

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

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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

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1 *The Leader of all leaders*

Soli Deo Gratia, Soli Deo Gloria.

2 *The authentic leader*

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9 *To the memory of a great leader*

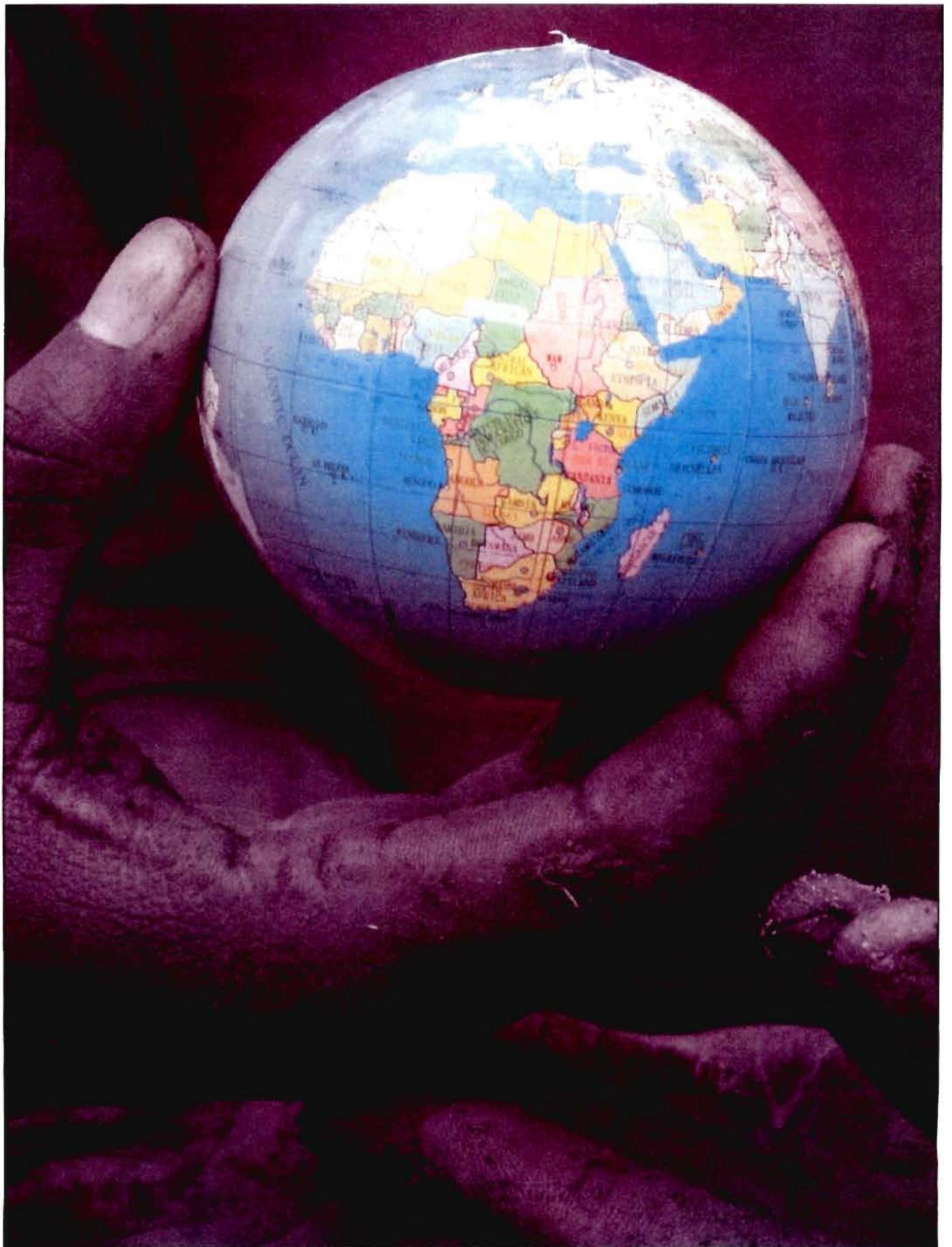
To my late father – who bestowed in me a scholarly heart – how I wish that we could share this moment.....

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 vertrouwe, 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 uiteindelijke 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 gebaser 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 geïdentifiseer 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 reflekeringsraamwerk. 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.

[Sleuteltermes: 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:

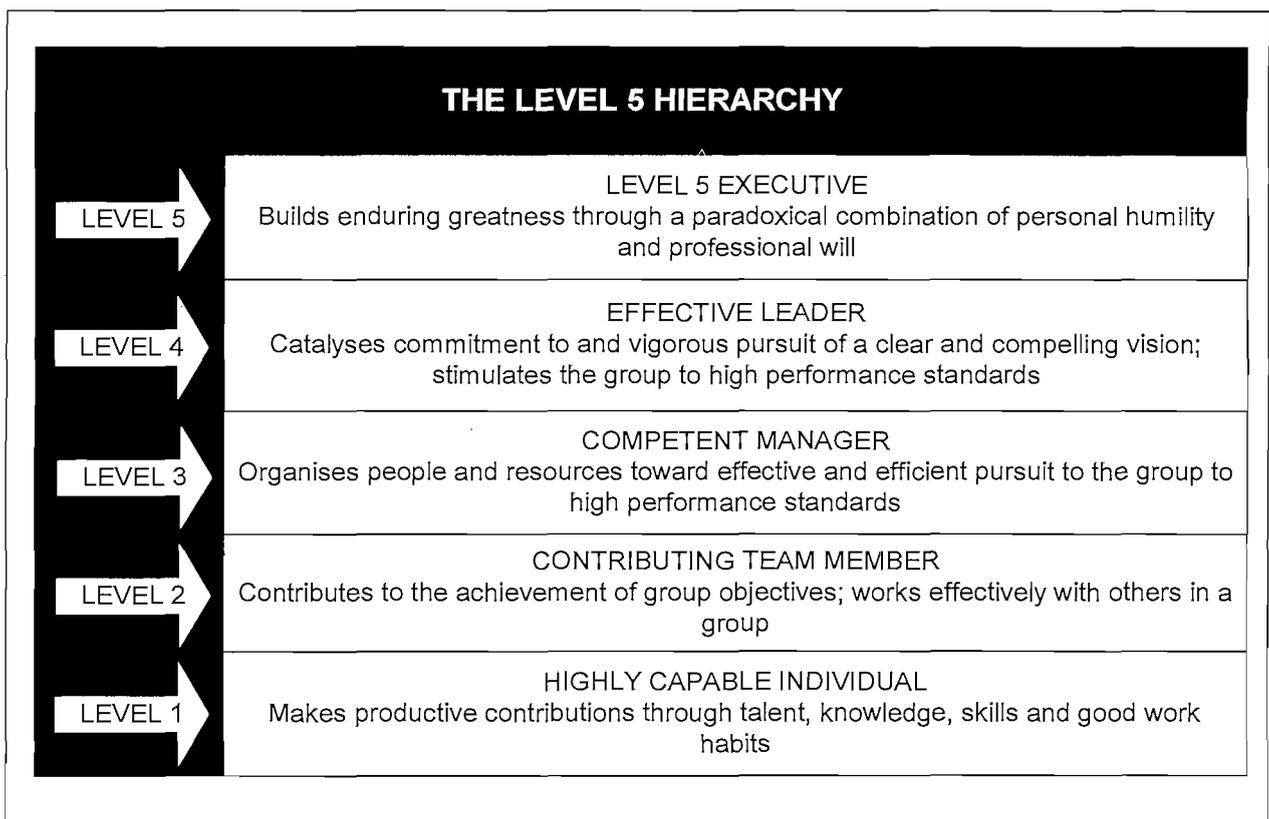


Figure 1.1 The level 5 hierarchy of leadership (Collins & Porras, 2000:20)

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:xxxix) 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

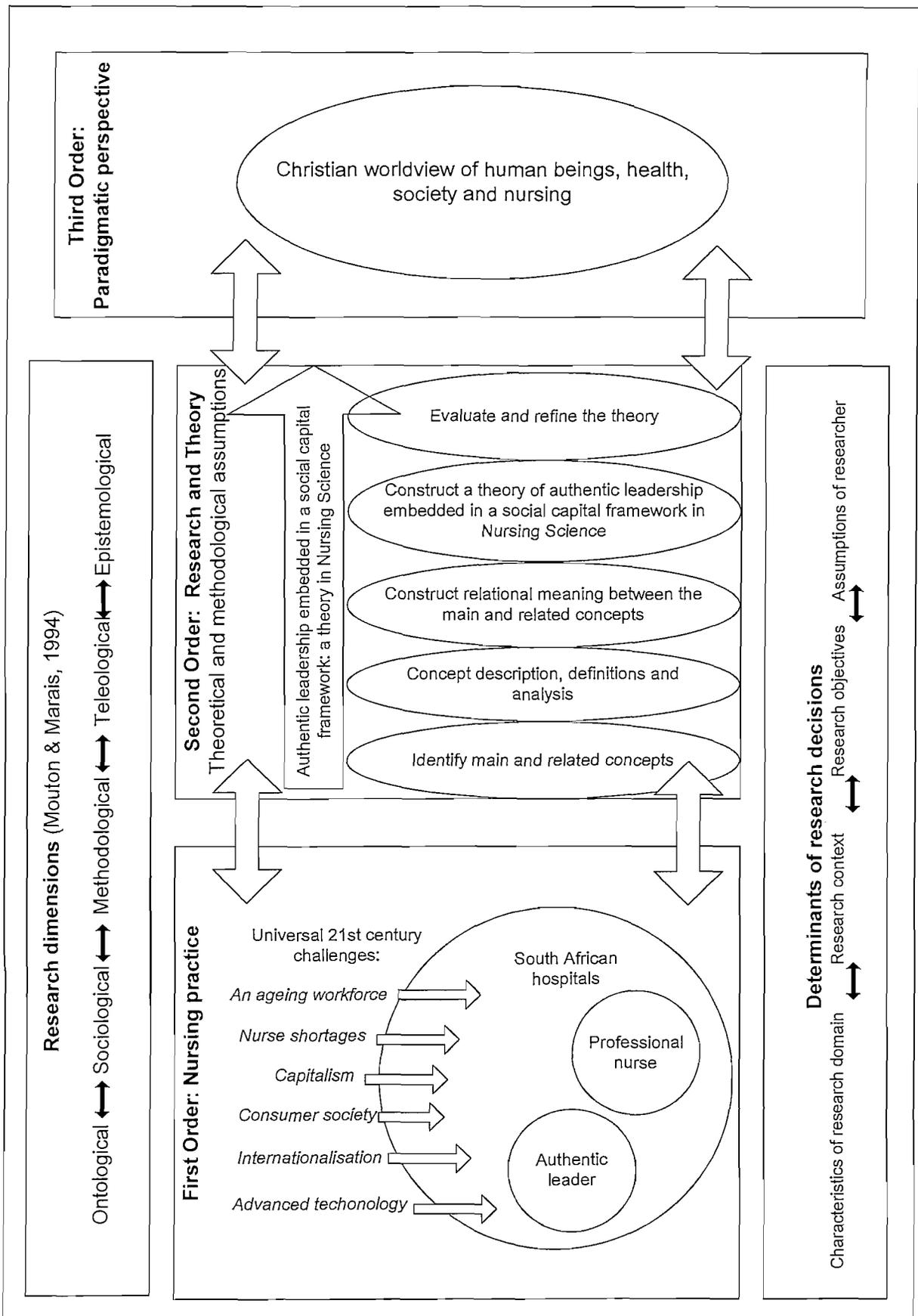


Figure 1.2 Research model by Botes applied to this research

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

Table 1.2 continues

PHASE 3: THEORY EVALUATION, REFINEMENT AND GUIDELINES FOR OPERATIONALISATION				
Research Objectives	Data Collection	Population & Sampling	Data Analysis	Rigor
<p>STEP 1: To evaluate and refine the theory of authentic leadership embedded in a social capital framework in Nursing Science</p>	<p>Results of Phase 2: Step 2 and an evaluation report compiled according to points for critical reflection of a theory (Chinn & Kramer, 1991)</p>	<p>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).</p>		<p>Strategies to enhance trustworthiness by Guba and Lincoln (1985:290)</p>
<p>STEP 2: To formulate guidelines for operationalisation of the theory</p>	<p>Results of Phase 2: Step 1</p>		<p>Inductive and deductive logic</p>	<p>Strategies to enhance trustworthiness by Guba and Lincoln (1985:290)</p>

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).

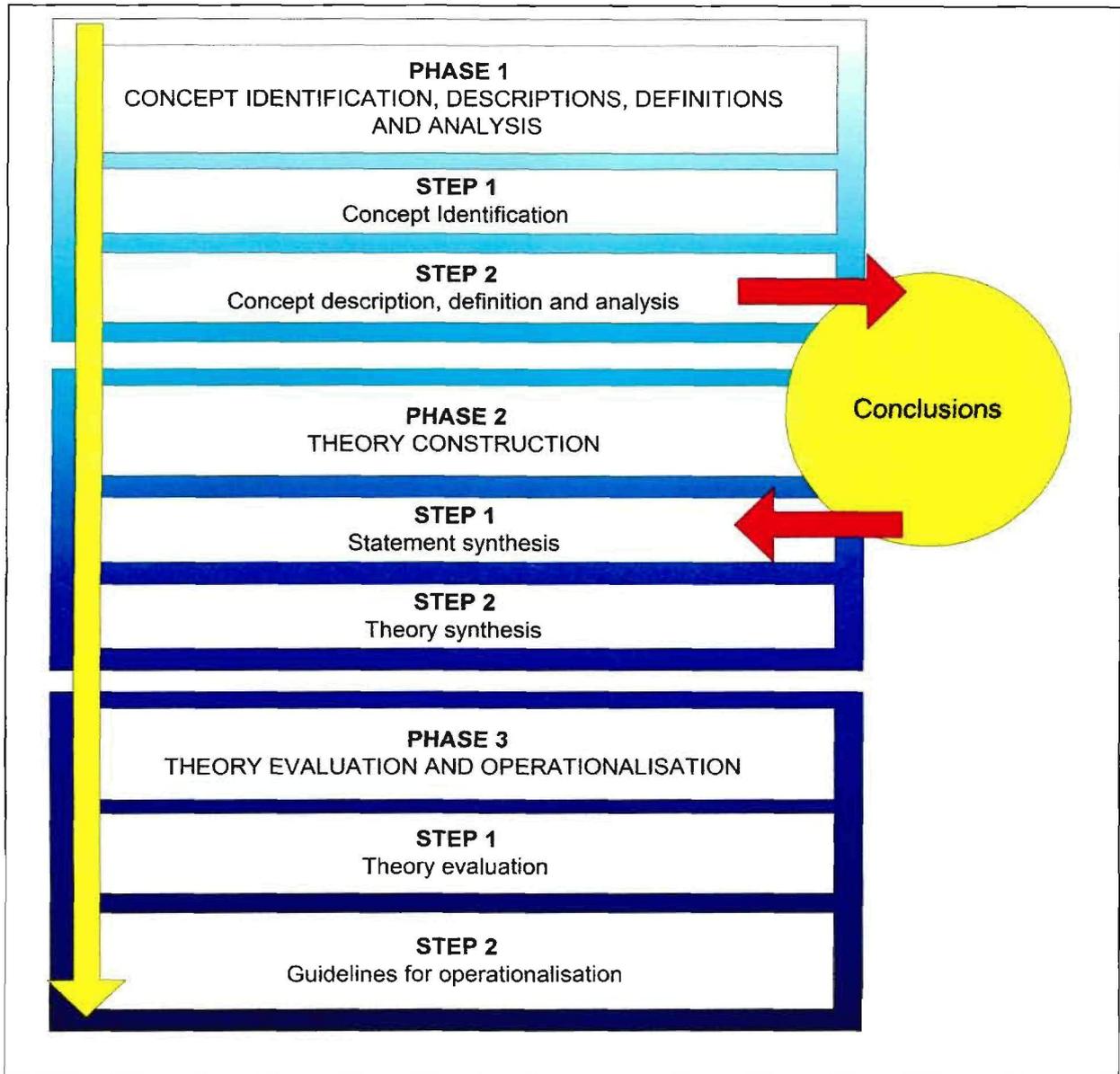


Figure 2.1 Flow of this research process

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).

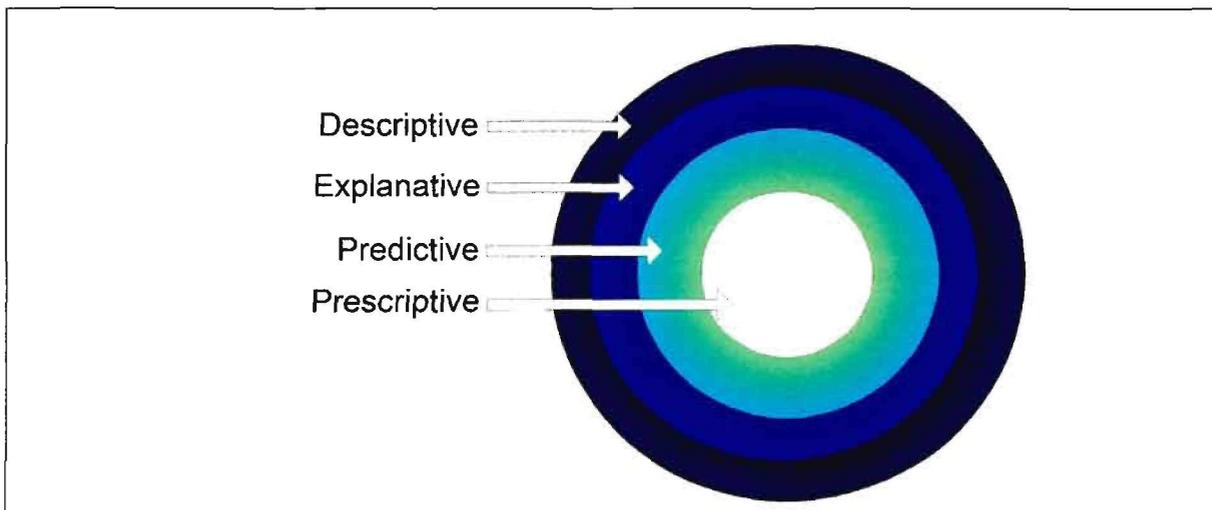


Figure 2.2 Functional classification of theories (Hunink, 1995:27-30)

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:

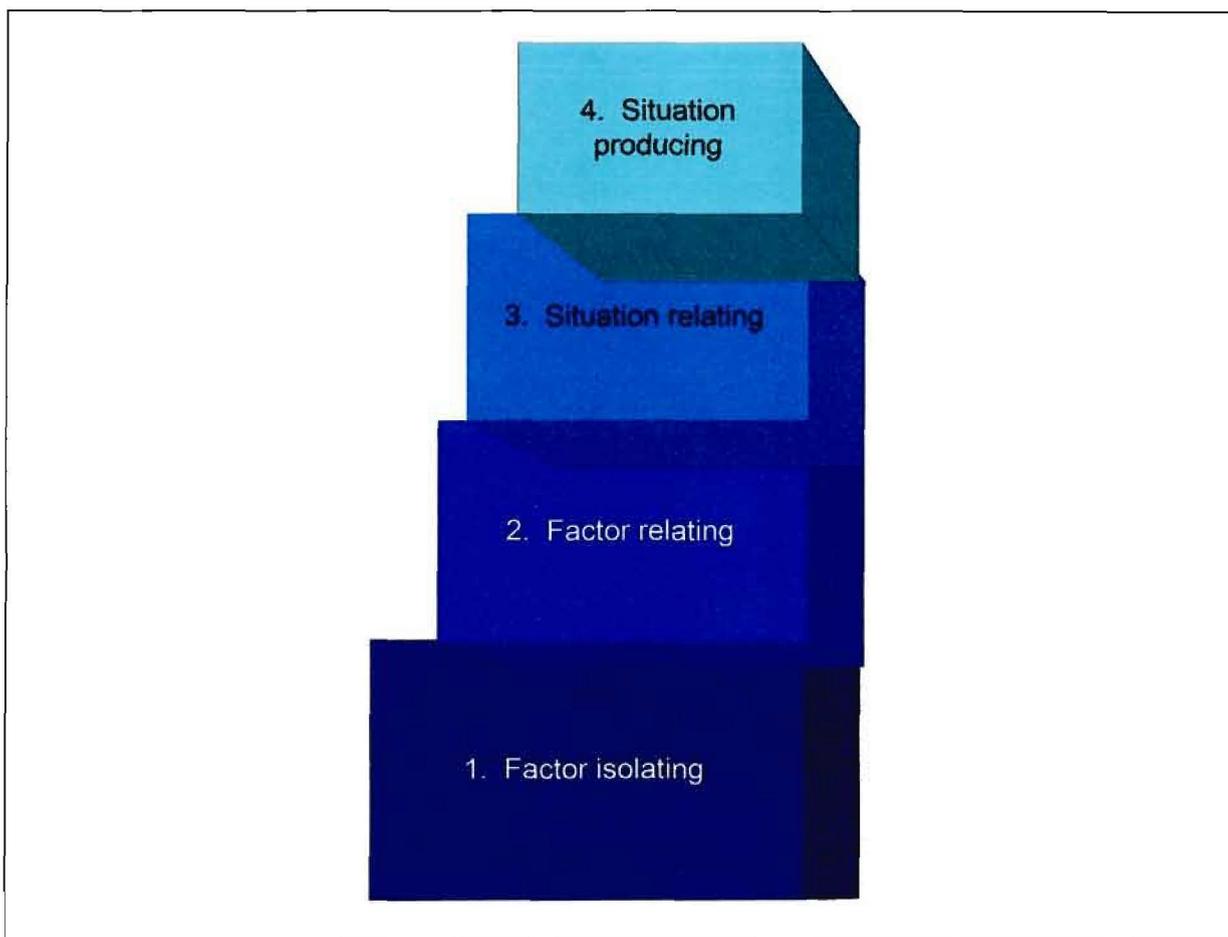


Figure 2.3 Level classification of a theory (adapted from Dickoff *et al.*, 1968:419-420)

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:

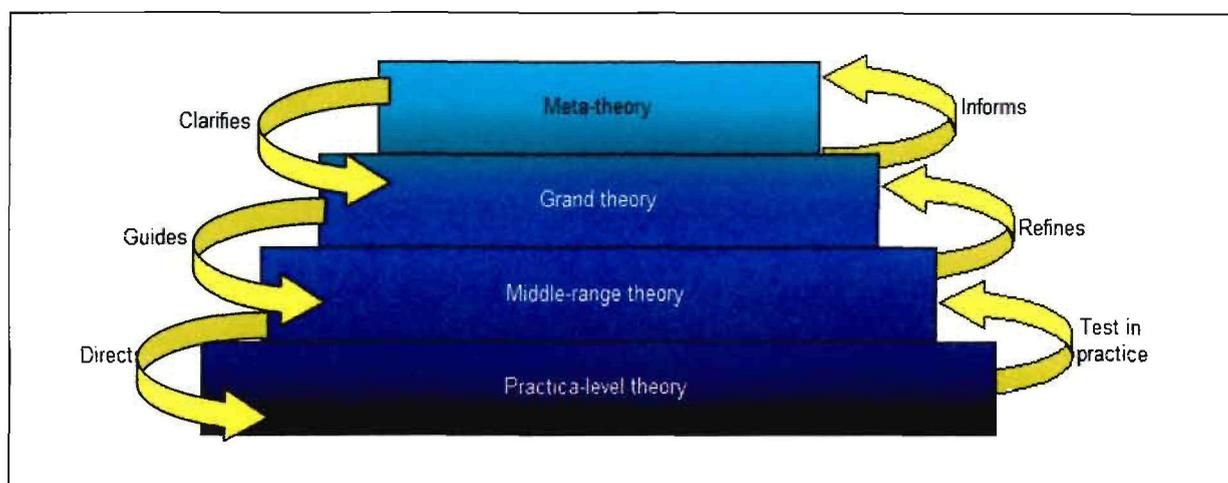


Figure 2.4 Scope of range classification of theories (Walker & Avant, 2005:16)

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 statement(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 utilised 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 <i>et al.</i> , (1968:415-423) was used.

Table 2.2 continues

<p>Data analysis (continues)</p>	<p>Although Dickoff <i>et al.</i> (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 (<i>in</i> 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:</p> <ul style="list-style-type: none"> • 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. <p>The survey list by Dickoff <i>et al.</i> (1968:415-416) was selected due to the functionality thereof in the process of concept identification.</p>
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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	<p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • Semantic clarity • Semantic consistency • Structural clarity • Structural consistency 	<ul style="list-style-type: none"> • 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. <i>The theory is applicable to other disciplines.</i>
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.
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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 voluntarily. 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 voluntarily. 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 <i>credibility</i> .
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 <i>transferability</i> 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 <i>dependability</i> .
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 <i>conformability</i> .

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
<p style="text-align: center;">Truth</p> <hr/> <p><i>This criterion refers to the degree that the research results are an actual portrayal of literature.</i></p>	<ul style="list-style-type: none"> • 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. 	<p style="text-align: center;">Credibility →</p> <ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • 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.
<p>Applicability</p>		<p>Transferability</p>
<p><i>The degree to which this research may be applied to another context/participants, and to found similar research results</i></p>	<ul style="list-style-type: none"> • The researcher worked alone on this research project and might become biased. • Holistic fallacy (Miles & Huberman 1994:437-439). 	<p style="text-align: center;">→</p> <ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • 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).
<p style="text-align: center;">Consistency</p> <hr/> <p><i>This criterion refers to the stable repeatability of this study over a time period and the manner in which this research can be audited.</i></p>	<ul style="list-style-type: none"> • The researcher worked alone on this research project and might become biased. • Holistic fallacy (Miles & Huberman, 437-439). 	<p style="text-align: center;">Dependability</p> <hr/> <p style="text-align: center;">→</p> <ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • 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.
<p>Neutrality</p>		<p>Confirmability</p>
<p><i>This criterion refers to the neutrality of this research versus the extend to which this research might be influenced by situations.</i></p>		<p style="text-align: center;">→</p> <ul style="list-style-type: none"> • 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*;
- 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; encyclopaediae; 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, ND LTD (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		Phase 2	Phase 3	Literature found per search engine
	Title search done	Literature found			
	Key word(s) used				
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	Dictionaries	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 encyclopaedias. 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 encyclopaedias

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	
Encarta 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

	<p>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.</p> <p>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 <i>to</i> other people". This is an important approach differentiation. When one views leadership as "what we do <i>with</i> 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.</p> <p>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.</p>
<p>George (2006:1-3), George and Sims (2007:5)</p>	<p>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.</p> <p>Authentic leaders are believable, trustworthy, reliable and genuine and have been placed in a responsible position.</p>

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

	<ul style="list-style-type: none"> • 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.
<p>American Association of Critical Care Nurses (AACN) (2008:1)</p>	<p>Authentic leaders are people that speak the truth and conform to fact and therefore, they are worthy of trust, reliance and belief.</p>
<p>Kerfoot (2006:1)</p>	<p>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.</p> <p>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.</p>

Table 3.8 continues

<p>Cashman (1997:1-2)</p>	<p>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?</p> <p>The process towards authentic leadership is as follows:</p> <ul style="list-style-type: none">• 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 <i>appreciation</i> the leader <i>creates value</i> whilst it also <i>energizes</i> 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. <p>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?</p>
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Table 3.8 continues

<p>Avolio, Gardner, Walumbwa, Luthans and May (2004:804)</p>	<p>An authentic leader is one of intense awareness of themselves and of others being aware of this self-awareness.</p>
<p>Pembroke (2002:17)</p>	<p>A leadership with three key dimensions: authentic navigation into the uncharted future, an authentic spiritual life, an authentic way of relating.</p>
<p>Shirey (2006:5-7)</p>	<p>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.</p>

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

<ul style="list-style-type: none"> • Real • Situational • Non-hierarchical • Relational 	<ul style="list-style-type: none"> • Internal origin • Intimate expression of what we are • Being in action • Authentic self-expression
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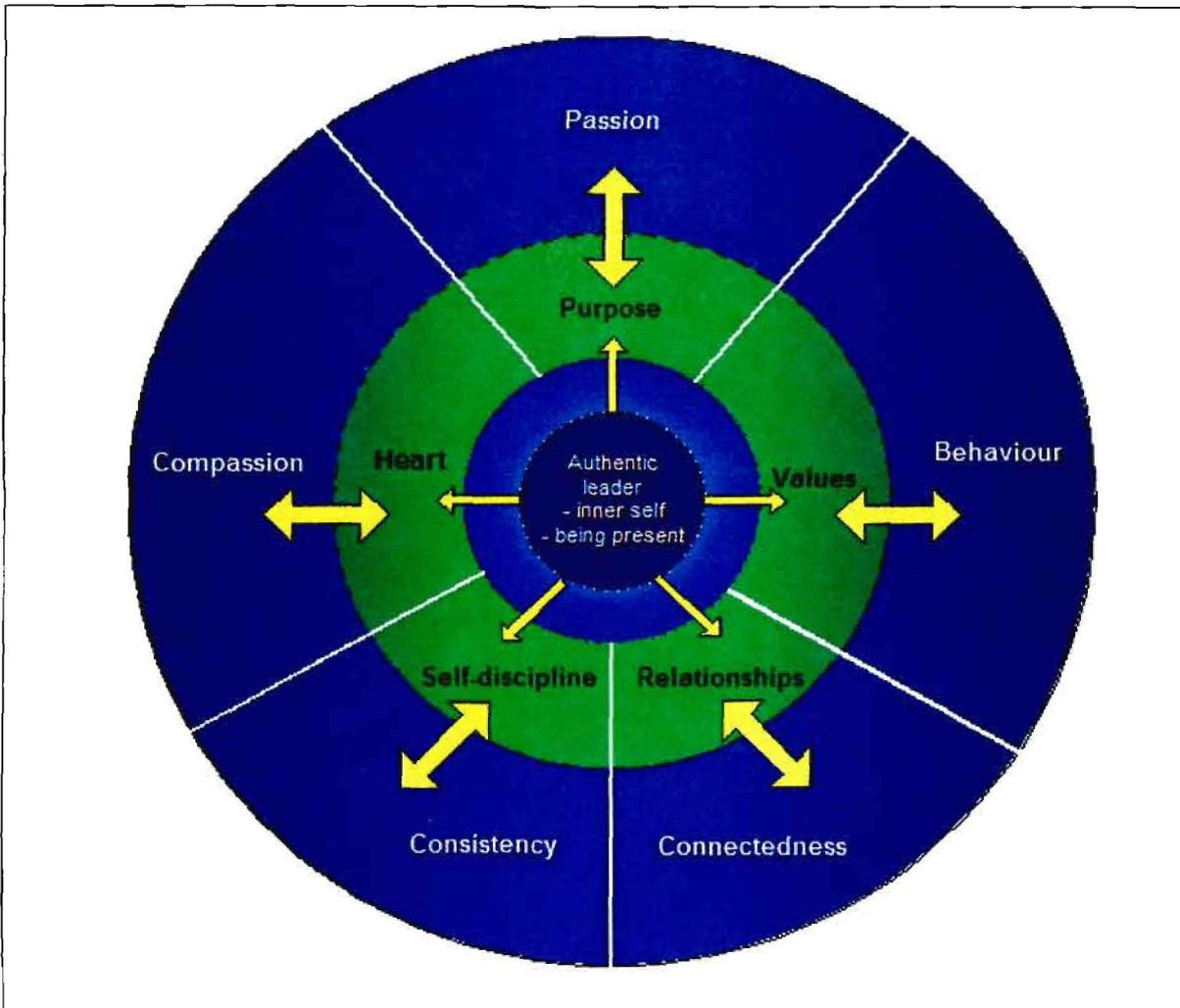


Figure 3.1 Characteristics of authentic leadership (George in Shirey, 2006:260)

Table 3.9 continues

<ul style="list-style-type: none"> • Results • Excite followers • Extraordinary levels of achievement • Meaning • Make performance meaningful • Integrated human being • In touch with oneself • Understand yourself • Being yourself with skill • Believable • Trustworthy • Reliable 	<ul style="list-style-type: none"> • How authentic you are • How deep and broad your self-expression • How much value are you creating • Intense awareness of themselves • Others being aware • Navigation • Spiritual life • Relating • New type of leadership • Character • Timeless attributes
--	--

Table 3.9 continues

<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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
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Table 3.9 continues

<ul style="list-style-type: none"> • Inspires excellence • Brings hope, love, inspiration • Relationship-centered principles • Followers ascribe authenticity • Honest • Integrity 	<ul style="list-style-type: none"> • Express yourself • Appreciate • Serve • Journey of authenticity • Remain true • Sincere
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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 were 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 | • Balanced life |
| • Relationship-centered | • Pursue purpose of your leadership with passion |
| • Remains true to yourself | • Serve |
| • A person, not a position | • Inspire |
| • Self-knowledge | • Navigate |
| • Self-awareness | • Connects with followers |
| • Learn from life narrative | • Empower |
| • Character | • Resulting in performance excellence |
| • Leading yourself | • Meaning in performance |
| • Practicing values and principles | |
| • Honest self-expression | |

<p>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 Practice solid values Support team Stay grounded Integrating your life Narrative nature Human weakness Acknowledge frailties Honest expression Connect with followers Person, not a position Speak the truth Conform to fact Honest Integrity Sincere Internal origin Intimate expression of what we are Being in action Self-expression (how deep and how broad) Intense self-awareness Character Timeless attributes Substance Speak from the heart</p>	<p>Know who she is Understand passions and purpose for your leadership Understand self Human weakness Sufficient self-knowledge Know yourself In touch with self</p> <p>Introspection Internal origin Self-awareness Intense self-awareness</p> <p>Experience Challenges Narrative nature Life stories Journey of authenticity Consultations Hardships</p> <p>True north Intense passions Pursue purpose with passion Passion</p> <p>Lead yourself Self-discipline Committed to a lifelong development process</p>	<p>Self-knowledge</p> <p>Self-awareness</p> <p>Learning from life narrative</p> <p>Pursue the purpose of leadership with passion</p> <p>Leading yourself</p>	<p>INTERNAL CAUSATIVE FACTORS FOR AUTHENTIC LEADERSHIP</p>
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<p>Intense passions Sufficient self-knowledge Tough empathy Display personal vulnerability Real display of honest emotions Pursue purpose with passion Acts under pressure Passion Introspection Compassion Empathy Self-discipline Know yourself Express yourself Journey of authenticity Remain true Committed to a lifelong development process Leading with heart and head Experience Consultations hardships</p>	<p>Moral compass Practicing values and principles Practice solid values Stay grounded Speak the truth Conform to fact Acts under pressure Honest Integrity Believable Trustworthy Reliable Worthy of trust, reliance and belief Character Timeless attributes Substance</p> <p>Acknowledge frailties Honest expression Self-expression (how deep and how broad) Speak from the heart Tough empathy Display personal vulnerability Real display of honest emotions Express yourself</p> <p>Balance intrinsic and extrinsic motivations Integrating your life Support team</p>	<p>Practicing values and principles</p> <p>Honest self-expression</p> <p>Balanced life</p>	
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PROCESS	<p>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</p>	<p>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 }</p>	<p>Serve Create value Navigate Inspire Empower Connects with followers</p>	PROCESS OF AUTHENTIC LEADERSHIP
CONSEQUENCES	<p>Extraordinary levels of achievement Meaning Results Values Performance excellence Makes performance meaningful</p>	<p>Extraordinary levels of achievement } Performance excellence } Results } Values } Meaning } Makes performance meaningful }</p>	<p>Resulting in performance excellence Meaning in performance</p>	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

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

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

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

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

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

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

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

94 The nursing service manager is continuously more interested in Elaine's lessons from
95 Saudi Arabia. This morning she said to Elaine that she is eager for suggestions to
96 enhance the quality of patient care in the whole hospital. Elaine welcomes the
97 opportunity to share information (**serve, empower**) although she might be confronted
98 with challenges. It seems as if Elaine isn't afraid to give her honest opinion (**practice**
99 **values and performance, honest self-expression**) and to give the facts (**practice**
100 **values and principles**), even though she knows that the hospital management is
101 distrusted by the staff due to incongruent behaviour. The unit's statistics revealed a
102 decrease in patient incidents and higher patient satisfaction against the rest of the
103 hospital (**resulted performance excellence**). At a management meeting the nursing
104 service manager stated that the surgical unit might reveal their secrets for this positive
105 outcome. Although Elaine's input (**serve**) to get her colleagues aligned
106 (**navigate, empower**) towards a culture of quality, has not been identified as the reason
107 for these outcomes, the hospital's management is aware of some sort of change
108 present in the surgical unit (**resulted performance excellence**). To Elaine, feedback
109 on these positive outcomes (**create value**) is good news although she would be ecstatic
110 when her colleagues experience that their participation in a team towards quality
111 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 infomatrix 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 and Taljaard, 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 <ul style="list-style-type: none"> • Situation-specific • Relationship-centered 	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

<ul style="list-style-type: none">• Balanced life• Pursue purpose of leadership with passion	<ul style="list-style-type: none">• 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
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PROCESS	<p>Process of authentic leadership</p> <ul style="list-style-type: none"> • Serve • Create value • Navigate • Inspire • Empower • Connects with followers 	<ul style="list-style-type: none"> • 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	<p>Manifestations of authentic leadership</p> <ul style="list-style-type: none"> • Performance excellence • Meaning in performance • Results 	<ul style="list-style-type: none"> • 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.

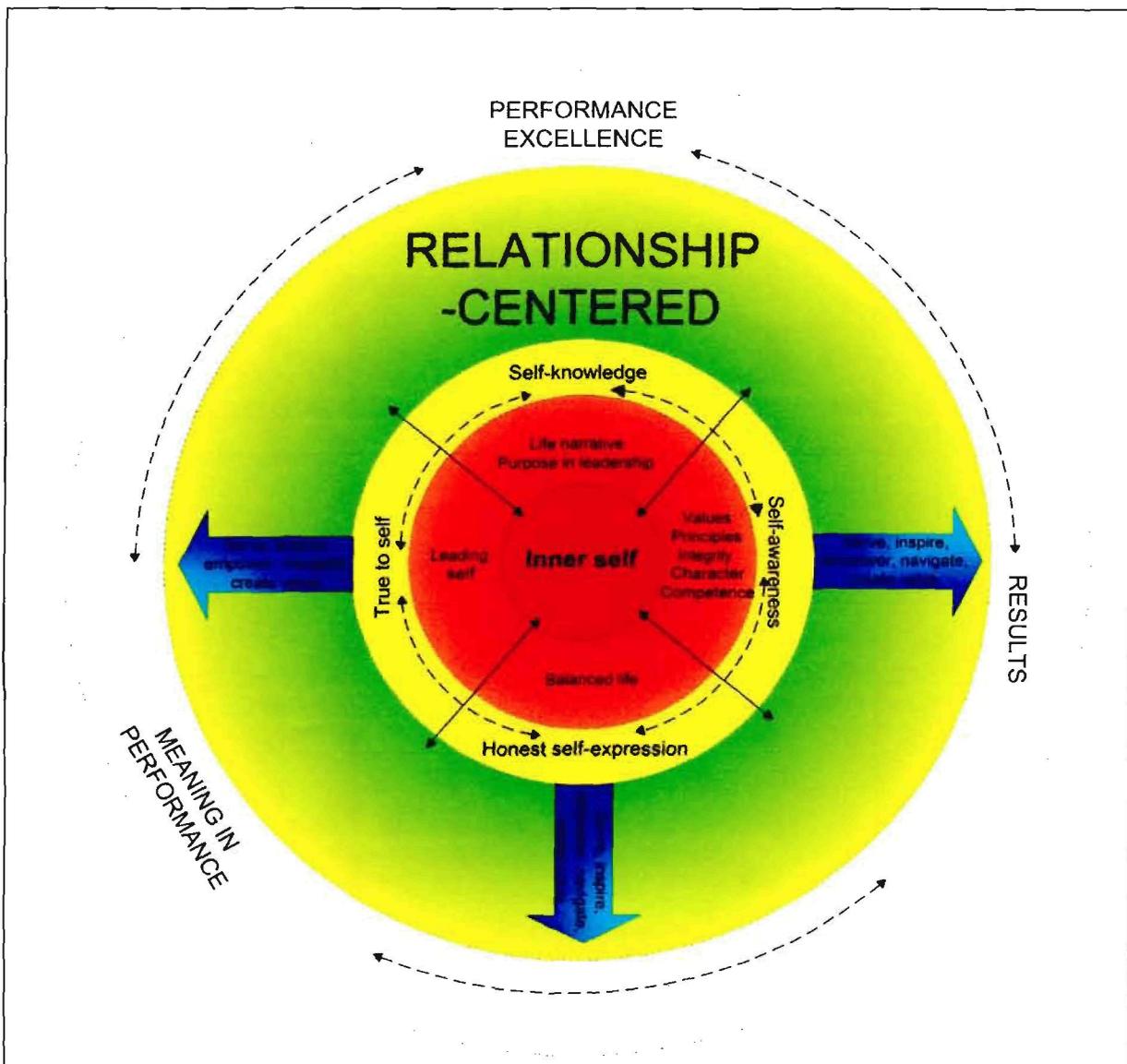


Figure 3.2 Authentic leadership in nursing

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-entrepreneurship 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
<p>THEORETICAL COMPETENCE</p> <p>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.</p>	<p>PROFESSIONAL ETHICAL PRACTICE</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • Recognise the differences in accountability and responsibility between professional nurses, enrolled nurses and auxiliary nurses. 	<ul style="list-style-type: none"> • 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.
<p>CLINICAL COMPETENCE</p> <p>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.</p>	<p>CLINICAL PRACTICE</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • 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.
<p>OCCUPATIONAL COMPETENCE</p> <p>Instrumented through professional performance.</p>	<p>QUALITY OF CARE</p> <ul style="list-style-type: none"> • Continuing education • Professional enhancement • Quality improvement • Research • Practice within an evidence-based framework • Inter-professional healthcare 	<ul style="list-style-type: none"> • 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

<p>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.</p>		<ul style="list-style-type: none">• 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.
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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 fourth 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.

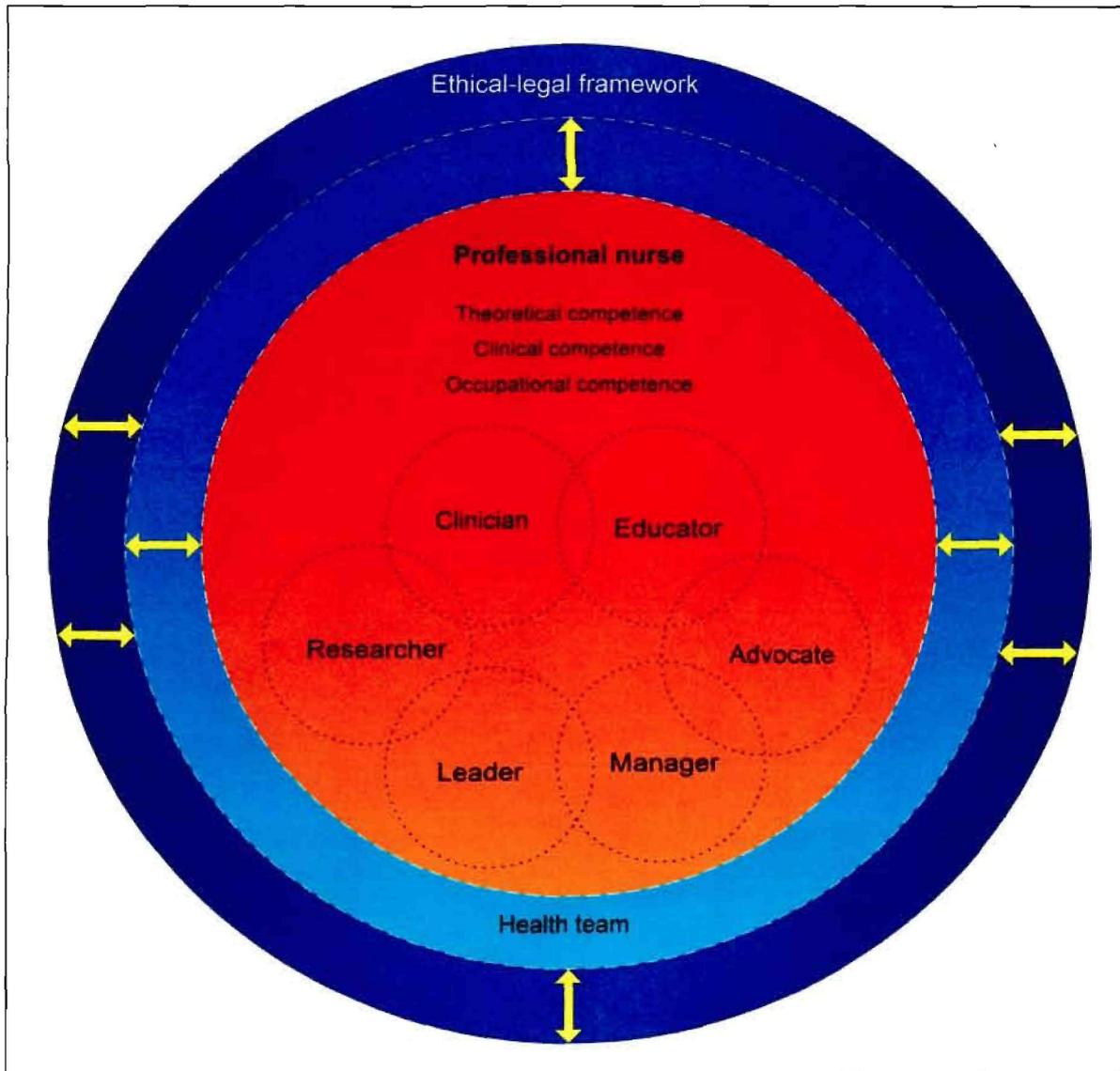


Figure 3.3 Professional nurse

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 lose scarce 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
<p>Goal 1: Eradicate extreme poverty and hunger</p>	<p>Halve the proportion of people living on less than a dollar a day and those who suffer from hunger.</p>
<p>Goal 2: Achieve universal primary education</p>	<p>Ensure that all boys and girls complete primary school.</p>
<p>Goal 3: Promote gender equality and empower women</p>	<p>Eliminate gender disparities in primary and secondary education preferably by 2005, and at all levels by 2015.</p>
<p>Goal 4: Reduce child mortality</p>	<p>Reduce by two-thirds the mortality rate among children under five.</p>
<p>Goal 5: Improve maternal health</p>	<p>Reduce by three-quarters the ratio of women dying in childbirth.</p>
<p>Goal 6: Combat HIV/AIDS, Malaria and other disease</p>	<p>Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.</p>
<p>Goal 7: Ensure environmental sustainability</p>	<p>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.</p>
<p>Goal 8: Develop a global partnership for development</p>	<p>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.</p>

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 track. 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 track 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 infancy 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 accommodates 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 1 243 500 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 of 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 linked 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. Alarming, 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 hospital 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 subsidies 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 acknowledges 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 hospital 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 losing 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 CPI 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 (Thom, 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 (Thom, 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 (Thom, 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

(Thom, 2007:1). In 2007 a salary increase was activated for nurses in the provincial hospitals and this caused an even greater discontent amongst nurses in the private healthcare industry. Nurse colleagues travelling to international destinations for better remuneration and working conditions (Mahlathi, 2006:1) are a reality. These reasons should urge private hospitals to provide more inviting remuneration packages to nurses (Thom, 2007:1). Netcare (2007:15) initiated a program to bring professional nurses abroad back to South Africa and in 2006 42 professional nurses returned to South Africa and another 102 professional nurses were lined up to return in 2007. Corporate permits to introduce 5000 professional nurses from India and Central Europe have been lodged by Netcare (2007:15) in an attempt to relief the staff shortages. According to Matsebula and Willie (2007:16), an interview with a HASA official indicated that nurses in general move over from public hospitals to private hospitals due to a reduced workload in private hospitals, a lower bed occupancy rate and more improved and professional resources. From the researcher's personal experience, specific units in private hospitals had extremely high turnover – and bed occupancy rates.

These nursing professionals are allocated to provide the service of nursing amidst the reality of severe shortages in staff – lack of sufficient amount of staff, lack of adequate trained, experienced and expert staff. Staff is ageing and cannot afford an early retirement but occupy positions without promotional possibilities.

Now that the private South African hospitals have been explored in terms of their core focus, their demographic data; funding and fee structures and human resources, the daily work-life faced by professional nurses are better understood.

v) Daily work-life of the professional nurse

Private hospitals have an average length of stay of three days (HASA, 2008b:14). When this length of stay is placed against the reality that there is only three beds per 1000 members of the private healthcare population, it portrays the high unit turnover. Netcare (2007:20) identified the following four reasons why there are an increase in private hospitalisation as an ageing society with a growth of admissions of patients aged 60 and older; patients older than 60 increase the length of stay; advanced technology that implies earlier diagnosis ability and increased treatment as well as the increase of classical lifestyle disease of diabetes, obesity and hypertension.

The investigations into private hospitals by Matsebula and Willie (2007:159-174) gives the impression that doctors as clients to private hospitals and not as employees, play a major

role in these hospitals. In the daily lives of professional nurses, this might imply less professional collaboration between nurse and doctor as Matsebula and Willie (2007:171) reported of private hospitals' challenge to influence doctor's compliance with infection control procedures.

An argument that originated from the researcher's personal experience in private hospitals is that occupation in private hospitals places the ethical challenge of financial priority on professional nurses' shoulders. The business of caring is now a financial institution and decision-making processes are influenced by the cost implications thereof. Cost drivers are monitored and managed healthcare interventions are conducted by professional nurses in order to ensure remuneration for nursing. Uninsured patients are stabilized and transferred to public hospitals or is closely managed according to Prescribed Minimum Benefits. Nurse-patient ratios and bed occupancy are established through financial projection. Various nursing staff members may experience a lack of appreciation from hospital management and from patients and doctors. Whilst medically insured patients demand the best care available, burnout of professional nurses is a frequent occurrence in private hospitals.

The micro level context, whether public or private hospitals, is the reality in which the professional nurse is employed. Being a professional nurse in South African hospitals is difficult. More than ever the professional nurse is in need of authentic leaders in nursing who can supply support and direction. Authentic leaders in nursing are called to support professional nurses by engaging into a relationship based on bonding, bridging and linking social capital. In this relationship leaders in nursing need to be authentic. They need to make the moral choice of being leaders inspire, empower, navigate and serve professional nurses. Through bonding, bridging and linking social capital, the authentic leader in nursing and the professional nurse can restore and enhance trust as high trust levels are essential in the functioning of South African hospitals.

In the following figure (Figure 3.4) the macro-, meso- and micro levels of the context in this research are visually portrayed.

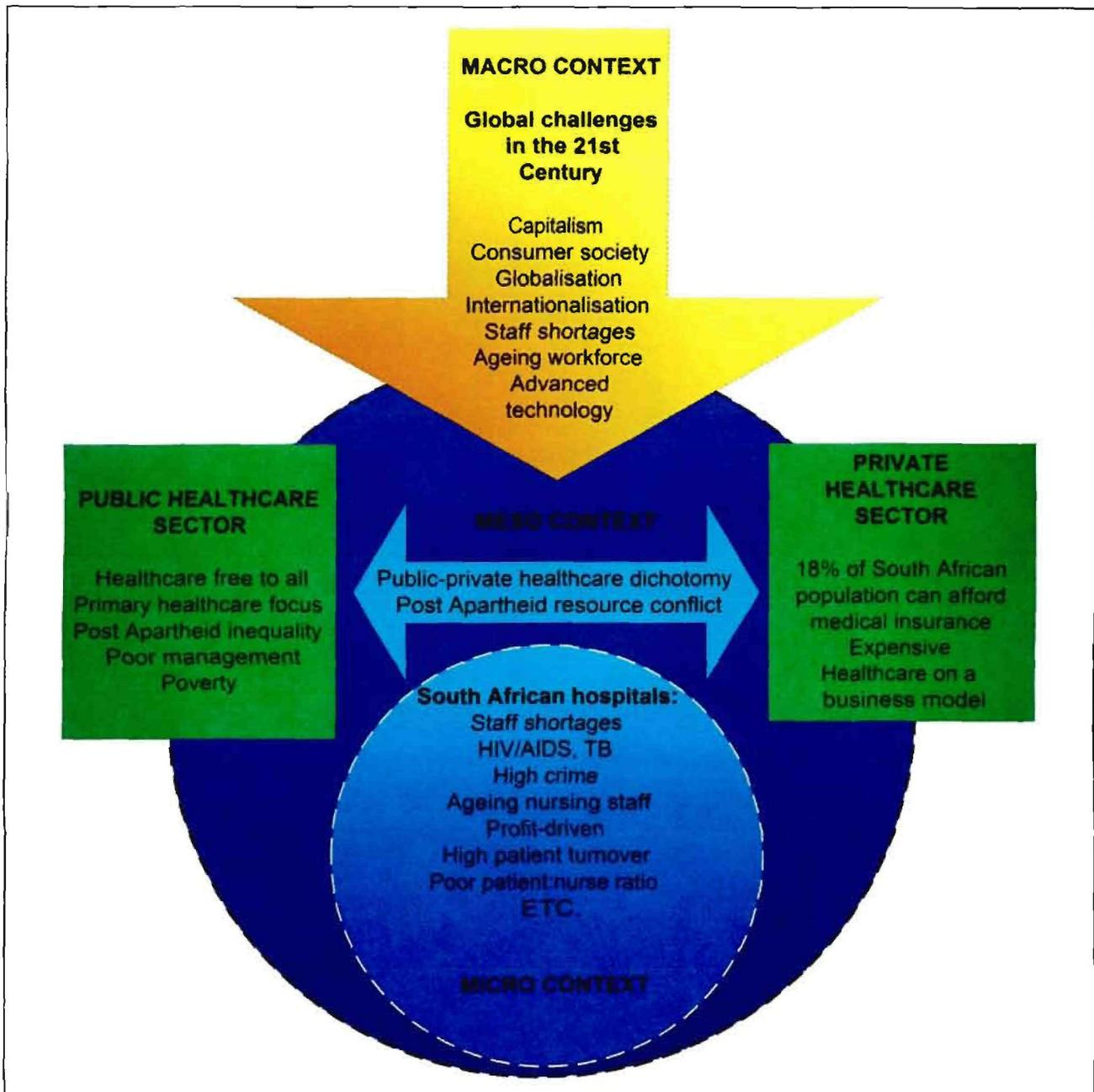


Figure 3.4 Context

3.6.4 CONCLUSIONS ABOUT THE CONTEXT

From the above literature analysis, the following conclusions are formulated about the context in this research:

- There is a dichotomy between overburdened and under-resourced public hospitals versus resourced but unaffordable private hospitals in South Africa.
- The public hospitals, which are part of a national health system with a primary healthcare focus and an ideal to provide healthcare to all, are slowly recovering from the inequalities of apartheid.

- Public hospitals serve the majority of South Africans of which poverty, unemployment, crime, HIV/AIDS, Tuberculosis and no medical cover is at the order of the day.
- Private hospitals, which functions on a business model, serve the minority of South Africans that can afford some form of medical cover.
- The global-economical and political challenges as well as the cultural diversity in South Africa, impact on the healthcare industry and enlarge the dichotomy between public and private hospitals even more.
- The public versus private hospital dichotomy implies a conflict for adequate resources in the form of human resources, financial resources and managerial resources.
- South African hospitals are interdependent with international and national challenges as well as challenges that present on ward-level in these hospitals.

3.7 SUMMARY

The objective of Chapter Three was to conduct the concept identification, description, definitions and analysis of the agent, recipient and context in this research. The realisation of the data collection was completed. A discussion followed on the process of concept identification done in this research. The process of concept analysis of the agent and authentic leader was discussed. The recipient and context were discussed with specific selected definitions. In the next chapter, the process of concept analysis with specific reference to the process and results of the main and related concepts follow.

CHAPTER FOUR

CONCEPT FRAMEWORK: PROCEDURE; GOAL; DYNAMIC

4.1 INTRODUCTION

The aim of Chapter Four is to conduct concept identification, description, definition and as needed, the analysis of the remaining main and – related concepts. Therefore, Chapter Four joins closely with Chapter Three in achieving the second objective in this research. Conclusion statements are formulated for the main and related statements.

4.2 REALISATION OF DATA

The realisation of the data with specific reference to data collection was discussed in Chapter Three (refers to point 3.2). In Chapter Four, specific reference is made with regard to the realisation of data collection for the procedure (social capital), goal (positive impact on the triple bottom line) and dynamic (trust).

The population was all available national and international sources of data. A purposive sampling was done in the form of advanced literature searches by means of search engines and according to specific selection criteria. Please refer to Table 3.1 for the list of the databases represented in the national and international search engines used. Data searches were conducted in three phases (refer to Table 4.1) which can be summarised as follows:

- *Phase 1: concepts searched by key words*

The following key word searches were done during the first broad search:

- social capital;
- triple bottom line; and
- trust.

- *Phase 2: advanced search options activated*

As the literature search results after phase 1 were large amounts, the first advanced search option was activated by limiting all the above key words to title searches.

- *Phase 3: advanced search options increased*

All the concepts underwent a third phase whereby advanced search options were increased.

The following advanced search options were added:

- social capital and nurs* and/or health*;
- social capital and nurse* and/or health* and/or lead*;
- triple bottom line and/or job stress* and/or job satis*;
- triple bottom line and/or job stress* and/or job satis* and/or nurs* retent*;
- triple bottom line and nurs* retent*;
- triple bottom line and work-life balance;
- triple bottom line and “healthy work environment”;
- triple bottom line and profit; and
- trust and nurs*.

Various sources of literature were used, including dictionaries, thesauruses, encyclopedias, textbooks, articles, theories as well as other forms of literature for example presentations and interviews. Please refer to Table 4.2 for a summary of the types of data used as well as Table 4.3 for a summary of data that were used and listed as “other”. Data saturation was reached when no new information surfaced in the literature searches (n = 204). Table 4.4 provides a summary of all the literature searches conducted for the procedure, the goal and the dynamic.

4.3 CONCEPT ANALYSIS: PROCEDURE AND LITERATURE ANALYSIS: GOAL AND DYNAMIC

The process of concept analysis is discussed in Chapter Two, and a short reference of this process is provided in Chapter Three (refers to point 3.2). For the sake of the applicability in Chapter Four, the steps followed in the process of concept analysis (Walker & Avant, 2005), are listed as follows:

- Step 1: the selection of main – and related concepts.
- Step 2: the aims or purpose 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).

Table 4.1 Summary of phases in literature searches for articles, textbooks and theories: procedure, goal and dynamic

Main and related concepts	Phase 1		Phase 2	Phase 3	Literature found per search engine
	Key word(s) used	Title search done Literature found	Concepts specified in title search	Advanced search conducted	
PROCEDURE	Social capital	EbscoHost: 5144 BiblioLine: 319 Science Direct: 88991 Emerald: 16578 ISI: 3478 Sabinet: 2508 Library cat. :45	Limited search to title	social capital and nurs* and/or health*; social capital and nurse* and/or health* and/or lead*;	EbscoHost: 457 BiblioLine: 161 Science Direct: 368 Emerald: 119 ISI: 4 Sabinet:120 Library cat. :9
GOAL	Triple bottom line	EbscoHost: 89 BiblioLine: 42 Science Direct: 426 Emerald: 243 ISI: 75 Sabinet: 129 Library cat. : 10	Limited search to title	triple bottom line and/or job stress* and/or job satis*; triple bottom line and/or job stress* and/or job satis* and/or nurs* reten* triple bottom line and nurs* reten*; triple bottom line and work-life balance; triple bottom line and "healthy work environment"; triple bottom line and profit;	EbscoHost: 49 BiblioLine: 16 Science Direct: 73 Emerald: 131 ISI: 24 Sabinet: 129 Library cat. : 2
DYNAMIC	Trust	EbscoHost: 60 694 BiblioLine: 19776 Science Direct: 186 363 Emerald: 456 ISI: 18 836 Sabinet: 286352 Library cat. : 584	Limited search to title	trust and nurs*.	EbscoHost: 129 BiblioLine: 1 Science Direct: 11 Emerald: 68 ISI: 38 Sabinet: 373 Library cat.: 52

Table 4.2 Summary of the types of data used for procedure, goal and dynamic (N=425)

Main and related concepts	Dictio- naries	Thesauri	Subject dictionaries	Encyclo- pedia	Journal articles	Text- books	Theories	Other	Total used
Social capital	4	8	7	5	63	6	1	22	116
Triple bottom line					27	4		42	73
Trust	3	2	1	1	1	3	-	4	15
TOTAL AMOUNT OF LITERATURE USED									n=204

Table 4.3 Summary of data listed as “other”

Data type	Social capital	Triple bottom line	Trust	Total amount of other sources of data
Report	4	7		11
Fact sheet		6		6
Power point presentation	1	3		4
Presentation paper	2		1	3
Information of governing body/council	2	7		9
Press release / press conference / Position statement		6		6
Working paper/ Support document/ Manual/ discussion paper	6	5	1	12
Web-based article / chapter	2	6		8
Unspecified document	5	2	2	9
Statistics report				-
Minutes from committee meeting				-
Total data used per concept	22	42	4	68

Table 4.4 Summary of all literature searches with literature used for procedure, goal, dynamic (n=204)

Search engines used	EBSCO		BIBLIO-		SCIENCE		EMERALD		ISI		SABINET		LIBRARY		OTHER	Sub-total	Dictio-naries	Total amount of literature used
	HOST		LINE		DIRECT						CAT.							
	F	U	F	U	F	U	F	U	F	U	F	U	F	U	U			
Social capital	457	11	161	4	368	13	119	30	4	1	120	5	9	6	22	92	24	116
Triple bottom line	49	6	16	4	73	7	131	4	24	2	129	4	4	4	42	73	-	73
Trust	129	1	1	-	11	-	68	-	38	-	373	-	52	3	4	8	7	15
	635	18	178	8	452	20	318	34	66	3	622	9	65	13	68	173	31	n=204

F = literature found during literate search

U = actual literature used

STEP 1: IDENTIFICATION OF MAIN- AND RELATED CONCEPTS

4.3.1 The identification of main and related concepts

The first step in the process of concept analysis is concept identification. The latter was done in accordance with the survey list by Dickoff *et al.* (1968:415-423). Please refer to Chapter 2 (refers to 2.5.2 and Table 2.3) where the survey list and its application in this research are discussed as well as Chapter Three, 3.3.1. According to the survey list, the allocation of the remaining main and related concepts is:

- procedure: social capital;
- goal: positive impact on the triple bottom line; and
- dynamic: trust.

Social capital as a main concept will undergo a concept analysis. The related concepts (positive impact on the triple bottom line, trust) are analysed by means of literature analysis.

4.4 CONCEPT DESCRIPTION, DEFINITION AND ANALYSIS: PROCEDURE [SOCIAL CAPITAL]

STEP 2: AIMS AND PURPOSES OF THE CONCEPT ANALYSIS

4.4.1 Aims and purposes of the concept description, definition and analysis of social capital

A challenge to this research was the irreconcilable status amongst authors and disciplines on the definition of social capital. According to authors (Dolfsma & Dannreuther, 2003:1 and Foley & Edwards, 1997:1) there are still not an undisputed or clear meaning of social capital – even more so in Nursing Science. Existing definitions are context specific and depended on both the level of investigation as well as the discipline and study field. The aim of the description, definition and analysis of social capital is to formulate a definition of social capital for Nursing Science. Therefore, the purposes of concept analysis are to clarify the meaning of social capital and by gaining optimal insight into this concept.

STEP 3: IDENTIFY ALL AVAILABLE USES OF THE CONCEPT

4.4.2 Identify all available uses of the concept social capital

The third step in the description, definition and analysis of social capital, is to find all the available uses of social capital.

4.4.2.1 All available definitions of social capital

Social capital as defined in all available dictionaries, subject definitions, thesauri and encyclopaediae were identified. Please refer to Table 4.5. Due to the discrepancy in literature about the definition of social capital, additional literature analysis was conducted.

Definitions of social capital in textbooks, theories and articles were also investigated. The uses of social capital were categorised into different disciplines (refer to Table 4.6) and according to various authors to display the uses of social capital across different subject fields. The uses of social capital were categorised under sociology, anthropology, economics and business management, industrial and labour relations, political sciences and an unspecified discipline.

Table 4.5 Summary of the uses of social capital in dictionaries, subject dictionaries, thesauri and encyclopaediae

Dictionary uses of social capital		Thesaurus uses of social capital		Encyclopaedia uses of social capital	
Source	Description	Source	Description	Source	Description
Investopedia (2008)	An economic idea that refers to the connections between individuals and entities that can be economically valuable . Social networks that include people who trust and assist each other can be a powerful asset . These relationships between individuals and firms can lead to a state in which each will think of the other when something needs to be done. Along with economic capital, social capital is a valuable mechanism in economic growth.	Roget's II: New Thesaurus (1995)	Quality Noun: High style in quality, manner, or dress refinement. Informal: class. A level of superiority that is usually high: calibre, merit, stature, value, virtue, worth. A distinctive element : attribute, character, characteristic, feature, mark, peculiarity, property, savor, trait. Degree of excellence : calibre, class, grade. People of the highest social level : aristocracy, blue blood, crème de la crème, elite, flower, gentility, gentry, nobility, patriciate, society, upper class, who's who. Informal: upper crust. Adjective: Exceptionally good of its kind: ace, banner, blue-ribbon, brag, capital, champion, excellent, fine, first-class, first-rate, prime, splendid, superb, superior, terrific, tiptop, top. Informal: A-one, bully, dandy, great, swell, topflight, top-notch. Slang: boss.	Reference.com (2008)	Social capital is a core concept in business, economics, organizational behaviour, political science, and sociology, defined as the advantage created by a person's location in a structure of relationships . "By analogy with physical capital and human capital – tools and training that enhances human productivity – the core idea of social capital theory is that social networks have value . Just as a screwdriver (physical capital) or a college education (human capital) can increase productivity (both individual and collective), so too social contacts affect the productivity of individuals and groups. It explains how some people gain more success in a particular setting <i>through their superior connections</i> to other people. There are in fact a variety of inter-related definitions of this term, in popular literature, which has been described as "something of a cure-all" (Portes, 1998) for all the problems afflicting communities and societies today.
Dictionary.com (2008)	An economic idea that refers to the connections between individuals and entities that can be economically valuable . Social networks that include people who trust and assist each other can be a powerful asset . These relationships between individuals and firms can lead to a state in which each will think of the other when something needs to be done. Along with economic capital, social capital is a valuable mechanism in economic growth.				
Oxford Dictionary (1989)	"Noun, the interpersonal networks and common civic values which influence the infrastructure and economy of a particular society ; the nature, extent, or value of these."	Wordsmyth (2002)	No results found in the search for social capital.	Encarta Encyclopaedia (2008)	No results found in the search for social capital.

Table 4.5 continues

Subject dictionaries					
The Concise Oxford English Dictionary (2008)	"...the networks of relationships among people who live and work in a particularly society , enabling that society to function effectively."	Thesaurus.com (2008)	No results found in the search for social capital.	Oxford Encyclopedia (2008)	No results found in the search for social capital.
The Concise Oxford Dictionary of Politics (2003)	"Social capital refers to the social networks , systems of reciprocal relations , sets of norms , or levels of trust that individuals or groups may have, or to the resources arising from them..."	Encarta Thesaurus (2007)	No search results found for social capital	Oxford World Encyclopedia (2008)	No results found in the search for social capital.
Dictionary of Social Sciences (2002)	"Interpersonal networks that provide people with resources or status, which they can exploit in other areas of social life and potentially leverage in the pursuit of economic or cultural capital . The principal example is educational accomplishment. ..."	Merriam-Webster Online Thesaurus (2008)	No search results found for social capital	Free Dictionary by Farlex Encyclopedia (2008)	No search results found for social capital
A Dictionary of Sociology (2005)	"A concept originally devised by James Coleman to describe the types of relations that exist between individuals as located within both families and communities , and that are said to exert a strong influence on levels of educational achievement..."	Thesaurus.com (2008)	No results found in the search for social capital.	Columbia Encyclopedia (2008)	No search results found for social capital
A Dictionary of Geography (2004)	" Assets , like roads, schools, and hospitals, which belong to society rather than to individuals ."	Oxford Paperback Thesaurus (2006)	No results found in the search for social capital.		
Oxford Dictionary of Business and Management (2006)	No results found in the search for social capital.	Oxford American Thesaurus for Current English (2002)	No results found in the search for social capital.		

Table 4.6 Text definitions of social capital by various authors, grouped into different disciplines

AUTHOR(S)	DEFINITION(S) OF SOCIAL CAPITAL
Social capital defined in Sociology	
Hanifan (1916:130)	<p><i>"We not refer to real estate or to personal property or to cash, but rather to that in life which tends to make those tangible substances count for most in the daily lives of people: namely good will, fellowship, sympathy, and social intercourse among the individuals and families who make up a social unit, - the rural community, whose logical centre is in most cases the school. In community building, as in business organisations, there must be an accumulation of capital before the constructive work can be done..."</i></p>
Jacobs (1961:138)	<p><i>"These networks are a city's irreplaceable social capital. Whenever the capital is lost, from whatever cause, the income from it disappears, never to return until and unless new capital is slowly and chancily accumulated."</i></p>
Baker (1990:619)	<p><i>'...a resource those actors derive from specific social structures and then use to pursue their interests; it is created by changes in the relationship among actors...'</i></p>
Coleman (1990:302)	<p><i>'Social capital is defined by its function. It is not a single entity, but a variety of different entities having two characteristics in common: They all consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure...'</i></p>
Bourdieu and Wacquant (1992:119)	<p><i>'...the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition...'</i></p>
Burt (1992:9, 355)	<p><i>'...friends, colleagues, and more general contacts through whom you receive opportunities to use your financial and human capital...'; '...the brokerage opportunities in a network...'</i></p>

Table 4.6 continues

<p>Portes and Sensenbrenner (1993:1323)</p>	<p><i>'...those expectations for action within a collectivity that affect the economic goals and goal' seeking behaviour of its members, even if these expectations are not oriented toward the economic sphere...'</i></p>
<p>Woolcock (1998:153)</p>	<p><i>'...the information, trust, and norms of reciprocity inhering in one's social networks...'</i></p>
<p>Fukuyama (1995:10)</p>	<p><i>'...the ability of people to work together for common purposes in groups and organizations...'</i> <i>'Social capital can be defined simply as the existence of a certain set of informal values or norms shared among members of a group that permit cooperation among them...'</i></p>
<p>Burt (1997:340)</p>	<p><i>'...a quality created between people, whereas human capital is a quality of individuals. Investments that create social capital therefore different in fundamental ways from the investments that create human capital...social capital is the contextual complement to human capital. Social capital predicts that returns to intelligence, education and seniority depend in some part on a person's location in the social structure of a market or hierarchy.refers to opportunity. The structural whole argument defines social capital in term of the information and control advantages of being the broker in relations between people otherwise disconnected in social structures.'</i></p>
<p>Fligstein (2001:1-44)</p>	<p><i>'The idea that some social actors are better at producing desired social outcomes than are others is the core notion that underlies the concept of institutional entrepreneurs (DiMaggio in Fligstein, 2001:5), actors with high levels of social capital (Coleman in Fligstein, 2001:17), or actors who engage in what has been called robust (Padgett & Ansell in Fligstein, 2001:4) or local action (Leifer in Fligstein, 2001:17).'</i></p>
<p>Portes (1998:6)</p>	<p><i>'...the ability of actors to secure benefits by virtue of membership in social networks or other social structures...'</i></p>

Table 4.6 continues

<p>Lin (1999:1-24)</p>	<p>'...social capital, as a concept, is rooted in social networks and social relations, and must be measured relative to its roots. Therefore, social capital can be defined as resources embedded in a social structure, which are accessed and/or mobilized in purposive actions. By this definition, the notion of social capital contains three ingredients: resources embedded in a social structure; accessibility to such social resources by individuals; and use or mobilization of such social resources by individuals in purposive actions. Thus conceived, social capital contains three elements intersecting structures and action: the structural (embeddedness), opportunity (accessibility) and action-oriented (use) aspects. "</p>
<p>Knoke (1999:18)</p>	<p>'...the process by which social actors create and mobilize their network connections within and between organizations to gain access to other social actors' resources...' (Knoke 1999, p. 18).</p>
<p>Social capital defined in Anthropology</p>	
<p>Bourdieu (1986:248)</p>	<p>Bourdieu's definition of social capital is "...the aggregate of actual or potential resources which are linked to the possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition or in other words, to membership in a group which provides each of its members with the backing of the collectivity-owned capital, a credential which entitles them to credit, in the various senses of the word". The underlying theoretical frameworks of symbolic capitalism and the critical theories of class societies (Wall, Ellen, Gabriele, Ferrazzi, Frans Schryer, 1998:300-322) provided the underlying theme of Bourdieu's definition – a definition that earned the criticism of being egocentric with little empirical analysis (Adam & Roncevic, 2003:155-183). In addition, Everingham (2001:113) claimed that Bourdieu should receive recognition for shaping the concept social capital. Characteristics of Bourdieu's definition is that the concept was viewed as instrumental, the source of social capital is both in social structure and social connections and the advantages of social capital are allocated to the possessors thereof (Everingham, 2001:113).</p>

Table 4.6 continues

Hannerz (1969; in Brass & Labianca, 1999:8)	"...The resources reflected in favours that friends and acquaintances did for one another as part of coping with poverty..."
Social capital defined in Economics & Business Management	
Loury (1992:100)	'...Naturally occurring social relationships among persons which promote or assist the acquisition of skills and traits valued in the marketplace . . . an asset which may be as significant as financial bequests in accounting for the maintenance of inequality in our society ...'
Schlicht (1984:62)	'...for the efficiency of any economic system that people obey the rules even if unobserved since this saves control costs, and their desire to appear to themselves as law-abiding citizens is a very important economic asset and can be considered as a kind of social capital – one might speak of 'moral capital' just in the same sense as von Weizsacker speaks of the " organizational capital " of a society as embodying the value of the organizational structures present within economy .'
Boxman, De Graaf and Flap (1991:52)	'...the number of people who can be expected to provide support and the resources those people have at their disposal...'
Schiff (1992:160)	'...the set of elements of the social structure that affects relations among people and are inputs or arguments of the production and/or utility function...'
Belliveau, O'Reilly and Wade (1996:1572)	'...an individual's personal network and elite institutional affiliations ...'
Pennar (1997:154)	'...the web of social relationships that influences individual behaviour and thereby affects economic growth...'
Tsai and Ghoshal (1998:465)	'..social capital encompasses many aspects of a social context, such as social ties , trusting relations , and value systems that facilitate actions of individuals located within that context.'
Nahapiet and Ghoshal (1998:243)	"...the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit . Social capital thus comprises both the network and the assets that may be mobilized through that network ...'

Table 4.6 continues

<p>The World Bank (1999:1)</p>	<p>The definition of social capital by the World Bank can also be viewed as a valued contribution in the conceptual analysis thereof. This definition is as follows: “..social capital refers to 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.”</p>
<p>Social capital defined in Industrial and Labour Relations</p>	
<p>Useem and Karabel (1986:184-190)</p>	<p>‘Social capital defined in our study as originating in an upper-class family, has positive effects on the careers of corporate managers with identical educational credentials.’</p>
<p>Tsai and Ghoshal (1998:465)</p>	<p>‘..social capital encompasses many aspects of a social context, such as social ties, trusting relations, and value systems that facilitate actions of individuals located within that context.’</p>
<p>Social capital defined in Political Science</p>	
<p>Putnam (1993:1; 1995)</p>	<p>Putnam’s definition of social capital was as follows: “Social capital here refers to feature of social organization, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions.</p>
<p>Fukuyama (1995:1; 1995:90)</p>	<p>‘...the ability of people to work together for common purposes in groups and organizations...’. Fukuyama also referred to Coleman’s (in Fukuyama, 1995:90) definition of social capital as ‘Social capital can be defined simply as the existence of a certain set of informal values or norms shared among members of a group that permit cooperation among them...’</p>
<p>Inglehart (1997:188)</p>	<p>‘...a culture of trust and tolerance, in which extensive networks of voluntary associations emerge...’</p>
<p>Unspecified discipline</p>	
<p>Thomas (1996:11)</p>	<p>‘...those voluntary means and processes developed within civil society which promotes development for the collective whole...’</p>

Table 4.6 continues

<p>Friedman and Krackhardt (1997:319)</p>	<p>'...the standing one has in a social organization and the concurrent ability to draw on that standing to influence actions of others in the organization and the concurrent ability to draw on that standing to influence actions of others in the organization. From a social capital perspective, what is critical to success is not individual attributes but the way one is embedded in an organization."</p>
<p>Brehm and Rahn (1997:999)</p>	<p>'...the web of cooperative relationships between citizens that facilitate resolution of collective action problems...'</p>
<p>Kreuter and Lezin (2002:228-254)</p>	<p>'..the process and conditions among people and organizations that lead to accomplishing a goal of mutual social benefit. Those processes and conditions are manifested by four, interrelated constructs: trust, social engagement, civic participation, and reciprocity...'</p>
<p>Pennings, Lee and van Witteloostuijn (1998:425-428)</p>	<p>'..the aggregate of firm members' connectedness with potential clients.'</p>
<p>Miles, Miles, Perrone and Edvinsson (1998:282)</p>	<p>'..social capital refers to connections with outside parties that give a firm or individual access to new knowledge...At the state or national level, however, social capital takes a different meaning, referring broadly to issues such as moral character, crime and trust.'</p>
<p>Sirianni and Friedland (2001:13)</p>	<p>'..those stocks of social trust, norms and networks that people can draw upon to solve common problems.'</p>
<p>Fountain and Atkinson (1998)</p>	<p>'..."Social capital" has become a critical enabler of innovation. Social capital represents the 'stock' created when a network of organisations develops the ability to work in collaboration to promote mutual productive gain. ...the glue that makes collaboration feasible in the New Economy is composed of trust and a norm of reciprocity, or enlightened self-interest, among decision makers in networks.... This 'glue' or social capital is a critical component of the value created by these cooperative relationships in terms of economic performance and innovative capacity.'</p>

Table 4.6 continues

Social capital defined in Education	
Coleman (1994:302)	<p><i>‘Social capital is any aspect of informal social organization that constitutes a productive resource for one of more actors....The term “capital” as part of the concept implies a resource or factor input that facilitates production, but is not consumed or otherwise used up in production... The other half of the concept, “social”, refers in this context to aspects of social organizations, ordinarily informal relationships, established for non-economic purposes, yet with economic consequences. ‘</i></p> <p>Coleman is viewed as the second major author in the coining of the concept social capital. Coleman’s work followed upon the efforts of Bourdieu. The definition of social capital according to Coleman is “...a variety of entities with two elements in common” they all consists of some aspect of social structure, and they facilitate certain actions of actors...within the structure” (Coleman in Portes, 1998:6). According to Coleman, (in Portes, 1998:6), networks of relationships, trust, social norms and reciprocity serve as the mechanisms that generate social capital.</p> <p>The definition of social capital by Coleman is viewed to have more functionality. He shifted the egocentric view of social capital to a sociocentric view. Through the definition of Coleman, social capital isn’t only defined as a social structure. The productivity of social capital is added whereby social capital isn’t the end in means. On the contrary, the inability to achieve certain objectives due to the absence of social capital is defended. Coleman further shifted the definition of social capital from an individualistic concept towards groups, families, institutions and organisations. The study and definition of social capital by Coleman represented an increase in empirical research.</p>

4.4.2.2 Dimensions of social capital

In addition to dictionary, thesaurus and encyclopedia uses of social capital as well as textbook, theories and articles' uses, the dimensions of social capital were added to the investigation process. Authors (Hean, Cowley, Forbes, Griffiths & Maben, 2003:1061) claim that the definition of social capital is dependent upon the comprehensive of the dimensions thereof. Social capital is viewed as a multi-dimensional concept with important attributes grouped within each dimension. Only a greater understanding of these dimensions may enhance a greater comprehension of the concept. In Table 4.7 the dimensions of social capital according to various authors are listed. Thereafter Figure 4.1 is provided as a useful representation of the multi-dimensional concept of social capital by Narayan and Cassidy (2001:72).

Table 4.7 Dimensions of social capital

Dimension of social capital	Author(s) that suggested this dimension
Trust	Coleman (1988); Collier (1998); Cox (1997); Kawachi et al. (1999a); Kilpatrick (2000); Leana and Van Buren III (1999); Lemmel (2001); Putnam (1993); Putnam et al. (1993); Snijders (1999); Welsh and Pringle (2001).
Rules and norms governing social action	Coleman (1988); Collier (1998); Fukuyama (2001); Portes and Sensenbrenner (1993).
Types of social interaction	Collier (1998); Snijders (1999).
Network resources	Kilpatrick (2000); Snijders (1999).
Other network characteristics	Burt (1997); Hawe and Shielle (2000); Kilpatrick (2000); Putnam (1995) adapted from (Hean <i>et al.</i> , 2003:1062).
Information social ties; formal social ties; trust; norms of collection action	Liu and Besser (2003).
Interpersonal trust; institutional trust; participation in civic society (formal or informal); trustworthiness.	Ton van Schaick (2002:15-17).

4.4.2.3 Types of social capital

In the above paragraphs attention was granted to what social capital is. In the quest to investigate all possible uses of social capital, reference need to be made to how social capital is used. According to Harper (2002:3) networks (formal and informal) is integral for the conceptualization of the concept social capital. These **networks** can be described as (Australian Bureau of Statistics *in* Harper, 2002:3) "... the **personal relationships** that are **accumulated** when **people** interact with each other in **families**, workplaces, neighbourhoods, local associations and a range of informal and formal meeting places." When referring to networks in the context of social capital, the following three types of social capital can be listed:

- **bonding** social capital - the strong horizontal **bonds** among **members** of a specific group;
- **bridging** social capital – the weaker, vertical, less dense and more crosscutting **ties** among **people** from different **groups**; and
- **linking** social capital – the **connections** present between **people** within a hierarchy with a variety of levels in power.

4.4.3 Characteristics of social capital

While all the uses and textbook definitions of social were investigated, descriptive and repeated words were highlighted. These words serve as the characteristics of social capital. These characteristics will be reduced in order to formulate the defining attributes of social capital.

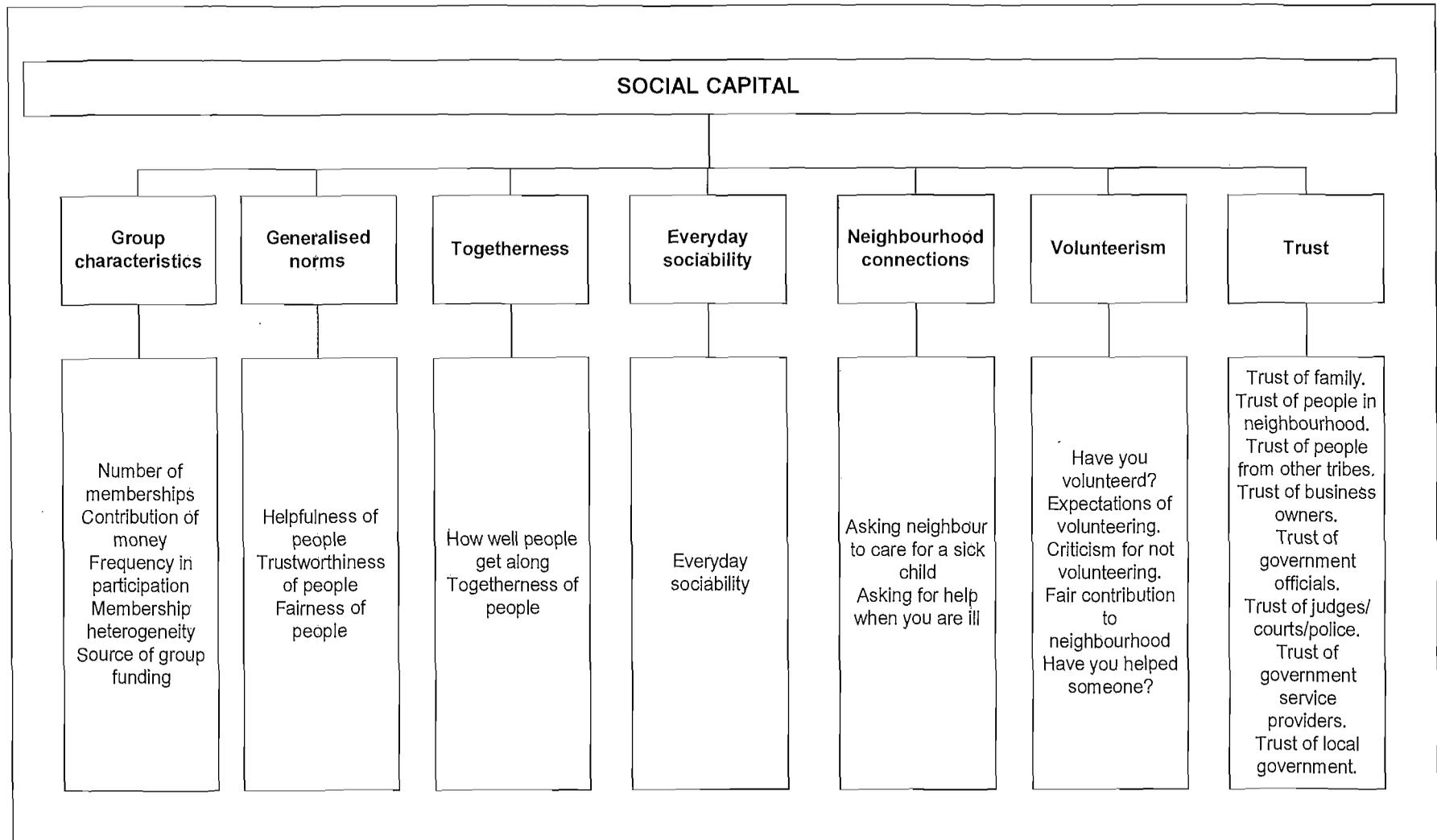


Figure 4.1 Dimensions of social capital (Narayan & Cassidy, 2001)

Table 4.8 Characteristics of social capital

<ul style="list-style-type: none"> • Access to resources, controlled by network members • Accumulates • Action-oriented • Actors • Advantages created by your social structure location or relationships • Aggregate of actual/potential resources linked to durable networks • Assets, belongs to society rather than the individual • Belonging to clubs, associations • Bonding • Bridging • Brokerage • Brokerage opportunities in networks • Civic society • Formal and informal participation • Common civic values • Community building 	<ul style="list-style-type: none"> • Networks • Results from networks, inheres in networks • Interpersonal networks • Influences the infrastructure and economy of a society • Provide people with resources and status • Can exploit in other areas of social life • Potentially leverage in pursuit of economic/cultural capital • Networks of relationships • Network resources • Social networks • Social networks include people that trust and assist each other • A powerful asset • Resources arising from them • Have value • Effect productivity of individuals and groups 	<ul style="list-style-type: none"> • Relationships • Relationship between individuals and firms • Each think of the other when something needs to be done • Types of relations (familial, communities) • Exert a strong influence on the levels of education • Relationships amongst people in a society that enables them to function more effectively • Benefits of ties • Formal and informal social ties • Relationships • Friends, colleagues, general contacts • Naturally occurring • Reputations • Resource access/mobilization • Derived in social structure • Used to pursue interests
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Table 4.8 continues

<ul style="list-style-type: none"> • Influences the infrastructure and economy of a society • Connections/connectedness • Connections between individual and entities • Connections with an economic value • Contextual compliment to human capital • Cooperative behaviour, cooperation, working together • Creates human capital, created by human capital • Creates network connections • Created by change in relationships • Critical enabler of innovation • Culture of trust and tolerance • Defined by function • Economic • Valuable mechanism in economic growth • Educational achievement • Embeddedness in social structure 	<ul style="list-style-type: none"> • Network characteristics • Durable networks of relationships • Resources • Linked to durable networks • Sums of resources accrued by possessing durable networks • Structures of networks • Individual position in networks • Norms • Sets of norms • Resources arising from them • Of reciprocity • Generalised norms • Helpfulness • Trustworthiness • Fairness • Rules and norms governing social action • Norms of collective actions • Economic outcomes • Outcomes 	<ul style="list-style-type: none"> • Embedded in social action • Secure benefits by membership in social networks • Shape the quality and quantity of society's social relations • Social interaction, social intercourse, social engagement • Social structure • Individual, group, dyadic • Private versus public • Socio-structural versus cultural • Bounded solidarity • Group characteristics • Social unit • Elements in social structure – influence relations • Solves problems of group/common problems • Status, elite institutional affiliations • Stock
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Table 4.8 continues

<ul style="list-style-type: none"> • Everyday sociability • Facilitates individual action, facilitates actions within social structures • Facilitates resolution of collective action problems • Fellowship • Glue that holds all together • Goals of mutual social benefit • Goodwill • Information and control advantages • Linking • Mobilise network connections • Moral capital, law-abiding citizens, morality • Multifaceted • Virtue • Worth • Degree of excellence 	<ul style="list-style-type: none"> • Number of people that provides support and resources available to those that provide the support • Opportunities, opportunities received to use for financial/human capital • Social outcomes • Process • Produce desired outcomes • Property of the group/individuals/dyads • Reciprocity exchange • Trustworthiness • Value introjection • Volunteerism • Level of superiority • Merit • Stature • Value • Good of its own kind 	<ul style="list-style-type: none"> • Success is the way one is embedded in social structures • Sum of social institutions that underpins society • Sympathy • Systems of reciprocal relations • Tangible substances of daily life • Togetherness • Trust • Levels of trust • The results of trust • Result in trust • Enforceable trust • Types: interpersonal trust, institutional trust • Distinctive element • Attribute • Characteristic
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STEP 4: DETERMINE THE DEFINING ATTRIBUTES (CONNOTATIONS)

4.4.4 Determine the defining attributes (connotations) of social capital

As stated in Chapter Three, the defining attributes, also referred to as the connotations of social capital, are those descriptions that are associated with social capital most frequently (Walker & Avant, 2005:68). Defining attributes are formulated through the reduction of the characteristics of social capital. The reduction of these characteristics was done in three steps and the process has been summarised in Table 3.9. A summary of the three phases in the reduction process is listed as follows:

- 1st Reduction: characteristics grouped into antecedents, process and consequences;
- 2nd Reduction: ordering similar reductions together; and
- 3rd Reduction: grouped characteristics reduced to single characteristics.

The defining attributes of social capital as reduced and refined, are listed as follows:

- Connectedness between people in the form of relationships
- Embedded in social structures (also referred to as networks)
- Trust
- Tangible and intangible resources
- Norms of reciprocity
- Potential social capital needs to be activated
- Actions to accumulate more social capital
- Bonding
- Bridging
- Linking
- Outcomes in the form of advantages in the access to -; control over – and the opportunity to acquire valuable resources.

These defining attributes are used in the formulation of a theoretical definition.

Table 4.9 The reduction process from characteristics towards defining attributes for the concept social capital

Units of meaning		1 ST REDUCTION: Characteristics grouped into units of meaning: antecedents, process, consequences	2 ND REDUCTION: Grouping similar characteristics together	3 RD REDUCTION: Reduce to single characteristics	Category
ANTECEDENTS	Actors Belonging to clubs, associations Civic society Connectedness between individual and entities Connections via economic value Contextual compliment to human capital Cooperative behaviour Cooperation, working together Culture of trust and tolerance Embedded in social structure Everyday sociability Fellowship Goal of mutual benefit Goodwill Moral capital Law-abiding citizens Multifaceted Networks Results from networks Inheres in networks Interpersonal networks Networks of relations Network resources Social networks Social networks include people that trust and assist each other Network characteristics Durable networks of relationships Resources Linked to durable networks	Belonging to clubs, associations Connections Connections via economic value Cooperative behaviour Cooperation, working together Everyday sociability Fellowship Goodwill Relationships Relationships between individuals and firms Types of relations (familial, communities) Relationships amongst people in a society that enables them to function more effectively Formal and informal social ties Naturally occurring Social interaction Social intercourse Social engagement Embedded in social action Private versus public Togetherness Number of people that provides support and resources available to those that provide the support Bounded solidarity Goal of mutual benefit Embedded in social structure Networks Results from networks	Connectedness between people in the form of relationships	CAUSATIVE FACTORS FOR SOCIAL CAPITAL	

<p>Structures of networks Individual position in networks Norms Set of norms Resources arising from norms Norms of reciprocity Generalised norms Helpfulness Trustworthiness Fairness Rules and norms governing social action Norms of collective actions Number of people that provides support and resources available to those that provide the support Property of the group/individuals/dyads Relationships Relationships between individuals and firms Each think of the other when something needs to be done Types of relations (familial, communities) Relationships amongst people in a society that enables them to function more effectively Benefits of ties Formal and informal social ties Friends, colleagues, general contacts Naturally occurring Reputations Resources access Resources mobilization Derived in social structure Used to pursue interests Embedded in social action Social interaction Social intercourse Social engagement Social structure Individual, group, dyadic Private versus public Socio-structural versus cultural</p>	<p>Inheres in networks Interpersonal networks Networks of relations Network resources Social networks Social networks include people that trust and assist each other Network characteristics Durable networks of relationships Linked to durable networks Structures of networks Individual position in networks Derived in social structure Socio-structural versus cultural Group characteristics Social unit Elements in social structure Status, elite institutional affiliations Reputation Merit Level of superiority Stature Virtue Degree of excellence Good of its own kind Character Attribute Success is the way one is embedded in social structure Actors Civic society, Law-abiding citizens Friends, colleagues, general contacts Individual, group, dyadic Friends, colleagues, general contacts Sum of social institutions that underpins society Property of the group/individuals/dyads</p> <p>Trust, levels of trust, enforceable trust Types: interpersonal trust, institutional trust Culture of trust and tolerance</p>	<p>Embedded in social structures (also referred to as networks)</p> <p>Trust</p>
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<p>Bounded solidarity Group characteristics Social unit Elements in social structure Status, elite institutional affiliations Stock Sum of social institutions that underpins society Tangible substances of daily life Togetherness Trust Levels of trust Enforceable trust Types: interpersonal trust, institutional trust Levels of superiority Merit Stature Virtue Worth Distinctive element Attribute Characteristic Degree of excellence Good of its own kind Systems of reciprocal relations Systems of reciprocal relations Sympathy Volunteerism Success is the way one is embedded in social structure</p>	<p>Tangible substances of daily life Stock Resources access Resources mobilization</p> <p>Each think of the other when something needs to be done Norms Set of norms Resources arising from norms Norms of reciprocity Generalised norms Helpfulness Trustworthiness Fairness Rules and norms governing social action Norms of collective actions Moral capital Systems of reciprocal relations Sympathy Volunteerism</p>	<p>Tangible and intangible resources</p> <p>Norms of reciprocity</p>
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PROCESS	Accumulates Aggregate of actual/potential resources linked to durable networks Bonding Bridging Brokerage Created by human capital Created by change in relationships The results of trust Formal and informal participation Influences the infrastructure and economy of a society	Creates human capital Creates network connections Created by human capital Created by change in relationships The results of trust	PROCESS OF SOCIAL CAPITAL	
	Community building Creates network connections Defined by function Facilitates individual action Facilitate actions within social structures Facilitates resolution of collective action problems Glue that holds all together Linking Mobilise network connections Potentially leverage in pursuit of economic/cultural capital Process Produce desired outcomes Reciprocity exchange Value introjection Volunteerism Influence relations Solves problem of group/common problems Critical enabler of innovation Brokerage opportunities in networks Action-oriented	Accumulates Aggregate of actual/potential resources Brokerage Community building Bonding Glue that holds all together Formal and informal participation Bridging Potentially leverage in pursuit of economic/cultural capital Linking Process Action-oriented Defined by function Facilitates individual action Facilitates action within social structures Facilitates resolution of collective problems Influence relations Mobilise network connections Influence infrastructure and economy of a society Value introjection Solves problem of group/common problems Reciprocity exchange		Potential social capital needs to be activated Actions to accumulate existing social capital Bonding Bridging Linking Actions to accumulate existing social capital

CONSEQUENCES	<p>Access to resources controlled by network members</p> <p>Advantages created by social structure location or relationships</p> <p>Assets – belongs to society rather than the individual</p> <p>Common civic values</p> <p>Educational achievement</p> <p>Information and control advantage</p> <p>Provide people with resources and status</p> <p>Can exploit in other areas of social life</p> <p>A powerful asset</p> <p>Resources arising from them</p> <p>Have value</p> <p>Effect productivity of individuals and groups</p> <p>Sums of resources accrued by possessing durable networks</p> <p>Outcomes</p> <p>Economic outcomes</p> <p>Social outcomes</p> <p>Desired outcomes</p> <p>Exert strong influence on the levels of education</p> <p>Secure benefits by members in social networks</p> <p>Shape the quality and quantity of society's social relations</p> <p>Results in trust</p> <p>Economic</p> <p>Valuable mechanism in economic growth</p> <p>Opportunities received to use for financial/human capital</p> <p>Creates human capital</p> <p>Creates network connections</p> <p>Produce desired outcomes</p> <p>Value</p>	<p>Access to resources controlled by network members</p> <p>Advantages created by social structure location or relationships</p> <p>Information and control advantage</p> <p>Opportunities received to use for financial/human capital</p> <p>Can exploit in other areas of social life</p> <p>Effect productivity of individuals and groups</p> <p>Assets – belongs to society rather than the individual</p> <p>Powerful asset</p> <p>Resources arising from men</p> <p>Have value</p> <p>Sums of resources accrued by possessing durable networks</p> <p>Value</p> <p>Provide people with resources and status</p> <p>Economic</p> <p>Valuable mechanism in economic growth</p> <p>Economic outcomes</p> <p>Educational achievement</p> <p>Outcome</p> <p>Social outcomes</p> <p>Desired outcomes</p> <p>Produce desired outcomes</p> <p>Exert strong influence on the levels of education</p> <p>Secure benefits by members in social networks</p> <p>Shape the quality and quantity of society's social relations</p> <p>Creates human capital</p> <p>Creates network connections</p> <p>Results in trust</p>	<p>Outcome (advantages in terms of access to, control over and opportunity)</p> <p>Outcome: (acquisition of valuable resources)</p> <p>Knowledge exchange</p>	MANIFESTATIONS OF SOCIAL CAPITAL
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4.4.5 Theoretical definition of social capital

A theoretical definition for social capital is formulated from the defining attributes that have been formulated from the characteristics of social capital. This definition is abstract and not measurable (Walker & Avant, 2005:27) but is an essential step in the theory construction process. The defining attributes of social capital have been highlighted in the definition.

Social capital in the form of **bonding, bridging and linking**, is a universal phenomenon of **connectedness** in the form of **relationships**. The presence of social capital is dependent on the **relationships** between people that is embedded in **social structures (networks)** characterised by **tangible/intangible resources, trust and norms of reciprocity**. Potential social capital needs to be **activated** whilst existing social capital can be **accumulated**. The outcomes of social capital are the advantages of access to -, control over - and the opportunity to **acquire** valuable **resources**.

STEP 5: CONSTRUCT A MODEL CASE

Step 5 in the process of concept analysis is the construction of a model case. According to Walker and Avant (2005:69), a model case is the presentation of a concept in its most truthful state. In the following paragraphs a model case for social capital is created. The defining attributes of social capital are highlighted in the model case and thereafter numerically cross-referenced with Table 4.8.

4.4.6 Model case of social capital

In the following paragraphs, a model case of social capital is provided.

1 Ward C, the neuro-surgical unit (**embedded in a social structure**) is a frenzy bustle
2 of healthcare activities. The nursing staff (**embedded in a social structure**)
3 consisting of two professional nurses, three staff nurses and three auxiliary
4 nurses hurry along in their purpose of nursing patients (**connectedness in the form**
5 **of relationship**) in a thirty-four-bed unit. The unit manager's (**embedded in a social**
6 **structure**) presence cannot be accounted for help with patients as she is overloaded
7 with administrative tasks. In this unit, the average admission time is two days and the
8 patient turnover extremely high. There is no time for uncertainty and the nursing team
9 (**embedded in a social structure**) learned that survival in this unit plays a heavy
10 weight on teamwork (**connectedness in the form of relationship, embedded in a**
11 **social structure**). Ward C is well known amongst hospital staff (**embedded in a**

12 **social structure**) as a unit with a close knit nursing spirit (**connectedness in the**
13 **form of relationship**) and team members that help each other (**norms of**
14 **reciprocity**).

15 Helen, a graduated professional nurse, is a new staff member (**embedded in a**
16 **social structure**) in the unit (**embedded in a social structure**). Although
17 there was too little time spent on induction, Helen experienced from her first day that
18 there was collaboration (**connectedness in the form of relationship; bonding**)
19 between the nursing staff and the health team (**bridging, linking**) on her shift. She
20 was supported in a buddy system (**connectedness in the form of relationship,**
21 **potential social capital needs to be activated**) by a co-worker. Helen
22 knew from the beginning her mentoring buddy would become a new
23 friend (**connectedness in the form of relationship; bonding**). She was a
24 newcomer to the unit, but was soon aware of dynamics between the nursing staff and
25 their unit manager (**embedded in a social structure**) as well as trans-professional
26 team members (**embedded in a social structure**), that caused great conflict
27 amongst her and her health team members.

28 The unit as part of a larger private hospital (**embedded in a social structure,**
29 **tangible/intangible resources**), functioned on a very strict hierargical structure
30 (**embedded in a social structure**). Helen was aware of the culture of inflexible
31 authority captured in the structural positions in the hospital (**embedded in a social**
32 **structure**). The neuro-surgical unit provides care to all neuro-surgical patients and
33 this call for intensive collaboration (**potential social capital activation, actions to**
34 **accumulate existing social capital**) between the nursing staff and neuro-surgeons;
35 neurologists; orthopedic surgeons; physicians; anesthetists; radiologists;
36 physiotherapists; occupational therapists; psychologists; case managers and
37 patients. Due to the costs and risks involved in the neuro-surgery provided positive
38 patient outcomes are dependent on competent team members and effective team
39 work. Due to this large collaboration process (**potential social capital needs to be**
40 **activated, actions to accumulate existing social capital**), various incidents of
41 conflict rose. Helen was in a sense numbed by the intensive financial orientation of
42 the service providers. She felt that economic benefit overshadowed decisions made
43 by team members that weren't to the benefit of the patient. It was an environment
44 that quickly clashed with Helen's values. She felt intensely uncomfortable in Ward C,
45 and she wanted to withdraw from that uncomfortable reality. But Helen knew that the

46 only way through was to face these conflicting realities.

47 Helen found herself in discussions with her mentor (**connectedness in the form of**
48 **relationships**) about her awareness of identified dynamics that may be resolved with
49 collaboration from management, colleagues and members of the trans-professional
50 team (**bonding, bridging, linking**). Helen experienced real support from her mentor.
51 Besides spending time (**tangible/intangible resources**) with Helen, she felt that she
52 could trust her mentor (**trust**). Her mentor, being employed in this ward for a few
53 years, voiced her own awareness of these dynamics. She undertook to assist
54 (**potential social capital needs to be activated, bonding**) Helen in the investigation
55 and resolution of these dynamics as she also felt that the dynamics were in conflict
56 with what she virtued as important in her profession.

57 Helen found that her mentor had regular interaction with key players (**embedded in a**
58 **social structure**) in Ward C due to working in the unit for such a long time (**access,**
59 **control and opportunity advantages, acquisition of valuable resources**). She
60 had an established network of relationships (**embedded in a social structure**) with
61 members of the trans-professional team. Helen's mentor agreed that she could
62 address these issues during her conversations with key players (**bridging, linking**).
63 This might activate an awareness of these conflicting values amongst the surgeons,
64 who enjoyed a great decision making position in the unit (**embedded in a social**
65 **structure, access, control and opportunity advantages**).

66 Helen decided that she would initiate purposive discussions (**actions to accumulate**
67 **existing social capital, bridging, linking**) with members of the trans-professional
68 team (**embedded in a social structure**) only through the facilitation of her mentor
69 (**bridging**). She had her first discussion with the unit manager (**embedded in a**
70 **social structure**). Being very busy, the unit manager was aware of Helen's initiative
71 to foster basic values in the unit. The unit manager agreed that she
72 would support Helen in her endeavors (**tangible/intangible resources, bonding**),
73 stated that it will not be easy nor will she have quick results. But that she would
74 accommodate Helen's needs to decrease the daily conflict experienced between the
75 nursing staff and members of the trans-professional team. For the next two months
76 Helen was introduced to doctors; physiotherapists; administrative staff and the rest of
77 the team (**bonding, bridging, linking, potential social capital needs to be**
78 **activated**) through her mentor and unit manager. Introductions usually lead to
79 discussions of daily conflicting events and suggestions were made spontaneously to

80 balance it out (**actions to accumulate existing social capital**). The majority of co-
81 workers agreed that the financial focus of the hospital did influence decisions and that
82 it did cause internal conflict. Helen was surprised to find that members of the health
83 team shared her concern and internal conflict and was willing to see how the current
84 system of service provision could be adapted in order to assist the health team
85 (**norms of reciprocity**).

86 Helen found that Ward C didn't have its own philosophy but functioned only in
87 accordance to the general philosophy of the greater hospital. She took the initiative
88 to formulate a unique philosophy for the unit. After she gained the support of her unit
89 manager and mentor (**access-, control- and opportunity advantages**), Helen
90 handed this philosophy out to key decision makers of in the unit. This philosophy
91 acknowledged the broader view of the hospital but aligned the unit's focus towards
92 non-financial aspects that were equally important. Ward C officially approved this
93 philosophy and each member of the health received a copy (**access-, control- and
94 opportunity advantages**). The unique ward philosophy became the new source of
95 direction (**tangible/intangible resources, access-, control- and opportunity
96 advantages**) in general meetings and during important decision making events
97 (**access-, control- and opportunity advantages**).

98 Head surgeons acknowledged Helen's leadership intervention during a management
99 meeting (**access-, control- and opportunity advantages**) and stated that they
100 experienced it to be a basic requirement that should be compulsory in all the units.
101 They requested that the nursing service manager should investigate the impact of this
102 intervention and to consider the broader application thereof to fellow units within the
103 hospital (**access-, control- and opportunity advantages**). Helen started to
104 experience generalised support from co-workers (**bonding, connectedness in the
105 form of relationships, tangible/intangible resources**). This awareness supported
106 Helen (**trust**) to provide a copy of the unit's philosophy to the nursing service
107 manager (**bridging**) during her daily round. The nursing service manager took the
108 philosophy with her for investigation. She returned the following week, stating that
109 she acknowledged that she always knew each unit should have its own philosophy,
110 but she was so overwhelmed with obligations that she didn't implement it. A process
111 was activated in the broader hospital that each unit should create their own
112 philosophy (**access-, control- and opportunity advantages**).

113 As Helen looked back over a year's employment in Ward C, she could see the
 114 changes amongst staff, management and patients (**access-, control- and**
 115 **opportunity advantages**). It was as if staff wanted to work in Ward C. All levels of
 116 personnel had a bit more tolerances with each other (**norms of reciprocity**). But the
 117 best of all was that she made friends (**connections in the form of relationships,**
 118 **bonding**) and new contacts (**accumulation**). She felt as if she was truly part of the
 119 unit (**connections in the form of relationships, bonding**) and that she could count
 120 on colleagues (**tangible/intangible resources, trust, norms of reciprocity**) to help
 121 her even if it was only for the sake of the team (**bonding**).

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

Table 4.10 Justification of the defining attributes (connotations) of social capital as utilised in the model case

Defining attributes of social capital	Reference to the line numbers of the model case
Connectedness between people in the form of relationships	4, 10, 13, 18, 20, 21, 23, 48, 105, 118, 120
Embedded in social structures (also referred to as networks)	1, 5, 9, 10, 11, 16, 25, 26, 29, 31, 32, 48, 105, 118, 120
Trust	53, 107, 121
Tangible and intangible resources	30, 52, 74, 97, 106, 121
Norms of reciprocity	13, 87, 117, 121
Potential social capital needs to be activated	21, 34, 40, 55, 79, 119
Actions to accumulate existing social capital	35, 40, 68, 82,
Bonding	19, 23, 51, 55, 74, 105, 119, 120, 122
Bridging	51, 63, 70, 79, 108
Linking	19, 51, 63, 79
Advantages to the access to -; control over -; opportunities for the acquisition of valuable resources)	59, 60, 66, 91, 95, 95, 98, 100, 104, 113, 115

4.4.7 Literature control of the defining attributes of social capital

In the above table the defining attributes of social capital were justified in a model case. In the following paragraphs these defining attributes are confirmed in literature by means of a literature control.

4.4.7.1 Causative factors for social capital (antecedents)

The presence of **connectedness** in the form of **relationships** were confirmed by various authors (Araya, Dunstan, Playle, Thomas, Palmer & Lewis, 2006:3080; Bandiera, Barankay & Rasul, 2008:745; Burt, 2000:354; Butler & Purchase, 2008:536; Carmeli, 2007:40; De Souza & Grundy, 2007:1407; Franke, 2005:9; Hawe & Shiell, 2000:871, Henderson, 2003:206; Ihlen, 2005:494; Lawson, Tyler & Cousins, 2008:447; Nyqvist; Finnäs, Jacobssen & Koskinen, 2008:348; Pesut, 2002:3; Pronyk, Harpham, Morison, Hargreaves, Kim, Phetla, Watts & Porter, 2008:1999; Veenstra, Luginaah, Wakefield, Birch, Eyles & Elliot, 2005:2799). The following authors confirmed that social capital is **embedded in a social structures** (also referred to as social networks): Burt (2000:350, 353); Butler and Purchase (2008:535); Bouma *et al.*, (2008:155); Franke (2005:1); Fukuyama (1999:3); Gopee (2002:609); Kritsotakis and Garmarnikov (2004:48); Lawson *et al.* (2008:447); Lin (1999:37); Pesut (2002:3); Pronyk *et al.* (2008:1999); Shortt (2004:18); Veenstra *et al.* (2005:2799).

The causative factors of **trust** are confirmed by Ahern and Hendryx (2003:1195); Araya *et al.* (2006:3080); Baron-Epel, Weinstein, Haviv-Mesika, Garty-Sandelon and Green (2008:908); Bellemare & Kröger (2007:184); Carmeli (2007:40); Franke (2005:9); Fukuyama (1999:3); Henderson (2003:506); Ihlen (2005:493); Lawson *et al.* (2008:447); Nyqvist *et al.* (2008:348), Pesut (2002:3); Schultz, O'Brien and Tadesse (2008:613); Shortt (2004:18). Carmeli (2007:640), van der Gaag and Snijders (2005:3) confirmed that **tangible/intangible resources** are a causative factor for social capital. In addition, various authors (Ahern & Hendryx, 2003:1196; Bellemare & Kröger, 2007:184; Burt, 2000:348; Butler & Purchase, 2008:532; Bouma *et al.*, 2008:155; Cattell, 2001:1505; Franke, 2005:9; Hawe & Shiell, 2000:871; Lin, 1999:37; Nyqvist *et al.*, 2008:348; Shortt, 2004:18) confirmed the presence of **norms of reciprocity**.

4.4.7.2 Process of social capital

With regard to potential social capital that needs to be **activated**, Firdmuc & Gërkhani (2008:273) acknowledged the creation of social capital. Lin (1999:41) indicated actions of capitalization and mobilization. Franke (2005:9) agreed that existing social capital can be **accumulated**. Social capital as an action process were confirmed by Bouma *et al.*

(2008:155) that referred to an enabling action; Firdmuc & Gërkhani (2008:279) referring to collective action, Ostrom(2000:176). The types of social action as bonding; bridging and linking were confirmed as follows:

- **bonding** by Carpiano (2008:579), Fernandez (2002:109), Patulny and Svendsen (2007:32), Rosenbaum and Rochford (2008:358, 371); Shortt (204:12); Svendsen and Svendsen (2004:98); Titeca and Vervisch (2008:2206); Veenstra (2005:2800);
- **bridging** by Burt (2000:361); Carpiano (2008:579); Fernandez (2002:108); Lin (1999:37); Patulny and Svendsen (2007:32); Svendsen and Svendsen (2004:66); Titeca and Vervisch (2008:2206) Sabatini (2008:3); and
- **Linking** by Carpiano (2008:579); Rosenbaum and Rochford (2008:371); Titeca and Vervisch (2008:2206).

4.4.7.3 Manifestations of social capital (consequences)

Burt (2000:347, 392); Cattell (2001:1514); Hawe and Shiell (2000:881); Ihlen (2005:494); Kwon and Arenius (2008:1) confirmed that social capital resulted in the manifestation of **access to , control over and opportunity advantages** in the **acquisition of valuable resources** has been confirmed by various authors (Baron-Epel *et al.*, 2008:908 – that referred to social support; Edmondson, 2003:1723; Bueno, Salmador & Rodriques, 2004:568; Ihlen, 2005:493 that referred to shared values, Lauder *et al*, 200677; Mitra, 2008:261; Pesut, 2002:3. Various authors (Ahern & Hendryx, 2003:1195; Bandiera *et al.*, 2008:745; Batt, 2008:488; Bjørnskov, 2006:29; Burt, 2000:379; Carmeli, 2007:40; Edmondson, 2003:1725; Franke, 2005:9; Fukuyama, 1999:10; Pronyk *et al*, 2008:1999; Sabatini, 2008:1) confirmed that social capital presented in different outcomes.

STEP 6: DEFINE THE EMPIRICAL INDICATORS (DENOTATIONS)

4.4.8 Denotations (empirical indicators) of social capital

Denotations (also referred to as the empirical indicators) are referents that can be used to identify the existence of social capital (Walker & Avant, 2005:72-73) in practice. The denotations for social capital have been organised with the causative factors for social capital (antecedents), the process of social capital and the manifestations (consequences of social capital). Please refer to Table 4.11:

4.4.9 Operational definition of social capital

The final step in the concept analysis of social capital (Walker & Avant, 2005:28), is to formulate an operational definition.

Social capital is present when there is a **social network** where there is a **togetherness-orientation**, when **social contact** is frequent and intense; there is **willingness** to help and when members of a team are **dependent** on each other. This social network has **high trust levels**, **group rules** and exhibits **reciprocity**. **Tangible and intangible resources** are available for this social network. **Bonding, bridging and linking** occurs between members of the social network towards each other as well as people and networks external to them. The **outcome** of bonding, bridging and linking is that members of the network gain **advantages** from their membership in the form of more **access** to and/or **control** over and/or **opportunities** for the acquisition of **valuable resources**. Social capital can be **activated** through purposive connectedness and relationships if it is absent in social networks or it can be **accumulated** when existing in social networks.

The authentic leader and the professional nurse have a relationship that is based upon a social capital framework. Bonding, bridging and linking are conducted within a social network. The authentic leader and professional nurses are part of this network to gain specific outcomes. In the event of the authentic leader, it is to lead the professional nurse that is influenced by various challenges. A visual presentation of social capital is provided in Figure 4.2.

Table 4.11 Denotations (empirical indicators) of social capital

Connotations of social capital		Denotations of social capital
ANTECEDENTS	<p>Causative factors for social capital</p> <ul style="list-style-type: none"> • Present amongst human beings as part of the social dimension • Connectedness between people in the form of relationships • Embedded in social structures (also referred to as networks) • Trust • Tangible and intangible resources • Norms of reciprocity 	<ul style="list-style-type: none"> • Social networks • Willingness to help each other • Team members are dependent on each other to conduct work • Togetherness-oriented • Group rules • Reciprocity • Trust levels • Tangible resources: facilities for groups • Intangible resources: Time • Social contact frequency, duration and intensity
PROCESS	<p>Process of social capital</p> <ul style="list-style-type: none"> • Potential social capital needs to be activated • Actions to accumulate existing social capital • Bonding • Bridging • Linking 	<ul style="list-style-type: none"> • Bonding • Bridging • Linking

CONSEQUENCES	Manifestations of social capital <ul style="list-style-type: none">• Access to, control over and opportunity for the acquisition of valuable resources	<ul style="list-style-type: none">• Access to valuable resources• Control over valuable resources• Opportunities for the acquisition of valuable resources
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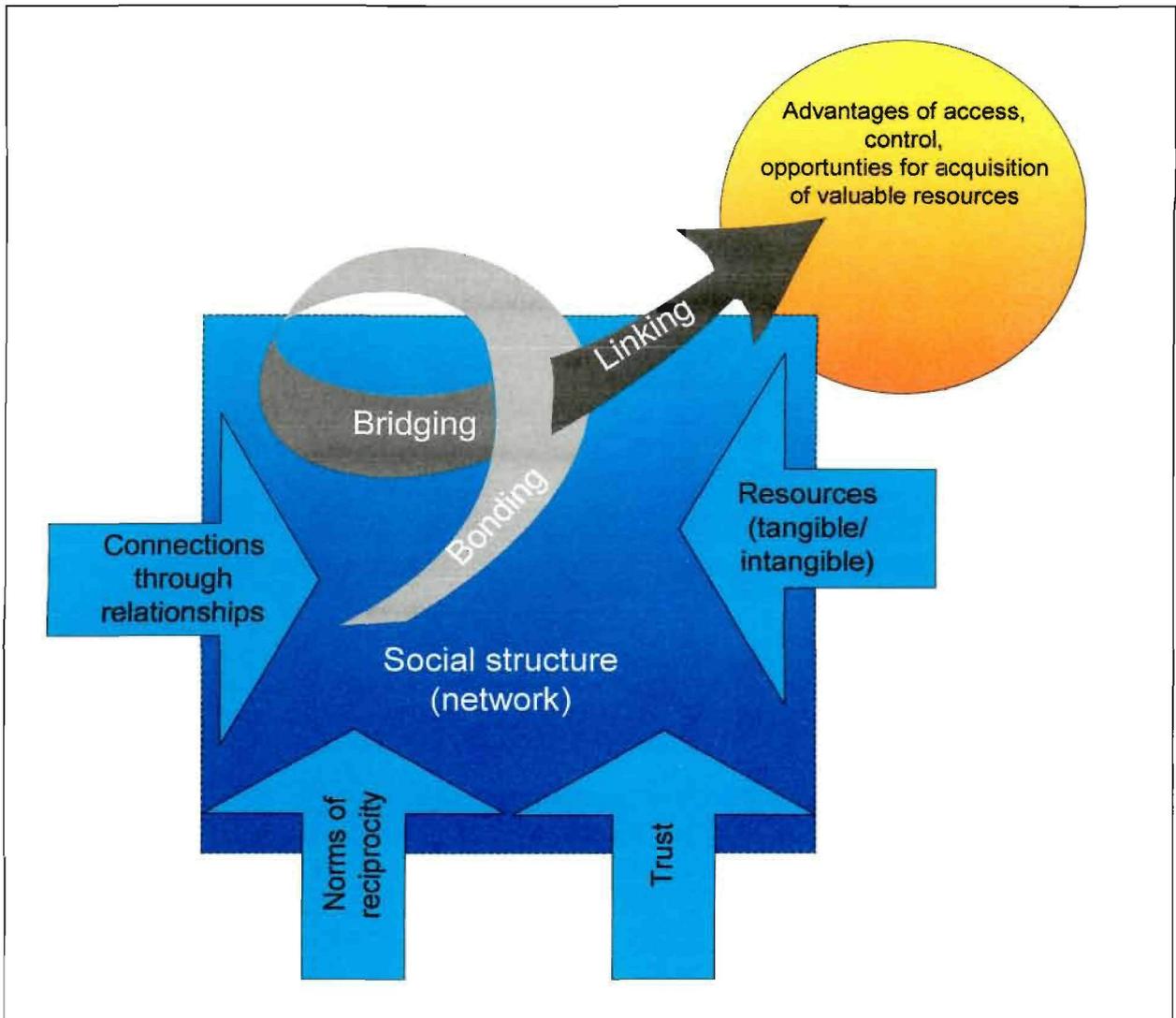


Figure 4.2 Social capital

4.4.10 Conclusions of social capital

From the above analysis of social capital, the following conclusions are drawn:

- Social capital is a multi-dimensional concept with three distinctive features: a social structure in the form of networks; natural connectedness between human beings within these networks in the form of formal and informal relationships and outcomes for those within these networks.
- Although human beings are social beings and functions also in a social sphere, social capital is not spontaneously present amongst people. Potential social capital can be activated through purposive connectedness and relationships and existing social capital can be accumulated with through bonding, bridging and linking.

- Social capital is present when there is trust, tangible and intangible resources within networks and when there are norms of reciprocity.
- The outcomes of social capital are that members in a network have the advantage of access to-, control over - and opportunities for the acquisition of valuable resources.

In the following part of Chapter Four, the literature analysis of the goal (positive impact on the triple bottom line) and the dynamic (trust) are done.

4.5 LITERATURE ANALYSIS: GOAL [POSITIVE IMPACT ON THE TRIPLE BOTTOM LINE]

The goal in this research is to positively impact the triple bottom line. When referring to the triple bottom line, the following spheres are included (Butcher, 2008:1):

- *people*: the increase in the well being of an organisation's employees and surrounding community;
- *profit*: a long-term positive economic impact; and
- *planet*: to increase the vitality and the health of the natural environment required to support the economy.

The triple bottom line is multi-dimensional and therefore each of the three spheres within the triple bottom line is under discussion.

In this research, interaction between hospital-based (context) authentic leaders in nursing (agent) and professional nurses (recipient), that is embedded in the framework of social capital (procedure), with the essential presence of trust (dynamic) may impact the triple bottom line (goal) positively.

4.5.1 Triple bottom line literature analysis

The concept, triple bottom line originated from the work of Elkington (2001:2) in 1994. The 1996 report published by SustainAbility titled "Engaging Stakeholders" and Elkington's book "Cannibals with Forks: the Triple bottom Line of 21st Century Business" published in 1997 (Elkington, 2001:2), introduced the triple bottom line concept. In 1995, Elkington (2001:2) co-referred the Triple bottom line (TBL) as the

3P formulation, stated as: 'people, profit and planet'. Shell, the international petroleum company, and the Netherlands were among the first to utilise the 3P formulation.

20th century thinking is characterised by the chronic neglect of the cultural and spiritual spheres of human activities (Tagar, 2003:6). The 21st century tends to view the balance between the different spheres of existence with greater depth. There is, therefore an acknowledgement that companies need to view success performance indicators in a broader perspective, as proposed by the TBL concept. TBL reporting is gaining popularity as a measurement tool for business evaluation. According to KPMG (*in* Colbert, 2006:22), 68% of the 250 global companies listed in the Fortune 500, have embraced TBL reporting, indicating its increasing popularity. . Tagar (2003:8) noted that this calibre of change should not be viewed as an outside-in event. Tagar urged that there is to change at the workplaces, in order to stimulate employees' growth. This implies that the TBL depends on the support of management and decision-makers within an organisation.

The TBL refers to the broader focus on organisational performance that exceeds economical output and also includes social and environmental performance. Van der Ende (2004:iii) referred to the accounting of the impact of a company's performance, and cites that it does not only span the financial factor. The impact that the company's activities have on society and the environment should also be calculated. According to Norman and MacDonald (2003:1), a company's success cannot be evaluated by the traditional financial bottom line, but should also be viewed based on it's the social/ethical and environmental performance. Ivey (*in* Taylor, 2006:29) urged that TBL reporting motivates companies to ensure that their actions to live up to all the stakeholders. Such stakeholders include shareholders, the community, employees, suppliers, the environment and suppliers. The TBL is also summarised as the evaluation of performance with regard to people, the planet and profit (van der Ende, 2004:33)

In this research TBL is used to capture the reality that the reporting of the impact on an industry should not be limited to financial parameters only. The researcher found that various authors had a similar view yet referred to TBL in a different manner. Norman and MacDonald (2003:4) as well as van der Ende called it corporate social responsibility. Colbert (2006:21) referred to sustainability reporting and corporate responsibility. According to Rossouw (2002:406) corporate governance is the

preferred term whilst Newton-King (2004:1) indicated environmental, economic and social sustainability. Musikanski (2005:2) described TBL description from a different angle by referring to sustainability that is achieved by managing economic, social and managerial impacts. TBL may also contain different meanings for different people. Therefore, Rossouw (2002:410) stated that TBL is an umbrella concept with a value-laden perspective. The TBL implies the acknowledgement of the essential relationship that is present between an organisation's economic, social and environmental performances.

TBL implies three spheres namely social, environmental and economic indicators (Foran, Lenzey & Dey, 2005:1-4). TBL should not be interpreted in a vertical line positions the spheres in order of importance. Van der Ende (2004:60) argued that the three factors in TBL line share equal importance. In addition, Rossouw (2002:409) stated that a corporation's social/ethical and environmental performance are essential for its sustained financial performance. Social and environmental issues should not be regarded as less important than conventional business factors.

In addition to the different names given to TBL, different authors have listed various components within TBL, as depicted below:

Table 4.12 Components within the three spheres of triple bottom line

	PEOPLE	PROFIT	PLANET
Author(s)	Social sphere of TBL	Economic sphere of TBL	Environmental sphere of TBL
Foran, Lenzey and Dey (2005:1-4)	<ul style="list-style-type: none"> • Employment generation • Income and government revenue 	<ul style="list-style-type: none"> • Gross operating surplus of profits • Import penetration • Export propensity 	<ul style="list-style-type: none"> • Greenhouse gas emissions • Primary energy uses • Land disturbances • Managed water use

Table 4.12 continues

<p>Van der Ende (2004:60)</p>	<ul style="list-style-type: none"> • Community relations • Reinvestments • Product integrity • Quality management • Environmental efficiency • Employees viewed as assets and not a cost 	<ul style="list-style-type: none"> • Financial indicators 	
<p>Tagar (2003:1-8)</p>	<ul style="list-style-type: none"> • Human, civil and community rights • Safeguarding of equality • Fairness • Equal opportunity • Social capital of the community • Level of contribution to local social and economic services • Proportion of profit reinvested in the community • Value added to local properties and equality of life 	<ul style="list-style-type: none"> • Material • Production • Distribution • Purchase of goods • Financial resources • Return on investment • Profit and loss 	<ul style="list-style-type: none"> • Level of renewability of resources used in the process • Pollution/contamination of natural resources • Waste management

Table 4.12 continues

<p>Hancock (2005:40-41)</p>	<ul style="list-style-type: none"> • Boost in staff morale • Improved image of the organisation in the community 		<ul style="list-style-type: none"> • Efficient energy use • Waste management • Water use • Reduction of toxic substances • Healing environment for patients • Healthy workplace for staff
<p>Rossouw (2002:409)</p>	<ul style="list-style-type: none"> • Moral obligations towards social transformation such as black economic empowerment and human capital development 	<ul style="list-style-type: none"> • Sustained social and environmental performance 	<ul style="list-style-type: none"> • Obligations to protect the natural ecology
<p>Norman and MacDonald (2003:19)</p>	<ul style="list-style-type: none"> • Diversity • Industrial relations • Health and safety • Child labour • Community 		

The process applied to evaluate an organisation's with TBL status, is referred to TBL reporting. TBL reporting grants organisations the opportunity to profit from reputation value as well as the trust and cohesion generated from organisational integrity (Painter-Morland, 2006:362). This reporting needs to be characterised by the following: clarity, timeliness, relevance, auditability, inclusiveness, transparency, completeness, neutrality and comparability (Painter-Morland, 2006:362).

In South Africa, Judge King (Rossouw, 2002:406) provided an initial report on corporate governance in 1994 and provided a second edition in 2002. This report

provided principles for corporate governance in South Africa. The report lists the core moral values of corporate governance, namely fairness, accountability, responsibility and transparency, thus implying an ethical undertone. Corporate responsibility can be conveyed in several ways (Taylor, 2006:29-31) and should not be limited to community services. Examples include: philanthropic efforts, working with hot topics, e increasing wealth at the bottom line of the pyramid and to supporting global communities.

There are various critiques against the triple bottom line, also referred to as the TBL rhetoric. Pava (2007:108) argued that TBL is multi-dimensional and implies certain limitations in the business ethics movements. The primary limitations noted are the inability towards consistent, meaningful and comparable tracking and measuring of environmental and social performance indicators. Although the limitations towards TBL reporting is acknowledged in this research, agreement is directed by Botha (2008:1), who stated that TBL implies that businesses are required to report in a more transparent manner. This demands that the impact that business has on employees, the community and the environment, needs to be reported.

The researcher acknowledges the limitations and critique against TBL reporting and agrees that TBL provides a multi-dimensional structure that could be used to discuss this study's multi-dimensional goals. Social capital entails a strong sociological dimension that already exceeds the risk of a bottom line evaluation of the goal only. In the following paragraphs a literature analysis of the three spheres within TBL is discussed. The economic sphere will be addressed briefly followed by an extensive analysis of the social and environmental spheres.

4.5.2 Positive impact on the profit sphere of TBL

The profit sphere of the TBL pertains to the financial dimension of both public and private hospitals in South Africa. It is argued that a positive impact on the profit sphere of the triple bottom line, implicates financial outcomes of public and private hospitals that can be established by means of financial measurements. The profit sphere of the TBL is described, firstly by investigating profit according to a financial management, operational management and an accounting perspective. Thereafter the relevance of profit this research, is described.

4.5.2.1 Profit from a financial management perspective

Financial management that includes budgeting; expenditure control and financial risk management (Muller *et al.*, 2006:414) are closely related to the strategic management processes of an organisation. Therefore, financial management contains more than only pure financial activities. The duties of financial managers are listed in the Financial Management Act (Act 1 of 1999) and entail i) preparing a budget according to regulatory and legal guidelines; ii) expenditure control, which refers to control exercised over the implementation of the budget; iii) enforcing and promoting the effective and transparent management of public entities, assets and liabilities, expenditure and revenue; and iv) ensuring that fiscal policies do not prejudice economic policies, materially nor unreasonably (Muller *et al.*, 2006:420).

With specific reference to the healthcare industry, financial management implies that the financial manager shall facilitate value for money, the optimal utilisation of resources and the maximisation of specified variables, according to the healthcare organisation's ownership (Muller *et al.*, 2006:422)

According to Brigham and Ehrhardt (2005:7) stockholder wealth maximisation is the primary objective of an organisation. Maximising fundamental stock prices are also beneficial to both society and to consumer (Brigham & Ehrhardt, 2005:8). Consumer benefits are reached when an organisation can provide high quality services at the lowest possible cost. With reference to the healthcare industry, consumer benefits are achieved when a hospital can provide low-cost and efficient, quality healthcare at the lowest cost possible. A consumer benefits focus leads to the introduction of new technology and products in an attempt to provide consumers with what they want and need. The generation of cash flow for the present and the future (Brigham & Ehrhardt, 2005:8), can be viewed as a parameter for evaluating the value of an organisation. Cash flow generation implies that an organisation' stock is valuable only if it generates cash flow, if cash is received as soon as possible and if investors have certainty about cash flow.

According to the Department of Education's national financial management certificate course (2007:3), profit is the overall aim of financial management. Mukhesi (2006:7) stated, with specific reference to the healthcare in South Africa, that financial management in the healthcare industry's profit companies are measured overall according to the amount of profit made by a company. Financial management

therefore implies profit maximisation, wealth maximisation, investment decisions for projects and financing decisions. The overall aim of financial management in non-profit organisations is to measure if an organisation utilised its funds in an efficient manner that benefited the community (Mukhesi, 2006:8) by minimising profit, maximising impact, efficiency and accountability.

4.5.2.2 Profit from an operations management perspective

Operations management entails the design, operations and improvement of the production systems. These are an organisation's predominant services or products (Chase, Aquilano & Jacobs, 1992:5). An organisation's corporate strategy is considered in the formulation of an operations strategy and is closely linked to the finance- and marketing strategies.

The three parameters utilised in financial measurements are cash flow, return on investment and net profit (Chase *et al.*; 1992:794-795). Cash flow is an important financial measurement as it implies the availability of cash to pay for day-to-day operational expenses. According to Chase *et al.* (1992:794), cash flow is a crucial factor that may lead to bankruptcy despite seemingly normal accounting reports. Return on investment is a relative measure that is based on the initial investment made to actualise organisation (Chase *et al.*, 1992:794). The third financial measurement is net profit. The net profit refers to the measurement of the hospital's outcomes in terms of rand value only (Chase *et al.*, 1992:794). The financial measurement of an organisation (in this research public and private hospitals) should entail all three measures and cannot be established when evaluating only one. For example, a hospital may have a high profit that is invested into new hospital equipment, and because this equipment is fixed in the hospital inventory, it may cause a cash flow crisis.

4.5.2.3 Profit from an accounting perspective

An accounting perspective implies the utilisation of the basic elements of assets, liabilities and owner's equity (Dempsey & Pieters, 1996:1). The goal of accounting is to ensure financial auditing practices as stated by the King II Report (*in Muller et al.*, 2006:439). According to Mukhesi (2006:28) accounting is the actions conducted to compile financial records required for financial reporting.

The profit status of an organisation is portrayed by a balance sheet wherein assets are reflected against interests in these assets, as part of an accounting equation (Dempsey & Pieters, 1996:4). An organisation's profitability can be analysed from the following ratio analysis (Dempsey & Pieters, 1996:546-553):

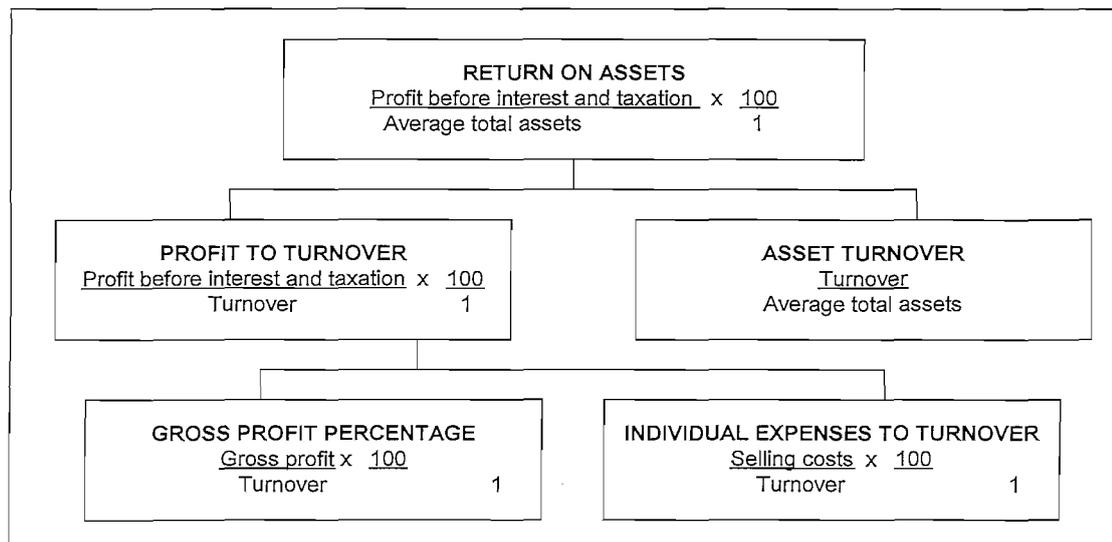


Figure 4.3 An organisation's profitability ratio analysis (Dempsey & Pieters, 1996:546)

- **Rate of return on assets** (Dempsey & Pieters, 1996:549-515)

- Rate of return on assets

The rate of return on assets is applied to measure the effectiveness with which management utilised the total amount of funds that were entrusted to them. The rate of return on assets is calculated by dividing the profit before interest and taxation by the average total assets. Profit before taxation is used and long-term loan interest is not calculated.

Asset turnover is the ratio that measures the effectiveness with which an organisation utilised its assets, by indicating how many sales the assets generated. Therefore, turnover is divided by the average total assets.

The profit to turnover ratio measures the organisation's ability to generate profits from sales and is calculated by dividing the organisation's profit prior to interest and taxation by the turnover.

- Gross profit as a percentage of turnover plus operating expenses analysis
This analysis enables the accountant to determine if specific expenses increased disproportional to the turnover.

- The profitability of external investments indicates the organisation' desire to retain external investments and is calculated by dividing the income from external investors by the book value of external investors.

- Return on own capital

The return on one's own capital is ratio analysis that is conducted by those with an interest in the organisation' returns, with the focus to invest in this organisation.

- Return on the ordinary shareholders' equity

Measures the profitability of one's own capital calculated by dividing the net profit attributable to ordinary shareholders by the average total ordinary shareholders' equity.

- Dividend per ordinary share

When the dividends paid and declared are divided by the number of issued ordinary shares, the distribution of profits per share is calculated.

- Earnings per share

The actual earnings per share are calculated by dividing the net profit attributable to ordinary shareholders by the number of issued ordinary shares.

4.5.2.4 Profit sphere on the TBL in this research

The above paragraphs described profit from three perspectives, namely financial management, operational management and accounting. The profit sphere in the TBL as applied to this research will now be explored.

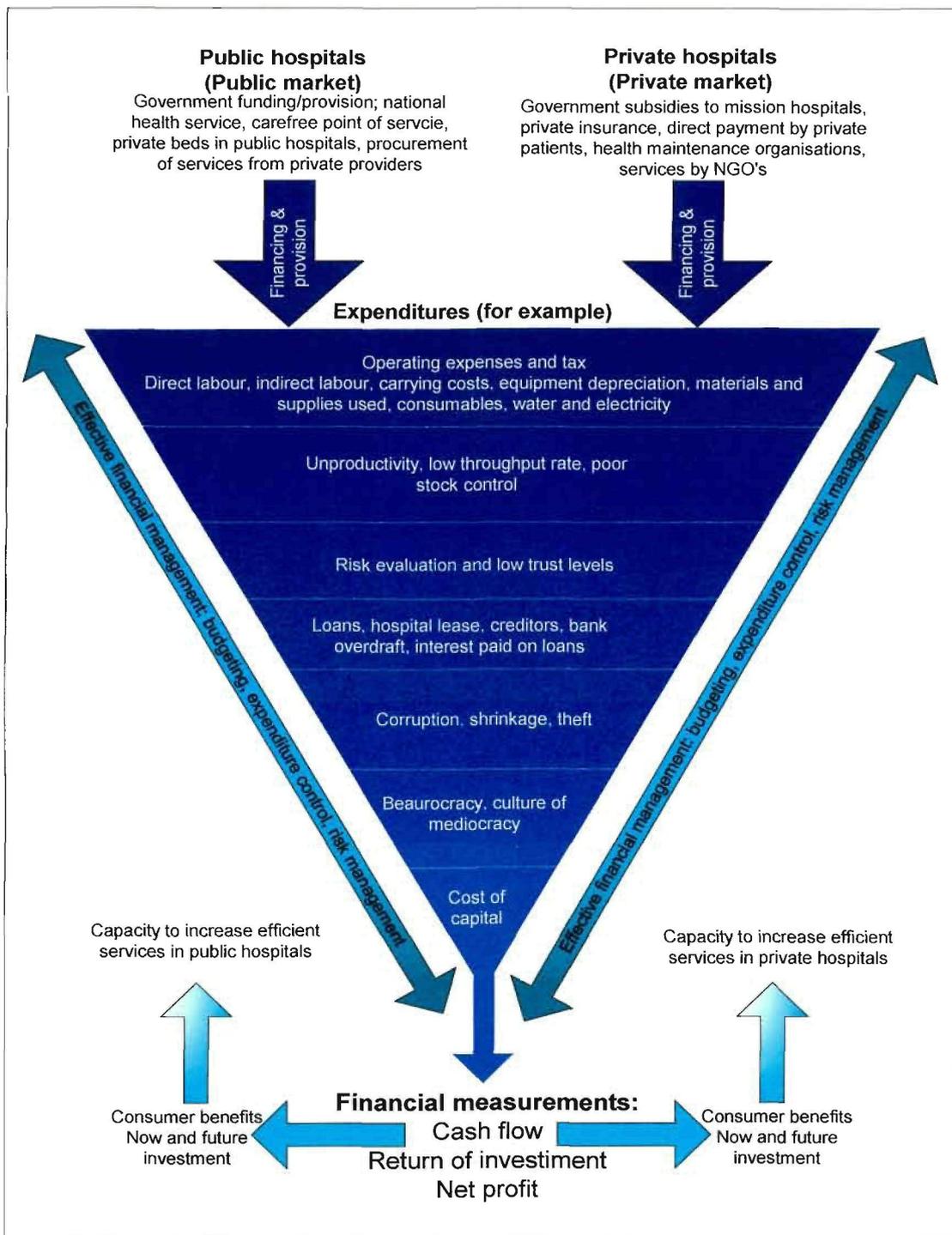


Figure 4.4 A graphic depiction of the financial dynamics in public and private hospitals in South Africa to indicate the profit sphere of the TBL

The profit sphere of the TBL is portrayed in Figure 4.4. Profit is indicated as one factor within a complex financial process. This financial process is illustrated as a funnel. The input into the funnel is viewed as the financial investment into the public and/or private hospitals in South Africa. Public hospitals depend predominantly on government funding and also receive other forms of financial input. Private hospitals'

funding originates from direct payments from patients with medical insurance and other forms of financial provisions. Funds that enter the public and private hospitals are used to render services and cover expenses. Financial management is applied to manage the utilisation of funds within service operations. Once all expenses are covered, the available funds are channeled towards the point of consumer benefits and re-investment into public and private hospitals, in a manner that enhances these hospitals' capacity to increase efficient healthcare. Cash flow remains essential during this process.

4.5.3 Positive impact on the people sphere of TBL

The people sphere within the TBL is also referred to as its' social dimension. In this research, the people sphere implies increased job satisfaction and decreased job stress, work-life balance and staff retention. These aspects are referred to as positive employee outcomes. In the following section includes a comprehensive literature analysis of these outcomes.

The concept “positive employee outcomes” is not widely used in literature. Several authors and their general use of the term positive employee outcomes are summarised in the Table 4.13.

Table 4.13 Different uses of positive employee outcomes in general studies

Author	Utilisation of the concept “positive employee outcomes”
Gevity Institute of the Cornell University (2005:1)	<ul style="list-style-type: none"> • Commitment to supervisors • Trust in management • Cooperation • Effort • Involvement • Lower employee turnover
Sukbin, Khan, Murmann (2000:65-72)	<ul style="list-style-type: none"> • Decreased job stress • Job satisfaction • Organisational commitment

Table 4.13 continues

Lowe (2007:4)	<ul style="list-style-type: none"> • Work-life balance • Less job stress • Job satisfaction
McQuarrie (1989:4)	<ul style="list-style-type: none"> • Supervisor satisfaction • Job satisfaction • Organisational commitment

The above table lists different uses of the concept “positive employee outcomes” as described by various authors. Words that appear repeatedly have been highlighted. It is clear that the majority of authors (Subkin, Khan, Murmann, 2000; Lowe, 2007 and McQuarrie, 1989) allocate job satisfaction, decreased job stress, commitment and staff retention as part of positive employee outcomes. For the purpose of this study, positive employee outcomes as part of the people sphere in TBL consist of decreased job-stress and increased job satisfaction, work-life balance and staff retention.

4.5.3.1 Positive employee outcome 1: Decreased job stress and increased job satisfaction

Job stress can be defined as the experience of stress when the demands exceed the positive results (ICN, 2008:1). Due to various reasons, nursing is viewed as one of the most stressful professions (AbuAIRub, 2004:73; Kirkaldy & Martin, 2000:77) in the present workplace. Kirkaldy and Martin (2000:77) reported increased rates of psychiatric admissions, physical illness and mortality amongst nurses. Furthermore, high levels of job stress have been cited as a primary reason why nurses choose to exit the profession (Kirkaldy & Martin, 2000:77).

High levels of job stress can be detrimental to humans, physically as well as emotionally. Literature (De Gucht, Fischler & Heiser, 2003:202) indicated that job stress and high work demands coupled with low levels of job control, may contribute to idiopathic chronic fatigue and irritable bowel syndrome. Stress has a detrimental impact on the nurse who experiences job stress, and to the organisation. Job stress is viewed as a major contributing factor to high staff turnover, absenteeism due to illness, organisational inefficiency, a decrease in the quantity and quality of care, increased costs in healthcare as well as decreased job satisfaction (AbuAIRub, 2004:73).

4.5.3.1.1 Causative factors for increased job stress

The causes for increased job stress have been grouped into organisational -, personal – and contextual factors.

- Organisational factors

The structure and the climate of an organisation are two primary causes of high levels of job stress amongst nurses (Kirkaldy & Martin, 2000:78). An organisation's bureaucratic constraints may increase job stress levels (Kirkaldy & Martin, 2000:79) amongst nurses. Lack of autonomy and limited participation in decision-making (ICN, 2008:1) as well as problems associated with administration and management have been identified as a reason for increased job stress amongst nurses (Kirkaldy & Martin, 2000:78). Nurses experience an increased level of job stress when financial implication receives priority above patient care (Roman, 2005:17). When nurses feel uncertain about their role expectations (Salmond, 2005:302) their level of job stress is increased. This is also the implication when nurses are uncertain about a patient's treatment plan (ICN, 2008:1).

Relationships with colleagues are listed as an important causative factor for job stress. Unhealthy relationships as well as the lack of support amongst colleagues and supervisors may increase job stress (Gelsema, van der Doef, Maes, Janssen, Akerboom, Verhoeven, 2006:289). Certain factors pertaining to career achievements may cause higher levels of job stress (Kirkaldy & Martin, 2000:78). Nurses also experience job stress due to conflict with other members of the healthcare team (Gelsema *et al*, 2006:289).

A lack of competent staff (ICN, 2008:1) as well as an excessive workload is listed as a leading reason for high levels of job stress (Lee, 2008:98). When discussing workload as a causative factor in higher levels of job stress, the distinction between quantitative and qualitative work overload, should be made (Kirkaldy & Martin, 2000:79). Quantitative workload by itself can be stressful. In a similar manner, qualitative workload with regard to complex jobs, insufficient resources and definite time constraints, may increase job stress. The International Council of Nurses (2006:53) stated that a high patient:nurse-ratio is a direct cause of job dissatisfaction amongst nurses. With regard to workload, Chinweuba (2007:83) reported that too little workload was a cause for job dissatisfaction amongst nurse educators. Furthermore, dealing with death and dying as part of patient care in the nursing

practice, is stressful (Kirkaldy & Martin, 2000:79). Rendering care to patients by itself can also be stressful, especially when nurses face the reality of work overload. Job control and control over a working day are important causes for increased levels of job stress. Lack of job control is, according to Gelsema *et al.* (2006:289), associated with burnout and health problems amongst nurses.

- Personal factors

Job stress is not a general phenomenon that is experienced equally by all nursing staff. Chinweuba (2007:82) found that nurse educators who had a higher level of education experienced more job stress. Kirkaldy and Martin (2007:79) reported that higher levels of job stress are present amongst professional nurses than non-professional nurses. People with a neuroticism characteristic in their personality might experience higher levels of job stress with the possibility that this job stress may contribute towards physical illness. Nurses with an internal locus of control and/or nurses with a type-A personality may experience higher levels of job stress (Kirkaldy & Martin, 2000:78). Thus, not all nurses will perceive and react to job stress in a similar manner. Another personal reason that may cause higher levels of job stress is self-perceived competence (Kirkaldy & Martin, 2000:79). A nurse might experience a nursing intervention as stressful when she either perceives herself as competent to conduct this intervention whilst she does not yet possess this competence. Emotional exhaustion may be a cause for job dissatisfaction (Karl & Peluchette, 2006:129). Nurses' emotional strain originates from dealings with terminal patients (ICN, 2008:1) and when they feel inadequately prepared to deal with the emotional needs of patients and their families.

Work-home interference is another causative factor of increased job stress amongst nurses (ICN, 2008:1) as they experience a role conflict within themselves. Other personal causative factors are poor career structures and inadequate career development (Chinweuba, 2007:83; ICN, 2008:1).

- Contextual factors

Intrinsic factors that originate from the job at hand are viewed as a reason for increased job stress (Kirkaldy & Martin, 2000:78). Specific clinical practice areas may cause increased job stress. Emergency rooms, intensive care units and psychiatric units might be more stressful for nurses than medical-surgical units and primary healthcare (Kirkaldy & Martin, 2000:79). General job demands (Gelsema *et al.*, 2006:289) in nursing may cause an increase in job stress. Chinweuba (2007:83)

reported that the reality of poor fit for the job is a very real cause for job stress amongst nurses.

4.5.3.1.2 Job stress versus job satisfaction

Literature (Chinweuba, 2007:87) reported that there is a correlation between job stress and job satisfaction. Chinweuba found that the presence of job stress might increase a nurse's experience of job satisfaction. Job stress can stimulate productivity and a feeling of fulfilment. Job stress and job satisfaction can be placed on a satisfaction versus dissatisfaction continuum (Cortese, 2007:309). Various aspects cause the movement of the nurse on this continuum towards increased or decreased levels of job stress versus the associated increased or decreased levels of job satisfaction. The primary impact factor on the job satisfaction – dissatisfaction continuum is job content (Cortese, 2007:309).

4.4.3.1.3 Strategies to decrease job stress and increase job satisfaction

As there is a direct link between job stress and job satisfaction (Chinweuba, 2007:87), strategies to decrease job stress will also influence job satisfaction amongst nurses. The strategies towards decreasing job stress and enhancing job satisfaction have been organised into organisational, personal and contextual strategies.

- Organisational strategies

According to Kirkaldy and Martin (2000:87) and Gelsema *et al* (2003:298), a healthy work environment will serve as a significant strategy to decrease job stress levels. In addition to a healthy work environment, job stress levels can be decreased by implementing prophylactic job stress programmes and effective stress management interventions. Stressors and stress are viewed as two variables that influence each other and therefore, a multi-dimensional approach towards the decrease of job stress by means of a healthy work environment, is proposed (Gelsema *et al*, 2003:298). The responsibility enables a healthy work environment is placed on management.

The improvement of communication channels (ICN, 2008:1) and the enhancement of nursing management (Cortese, 2006:303) are two strategies towards enhancing job satisfaction. Team building strategies can be implemented to increase co-operation and minimise conflict (AbuAlRub, 2004:78). Attention and effort should be granted to elevating social support amongst nurses, members of the health team and their

supervisors. The ICN (2008:1) suggested that there should be a correspondence between workload and workers' capability and resources.

- Personal strategies

Social support amongst nurses in the workplace has been identified as an important buffer against job stress (AbuAlRub, 2004:77). Since nurses will experience job stress differently, a variety of personal strategies to both cope with and decrease levels of job stress are needed. According to Lee (2008:87), job stress levels might decrease when a nurse's competence increases. Confronting stressors verbally, expressing feelings, gaining distance from nursing practice and/or patient contact and intellectualisation are possible strategies. Periodic avoidance behaviour might decrease job stress. Interventions to enhance nurses' physical and emotional well being are motivated. Such interventions include sufficient nutritional intake, exercise and alternations in chemical substance use (Lee, 2008:87).

- Contextual strategies

Karl and Peluchette (2006:129) reported that the presence of fun in nursing might decrease emotional exhaustion with associated high levels of job dissatisfaction. The most appropriate solution for decreasing job stress in the context of a specific job is a healthy work environment. An effective human resource management team (Marchington & Wilkinson, 2007:73) is an important factor for decreased job stress. Chinweuba (2007:88) reported that when nurses experience more control over their workday, it might decrease levels of job stress. Effective nursing management has been identified as the primary strategy to decrease levels of job stress amongst nurses (Cortese, 2006:303). Salmond (2005:308) added that a mentoring process by older and more experienced nurses might be effective in assisting nurses who experience job stress.

Job stress and job satisfaction are two factors in the people sphere of the TBL that are related to the context presented in Chapter Three (refer to 3.6). The contextual challenges experienced on the macro-, meso- and micro levels in this research drafts an environment in which high levels of job stress and associated job dissatisfaction are a possibility. It is argued that the authentic leader in nursing, and the professional nurse interaction that is embedded in social capital, might render a positive impact by decreasing job stress and increasing job satisfaction.

4.5.3.2 Positive employee outcome 2: Work-life balance

The second outcome in the people sphere of the TBL is work-life balance. A literature analysis of work-life balance follows.

4.5.3.2.1 Definition of work-life balance

Work-life balance refers to the attempts made by both the employee and the employer to assist the employee in gaining balance between her work-life and her family life. Work-life balance is the employee's right to have a fulfilled life both inside and outside of paid work that should be beneficial to the employee, the business and society (The Work Foundation, 2008:1). Against this broader definition of a work-life balance, the Irish Business and Employers Confederation (IBEC) (2006:17) allocated flexible working hours, flexible leave and flexible workplace location that is negotiated between the employer and employee, positioned within the correct legal framework, to accommodate the employee's needs outside the workplace, yet preventing adverse affects towards the team, the customers and business. This could be noted as a comprehensive definition for work-life balance. Thus, the IBEC view flexible working arrangements as the way in which work-life balance can be achieved. A simplified yet effective definition of work-life balance is the ability to experience daily achievement and enjoyment in the four quadrants of human life, namely work, family, friends and self (Bird, 2003:1).

The strive towards acquiring work-life balance is a phenomenon that is experienced worldwide especially in economic systems that are performance driven. The concept "work-life balance" was created in 1986 and is viewed as the response that flows from Americans' unhealthy choices. The choices implied the pursuing of corporate goals at the cost families, friends and leisure activities (Halpin, 2008:1). Halpin further argued that the neglect in one area of a person's life will influence the rest of the whole and therefore, this neglect has had detrimental effects on people. The Work Foundation (2008:1) stated that the work-life balance phenomenon has arrived due to global changes and will grow more persistently.

4.5.3.2.2 Reasons for work-life imbalance

The causative factors for a work-life imbalance have been identified. Halpin (2008:1) summarised the results of a performance driven culture that resulted from the information age transformation, as a causative factor. Information is more readily available and this has generated increased competition that has led to the intensification of work. Employees are therefore expected to work more while they

enjoy less security. The Work Foundation noted specific reasons for the arrival of the work-life balance phenomenon based on United Kingdom research results. The researcher associated similarities with South Africa. The Work Foundation found that the labour market structure changed during the transformation from an industrial era to an information age. Employees spend longer hours to become educated and wanted to retire at a younger age. X-generation workers brought new perspectives to the workplace and they were not afraid to negotiate flexible working hours. Between 1990 and 2000, the United Kingdom indicated that mothers with young children showed the largest growth in the labour market participation. From 2000 to 2025, the majority of the United Kingdom's population will be immigrants.

Great emphasis is placed on the accession of the X generation members to the workplace and the aspiration towards a work-life balance. It is generally stated that this generation work to live and does not live to work. This is portrayed in a study by the Boston College's Sloan Work and Family Research Network (2008:1-2). They found that X'ers value time with their families more and therefore this generation experienced moderate to severe interference between their careers and their work-life. A calculated that 45% of X'ers will leave the workplace within three years should their work-life balance requirements not be met. Canadian research confirmed the strong association between X generation and work-life balance. Lowe (2007:43) reported that employees aged between 31 to 40 years experienced great difficulty in establishing and maintaining a work-life balance.

There is a direct association between the increase in working hours (Lowe, 2007:40), decreased in job satisfaction and an influence work-life balance. Today, more employees are overworked and professionals are even more overworked than non-professionals (Sloan Work and Family Research Network, 2008:2-6). A Canadian study indicated that professionals inter alia, experienced great difficulty in work-life balance (Lowe, 2007:40). Increased working hours are an example of poor decisions according to Halpin (2008:1). From 1977 to 1997, the general full-time American employee has increased his working hour week by 3.5 extra hours to 47.1 hours per week. Payne-Harker (2006:6) argued that work-life balance is especially hard for nurses to achieve, due to long hours, rotating shifts and varied working hours.

With a specific focus on nurses, Wigham (2002:1) stated that 50% of the nurses in Northern America's national health system suffer from poor physical and psychological health. Wigham portrayed the lack of a work-life balance as a global

reality, when a study by the Royal College of Nursing identified that a large number of staff had no access to self-rostering, childcare and flexible working hours. Although two-thirds of nurses have children and/or dependants, most nurses receive only the basic elements of a work-life balance. Nurses are categorised as employees with the lowest level of work-life balance and as experiencing great difficulty in acquiring and maintaining this balance (Payne-Harker, 2006:6).

4.5.3.2.3 Factors to enhance work-life balance

The construction of work-life balance contains various aspects from the employee's as well as the employer's perspective. It is a relationship of give and take and a reciprocity responsibility that should be viewed as essential in order to gain organisational success (IBEC, 2006:26). Furthermore, the IBEC (2006:26) stated that work-life balance is not a "one size fits all" reality. It is a challenge to break away from fixed working schedules and becoming creative, innovative and flexible. There is a direct association between work-life balance and happier, more rounded people that experience less job stress and burnout (Stuttle, 2005:1).

4.5.3.2.3.1 Work-life balance policy

Policies within the workplace are viewed as a practical solution towards work-life balance. Work-life balance policy should be geared to assist employees to combine work with other aspects in their lives while establishing the development of a committed and productive workforce to the employer (National Framework Committee for work-life balance policies in Ireland, 2008:1). The National Framework Committee for work-life balance policies in Ireland (NFCI) has presented comprehensive information on work-life balance during the literature searches conducted during data collection. In December 2007 the NFCI published the report for work-life balance policies that was conducted in collaboration with the European Union.

- The principles of work-life balance policy

Work-life balance policy is based on the principle that the policies should benefit the employee as well as the organisation and need to address the dynamic needs of the employee and the organisation. Policies should assist the employee to combine her personal life outside the workplace (her family life and caring responsibilities) and still meet the needs of the employer (The Work Foundation, 2008:1). Work-life policy should include a broad description of the different types of leave (maternity, adoptive, force majeure, parental). Work-life balance policy should contribute equality in the

workplace. Equality in work-life policy implies that recognition is provided towards the meaningful participation in the social, cultural and economic life that is accessed by being employed. Work-life balance policies should be applicable to both men and women. Work-life balance policy should reflect the reality of each individual in the workplace (IBEC, 2007:8-9).

- Work-life balance best practice guidelines

Work-life balance policy can take note of best practice guidelines. The following list reflects best practice guidelines for work-life balance as published by The Work Foundation (2008:1):

- organisations are motivated to research other organisation's experiences of work-life balance as a means to gain greater understanding;
- prior to implementing a work-life balance program, management as well as staff representatives should be consulted;
- management can be supported in work-life balance by monitoring progress and amending implementations as appropriate;
- securing measures of success , for example sickness and absenteeism rates, staff turnover, productivity indices;
- reviewing the needs of the employee as well as the organisation with regard to the ethical-legal framework, customer needs and employee satisfaction.

4.5.3.2.3.2 Employer factors

Lowe (2007:43) placed the responsibility to assist the employee towards work-life balance, on the employer. Work-life balance can be viewed as an essential human relation aspect (IBEC, 2007:9) that should support work-life balance policy. The existence of a work-life policy is futile if the employer does not establish an effective communication programme that can convey work-life balance to the organisation and fixate work-life balance within the organisation's culture (IBEC, 2006:5). In addition, the workplace culture (Payne-Harker, 2006:6) should be positive towards work-life balance as this is essential for more positive employee outcomes. The benefits of employee work-life balance towards the business (The Work Foundation, 2008:1) might act as a catalyst for the employer's support thereof. Increased productivity, decreased absenteeism, improved customer experience, improved recruitment and retention, reduced overheads plus a more equitable, motivated and satisfied workforce are aspects of work-life balance that is beneficial to the employer.

According to Lowe's (2007:43) extensive research results, employees in general find work-life balance easier in the event of decreased job stress; a job that can provide a healthy work-life balance; flexible schedules and working hours; positive employee-supervisor relationships and a supervisor that assists employees towards acquiring work-life balance. Stuttle (2005:1) stated that the employer should ensure that the demands of patients could be met within the employees' contracted hours. There is a direct association between employee productivity, increased employee motivation and flexible working hours (IBEC, 2006:5). Even the seemingly non-employer aspects of adequate employee nutrition and physical activity should be part of a work-life balance programme (IBEC, 2006:28-29). Childcare is viewed as a major factor in work-life balance (IBEC, 2006:10-11). Employers can investigate various childcare options with employees, as this does not imply that the employer should activate childcare services for employees.

Hurst, French and Daniels (2008:2) provided six factors that employers can consider in their endeavours to assist employee's work-life balance. Firstly, the employer can assist by identifying and developing strategies to assist employees to cope with workload demands. Secondly, employees' roles should be aligned with job descriptions and desired outcomes. Thirdly, the employer should support assertive and appropriate behaviour in the workplace. Fourthly, the employer can investigate increased control levels as well as new ways for employees to take more control. The employer should provide support in work-life balance by encouraging the three parts of work-life balance, namely flexibility, training and employee support. The sixth aspect of employers' assistance towards employee work-life balance is to portray an attitude and belief that the organisation can cope with difficult situations.

In the following table (refer to Table 4.14), the different types of work-life balance practices are portrayed. The National Framework prescribes these practices for work-life balance polices (2007:8-9). This table demonstrates the multiple strategies available to the employer to assist the employee towards work-life balance.

Table 4.14 Types of work-life balance practices

	Flexible working arrangements	Supportive arrangements
Help balance work and personal life demands	<ul style="list-style-type: none"> • Part-time work • Flexi-time arrangements • Job-sharing • Tele-working/working from home • Term-time work • Saving hours and staggered hours • Compressed working hours • Shift working • Shift swapping • Self-roistering • Annual hours • Time off in lieu 	<ul style="list-style-type: none"> • Work-family management training • Employees counselling/assistance • Work-family co-ordinator • Research on employee needs • Financial contributions • Non-family related long-term leave
	Childcare arrangements	Additional family related leave
Ease caring responsibilities	<ul style="list-style-type: none"> • Workplace nursery • Contracted child care places • Childminding • Childcare resource and referral • Financial assistance • Holiday play schemes/summer camps 	<ul style="list-style-type: none"> • Maternity leave above statutory minimum • Parental leave above statutory minimum • Paternity leave above statutory minimum • Leave for family reasons (including elderly) • Adoption leave • Career break scheme

4.5.3.2.3.3 Employee factors

Work-life balance is not only the responsibility of the employer, each employee should engage in work-life balance. In order to support work-life balance, nurses need the support of policy makers as well as human relations departments and visa versa. According to Stuttle (2005:1), work-life balance in the workplace is a chain reaction. When the work team feels appreciated and supported, it will enhance and maintain the team's well being. Consequently, this will provide nurses with emotional

energy. The following list includes strategies towards a work-life balance as actioned by employees, are listed:

- the employee should re-identify her values and priorities in work- and family life and honour these values and priorities (Wigham, 2002:1);
- participate and support team work (Stuttle, 2005:1), to create support networks in both the work and family life environments (Wigham, 2002:1);
- empower patients (Stuttle, 2005:1);
- establish clear boundaries between working life and home life (Wigham, 2002:1); to enter into an agreement of what employees can realistically do when on duty but also who to assist when they are off duty (Stuttle, 2005:1);
- clarify with people that need nurses' services what they can expect from them (Stuttle, 2005:1)
- learn to say no and to delegate tasks both at work and at home (Wigham, 2002:1); and
- apply basic healthy living practices by regular exercising and healthy eating habits (Wigham, 2002:1).

In this research, positive employee outcomes within the people sphere of the TBL implies the acquisition and maintenance of work-life balance. It is argued that work-life balance for nurses is a goal for the authentic leader, and professional nurse interactions that are based on a social capital framework, with the dynamic of trust.

4.5.3.3 Positive employee outcome 3: Staff retention

Staff retention is a complex aspect in human resource management as staff retention in the healthcare sector is a national and international concern. According to the International Council of Nursing (ICN) (*in* Zurn, Dolea & Stilwel, 2005:1) and confirmed by DENOSA (2008A:1), there were 30 000 vacant posts in the healthcare industry in South Africa in 2003. In the broader South African healthcare sector, a total of 52 574 vacant posts were reported during 2001-2003 (DENOSA A, 2008:1). Furthermore, DENOSA argues that if there is such a shortage of nurses in South Africa, it implies that one nurse does the work of more than one person, increasing the risk of medico-legal hazards. There is a direct correlation between the adequate supply of qualified nurses and the quality of the care rendered (ICN, 1999:1) and therefore, the retention of nursing staff is viewed as crucial and practices that decrease nursing staff retention is condemned. This refers to practices of recruiting

foreign nurses to countries characterised by authorities who fail to address human resource planning, as well as specific problems that cause nurses to leave the nursing profession (ICN, 1999:1).

According to the South African Department of Public Services and Administration (DPSA) (2006:12), staff retention in general entails both the recruitment and retention strategies of staff. Employed staff with crucial skills within the organisation is a specific focus in the retention strategies. Staff retention strategies are also a compendium of psychological and operational factors of the employee and the job appointed that needs to be considered. The employee's goals, behaviours and perceptions of herself are listed as psychological factors to consider. Staff retention can exceed the day-to-day human resource management (Hendricks, 2006:1) within an organisation; it is a managerial approach, which tends to develop as a specific strategy. This managerial approach needs to be broad enough to engulf both internal and external aspects of the organisation.

According to the South African Department of Social Development for the Eastern Cape Province's (SADSA) Attraction and Retention policy for 2008, employee recruitment and retention in general, is a crucial process driven by the human resource manager. Staff retention implies finding the best staff member for a specific job and keeping this staff member in this job. This involves interlinked interventions by the human resource department with employees who have scarce skills that are crucial to the organisation. The process of staff retention should be applicable to the operational aspects of the job and should absorb the psychological aspects of the employee (Hendricks, 2006:2). It could be seen as an excellent opportunity towards staff motivation (SADSA, 2008:1-2). Ellenbecker (2003:305) provided a theoretical model for job retention, with specific reference to the healthcare industry that can be portrayed as follows:

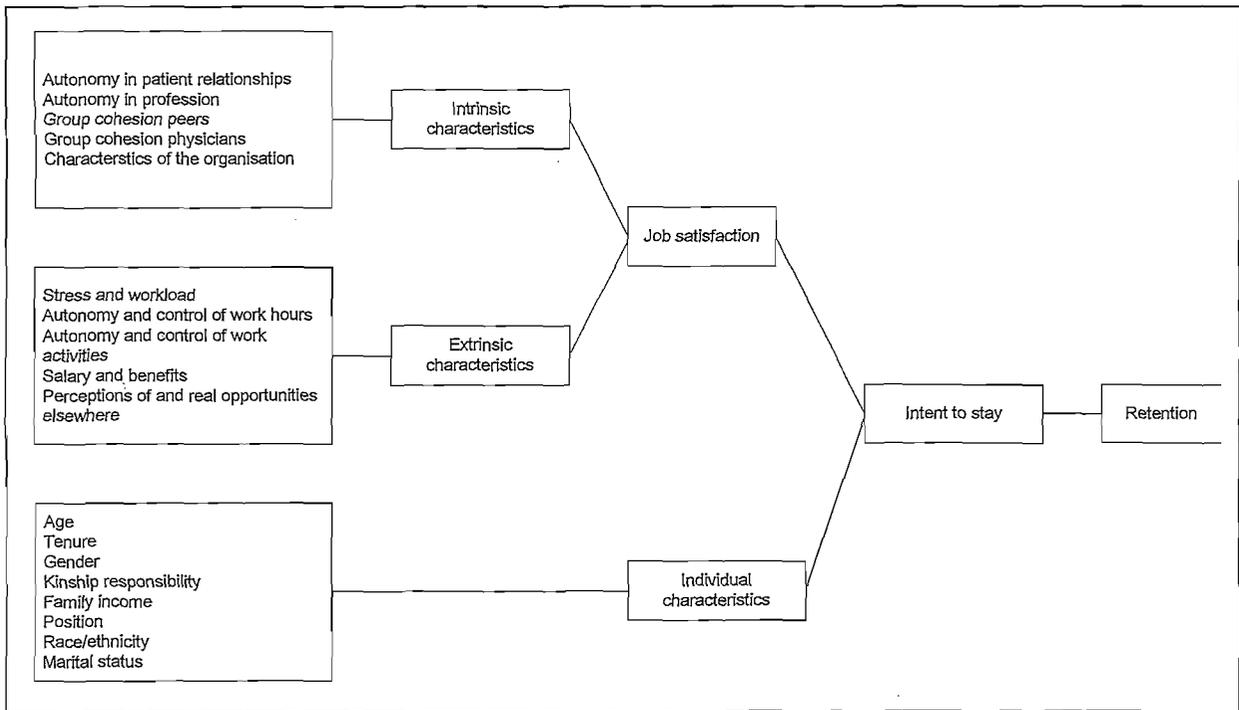


Figure 4.5 Theoretical model of job retention (Ellenbecker, 2005:305)

In summary, the model implies that two aspects need to be considered for an employee's intent to stay namely job satisfaction and individual characteristics such as age, gender, position, marital status etcetera. Job satisfaction, in return, is divided into intrinsic and extrinsic characteristics.

The reasons for the lack of staff retention are identified as a global challenge. The modern day employee's attitude and the environment has changed towards a reality where she is more self-directed and wants to both work on her own terms, whilst expecting development within the work environment (SADSA, 2008:2). The Generation X versus Baby Boomers debate continues in the discussion of staff retention. Generation X employees have lead to a new culture in human resource management where employee loyalty is not measured by the number of years employed but as the employee's contribution to an organisation (Holtz, 2005:4). Generation X is an international phenomenon and therefore the global calls of staff shortages. The global challenges for staff shortages introduced massive recruitment campaigns. There is an awareness from the World Health Organisation as reported by the ICN (1999:2), that is not only the impact of recruitment campaigns of foreign nurses that leads to the shortages of nursing staff, but also the unethical methods that certain recruitment agencies followed. Within this global crisis the internal

mobility as well as the ease with which job-hopping takes place (DPSA, 2006:14) complicates staff retention.

However the WHO (*in* ICN, 1999:2) identified organisational-specific reasons for the shortages in nursing staff. The misutilisation and the misdistribution of nurses; management and compensation practices as well as financial constraints and the inappropriate career structures in nursing are listed. The lack of a clear link between performance and compensation, in the healthcare industry specifically, has been identified as a reason for staff shortages (Holtz, 2005:4). Another contributor is the fact that the employee experience that her work is viewed as unimportant and unappreciated. Although financial reasons (DPSA, 2006:14) have been identified, moral distress (Fontaine & Gerardi, 2005:35), the lack of opportunities for career advancement (DPSA, 2006:14; Holtz, 2005:4); unclear organisational goals (Holtz, 2005:4), leadership and management style of current organisations and poor work challenges (DPSA, 2005:14) are added to the list. A major reason identified for poor staff retention is the effect of a poor work environment. A poor work environment in general is viewed as an important cause for low staff morale, low levels of motivation, lack of strategic direction with lack of leadership and communication and a lack of empowerment (DPSA, 2006:14). With specific reference to South Africa, affirmative action and employee equity (DPSA, 2006:14) have been identified as reasons that may cause poor staff retention.

From the above paragraphs the multi-factor reasons for staff shortages are clear. As stated, staff retention is a complex process within the human resource infrastructure and therefore, there is no a simple solution. In the following paragraphs, the need for strategies to enhance staff retention is argued. These strategies are tabled according to corresponding strategies. Please refer to Table 4.15.

Staff retention should be applied within the framework of human resource management (Hendricks, 2006:3). In general, staff mobility and turnover trends should be analysed as well as the identification of the exact skills that need to be retained. In addition, the human resource management system should portray a clear link between effective recruitment and selection with continuous monitoring and evaluation of the effectiveness thereof. Staff retention should enjoy attention in all the key aspects of human resource management and includes human resource planning, recruitment and selection; optimal human resource utilisation, human

resource development; compensation and benefits; employee and labour relations as well as safety and health in the workplace (DPSA, 2006:13; Holtz, 2005:5).

There is specific South African legislation that is essential in the human resource management framework and include the Constitution of the Republic of South Africa, 1996 (Act 108 of 1996); the Labour Relations Act, 1995 (Act 66 of 1995); the Basic Conditions of Employment Act, 1997 (Act 75 of 1997) and the Employment Equity Act, 1998 (Act 55 of 1998) (Muller *et al*, 2005:260).

Table 4.15 Strategies to enhance staff retention

Strategies to enhance staff retention	Authors
Focus on the psychology of employee and how motivated they are, enhance employees' self-esteem through feedback, encourage self-actualisation	DPSA (2006:13), Holtz (2005:7-8, 10)
Flexible scheduling, phased retirement	Alspach (2007:16), Holtz (2005:5)
Understand what people truly value in their career, meeting the non-tangible needs of the employee	Holtz (2005:5, 10),
Strong team spirit, connecting organisation and employees with a sense of belonging, collaborative practice culture	Holtz (2005:6-7); Kramer and Schmalenberg (2008:59)
Open communication, direct and regular and timeous feedback, communication-rich culture, true open door policy	Geedey (2006:17), Holtz (2005:7-8), Kramer and Schmalenberg (2008:59)
Healthy work environment	Alspach, (2007:11), Kramer and Schmalenberg (2008:56), Pinkerton (2005:138)
Culture of accountability	Kramer and Schmalenberg (2008:59)
Adequate amount of nurses on the staff	Kramer and Schmalenberg (2008:59)
Leaders that are competent, credible and visible, authentic leadership	Alspach (2007:12), Kramer and Schmalenberg (2008:59)
Shared decision making	Kramer (2008:59)

Table 4.15 continues

To encourage nurses for professional practice and continued growth, talent management, mentoring program, training	Alspach (2007:16), Kramer and Schmalenberg (2008:59)
Recognise the value of nurses' contributions, recognise volunteerism	Alspach, (2007:16), Geedey (2006:17), Kramer and Schmalenberg (2008:59)
Recognise nurses' contributions to practice	Kramer and Schmalenberg (2008:59)
Employment benefits	Alspach (2007:11)
Incentives and funding	Stone, Clark, Cimiotti and Correa-de-Araujo (2004:1984)
Magnet status of the hospital	Alspach (2007:12)
Ergonomic factors, keep environment simple	Alspach (2007:13), Geedey (2006:17)
Encourage humour in the workplace	Geedey (2006:17)
Clear values and expectations	Geedey (2006:17)
Incentives and disincentives	SADSA (2008:10)
Continue to promote the role of nursing	ICN (2007:2)
To clearly define nurses' scope of practice in order to let nurses work to their full potential and to provide a legal framework to inform patients and the public of the abilities of the nurses.	ICN (2007:2)

Nurse shortages and nurse migration is a reality that has been identified as a challenge for the nursing the profession, a challenge for the authentic leader and the professional nurse. In fact, staff shortages are a global crisis that is experienced on the macro-, meso- and micro levels in the context of this research. Staff retention is listed as a goal that is attainable when there are authentic leaders in nursing and professional interaction that is based on social capital and aggregated by trust.

4.5.4 Positive impact on the planet sphere of TBL

In this research the planet sphere of TBL refers to healthy work environment (also referred to as a positive practice environment).

4.5.4.1 Healthy work environment

The importance of a healthy workplace has been linked to staff retention in nursing (ICN, 2007:1-4) as well as patient outcomes. The ICN (2007:1-4) stated that a positive practice environment for nurses are settings that *“support excellence and decent work, strive to ensure health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations”*.

The elements of a healthy work environment (ICN, 2007:1-7) can be listed as occupational health, safety and wellness policies that address workplace hazards; to discriminate against physical and psychological violence as well as issues pertaining to personal security; a healthy work-life balance; job security; safe staffing levels; professional identify, autonomy and control over practice; equal opportunities and treatment; fair and manageable workloads; an organisational climate that reflects effective management and leadership practices; good peer support; shared values, worker participation in decision making; professional development and career development opportunities; decent pay and benefits; support and supervision; transparency and open communication; recognition programmes and access to adequate equipment, supplies and support staff.

A healthy work environment is viewed as an essential factor in the decreasing of job stress, the increasing of job satisfaction, work-life balance and staff retention amongst nurses. The healthy work environment is part of the environmental sphere of the TBL and is viewed as a goal that might be attainable if there is interaction between the professional nurse and the authentic leader that is embedded in a social capital framework cemented by trust. Please refer to Figure 4.6 for a visual portrayal of TBL.

In this research, the authentic leader engages in a relationship with the professional nurse that is employed in South African hospitals. This relationship refers to the connection between the authentic leader in nursing and the professional nurse that is embedded in a social capital framework by means of bonding, bridging and linking. The outcome of this connectedness is the reciprocal presence of trust which will have a positive impact on the TBL. This implies a positive impact on the people sphere of TBL by decreasing professional nurses' level of job stress and increasing job satisfaction levels, to enhance and maintain professional nurses' work-life balance and to increase the retention of professional nurses. Secondly, the outcome of this

trust relationship between the authentic leader in nursing and the professional nurse that is embedded in a social capital framework is that it enhances the profit sphere of TBL by means of increased consumer benefits as well as present and future investments. Thirdly, the outcome of the trust relationship between the authentic leader in nursing and the professional nurse is a positive impact on the planet sphere of TBL, referring to an increased healthy work environment for professional nurses employed in South African hospitals.

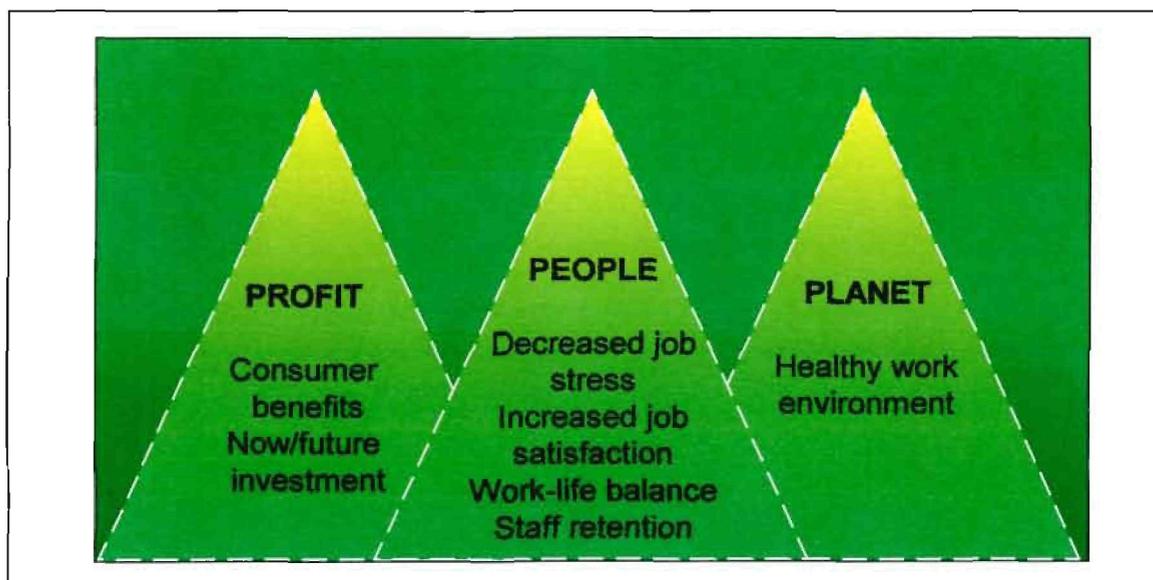


Figure 4.6 Positive impact on the triple bottom line

4.5.5 Conclusions of a positive impact on the triple bottom line

- The TBL refers to an organisation's auditing and reporting responsibility within three integrated spheres, namely the planet, which refers to natural capital; people, or the human capital and profit, also referred to the financial sphere.
- TBL is a complex phenomenon that should be addressed on an organisational managerial level as well as on the socio-psychological level of employees.
- The positive employee outcomes of decreased job stress and increased job satisfaction, work-life balance and staff retention will impact human capital positively. These positive employee outcomes should be managed in close participation with human resource management.
- The standards of a healthy work environment as authentic leadership, meaningful recognition, appropriate staffing, effective decision-making, true collaboration and skilled communication, can be utilised as a strategy to enhance natural capital.

- The financial sphere in TBL is evaluated according to an organisation's positive financial results.

4.6 LITERATURE ANALYSIS: DYNAMIC (TRUST)

The sixth concept in this research according to the survey list (Dickoff *et al.*, 1968:419) is the dynamic, which has been identified as trust. Trust is the dynamic that is necessary for all the listed main and related concepts to function together according to the survey list. *It is argued in this theory that if trust is not present in the social capital based relationship between the authentic leader in nursing and the professional nurse, this theory will not work.*

4.6.1 Literature analysis of trust

Trust serves as a related concept in this research and is described through the process of literature analysis (Walker & Avant, 2005:67). Prior to the literature analysis, the different uses of trust was investigated and listed (refer to Table 4.16). The uses of trust were grouped into psychological uses, sociological uses, legal uses and financial uses.

Trust is viewed as essential for leadership and the lack of trust implies the impossibility for a leader to lead (Robbins, 2008:74). With specific reference to this study, there is also a link between trust and social capital. Kramer (1999:3) reported that trust is a form of social capital that has been discussed on three levels with regard to its' constructive effects on the increasing of spontaneous sociability amongst members; ability to facilitate appropriate types of deference towards organisational authorities and thirdly, to reduce intra- and inter-organisational transaction costs.

From a psychological perspective (Anon, 2008:1), trust is used as a heuristic device in social decision making processes. Kramer investigated the relationship between trust and different types of voluntary deference in hierarchical relationships within an

Table 4.16 Different uses of the concept trust

Psychological uses		Sociological uses		Legal uses		Financial uses	
Dictionary used	Uses of trust	Dictionary used	Uses of trust	Dictionary used	Uses of trust	Dictionary used	Uses of trust
WordNet (2008)	<ul style="list-style-type: none"> To have confidence or faith in... Entrust: confer a trust upon Hope: expect and wish To allow without fear Reliance: certainty based on past experiences To believe, to be confident about something Faith: complete confidence Extend credit to 	WordNet (2008)	<ul style="list-style-type: none"> Confidence: a trustful relationship The trait of believing in the honesty and reliability of others 	WordNet (2008)	Something held by the trustee for the benefit of the beneficiary	WordNet (2008)	Consortium of independent organisations formed to limit competition by controlling the production and distribution of a product or service
		Wikipedia (2008)	Trust is confidence reliance. We may have confidence in events, people or circumstances or at least in our beliefs and predictions about them, but if we rely on them, confidence allow doesn't amount to trust	The Free Dictionary (2008)	<ul style="list-style-type: none"> Custody, care A legal title to property held by one party for the benefit of another 	Book-keepers-list (2008)	A tax entity created by a trust agreement. This entity distributes all or part of its income to beneficiaries as instructed by the trust agreement. This entity is required to pay taxes on undistributed income.

Merriam-Webster Online (2008)	<ul style="list-style-type: none"> Noun Assured reliance on the character, ability, strength or truth of someone or something, on in which confidence is placed. Dependence on something future or contingent Trustworthiness 	Merriam-Webster Online (2008)	A charge or duty imposed in faith or confidence or as a condition of some relationship, something committed or entrusted to one to be used or cared for in the interest of another	Merriam-Webster Online (2008)	A property interest held by one person for the benefit of another	Wikipedia (2008)	Trust was form of business entity used in the late 19 th century with intent to create a monopoly.
		The Free Dictionary (2008)	A relationship of reliance	Reference.com (2006)	Fiduciary relationship	The Free Dictionary (2008)	Trust Company, "bank"
The Free Dictionary (2008)	<ul style="list-style-type: none"> Noun and verb Synonyms: faith, confidence, reliance, dependence 	Wikipedia (2008)	Trust is the belief in the good character of one party, presumed to seek to fulfil policies, ethical codes, law and their previous promises. A sociological perspective.	Real-estate Dictionary (2008)	A right to a piece of property that is held for the benefit of another.	Reference.com (2006)	Monopolistic or semi monopolistic control over commodity or service
Cambridge Learner Dictionary (2008)	I trust that....	Cambridge Learner Dictionary (2008)	Trust somebody with... Trust somebody to...			Reference.com (2006)	Cartel

organisation. According to Kramer (1999:3), hierargical relationships imply different types, for example the leader-follower; the manager-subordinate and the employer-employee. The role of trust within these relationships is of great importance (Kramer, 1999:3). The reasons why trust is crucial in organisational, hierargical relationships are portrayed according to the leader-follower relationship: firstly a leader cannot always take the time and effort to explain the rationale for all the decisions that are made within an organisation. Secondly, followers' performance cannot always be monitored and the leader needs to trust individual's willingness to pursue the group goal as well as their personal feelings to oblige to group rules and standards. Thirdly, when conflict arises, the level of trust influences the followers' acceptance of the outcomes of resolution.

Trust can also refer to confidence as the opposite of trust, distrust, refers to suspicion (Covey & Merrill, 2006:5). Having trust in a person means that you have confidence in that person's abilities and integrity. Again, taking an opposite view, when you have distrust in a person, you raise suspicion about that person's capabilities, agenda, track record and integrity. "You know it when you feel it", is the definition of trust by Jack Welch, former CEO of General Electric (Covey & Merrill, 2006:5). Therefore, the difference between a high-trust and a low-trust relationship are distinguishable. Another use of trust is in the economics of trust (Covey & Merrill, 2006:13). The economics of trust refer to the formula that is based on the principle that trust always affects speed and cost. In other words, low trust = low speed + high costs and high trust = high speed + low costs. The economics of trust further implies that as a person would pay tax on purchases, the same manner lower trust levels can be described as tax expenditure. With lower levels of trust, one is definitely going to pay a form of tax. Again, on the opposite, there are dividends when there are higher levels of trust (Covey & Merrill, 2006:17-19). Please refer to figure 4.5 for a diagrammatic portrayal of the taxes and dividends hidden in trust. Trust is viewed as the hidden formula in organisational success (Covey & Merrill, 2006:20). It can be explained in the following formulas:

- **The standard formula for organisational success:** $S \times E = R$
(strategy x execution = results)
- **The standard formula for organisational success with the hidden variable of trust:**
 $(S \times E)T = R$
([strategy x execution] multiplied by trust = results)

The above formulas indicate that an organisation may have efficient strategy and effective execution but can still be derailed due to low levels of trust (Covey & Merrill, 2006:20).

Again, on the opposite of the continuum, high trust levels may serve as the performance multiplier. The tax and dividend results of trust as hidden variables within an organisation are graphically portrayed in Figure 4.7. This figure indicates that the lower the level of trust in an organisation, the higher the tax expenditure. In an organisation with high trust levels the dividends will increase.

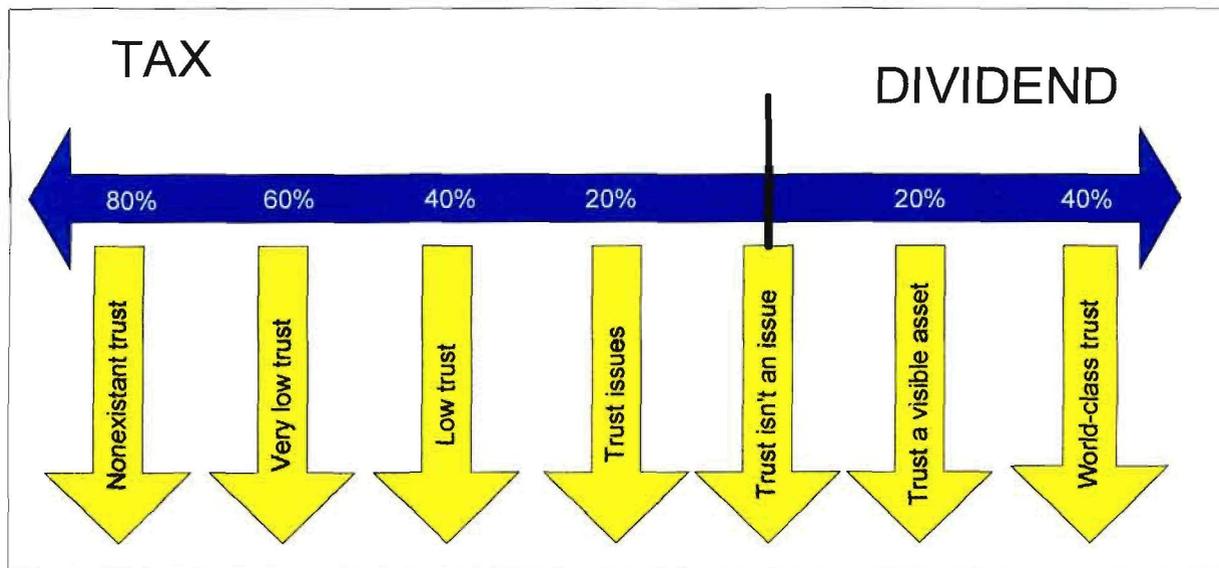


Figure 4.7 Tax-dividend costs hidden in trust levels (adapted from Covey & Merrill, 2006:22-24)

According to Chua, Ingram and Morris (2008:436) there is a distinction between cognitive – and affect-based trust. Cognitive-based trust can be associated with task advice, economic resources and career guidance ties whereas affect-based trust is associated with career guidance ties and friendship. Affect-based trust is also negatively associated with economic resource ties. In summary, these authors agreed that trust is a useful tool in the explanation of managerial outcomes.

Before two theories of trust are discussed, Covey and Merrill's (2006:25) myth versus reality table of trust by is provided. This table serves as an eye opener into the visibility of trust. Please refer to Table 4.17.

Table 4.17 Myths and realities about trust

Trust myths	Realities about trust
Trust is soft	Trust is hard, real and quantifiable. It measurably affects both speed and cost
Trust is slow	Nothing is as fast as the speed of trust
Trust is build solely on integrity	Trust is a function of both character (which includes integrity) and competence
You either have trust or you don't	Trust can both be created and destroyed
Once lost, trust cannot be restored	Though difficult, in most cases lost trust can be restored
You can't teach trust	Trust can be effectively taught and learned, and it can become leveragability, strategic advantage.
Trusting people is too risky	Not trusting people is a greater risk
Trust is established one person at a time	Establishing trust with the one establishes trust with the many

4.6.1.1 Theories of trust

Two theories of trust are discussed in this literature analysis. The theories of trust by Fukuyama (Brewster, 1998), is used due to Fukuyama's positioning of trust in social capital. The second theory of trust is by Covey and Merrill (2006).

4.6.1.1.1 Fukuyama

Trust is analysed from the theory of trust by Francis Fukuyama as published in 1995 in the book "Trust: the social virtues and the creation of prosperity", and his later publication of "Social capital and civil society" (Brewster, 1998:1). Fukuyama (*in* Brewster, 1998:1) explored and described trust with close association with social capital. Social capital is referred to the "*the ability of people to work together for common purposes in groups and organisations*" and can be divided into familial versus voluntary associations. Fukuyama argued that trust manifest as a type of social capital in the form of spontaneous sociability. Spontaneous sociability is the forms of extra-role, different forms of cooperative and altruistic behaviour of members in a social community in order to enhance their collective well being as well as the attainment of their collective goals. Trust is seen as an epiphenomenal product that arises as an outcome of social capital and does not constitute social capital.

Familial social capital refers to the amount of social capital amongst family members as well as their amount of trust towards family members and towards outsiders. Voluntary associations refer to voluntary membership and can be described as trust towards strangers, also referred to as non-kin relationships. Furthermore, voluntary associations are the groups of non-kin people that come together and that work together for a common goal. The higher amount of trust that can be placed in non-kin relationships, the better the ability to form economic corporations that can compete in the outside world.

The levels of trust are inherent within society (Brewster, 1998:7). According to Fukuyama there are specific cultural habits that affect family exclusiveness, which in return implies the family structure openness as well as the amount of non-kin interaction. In the event of families with a closed family structure that isn't open towards non-kin interaction, these families have low-trust levels and will therefore have no trust in voluntary associations. On the other hand, families with an open family structure with positive non-kin interaction are referred to as high-trust levels families. High-trust families will more easily have trust in voluntary associations. Fukuyama argued that the amount of trust in voluntary associations have a direct impact on the size and successful survival of corporations in the world economy. Low-trust groups will according to Fukuyama (*in* Brewster, 1998:34) require government intervention and support towards global economic participation. Please refer to figure 4.8 for a graphic portrayal of the theory of trust.

4.6.1.1.2 Covey and Merrill

According to Covey and Merrill (2006:29) people generally want to be trusted as this is a very inspiring and motivating dynamic and therefore trust is something that people should better without manipulation. Trust is a function of character (integrity, motive, intent) and competence (capabilities, skills, results, track record). Trust runs in a ripple effect from the inside out and is exhibited in five contexts in which trust can be established (Covey & Merrill, 2006:33).

- **Self-trust**

This is the first and most internal wave and refers to a person's confidence in her ability to achieve goals, to inspire others to trust and to keep her commitments. The goal is to become trustworthy and credibility is the key principle that underpins self-trust (Covey & Merrill, 2006:34).

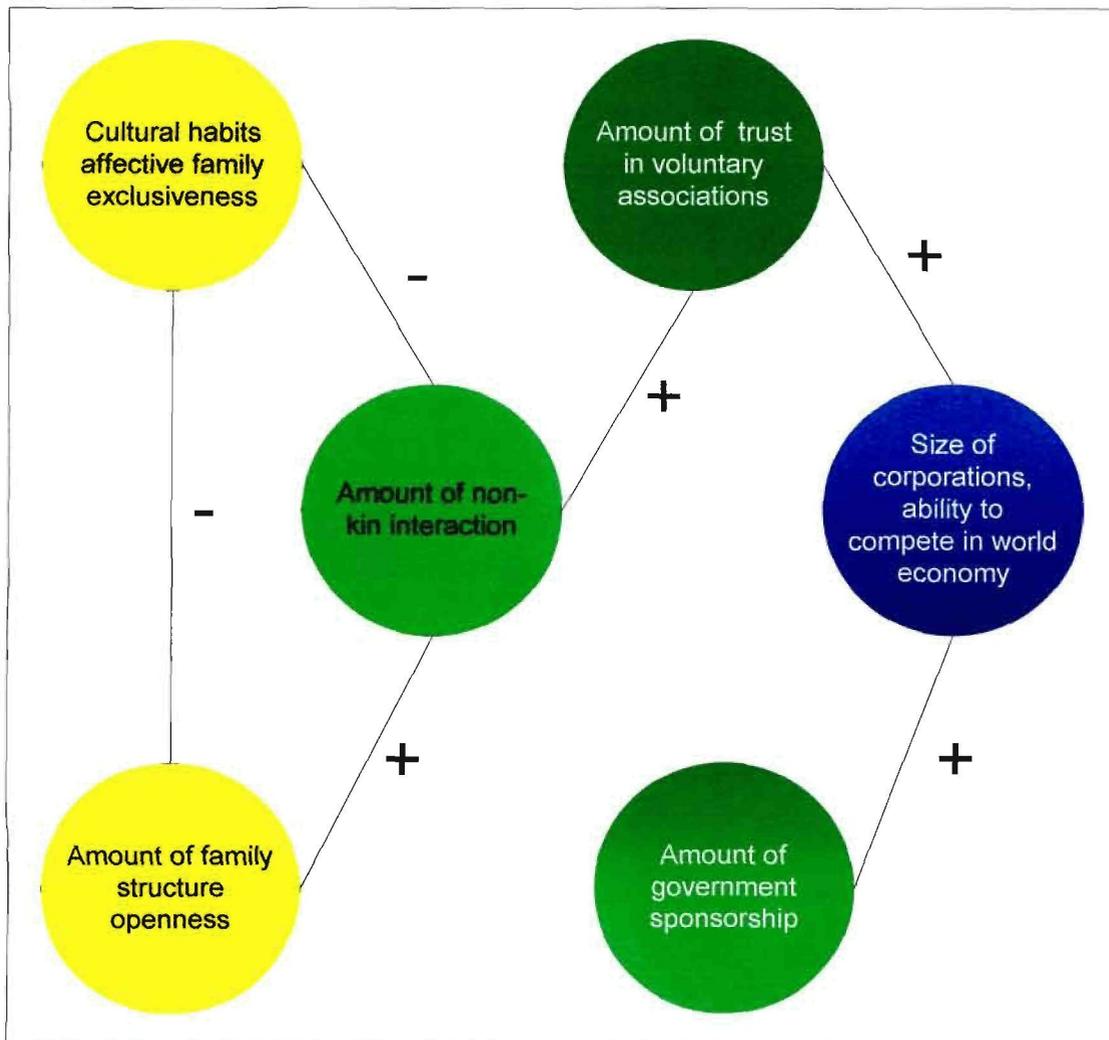


Figure 4.8 Brewster's (1999) exposition of Fukuyama's theory of trust

- **Relationship trust**

This wave indicates how to both establish and increase trust accounts between people. Consistent behaviour is the key to relationship trust. Thirteen behaviours have been identified as the building blocks for consistent behaviour (Covey & Merrill, 2006:34). These behaviours can be learned and if mastered, can increase the ability to create trust as well as to enhance relationships and to achieve better results.

- **Organisation trust**

This wave is applied to how leaders can generate trust in various types of organisations. Alignment serves here as the principle during which systems, structures are created to promote organisational trust dividends (Covey & Merrill, 2006:34).

- **Market trust**

At this level the economic impact of trust becomes visible (Covey & Merrill, 2006:35). Reputation is the underlying principle for market trust. Market trust refers to a company's brand as well as the trust this brand holds for investors and customers. With high-trust brands clients will buy more products and investors will invest more.

- **Societal trust**

This is the fifth wave and refers to the creating of values for the society at large as well for each other. Contribution serves as the principle that is underlying societal trust. The reciprocity of giving contributing and giving back, counteract low-trust levels. Furthermore, contribution inspires others to also create value and contribute (Covey & Merrill, 2006:35).

Trust can be established and restored (Covey & Merrill, 2006:35, 39). Covey and Merrill referred to the five waves of trust that is a ripple effect; this is portrayed in the following diagram:

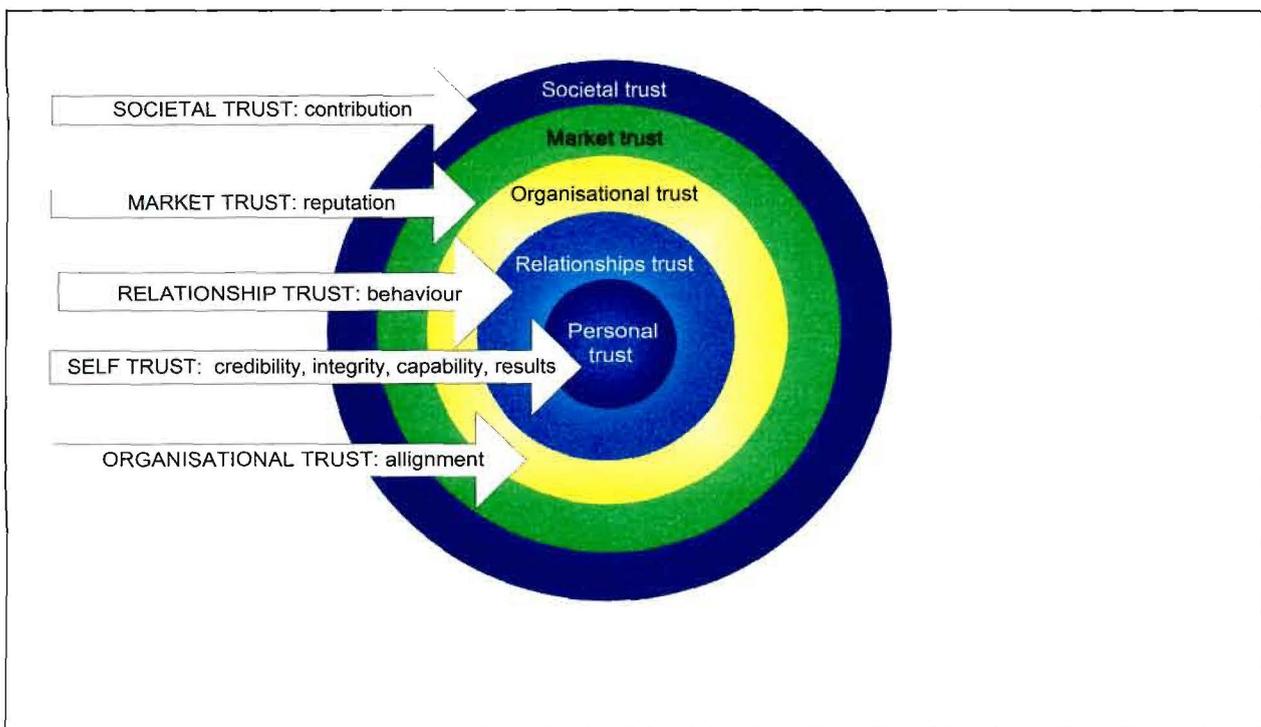


Figure 4.9 The five waves of trust (adapted from Covey & Merrill, 2006:33)

According to Covey and Merrill (2006:286), the difference between a manager and a leader is the ability to inspire trust. This assumption is conflicting in the nursing profession as nurses are both managers and leaders. Still, the process of establishing trust, extending trust and

becoming more trustworthy as derived from the SMART Trust™ matrix serves as a functional tool also to nurses. The SMART Trust™ matrix is based on the smart trust judgement spot that occupies the space between distrust (with suspicion) and blind trust (gullibility). This matrix states that life is overflowing with risk and the ideal is to have trust that is risk-free. Therefore the objective is optimal risk-management through the process of analysis and propensity of trust. Propensity of trust refers to that grey area where one decides with your heart whereas the analysis refers to a cognitive decision-making process. The SMART Trust™ Matrix is displayed in figure 4.10.

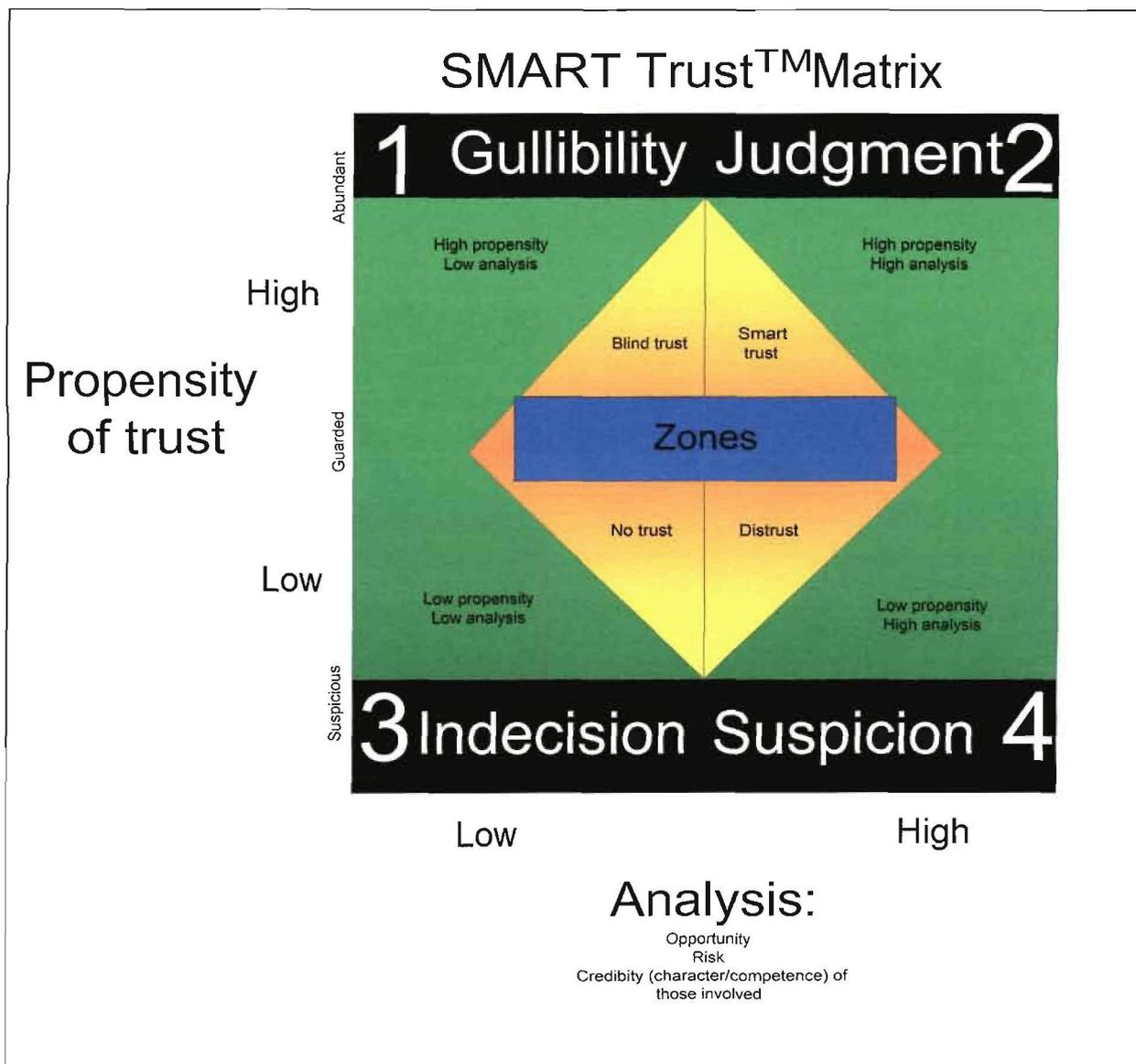


Figure 4.10 SMART Trust™ Matrix (Covey & Merrill, 2006:290-295)

In the above paragraphs a literature analysis of trust was conducted. In this research the authentic leader in nursing stands in a relationship with the professional nurse that is based

on the framework of social capital. This implies that the authentic leader in nursing uses bonding, bridging and linking to establish and maintain her connectedness with the professional nurse. The relationship between the authentic leader in nursing and the professional nurse is reciprocal due to the presence of trust. Trust is the essential dynamic that needs to be present for this the theory for authentic leadership embedded in a social capital framework in Nursing Science, to be functional.

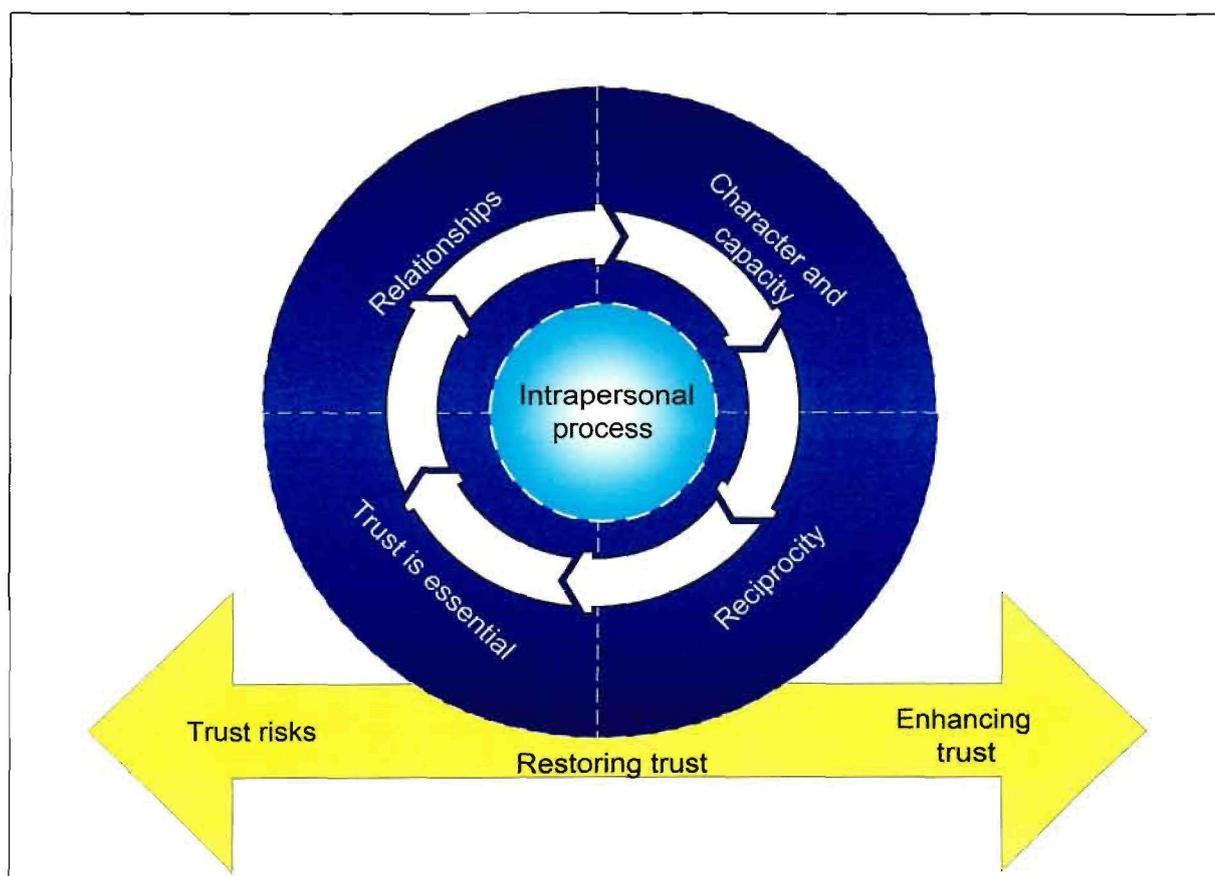


Figure 4.11 Trust

4.6.2 Conclusions of trust

- Trust is both an intra- and interpersonal process. The intrapersonal process is an internal psychological decision to confide in somebody or something. The interpersonal process is the relationship in which the person, on whom the trust was bestowed, acknowledges this trust through reciprocity.
- Trust is essential for personal as well as organisational success as economic trust can be calculated in a financial value towards tax or dividend.
- Trust is risky but it is an essential characteristic for the world economy and therefore people should learn how to enhance trust levels.

- Trust implies both character, which entails integrity, motive and intent, as well as competence that refers to capabilities, skills, results and track record.
- Trust is dynamic as it can be damaged as well as established, restored, maintained and enhanced through the ripple effect of the wave of trust that moves from inside a person towards society.
- Through the utilisation of SMART trust TM matrix, trust judgement and decisions can be made through propensity and analysis as a means of optimal risk management.

4.7 SUMMARY

The aim of Chapter Four was to conduct a concept analysis of the procedure, namely social capital as well as a literature analysis of the goal (positive impact on the triple bottom line) and dynamics (trust). The six steps for concept analysis were followed. In the analysis of social capital, TBL and trust, conclusions were formulated accompanied by a graphic portrayal. In Chapter Five the process of theory synthesis follows.

CHAPTER FIVE

THEORY DESCRIPTION, EVALUATION, REFINEMENT AND GUIDELINES FOR OPERATIONALISATION

5.1 INTRODUCTION

The process of statement synthesis, theory construction, theory evaluation and the formulation of guidelines for the operationalisation thereof are described in Chapter Five. An overview is given of the steps used in the construction of a theory of authentic leadership embedded in a social capital framework in Nursing Science. During the description of the theory a visual presentation is provided. The evaluation and refinement of the theory is described. The final aspect in Chapter Five is the formulation of guidelines for the operationalisation of the theory.

5.2 OVERVIEW OF THEORY CONSTRUCTION

In Chapters Three and Four, the main- and related concepts in the theory of authentic leadership embedded in a social capital framework in Nursing Science were identified, described, defined and if needed, analysed. Chapter Five continues with the process of theory construction by activating statements synthesis. This implies the construction of relational statements between the main concepts (authentic leadership in nursing and social capital) and the related concepts (professional nurse, South African hospitals, positive impact on the triple bottom line and trust). Relational statements refer to the relational meaning that exists between concepts (Walker & Avant, 2005:27). Statement synthesis is a combination of two actions, namely to move from evidence to conclusions and then to generalise these conclusions to a more abstract level.

The conclusions formulated for the main- and related concepts are listed in Table 5.1. From these conclusions, statements are synthesized (Walker & Avant, 2005:88). After relational meaning between concepts was formulated, theory synthesis is done. Theory synthesis is done by describing the relationships between the main – and related concepts (Walker & Avant, 2005:135).

Table 5.1 Formulated statements of the main- and related concepts (N=36)

Authentic leadership in nursing	Professional nurse	South African hospitals	Social capital	Positive impact on triple bottom line	Trust
<p>1. Authentic leadership in nursing is a 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 honest self expression and her effort to remain true to herself.</p> <p>2. Authentic leadership in</p>	<p>9. To man, a professional nurse symbolises an accountable, capable and responsible person that adheres to an ethical, professional practice.</p> <p>10. 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</p>	<p>14. There is a dichotomy between overburdened and under-resourced public hospitals versus resourced but unaffordable private hospitals in South Africa.</p> <p>15. The public hospitals, which are part of a national health system with a primary healthcare focus and an ideal to provide healthcare to all, are slowing recovering from the inequalities of apartheid.</p> <p>16. Public hospitals serve the majority of South Africans</p>	<p>21. Social capital is a multidimensional concept with three distinctive features: a social structure in the form of networks; natural connectedness between men within these networks in the form of formal and informal relationships and outcomes for those within these networks.</p> <p>22. Although human beings are social beings and functions in a social sphere, social capital is not spontaneously present amongst people. Potential</p>	<p>25. The triple bottom line refers to an organisation's auditing and reporting responsibility within three integrated spheres, namely the planet, which refers to the environment sphere; people, or the social sphere and profit, also referred to the financial sphere.</p> <p>26. Triple bottom line is a complex phenomenon that should be addressed on an organisational-managerial level as well as on the socio-psychological</p>	<p>31. Trust is both an intra- and interpersonal process. The intrapersonal process is an internal psychological decision to confide in somebody or something. The interpersonal process is the relationship in which the person, on whom the trust was bestowed, acknowledges this trust through reciprocity.</p> <p>32. Trust is essential for personal as well as organisational success as economic trust</p>

<p>nursing is an inside-out process whereby the authentic leader's internal choices are displayed through her behaviour.</p> <p>3. The authentic leader in nursing learns from her life narrative by using these life experiences to direct her leadership purpose. The authentic leader in nursing knows her leadership purpose and therefore pursues this purpose with passion.</p> <p>4. The authentic leader in nursing can stay on track by practicing her values and principles, maintaining a</p>	<p>accountability.</p> <p>11. Due to specific competences the professional nurse is legally licensed to practice comprehensive nursing as a member of the health team.</p> <p>12. The professional nurse portrays the integrated roles of a clinician, educator, advocate, manager, leader and researcher in her professional capacity.</p> <p>13. The professional nurse practices nursing in the domains of the clinical practice, administration, education and research.</p>	<p>of which poverty, unemployment, crime, HIV/AIDS, Tuberculosis and no medical cover is at the order of the day.</p> <p>17. Private hospitals, which functions on a business model, serve the minority of South Africans that can afford some form of medical cover.</p> <p>18. The global-economical and political challenges as well as the cultural diversity in South Africa influence the healthcare industry and enlarge the dichotomy between public and private hospitals even more.</p> <p>19. The public versus</p>	<p>social capital can be activated and existing social capital can be accumulated through bonding, bridging and linking social capital.</p> <p>23. Social capital is present when there is trust, tangible and intangible resources within these networks and when there are norms of reciprocity.</p> <p>24. The outcomes of social capital are that members in a network have the advantage of access to-, control over - and opportunities for the acquisition of valuable resources.</p>	<p>level of employees.</p> <p>27. Through the positive employee outcomes of decreased job stress and increased job satisfaction, work-life balance and staff retention, the social sphere of an organisation is impacted positively. These positive employee outcomes should be managed in close participation with human resource management.</p> <p>28. The standards of a healthy work environment as authentic leadership in nursing, meaningful recognition, appropriate</p>	<p>can be calculated in a financial value towards tax or dividend.</p> <p>33. Trust is risky but it is an essential characteristic for the world economy and therefore people should learn how to enhance trust levels.</p> <p>34. Trust implies both character, which entails integrity, motive and intent, as well as competence that refers to capabilities, skills, results and track record.</p> <p>35. Trust is dynamic as it can be damaged as well as established, restored, maintained and enhanced through the ripple effect of</p>
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<p>balanced life and by leading herself.</p> <p>5. To the authentic leader in nursing, people are important and therefore authentic leadership in nursing is relationship-centered. The authentic leader in nursing connects with and serves her followers.</p> <p>6. Although most people in nursing have the potential to be authentic leaders in nursing, authentic leadership in nursing is very hard work and a difficult task that requires sacrificial growth and a lifelong journey. This in</p>		<p>private hospital dichotomy implies a conflict for adequate resources in the form of human resources, financial resources and managerial resources.</p> <p>20. South African hospitals are interdependent with international and national challenges as well as challenges that present on ward-level in these hospitals.</p>		<p>staffing, effective decision-making, true collaboration and skilled communication, can be utilised as a strategy to enhance the environmental sphere.</p> <p>29. The financial sphere in the triple bottom line is evaluated according to an organisation's consumer benefits as well as the current and future investments.</p> <p>30. Effective financial management is necessary to ensure positive financial outcomes.</p>	<p>the wave of trust that moves from inside a person towards society</p> <p>36. Through the utilisation effective trust judgement, decisions can be made through propensity and analysis as a means of optimal risk management.</p>
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<p>combination with traditional organisational views of leadership is the reason for a short fall.</p> <p>7. The authentic leader in nursing serves followers and utilises inspiration, navigation, empowerment and commitment to create value.</p> <p>8. Authentic leadership in nursing is associated with results and high standards and to make performance meaningful to followers.</p>					
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5.3 ASSUMPTIONS OF THE THEORY

Prior to the description of the theory for authentic leadership embedded in a social capital framework in Nursing Science, the assumptions that form the basis of this theory formulated.

- The authentic leader in nursing aspires self-actualisation and lives a purpose-driven life where she exerts the decision to assimilate her authentic leadership in nursing. She accepts her responsibilities and the consequences that flow from her decision to pursue her authentic leadership purpose.
- The theory for authentic leadership embedded in a social capital framework in Nursing Science is contextual to the macro-, meso- and micro levels as described in this research.
- The professional nurse and the authentic leader in nursing can connect on a personal level.
- It is the ideal that the relationship between the authentic leader in nursing and the professional nurse is embedded in positive social capital.
- Trust is the essential ingredient that facilitates the reciprocal relationship between the authentic leader in nursing and the professional nurse and leads to the result of positive impact on the triple bottom line. The absence of trust or low levels of trust implies that there will not be a reciprocal relationship between the authentic leader and the professional nurse and this theory will not work.

5.4 DESCRIPTION OF THE THEORY

In this research, the theory is described with the assistance of a visual presentation. This presentation exhibits the theory in a graphic manner in order to indicate the relationship that exists among and within statements (Walker & Avant, 2005:136). A tentative visual presentation for a theory of authentic leadership embedded in a social capital framework in Nursing Science is provided in Figure 5.1. This visual presentation was submitted with the theory description to a panel of experts during theory evaluation. In the refinement of the theory a final visual presentation is formulated.

The theory is described with specific reference to the purpose, context, overview, structure and process.

5.4.1 Purpose of the theory

The purpose of this theory for authentic leadership embedded in a social capital framework in Nursing Science is to have a positive impact on the triple bottom line. As the triple bottom line implies three spheres, the purpose of the theory can be stated as follows:

- A positive impact on the people (social) sphere of the triple bottom line as evidenced by a decrease in the job stress levels and an increase in the job satisfaction levels of professional nurses; a balance in professional nurses' work-life and an increase in the staff retention.
- The positive impact on the profit (economical) sphere of the triple bottom line as evidenced by increased consumer benefits and an increase in now and future investments into both the public and private hospitals.
- The positive impact on the plant (environmental) sphere of the triple bottom line is the establishment and maintenance of a healthy working environment.

5.4.2 Context of the theory

The context of the theory is the three levels namely the macro-, meso- and micro levels. The macro level is the international arena whereas the meso level refers to the Republic of South Africa. The micro level is the South African hospitals where professional nurses are employed. The three levels in the context are interdependent and interconnected, implying that factors on one level will impact on the other.

5.4.3 An overview over the theory

Professional nurses employed in South African hospitals, which form the largest part of the healthcare industry, are impacted by international, South African and hospital challenges. She is overburdened by staff shortages, poor nurse:patient ratios and inequalities in resources. There is a call amongst professional nurses for leaders in nursing to lead the nursing profession influenced by these challenges. The professional nurse is part of the health team and functions within an ethical-legal framework. The daily work-life of the professional nurse requires theoretical, clinical and occupational competence from her as she needs to integrate the roles of clinician, educator, patient advocate, manager, leader and researcher.

The authentic leader in nursing is a person in any also within the healthcare industry. The authentic leader is not necessarily in a managerial or senior position. This leader has

surfaced due to followers' call of a different type of leader. The authentic leader in nursing is a person that takes the effort to be true to herself. This is a process of continuous self-awareness to enhance self-knowledge and to expression oneself honestly. The authentic leader has learned from her life narrative and she pursues her purpose for her leadership in nursing with passion. She has the ability to lead herself, to balance all the dimensions of her life and she practices her values and principles, the authentic leader exhibits integrity, character and competence.

The leadership process followed by the authentic leader in nursing is that she connects with and serves her followers. This provides the platform for the authentic leader in nursing to inspire, empower and to navigate followers and to create values. The authentic leader in nursing is associated with results recognised by performance excellence and meaning in performance.

The relationships established between the authentic leader in nursing and the professional nurse is embedded in a social capital framework. This refers that the authentic leader in nursing and the professional nurse are members of a social structure (network) in which there are connections in the form of relationships, trust, norms of reciprocity and tangible/intangible resources. Potential social capital can be activated and existing social capital can be accumulated through bonding, bridging and linking. The outcomes of social capital rest with the professional nurse and the authentic leader in nursing as they have the advantage of access to -; control over and opportunities to acquire valuable resources.

As social capital accumulates between the authentic leader in nursing and the professional nurse, their relationship becomes compounded in trust. The existence of trust is imperative for this theory to work.

In a hospital ward that has high trust levels and positive social capital, there might be a positive impact on the triple bottom line in the form of profit (financial outcomes), people (positive employee outcomes) and the planet (a healthy work environment).

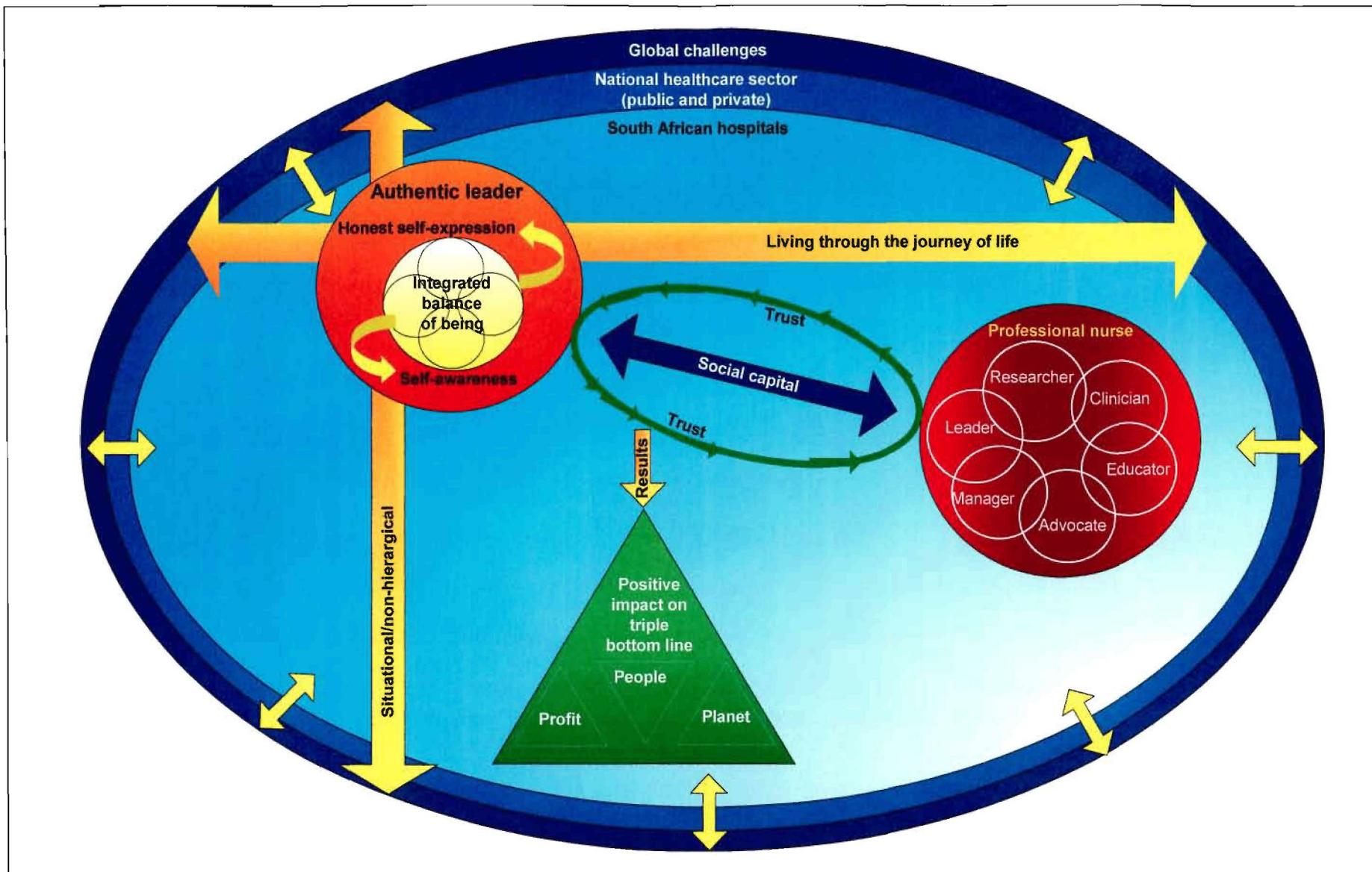


Figure 5.1 Tentative visual presentation of the theory for authentic leadership embedded in a social capital framework in Nursing Science

Public hospitals:
 Free access
 Nurse driven
 Over-burdened
 Understaffed
 87 870 beds for > 40 million patients
 HIV/AIDS

Private hospitals:
 Costing
 Profit-centred
 27 586
 7 million insured patients
 Staff shortages
 Over-se

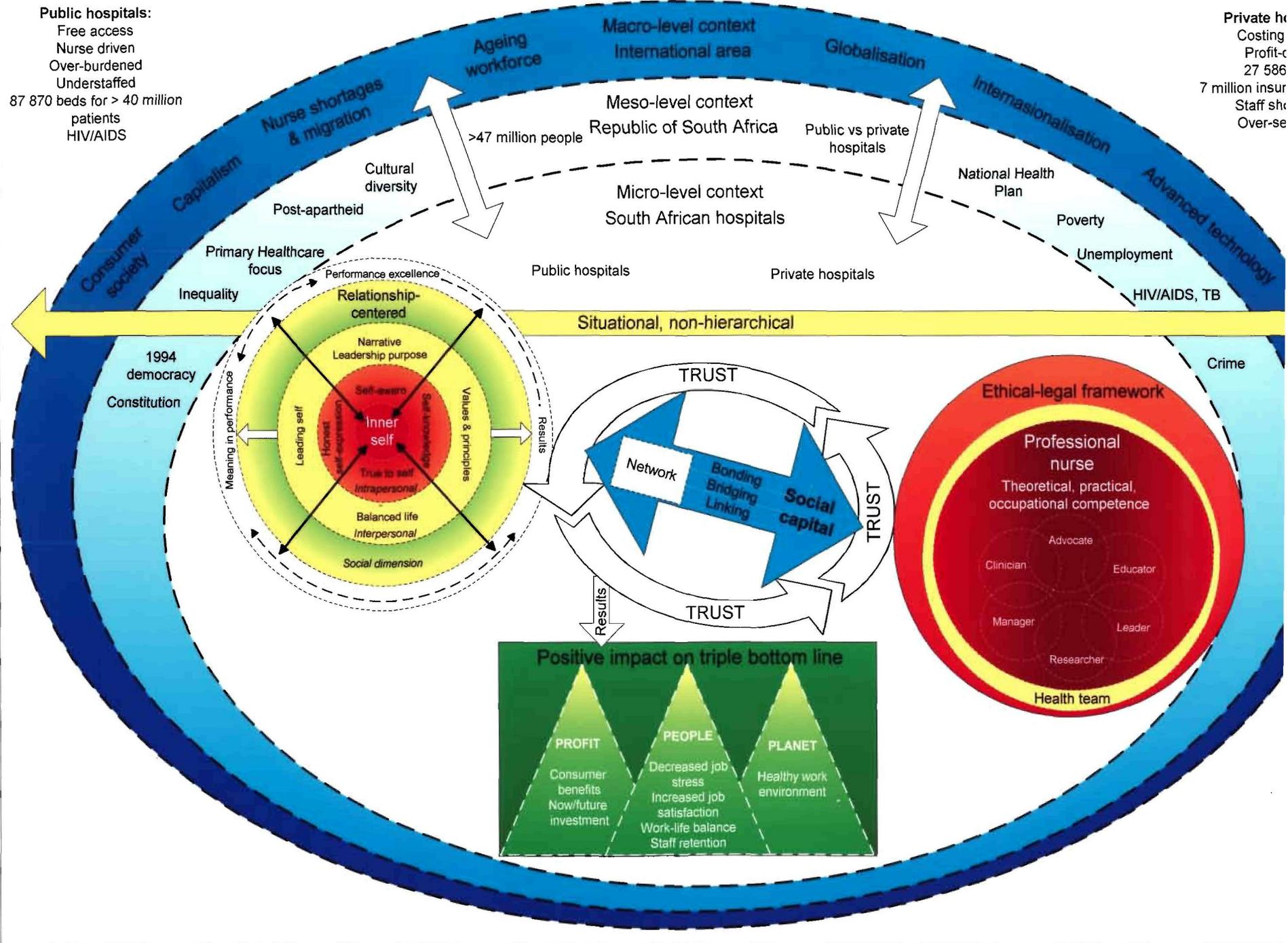


Figure 5.2 Visual presentation of the theory for authentic leadership embedded in a social capital framework in Nursing Science

5.4.4 Structure of the theory

The theory is graphically portrayed in the form of a visual presentation. This presentation serves as a schematic drawing with symbols and arrows as a graphic version to the linguistic theory (Walker & Avant, 2005:136). During the course of 5.4.4, the theory for authentic leadership embedded in a social capital framework is described with regard to the definitions of the concepts, the structural form and the relational statements that are presented.

5.4.4.1 Definitions of the concepts

The definitions for authentic leadership in nursing; the professional nurse; South African hospitals; social capital; positive impact on the triple bottom line and trust are as follows:

- **Authentic leadership**

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, 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 balance 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.

- **Professional nurse**

A person registered to provide comprehensive nursing within an ethical-legal framework and as a member of the health team. The professional nurse has theoretical; clinical and occupational competence as well as the ability to make decisions independently, resulting in responsibility and accountability. In the provision of comprehensive nursing the professional nurse integrates the roles of clinician, educator, advocate, manager, leader and researcher within the nursing domain.

- **Context**

The conditions and circumstances of events those are present in three interdependent and interconnected levels namely the macro-, meso and micro spheres. The macro-level sphere

refers to the international arena; the meso-level sphere to the Republic of South African and micro-level sphere is the South African hospitals.

- **Social capital**

Social capital in the form of bonding, bridging and linking, is a universal phenomenon of connectedness in the form of relationships. The presence of social capital is dependent on the relationships between people that is embedded in social structures (networks) characterised by tangible/intangible resources, trust and norms of reciprocity. Potential social capital needs to be activated whilst existing social capital can be accumulated. The outcomes of social capital are the advantages of access to, control over - and the opportunity for the acquisition of valuable resources.

- **Positive impact on the triple bottom line**

When interventions have a positive impact that is equally distributed into the three spheres of people, referring to the social dimensions; the planet, referring to the environmental dimension and profit, referring to the financial dimension as established through the auditing and reporting responsibilities of an organisation.

- **Trust**

Trust is the psychological process to confide in somebody or something and then to acknowledge this trust through reciprocity. Trust moves from inside out from a person to society. It is a dynamic process where trust can be restored and enhanced and is essential for organisational success.

5.4.4.2 Structural form of the theory

The structural forms of the theory corresponded with the parts of the theory that they represent (Walker & Avant, 2005:28). In this research a visual presentation was formulated by using circular -, square and linear structure. The visual presentation of the theory is in colour. The selection of the colour is to exhibit the visual presentation clearly and there is no additional meaning to the use of colour.

CIRCULAR STRUCTURES IN THE THEORY

Circular structures in the theory represent parts of the theory that is a unit with definite boundaries and continuous activity. The context, authentic leader and the professional nurse are circular structures.

The context of the theory is represented by three concentric circular structures. The external circular structure represents the macro level context referred to as the international arena. Within this circular structure the following challenges are listed as factors that impact on the meso- and micro levels: globalisation; advanced technology; ageing workforce; nurse shortages and migration; capitalism and a consumer society, MDG's; global warming and climate changes; world health; peace and security. The internal defining line of the circular structure of the macro level context is dotted to be permeable.

Within the external circular structure is a middle circular structure that represents the meso level context referred to as the Republic of South Africa. The boundary lines of this circular structure are permeable as to illustrate those factors of the macro- and micro levels can impact on the meso level and visa versa. The following challenges are listed in the middle circular structure of the meso level context: population > 48 million people; post-apartheid inequality; 1994 democracy; National Health Plan South African Constitution and human rights; primary healthcare focus; HIV/AIDS; TB; public versus private healthcare industry; poverty and unemployment; crime.

The internal circular structure within the middle circular structure represents the micro level context, namely the South African hospitals. Public hospitals versus private hospitals are distinguished from each other. The following public hospital challenges are listed within the internal circular structure: district, regional and tertiary hospitals; free access; nurse-driven; 87 870 usable beds for > 40 million people; HIV/AIDS; overburdened and understaffed. Costing model; profit driven; 27 586 usable for <8 million people; medical insurance; staff shortages; over-servicing. The boundary lines of the internal circular structure are dotted, indicating that it is permeable.

Authentic leadership in nursing is presented as a circular structure. This structure is four concentric circles that are interested from the internal circle outwards. The internal circle is the inner self of the authentic leader in nursing. The inner self of the authentic leader in nursing is interconnected and interdependent with the intrapersonal; interpersonal and social dimensions. The intrapersonal dimension is presented in a circle around the internal circle of the inner self. This circular structure presents the activities of self-awareness, self-knowledge, honest self-expression and being true to oneself. The third circular structure represents the interpersonal dimension where the authentic leader exhibits the behaviours of a balanced life, of leading herself, of learning from her life narrative, of pursuing the purpose of her leadership with passion and of practicing values and principles of which values,

character and competence are listed. The fourth circular structure of authentic leadership in nursing is the social dimension in which the authentic leader is engaged into relationships. The external circular structure of authentic leadership represents the results of performance excellence and meaning in performance that are associated with the authentic leader in nursing.

The professional nurse is another circular structure that contains concentric circles. The external circular structure that represents the professional nurse illustrates the ethical-legal framework in which the professional nurse work. Within the external circular structure is a middle circular structure that represents the health team in which the professional nurse participates. The internal circular structure is that of the professional nurse's competence (theoretical, practical and occupational). Within the internal circular structure are six small, overlapping circular structures that represent the roles of the professional nurse (advocate; educator; leader; clinician; manager and researcher). All the circular structures' lines are dotted as the external-, middle and internal circular structures that represent the professional nurse are permeable.

SQUARE STRUCTURES IN THE THEORY

Social capital is represented in a combination of square structures. The social structure also referred to as a network in which the authentic leader in nursing and the professional nurse is connected in the form of relationships, are square. The boundaries of the square structure of social capital are dotted lines.

A positive impact on the triple bottom line is presented in a rectangular structure in which three triangles are presented. The three triangles within the rectangular structure represent the three spheres of the triple bottom line, namely the profit, people and planet. The three spheres of the triple bottom line were presented in line with each other, indicating that each sphere is of equal importance.

LINEAR STRUCTURES IN THE THEORY

The use of lines and arrows are described as linear structures in this theory. The two-way linear structures that are running from the macro-level sphere over the meso-level sphere into the micro-level sphere of the context represents the interdependent and interconnected nature of the three levels of the context.

A two-way linear structure is stretching through the context in a horizontal direction and represents the non-hierarchical and situational position of the authentic leader in nursing. The circular structure of the authentic leader in nursing anchors to this horizontal linear structure. This represents that authentic leadership is dependent on specific situations and that authentic leaders in nursing are non-hierarchical.

A two-way arrow stretches between the circular structure of the authentic leader in nursing and the professional nurse. This arrow indicates the connectedness between the authentic leader in nursing and the professional nurse as part of the social capital framework. The square structure of social capital is anchored on to this two-way linear structure. A linear structure surrounds the two-way linear structure that represents the connectedness between the authentic leader in nursing and the professional nurse and social capital. This linear structure indicates the continuity of trust.

The final linear structure is the one-way arrow that is stretching from the linear structure representing trust towards the rectangular structure of the positive impact on the triple bottom line and represents the results of trust.

5.4.4.3 Relational statements

The following relational statements were formulated from the conclusion statements (please refer to Table 5.1). A cross reference was conducted between these relational statements and the conclusions statements.

- The authentic leader in nursing and the professional nurse is in a reciprocal relationship that is embedded in social capital and reciprocal due to the presence of trust. This relationship can be in the macro-, meso- or micro- levels and is situation-specific and non-hierarchical. *(Cross referenced with conclusions nr: 1, 2, 5, 7, 11, 20, 21, 23, and 30).*
- Through the reciprocal relationship between the authentic leader in nursing and the professional nurse, the authentic leader in nursing serves the professional nurse as well as navigates, inspires, empowers and creates value. In return, the outcome of this reciprocal relationship with the professional nurse is a positive impact of the triple bottom line. *(Cross referenced with conclusions nr: 1, 2, 3, 4, 5, 7, 8, 9, 10, 24, 25, and 31).*
- The professional nurse as a multi-dimensional health team member with educational and practical competence performs the roles of clinician, educator, advocate, manager,

leader and researcher and is employed in South African hospitals which are interdependent with the national health sector and global challenges and urges the professional nurse to call upon the authentic leader for direction. *(Cross referenced with conclusions nr: 10, 11, 12, 13, 14, 18, 19, and 20).*

- The authentic leader knows the purpose of her leadership through her life narrative. She pursues this leadership purpose with passion whilst she exhibits behaviours of a balanced life, practicing values and principles, integrity, character and competence, that portray her inner-self from an inside-out direction. As the authentic leader in nursing expresses herself honestly, is aware of herself, knows herself and true to herself, the professional nurse will ascribe authenticity to the authentic leader in nursing. *(Cross referenced with conclusions nr: 1, 2, 3, 4, 5, 6, and 7).*
- The authentic leader uses bonding, bridging and linking to activate and/or accumulate social capital between herself and the professional nurse. This social capital is dependent upon a social structure/network, a relationship between the authentic leader in nursing and the professional nurse, tangible and intangible resources as well as trust and norms of reciprocity. *(Cross referenced with conclusions nr: 5, 7, 11, 21, 22, 23, and 24).*
- Social capital in the form of bonding, bridging and linking leads to the outcomes of advantages in the access to -, control of – and opportunities in the acquisition of valued resources which increased levels of trust and have a positive impact on the triple bottom line *(Cross referenced with conclusions nr: 21, 22, 23, 24, 25, 31.)*
- The relationship between the authentic leader in nursing and the professional nurse which is embedded in a social capital framework enhances trust. Enhanced levels of trust impacts the triple bottom line positively as it inspires the professional nurse towards performance excellence and meaning for this performance. *(Cross referenced with conclusions nr: 7, 8, 9, 10, 21, 23, 24, and 31).*
- The three levels of the context, namely macro-level (international arena), meso-level (Republic of South Africa) and the micro-level (South African hospitals) are independent and interconnected. Therefore factors on one level impact directly and indirectly on the other levels. *(Cross referenced with conclusions nr: 14, 20).*

5.4.5 Process description

The process of the theory for authentic leadership embedded in a social capital framework in Nursing Science is described with reference to the tentative model presented in Figure 5.1.

South African hospitals are the predominant context in which this theory occurs. These hospitals are interdependent with the national healthcare sector as well as the international

arena. There are challenges on each level of the healthcare sector that influence these interdependent spheres. From the international arena, the challenges are the shift from an industrial - to a knowledge age characterised by globalisation, advanced technology; capitalism with a consumer society; an ageing workforce amidst staff shortages and increased migration. In the national arena, the present South African socio-political and financial challenges are of great concern. On the South African hospital level, the challenges of the public and private healthcare sectors are experienced in form of resource shortages with a public patient population that are impoverished against a private hospital scenario where healthcare is managed from an economic model.

The professional nurse, employed by South African hospitals, is overburdened and in search of a different type of leader. The professional nurse has obtained the practical and educational capacity to be legally registered to conduct comprehensive nursing within an ethical-legal framework, as part of the health team and through the integration of the professional nurse's roles, that of clinician, educator, advocate, manager, leader and researcher.

The authentic leader in nursing is a person also employed in South African hospitals, who is not dependent upon hierarchy or position to exert authentic leadership. The authentic leader in nursing's authenticity status is ascribed to the leader by her followers according to the behaviours and honest expression exhibited by the authentic leader. The authentic leader knows the purpose of her leadership and pursues this purpose with passion. She is aware of herself and knows herself; she can express herself honestly and remain true to herself. The authentic leader in nursing practices her values and principles, she can lead herself and she maintains a balanced life. People are important to the authentic leader in nursing as her authentic leadership is centered in relationships. The authentic leader in nursing connects with followers and serves followers whilst she inspires, empowers, navigates followers, create values and enhance performance excellence.

The authentic leader in nursing uses the framework of social capital in her connectedness with the professional nurse. This implies that the authentic leader uses bonding, bridging and linking as mechanisms to achieve outcomes whilst it activates potential social capital and accumulates existing social capital. Both the authentic leader in nursing and the professional nurse may have advantages with regard to the access to-, control over – and opportunities to the acquisition of valuable resources.

During this relationship between the authentic leader in nursing and the professional nurse, which is embedded in social capital; trust is restored and enhanced by means of reciprocity. The presence of high levels of trust results in a positive impact on the triple bottom line of the organisation. The positive impact on the triple bottom line of the organisation implies to that the three spheres of planet (environment sphere); people (social sphere) and profit (financial sphere) are equally positively impacted. The presence of trust is the essential link for this theory to work.

5.5 EVALUATION OF THE THEORY

According to Chinn and Kramer (1991:128), the aim of theory evaluation is to establish how this theory works as a means to gain more insight into this theory and to know how to develop this theory further in order to enhance this understanding. Furthermore, theory evaluation can assist to reflect how the theory relates to research, practice and educational activities. In this section, the theory for authentic leadership embedded in a social capital framework in Nursing is evaluated.

5.5.1 Evaluation criteria

Chinn and Kramer (1991:128-129) provided a framework for theory evaluation by asking five fundamental and interrelated questions about the characteristics of the theory. These questions have been derived from a list of authors that provided methods of theory evaluation. As these questions are asked, the evaluator should reflect upon the purposes of the theory. The five questions that are addressed during theory evaluation are: 1) how clear is this theory?; 2) how simple is this theory?; 3) how general is this theory; 4) how accessible is this theory and 5) how important is this theory? Each question is accompanied by a response, which can be viewed as criteria that can be used for theory evaluation. The questions for critical reflection, the criteria for theory evaluation and the application thereof have been listed in Chapter Two (Table 2.8)

Before the theory for authentic leadership embedded in a social capital framework in Nursing Science was submitted to a panel of experts, the researcher conducted a self-evaluation. This self-evaluation can be viewed as Annexure C.

5.5.2 Panel of experts

In the following paragraphs the realisation of the evaluation of the theory for authentic leadership embedded in a social capital framework in Nursing Science, is described.

5.5.2.1 Panel member selection and realisation

As indicated in Chapter Two point 2.5.5, a panel of experts was assigned to conduct a thorough evaluation of this theory according to the criteria for theory evaluation by Chinn and Kramer (1991:128-139). The members for this panel were purposively sampled according to the following inclusion criteria:

- a member should have obtained at least a doctoral degree as a minimum qualification;
- should have expertise in one of the following fields: theory construction and/or leadership and/or social capital;
- must have at least two years occupational experience in theory construction and/or leadership and/or social capital; and
- must be willing to act on the panel and provide written consent for voluntary participation.

From these inclusion criteria six participants (n=6) were selected to act as members. Please refer to Table 5.3 for an outline of the panel members and the representation of the inclusion criteria.

5.5.2.2 Realisation of theory evaluation

The evaluation of the theory for authentic leadership embedded in a social capital framework conducted by the panel of experts is described below. This is conducted according to the criteria for theory evaluation by Chinn and Kramer (1991:128-139).

5.5.2.2.1 Clarity

Clarity as a criterion for evaluation refers to both clarity and consistency. The theory is evaluated with regard to semantic clarity and semantic consistency as well as structural clarity and structural consistency.

Table 5.3 Panel of experts sample representation

INCLUSION CRITERIA	PANEL MEMBERS (n=6)					
	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5	Nr 6
PhD minimum qualification	Yes	Yes	Yes	Yes	Yes	Yes
Area of expertise	Leadership	Theory construction	Theory construction	Theory construction	Leadership	Leadership and theory construction
At least two years occupational experience in theory construction or leadership or social capital	Leadership	Theory construction	Theory construction	Theory construction	Leadership	Leadership and theory construction
Willing to act on panel	Yes	Yes	Yes	Yes	Yes	Yes
Written consent for voluntary participation	Yes	Yes	Yes	Yes	Yes	Yes

- Semantic clarity

Semantic clarity was obtained through provision of all assumptions from the start of this research. The researcher's philosophical position declared the meta-theoretical, theoretical and methodological assumptions. The research remained congruent to these assumptions during the process of theory construction. The assumptions stated can be listed as follows:

- *Meta-theoretical assumptions:* man as a human being, society, health, nursing and nursing science, existentialism and critical social theory.
- *Theoretical assumptions:* theory, authentic leadership, embedded, social capital, framework, Nursing Science, models and theories of social capital and authentic leadership (refer to 1.7.3.3.1).
- *Methodological assumptions:* epistemology.

Two main and four related concepts were identified using the survey list by Dickoff *et al.* (1968:415-435) and the classification of the main and related concepts remained unchanged during the course of theory construction. The main concepts were authentic leadership and social capital. The professional nurse, South African hospitals, positive impact on the triple bottom line and trust were the identified related concepts. The main concepts underwent the

process of concept description, definition and analysis. A theoretical definition and operational definition as well as conclusions were formulated for the main concepts. The related concepts were analysed by means of a literature analysis and conclusions were formulated. The definitions of the main and related concepts remained congruent during the research.

The authentic leader in nursing and social capital are new concepts in nursing science and therefore the definitions of these concepts had to be formulated in such a manner that empirical indicators could be allocated and that contextual meaning could be maintained. During the course of the research the main and related concepts were consistently defined with economy of words.

Five (5) members agreed upon the semantic clarity of the theory. One (1) member reported her uncertainty about the dimensions of the authentic leader in nursing and the professional nurse. The semantic clarity of the research was upgraded to clarify the dimensions of the authentic leader in nursing and the professional nurse. One (1) member of the panel identified the use of specific words that weren't used frequently and that could be replaced.

- Semantic consistency

Six (6) members reported that the criteria for semantic consistency were met. One (1) panel member stated that the essential presence of trust needed for this theory to work, should be stated clearly. The theory was systematically described with specific reference to the assumptions, the main and related concepts, and the definition of each concept, the aim and purpose of the theory, the structure as well as the process of the theory. The main and related concepts were used in congruency of the definition of these concepts as well as the relational meaning between these concepts.

- Structural clarity

According to the panel members (n=6), all agreed that the structural clarity of the theory was met. The main and related concepts as well as the relationships between these concepts and the process were integrated into one structure and into a coherent whole. The researcher used a visual presentation to describe the theory.

- Structural consistency

Six (n=6) members of the panel agreed that the theory complied with the criteria for structural consistency.

5.5.2.2.2 Simplicity of the theory

During the construction of the theory for authentic leadership embedded in a social capital framework, main and related concepts were identified, described, analysed and as applicable, analysed. During the process of statements synthesis, the relationships between the main and related concepts were formulated. Six (n=6) reported that the theory was simplistic enough to comprehend.

5.5.2.2.3 Generalisability of the theory

The generalisability of the theory was confirmed by six (n=6) panel members. The theory for authentic leadership embedded in a social capital framework in Nursing Science is contextual and a middle-range theory. Therefore, this theory cannot be generalised. The context of the theory has been described with regard to the macro-, meso and micro contexts. Through the detailed description of the context, the transferability of the theory was enhanced. The activation of authentic leadership in nursing is dependent upon the intra-personal and interpersonal dynamics of the authentic leader in nursing as well as the situation and relationships in which she is engaged as well as her unique life story. The authentic leader's engagement into a connected relationship is only possible if it is embedded in a social capital framework. The relationship between the authentic leader in nursing and professional nurse has to be reciprocal to restore and enhance trust levels. A trust relationship between the authentic leader and professional nurse is necessary for the outcome of a positive impact on the triple bottom line.

5.5.2.2.4 Accessibility of the theory

The empirical indicators for authentic leadership and social capital were formulated according the preconditions, process and results of these main concepts. The concepts were described and defined and relational statements formulated and will assist in the allocation of empirical indicators. All six (n=6) members of the panel of experts reported that the presence of clear empirical indicators is important.

5.5.2.2.5 Importance of the theory

The importance of the theory for authentic leadership embedded in a social capital framework in Nursing Science was accentuated by all six (6) members of the panel. This importance was especially against the current international-, national and local challenges that impact on the nursing profession. Two (2) panel members confirmed that this theory arrived at a crucial time in history.

5.6 REFINEMENT OF THE THEORY

The theory was submitted to the panel of experts in the form of a tentative visual model. The refinement of the theory implied that the researcher returned to the conclusion- and relation statements and investigate these statements to be clear. The following evaluative feedback from the panel members directed the researcher to adapt into the theory:

- Trust is essential for this theory to work.

The essential presence of trust was elaborated in the description of the theory.

- The dimensions of the authentic leader to be portrayed in the model

The integrated roles performed by the professional nurse received greater attention as well as the intra- and interpersonal process from the inner-self towards the social dimension were added to the visual presentation and clearly described in the theory.

- The use of specific words to be stated in a more concise manner.

The researcher's mother tongue is Afrikaans. English members on the panel provided feedback of more concise English vocabulary which was adapted in the research.

The concepts' definitions, conclusion statements and relational meanings were refined. The tentative model was replaced with the final model in which the feedback of the panel members was portrayed.

5.7 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 were utilised 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.

5.8 GUIDELINES FOR OPERATIONALISATION

The guidelines for operationalisation are divided into three categories, namely the micro -, meso and macro levels. These levels are shortly described, followed by guidelines for operationalisation of this theory.

5.8.1 Micro level guidelines for operationalisation

The micro-level refers to psycho-social dimension of the professional nurse and the authentic leader. The psychological dimension refers to the intra-personal dynamics present within a person. The social dimension refers to the interpersonal dynamics between people. Please refer to Table 5.3.

5.8.2 Meso level guidelines for operationalisation

The meso level refers to the time-spatial context on hospital level and the practice setting in which the authentic leader and professional nurse are occupied with nursing. This implies that hospital factors are taken into consideration in the formulation of the guidelines. The following organisational factors are found on the meso-level:

- Organisational structure.
- Mission and vision.
- Organisational culture and values.
- Organisational governance.
- Specific organisational issues.
- Organisation policies, structures and procedures (decision-making, accountability, communication, information flow).

Please refer to Table 5.4 for the meso-level guidelines for operationalisation of this theory.

5.8.3 Macro level guidelines for operationalisation

The macro-level for operationalisation guidelines refer to the socio-political and national context. The following factors were taken into consideration with regard to the macro-level:

- National social and political climate (democracy and transformation) and rival philosophies.
- Social partnerships and coalitions.
- National health sector and the National Health Plan.
- South African civil society.
- Corporate governance .

The macro-level guidelines for operationalisation are listed in Table 5.5.

5.7 SUMMARY

Chapter Five captured the process of statement – and theory synthesis. Relational statements were formulated and synthesised into a theory for authentic leadership embedded in a social capital framework. A model as a graphic portrayal of the theory and the relational meanings within the theory was designed. The theory was discussed in the sequence of the agent, the recipient, the context, the procedure, the goal and the dynamics. After submitting the theory to a panel of experts for evaluation, the theory was refined. Guidelines for operationalisation on a micro-; meso- and macro level were formulated. In Chapter Six, the theory for authentic leadership embedded in a social capital framework are evaluated by the researcher, limitations are discussed as well as recommendations for nursing science, the nursing practice and – research.

Table 5.3 Guidelines for operationalisation on micro-level

OBJECTIVE	GUIDELINES
<p>MICRO-LEVEL OPERATIONALISATION OBJECTIVE 1:</p> <p>Reciprocal trust relationship between the authentic leader and the professional nurse</p>	<ol style="list-style-type: none"> 1. Relationships between the authentic leader in nursing and the professional nurse are to be seen as a double-sided account into which both the professional nurse and the authentic leader in nursing should invest in order to withdraw. 2. Invest into energy-cumulative relationships rather than wasting energy on negative relationships. 3. Focus more on interpersonal support and intrapersonal and interpersonal performance than position and ranking between professional nurses amongst the health team. 4. Reiterate the importance of supportive trust relationships amongst professional nurses as part of the health team. 5. Establish a caring atmosphere were professional nurses, although working very hard, still enjoy their work. 6. Use effortless and free communication as a mechanism to enhance open and transparent, supportive relations between professional nurses with the health team. 7. Stop the inferiority complex that professional nurses might have as part of the health team and start to focus on self-confidence. 8. Trust to be concretised as an important dynamic that needs to be identified, restored, maintained and enhanced between the authentic leader and the professional nurse. <ol style="list-style-type: none"> a. Training to professional nurses as well as other members of the health team with specific focus on self-trust and organisational trust, the necessity and implications of trust in their working environment and mechanisms to restore, maintains and enhances trust. b. The focus in intrapersonal en interpersonal relationships amongst professional nurses and other should be that of personal accountability to enhance my own trustworthiness.

Table 5.3 continues

	<p>c. Set the norms of the accepted behaviour of professional nurses as integrity, results-focus, capabilities on individual performance and credibility.</p> <p>9. Motivate teamwork that is based on excitement, creativity and that is purposive.</p> <p>10. Employ the importance of active listening as a mechanism to restore, maintains and enhance trust.</p> <p>11. Reinforce with professional nurses the importance of reputation as an important factor in trust relationships. It is not only the nursing profession nor a hospital to have a good reputation as each professional nurse should come to see the importance of their own personal reputation in order to better the reputation of the profession and facilities.</p> <p>12. Stay loyal to a personal zero-tolerance against corruptive behaviour.</p> <p>13. Positive reinforcement for people that stands true to their values and acts with integrity.</p>
<p>MICRO-LEVEL OPERATIONALISATION OBJECTIVE 2:</p> <p>Enhance the intrapersonal dynamics of the professional nurse in order to have relations between him/her and the authentic leader in nursing</p>	<p>1. Focus on truth as an essential factor for healthy interpersonal relations.</p> <p>2. Prevent and manage in burnout amongst professional nurses.</p> <p>3. Performance appraisals should include that the professional nurses take responsibility for personal empowerment.</p> <p>4. Challenge professional nurses to broaden their current dogmatic beliefs.</p> <p>5. Empower professional nurses by means of training to understand the pillars of healthy relationships.</p> <p>6. Mechanisms to establish and maintain personal integration by means of self-awareness, enhancement of self-knowledge, self-evaluation of one's ability of empathy towards others and information on emerged and submerged emotions as part of the self.</p> <p>7. Self-care of the professional nurse as a form of respect to self and others.</p>

Table 5.3 continues

<p>MICRO-LEVEL OPERATIONALISATION OBJECTIVE 3:</p> <p>Enhance the interpersonal relationships between the professional nurse and the health team</p>	<ol style="list-style-type: none">1. The focus in health team collaboration should be on cooperation rather than competition.2. Replace suspicion between team members with trust and respect.3. Activate mechanisms that can assist in the construction of social networks as a measure to enhance the activation and accumulation of social capital.4. Members of the health team to be more humble and to seek win-win relationships
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Table 5.4 Guidelines for operationalisation on a meso-level

OBJECTIVES	GUIDELINES
<p>MESO-LEVEL OPERATIONALISATION OBJECTIVE 1:</p> <p>To establish the current social capital and trusts levels of hospitals</p>	<ol style="list-style-type: none"> 1. Use available tools to assess the social health status of a hospital with specific reference to the trust levels and the present of social capital as well as the status of social capital. 2. Trust can be an abstract theme amongst professional nurses that may provoke emotional reaction. Through training and information, professional nurses can learn to identify behaviours that may build or destroy trust. 3. Hospitals should be evaluated for betrayal-behaviour which should be replaced with trust-building alternatives.
<p>MESO-LEVEL OPERATIONALISATION OBJECTIVE 2:</p> <p>To enhance the level of trust within hospitals</p>	<ol style="list-style-type: none"> 1. Establish a hospital culture of trust whereby credibility and behaviours to enhance organisational trustworthiness is the norm. 2. Activate mechanisms to enhance an organisation's behaviours and in return, increase organisational trust levels 3. Create transparency by not pretending and not withholding information from employees. 4. Value telling the truth even when it implies the potential of disruption and not to tolerate flattering, double-talk or telling half-truths. 5. Value loyalty amongst employees and therefore doesn't tolerate plagiarism, selling each other out, sweet-talk people in their face with bad feedback in their absence and by giving credit to those that deserve it. 6. Admit and also correct mistakes rather than covering up and denying mistakes, problems, and challenges. 7. Establish a culture of respect that should stretch beyond personal gain but to have respect for all levels of employees within the organisation.

Table 5.4 continues

	<ol style="list-style-type: none"> 8. Give responsibility with authority in order to extend trust as visible in symbols of trust in an organisation's policies and procedures. 9. Listens first in order to understand and don't pretend to be listening and to speak first. 10. Clarify the expectations about professional nurses and authentic leaders in nursing. 11. Invest in improvement of hospitals. 12. Invest in efficient financial management. 13. Be realistic about challenges and problems and not afraid to name the real issues. 14. Take responsibility for actions and outcomes and don't blame poor results on others. 15. Investigate the current hospital symbols, structures and systems to establish if these cause high levels of distrust within the hospital. 16. Start with an alignment process to address all the hospital's symbols, structures and systems that increase distrust towards an organisation of trust. 17. Evaluate if a hospital has integrity by establishing if trust, respect and honesty are reflected in the systems and structures of the hospital. 18. Realign policies of distrust in hospitals. <p>Establish if a hospital has a bureaucratic or non-bureaucratic culture.</p>
<p>MESO-LEVEL OPERATIONALISATION OBJECTIVE 3:</p> <p>To enhance the quality of leaders within hospitals</p>	<ol style="list-style-type: none"> 1. Challenge the traditional views of leadership towards the reality of authentic leadership. Leadership should be viewed as a journey and not a destination. 2. A balance between the importance of management and leadership should be present. 3. Place again the focus on personal accountability as part of leadership qualities. 4. Facilitate hospitals leaders to find purpose in their leadership based on their life stories. 5. Focus on the person and not the position, therefore, hospitals should demonstrate openness towards non-traditional manners of leadership styles.

Table 5.4 continues

	<ol style="list-style-type: none">6. Hospitals can return to the basic action of searching for role-model hospital leaders and to ascribe the reasons why leadership was ascribed to them.7. Be actively and consciously involved in the development of authentic leadership in each hospital.8. Hospitals to understand what qualities they bring to leadership and which qualities need to be developed further.9. Reflect on hospitals and leaders that have lost their way over the past decade – then identify why these hospitals/leaders lost their way and how can this be prevented at this specific hospital.10. Through honest self-evaluation, identify if there is signs of derailment in the leadership of the hospital and how this can be prevented.11. Let a hospital list all past difficulties that it had to overcome, how it was overcome and what was the effect thereof.12. List the values, leadership principles and ethical boundaries to direct authentic leadership on a hospital level.13. List important relationship that the hospital share and indicate why these relationships are important and establish a professional support networks.14. Invest in training of hospital management into Level 5 Leadership.
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Table 5.4 continues

<p>MESO-LEVEL</p> <p>OPERATIONALISATION</p> <p>OBJECTIVE 4:</p> <p>To enhance authentic leadership in hospitals</p>	<ol style="list-style-type: none">1. Hospitals to list previous leadership experiences that they are proud.2. Human resources to assist in providing:<ol style="list-style-type: none">a. Sufficient structure in the work environment of the authentic leader.b. Performance appraisals built on actual results with a consequential effect.c. Authentic leadership training and development programmes to the hospital.d. A programme for the identification of authentic leadership amongst all levels of staff.e. A needs assessment process whereby the needs of employees that are potential authentic leaders are identified and an action programme formulated.f. Place greater focus on personal discipline. This implies a wellness programme to be compiled by employees themselves.
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Table 5.5 Guidelines for operationalisation on a macro-level

OBJECTIVE	STRATEGY
<p>MACRO-LEVEL OPERATIONALISATION OBJECTIVE 1:</p> <p>Increased market trust that will influence reputation of South African hospitals positively</p>	<ol style="list-style-type: none"> 1. Activate a program to build the brand of both public and public hospitals aimed to increase South Africans' trust in these organisations. 2. Public and private hospitals should strive to: <ol style="list-style-type: none"> a. Be transparent about specific governance of these organisations for example for public to have full access via the World Wide Web to the financial reports of hospitals and the management of large challenges experienced by these hospitals. b. The experiences, feedback and comments of all consumers of South African hospitals can complete a short evaluation questionnaire during which their trust levels in South African hospitals can be established. c. The national governance of both public and private hospitals to talk straight and honestly about the status of these hospitals. 3. Application of collaborative and conscious effort to change the behaviour of managers and leaders with regard to delivery results. 4. Investigate and amend national symbols of distrust present in the policy, structures and procedures of the national healthcare sector. 5. Organisational and corporate wrongs need to be corrected on national level. 6. Prevent the presence of denying by starting to get real and face reality of the current socio-economic status of South Africa within a global economy.

Table 5.5 continues

<p>MACRO-LEVEL OPERATIONALISATION OBJECTIVE 2: Support for nursing profession</p>	<ol style="list-style-type: none"> 1. The nursing profession to have representation within the Minister of Health's office. 2. Staff retention strategies implemented on a national level to be roll-out to hospitals. 3. Through effective result-based communication, enhance the nursing profession's reputation with the public. 4. National voice for professional nurses as members of the health team without an inferiority complex. 5. Professional nurses trained and empowered to become national leaders and managers. 6. Government and corporate society's declaration of the support towards the nursing profession.
<p>MACRO-LEVEL OPERATIONALISATION OBJECTIVE 3: Corporate governance</p>	<ol style="list-style-type: none"> 1. Social responsibility as a priority amongst South African hospitals groups. 2. Balance auditing and reporting criteria to cover the people, planet and profit spheres of the triple bottom line. 3. Members on national boards to have integrity, intent, capability and results. 4. To display a zero-tolerance against behaviour that decrease trust levels of members of society and investors. 5. Corporate support from private sector to the public sector with regard to technology. 6. Launch national awards and contests whereby authentic leadership, civil society and trust are rewarded with sufficient media cover. <p>Restore and enhance trust, invest in social capital and increase nursing profession's reputation through corporate social responsibility programs aimed at youth, women development, culture, arts, sports, the environment, education and training as well as health.</p>

Table 5.5 continues

<p>MACRO-LEVEL OPERATIONALISATION OBJECTIVE 4: Social capital perspective</p>	<ol style="list-style-type: none"> 1. Focus on social networks with bridging, bonding and linking social capital as a mechanism to meet challenges in the healthcare sector. 2. Private-public partnerships based on a social capital framework. 3. Virtual support groups for professional nurses as well as other members of the health team. 4. A developed social capital policy for the national healthcare sector which includes the public and private hospitals. 5. Promoting in community building through a social capital perspective.
<p>MACRO-LEVEL OPERATIONALISATION OBJECTIVE 5: Enhanced trust levels on a national (societal) level</p>	<ol style="list-style-type: none"> 1. Support and participate in the empowering of existing organisations (private and public) with the aim of teaching these organisations about trust in order to restore and enhance trust. 2. Results communication from healthcare sector to media whereby members of society are informed of the results obtained within nursing apart from continuous negative media coverage. 3. National leadership exhibits their commitment to trust in all spheres namely personal, organisational, market and society. 4. National governance structures to have clear goals and objectives as well as measurement tools.

CHAPTER SIX

EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS FOR NURSING SCIENCE, - PRACTICE AND - RESEARCH

6.1 INTRODUCTION

Chapter Six is a retrospective evaluation of this research. The evaluation includes a critical reflection on the selected research design and – method. Limitations to this research are discussed. Recommendations are formulated for Nursing Science, the nursing practice and nursing research.

6.2 EVALUATION OF THE STUDY

The evaluation of this research is divided into a critical reflection of the central theoretic statement followed by a personal narrative by the researcher.

6.2.1 Central theoretical statement

At the beginning of this research, the researcher formulated the central theoretical statement that will now be used as guideline to evaluate this research. The central theoretical statement was as follows (referred to Chapter One, 1.7.3.1):

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.

- **Identification of main and related concepts**

The main and related concepts were identified according to the survey list by Dickoff *et al.* (1968:415-435). The agent was authentic leadership in nursing and the procedure was social capital. These were the two main concepts. The related concepts were the recipient, namely the professional nurse; the context was South African hospitals, the goal was a positive impact on the triple bottom line and the dynamic was trust. .

- **Comprehensive literature review**

All available national and international literature served as the population. A total of 461 (N=461) literature were investigated. The following summary of the sample size can be provided:

- authentic leadership in nursing n=116.
- professional nurse n=18.
- South African hospitals n=87.
- social capital n=116.
- positive impact on the triple bottom n=73.
- trust n=15.
- **N = 461.**

- **Concept description, definition and analysis**

The main concepts, authentic leadership in nursing and social capital were described, defined and analysed. A literature analysis was done for the related concepts (professional nurse, South African hospitals, positive impact on the triple bottom line and trust).

The concept analysis of authentic leadership in nursing and social capital lead to the formulation of defining attributes (connotations) and empirical indicators (denotations). The defining attributes for authentic leadership were divided as follows:

- antecedents: external causative factors for authentic leadership;
- antecedents: internal causative factors for authentic leadership;
- process of authentic leadership;
- consequences: manifestations of authentic leadership.

The defining attributes for social capital were:

- antecedents: causative factors for social capital;
- process of social capital;
- consequences: manifestations of social capital.

Theoretical and operational definitions were formulated for authentic leadership in nursing and social capital. Literature analysis was done for the four related concepts. Conclusion statements were formulated for the main and related concepts.

- ***Construct relational meaning***

The conclusion statements formulated for the main- and related concepts were used for statement synthesis. A total of 88888 conclusion statements were formulated and relational statements were completed.

- ***Construct a theory***

A theory for authentic leadership embedded in a social capital framework in Nursing Science was constructed. This theory can be categorised as a middle-range theory.

- ***Panel of experts***

A panel of experts (n=6) evaluated the theory according to the critical reflections by Chinn and Kramer (1991:135-136). The panel's feedback was reported and the theory was refined in accordance.

- ***Valuable contribution***

As this theory construction unfolding, the researcher's awareness of intensity of the challenges faced by professional nurses daily grew deeper. By utilising the theory for authentic leadership embedded in a social capital framework in Nursing Science can assist authentic leaders in nursing to lead these challenged professional nurses and a challenged nursing profession.

6.2.2 Personal narrative

The in-depth investigation into authentic leadership in nursing activated self-awareness within the researcher. This led to a personal journey that is presented in a short narrative.

PERSONAL NARRATIVE

This short narrative serves an important overture into this thesis. It is a brief story of the real-life novice managerial and leadership experiences of the researcher that had a direct impact on this research.

Nursing has always been a contradictory theme in my life. A reality where half of myself dreaded the day-to-day duties of a nurse versus the other half, a person with an untamed passion to assist in the life-support of the profession status into an ever-changing future. After initial graduation I set myself out to experience every form of the nursing profession available, and I did. My professional employment history witnessed that of hospitals, communities, administration, the corporate ladder, academics and private practice. I have always been aware that something was lacking in me to take my professional portfolio to a next level rather than a next discipline. As years went by, I became aware that I lacked managerial and leadership ability and that I yearned for an opportunity.

In 2006, I took the road less travelled and embraced the opportunity to manage my own business. This business stimulated my creativity and I felt “ready” for the challenge. I stepped out of the nursing profession into a business-zone, naïve about the painful prospects to be felt.

I started out with a small venture with three staff members. I cannot recall that I did anything more than using common sense and a little bit of managerial teachings. The rest was just hard work, painful mistakes, faith, support from others and the grace of God. As with any start-up business, it soon reached a phase where it occupied my life. It was an all-consuming ‘thing’ and I sometimes dreaded its creation. I often sought wisdom from my husband and business partner, who will calmly confirm to me that the growing pains of a young business and a small company is sometimes unbearable and then he provided the essential news: this is a critical part in the survival of the company – hang in there! ...small words for an intense and life-changing journey. The survival in the business world whilst stemming from “nursing world (a caring world) was very painful.

Within 18 months, the company grew by approximately 20% per month. In February 2008 the company had twenty-five employees and was in the process of black economic empowerment. It was a time of rapid growth characterised by extremely difficult growing pains.

In retrospect, the past 18 months have been some of the most disliked but simultaneously, the most precious months in my life. I became aware of myself, my lack of managerial skills in a time when a good manager was needed. I became aware of my primitive leadership ability based upon theoretical information, in a time when a real leader was needed. I came to see that I really did lack these two aspects in my personal and professional mounting. In a time of continuous and intense exhaustion, I realised that I gained inside into the difficult realities of being a leader and a manager. Whether a nurse or not, these responsibilities remain difficult and complex.

Leadership has always been a passionate theme to me. I tend to believe it is due to my strong conviction to support the maintenance and development of the nursing profession's professional status. Today I can say that I desperately needed a manager, and had to become one. I desperately needed a leader and decided to be the leader myself. The day I realised that I can only give who I truly am, and only if I feel really passionate about the company, I was able to motivate colleagues and employees to share in this passion. In times of exhaustion and uncertainty I could start to say, "I am here, I am holding on strongly, you can too..."

I tasted the lonely and painful, frustrating yet fortunate reality of being a manager. I also tasted the exhausting and frightening yet satisfactory reality of being a leader. And today I feel as if I can say I can be a nurse manager and a nurse leader, or rather, I choose to be. Today I understand why I started with this research in the first place and today I seem to be comfortable to claim that leadership has become an even more important reality to me.

I truly believe that the nursing profession desperately needs more leaders.

I call upon you, member of the nursing profession, to become the leader that the world needs today to ensure survival and growth in a turmoil time. But I have to warn you, it is a status-less, servant position and a humbling experience....

20 February 2008

6.3 LIMITATIONS OF THIS RESEARCH

The following limitations were identified:

6.3.1 The utilisation of the internet and the speed of information

This research was conducted over a period of two years and started in April 2007 until November 2009. A limitation to this research is that search engines, the internet and the speed of information are increasing and therefore there might already be new journal articles available not included in this research.

6.3.2 High purchase prices for articles

A second limitation was the availability of journal articles due to the fact that articles need to be purchased. Membership to the Ferdinand Postma Library of the Potchefstroom Campus of the North-West University enabled the researcher entrance to national and international search engines and advanced search strategies. Access to international-acclaimed search engines does not imply access to research articles, as many articles need to be purchased. The United States Dollar exchange rate against the South African Rand implied that the researcher could not afford all the available articles.

6.3.3 Social capital expert in South Africa

During the purposive sampling of the members to act on the panel of experts for theory evaluation, the researcher couldn't find a social capital expert in South Africa.

6.4 RECOMMENDATIONS

Recommendations are formulated for nursing science, nursing practice and nursing research.

6.4.1 Recommendations for nursing science

The recommendations formulated for nursing science are categorised into authentic leadership, curriculum development and in-service training. These categories are described briefly:

6.4.1.1 Authentic leadership in nursing

- Cultivate a culture of lifelong learning amongst professional nurses as an essential ingredient towards continuous growth which is an essential characteristic of authentic leadership.
- Greater focus on self-discipline as a criterion for authentic leadership.
- Training on authentic leadership with the aim of activating authentic leaders.
- Training on trust in order to restore and enhance trust levels.

6.4.1.2 Curriculum development

Curriculum development pertains to the curriculum as approved by SANC that enables nurses to register as professional nurses (general, psychiatric, community and midwifery) as well as post-basic curriculum:

- Authentic leadership to be added to established curricula with the attention to the intra- and interpersonal dynamics activated when learning about authentic leadership.
- Social capital theory is the second theme that should be introduced into curriculum. This curriculum should aim to introduce social capital to nursing science students and increase their awareness of the types of social capital, the presence of social networks and the results when part of social networks.
- Trust theory is listed as the third theme that should be added into the curriculum with specific focus on i) the restoring and enhancing of trust levels; ii) the essential nature of trust in working relationships and iii) what fosters and what diminishes trust.
- Curriculum on authentic leadership, social capital and trust should integrate the micro-, meso- and macro-levels context.
- Curriculum in nursing science that introduces the impact of globalisation to the healthcare sector and how this phenomenon is changing existing views.
- Policy writing course that introduce the role of policy in trust restoration, social capital and authentic leadership development.

6.4.1.3 In-service training

Professional nurses currently employed in South African hospitals can receive in-service training on the following themes:

- Training on authentic leadership in an attempt to stimulate the emergence of authentic leaders from the nursing practice.

- Training on trust in order to restore and enhance trust levels amongst professional nurses and other members of the health team.
- The essential present of trust in effective working relationships.
- Social capital framework as a mechanism for social support and connected relationships.
- Professional nurses' impact on the triple bottom line.
- Training on policy writing to empower professional nurses to participate in increasing the levels of trust within an organisation.

6.4.2 Recommendations for nursing practice

The following recommendations with regard to the theory for authentic leadership embedded in a social capital framework for the nursing practice are formulated:

- A voice amongst professional nurses employed in South African hospitals to identify authentic leaders amongst them.
- The activation of a "Heart of Nursing" programme that is focused on establishing and restoring nurses passion for nursing.
- A mentoring program where established nurse leaders actively participate in the development of novice leaders.
- Make social networks amongst nurses more concrete by indicating the frequency of and level of contact.
- Utilise bridging and linking social capital as mechanisms to connect nurses with other members of the health team.
- Activate an authentic leadership development programme that is aimed at training all professional nurses with the objective of being a catalyst in the activation of authentic leadership.
- Awareness program amongst healthcare professionals about their responsibility towards the reporting and auditing pertaining to the triple bottom line.
- Activation of a trust program aimed to restore and enhance trust levels between healthcare professionals.
- An information centre that can train and support professional nurses on work-life balance.
- Initiate awareness amongst professional nurses of the interconnected dynamics of global events and national events on healthcare rendered on hospital.
- Activism against a hierarchical organisational structure that is focused on formal authority.

- Establish values of integrity, competence, results and intent amongst healthcare workers.
- Management to engage into leadership development and to have a leadership – management balance.
- Establish and maintain healthy work environments.
- To provide support to professional nurses at present employed in burdened South African hospitals.
- Establish policies in hospitals to support the development of authentic leadership amongst professional nurses.
- Policies that direct the organisational structure, culture and processes to restore and increase trust levels.
- Policies to manage those who breach trust and other expected social norms to activate sanctions that are enacted as a component of an ethical organisation.

6.4.3 Recommendations for nursing research

It is recommended that the following research problems might be meaningful to explore in nursing research:

- The operationalisation of the theory for authentic leadership embedded in a social capital framework.
- How to increase the amount of authentic leaders amongst professional nurses within the nursing profession.
- Trust levels amongst professional nurses in public and private hospitals and how to restore and enhance these trust levels.
- The presence of social networks amongst professional nurses and the impact of these networks.
- South African hospital's trust levels and how to restore/enhance these trust levels.
- Policy research that will enhance trust levels amongst healthcare professionals.
- Policy research about leadership development in the healthcare sector.
- Introduce a policy research tool to establish hospitals' level of social capital, levels of trust and the presence of authentic leadership.

6.5 SUMMARY

The aim of Chapter Six as the final chapter in this research was to provide a comprehensive evaluation of this research. An honest critical reflection of the research was done according to a list of factors that were selected as a framework for theory evaluation. The limitations of the research were investigated followed by recommendations for nursing science, nursing practice and nursing research.

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ANNEXURE A

Tabled and summarised literature review by Covey (2004:352-359) of leadership theories

Table A1 Literature review of all the leadership theories (Covey, 2004:352-359)

Leadership theory	Summary	Year and representative authors
Great-man theories	<ul style="list-style-type: none"> History and social institutions shaped by leadership of great men and women (examples: Moses, Mohammed, Jeanne d'Arc, Gandhi, Churchill etc). "No such thing as leadership by masses. The individuals in every society possess different degrees of intelligence, energy and moral force, and in whatever direction the masses may be influenced to go, they are always led by the superior few." 	Dowd, 1936.
Trait theories	<ul style="list-style-type: none"> Leader endowed with superior traits and characteristics that differentiate him from his followers. Research addressed two questions: What traits distinguish leaders from other people? What is the extend of those differences? 	LL Barnard, 1926; Bingham, 1927; Kilbourne, 1935; Kirkpatrick & Locke, 1991; Kohs & Irlle, 1920; Page, 1935; Tead, 1929.
Situational theories	<ul style="list-style-type: none"> Leadership is the product of situation demands: Situational factors determine who will emerge as a leader rather than a person's heritage. Emergence of a great leader is the result of time, place and circumstance. 	Bogardus, 1918, Hersey & Blanchard, 1972, Hocking, 1924, Person, 1928; H Spencer.
Personal-situational theories	<ul style="list-style-type: none"> Combination of great-man, trait and situational leadership. Study of leadership must include affective, intellectual and action traits, as well as the specific conditions under which the individual operates. Conditions included: personality traits, nature of group and its members, event confronting the group. 	Barnard, 1928; Bass, 1960; JF Brown, 1936; Case, 1933; CA Gibb, 1947, 1954; Jenkins, 1947; Lapiere, 1938; Murphy, 1941; Westburgh, 1931.
Psychoanalysis theories	<ul style="list-style-type: none"> Leader functions as a father-figure: source of love or fear, embodiment of the superego, emotional outlet for followers' frustrations and destructive aggression. 	Erikson, 1964; Frank, 1939; Fromm, 1941; H Levison, 1970; Wolman, 1971.

Table A1 continues

<p>Humanistic theories</p>	<ul style="list-style-type: none"> • Humanistic theories deal with the development of the individual in effective and cohesive organisations. • Human beings are by nature-motivated beings, organisations are by nature structured and controlled. • Leadership is to modify organizational constraints to provide freedom for individuals in order to realise their full potential and contribute to the organisation. 	<p>Argyris, 1957, 1962, 1964; Blake & Mouton, 1964, 1965; Hersey & Blanchard, 1969, 1972; Likert, 1961, 1967; Maslow, 1965; McGregor, 1960, 1966.</p>
<p>Leader-role theory</p>	<ul style="list-style-type: none"> • Characteristics of the individual and the demands of the situation interact in a way to allow one or a few individuals to emerge as leaders. • Groups are structured based upon the interactions of the members of the group, group becomes organised according to different roles and positions. • Leadership is one of the differentiated roles, and the person in that position is expected to behave in a way that differs from others in the group. • Leaders behave according to how they perceive their role and what others expect them to do. • Mintzberg: leadership roles are figurehead, leader, liaison, monitor, disseminator, spokesman, entrepreneur, disturbance handler, resource allocator and negotiator. 	<p>Homans, 1950; Kahn & Quinn, 1970; Kerr & Jermier, 1978; Mintzberg, 1973; Osborn & Hunt, 1975.</p>

Table A1 continues

<p>Path-goal theory</p>	<ul style="list-style-type: none"> • Leaders reinforce change in followers by showing followers the behaviours through which rewards may be obtained. • Leaders also clarify follower's goals and encourage them to perform well. • Situational factors will determine the way leaders will achieve these path-goal purposes. 	<p>MG Evans, 1970; Georgopoulos, Mahoney & Jones, 1957; House, 1971; House & Dessler, 1974.</p>
<p>Contingency theory</p>	<ul style="list-style-type: none"> • Effectiveness of a task – or relations-oriented leader is contingent upon the situation. Leadership-training programs modeled after this theory help a leader identify his/her orientation and to adjust better to the favourability of the situation. 	<p>Fiedler, 1976; Fiedler, Chemers & Mahar, 1976.</p>
<p>Cognitive leadership: Twentieth-century Great-man</p>	<ul style="list-style-type: none"> • Leaders are persons who by word/personal example markedly influence behaviours, thought, feelings of a significant number of their fellow human beings. • Gaining an understanding of the nature of the human minds, both the leader and followers, provides insight into the nature of leadership. • Collins: difference between organisations that produce sustained great results and those that don't are that the great organisations are led by what he calls Level 5 Leaders – those with a paradoxical combination of humility and fierce resolve. 	<p>H Gardner, 1995; J Collins, 2001.</p>

Table A1 continues

<p>Theories and models of interactive processes: Multiple-linkage model, multiple-screen model, vertical-dyad linkage, exchange theories, behaviour theories, communication theories</p>	<ul style="list-style-type: none"> • Leadership is an interactive process. • Theories of leader's initiation structure, the relationship between a leader's intelligence and his or her group's performance, relationship between the leader and each individual rather than the group and social interaction as a form of exchange or behavioural contingency. 	<p>Davis & Luthans, 1979; Fiedler & Leister, 1977; Fuld & Wendler, 1982, Graen, 1976, Green, 1975, Yuki, 1971.</p>
<p>Power-influence: Participative leadership, Rationale-deductive</p>	<ul style="list-style-type: none"> • Participative leadership. • Examines how much power the leader possesses and exerts. • Unidirectional causality. • Participative leadership deals with power sharing and empowerment of followers. 	<p>Coch & French, 1948, Gardner, 1990; Lewin, Lippitt & White, 1939; Vroom & Yettoon, 1974.</p>

Table A1 continues

<p>Attribution, information, processing and open systems</p>	<ul style="list-style-type: none"> • Leadership is a socially constructed reality. • Individual, processual, structural and environmental variables are mutually causal phenomena in leadership studies that is delineating cause and effect among these variables is difficult. 	<p>Bryon & Kelly, 1978; Katz & Kahn, 1966; Lord, 1976, 1985; Lord, Binning, Rush & Thomas, 1978; Mitchell, Larsen & Green, 1977; Newell & Simon, 1972; HM Weiss, 1977.</p>
<p>Integrative: Transformational, values-based</p>	<ul style="list-style-type: none"> • Leaders and followers raise one another to higher levels of morality and motivation. • Followers are assumed to transcend self-interest for the good of the group, consider long-term objectives, and develop and awareness of what is important. 	<p>Bass, Bennis, 1984, 1992, 1993; Burns, 1978; Downton, 1973; Fairholm, 1991; O'Toole, 1995; DePree, 1992, Tichy, Devanna, Renesch.</p>
<p>Charismatic leadership</p>	<ul style="list-style-type: none"> • Leaders possess exceptional qualities as perceived by subordinates. • Leader's influence not based upon authority or tradition but upon the perceptions of his/her followers • Explanations are attribution, objective observation, self-concept theory, psychoanalytic, social contagion. 	<p>Conger & Kanungu, 1987; House, 1977; Kets se Vries, 1988; J Maxwell, 1999; Meindl, 1990; Shamir, House & Arthur, 1993; Weber, 1947.</p>
<p>Competency-based leadership</p>	<ul style="list-style-type: none"> • One can learn and improve critical competencies that tend to predict the differences between outstanding performers (leaders) and average performers. 	<p>Bennis, 1993. Boyatzis, Cameron and Quinn.</p>

Table A1 continues

<p>Aspirational and visionary leadership</p>	<ul style="list-style-type: none"> • Kouzes & Posner: leaders ignite subordinates' passions and serve as a compass by which to guide followers. • Leadership the art of mobilising others to want to struggle for shared aspirations. • Emphasis in the follower's desire to contribute and leader's ability to motivation others to action. • Respond to customers, create vision, energise employees, thrive in fast-paced "chaotic" environment. • Articulation visions, embodying values, creating environment within which things can be accomplished. 	<p>Burns; Kouzes & Posner, 1995; Peters; Waterman, 1990; Richards & Engle, 1986.</p>
<p>Managerial and strategic leadership</p>	<ul style="list-style-type: none"> • Integration between external and internal partnerships. • Drucker: three components of integration – financial, performance and personal. Leaders responsible for performance f their organisation and community as a whole. Fill roles and possess special characteristics. • Kotter: leaders communicate vision and direction, align people, motivate, inspire and energise followers. Leaders are change agents and empower of their people. • Leadership process of giving purpose (meaningful direction) to collective effort, causing willing effort to be expended to achieve purpose. • Effective managerial leadership spawns effective managerial work. • Leadership that is dependent upon time and place, individual and situations are favoured. 	<p>Drucker, 1999; Jacobs & Jaques, 1990; Jaques & Clement, 1991; Kotter, 1998, 1999; Buckingham & Coffman, 1999; Buckingham & Clifton, 2001.</p>

Table A1 continues

<p>Results-based leadership</p>	<ul style="list-style-type: none"> • Ulrich et al: leadership brand that describes distinct results leaders deliver, links results with character. • Leaders have moral character, integrity, energy in addition to technical knowledge and strategic thinking. • Demonstrate effective behaviours that further organizational success. • Leadership results are measurable, can be taught and learned. • Practices: strategy, execution, culture and structure. 	<p>Ulrich, Zenger & Smallwood, 1999; Nohria, Joyce & Robertson, 2003.</p>
<p>Leader as teacher</p>	<ul style="list-style-type: none"> • Establish a "teachable point of view". • Motivating others by teaching stories. • Tichy: effective leadership equates with effective teaching. 	<p>DePree, 1992; Tichy, 1998.</p>
<p>Leadership as a performing art</p>	<ul style="list-style-type: none"> • Leadership is a covert – leaders don't outwardly perform leadership actions. • Leaders perform unobtrusive actions that encompass all the things a leader or manager does. • Metaphors used: orchestra conductors, jazz ensembles. 	<p>DePree, 1992; Mintzberg, 1998; Vail, 1989.</p>
<p>Cultural and holistic leadership</p>	<ul style="list-style-type: none"> • Ability to step outside the culture to start evolutionary change processes that are more adaptive. • Ability to include important stakeholders, evoke fellowship, empower others. • Wheatley's holistic approach: leadership is contextual and systematic. • Create synergistic relationships between individuals, organisations and environment. • Promote learning organisations through adherence to the five disciplines. • Senge: leaders play three roles: designers, stewards, teachers. 	<p>Fairholm, 1994; Senge, 1990; Schein, 1992; Wheatley, 1992.</p>

Table A1 continues

<p>Servant leadership</p>	<ul style="list-style-type: none"> • Leaders lead by serving others (employees, customers, community). • Characteristics: listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to other's growth, community building. 	<p>Greenleaf, 1996; Spears & Frick, 1992.</p>
<p>Spiritual leadership</p>	<ul style="list-style-type: none"> • Involves influencing people's souls rather than controlling action. • Fairholm – leadership involves connecting with others. • Leaders must include spiritual care into their practice. • Leader's influence stems from his/her knowledge of the organisational culture, customs, values and traditions. 	<p>DePree, 1989; Etzioni, 1997; Greenleaf, 1977; Hawley, 1993; Keifer, 1992; J Maxwell, 1989; Vail, 1989.</p>

ANNEXURE B

Approval certificate from the Ethics Committee, North-West University's Institutional
Office



NORTH-WEST UNIVERSITY
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Geagte prof Klopper

GOEDKEURING VIR EKSPERIMENTERING MET MENSE (KWALITATIEWE NAVORSING)

Hiernee wens ek u in kennis te stel dat die projek van mev Petra Bester getiteld "A Theory for leadership development for Nursing Science" goedgekeur is met nommer 07K01.

Gebruik asseblief die nommer genoem in paragraaf 1 in alle korrespondensie rakende bogenoemde projek en let daarop dat daar van projekleiers verwag word om jaarliks in Junie aan die Etiëkkomitee verslag te doen insake etiese aspekte van hulle projekte asook van publikasies wat daaruit voortgespruit het. U sal in Mei vanjaar die dokumentasie hieroor ontvang.

Goedkeuring van die Etiëkkomitee is vir 'n termyn van hoogstens 5 jaar geldig (volgens Senaatsbesluit van 4 November 1992, art 9.13.2). Vir die voortsetting van projekte na verstryking van hierdie tydperk moet opnuut goedkeuring verkry word.

Die Etiëkkomitee wens u alle voorspoed met u werk toe.

Vriendelike groete

ESTELLE LE ROUX
SEKRETARIAAT

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ANNEXURE C

Self-evaluation of the theory for authentic leadership embedded in a social capital
framework according to the criteria for critical reflection
(Chinn & Kramer, 1991:128-139)

Table C1 Self-evaluation of the theory according to the criteria for critical reflection by Chinn and Kramer (1991:128-139)

Fundamental question	Response to question with criteria for theory	Applied evaluation of the theory for authentic leadership embedded in a social capital framework
How clear is the study?	<p>Refers to how well can the theory be understood and consistent are ideas conceptualised. Understandability of the theoretic meaning that relates to the concepts: semantic clarity and consistency. Understandability of the connections between the concepts in the theory: structural clarity and consistency.</p> <p>Semantic clarity (Chinn & Kramer, 1991:130-131) refers to the following:</p> <ul style="list-style-type: none"> • The concepts in the research are clearly defined and empirical indicators can be assigned to definitions. • Definitions in the research have general traits that bring a contextual meaning and richness. • Definitions have also specific traits to bring clarity and accurate direction for the empirical indicators. • Concepts are constantly defined with meanings common to the nursing profession. 	<p>Semantic clarity</p> <ul style="list-style-type: none"> • The main concepts, authentic leadership and social capital underwent a comprehensive concept analysis whereby the connotations and denotations were identified and a theoretical and operational definition was formulated for each concept. • The related concepts (the professional nurse, South African hospitals, a positive impact on the triple bottom line and trust) underwent a literature analysis. Conclusions about each related concept were formulated as well as definitions. • The definitions of the main and related concepts contain both general and specific traits that can add richness to this theory as well as clarity to identify empirical indicators to these definitions. • Social capital is a concept that is predominantly used in socio-economic and political sciences. Through the process of concept analysis, social capital was defined to be useful and have meaning within nursing. Authentic leadership was analysed and a definition formulated as this is a relatively new concept with minor literature in nursing available.

Table C1 continues

<ul style="list-style-type: none"> • No strange or unknown words are used. • There is not an excessive verbiage but an economy of words. • There is not an excessive usage of narrative and examples that can obscure clarity. <p>Diagrams are used to enhance clarity and these diagrams are simple in expression and self-explanatory.</p> <p>Semantic consistency (Chinn & Kramer, 1991:131-132) refers to the consistency in the presentation of the theory and implies the following:</p> <ul style="list-style-type: none"> • The uses of the concepts are consistent with the definition of these concepts. • Keywords are explicitly defined. <p>There is a consistency between the purpose of the theory, the definitions of the concepts and the relationships and the assumptions of the theory.</p>	<ul style="list-style-type: none"> • The utilisation of the concepts are repeatedly positioned in the context of South African hospitals and in relation to the professional nurse in order to enforce these definitions with reference to the nursing profession. • During the concept analysis of authentic leadership, the phrase "integrated balance of being" was formulated to refer specifically to the dynamic intrapersonal process that is conducted within the authentic leader during the development of authentic leadership. Besides this phrase, no strange or unknown words were used. • The researcher's writing style might lack conciseness and there might be verbiage overload. Yet, the goal is to enhance the meaning of the theory, upon which, the researcher might state that it is for the reader to indicate excessive verbiage. • Narrative and examples are directed strictly towards the context of this research. • A variety of diagrams were used to enhance clarity. Diagrams were designed with effectiveness through simplicity in expression and being self-explanatory, as guidelines. Colour was added to diagrams.
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Table C1 continues

	<p>Structural clarity (Chinn & Kramer, 1991:132-133) indicates the understandability of the connections and reasoning of the theory and implies the following:</p> <ul style="list-style-type: none"> • the ability to recognise the underlying conceptual network whereby concepts are organised and interconnected into a coherent whole; and • include all major relationships into one structure. <p>Structural consistency (Chinn & Kramer, 1991:133) refers to the utilisation of different structural forms in a theory. The following characteristic are to be evaluated:</p> <ul style="list-style-type: none"> • the utilisation of one predominant structural form through the theory. 	<p>Semantic consistency</p> <ul style="list-style-type: none"> • The utilisation of the main and related concepts in this research was consistent to the definitions of these concepts. • Keywords were defined during the process of concept – or literature analysis. • The researcher aimed to maintain a consistency between the purpose of the theory (to formulate a theory for authentic leadership embedded in a social capital framework); the definitions of the main- and the related concepts and the relational statements that were formulated between these concepts. <p>Structural clarity</p> <p>As the conclusions of each concept were assimilated into the formulation of relational statements, the researcher aimed to identify and combine all the interconnected relations between the main and related concepts into a coherent whole. The model was used as a diagrammatic summary of all the major relationships that was combined into one structure.</p>
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Table C1 continues

		<p>Structural consistency</p> <ul style="list-style-type: none"> • The model as a diagrammatic presentation of the theory was used as a method to ensure the utilisation of one structure through the theory. • When aspects of the theory or sub-structures in the model were portrayed, the exact structure that was used in the model, was selected.
<p>How simple is this theory?</p>	<p>This refers to the amount of theoretic relationships that are present amongst concepts. Complexity indicates multiple relationships whilst simplicity refers to minimal amount of interrelationships between concepts (Chinn & Kramer, 1991:133-134). The degree of simplicity or complexity is dependent on the broadness of the theory whereby broad theory is applicable to general practice but complex theories enhances the comprehension of complex practice situations.</p>	<p>The theory for authentic leadership embedded in a social capital framework entails both simplicity and complexity in theoretic relationships. Authentic leadership and social capital are two complex and multi-faceted concepts. Multiple relationships surrounding these concepts were valid. The professional nurse, the interdependent levels of the context and trust, were although still multiple in relations, more simplistic than the above noted main and related concepts. The triple bottom line as related concept already implied a interrelated combination of three spheres (profit, people, planet) and this implied complexity due to multiple relationships.</p>
<p>How general is this theory?</p>	<p>Implies the breadth of scope of the theory whereby a theory can be applied to a broad variety of situations or not (Chinn & Kramer, 1991:134-135). The concept's scope and purposes in the theory reflect the generability thereof</p>	<p>Although this research is strictly context-bound, social capital as a phenomenon in the social dimension, and authentic leadership and trust found in the psychosocial dimension are broadly applicable to a variety of situations.</p>

Table C1 continues

<p>How accessible is this theory?</p>	<p>Accessibility refers to the theory's access to identify empirical indicators for concepts as well as the attainability of the theory's outcomes (Chinn & Kramer, 1991:135). The purposive application of the theory as well as the testing and generating of relationships and the clarification of conceptual meaning are mechanisms to enhance the accessibility of the theory.</p>	<ul style="list-style-type: none"> • During the process of concept analysis, the empirical indicators of the main concepts were identified. • Guidelines were formulated for the operationalisation of this theory. • The theory was submitted to a panel of experts to evaluate the accessibility thereof.
<p>How important is this theory?</p>	<p>The importance of the theory implies to the practical value or significance thereof (Chinn & Kramer, 1991:136-137). The characteristics of valuable theories are when the theory is future-focused and when this theory can activate a reality in nursing.</p>	<ul style="list-style-type: none"> • Authentic leadership has been identified as one of the essential criteria for the establishing and sustaining of a healthy work environment by the AACCN (2005:14). • Social capital, an important organisational and managerial tool has been reported by international and national literature. The value of social capital to the nursing profession facing extreme staff shortages and workforce challenges is held within the professional and personal value of the reader. • The nursing profession is in peril, the researcher is of the opinion that this theory is valuable to nursing as it attempts to give direction to the profession. • Although this theory is future-focused, the value thereof is also subjective to the evaluation of the reader and the professional and personal values of the reader.

ANNEXURE D

Theory evaluation package handed to the members of the panel of experts:

- 1) Letter of informed consent
- 2) Example of a user-friendly evaluation package



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8 October 2008

1. LETTER OF INFORMED CONSENT

Informed Consent Form for the members of the Panel of Experts, invited to participate in the evaluation of the constructed theory titled “Authentic leadership embedded in a social capital framework: A theory in Nursing Science”

Petra Bester (PhD-Candidate)

School of Nursing Science, North-West University (Potchefstroom Campus)

Promoter: Prof Hester C Klopper

PART 1: INFORMATION SHEET

1.1 Purpose of the research

The overall aim of the research is to construct a theory for authentic leadership embedded in a social capital framework.

1.2 Type of Research Intervention

This data collection requires that members of the panel of experts will study the constructed theory and evaluate this theory according to specific criteria. Each panel member will receive a pre-compiled theory evaluation package that needs to be completed and faxed to 086 684 8379 by 13 October 2008.

1.3 Participant Selection

Members of the panel have been selected to participate in this research due to the fact that members have expertise in authentic leadership or social capital or theory construction or a strong ability towards logical argumentation. Members with one or more of this expertise and from a professional and personal perspective can provide valuable feedback after the theory has been evaluated.

1.4 Voluntary Participation

Participation as a member of the Panel of Experts is voluntary.

1.5 Procedures

Members will receive a theory evaluation package that will contain excerpts of Chapter Five of the thesis where the theory for authentic leadership embedded in a social capital framework are described. The theory evaluation criteria by Chinn and Kramer (1991:128-139) are provided in this package as well as a pre-compiled theory evaluation report. This report is divided into five sections, namely: Section A: Clarity of the theory, Section B: Simplicity of the theory, Section C: Generality of the theory, Section D: Accessibility of the theory and Section E: Importance of the theory. After these five sections are completed, the report that is a total of six pages, are to be faxed to 086 684 8379, accompanied by the part of this letter whereby signed consent is provided.

1.6 Risks and Discomforts

The anticipated discomfort for participation is that only two calendar weeks are granted for participation, implying that members of the Panel of Experts might experience time constraint-related pressure.

1.7 Benefits

Benefits for participation might be to have input into the review of a constructed theory that might have a valuable impact on the nursing profession.

1.8 Confidentiality

Members' participation and their evaluation feedback will be confidential although the feedback will be discussed in the thesis. Anonymity is respected should members prefer not to add their names to the theory evaluation report.

1.9 Sharing the Results

The feedback of the theory evaluation report package will be analysed and the discussions in the thesis will be forwarded to member of the Panel as soon as the process of data analysis and reporting are finalized. After the thesis is completed, interested members of the Panel can provide their needs for a soft copy.

1.10 Right to Refuse or Withdraw

Members of the Panel can withdraw participation at any stage without discrimination.

1.11 Who to Contact

Petra Bester (PhD-candidate) can be contacted at the following contact details during the process of theory evaluation: 072 756 4886, (office) 016-932 4077, petra@moyen.co.za, (fax) 086 684 8379.

PART 2: CERTIFICATE OF CONSENT

I have read the foregoing information and have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the theory evaluation process at any time without discrimination.

Print name of participant _____

Signature of participant _____

Date _____

Please fax this certificate of consent to 086 684 8379 accompanied by the evaluation package.

Thank you

(This letter of informed consent was applied according to the guidelines provided by the WHO consent for qualitative research template, [http://www.who.int/rpc/research_ethics/ICF-qualitativestudies_for_print.pdf] [Date accessed: 9 September 2008])

THEORY EVALUATION REPORT

A theory for authentic leadership embedded in a social capital framework (P Bester)

SECTION A: CLARITY OF THE THEORY

Refers to how well can the theory be **understood** and how consistent are ideas **conceptualised**. Understandability of the theoretic meaning that relates to the concepts: semantic clarity and consistency. Understandability of the connections between the concepts in the theory: structural clarity and consistency.

Please indicate with a X if met, not met or other and provide comments as applicable

THEORY EVALUATION CRITERIA	COMMENTS			
		Met	Not met	Other
<i>Semantic clarity (Chinn & Kramer, 1991:130-131)</i>				
Concepts are clearly defined and empirical indicators can be assigned to definitions.				
Definitions have general traits that bring contextual meaning and richness.				
Definitions have specific traits to bring clarity and accurate direction for empirical indicators.				
Concepts are constantly defined with meanings common to the nursing profession.				
No strange or unknown words are used.				
Economy of words and not an excessive verbiage.				

No excessive usage of narrative and examples.				
Diagrams enhance clarity and simple in expression and self-explanatory.				
<i>Semantic consistency (Chinn & Papan 1991 131-132)</i>				
Concepts are used consistent with the definition of these concepts.				
Keywords are explicitly defined				
Consistency between the purpose of the theory and the definitions of the concepts as well as the relationships and the assumptions.				
<i>Structural clarity (Chinn & Papan 1991 132-133)</i>				
Recognises the underlying conceptual network whereby concepts are organised and interconnected into a coherent whole.				
Includes all major relationships into one structure.				
<i>Structural consistency (Chinn & Papan 1991 133)</i>				
Utilisation of one predominant structural form through the theory.				

Additional evaluation comments to SECTION A

SECTION B: SIMPLICITY OF THE THEORY

The amount of **theoretic relationships** that is present amongst concepts. Complexity indicates multiple relationships whilst simplicity refers to minimal amount of interrelationships between concepts (Chinn & Kramer, 1991:133-134). The degree of simplicity or complexity is dependent on the broadness of the theory whereby broad theory is applicable to general practice but complex theories enhances the comprehension of complex practice situations.

SECTION C: GENERALITY OF THE THEORY

Implies the **breadth of scope** of the theory whereby a theory can be applied to a broad variety of situations or not (Chinn & Kramer, 1991:134-135). The concept's scope and purposes in the theory reflect the generability thereof.

SECTION D: ACCESSIBILITY OF THE THEORY

Accessibility refers to the theory's access to **identify empirical indicators** for concepts as well as the attainability of the theory's outcomes (Chinn & Kramer, 1991:135). The purposive application of the theory as well as the testing and generating of relationships and the clarification of conceptual meaning are mechanisms to enhance the accessibility of the theory.

SECTION E: IMPORTANCE OF THE THEORY

The importance of the theory implies to the **practical value or significance thereof** (Chinn & Kramer, 1991:136-137). The characteristics of valuable theories are when the theory is future-focused and when this theory can activate a **reality in nursing**.

Dear Panel Member

Thank you for taking the time to complete this theory evaluation report.

Kindly fax the five pages as well as the signed consent letter back to

086 684 8379 (total of 6 pages).

Thank you