Table 3.8 continues

Cashman (1997:1-2)	Authentic leadership has an internal origin. It isn't what a person does that makes him an authentic leader. No, authentic leadership originates from somewhere deep inside a person. It is an **intimate expression of what we are**, it is the process of our being in action and in fact, authentic leadership is at its deepest level an **authentic self-expression that creates value**. Cashman asked the following three questions in pursue of describing authentic leadership: firstly, do you know how authentic you are? Secondly, how deep and broad is your self-expression? And thirdly, how much value are you creating? The process towards authentic leadership is as follows: • Know yourself authentically. First be more effective yourself before you want effectiveness from others. The authentic leader needs to **practice** that which he **wishes others would be**. • Express yourself authentically. An authentic leader expresses himself as the words flow from his **heart** and from his **experience**. The true voice of a leader is that of **integrity** that originates from a leader's **character**. When a leader speaks with integrity and not merely focus on presentation style, then it may create synergy, trust and connectedness with followers. • **Appreciate** authentically. The detrimental effect of criticism is replaced with appreciation within the authentic leader. Through appreciation the leader creates value whilst it also energizes people in their eagerness to exceed their perceived limits and reach their goals. • **Serve** authentically. It is a spiritual and emotional breakthrough for the authentic leader to acknowledge that all realised goals are a team effort and not a sole achievement. To serve authentically is to mobilise from a control perspective to a place of service. Cashman added that the power of an authentic leader is not by being right, but by **being real**. A leader should ask herself where is her leadership coming from. Does it originate from somewhere very deep within you or is it an external, superficial personification?

Table 3.8 continues

Avolio, Gardner, Walumbwa, Luthans and May (2004:804)	An authentic leader is one of **intense awareness of themselves** and of **others being aware of this** self-awareness.
Pembroke (2002:17)	A leadership with three key dimensions: authentic **navigation** into the uncharted future, an authentic spiritual life, an authentic way of **relating.**
Shirey (2006:5-7)	Authentic leadership is a **new type** of leadership. After the worldwide awareness followed with companies like Enron and Tycon, the public has an outcry towards a leader that has **character** and provides **genuine**, ***timeless attributes*** *towards leadership.* By *knowing that* **being real** about one's **true north** gives and evolving opportunity for an individual to engage in this **journey of authenticity** and this in the end will enhance a person to become more authentic. It can assist a person to remain **true** to his identity, emotions, preferences and core values. Please refer to the Figure 3.1 where Shirey (2006:260) illustrates the characteristics of authentic leadership as initially listed by George in a complex adaptive system.

3.4.3 Characteristics of authentic leadership

During the investigation into the uses of the concept authentic leadership, descriptive and repeated words were highlighted to assist the researcher in the listing of characteristics of authentic leadership. These characteristics are used in the reduction process towards the formulation of the connotations of authentic leadership. Please refer to Table 3.9 for the full list of characteristics of authentic leadership.

Table 3.9 Characteristics of authentic leadership

• Real	• Internal origin
• Situational	• Intimate expression of what we are
• Non-hierarchical	• Being in action
• Relational	• Authentic self-expression

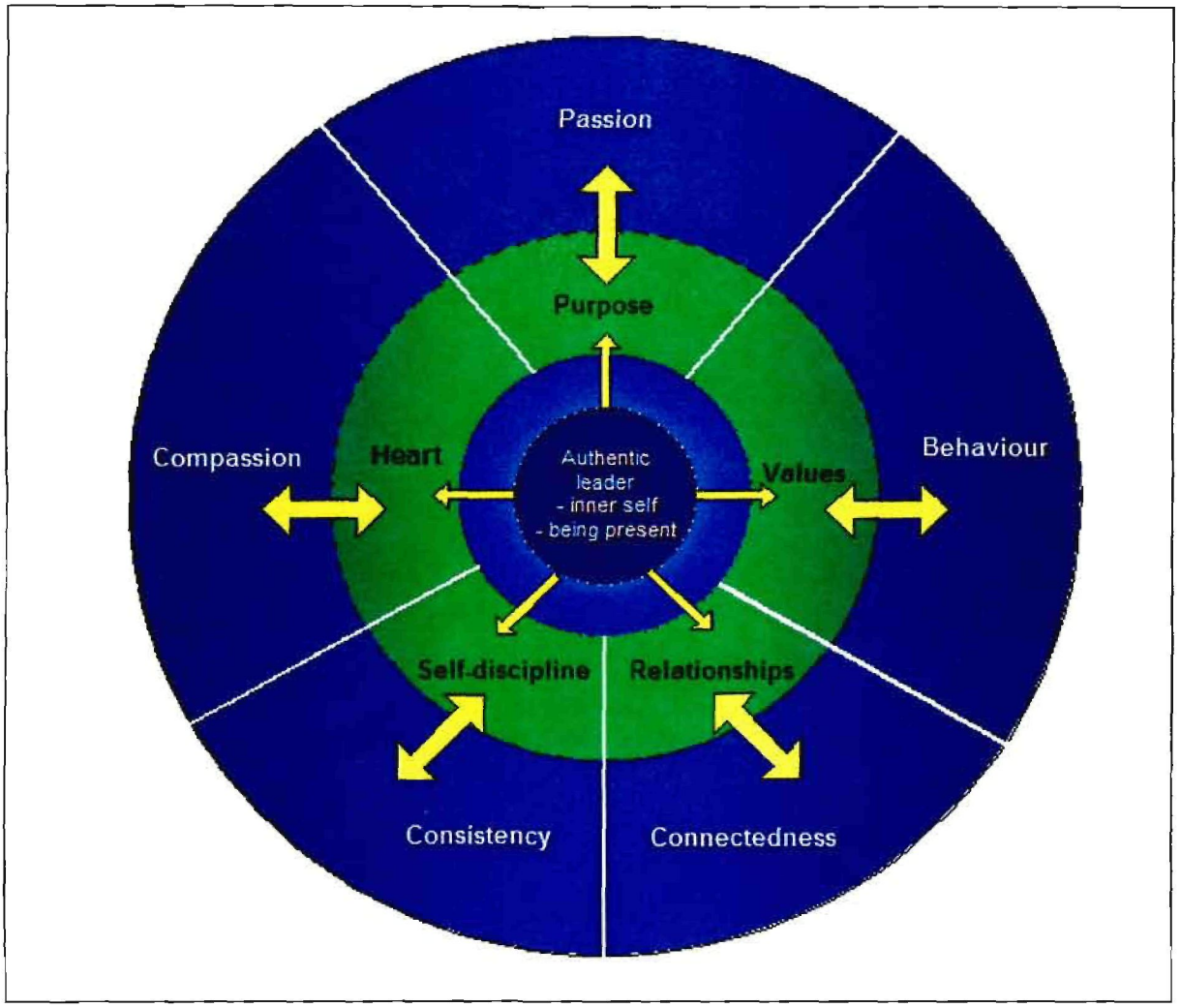

Figure 3.1 Characteristics of authentic leadership (George *in* Shirey, 2006:260)

Table 3.9 continues

• Results	• How authentic you are
• Excite followers	• How deep and broad your self-expression
• Extraordinary levels of achievement	
• Meaning	• How much value are you creating
• Make performance meaningful	• Intense awareness of themselves
• Integrated human being	• Others being aware
• In touch with oneself	• Navigation
• Understand yourself	• Spiritual life
• Being yourself with skill	• Relating
• Believable	• New type of leadership
• Trustworthy	• Character
• Reliable	• Timeless attributes

Table 3.9 continues

• Genuine • Responsible position • Being his unique self • Know who he is • True north • Moral compass • Narrative nature • Service • Empowerment of people • Bring people together • Shared mission and values • Empower to lead • Serve • Creating value • Lead themselves • Challenges • Hardships • Self-awareness • Practicing values • Principles • Balance extrinsic and intrinsic motivations • Staying grounded • Integrating your life • Understand passions and purpose for your leadership • Human weakness • Acknowledge frailties • Honest expression • Connects with followers • Stimulate followers to take risks • Speak the truth • Conform to fact • Worthy of trust, reliance and belief	• 21st century • Different type of leader • Substance • Inspire • Speaks from the heart • To accomplish things • Short supply • Person • Not a position • Together with • Relationship-focus • Intense passion • Sufficient self-knowledge • Enduring relationships • Tough empathy • Person vulnerability • Real display of honest emotions • Pursuing purpose with passion • Life stories • Practice solid values • Acts under pressure • Values • Experience • Consultation • Introspection • Personal beliefs • Leading with heart and head • Passion • Compassion • Empathy • Connected relationships • Personal level • Self-discipline • Know yourself

Table 3.9 continues

• Inspires excellence	• Express yourself
• Brings hope, love, inspiration	• Appreciate
• Relationship-centered principles	• Serve
• Followers ascribe authenticity	• Journey of authenticity
• Honest	• Remain true
• Integrity	• Sincere

STEP 4: DETERMINE THE DEFINING ATTRIBUTES (CONNOTATIONS)

3.4.4 Determine the defining attributes (connotations) of authentic leadership

The defining attributes or connotations of a concept are those attributes that are associated with the concept most frequently and assist an analyst to gain the broadest insight into the concept as possible (Walker & Avant, 2005:68). According to Walker and Avant (2005:68), the formulation of the defining attributes of a concept is not immutable, but may change as the researcher's understanding of a concept develops.

The reduction of the characteristics of authentic leadership towards defining attributes was done in three phases. Please refer to Table 3.10 where all the phases in the reduction process are declared. The three phases are listed as follows:

- *1st Reduction: characteristics grouped into antecedents, process and consequences.*

A defining attribute is either an antecedent or consequence (Walker & Avant, 2005:72-73). The listed characteristics where organised into antecedents, process and consequence. The antecedents were the preconditions necessary for authentic leadership to occur. The researcher divided the antecedents into external causative factors and internal causative factors. External causative factors were characteristics external from the authentic leader. Internal causative factors were characteristics were antecedents within the intra-personal sphere of the authentic leader. Characteristics associated with leadership actions were grouped under process. Characters associated with the consequences of authentic leadership were grouped together.

- *2nd Reduction: ordering similar reductions together*

With the assistance of the Oxford Dictionary, characteristics with similar meaning were clustered together.

- *3rd Reduction: grouped characteristics reduced to single characteristics*

Clusters of characteristics were reduced to single characteristics that were the most descriptive of each cluster and that provide as much insight as possible. The results of the 3rd reduction process were listed as the defining attributes.

The defining attributes of authentic leadership depicted from the reduction and refining process and that are captured in the theoretical definition of authentic leadership, are listed as follows:

- Situation-specific
- Relationship-centered
- Remains true to yourself
- A person, not a position
- Self-knowledge
- Self-awareness
- Learn from life narrative
- Character
- Leading yourself
- Practicing values and principles
- Honest self-expression
- Balanced life
- Pursue purpose of your leadership with passion
- Serve
- Inspire
- Navigate
- Connects with followers
- Empower
- Resulting in performance excellence
- Meaning in performance

Table 3.10 The reduction process from characteristics towards defining attributes for the concept authentic leadership

Units of meaning	1ST REDUCTION: Characteristics grouped into units of meaning: antecedents, process, consequences	2ND REDUCTION: Grouping similar characteristics together	3RD REDUCTION: Reduce to single characteristics	Category
ANTECEDENTS	Situational Non-hierarchical Relational Responsible position Relationship-focused Followers ascribe authentic leadership Relationship-centered principle Enduring relationships Others being aware	Situational Non-hierarchical Responsible position Followers ascribe authentic leadership 21st century challenges Different type of leader In short supply New type of leader	Situation-specific	EXTERNAL CAUSATIVE FACTORS FOR AUTHENTIC LEADERSHIP
	Relating New type of leader 21st century challenges Different type of leader In short supply Connected relationships on a personal level	Relational Relationship-centered principle Relating Relationship-focused Connected relationships on a personal level Enduring relationships Others being aware	Relationship-centered	
	Real Challenges Genuine In touch with self Understand self Being yourself with skill Believable	Real Genuine Sincere Remain true Being yourself with skill Being in action	Remains true to yourself	
	Trustworthy Reliable Worthy of trust, reliance and belief Know who she is	Person not a position Compassion Empathy Leading with heart and head	A person, not a position	

	True north Moral compass Understand passions and purpose for your leadership Lead yourself Life stories Self-awareness Practicing values and principles Balance intrinsic and extrinsic motivations	Know who she is Understand passions and purpose for your leadership Understand self Human weakness Sufficient self-knowledge Know yourself In touch with self	Self-knowledge	**INTERNAL CAUSATIVE FACTORS FOR AUTHENTIC LEADERSHIP**
	Practice solid values Support team Stay grounded Integrating your life	Introspection Internal origin Self-awareness Intense self-awareness	Self-awareness	
	Narrative nature Human weakness Acknowledge frailties Honest expression Connect with followers Person, not a position Speak the truth Conform to fact Honest Integrity Sincere	Experience Challenges Narrative nature Life stories Journey of authenticity Consultations Hardships	Learning from life narrative	
	Internal origin Intimate expression of what we are Being in action Self-expression (how deep and how broad) Intense self-awareness	True north Intense passions Pursue purpose with passion Passion	Pursue the purpose of leadership with passion	
	Character Timeless attributes Substance Speak from the heart	Lead yourself Self-discipline Committed to a lifelong development process	Leading yourself	

	Intense passions			
	Sufficient self-knowledge	Moral compass		
	Tough empathy	Practicing values and principles		
	Display personal vulnerability	Practice solid values		
	Real display of honest emotions	Stay grounded		
	Pursue purpose with passion	Speak the truth		
	Acts under pressure	Conform to fact		
	Passion	Acts under pressure		
	Introspection	Honest		
	Compassion	Integrity	Practicing values and principles	
	Empathy	Believable		
	Self-discipline	Trustworthy		
	Know yourself	Reliable		
	Express yourself	Worthy of trust, reliance and belief		
	Journey of authenticity	Character		
	Remain true	Timeless attributes		
	Committed to a lifelong development process	Substance		
	Leading with heart and head	Acknowledge frailties		
	Experience	Honest expression		
	Consultations	Self-expression (how deep and how broad)		
	hardships	Speak from the heart	Honest self-expression	
		Tough empathy		
		Display personal vulnerability		
		Real display of honest emotions		
		Express yourself		
		Balance intrinsic and extrinsic motivations		
		Integrating your life	Balanced life	
		Support team		

PROCESS	Serve Service Appreciate To accomplish things Inspire Navigate Inspire excellence Brings hope, love, inspiration Stimulate followers to take risks Connects with followers Create value Empower to lead Bring people together Empower people Excite followers	Serve Service Appreciate Creating value To accomplish things Navigate Inspire Inspire excellence Brings hope, love, inspiration Stimulate followers to take risks Excite followers Empower to lead Empowerment of people Connects with followers Bring people together	Serve Create value Navigate Inspire Empower Connects with followers	**PROCESS OF AUTHENTIC LEADERSHIP**
CONSEQUENCES	Extraordinary levels of achievement Meaning Results Values Performance excellence Makes performance meaningful	Extraordinary levels of achievement Performance excellence Results Values Meaning Makes performance meaningful	Resulting in performance excellence Meaning in performance	**MANIFESTATIONS**

3.4.5 Theoretical definition of authentic leadership

From the above defining attributes, a theoretical definition of the concept authentic leadership is formulated. The theoretical definition contains the defining attributes of authentic leadership (typed in bold) as outlined in the connotations. Although this definition is not measurable and abstract (Walker & Avant, 2005:27), it is essential in the process of theory construction.

Authentic leadership in nursing is the process whereby the authentic leader **inspires**, **navigates** and **empowers** followers towards **results** in the form of **performance excellence** and **meaning in their performance**. As authentic leadership is **relationship-centered**, this process unfolds when the authentic leader **connects with** and **serves her followers**. Authentic leadership is conducted by the authentic leader who is **a person, not a position** that **remains true to herself**. Her authentic leadership evolves through her **commitment to a lifelong developing process** of **applying her life narrative** to direct her to **pursue her leadership purpose with passion**; to increase her **self-knowledge** by means of increased **self-awareness**; to **express herself honestly**; to **integrate her life** and to **lead herself**. As the authentic leader **practices her values and principles**, she displays **integrity** and **character**. The emergence of authentic leadership is enforced through the presence of **specific situations**.

STEP 5: CONSTRUCT A MODEL CASE

3.4.6 A model case of authentic leadership in nursing

In the following paragraphs, a model case of an authentic leader is described. The model case is used in theory construction to portray all the defining attributes of authentic leadership. The aim of this model is to provide a genuine example of authentic leadership. During this discussion, the defining attributes are highlighted in bold during the description. The model case is derived from the defining attributes of authentic leadership as derived from the concept analysis and listed in Table 3.10.

1 In this 250-bed private hospital, high patient turnover is a regular sight. It causes great
2 exhaustion to the nurses that need to work amidst a poor nurse:patient ratio. A general
3 sense of burnout is sensed when one speaks with the staff. They don't hesitate to
4 verbalise their loss of meaning in their work and the dissatisfaction it causes. After all, this
5 hospital operates within a profit-driven perspective. Everything, even human interaction

and caring is calculated into measurable quantities and evaluated against a profit motive. A regular complain from nurses are the increase in their workload whilst there are still professional nurse positions vacant since colleagues left for greener pastures abroad (**situation-specific**). Management's quarterly feedback claims the same message over and over again: we have to keep operational costs low, we cannot find suitable staff and we cannot provide a quick solution. Great conflict has aroused after the hospital management received large performance bonuses despite professional nurses' complain of vacant positions, poor salaries and inflexible policies to cost operational costs. The nursing staff yearns for a person that would listen to their frustrations (**situation-specific, person not a position**), that would bring some hope of future solutions. To make matters worse, even the two general surgeons have left for Australia. The impact of these losses is that locum surgeons from neighbouring towns are standing in to assist with surgery in a hospital with eleven busy operating theatres. Poor communication between burnt out staff and distant, over-burdened doctors causes continuous crisis management (**situation-specific**).

Although Elaine is a relative new employee, she is intensively aware (**connected with followers**) of all the factors (**situation-specific**) that causes all this complains amongst her colleagues. She finds herself worried (**self-awareness, self-knowledge**) about the effect of these complains on the patients in the unit as well as the on the morale of the nurses. Elaine has recently returned from working in a 500-bed hospital in Saudi Arabia. By managing the general surgery unit of this massive hospital, Elaine gained hands-on experience (**learning from your life narrative**). But she still tastes the hardships that accompanied her life abroad (**learning from your life narrative**). She reminds herself to view her Saudi Arabia experiences as a time of intense personal growth (**learning from your life narrative, self-knowledge, leading self**). The reality was that this endeavour removed Elaine from a professional- and personal comfort zone (**learning from your life narrative**). The challenge was not only the exhaustive workload, but also the crisis she experienced by working with colleagues from unknown cultures (**situation-specific**) and the confrontation of loneliness. Elaine was more than anything else, confronted with herself (**self-awareness, self-knowledge**). She questioned her passion for nursing (**pursue leadership purpose with passion**) frequently and at one stage considered to leave the nursing profession completely (**honest self-expression**). It was during this difficult life challenge that Elaine had to rediscover who she really was (**remains true to yourself, self-awareness, self-knowledge, learning from your life narrative**), what is her purpose (**pursuing leadership purpose with passion**) and

where is she heading. A period of painful, honest introspection and retrospection (**self-awareness, self-knowledge, leading self, honest self-expression**) enabled Elaine to realign her life purpose. Today is one of those crisis-filled days whereby Elaine continuously remind herself why she has decided to return to Saudi Arabia and accepted the position in this surgical unit (**pursue leadership purpose with passion**). Besides, just watching the facial expressions of her stressed colleagues, people she has learned to know (**relationship-centered**), clarifies this purpose (**self-knowledge**).

During the past few months that Elaine has been employed in the surgical unit, she has started to have positive relations (**relationship-centered, connections with followers**) with her colleagues. She has always felt that she works better in a team (**relationship-centered**) if they knew each other better and supported each other (**relationship-centered**). Although she occupies a senior position, she finds herself talking to colleagues about her current experiences (**honest self-expression**) in relation to experiences (**learn from your life narrative**) in Saudi Arabia. Although everybody in the unit's workloads are overloaded (situation-specific), it seems as if colleagues listen to Elaine's stories as one professional nurse stated "I listen to Elaine's stories...yes, I want to hear more about Saudi Arabia, but what I actually enjoys is hearing how Elaine tells from her heart, how she appreciates it to be back in this busy ward..I mean, there must be a reason why she chose us..." (**honest self-expression, connection with followers, meaning in performance**).

Since Elaine has joined the ward, her colleagues are aware of her activism towards quality nursing (**practice values and principles, pursue leadership purpose with passion**). She finds herself demonstrating better techniques (**navigate, empower**) and challenges the unit manager towards best practice guidelines (**inspire**). Just the fact that Elaine negotiated permission from the unit manager to have a daily, short in-service training programme to enhance the quality in the ward, has caused her colleagues to take notice of how important this matter is to Elaine (**remains true to yourself, practice values and principles, serve**). When tired or down, Elaine reminds herself that she needs to be a role model for quality nursing to her colleagues (**self-awareness, pursue leadership purpose with passion, inspire**). Slowly colleagues are buying into this quality-orientation (**navigate**) motivated by Elaine. Needless to say, Elaine holds a bachelor's degree and post-graduate qualifications in nursing (**remains true to herself, leading self**). Her competence and skill (**remains true to herself, a person not a position**) is portrayed through all her activities and the manner in which she interacts with people (**relationship-centered, remains true to yourself,**

leading self). Elaine has never boasted about her qualifications (**practice values and principles**). She calls herself a nurse (**remains true to herself, self-knowledge, honest self-expression**), a colleague and a friend, trying to bring change (**serve, navigate**) for the better (**resulted performance excellence**) into a chaotic busy unit.

Today is one of those typical busy days (**situation-specific**), too many patients, and too little experienced staff. As everything seems upside down, Elaine remains in control as she has to handle one crisis after another (**remains true to yourself, leading self, practice values and principles**). She confirms to herself that the outcome of this chaos might just be positive. Although she anticipates that the unit might have positive financial output (**resulted performance excellence**) due to the quality-orientation that is slowly adapted, she knows there are more. She knows that her colleagues are starting to complain less and they might just start to feel part of the team (**meaning in performance**). Therefore, Elaine remains calm and doesn't exchange quality nursing for immediate gratification (**practice values and principles**). And slowly, as Elaine's colleagues are starting to experience support and fulfilment in working together in that unit, it confirms her purpose (**meaning in performance, results, pursue leadership purpose with passion**).

The nursing service manager is continuously more interested in Elaine's lessons from Saudi Arabia. This morning she said to Elaine that she is eager for suggestions to enhance the quality of patient care in the whole hospital. Elaine welcomes the opportunity to share information (**serve, empower**) although she might be confronted with challenges. It seems as if Elaine isn't afraid to give her honest opinion (**practice values and performance, honest self-expression**) and to give the facts (**practice values and principles**), even though she knows that the hospital management is distrusted by the staff due to incongruent behaviour. The unit's statistics revealed a decrease in patient incidents and higher patient satisfaction against the rest of the hospital (**resulted performance excellence**). At a management meeting the nursing service manager stated that the surgical unit might reveal their secrets for this positive outcome. Although Elaine's input (**serve**) to get her colleagues aligned (**navigate, empower**) towards a culture of quality, has not been identified as the reason for these outcomes, the hospital's management is aware of some sort of change present in the surgical unit (**resulted performance excellence**). To Elaine, feedback on these positive outcomes (**create value**) is good news although she would be ecstatic when her colleagues experience that their participation in a team towards quality nursing made all the difference (**meaning in performance**).

112 As Elaine is really exhausted at the end of the day, she is off to the gym with a friend
113 (**leading self, balanced life**). She still needs to complete an assignment of the
114 infomatrics course tonight (**leading self**). She is tired but forces herself to exercise,
115 knowing that it essential for her well-being (**self-knowledge**).

In the following table, a numerical justification is done of the defining attributes that were embodied in the authentic leadership model case formulated above.

Table 3.11 Justification of the defining attributes (connotations) of authentic leadership as utilised in the model case

Defining attributes of authentic leadership	Reference to the line numbers of the model case
Situation-specific	9, 14, 20, 22, 33, 81
Relationship-centered	48, 50, 51, 52, 76
Remains true to self	40, 69, 74, 74, 76, 78, 83
A person, not a position	15, 75
Self-knowledge	23, 30, 35, 40, 43, 48, 78, 115
Self-awareness	23, 35, 40, 42, 71
Learning from life narrative	27, 28, 29, 31, 40, 55
Leading yourself	30, 43, 74, 77, 83, 113, 114
Practice values and principles	63, 69, 77, 83, 84, 90, 98, 99
Honest self-expression	37, 43, 54, 60, 78, 99
Balanced life	113
Pursue leadership purpose with passion	36, 41,46, 63, 71, 93
Serve	69, 79, 97, 105
Create value	108
Inspire	65, 71
Navigate	64, 72, 79, 105
Empower	65, 97, 105
Connection with followers	21, 50, 60
Resulted performance excellence	80, 86, 102, 103, 108
Meaning in performance	61, 88, 110

3.4.7 Literature control of the defining attributes (connotations) of authentic leadership

A literature control of the antecedents, process and consequences of authentic leadership as displayed in this research, was conducted. The defining attributes of authentic leadership in nursing are highlighted.

3.4.7.1 External causative factors for authentic leadership (antecedents)

Authentic leadership that emerges in **specific situations** are confirmed by various authors (Avolio & Gardner, 2005:316, 327; Bass & Steidlmeier, 1999:211; Branson, 2007:226; Cooper, 2005:476; George, 2006:1; George, Sims, McLean & Mayer, 2007:130; George, 2008:1; Goffee & Jones, 2006:99; Goffee & Jones, 2006c:24; Goffee & Jones, 2006e:22; Goffee & Jones, 2006f:55; Kleiner, 2007:1; May, Chan, Hodges & Avolio, 2003:247; Taljaard, 2007:8; Weber, 2004:2). Gardner, Avolio, Luthans, May and Walumbwa (2005:346) referred to the antecedents of trigger events and personal history as antecedents to authentic leadership.

Authentic leadership is **relationships-centered** as confirmed by Avolio and Gardner (2005:332-333); Cashman (2007:6); George *et al*, (2007:136); Goffee and Jones (2006:99); Goffee and Jones (2006e:22); Goffee and Jones (2006f:55); Ilies, Morgenson and Nahrgang (2005:381); Kerfoot (2006:595) and Wollenburg (2004:1789).

3.4.7.2 Internal causative factors for authentic leadership (antecedents)

The authentic leader **remains true to self** was confirmed by various authors (Avolio & Gardner, 2005:320; Bass & Steidlmeier, 1999:198; Bennis, 2004:4; Broughton, 2001:14; Endrissat, Müller & Kaudela-Baum, 2007:211; Fensen, 2000:1; Gardner & Schermerhorn, 2004:271; Goffee & Jones, 2006b:52; Kellerman, 2008:17; May *et al.*, 2003:249; Pembroke, 2002:17; Shamir & Eilam, 2005:397 and Stern, 2004:10).

The following literature confirmed that an authentic leader is **a person, not a position**: Bass and Steidlmeier (1999:189), which referred to the individual consideration in leadership; Broughton (2001:4) with specific reference of a person to possess warmth; Callan, Mitchell, Clayton and Smit (2007:8); Kerfoot (2006:595) and Sharma *in* Shelton (2008:2).

The authentic leader has **self-knowledge** (Branson, 2007:226, Callan *et al.,* 2007:18; Gardner & Schermerhorn, 2004:272; George, 2006:1; George *et* al, 2007:130; Goffee & Jones, 2006:99; Goffee & Jones, 2006e:21; Goffee & Jones, 2006f:55; Kellerman, 2008:17; May *et al*, 2003:249; Shirey, 2006:261) as well as being **aware of self** (Avolio & Gardner,

2005:317; Bowman & Garten, 2005:15; Branson, 2007:226, 238; Callan *et al.,* 2007:9; Gardner *et al.*, 2005:345; Gardner & Schermerhorn, 2004:272, Goffee & Jones, 2006d; Ilies *et al.,* 2005:376; May *et al.*, 2003:250; Sharma *in* Shelton, 2008:2; Shirey, 2006:261; Sparrow, 2005:421; Toor & Ofori, 2008:625).

The following authors confirmed that the authentic leader **learns form a life narrative** (George, 2006:1; George *et al*, 2007:130; Goffee & Jones, 2006b:52; Jensen, 2006:28 and Shamir & Eilam, 2005:402-403).

That the authentic leader **practices values and principles** were confirmed by various authors (Avolio & Gardner, 2005:321, 324; Bass & Steidlmeier, 1999:191, 193, 196; Bowman & Garten, 2005:16; Branson, 2007:226, 239; Broughton, 2001:14; Callan *et al.*, 2007:8; Cashman, 2007:6; Fensen, 2000:1; Gardner *et al.*, 2005:346; Gardner & Schermerhorn, 2004:271; George, 2006:1; George *et al.*, 2007:130, 134; Ilies *et al.*, 2005:380; Johnson, 2002:7; May *et al.*, 2003:248; Sharma *in* Shelton, 2008:2, Shamir & Eilam, 2005:397; Shirey, 2006:260; Sparrowe, 2005:424 andTaljaard, 2007:8).

Bennis (2004:4), Fensen (2000:1), Ilies *et al.*, (2005:381), Johnson (2007:36) and Sparrowe (2005:422) confirmed that the authentic leader uses **honest self-expression**. According to Shamir and Eilam (2005:396), the act of authentic leadership is already a form of honest self-expression. The authentic leader **balance her life** by means of integration between work, family, friends and community commitments, as confirmed by Avolio and Gardner (2005:325); George (2006:1); George *et al.* (2007:130, 135, 137), Kellerman (2008:17); Sharma *in* Shelton (2008:2).

Bennis (2004:5), Bowman and Garten (2005:16), Cashman (2007:6), Kerfoot (2006:596) and Shirey (2006:260) confirmed that the authentic leader **pursue her leadership purpose with passion**. Blohowiak (2000:38) referred to it as facing your motives and answer why you have stepped to the front volunteering yourself as a leader. Shamir and Eilam (2005:397) concluded that the authentic leader has a deep-rooted purpose in her leadership with an eudemonia value.

The authentic leader **leads herself** by means of being committed towards a lifelong development process and by having self-discipline, as confirmed by Endrissat et *al.,* (2007:211), Gardner and Schermerhorn (2004:272), George (2006:1), Sharma *in* Shelton, (2008:2) and Shamir and Eilam, (2005:406).

3.4.7.3 Process of authentic leadership

The following authors confirmed that to **serve** is part of the process of authentic leadership: Bass and Steidlmeier (1999:189); George (2006:1) and George (2008:1). Gardner and Schermerhorn (2004:274); George (2006:1); Goffee and Jones (2006c:24); and Katz and Miller (2008:10) confirmed that the authentic leader **creates value**. **Inspiration** as a process by the authentic leader has been confirmed by Bass and Steidlmeier (1999:184); Gardner and Schermerhorn (2004:274-5) – referred to as giving hope; George (2006:1) and Goffee and Jones (2006c:24). The following authors confirmed that the authentic leader **navigates** followers: Avolio and Gardner (2005:326) – leading by example; Fensen (2000:1); Pembroke (2002:17), Toor and Ofori (2008:625). That the authentic leader **connects with followers** was confirmed by Bass and Steidlmeier (1999:187); Endrissat *et al.* (2007:212); George (2006:1); Sharma *in* Shelton (2008:2) and Wollenburg (2004:1789). Bass and Steidlmeier (1999:211) and George *et al.* (2007:137) confirmed that the authentic leader **empowers** followers.

3.4.7.4 Manifestations of authentic leadership (consequences)

Performance excellence as a **result** of authentic leader was confirmed by various authors (Bass & Steidlmeier, 1999:211; Branson, 2007:226; Cashman, 2007:6; Gardner *et al.*, 2005:346; Gardner & Schermerhorn, 2004:273; George, 2006:1; George *et al.*, 2007:130;; Kerfoot, 2006:596; Schermerhorn & McCarthy, 2004:51 and Sharma *in* Shelton, 2008:2). Yammarino, Dionne, Schriesheim and Dansereau (2008:698) referred to hard and soft performances with regard to the individual, group and organisation. Avolio and Gardner (2005:231), Bennis (2004:4) and Fensen (2000:1) confirmed that authentic leadership implies that followers get **meaning from performance**.

STEP 6: DEFINE THE EMPIRICAL INDICATORS (DENOTATIONS)

3.4.8 Denotations (empirical indicators) of authentic leadership

The formulation of denotations is the last step in the process of concept analysis. Denotations aim to provide empirical indicators that will enable the answer to the question "How can we identify the existence of authentic leadership and where can we start to measure it?" (Walker & Avant, 2005:3). Denotations are the empirical indicators essential to make authentic leadership visible in practice. These empirical indicators are formulated from the literature searches and the defining attributes (connotations). The formulation of the denotations were conducted according to the three four categories of external causative

factors for authentic leadership (antecedent); internal causative factors for authentic leadership (antecedent), process of authentic leadership and the manifestations of authentic leadership (consequences). Walker and Avant (2005:73-74) stated that clear denotations are necessary in theory to assist in the process of instrument development. Denotations are also functional in practice because these empirical indicators provide with clear referents in which authentic leadership can be identified in nursing practice. Please refer to Table 3.12 for the denotations of authentic leadership.

3.4.9 Operational definition of authentic leadership

Authentic leadership is the process whereby the authentic leader **inspires**, **navigates** and **empowers** followers towards **results**, **performance excellence** and **meaning in their performance**. As authentic leadership is **relationship-centered**, this process unfolds when the authentic leader **connects with** and **serves her followers**. Authentic leadership is conducted by the authentic leader who is **a person, not a position**, which **remains true to herself**. Her authentic leadership evolves through her **commitment to a lifelong developing process** of **applying her life narrative** to direct her to **pursue her leadership purpose with passion**; to increase her **self-knowledge** by means of increased **self-awareness**; to **express herself honestly**; to **integrate her life** and to **lead herself**. As the authentic leader **practices her values and principles**, she displays **integrity** and **character**. The emergence of authentic leadership is enforced through the presence of **specific situations**.

Table 3.12 Denotations (empirical indicators) of authentic leadership

	Connotations of authentic leadership	Denotations of authentic leadership
ANTECEDENTS	**External causative factors for authentic leadership** • Situation-specific • Relationship-centered	• Voicing the need for authentic leadership in nursing • Deeper connections established between people • Awareness amongst people that a team is better than one
	Internal causative factors for authentic leadership • Remains true to yourself • A person, not a position • Self-knowledge; Self-awareness • Learning from life narrative • Integrity • Character • Leading yourself • Practicing values and principles • Honest self-expression	• Consistent behaviour, keep promises • Speaking the truth, openness • Decisions taken for an organisation is to the long-term benefit of the organisation, not to suit the selfish ideals of a person, not egocentric • Emotional intelligence, interpersonal skills • Having a passion for your work • Maintain high standards • Accountability for performance • Admitting mistakes • Regular formal and informal training courses

	• Balanced life • Pursue purpose of leadership with passion	• Skilled, competent • Telling your life story, acknowledge other's life story • Self-confidence, positive self-esteem, self-acceptance • Feeling obliged to step up and lead • Can name personal values, gives opinion • Clear ethical boundaries • Healthy relations with family and friends outside the working environment • High trust levels

PROCESS	**Process of authentic leadership** • Serve • Create value • Navigate • Inspire • Empower • Connects with followers	• Treating others as equals • Sharing your life story • Colleagues are helping each other • Asking a colleague why things are done in a certain way • Colleagues are aligned around a shared mission • Knowing aspects about colleagues' personal life • Everybody knows what is expected from them
CONSEQUENCES	**Manifestations of authentic leadership** • Performance excellence • Meaning in performance • Results	• Performance self-evaluation • Responsibility for results above responsibility for activities • Results are communicated • Maintain high standards

3.4.10 Scientific critique against authentic leadership

The main critique against authentic leadership is the lack of empirical evidence and the absence of clear measurement instruments (Shirey, 2006:5). The theoretical as well as the empirical base of authentic leadership is in an infant phase and research about this theme is motivated. Another critique stipulated by Shirey is the risk to focus again only on successful authentic leaders and therefore focusing actually on traits and characteristics.

The researcher acknowledges the lack of empirical evidence and the absence of clear measurements instruments about authentic leadership. Concept analysis of authentic leadership implies the formulation of empirical referents (Walker & Avant, 2005:73), which are useful for instrument development. In this research the lack of empirical evidence is viewed as a stimulus for concept analysis and theory construction. During the process of concept analysis, the defining attributes of the concept authentic leadership are formulated. These attributes are a list of characteristics that are associated with authentic leadership that it enables the researcher to gain better insight into this concept (Walker & Avant, 2005:68). Although the defining attributes are alterable over time (Walker & Avant, 2005:58) the contextual nature of this research is described as a means to enhance repeatability. The overall aim of the concept analysis of authentic leadership is to formulate a definition of authentic leadership for Nursing Science. The purposes of this concept analysis are to gain more insight into the concept authentic leadership in order to clarify the meaning thereof. The concept analysis of authentic leadership is broad whereby an additional literature analysis is conducted after all available uses of this concept were searched. The characteristics of the authentic leader are a part of the whole understanding of authentic leadership.

As declared in Chapter One, the researcher supports the philosophical view of existentialism and social critical theory. This implies that the concept analysis of authentic leadership exceeds basic characteristics but delve deep into the core existence of the authentic leader.

3.4.10.1 Literature associations of authentic leadership

According to Shirey (2006:6) there are associations in literature between authentic leadership with different types of leadership. Content in authentic leadership can be associated with transformational -, servant and Zen leadership. The *authenticity*

factor, the intensity of self-knowledge as well as the transparency that is part of an authentic leader's character is however unique to authentic leadership. Both Zen – and servant leadership has a strong spiritual focus with trust, hope, perseverance, courage and integrity as virtues.

Covey (2004:352-358) conducted a literature search of all the literature theories that have been conducted over a century. A total of 24 theories have been summarised. Leadership theory has been developing over a century and brought about new types of leadership types and leadership styles. Authentic leadership is a new supplement to the existing leadership theories. The aim of concept analysis in this research is to formulate a definition for authentic leadership in Nursing Science. This might enable the setting of clear boundaries that may be surpassing transformational-, Zen- and servant leadership.

As declared in Chapter One, the researcher supports the philosophical view of existentialism and social critical theory. This implies that the concept analysis of authentic leadership exceeds basic characteristic but delve deep into the core existence of the authentic leader.

3.4.10.2 Benefits of authentic leadership

The benefits or positive outcomes of authentic leadership **exceed external symbols** of performance and success. According to Cashman (1997:1-2), authentic leadership add **value** through **synergy**. When an authentic leader can touch his organisation through **personal presence, relationships** and **authentic self-expression**, this applied personal power can **create values** within the organisation. Kerfoot (2006:1-2) reported that a healthy workplace is dependent upon the ability of authentic leaders. Was there a tendency to evaluate leaders only by external outcomes? A literature study by Shirey (2006:7) confirmed that authentic leaders do have the ability to **create lasting organisational values** that may extend beyond the basic success criteria.

The importance of the emergence of authentic leadership is evident in the priority ascribed to this factor by the American Association of Critical-Care Nurses (AACCN), (Kerfoot, 2006:1). The AACCN listed authentic leadership as one of six criteria essential to establish and sustain a **healthy work environment**. The AACCN furthermore acclaimed that the inattention to authentic leadership may cause

detrimental effects of which patient safety, staff recruitment and - retention and a financial sustainability are listed. Summarised, an organisation's journey towards excellence begins by the acknowledgement and development of authentic leadership.

In the above paragraphs and tables, literature was investigated into the uses of authentic leadership in dictionaries, thesauruses and encyclopaedias. As portrayed in the realisation of the data collection, there is a limited amount of literature available on the uses of authentic leadership in the above sources. Therefore, this concept was investigated further. Table 3.4 summarised different authors' definition of authentic leadership and Table 3.5 provided supplementary literature of this concept. During the course of literature analysis, the characteristics that repeated were highlighted. These defining characteristics are uses in step 4 of the concept analysis process, namely to determine the defining attributes of authentic leadership.

The researcher acknowledges the lack of empirical evidence and the absence of clear measurement instruments for authentic leadership. Concept analysis of authentic leadership implies the formulation of empirical referents (Walker & Avant, 2005:73), which are useful for instrument development. In this research the lack of empirical evidence is viewed as a stimulus for concept analysis and theory construction. During the process of concept analysis, the defining attributes of the concept authentic leadership are formulated. These attributes are a list of characteristics that are associated with authentic leadership that it enables the researcher to gain better insight into this concept (Walker & Avant, 2005:68). Although the defining attributes are alterable over time (Walker & Avant, 2005:58) the contextual nature of this research is described as a means to enhance repeatability. The overall aim of the concept analysis of authentic leadership is to formulate a definition of authentic leadership for Nursing Science. The purposes of this concept analysis are to gain more insight into the concept authentic leadership in order to clarify the meaning thereof. The concept analysis of authentic leadership is broad whereby an additional literature analysis is conducted after all available uses of this concept were searched. The characteristics of the authentic leader are a part of the whole understanding of authentic leadership.

As declared in Chapter One, the researcher supports the philosophical view of existentialism and social critical theory. This implies that the concept analysis of

authentic leadership exceeds the basic characteristics thereof, but delves deep into the core existence of the authentic leader.

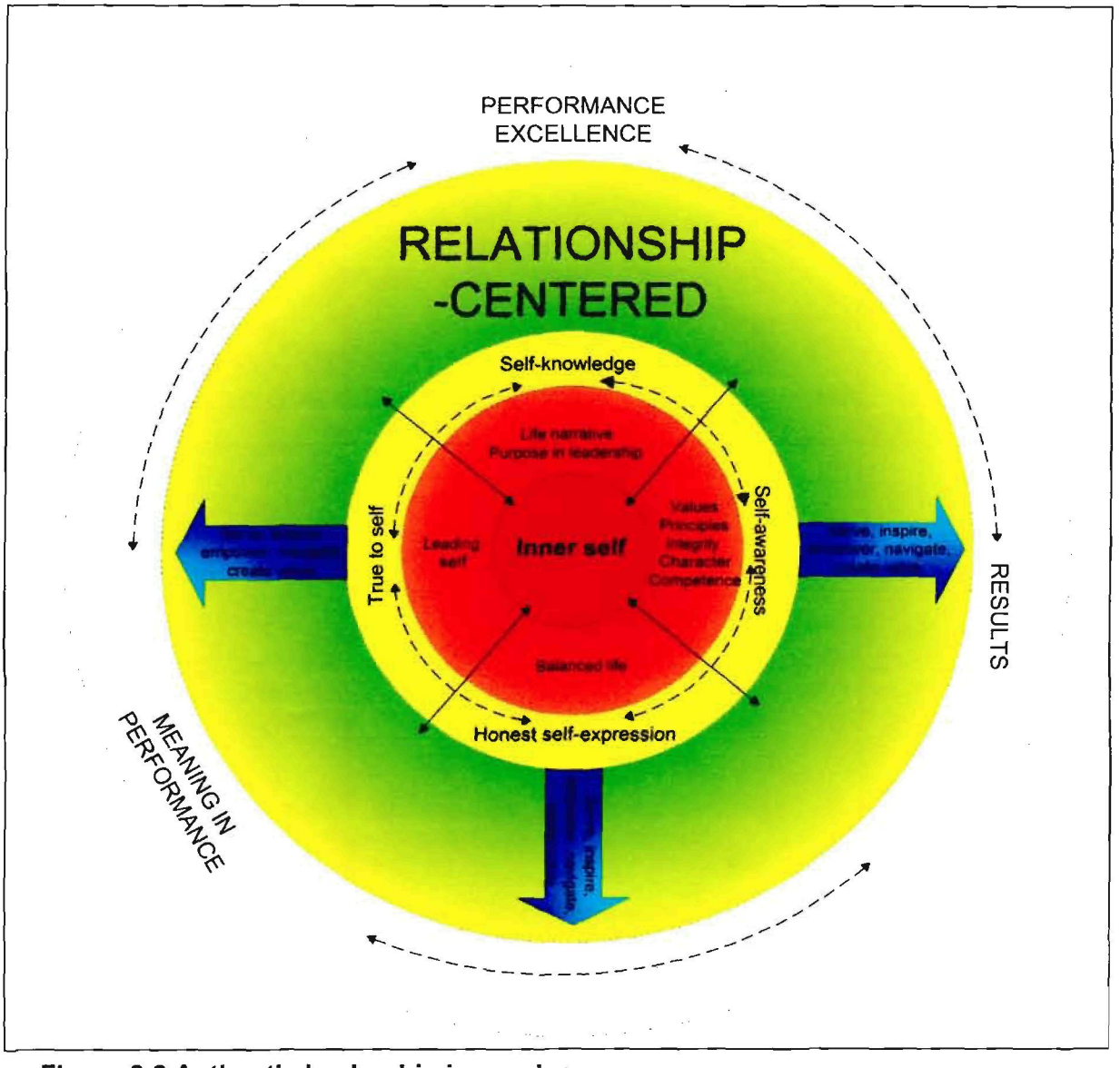

Figure 3.2 Authentic leadership in nursing

3.4.11 Conclusions of authentic leadership in nursing

In the foregoing paragraphs, a concept analysis of authentic leadership was done. The following conclusions about authentic leaders are deduced:

- Authentic leadership is complex human dynamic of intra- and inter-personal phenomenon with continuous communication between the authentic leader's inner self with people in the social sphere. This is done by means of the

authentic leader's ability of self-awareness, her self-knowledge, her ability to express herself honestly and her ability to remain true to herself.

- Authentic leadership is an inside-out process whereby the authentic leader's internal choices are displayed through her behaviour.
- The authentic leader learns from her life narrative by using these life experiences to direct her leadership purpose. The authentic leader knows her leadership purpose and therefore pursues this purpose with passion.
- The authentic leader can stay on track by practicing her values and principles, maintaining a balanced life and by leading herself.
- To the authentic leader people are important therefore authentic leadership is relationship-centered. The authentic leader connects with and serves her followers.
- Authentic leadership is very hard work and a difficult task that requires sacrificial growth and a lifelong journey. This in combination with traditional organisational views of leadership is the reason for a short fall.
- The authentic leader serves followers and utilises inspiration, navigation, empowerment and commitment to create value.
- Authentic leadership is associated with results and high standards as well as to make performance meaningful to followers.

3.5 LITERATURE ANALYSIS: RECIPIENT [PROFESSIONAL NURSE]

The first related concept that is described and defined by means of a literature analysis is the recipient. According to the survey list (Dickoff *et al.*, 1968:419) the recipient receives the actions as conducted by the agent. In this research the recipient is **professional nurses** employed in South African hospitals. Firstly, the professional nurse will be defined and thereafter the concept professional nurse is described according to competency, attributes, role profile and nursing practice.

According to Section 43(1) in the Nursing Act (no 33 of 2005), a person that is registered in one of the contemplated categories of Section 31, is allowed to use the title "Registered Professional Nurse" with the associated abbreviation of "RN". In this research the concept *professional nurse* is used which is similar to the term registered professional nurse.

3.5.1 Definitions of a professional nurse

According to the International Council of Nurses (ICN) (2004:1), patients, employers and the public have the right to know that a person who uses the title "nurse" is legally qualified to do so. The person who is referred to as a "nurse" (ICN, 2004:1), implies an individual who is responsible and accountable for his/her actions and adheres to ethics and a professional code of practice. In addition, the South African Nursing Council (SANC, 2005:99) define a professional nurse is as person who is licensed as a professional nurse under the Nursing Act (no 33 of 2005); who assumes responsibility and accountability for independent decision making, in such a practice and is educated and competent to practice comprehensive nursing.

3.5.2 Competencies and attributes of the professional nurse

Competencies, as defined by the Canadian Nurses Association (CNA) (2000:6), refers to the specific knowledge, skills, personal attributes and judgement that a registered nurse requires and that is applied to ensure practice that is ethical and safe within a designated role and setting. Competency development is initiated in undergraduate nursing education (Bryant, 2005:23). During undergraduate education, the goal is to establish a professional nurse's competency to enable her to fulfil the competency required for her professional nursing role, at an expected standard. However, the professional nurse's competence should be developed continuously. Traditionally, professional nurses' competence focus was predominantly on initial competence whilst continuing competence has been neglected and this poses a great challenge at present (Bryant, 2005:24). The presence of international nursing skills councils serve as an example of the focus shift to competence development amongst professional nurses. In addition, the World Health Organisation (WHO) (2008:17) stated that the nurse has a personal responsibility to maintain high competence.

In 2002 the ICN developed broad and generic international nurse competencies that formed part of an international nursing regulation commitment (Bryant, 2005:25). A comprehensive literature study by Bryant (2005, 28-30) revealed increased attention placed on competence assessment and evaluation as well as the developmental stages of assessment tools. Different nursing councils stated different standards and domains in which the competence of registered nurses can be categorised. The Australian Nursing and Midwifery Council (ANMC) (2005:18) categorised registered nurse competence into the domains of professional practice, critical thinking and

analysis, provision and coordination of care, collaborative and therapeutic practices. The Nursing Council of New Zealand (2006:1-6) uses the domains of professional responsibility, management of nursing care, interpersonal relationships and inter-professional healthcare and quality improvement. Locally, Subedar (2004:1-9) of the SANC outlined the professional nurse's competencies into three categories, namely theoretical competencies, clinical competencies and occupational competencies. Although the SANC promoted a competency framework for nursing practice in general, this competency framework also applies to the professional nurse and is categorised as: the professional ethical practice, clinical practice and quality of care. Please refer to Table 3.14 for a synthesized attempt to categorise the competencies of nursing as stipulated by the SANC, with the domains of professional nurse competencies according to other nursing councils. This table provides examples of the application of these competencies in the nursing practices.

Besides the focus on professional nurse competencies, the CNA (2000:1) notes to the importance of continuous competence of professional nurses. This refers to professional nurses' ongoing ability to apply and integrate their skills, knowledge, judgement and personal attributes in practising nursing safely and ethically. Continuous competence of professional nurses can be established through a continuous competence programme that focuses on the acquisition, promotion and maintenance of professional nurses throughout their professional career life (Joint position statement of CNA and CASN, 2004:1). Career development is an important factor that could assist the nursing profession in meeting worldwide challenges and ensuring the delivery of high quality care (ICN, 2007:1-3). This career development should be geared towards embracing the global challenges and should therefore provide mobility, access to nursing-entrepreunering and independent practice opportunities to both support and sustain an effective educational system.

3.5.3 Role profile of the professional nurse

The professional nurse plays different roles in her professional capacity. Various roles were found in available national and international literature. These roles are discussed in the following paragraphs.

3.5.3.1 The professional nurse as clinician

The professional nurse's first role is that of a clinician and refers to her role as care provider in the clinical nursing practice (Aud, 2004:306; ICN, 2006:3; College &

Association of registered nurses in Alberta [CARNA], 2005:3). As a clinician, the nurse is associated with addressing the patient's physical, psychosocial and spiritual needs (Aud, 2004:306). In the role of clinician, the professional nurse is responsible for patient education and direct care assistance. These interventions are done with an attitude of partnership with the patient by means of shared decision-making (Aud, 2004:306). The direct care of the patient's physical needs refers to basic nursing utilising the nursing process and implementing nursing interventions for identified signs and symptoms. Within a clinician role, the professional nurse provides psychosocial - and spiritual care by for example, effective listening, encouraging reminiscence and providing emotional support.

Applying a partnership attitude with patients that enable shared decision-making, the professional nurse utilises an effective referral system and provides patients with honest feedback. Within the role of clinician, the nurse has the responsibility to determine, implement and maintain standards of high quality nursing. In addition, CARNA (2005:3) listed that the professional nurse, as direct care provider, also acts as a case manager; a decision-maker and problem solver; care coordinator (also listed by the Nursing Council of Hong Kong [NCHK], 2004:5), planner and evaluator; critical thinker, assessor and interpreter; participant; developer and leader in quality improvement activities.

3.5.3.2 The professional nurse as educator

The professional nurse's second role is that of an educator (Aud, 2004:306; ICN, 2008:1; ICN, 2006:3; [NCHK], 2004:5). This role implies the transmission of information to the patient. According to the research of Aud (2004:306), the nurse as educator provides information that is appropriate and applicable to specific patients and their needs. Furthermore, the professional nurse is responsible for promoting a supportive learning environment for nursing students whilst simultaneously ensuring and respecting patients' rights; promoting self-reflection and practice-reflection to cultivate an environment that is supportive towards life-long learning (CARNA, 2005:6; Pelletier; Barkley; Brennan; Graham; Heinzig & Hubert, 2006:6-8).

3.5.3.3 The professional nurse as advocate

In addition to being a clinician and educator, the professional nurse is also an advocate for patients (Aud, 2004:306; ICN, 2006:1; [NCHK], 2004:5). This role empowers of patients to obtain the required information, care and resources and acts on patients' behalf when a patient is unable to (CARNA, 2005:4). Within the role of patient advocate, the nurse-advocate could be viewed as a person who shows

Table 3.13 Professional nurse competencies

A combination of information gathered from the ANMC (2005:1-8), Canadian Nurses Association and the Canadian Association of Schools of Nursing (2004:1-3), Nursing Council of New Zealand (2006:1-6) and the SANC (*in* Subedar, 2004:1-9).

Main competencies according to the SANC	Domains in nursing competence	Possible application
THEORETICAL COMPETENCE Competence that is instrumented through theory and practice is mainly cognitive in nature and linked to the universal and the general understanding of subjects. Theoretical competence is an expression of what the health professional has to know about and why she needs to know it.	**PROFESSIONAL ETHICAL PRACTICE** • Ethical-legal framework. • Accountability. • Comply with relevant legislation. • Practice in accordance with the codes of ethics that govern the nursing profession. • Integrate organisational policies and guidelines with professional standards. • Practice in such a way that acknowledges the cultures, values, dignity, beliefs and rights of all.	• Demonstrate understanding and insight into the Nursing Act (no 33 of 2005). • Identify the legal and illegal implications of nursing interventions. • To identify unethical professional practice with regard to privacy and confidentiality. • To both describe and adhere to the legal requirements of medication. • Recognises your own beliefs and values and the impact of these factors on nursing. • To provide cultural sensitive care. • To practice in confirmation of the regulations by the South African Nursing Council. • Demonstrates effective engagement in ethical decision-making. • To take appropriate action in the event of unsafe practice. • To act as an advocate in order to protect human rights. • To respect patients' right to the access of information and the right to informed choice. • To illustrate a balance between professional responsibilities versus personal and employment rights.

Table 3.13 continues

	• Recognise the differences in accountability and responsibility between professional nurses, enrolled nurses and auxiliary nurses.	• To appropriately intervene in healthcare that will not compromise the privacy, the safety and the dignity of patients. • To meet the requirements of the professional nurses' regulatory bodies for continuing competence.
CLINICAL COMPETENCE Competence within the clinical practice that is based on experience and handed over and instrumented by participation in practice. Clinical competence is independent of person and context and is competencies within clinical interventions and actions that are based on values and theories.	**CLINICAL PRACTICE** • Care provision. • Care management. • Fulfils the duty of care. • Integrates nursing, knowledge, skills and attitudes to provide safe and effective nursing. • Understand and practice within scope of practice. • Interpersonal relationships.	• To undertake comprehensive and accurate nursing assessment of patients in a variety of settings. • To provide planned nursing care in order to achieve identified outcomes. • Reflects and evaluates the effectiveness of nursing with peers and experienced nurses. • To provide health education that is appropriate for the needs of a patient and within the framework of nursing. To ensure accuracy of documentation. • Evaluate the patient's progress with regards to expected outcomes. • To ensure that a patient has sufficient explanation of the effects, the consequences and the alternatives of proposed treatment regimes. • To perform nursing according to recognised practice standards. • Promotes and environment that facilitates independence, client safety, health and quality of life. • Communicates effectively.

Table 3.13 continues

		• To practice nursing in partnership with the patient if possible. • To establish, maintains and concludes therapeutic interpersonal relationships with patients. • To use relevant evidence-based assessment framework in order to collect data about the patients' physical socio-cultural and mental health. • To determine agreed priorities for patient need intervention strategies. • Use resources efficiently and effectively in provision of care. • Performs procedures safely and with confidence. • To prioritise workload that is based on the needs, acuity and optimal time for intervention of the patient. • The ability to respond effectively to situations that change rapidly.
OCCUPATIONAL COMPETENCE Instrumented through professional performance.	**QUALITY OF CARE** • Continuing education • Professional enhancement • Quality improvement • Research • Practice within an evidence-based framework • Inter-professional healthcare	• Maintains professional development • Identify the relevance of research in order to improve health outcomes • To use the best available evidence, nursing expertise and the respect for the values and the beliefs of patients during the provision of nursing. • To support and contribute towards nursing and healthcare research. • To participate in quality improvement activities. • To demonstrate analytical skills in the assessment and evaluation of health information and research evidence.

Table 3.13 continues

Occupational competencies are competencies within the role and the functions of the nurse and are connected to knowing and how to make things happen in an organisational structure. An expression of what the nurse takes care of and is responsible for.		• To participate and to collaborate with members of the trans-disciplinary team in order to co-ordinate and facilitate care. • To both recognise and value the skills and the roles of members of the trans-disciplinary team in the health delivery system. • To use appropriate strategies in order to manage one's own responses in professional work environment. • To contribute towards the professional development of others and to enhance the nursing practice. • To use the best available guidelines, evidence and standards in order to evaluate nursing performance. • To demonstrate a commitment towards continuing competence of oneself as a professional nurse through reflective practice, lifelong learning and by integrating learning into practice. • Work with employers in order to ensure that the practice environment support professional nurse competence and the continuation thereof.

respect for human rights as well as patients' rights to enable dignity, respect, and quality of life, patients' rights towards self-determination and access to information.

According to the ICN (2006:2), the nurse is responsible for promoting an environment in which the above can unfold. CARNA (2005:4) further stated that the professional nurse, as clinician, fulfills the role of health policy advocate (also listed in NCHK, 2004:5). Healthy public policy advocacy could be acquired through political action on local, provincial, national and international levels (CARNA, 2005:4).

3.5.3.4 The professional nurse as researcher

The forth role examines the professional nurse as researcher (ICN, 2008:1; ICN, 2006:3) As a researcher, the professional nurse refines and validates existing knowledge and generates new knowledge that could influence nursing (CARNA, 2005:6). This role implies that the professional nurse participates in continuous ethical standards in research; shares knowledge gained through research, ensures high standards in research processes and identifies essential resources to answer identified research questions. These responsibilities are only obtainable if the professional nurse supports a practice environment that, in turn supports research through by integrating research findings in the practice (Pelletier *et al.*, 2006:6-8).

3.5.3.5 The professional nurse as manager/administrator

Healthcare delivery management and the representation of nursing services (CARNA, 2005:5) are key aspects of this role. As manager, the nurse encourages participative decision-making and supports a positive practice environment. According to Pelletier *et al* (2006:5-8) the professional nurse is responsible for establishing a system to address ethical challenges and to apply information to ensure optimal human resources. The nurse as administrator also promotes practice environments that support continuous professional development of professional nurses. The professional nurse, as manager, supports nurse leadership (CARNA, 2005:5). The NCHK (2004:5) listed the professional nurse as supervisor as a role that is separate to that of a manager.

3.5.3.6 The professional nurse as leader

According to CARNA (2005:3-5) the professional nurse, as leader, is essential for quality improvement and to lead healthy public policy development and to implement primary healthcare models. As leader, the professional nurse as leader can collaborate and communicate with members of the trans-disciplinary and policy makers. The Nurses Council of Hong Kong (2004:5) identified both the role of a leader and the role of a change agent within professional nurses.

The professional nurse is multi-dimensional, as she mobilises six different roles whilst combining theoretical, clinical and occupational competence within an ethical-legal framework as a member of the health team. The professional nurse therefore cannot be described nor understood in a simple manner. The complex and multi-dimensional view of the professional nurse correlates with the researcher's view of man and existentialism, whereby man is 'n unit of different parts and her existence and the experience thereof is as important as empirical fact. In this research, the professional nurse is the recipient of authentic leadership. The authentic leader is familiar with the competence, attributes and multi-dimensionality of the professional nurse.

3.5.4 The nursing practice of the professional nurse

The final component of the literature analysis that examines the professional nurse, explores the nursing practice. The goal of this analysis is not to describe the context in which the professional nurse practices but to provide a basic outline of the nursing practice in order to gain greater inside into the professional nurse.

According to CARNA (2005:3), the major domains in which the professional nurse practices are the clinical practice, administration, education and research. The nursing practice, also referred to as the practice environment can be described as practice-environment factors that influence nurse-patient relationships and include resources; role expectations; fiscal realities; policies and structures; members of the trans-professional team as well as the type of nursing being delivered (Pelletier *et al*, 2006:3). The professional nurse can be viewed as inseparable from the nursing practice due to the heavy ethical responsibility placed upon nurses to carry personal responsibility and accountability for the nursing practice (ICN, 2006:2).

The nursing practice is regulated by the practice's scope (Subedar, 2004:97-99). The scope of practice provides a compass for nurses to ensure comprehensive nursing. The SANC listed the scope of practice to which the professional nurse should adhere to when practicing her nursing qualifications. The scope of practice of professional nurses are applicable to all professional nurses registered under the Nursing Act of 2005 and is listed in Regulation number R2598 of 30 November 1984 (SANC, 2008:1). The scope of practice of professional nurses are summarised as:

- to provide of emergency care;
- to provide of comprehensive nursing to all people in all healthcare settings;

- to ensure the delegation of nursing care to competent practitioners only;
- to take responsibility and accountability for the nursing of people that have complicated and unstable health conditions; and
- to take responsibility and accountability for the nursing management of individuals, groups and communities.

The analysis of the regulations pertaining to professional nurses is approached from the constitutional context that underwrites the professional nurse's regulation. The South African Constitution is active in the three spheres of government, namely that of national; provincial and local governance (Muller *et al*, 2005:7-9). Within the constitution, the National Health Act (2003) regulates the national health system on a national, provincial and a district level with a Batho Pele focus. The national patient charter (Muller *et al*, 2005:7), which is a list of patient rights, is viewed as another important regulatory boundary that the professional nurse should be well informed of. The new Nursing Act (no 33 of 2005) (SANC, 2008:1) came into effect on 15/12/2006 (SANC, 2008:1). According to Subedar (SANC, 2008:1-9), the intention of the new Nursing Act, 33 of 2005, is to promote professional accountability; to create a regulatory mechanism and to transform the regulatory environment that is applicable to the nursing profession. Subedar further stated that the new Nursing Act, 33 of 2005's impact on the nursing practice is as follows: within the context of public protection, this act will regulate nursing; the new act will align nursing practice to ensure that health priorities are adequately addressed; it implies a revision of the scope of practices of nurses and to review the education requirements for entry level practice; the standards and competency requirements for nursing practice are regulated and the final impact is that of a continuing professional development programme to be implemented. In addition to the above regulatory bodies, the South African Nursing Council (2008:1) published the nurse's rights and stipulated that within the constitution of South Africa, nurses too have rights.

The professional nurse renews her registration at the SANC annually. The SANC provides the Regulations regarding registers (No R3598 of 24 October 1968) as a legal instrument to guide the professional nurse in the process of registers. The professional nurse is responsible for submitting a request for registration to the SANC. Any change in her personal particulars and additional qualifications are to be registered at the SANC. The professional nurse is also required to request to the SANC if she wants her name to be removed or re-registered on the register.

With regard to professional conduct, the SANC provided regulations that serve as the acts of omissions when the SANC may take disciplinary steps against a professional nurse. These

acts and omissions are outlined in Regulation number R387 of 15 February 1985). Regulation number R1201 of 31 July 1970 stipulates the distinguish devices and rule for uniforms for professional nurses. These devices can be summarised as a silver badge of the SANC that is positioned onto dull cherry coloured epaulettes.

In the following drawing the professional nurse is portrayed in a graphically. Please refer to figure 3.3.

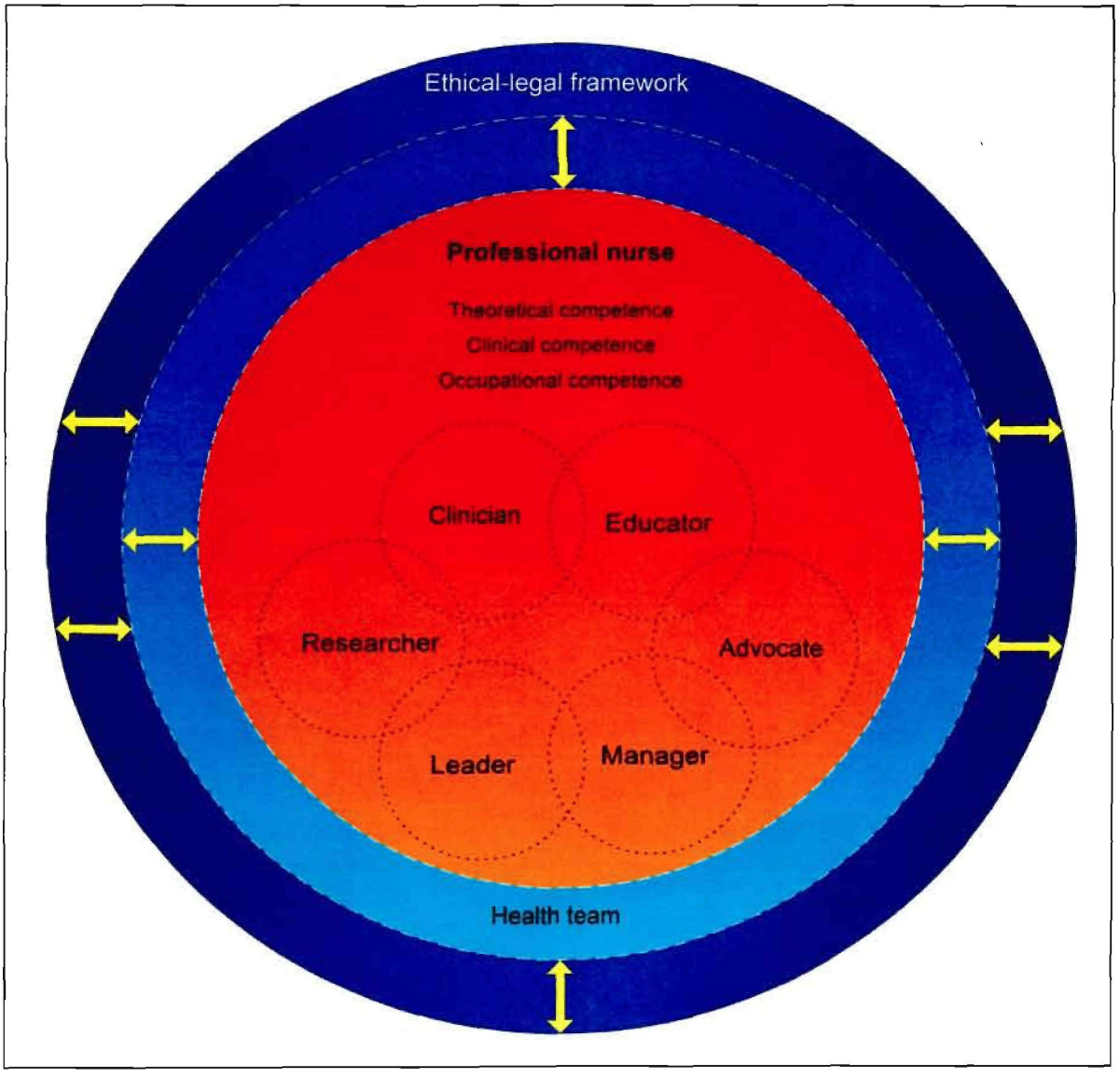

Figure 3.3 Professional nurse

3.5.5 Conclusions of the professional nurse

From the above literature analysis, the following conclusions have been formulated:

- To man, a professional nurse symbolises an accountable, capable and responsible person that adheres to an ethical, professional practice.

- The professional nurse has theoretical, clinical and occupational competences that are exhibited in a professional-; clinical-; ethical practice and through the quality of care as well as the ability of independent decision-making, responsibility and accountability.
- Due to specific competences the professional nurse is legally licensed to practice comprehensive nursing as a member of the health team.
- The professional nurse portrays the integrated roles of a clinician, educator, advocate, manager, leader and researcher in her professional capacity.
- The professional nurse practices nursing in the domains of the clinical practice, administration, education and research.

In this research the authentic leader inspires the professional nurse towards performance excellence. The authentic leader utilises social capital as a framework, upon which this relatedness and connectedness with the professional are established and maintained.

3.6 LITERATURE ANALYSIS: THE CONTEXT [SOUTH AFRICAN HOSPITALS]

The context refers to the place where the authentic leader (agent) and the professional nurse (recipient) are present and active to conduct the procedure (social capital). The context in which this study unfolds is divided into a macro-, meso and micro level. The following aspects of the context of this research, as listed in Chapter Two (refer to point 2.3.5), will be discussed:

- **Macro context**: International arena
- **Meso context**: The Republic of South Africa
- **Micro context**: South African hospitals

The macro-, meso- and micro context are the spheres in which the authentic leader and the professional nurse are found. The three levels are interconnected and interdependent. This implies that factors on one level will have a direct impact on the other two levels. Therefore, factors impacting any level of the context will also influence the authentic leader and the professional nurse.

3.6.1 Macro level: International arena

The **macro level** context is the international area in which healthcare is positioned as part of the world economy. The international healthcare arena faces multiple universal and

inevitable challenges. This reality has been discussed as part of the background to this research. These challenges can be summarized as globalisation, advanced technology, nursing shortages and migration, an ageing workforce as well as capitalism with an increased consumer society.

- **Globalisation**

The shift from the 20th to the 21st century has been characterised by major social and economic change (McLachlan, 2008:14). It was a shift towards information technology and globalisation. Globalisation refers to greater economic, political and social interaction between countries and the reduction of boundaries (Mittelman *in* McLachlan, 2008:14). The outcome of globalisation is the maintenance of a world economy with the subsequent relocation of expertise. The focus in globalisation is world systems (Herdman, 2004:237) international companies gave input into the companies of developing nations. The establishment of the European Community caused in integration between the economies of different countries into one economy. Another outflow of globalisation and the fall of boundaries is the facilitation of especially nurse migration (Harrington, 2004:196). Herdman (2004:237-238) stated that globalisation and associated capitalism (discussion to follow), have been associated with colonialism.

There are warning signs that globalisation might cause great social inequality and social exclusion. The nursing profession should be aware of the risks of globalisation. Through international health policy, nursing education, labour relations and emigration/immigration, attempts are made to manage the impact of globalisation on the nursing profession. Furthermore, globalisation is inseparable from advanced technology as technology is utilised to extend our traditional geographical boundaries. Advanced technology is listed as the second challenge that impacts on healthcare.

- **Advanced technology**

During the past decade, medical technology has become increasingly more expensive and more powerful (Borthwick & Galbally, 2001:75). Advanced technology has changed communication and travel to such an extent that geographical space has diminished (Austin, 2001:2). The introduction of the World Wide Web has changed the view of technology forever. The Internet caused a great difficulty to draw the line between domestic and international issues as news are no longer in solidarity. Satellites, televisions and broadcasting technology have let to the reality where people can watch unfolding tragedies on a different continent. Advanced technology has been fortified with the Human Genome Project (Austin, 2001:2), which opens enormous ethical questions.

The Human Genome Project that was launched in 2000 opened up a new world of genetic possibility and genetic discrimination (Austin, 2001:4). The increased risk that is associated with advanced technology is the illegal and unhealthy application thereof. The use of information technology in healthcare is cause for concern as it may endanger privacy and confidentiality (Austin, 2001:4). Besides the reality of Dolly, the famous cloned sheep, genetically modified food is a reality in the global marketplace (Austin, 2001:5). Advanced technology in the field of potent pharmaceuticals and vaccines are essential to fight disease. Accessibility to these vaccines and pharmaceuticals depend on the consumer's ability to afford it. The ethical rhetoric is a reality amongst pharmaceutical companies. The United Nations (2008b:1) has introduced their support to space technology to be utilised in the search for solutions for health, climate changes and for food security.

As advanced technology is a challenge that impacts on the healthcare industry, the authentic leader in nursing and the professional nurse should find a way to mediate advanced technology without compromising quality patient care. The utilisation of advanced technology might be difficult for an older workforce especially when noting that the international workforce, in general, is ageing. An ageing workforce is the third international challenge that impacts the healthcare industry.

- **Ageing workforce**

An ageing workforce is part of the international demographics (Turner & Williams, 2005:6), which is anticipated to have major socio-economic and political effects in the global area. The current ageing workforce does not have sufficient investments to afford retirement and according to Turner and Williams (2005:6), a household containing four generations might become a reality. Besides the ageing proportion of the baby boomers, younger generations tend to enter into life events at a later age (Turner & Williams, 2005:8). In addition to this dilemma it is anticipated that by 2031 the death rate will exceed the birth rate.

The impact of the ageing workforce on nursing was anticipated two decades ago. According to Ehlers (2003:65), the median age of professional nurses was 49 years. In the United States of America (USA), baby boomers are the largest generation group represented in the nursing profession. During 1996, an astonishing 91% of all the nurses in the USA were older than 30 years. From these figures, it was anticipated that from 2005 the baby boomers professional nurses would naturally start to scale down on work duties (Ehlers, 2006:65) and will be in their prime retirement years by 2010. With specific reference to South Africa, an ageing workforce in nursing is not only a challenge to hospitals and caring facilities, there is a concern that nurse educators are also within the baby boomer generation group as a

worldwide median age group for nurse educators in 2003 was 50 years (Ehlers, 2003:66). Turner and Williams (2005:19) stated that the challenge of an older workforce to be able to stay in a job for longer and to be able to really offer quality work for remuneration.

The authentic leader in nursing and the professional nurse are exposed to the impact that an ageing workforce has on all three levels of the context. The challenge of an ageing workforce is complicated when nurse shortages and migration are listed as another challenge in the international arena.

- **Nurse shortages and migration**

In the international arena with globalisation, there is an increased demand for professional skills in the international financial market of which, nursing (Borthwick & Galbally, 2001:75), represents a large part of the healthcare industry. As money shifts from the public sector towards the private sector, so does the skills that accompany this resource. A major reason for nurse shortages is the retirement of large numbers of baby boomer generation nurses with a decline in the number of new nurses entering the profession (Emerson & Records, 2005:9). There are referrals to the push-and-pull factors that facilitate the migration of nurses. According to Harrington (2004:197), unsafe work environments, excessive workloads, poor pay, high inflation and political instability are major reasons that push nurses out of their countries and into the international pool of migrating nurses. The factors that attract nurses to new countries are higher salaries, work and study opportunities for the family members, hard currency, career development and better working conditions. The dynamic migration of nurses in the international arena fortifies the importance of international policies and standards for nursing (Herdman, 2004:238).

Ehlers (2003:63) reported that the significant impact of nurse shortages will be between 2005-2020 as this is the period during which the baby boomers will start to retire. According to Ehlers (2003:65) there was an alert about the pending nursing staff shortages two decades ago. Although various options to address nurse shortages have been submitted, the golden solution lies in increasing the supply of professional nurses.

A comprehensive report by the World Health Organisation (WHO) (Buchan *et al.*, 2003:6) indicated an increase in international nurse migration with a continued nurse shortage to have an anticipated detrimental effect on developing and industrialised countries. Developing countries loose scares skills and this has a direct impact on their healthcare delivery system (Buchan *et al,* 2003:8). The amount of working female migrants has increased significantly. The international nurse migration tendency can only be dealt with

effectively when developing imbalances have equalised. These imbalances give rise to ever-increasing push and pull factors that stimulate migration (Buchan *et al,* 2003:9).

Nurse shortages and the migration of nurses can be viewed as opportunities that although detrimental to the professional nurse have intensified the activation of authentic leadership. As one acknowledges the impact that nurse shortages and migration have on the healthcare industry in general, it is distressing to note that capitalism and a consumer society might increase these nurse shortages. Capitalism and a consumer society are identified additional challenges to in the international area that impacts all three spheres of the context.

- **Capitalism and consumer society**

Capitalism and associated individualism is at the order of the day (Borthwick & Galbally, 2001:75) which affects all the areas of a person's life. There is an international increase in income as well as an increase in healthcare inequities whereby national governments have less power against international financial markets. Furthermore money is shifted from public to the private sector. With specific reference to the healthcare industry, the general patient expects more for medical services and clients in the private healthcare sector increase the healthcare inequities.

According to Herdman (2004:237), globalisation led to international companies that are difficult to be governed under national government structures. As a result, governments are formulating policy to ensure the structure for capitalism. Within this capitalistic structure, nursing amongst other types of services, is viewed as a commodity. Due to the high price placed on nursing in developed countries, nurses are recruited from developing and underdeveloped countries, as this is a cost-effect solution. Globalisation marks the end of the Cold War and introduced the new reality of competitorship. Competition is the order of the day as capitalism has lead to a consumer society (Austin, 2001:2). The fact that globalisation caused an increase in capitalism and a consumer society causes is worrying as Bauman (*in* Austin, 2001:2) stated. The initial idea of globalisation was universalism with the goal of more equality, yet this ideal has changed into a profit-driven phenomenon. Within the nursing profession, nursing seems to have become a commodity (Disch, 2003:57); a reality that should be confronted by nurses themselves.

Within the global economy characterised by capitalism, the United States of America experienced a potential bankruptcy crisis. Fears of a Wall Street recession (Tymkiw & Isidore, 2008:1) are reported after the United States of America's government had to pay 700 billion US$ to bail out private American banks to bring immediate financial relief. *According*

to Pitzke (2008:2), this global financial crisis marks the end of an era that will shatter the foundations of United States capitalism. The global market is interconnected and the American economic crisis urged the United Nations (Montas & Yeves, 2008:1) to take action in order to restore confidence in financial markets and to manage the impact that this global financial crisis will have on the developing world, including setbacks to the millennium developmental goals.

Capitalism and a consumer society are impacting the healthcare industry. The presence of capitalism and consumerism as well as the current instability thereof could be viewed as factors that enhance the emergence of authentic leaders in nursing. Within the international arena where capitalism and a consumer society impact the healthcare industry, it is interesting to note positive international attempts to make the world a better place. The millennium developmental goals are such an attempt. In the following paragraphs MDG's are discussed.

- **Millennium developmental goals (MDG's)**

There is an international attempt through the collaboration of developed and developing countries, governments, private sectors and civil society, to make life better for all. This is demonstrated by the launch and maintenance of the millennium developmental goals, shortly referred to as MDG's. The MDG's are eight goals that were established by 189 member states of the United Nations, as part of the Millennium Spring Summit in 2000 (MDG Campaign Toolkit, 2008:3). The aim of these goals is to relieve poverty and to ensure better lives to all. The eight goals are categorised under this aim. The completion date of the MDG's is 2015 and therefore, the process is now halfway. The MDG should be viewed as a global plan of action (Landsberg, 2008:1) with a specific focus develop and uplift developing countries with assistance from developed countries. The plan is developed to be executed through partnerships and civil society and therefore, Landsberg (2008:1) warned that to get mutual responsibility and accountability to ensure that the MDG's realize by 2015, is a great challenge. The eight goals of the Millennium Declaration are listed below (please refer to Table 3.14), accompanied with established targets to be obtained (MDG Campaign, 2008:8-9).

Table 3.14 MDG goals and targets

MDG goals	MDG Targets
Goal 1: Eradicate extreme poverty and hunger	Halve the proportion of people living on less than a dollar a day and those who suffer from hunger.
Goal 2: Achieve universal primary education	Ensure that all boys and girls complete primary school.
Goal 3: Promote gender equality and empower women	Eliminate gender disparities in primary and secondary education preferably by 2005, and at all levels by 2015.
Goal 4: Reduce child mortality	Reduce by two-thirds the mortality rate among children under five.
Goal 5: Improve maternal health	Reduce by three-quarters the ratio of women dying in childbirth.
Goal 6: Combat HIV/AIDS, Malaria and other disease	Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.
Goal 7: Ensure environmental sustainability	Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources. By 2015, reduce by half the proportion of people without access to safe drinking water. By 2020 achieve significant improvement in the lives of at least 100 million slum dwellers.
Goal 8: Develop a global partnership for development	Further develop an open trading and financial system that includes a commitment to good governance, development and poverty reduction –nationally and internationally. Address the least developed countries' special needs, and the special needs of landlocked and small island developing states. Deal comprehensively with developing countries' debt problems. Develop decent and productive work for youth. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries. In cooperation with the private sector, make available the benefits of new technologies – especially information and communications technologies.

The World Bank and International Monetary Fund's Global Monitoring Report of 2008 (World Bank, 2008:3) recorded that the Sub-Saharan Africa and South Asia regions will find it extremely difficult to obtain the above goals by 2015. The international target to reduce extreme poverty by 2008 is on tract. Despite an increase of 7% growth in developing countries over the past five years, the current financial challenge facing rich and developed countries might hinder poverty eradication in the near future. Sub-Saharan African is falling short of this goal whilst approximately 20 developing countries that are burdened by conflicts and/or war, had a low growth total. It is anticipated that more than 50% of the developing world lacks basic sanitation (World Bank, 2008:2).

Specific information from the World Bank (2008e:1) indicated that the obtaining the first goal, namely to eradicate extreme poverty and hunger, is not immune to intense resistance. Although on tract with the MDG's target goals, poverty remains a global problem as one in four people survive on less than US$ 1.25 per day. Ravallion (World Bank, 2008e:1) reported that the cost of living in developing countries is higher than initially calculated and this implies that an approximate 400 million people lived below the poverty line in 2005. Although there is a discrepancy between the World Health Organization (WHO) (2005:1) and the World Bank (2008e:1) with regard to the poverty status globally, these statistics remain alarming. According to the WHO, approximately 1 billion people lived in extreme poverty and survived on less than 1$ daily, in 2005.

With regard to the second MDG goal (Achieve universal primary education) the completion of primary school, empowerment of women, nutrition and basic sanitation goals will not be met by 2015, according to the current status. Although forty million children are attending school (World Bank, 2008:2) and there is a decrease of 60% in gender disparity in primary and secondary schools, approximately 75 million children of primary school age still do not attend school. Although three million more children survive each year, 190 000 children < 5 years and 10 000 women die weekly due to treatable complications associated with pregnancy and childbirth (World Bank, 2008:2). Internationally there are 33 million people affected with the HI-virus whilst more than two million people die annually from AIDS. Malaria kills more than a million people per year (World Bank, 2008:2). Combating HIV/AIDS, malaria and other diseases, is goal number six. Investigations into the WHO's (2005:1) HIV/AIDS statistics indicated that more than 40 million people globally, are living with HIV/AIDS whereby three million people were killed by AIDS in 2003, making AIDS a leading cause of death.

The launch of MDG portrays international collaboration attempts to uplift poverty struck communities found worldwide. Despite these uplifting ideals the world is affected by climate

changes due to global warming. In fact, global warming and the associated climate changes are listed as challenges that impacts communities significantly.

- **Global warming and climate changes**

Globally, people are affected by climate-related disasters, causing major impact on the socio-economic functioning of countries. Billions of people are threatened by global warming and cultures are endangered (Calabria, 2006:1). Known temperatures in Africa and Latin America can change dramatically as early as 2020-2029. This is especially alarming when one acknowledges that the Arctic temperatures are rising at double the speed than the rest of the world. The greenhouse will bring about greater risks for heat waves, drought in sub-tropical areas, melting of ice and snow and causes precipitation in northern latitudes (World Bank, 2008:10). Due to the fact that developing countries cannot adapt to climate changes in the manner rich countries do, more than 200 million people are affected by the impact of these disasters, annually (World Bank, 2008:3). Warnings have been spread and according to the United Nations, early reduction of gasses to reduce the greenhouse effect is an essential to reduce the expenditure necessary by 2030 to mitigate and adapt to climate changes.

The effect that the environment will have on the health of poor people, are easily negated. According to the World Bank (2008:12), there is a link between economic burdens associated with poor environmental health. Diarrhoea, malaria and lower respiratory infections are listed as detrimental environmental effects on the poor living in developing countries. The first initiative to decrease gas emissions to place legal commitment to decrease global warming, originated from the Kyoto Protocol (2008:1). The implication of global warming and climate changes are visible when one notes that the United Nations Educational, Scientific and Cultural Organisation (Montas & Yeves, 2008:3), has been requested to participated in the protection of the rich cultural heritage of nations across the world that are endangered due to global warming.

Climate changes will not only impact on poor communities, it may influence the health status of the world.

- **World health**

The world's health status is a factor that impacts the macro- as well as the meso- and micro levels in the context of the professional nurse. The World Health Organisation (WHO) have published the 2008 World Health Report (WHO, 2008:1-148) in which a call is made that healthcare should return to a primary healthcare approach. Despite a great variety of attempts to enhance the health of people globally, there are still shortcomings and failures in healthcare delivery that lead to dangerous imbalances in the health of all the populations (WHO, 2008:XV). In general, people are living longer and fewer children die compared to the statistics of the mid-seventies. But, the gap between the rich and poor is increasing. According to Montas and Yeves (2008:2), the mistrust that people have in healthcare as well as the unequal access to this healthcare might threaten social stability. The high food and fuel prices are viewed as an important factor that will impact the health of people globally (World Bank, 2008b:1). These high prices will enlarge malnutrition, causing a detrimental long-term impact on human lives, from infanthood to adult life. Due to the current global food crisis, US$1.2 billion was handed for rapid financing to poor people.

Strategies to maintain and enhance the world's health status are influenced by a lack of global peace and security. As indicated in the paragraphs below, world peace and security are challenges at present.

- **Peace and security**

The international arena is still hindered under the detrimental effects of war, conflict and crime. Danon, a United Nations representative from France (United Nations, 2008a:3), stated that the international security is compromised and threatened globally. According to Landsberg (2008:1) conflict is threatening global peace and security. Terrorism, the illicit small arms and light weapons industry and the Russian Federation's military aggression (Tsiskarashvili *in* United Nations, 2008a:1), impacts global security severely. According to Young of the International Committee of the Red Cross (United Nations, 2008a:3), hundreds of civilians are killed by cluster munitions, annually.

Reigning conflict in the Middle East, and conflict struck areas on other continents, caused multiple deaths and high expenditure to gain stability in affected areas like Afghanistan, Pakistan, Israel and Iran and these conflicts pose a humanitarian challenge to the rest of the world (Khalilzad *in* United Nations, 2008:1). According to the Security Council of the United Nations (2008:1), the Taliban is still fighting a war of perception, causing a very complex and flammable situation in the Middle East. International terrorist activities are a reality, causing

the increase in internal troops. Furthermore, the United Nations (2008:1) reported that Middle East security is not a matter of military security, but improving the daily lives of Afghans. A clear link between the conflict in the Middle East and opium cultivation and production (United Nations, 2008:3) is drawn, indicating that warlordism, factional rivalries and strong nexus with the drug trade (Furukh *in* United Nations, 2008:1) should be considered when assessing peace and security in the Middle East. Globally, atomic energy in military use has grown into a huge concern. The United Nations Disarmament Committee (United Nations, 2008a:1) has activated an atomic energy safeguard system to provide standards for safety and security.

The preceded paragraphs illustrate the complex and inter-dependent challenges that the international arena is facing. Despite brave attempts by international bodies, such as the United Nations and the World Health Organisation, there is no quick and simple solution to these current global challenges. As the macro-, meso- and micro levels are independent and interconnected these global challenges impact directly on the Republic of South Africa as well as South African hospitals. The nursing profession as part of the larger healthcare industry within a world economy is also influenced by these international challenges.

In this research the professional nurse experiences the burden of staff shortages and an ageing workforce in her work environment. The profit-driven phenomenon associated with capitalism conflicts with the professional nurse's caring ethos. The international socio-economic and political instabilities impacts on the health status of the world, increasing the overburdened reality in which the professional nurse works. The nursing profession is in peril. This scenario increases the call for leaders in nursing that are different, namely leaders with authenticity that can direct the nursing profession into an unknown and unstable future.

3.6.2 Meso level: Republic South Africa

On a meso level the Republic of South Africa and the broader healthcare that is provided in South Africa becomes the point of reference.

- **General South African demographics**

Sub-Saharan Africa had a total population of 781.3 million people in 2006 (World Bank, 2008c:1) and an annual population growth of 2.5%. This population is found in a surface area of 24 241.9 square meters. Life expectancy at birth is 50.5 years with an infant mortality rate of 93.8 per 1000 in 2006 (World Bank, 2008c:1). South Africa, also referred to as the rainbow nation, is a kaleidoscope of cultures.

The 2008 midyear population statistics by Statistics South Africa (2008) estimated that South Africa accommodations a population of 48 687 000 South Africans. Of this almost 49 million people, 79% of the total South African population are African (38 565 100). The remainder of the population are compiled as follows: 4 379 200 Coloured (9% of the total South African population) and 1243 500 Indian/Asian (2.6% of the total South African population) and 4 499 200 White (9.2% of the total South African population). 52% of the total South African population is female. The African population is again diverted into different cultures and languages. South Africa has eleven official languages of which nine languages are African languages, namely isiNdebele, isiXhosa, isiZulu, Sepedi, Sesotho, Setswana, siSwati and Xitsonga.

The population grouped within South African provinces is as follows (Statistics South Africa, 2008:3):

- *Largest population:* Gauteng province houses 10.5 million people or 21.5% of the total South African population.
- *Second largest population*: KwaZulu-Natal accommodates 10.1 million people or 20.8% of the total South African population.
- *Smallest population*: An estimated 1.1 million South Africans (2.3% of the total South African population) is situated in the Northern Cape

- **South African health statistics**

The health statistics of the South African population is an important factor to describe the meso-level context in which the professional nurse is laborious. In the following paragraphs, prevalent statistics are listed.

i) Literacy rates

According to Ngoma, Delany, Diako and Lopes (2003:38), there are discrepancies in the available data about the literacy rates of the South African youth with rates between 91,3% to 86.8%. Although it is enforced in South Africa that children should attend school for the period six to fifteen years, the World Bank's (2008c:1) Sub-Saharan Africa literacy rate for youth females in 2006 indicated that 64.3% of females between the ages of 15-64 were literate.

ii) HIV/AIDS prevalence

Although HIV/AIDS prevalence statistics provided different rates, these statistics remain alarmingly high. The 2006 HIV prevalence statistics by the World Bank (2008c:1), indicated

that in the Sub-Saharan African region, a total of 5.7% of the population between the ages of 15-49, were infected with the HI-virus. According to the Nelson Mandela/HRSC HIV/AIDS statistics (*in* Ngoma *et al.,* 2003:39), there was a prevalence rate of HIV amongst South Africans aged 15-24, of 9.3%. These rates increased with age and peaked between 25-29 years for women and 30-35 years for men. The WHO (2005:4) HIV/AIDS statistics for 2003 indicated that the prevalence of HIV in people aged 15-49 were 21.5% against the 7.1% for the WHO African Region. The most recent HIV-prevalence rates released by Statistics South Africa (2008:3) indicate a prevalence of 11% of whom an estimated 5.35 million South Africans are HIV-positive.

iii) Mother and child care

According to the South African Demographics and Health Survey (SADHS) of 2003, diarrhoea in children under the age of five, is a major cause for death in Sub-Saharan Africa. Infant and child mortality rates were higher in rural than urban areas. The mortality rate for children under five was 58 per 1 000 children whilst the infant mortality rate was 43 per 1000 in 2003.

iv) General health

The SADHS (2003:22) indicated that 8.44% of female and 31.15% of South African males are smokers. In 2003, 21.3% of South African males reported a form of alcohol dependence (Health Systems Trust, 2008:1). The two major chronic conditions reported by SADHS (2003:22) were high blood pressure and arthritis. With regard to obesity, 23% adult women and 9% adult men were regarded as obese in 2003 (SADHS, 2003:23-24). Obesity is more present amongst South African in urban areas than rural areas. White South African males are more overweight than African, Coloured or Indian South Africans. In South African females, overweight is present equally amongst whites, blacks and coloured people. In the private health sector, men between 60-64 years of age reported to have 58.8 per 1000 patients with diabetes in 2007 (Health Systems Trust, 2008:1). During 2002, 410 per 100 000 people died in South Africa due to cardiovascular disease against 404 per 10 000 in the WHO African Region. Asthma is affecting 9% of South African males in the workplace (SADHS, 2003:28). 31.7 per 100 000 South Africans died due to fatal road accidents in 2007 (Health Systems Trust, 2008). Also in 2007, the Health Systems Trust (2008:1) reported 10.9 reports of malaria per 100 000 South Africans.

v) Social statistics

The SADHS (2003:29-30) indicated that orphan-hood of children below 14 years are high in South Africa and only one third of children, under the age of one , live with both their parents. More than 16% of South Africans are dependent on a grant of some sort and 40% of all social grants go to elderly pension or child support (SADHS, 2003:31). In 2002, only 73% of the rural South African population had access to improved water resources and 66% lacked access to improved sanitation (WHO, 2005:4).

vi) Health systems

The density per 1000 members of the population to healthcare team members in 2004 were as follows: physicians 0.77, nurses in general 4.08, dentists 0.13, pharmacists 0.28 and 0.20 community health workers (WHO, 2005:5). The government had a general health expenditure of 38.6% against 61.4% in the private sector.

vii) MDG status in South Africa

The health status of South Africa by the WHO (2005:6-7) applied to the MDG's indicated the following:

- **Goal 1** (Eradicate extreme poverty and hunger): in 2000 12% of children fewer than five years were underweight.
- **Goal 4** (Reduce child mortality): although the child mortality for children under five years improved from 1999 to 2004, infant mortality rate increased from 53 in 2003 to 54 in 2004.
- **Goal 5** (Improve maternal health): the maternal mortality per 10 000 births decreased from 340 in 1995 to 230 in 2000.
- **Goal 6** (Combating HIV/AIDS, malaria and other diseases): the death rate associated with Tuberculosis increased from 46 per 100 000 people in 2000 to 135 people in 2004.

The South African health statistics indicate the presence of two healthcare groups in South Africa, public patients and private patients. This implies that the management of the health status of South Africans on the meso-level context cannot be conducted within one sector only. This dichotomy in the meso-level context impacts the micro-context of the professional nurse in the South African hospitals directly. The dichotomy between public and private patients are better understood when South Africa is viewed from a post-apartheid perspective.

- **Post-apartheid South Africa healthcare**

Typical to present situations in South Africa, the healthcare sector is also characterized by teething that resulted following the transforming of this sector after the country became a democracy in 1994. Unequal resource allocation from an apartheid regime had to be corrected and new legislation has been passed (South Africa Info, 2006:2). Because the state diverted its focus to primary healthcare, the private healthcare industry took over secondary and tertiary services. The majority of health professionals work in the private healthcare industry in South Africa (South African Info, 2006:1). This necessitated the employment of 450 foreign doctors, from Cuba especially, to address the immediate doctor shortages in state hospitals. Newly graduated healthcare professionals must now complete compulsory community service to understaffed hospitals (Mahlathi, 2006:1). Cullinan (2006:1) suspected that public health institutions are run with half the staff needed and approximately one third of health posts countrywide are vacant. Another effect of the state's transformed healthcare focus to primary healthcare, is the reality of a dysfunctional system challenged with ineffective referrals, poor access to specialized services (Cullinan, 2006:2) and bottle-neck emergency rooms, flooded with minor ailments and primary healthcare needs, as the result of over-burdened clinics.

- **Ethical-legal framework for healthcare in South Africa**

The healthcare sector in South Africa is regulated by a comprehensive set of legal frameworks. At the top of this framework is the Constitution of the republic of South Africa (Nr 108 of 1996) with the Bill of Rights. The Constitution was passed in the post-apartheid democracy. The Bill of Rights, which is part of the Constitution, is the cornerstone for a democratic South Africa Healthcare is furthermore regulated by the National Health Act (Act nr 61 of 2003); Mental Healthcare Act (Act nr 17 of 2002); Employment Equity Act (Act nr 55 of 1998); Occupational Health and Safety Act (Act nr 85 of 1993); Health Professions Act (Act nr 56 of 1974) and the Nursing Act (Act nr 33 of 2005). In South Africa the Board of Healthcare Funders regulates medical schemes. In January 2008, medical schemes reported a 20% tariff increase in private hospital rates. This planned increase was prevented by the intervention of the former South African Minister of Health, Dr Tshabalala-Msimang.

The South African Constitution and the ethical-legal framework for healthcare in South Africa provide clear boundaries that can direct healthcare decisions. The professional nurse is bound to work within the ethical-legal framework of South Africa. Despite the presence of an ethical-legal framework, South African healthcare is divided into a public - and private sectors.

- **Public versus private healthcare sectors**

The South African healthcare sector is characterized by a large public health sector and a smaller mushrooming private healthcare sector that caters for approximately 18 % of the South African population of middle and high-income earners (Anon, 2008:1). Health services run from the most basic primary health care – that is provided by the state free to all. Highly specialized and advanced technological services that is especially available in the private healthcare sector. The public healthcare sector is characterized by being under-resourced and over-burdened. According to Cullinan (2006:1-4), patients die unnecessarily due to the poorly managed and gruesome conditions in public hospitals in South Africa. Approximately 80% of the population depend on free healthcare. It is clear those high levels of unemployment and poverty remains a complex crisis in South Africa with no immediate resolutions for the public healthcare sector (South Africa Info, 2006:1).

According to Khumalo (2008:1), the usage of public healthcare facilities by South Africans has doubled over the past eight years. Between 2006 and 2007, over 101 million visits at public healthcare services were reported. More public health services have been built to supply in the primary healthcare needs of South Africans.

Professional nurses are employed in both the public and private healthcare sectors. Both sectors have complex challenges that influence professional nurses as nursing represent a major part of healthcare professionals. The professional nurse within the public healthcare sector is faced with overburdened and underfunded facilities. The professional nurse within the private healthcare sector is influenced by the realities of a profit-driven business model in which caring has become a commodity. In both healthcare sectors the professional nurse face ethical challenges. This reality increases the professional nurses' need for an authentic leader in nursing. In addition to the ethical challenges found in the conflicting public and private healthcare sectors, there are typical South African challenges added to the meso level context.

- **Typical South African challenges**

In the following paragraphs, challenges that are typical to the current South African context are listed.

At present the South African Department of Health (2008:1) estimates that there are 22.5 million people who are living with HIV in Sub-Saharan Africa. In 2007 the reported three million people who were on anti-retroviral medication, 429 000 people were from South

Africa. The South African government's ARV tender is the largest in the world in order to assist with the large amount of HIV/AIDS patients. According to former health minister Dr Tshabalala Msimang (Khumalo, 2008:1), 478 000 patients received anti-retroviral drugs in South Africa. The UNAIDS (Khumalo, 2008:1) stated that HIV/AIDS is stabilising in South Africa along with Malawi and Zambia. There is a parallel link between HIV/AIDS and Tuberculosis. According to the Health Systems Trust (2008:1), 998 per 100 000 South Africans had tuberculosis in 2006. The WHO (2005:4) estimated a TB prevalence associated with HIV of 670 per 100 000 South Africans against 518 for the WHO Africa Region. According to the Department of Health (2008:1), Cryptococcus neoformans is now viewed as the second largest cause of death in patients with AIDS in Sub-Saharan Africa whereby 10 per 1000 AIDS patients contract this disease. This implies that the impact of HIV/AIDS on the South African population is greater than suggested.

Poverty and unemployment are major challenges on the meso-level context. According to the World Bank (2008a:2) the number of poor people in Sub-Saharan Africa have doubled. The MDG monitoring map on the eradication of poverty and extreme hunger indicated that South Africa received US$5-19 aid per capita (World Bank, 2006a:1), clearly implying the financial pressure experienced by the largest part of the South African population. This financial pressure is increased when realizing that South African has the highest unemployment rate globally (Bhorat, 2006:1) exceeding countries like Chile, Mexico, Poland and Turkey. Unemployment is not only present in the broad and narrow unemployment segments, but it is also affecting South Africans with tertiary education especially those with African certificates and diplomas (Bhorat, 2006:13). It is in conflict with to list the deepening poverty status of the majority in South Africa whilst finding that 108.8 per 1000 people in South Africa are internet users (Bhorat, 2006:1).

Poverty in South Africa is a theme passionately objected by many. As Munnik and Wilson (2002:3) reported, the presence of the Anti-privatization Forum and the Landless People Movement's presence at the 2002 World Summit on Development and Sustainability in Johannesburg portrayed a clash with the neo-liberal policies of the African National Congress (ANC). This is in contrast with the Reconstruction and Development Program for sustainability and development that the ANC launched in 1994. Again, no single or simple solution can be applied to decrease the poverty and unemployment in South Africa.

Crime is a current crisis in South Africa and a reality that affects all spheres life in South Africa. Demombynes & Ozler (2003:2) concluded that crime is not only a major challenge in South Africa, but it serves as a major reason why professionals are leaving the country and the link between crime and inequality, makes it a very difficult challenge to address. Sexual crimes are highly rated on the crime statistics in South Africa. According to Gerretson (2007:1), 70% of all the sexual crimes in South Africa are committed against children and 99.5% of the offenders are men. According to Gerretson violence identified with masculinity and problem-solving, are an incorrect social view by younger South African males. Furthermore, the high rate of rape and violence against children and women in South Africa is link to a prevalent culture of domination and aggression. South Africa presents with the highest rape statistics worldwide (Gerretson, 2007:1). Within 100 000 cases, 117 cases of rape are reported of whom 40% are children. The South African Police Department's (SAPD) crime statistics for the period from 1 April 2001 to 30 September 2007 pictured a grave reality. During the April to September 2007 period there was a total of 116 455 burglaries at residential premises, 22 887 cases of rape and 96 499 assaults with the intent to inflict grievous bodily harm (SAPD, 2008:1). When addressing the crime challenges in South Africa, the realisation of the impact of corruption (Afrimap, 2007:33) needs attention. In South Africa, corruption has been a very real theme, confirmed by the launching of a National Anti-Corruption Program in 1997 and a Public Anti-Corruption Strategy in 2002, both by the South African Government. In 2004, South Africa pioneered with the formulation of the Prevention and Combating of Corruption Act (Afrimap, 2007:33) as well as the Protect Disclosures Act for whistleblowers in 2000. A more recent addition to the crime challenges in South Africa is the impact of xenophobia. In April 2008, former president Thabo Mbeki addressed a press conference of the United Nations (2008e:1), acknowledging the need for assistance by both the United Nations and the African Union.

South Africa experiences a massive brain drain of healthcare professionals to countries such as Canada, Australia, USA and Britain mainly due to the excellent experience that these professionals gained in South Africa. Stock taking of human resources for healthcare in South Africa at the end of 2004 indicated that 98 490 professional nurses and midwives, 35 266 enrolled nurses and 50 703 nurse auxiliaries were registered with the SANC (Mahlathi, 2006:1). The SANC also reported a massive amount of professional nurses are scraping their names from the scroll and does not want to remain within the nursing profession. Recent statistics about the manpower distribution of registered nurses in Gauteng versus the population was as follows: registered nurses = 27 201, Gauteng general population = 96 88100 (SANC, 2008:1). In a statement by Evans, the World Health Organisation assistant director-general (Dlamini, 2006:1), health worker shortages in 57 countries, of which South

African was one of these countries, had a detrimental effect in the provision of essential life-saving interventions. According to Evans the shortages are very acute and severe in Sub-Saharan Africa.

The meso level context, namely the Republic of South Africa, is characterised by influences filtered from global challenges as well as challenges typical to South Africa. South Africa's transition to a new democracy in 1994 brought about major shifts. As with the macro level context, there is no simple and fast solution to the resolution of challenges. Again, complex challenges reasons multi-facet strategies. The macro- and meso levels impact the hospitals in which the professional nurse is laborious and visa versa.

The challenged reality that the professional nurse faces, in the meso level context, increases her need for an authentic leader in nursing. An authentic leader in nursing who can restore the passion for nursing and who understands the challenges that the professional nurses face within the South African healthcare industry. The professional nurse needs the support of an authentic leader who is relationship-centered and who can commit to a relationship with the professional nurse through bonding, bridging and linking social capital.

3.6.3 Micro level: South African hospitals

Examining professional nurses and nurse leaders employed in private hospitals in nine provinces in South Africa, this context is found on the micro level and is contextual in nature. South African hospitals is best described as a dichotomy between two industries, a public healthcare sector with a primary healthcare focus and patients that cannot afford medical care versus a private healthcare sector for a minority of the South African population that can afford a type of medical care and should therefore, carry the high costs of the private sector. There are overlapping areas between the public and healthcare sector for example public-private partnerships, prescribed minimum benefits and interventions of social responsibility from the private sector into the public one. But, there is also conflict between the public and private healthcare sectors, not only for resources, but also in the core focus of these industries, that evoked confrontations between the former Minister of Health, Dr Tshabalala-Msimang and private healthcare sector stakeholders.

In the following paragraphs the author attempts to provide a comprehensive description of the hospital-level context in which the professional nurse conducts nursing. Public and private hospitals are described separately relating to their core focus, descriptive demographic data, funding and fee structures and their impact on nursing, human resources

with specific reference to professional nurses and the daily work-life of professional nurses. The researcher gained experience in both the public and private healthcare sectors of South Africa with hands on contact with the crisis that is experienced by professional nurses on a daily basis in private hospitals in Gauteng and the North-West Province.

3.6.3.1 Public hospitals in South Africa

The public healthcare sector is a world with unique dynamics and challenges especially when one realises that these hospitals are divided between the social realities typical to South Africa and the ideologies of a post-apartheid government.

i) Core focus

The public hospitals as part of the public healthcare industry, inherited a defragmented system with the new democracy in 1994 (Cullinan, 2006:5). The ANC launched the National Health Plan for South Africa in 1994 leading to divert healthcare into a primary healthcare focus. Prior to this initiative, the public healthcare sector had a curative focus and was doctor-dependent for medical services (Cullinan, 2006:5). South Africa's new Constitution was introduced in 1996 and Clause 27.1 stated everybody's right to free access to i) healthcare services which includes reproductive health; ii) sufficient water and food and iii) social security and social support should you be unable to provide social security to your family by yourself (Cullinan, 2006:5). The White Paper on Health Services Transformation in 1997 contained the ANC's blueprint for primary healthcare leading to a nurse-driven, decentralised healthcare system with greater access to healthcare services on a district level (Cullinan, 2006:6).

With specific reference to public hospitals, boundaries were established between the responsibilities on a national, provincial and district level. On a national level, legislation and policy are made that should be implemented into provincial hospitals by and through the supervision on a provincial level. And according to Cullinan (2007:5), failure to keep provincial services accountable for national programmes are visible. In addition, the National Health Act was only launched in 2004 and provided more guidance in the management of the national health system (Cullinan, 2006:6-7). The transition from a doctor-driven, curative health system in an apartheid era towards a primary healthcare system that is preventative and nurse-centered, called for competent managers. A report by the DOH (2008:109) indicated that public hospital reform is essential for the reform of health systems in South Africa and that the current status of public hospitals with specific reference to regulations and

governance structures, are inconsistent with reforms of health systems besides public hospitals.

The primary healthcare's core focus within a transition health system sketches a context with multiple challenges and obstacles despite a heart-based intention to provide healthcare to all South Africans. A system where no one is denied care but complicated by insufficient management, calls for possible conflict.

ii) Demographic data

The national health system is divided in 53 health districts with accesses to primary healthcare clinics and district hospitals (Cullinan, 2006:7). There is an estimated 388 public hospitals of which 64% are district hospitals and 16% are secondary and specialised hospitals. Alarmingly, less than 4% of public hospitals are national or provincial hospitals. South Africa has 15 tertiary hospitals which are according to an assessment by Doherty, Kraus and Herbst (2004:67), overstock on specialities and resources to the detriment of district hospitals. On 23% of public hospitals have high care and/or intensive care unit beds with a total of 1783 counted in 2007 (Bhagwagee & Scribante, 2007:1132). According to the Health Systems Trust (2008:1), the public sector had 100 147 useable hospital beds in 2004 that decreased 87 870 beds in 2005. Thom (2007:1) reported that there is mistrust in public hospitals and a decrease in public hospital beds that this leads to more patients and business for the private sector.

Public hospitals may provide general and/or specialised care (DOH, 2006:6) and various levels of care, namely ambulatory care, inpatient care, acute, sub-acute and chronic care (DOH, 2006:6-8). There are four levels of inpatient facilities grouped in public South African hospitals (DOH, 2006:8), namely level 1, level 2, level 3 and specialised hospitals. Level 1 hospitals have an in- and outpatient services and general medical practitioners, a functional operations theatre and surgery under general anaesthesia is performed. A level 2 hospital refers to a the combination of the services of both general practitioners and specialists with staff permanently employed in the six basic specialities of medicine, surgery, orthopaedics, gynaecology, psychiatry and paediatrics as well as diagnostic radiology and anaesthetics. When a hospital provides specialist and sub-specialist care, it is categorised as a level 3 hospital. The DOH (2006:10) have a list of specialities divided into three groups and a level 3 hospital should have at least 50% of the range in Group 1 specialities. Specialised hospitals imply hospitals with a specific focus for example TB, psychiatry, maternity, spinal injuries, infectious diseases etcetera (DOH, 2006:10). Public hospitals levels are usually combined with the following known allocations:

- Level 1 hospital = District hospital and South Africa has 52 district hospitals.
- Level 2 hospital = Regional hospital. There are 63 regional hospitals
- Level 3 hospital = Tertiary 1 (also referred to as a provincial tertiary hospital), a Tertiary 2 (also referred to as a national referral hospital) or a Tertiary 3 (also referred to as a central referral hospitals), all depending on the specialities of each hospital.

Finally, Cullinan (2006:11) reported that the initial architectural planning and structure of public hospitals are ineffective for the current uses causing overcrowded units with inappropriate infrastructure.

From the above demographics it is clear that there are only 87 870 usable public hospitals beds (and this amount of beds is decreasing) for more than 40 million South Africans. Public hospitals are overburdened and stuck within a national changing process.

The professional nurse occupied in public South African hospitals experience the reality where hospitals cannot provide for the needs of their patients. There is no elementary solution to the professional nurse caught within the reality of not being able to provide quality nursing due to variables beyond her control. This dilemma increases her need for authentic leadership in nursing.

The various types of public hospitals in South Africa need funding in order to operate. In the following description the funding and fee structures of public hospitals are addressed.

iii) Funding and fee structure

Public hospitals imply public ownership and therefore mean that these hospitals and services provided by the hospitals are conducted by government employees in hospital facilities that are either leased properties or in a public-private partnership (DOH, 2006:5). South African hospitals' access are either subsidised units that are open to the public in general and no access can be denied to patients in subsidised units against restricted units with public hospitals. Restricted units are allocated to a specific group, for example the correctional services or a specific mine group (DOH, 2006:6). Within the South African population the largest amount of patients cannot afford basic healthcare and are totally dependent upon the public healthcare sector for care, even on specialised levels of care.

According to Thomas and Muirhead (2000:3-4), the primary healthcare focus implicated a major resource allocation to other facilities than hospitals that started just after 1994 and

flattened around 1997. The outcome was unequal financial and resource distribution to the public health sector in general with the reality that idealism objectives and policies couldn't be reached. As interprovincial allocation remains unequal, the public healthcare sector has become too dependent upon the money of South African taxpayers.

Due to these subsides public hospitals imply open access to all; cost management might be viewed to be extremely difficult. Within the context of public hospitals, the researcher became aware through personal experience of the absence of cost implications amongst public hospital staff as well as patients. On the other hand, the ineffective management of public hospitals combined with the lack of accountability between national and provincial departments implies a possible lack in a sufficient infrastructure. Again, upon personal experiences, the professional nurse is exposed to situations where there isn't sufficient resources to provide quality care to patients.

In addition to the funding and fee structures of public hospitals, human resources form a major part of the operational expenditure of these hospitals. In the following paragraphs the human resources in public hospitals are discussed.

iv) Human resources

Professional nurses are amongst other professions, experiencing the burden of staff shortages and an ageing workforce. The SANC (2007:1) indicated in recent statistics that 35% of professional nurses are between the ages of 40-49 years. This is causing pressure on the human resources of the healthcare system in general when one acknowledge that only 3% of professional nurses are younger than 30 years and that the average age that nursing students commence nursing training for the first time, is at 26 (SANC, 2007:2). The professional nurse ratio to the South African population was 1 nurse to 461 patients in 2007 (SANC, 2007:1). This is an alarming thought as this ratio is for professional nurses in general, occupied in all levels of the healthcare system, in public and private facilities.

In 2006, a study conducted by the Department of Public Service and Administration (DPSA) (2006:2) concluded that public hospitals were burdened under poor hospital management. There was a reported culture of bureaucracy and a tolerance towards incompetence within public hospitals (DPSA, 2006:12). The DOHA (2008:334) acknowledged that hospitals managers lack the skill for efficient managerial tasks and therefore training has been initiated to enhance their managerial skill in 2008.

Many nurses exchanged the provincial healthcare sector for that of the private health industry with a carrot of increased benefits and better working conditions held in front of their noses. The Department of Health (Mahlathi, 2006:1) acknowledged that low health professional salaries are a major cause for loosing staff. In the units with hands on nursing interventions, professional nurses are increasingly confronted with the grim realities of HIV/AIDS and TB (Cullinan, 2006:1; South Africa Info, 2006:1), visible effects of crime and the lack of resources of which finances is a prominent facet. As already stated, lack of finances implicates insufficient resources to provide the basic care to patients.

Professional nurses represent a kaleidoscope of cultures and languages. Professional nurses are registered at the South African Nursing Council (SANC) and obtained either a national diploma or a Nursing degree from different training institutions. In Gauteng, the amount of professional nurses that obtained a bachelors degree are a median of 99.8 students against a median of 479.2 students that obtained a diploma (SANC, 2008:1).

In the above paragraphs public South African hospitals have been described in terms of the demographics, the funding of these hospitals and the human resources within these hospitals. All the above factors impact on the daily work-life of the professional nurse.

v) *Daily work-life of the professional nurse*

The daily work-life of professional nurses in public hospitals is reported to be a shocking reality. The overburdened status of public hospitals is present when assessing the increase in patient admissions of 7% (HASA, 2008b:18) in public hospitals that has had an acute hospital bed ratio of 2.6 beds per 1000 members of the South African population (HASA, 2008b:14) already in 2006. Patients average length of stay is 4.3 days against 3 days in private hospitals (HASA, 2008b:14), implying that patients stay longer although the amount of staff is decreasing. HIV/AIDS have been identified as a major cause for increased hospitals admissions and according to Cullinan (2006:20), children and elderly patients were crowded out due to HIV/AIDS patients. It is estimated that there is annually an increase in 100 000 HIV/AIDS patients in South African hospitals in general.

Staff shortages are a crisis to professional nurses that decrease the quality of care (DPSA, 2006:22). High stress levels amongst nurses in general have been identified by the DPSA (2006:2) where staff shortages imply unbearable workloads. Cullinan (2007:21) confirmed that both nurses and doctors are exposed to the detrimental effect of understaffing and poor working conditions.

Incidence of endemic infections and even fatalities has brought to light the reality of poor infection control and hygiene in public hospitals (Cullinan, 2006:19). A painful example remains the death of 19 babies that died at the Mahatma Ghandi Hospital in 2005 due to infections (Matsebula & Willie, 2007:171). One of the basic protocols in infection control, the basic hand washing protocol, was identified as one of the reasons causing high infection rates. Malfunctioning of equipment (Cullinan, 2006:22) is another reality in the daily work-life of public hospital-based professional nurses. Furthermore, theft of linen, medicine and stock has been identified by Cullinan (2006:22). Finally, Cullinan (2006:20) reported that the lack of autonomy by unit managers in public hospitals were a major concern.

3.6.3.2 Private hospitals in South Africa

The context of private hospitals in South Africa has both similarities and discrepancies from the public hospitals that are described in the following paragraphs.

In 2007 15% of the South African population were paid members of medical schemes indicating that 85% of South Africans could be classified as public patients (Netcare, 2007:26). In more detail, within the total South African population that includes dependents, it is calculated (Netcare, 2007:34) that 7 million South Africans are medically insured, 7-13 million South Africans are formally employed and uninsured and 25-28 million South Africans are unemployed and uninsured.

i) Core focus

The predominant characteristic that differentiates public hospitals from private hospitals, are the core difference in focus. Whilst public hospitals are an extended service within a National Health Plan that is Primary Healthcare driven, private hospital industry in South Africa is based on a costing model and the negotiations for prices (HASA, 2008b:33). HASA (2008b:2) confirmed that emotion is the major drive in healthcare decisions in private hospitals. In 2001 the Medical Schemes Amended Act (Act 55 of 2001) was introduced in order to regulate reinsurances and to improve the Registrar of Medical Scheme's regulatory capacity (DOH, 2008:336). Thom (2007:1) reported the increased perception that private hospitals have better quality healthcare that caused an increase in the utilisation of private hospitals. Private hospitals are sold to patients through the indirect selling power of doctors (Matsebula & Willie, 2007:165) and incentives play a major role.

ii) Demographic data

Private hospitals are busy hospitals. Thom (2007:1) reported that whilst the private hospitals wanted to add more beds, public hospitals are reducing beds. It is calculated that 22% of the hospital beds in South Africa are situated in private hospitals that maintains a 60-65% bed occupancy rate, weekends calculated. The Health Systems Trust (2008:1) concluded that there are at present 28 980 usable beds in private hospitals in South Africa. Of the 22% of hospital beds in private hospitals, 84% of private hospitals have high care (HIC) – and/or intensive care units (ICU) with a current amount of 2385 HIC/ICU beds (Bhagwagee & Scribante, 2007:1132). With seven million paid members of medical schemes, it is alarming to note that private South African hospitals are treating three million patients annually of whom 1.5 million patients were hospitalised (HASA, 2008b:3). The hospital buildings in the private sector is subjective legislation and regulations (Doherty *et al*, 2007:67) and the Department of Health is not obliged to inspect or accredit these hospitals.

There is an increased demand for private hospitals in South Africa as Netcare (2007:26) reported an increase of 3% in medical scheme beneficiaries within a period of 9 months by December 2006. The emergence of "Black diamonds" is one major reason amongst other for the increase in medical scheme beneficiaries (Netcare, 2007:31). "Black diamonds" refer to the black, middle class population that earns more than R7000.00 per month, have tertiary education and are working professionals (Netcare, 2007:31). 12% of the black population is classified to be "Black diamonds" and they are now 54% of the black buying power.
In general, the majority of private hospitals are classified as short-stay hospitals and patients stay for less than 30 days (Matsebula & Willie, 2007:160) with an average size of less than 200 beds. The distribution of private hospital beds according to hospital group owner (Matsebula & Willie, 2007:163) are listed as follows:

- Netcare: 42 hospitals, 7302 beds.
- Medi-Clinic: 44 hospitals, 6401 beds.
- Life Healthcare: 56 hospitals, 7300 beds.
- Clinix Health Group: 4 hospitals, 511 beds.
- Melomed: 3 hospitals, 351 beds.
- Mining: 5 hospitals, 1470 beds.
- Joint Medical Holdings: 4 hospitals, 367 beds.
- Community Health Care: 4 hospitals, 467 beds.
- Independent: 54 hospitals, 3417 beds.

Gauteng (95) and the Western Cape (39) have the largest distribution of private hospitals (Matsebula & Willie, 2007:163). Private hospitals services include theatres, joint replacements, cardiothoracic, vascular surgery, neurosurgery, MRI scanning, catheterisation labs, 24 hour emergency and trauma units. Duplicating services amongst private hospitals are a reality and it depends predominantly of the expectations of shareholders. Within the public sector there is a competition of priorities and therefore duplication of services are absent (Matsebula & Willie, 2007:163). A more recent tendency in the services of private hospitals is the launching of centres of excellence.

The demographic data of the private hospitals contrast with that of public hospitals. The major characteristic of private hospitals is the profit-driven focus in which funding and fee structures provide essential background information.

iii) Funding and fee structure

There are at present 147 medical schemes in South Africa that service seven million people (DOH, 2008:336). These schemes can be viewed as a massive, single funding engine of 7% of all healthcare expenditure in South Africa. According to HASA (2008b:13) price increases in the private healthcare sector from 2005 have exceeded the CPIX of 4.7%. Specific increases have caused conflict between the Minister of Health, Dr Tshabalala-Msimang and private hospitals stakeholders. Within the medical scheme groups are GEMS, a restricted medical scheme for government employees. In 2007, GEMS had 166 000 principal members and 400 000 lives insured, making this the largest restricted fund at present in South Africa (Netcare, 2007:34). According to Section 36 of the National Health Act (Act 61 of 2003), private hospitals in future will have to apply for a certificate of need as part of a regulatory mechanism and licensing requirement (Matsebula & Willie, 2007:170).

Private hospital tariffs differ between hospitals. Funding and fee structures in the private hospitals are becoming increasingly more complex with per diem, diagnostic related groupings (DRG), fixed fees, capitation and fee-for-service alternatives (HASA, 2008b:36-37). Professional nurses aren't immune against the financial factors of patient's fee structures but needs to buy into specific mechanisms to ensure that a patient's fee structure are managed correctly from admission to discharge. Examples are that patient files might be colour-coded to indicate the fee structure. The possibility exists that a per diem patient might imply higher costs to the hospital and therefore the professional nurse should pay additional

awareness towards saving principles. On the other hand, a patient on a fee-for-service structure might easily be over billed.

The self-pay market, especially by maternity patients, has been increasing in private hospitals (Thorn, 2007:1). Besides South African medical scheme members that are the major patient group to private hospitals, there are an increase in foreign patients of who are patients from predominantly North Africa, medical tourists and emigrated South African abroad that return for medical intervention (Thorn, 2007.1).

Private hospitals are expensive service providers and yet, patients are unfamiliar of actual costs. HASA (2008b: 1) reported that the presence of the middle-man in the private healthcare industry and managed healthcare interventions, patients remains unaware of hospital costs. In 2007, Netcare (2007:9) announced that a typical account of patient implied a 55% of all expenses ward and theatre equipment fees, 15% of expenses were for drugs and 30% of expenses were allocated to surgical and consumables. Private hospitals have been criticised for over-servicing of patients due to the presence of an incentive structure as well as the presence of various specialists at hospitals that want to use their own facilities (Thorn, 2007:1).

As with public hospitals, human resources are a cost drive in the operational expenditures of any hospital. The human resources typical to private South African hospitals are described in the following paragraphs.

iv) Human resources

Burdened diseases such as HIV/AIDS, diabetes mellitus and obesity are impacting private hospitals (HASA, 2008b:25). Private hospitals are also experiencing staff shortages and an ageing staff corps as with public hospitals. However, private hospitals have 7000 medical specialists against only 4000 in public hospitals that need to address a very large population.

Doctors are viewed as an essential commodity in private hospitals. Doctors and their specialities are viewed as a major attraction for technology and infrastructure factors in private hospitals' business decisions (Matsebula & Willie, 2007:165). The medical arms race (MAR) has become reality in private hospitals, whereby a hospital will invest in expensive equipment and technology to attract specialists to make that hospital more competitive.

The major concern for private hospitals with nurse shortages, are the impact that this has on cost containment when one views that 77% of the total costs in private hospitals are for staff