THE CASE FOR AN EXECUTIVE COACHING MODEL FOR PRIVATE HEALTHCARE IN SOUTH AFRICA

by

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CHAPTER 1

SCIENTIFIC BACKGROUND AND CONTEXT OF THIS STUDY

1.1 INTRODUCTION AND PROBLEM ANALYSIS

Leadership does not exist in isolation. The leadership context is dynamic and becoming more and more influential as boundaries disappear and global events affect the organisational village.

Leadership is not restricted to the individual anymore, but extends to the context. Within healthcare globally in general and South African healthcare in particular, superlative leadership is required to surpass ongoing challenges from both the political and socio-economic environment (Shisana, 1994). The key to developing such leadership lies within the context and practice of executive coaching (Buys, 2007).

In recent years significant players in the South African corporate arena such as Standard Bank, Old Mutual and Unilever have embraced executive coaching and recognised the value and return on investment that this intervention brings (Rostron, 2006). The return on investment brought by executive coaching to Unilever in South Africa has not been documented, but the return brought to Unilever in North America is well documented (Podolny, 2005). Tertiary Education is recognising the value of executive coaching and including the theory and practice in executive development programmes (Horner, 2006).

The need for coaching or even executive coaching requires empirical research and data to support this form of intervention. Decades of apartheid have denuded South Africans in general, and South African women in particular of their confidence and voice (Akande, 1994). On an individual level, coaching plays a significant role in empowering from within, recognising inherent talent within the personal context and developing that talent beyond the realms of what previously existed. Within the corporate context, executive coaching empowers the individual as well as the team to develop and embrace complex challenges (Alexander, 2005). In the team context, where leadership plays a pivotal role, executive coaching not only empowers the team

but provides the leader with insights in an authentic and dynamic context (Horner, 2006).

The scourge of the human immuno-deficiency virus has taken its toll on human capital in South Africa and no leader is unaffected by it. The permanence of the pandemic continues to raise new and ever more challenging issues for leaders in the healthcare sector. The context provided by a new democracy also introduces challenges for leadership as women and other previously disadvantaged professionals enter the workforce (Brown, 2005). With the release of the World Health Organisation's report on the sustainability and ranking of healthcare in developing nations (2008, 31) the South African Government has placed increased pressure on the private healthcare sector to improve access and reduce the costs of private healthcare. This highly politicised process forces the private healthcare sector to adapt, change and become even more efficient and as a consequence demand a new focus of the leadership (HASA, 2008).

This dynamic context demands a new breed of leader, an all aware and acutely sense leader who responds both to the situation as well as strategically. This new leader is aware of strategic, operational and team dynamics. Intrinsically the new leader is aware of self, and the constraints and strengths that are brought by self as the context shifts.

A number of interventions have been used to develop awareness and to grow the healthcare context. Executive coaching as an intervention remains untapped, providing potentially a wealth of resources personal and professional, perfectly suited to the humanistic environment which is healthcare.

Rostron (2005) asserts that consensus has been reached among practitioners that if coaches are to succeed they themselves need to understand a business or system, as well as a psychological or person-centred point of view. In addition to coaching effectively therefore, the coach must understand the growth and development of adults within a particular work environment. Furthermore coaches must understand intra and inter-personal contexts where social, economic and political realities impact on personal and professional development daily. Underscoring the views of McAlearney (2005) the healthcare context is a good example of this.

As mentioned previously, the South African healthcare environment is highly politicised emanating from the constitutional principle of the access to healthcare being a right and not a privilege. Eighty percent of the population are serviced by the public sector for reasons of economic status (HST, 2005 and WHO, 2008). The public health sector has been plagued by challenges not least the pandemic of HIV/ AIDS. Overwhelming patient volumes have caused many healthcare workers to leave the country and seek employment in developed countries (HST, 2005). Overwhelming volumes have placed stress on under-resourced healthcare systems which in turn have created innumerable challenges for managers and executive teams (Dovey, 2002).

There are constant calls for leaders to motivate their teams (Mbeki, 2007). Motivation stems from self, and if self is not healthy, can self truly inspire others and lead others (Covey, 1990). Leadership and coaching are a function of each other (Hargrove, 1999). Coaching therefore creates the space for dynamism, for inspiration, for change, for development, for motivation and also for organisational growth (Anderson, 2004). This in itself provides the platform as well as the response necessary for addressing the challenges facing both the public and private healthcare sectors.

1.2 LEADERSHIP AND THE SOUTH AFRICAN CHALLENGES IN HEALTHCARE

In the view of Bennis (2002), leadership is a complex process by which people are influenced in order to accompany an objective in such a way that the organisation becomes more cohesive and coherent. A true leader inspires people to achieve and also learns by the experience. By empowering and inspiring others, a true leader gains a following as opposed to imposing control through the use of positional power and merely executing a task. Leadership is based on intuition, and guided by a common vision, strategies, goals and values which people follow through own choice (Jooste, 2003).

Against the South African landscape, leadership now plays an even greater role, given the general economic challenges which South Africa faces as the powerhouse within NEPAD as well as the African continent. Never has the microcosm of leadership in the South African context had to contend with so many external challenges such as

competition for markets, peace-keeping to provide stability within the region, continental poverty, emerging conflict, the pandemic created by the human immuno-deficiency virus, extensive unemployment as well a declining employment rate in the formal sector, and an emerging youth hungry for opportunity following political transformation. Within the organisation itself, leadership cannot ignore issues of equity and transformation, emerging stakeholders from every sphere of community, affirmative action and gender equality, and a strong and knowledgeable consumer voice which challenges service and quality against the backdrop of the best Constitution and a powerful Bill of Rights (Anthony, 2005).

As the milieu that is South Africa changes, leaders will require greater flexibility and have to develop beyond the fear of the unknown. Autocracy will give way to leadership which embraces flexibility, openness, transparency, accountability and communication with all stakeholders. This is evidenced by the shift in the relationship between the custodians of public healthcare and the private sector, made up of private healthcare groups, medical aid funders, medical specialists, pathologists and radiologists (HASA, 2008).

The shifts required are a prerequisite to organisational survival beyond the short to medium term. On a personal level, leaders will be challenged to become reflective and self-critical, to challenge and make changes while responding appropriately (Chapman, 2001). Positional power may all but dissipate, creating an environment fertile for situational leadership and coaching. The values published by the private healthcare sector and publicly lauded will require internalisation at all levels of the organisation, but particularly at that of the executive level.

While all business processes may be managed either well or to the detriment of the organisation, the wellness and morale of the human component will determine the long term future of healthcare in South Africa (HASA, 2008).

Healthcare in South Africa is ready for coaching and more especially executive coaching. Many healthcare professionals are returning to serve in South Africa and are returning fresh and rejuvenated from the international experience (Ncayiyana, 2004). The healthcare professionals who have remained need most of all to be motivated and numerous studies show that remuneration is not the primary driver (Department of Health, 2006). Strong, dynamic and inspirational leadership along

with working conditions conducive to job satisfaction have been identified as the primary drivers.

In the private sector it may appear that conditions are better, although staff turnover rates seem to indicate the contrary (Netcare, 2006). The private healthcare sector has reported good extended after tax profits over the last five (5) year period and continues to show growth despite servicing only 20% of the population. Scheme spend per patient has continued to increase and healthcare groups have diversified, amalgamated and extended services (HST, 2006). As has always been true of the South African private healthcare sector, quality of care is regarded as exceptional and in keeping with the developed world (WHO, 2007). But the challenges for executives in the private healthcare sector have also extended as the challenges from government have increased. If the private sector does not respond and equip its leaders with new skills, its very existence in the South African milieu is threatened (Rostron, 2006).

In that context, this thesis seeks to explore and make the case for executive coaching in healthcare.

1.2.1 The non-governmental (NGO) sector

Non-governmental organisations are a valuable source of complementary healthcare resources in South Africa (HST, 2007). Although the contribution of this sector is not examined in the body of this research for the sake of completeness the sector is discussed albeit briefly.

Typically populated by faith-based and community based organisations, this sector serves an inordinate number of citizens mostly from a foreign funded base (HST, 2006). Created out of necessity to supplement a crippled public sector, such organisations are typically led and staffed by social entrepreneurs (Sunter, 2006). A number of executives in the South African NGO health sector have received pro bono coaching (Koetsier, 2006) to the extent that in the next round of funding proposals from the American government, capacity development through the medium of coaching and executive coaching will be funded specifically to motivate and develop the leadership of 100 PEPFAR (President's Emergency Provision for Aids Relief) NGO partners who enjoy support fro President George Bush's initiatives around the human immuno-deficiency virus in particular (PEPFAR, 2006).

As South Africa transforms, the NGO sector, like all other sectors has also begun to face the same strategic challenges most organisations face as they move through the organisational life cycle (HST, 2006). The struggle mentality while inspiring and creative, has become outdated and modern leadership and business practices are demanded. As donors become more demanding of results for Rands spent, NGO leadership in the healthcare sector in particular is recognising the need to rise to this challenge (Holst, 2006). Coaching in general and executive coaching in particular can provide the context, framework and environment for this change, development and growth (Holst, 2006). The NGO healthcare sector is also largely dominated by women, providing an exciting platform for executive coaching and mentoring to this previously disadvantaged sector of the population (PEPFAR, 2006).

For the purposes of this research executive coaching initiatives conducted in this sector will not be cited, but merely listed as comparisons to initiatives taken within the public and private healthcare sectors where these exist.

1.3 PROBLEM DEMARCATION

1.3.1 Statement of the problem

The South African healthcare sector is characterised by divides, both ideologically, financially and in terms of results. The patient profile served by each component of the sector is clearly identifiable (HASA, 2009).

Today's senior-level healthcare executives have no shortage of challenges to overcome (Hutton & Angus, 2003). Balancing the demands of multiple stakeholders, from patients to medical practitioners to boards, can leave healthcare executives feeling overwhelmed and unable to keep pace with the challenges of a rapidly changing environment. Meeting these challenges demands a unique balance of technical and inter-personal skills, self-knowledge, and the ability to set and meet performance goals. An effective tool available to senior healthcare executives is executive coaching (Buys, 2007).

It remains as to whether executive coaching is appropriate or contextually timeous for private healthcare in South Africa.

1.3.2 Statement of sub-problems

Given the divergence of organisational cultures as well as the objectives of the three (3) healthcare contexts, ie the public, private and non-governmental sectors, the study needed to identify whether executive coaching and a pre-determined model would be appropriate for the private healthcare sector in South Africa.

1.3.3 Operationalisation of research problems

In this study, research would be conducted on the success of executive coaching in South African healthcare, as measured in a sample of managers in the following manner:

i) The manner in which executive coaching had been provided in the private healthcare sector in the 226 private hospitals in South Africa (HST, 2007), across the three (3) major groups – Netcare, Lifehealth and MediClinic as well as the Independents.

(ii) The results of executive coaching interventions in the sectors mentioned above, and specifically whether executive coaching had improved personal leadership performance and/ or organisational performance.

(iii) The value of the conceptual model developed specifically for healthcare.

1.4 DEFINITIONS OF TERMINOLOGY

1.4.1 Leadership

Leadership was defined as lifting a person's vision to higher sights, raising performance to a higher standard, and building personality beyond normal limitations (Drucker, 2006). In any single year in US organisations, 25% to 30% of leaders were in transition and there was very little formal research or theory to support them in these pivotal periods (Wasylyshyn, 2003). Through executive coaching offered within the first 90 days of the new leader's tenure, leaders were encouraged to be more introspective, understand themselves as well as the challenges of the new

position. Within the coaching context, early wins could be secured, success negotiated and alignment achieved with the strategy, structure, systems and skills of the organisation (Wasylyshyn, 2003).

1.4.2 Management

The manager was the dynamic life-giving element in every organisation (Drucker, 1968). The manager was that person that gave direction to all tasks and processes, in turn, inspiring the perpetuation of the organisation (Drucker, 1986). Management in essence involved setting goals and objectives, creating the relevant budget vis a vis the objectives, creating plans to achieve the objectives, organising the implementation of the goals and objectives and then monitoring all the processes described to ensure progress (Kotter, 1996). The divide between management and leadership became clear when dealing with transformation as leaders were central to change (Hattingh, 2005).

1.4.3 Coaching and mentoring

Coaching was distinguished from mentoring in that coaching focussed on enhancing knowledge or a specific skill, while mentoring was the transfer of experience from a mature employee to a less experienced employee in order to develop and grow the mentee's contextual understanding (Meyer & Fourie, 2004).

Jackson (2005) identified three (3) main types of coaching, namely life skills coaching, business coaching and executive coaching. Executive coaching focuses on the interrelationship between professional and personal agendas.

Coaching delivers results as a result of the relationship between the two parties and the means and style of communication used. The material used during the process is generated by the coachee, albeit stimulated by the coach. Coaching is about unlocking potential to maximise performance, but helping the person learn as opposed to teaching them (Whitmore, 2002).

1.4.4 Executive coaching

Executive coaching by contrast to coaching, seeks to align personal and team objectives with strategy and deliver return on investment (Walker, 2004).

Executive coaching addressed winners and superior performers, senior employees seeking an edge or advantage. Executive coaching was about creating the impossible future, not filling gaps in competency. Executive coaching explored powerful new possibilities for leaders and organisations and promised to deliver extraordinary and tangible results, bringing people into alignment with their greatest aspirations, while linking them with the needs of their organisations. Executive coaching transcended the coaching context in preparation for the higher level, including constructs such as emotional intelligence (Hargrove, 1999).

1.5 RESEARCH OBJECTIVES, PROPOSITIONS AND SUPPORTING LITERATURE

1.5.1 Research objectives

The aim of this research was twofold: firstly, to examine the extent to which executive coaching had been provided to the private healthcare sector in South Africa and, secondly, to establish whether executive coaching had improved personal leadership performance and/ or organisational performance. The research was made up of a literature study (Chapters 2 to 5) in the first part, the concept of a model for executive coaching in healthcare in South Africa (Chapter 6), and quantitative and qualitative data collection and analysis in the second part.

The objectives of this research were to answer the following fundamental questions in terms of executive coaching:

i) How had coaching evolved internationally as a discipline?
ii) How had coaching evolved in South Africa?
iii) How had executive coaching evolved and been offered to the private healthcare sector in South Africa?
iv) Was the relationship between leadership and coaching symbiotic or mutually exclusive, and how did management come into the equation?
v) Could an executive coaching model tailor-made for private healthcare in South Africa provide a vehicle for the grooming of potential leaders?

vi) Could an executive coaching model tailor-made for private healthcare in South Africa potentially provide the vehicle for synergies and the growth of the sector?

vii) Was there merit in applying a tailor-made executive coaching model and what will the testing of the model reveal?

viii) Did executive coaching in private healthcare create a positive return on investment?

1.5.2 Propositions

The development of two (2) propositions followed from the literature reviewed and the research undertaken. The consequence of the propositions is discussed within Chapter 8, although the propositions are reflected again for ease of reference in Chapter 7 where the research methodology and data analysis are discussed.

1.5.2.1 Proposition 1

There is a positive improvement in the performance of those leaders who have had coaching at the executive level in the South African private healthcare context.

This proposition was supported by the research conducted by McAlearney (2005) and Sherpa (2009) in the United States. McAlearney (2005) ascertained that executives who had joined the healthcare industry from other sectors considered the industry to be 15 years behind other industries. The outcomes of this research showed that the future presents many opportunities for healthcare organisations in the United States to improve leadership capacity through mentoring, coaching and other leadership development activities (McAlearney, 2005). There was widespread support for the premise that healthcare managers and healthcare executives needed continuous skills development to cope with challenges in that industry (Hartman & Crow, 2002).

The dynamic nature of the industry was particularly challenging and required advanced executive expertise. This was reinforced by the research of McAlearney (2005) and Hartman and Crow (2002) which established that management approaches used by many healthcare organisations lagged behind other industries .

1.5.2.2 Proposition 2

An executive coaching model specific to private healthcare will deliver better outcomes for leaders who have had coaching as opposed to leaders who have not been exposed to a healthcare specific coaching model.

This proposition would be supported by research conducted by Dovey (2002) in the Eastern Cape. The research endorsed the role of leadership coaching based on a specific healthcare orientated model underpinning work-based learning. The study elucidated the political and social context of healthcare, explaining how South Africa's recent history had had a profound impact on the complexity of problems presenting, in particular around human resources.

1.6 METHODOLOGICAL ASSUMPTIONS, METHOD AND EMPIRICAL PROCEDURES

This research was a study in the field of leadership, directed towards the development of systematic knowledge concerning the value of executive coaching in South African private healthcare. The full extent of the research and the methodology deployed is discussed in Chapter 7 of this thesis.

1.6.1 Population, sample and sample size

The Human Resource departments of all private hospital groups and independents would be contacted to firstly secure permission for the research to be undertaken and secondly to establish whether any executive coaching interventions had been launched. In the event of coaching interventions having been implemented, the questionnaire would be sent electronically to the Hospital Managers in that organisation, to establish the extent of the programme as well as the return on investment.

Prior to the electronic distribution of the questionnaire, a pilot study to test the content validity of the questionnaire would be undertaken with the Human Resource Executives of the Netcare Regional Office – Coastal.

A structured questionnaire based on the research objectives would be conducted by email with hospital managers:

- All Hospital Managers of the private sector groups namely
    - Clinix Health Group (four (4) hospitals)
    - Independent (64 hospitals)
    - Joint Medical Holdings (four (4) hospitals)
    - Life Healthcare (56 hospitals)
    - Medi-Clinic (44 hospitals)
    - Melomed (three (3) hospitals)
    - Mining (five (5) hospitals); and
    - Netcare (46 hospitals).

Hospital managers who indicated their willingness to test the integrated model would be interviewed telephonically and hospital managers who had experienced executive coaching would participate in the exercise to determine the return on investment of executive coaching.

- The total sample size was therefore 226 based on the number of Hospital Managers and on the assumption that each hospital only had one Hospital Manager.

1.6.2 Data collection methods and analysis

The data collection methodology as well as tools for analysis are discussed extensively in Chapter 7.

1.6.2.1 Quantitative, qualitative data collection and analysis

The data from the individual questionnaires would be recorded electronically (via email). Interviews would be conducted with the hospital managers who indicated that they wish to be involved in the testing of the integrated model and this data would be transcribed to include all possible context such as setting and social context given the nature of the research. Thick description (Leedy, 1993) would be used to capture imagery, interpretative comment and contextual knowledge given the subject matter and the importance of measuring the relative return on investment both for the subject personally as well as for the organisation.

The qualitative interview would also address the testing of the model so as to answer the remainder of the research questions as listed in paragraph 1.5.1 above.

The research provided the first contribution to knowledge in an academic context as far as any study of executive coaching in healthcare is concerned, the literature study having confirmed that no previous research was undertaken. Not only would a tailor-made executive coaching model be tested in the healthcare environment, but the research would assimilate and integrate the theory available at the time.

1.7 IMPORTANCE OF THIS STUDY FOR BUSINESS LEADERSHIP

Executive coaching is the only tool that provides both the person as well as the organisation with a return on investment. The research conducted as well as the creation of an executive coaching model would be a significant contribution to knowledge as no data or model exist within the sector.

The healthcare sector within South Africa was facing a crisis of leadership (HASA, 2008). The public sector had de-medicalised all Hospital Manager appointments, appointing a large number of previously disadvantaged candidates. For the private healthcare sector, a number of restructuring initiatives had changed the business models of Netcare, Lifehealth and Medi-Clinic Holdings extensively, as all three (3) had entered the international market, following changes to the regulatory framework within South Africa (HASA, 2008). The non-governmental sector had mushroomed as a result of increased donor funding particularly from the American government, creating a surge of growth and no measure of return on investment, either from an organisational or a stakeholder perspective. A reflective executive coaching model would create stability as well as extend return on investment to both individuals as well as organisations in all sectors be they public, private or non-governmental.

Hospital Managers in South Africa faced innumerable challenges from a wide range of stakeholders. The change to disease profiles in South Africa with the hiatus of the HIV/AIDS epidemic manifesting approximately two (2) years ago had also provided challenges in terms of level of care and sustainable financial models (HST, 2007). Legislation governing the pharmaceutical industry continued to provide challenges to the private sector profit model (HASA, 2008). As the government moved to make healthcare more accessible to the majority of South Africans, Hospital Managers and

healthcare executives were under pressure to design, implement and review more cost effective models of care (HASA, 2008).

The number of skilled health professionals who continued to leave the country for the international environment posed an enormous challenge to health sector management who were faced with fewer human resources from within a reduced skill pool (HST, 2007). Aligned with the influx of African nationals into South Africa the challenges of dealing with multi-cultural and diverse workforces continued to increase (HASA, 2008).

Transformation following the legislation of affirmative action and the integration of skills from a diverse cultural pool had not been smooth. Research had demonstrated that high level employees remained constantly sought after and highly mobile raising the need for coaching initiatives (including mentoring) (HST, 2007).

Coaching at the executive level within the healthcare sector could make a significant contribution to sector growth, managing change and transformation, and leadership development. With the implementation of a National Health Insurance model mooted, the integration of the sector from the perspective of both public and private health became critical as opposed to desirable (HASA, 2009).

1.8 LIMITATIONS OF THIS STUDY

The executive coaching field in South Africa is very new and under-developed and very little data existed regarding outcomes or even the description of interventions. Many definitions and constructs were foreign to many executives, making the collection of data very challenging as perceptions of coaching may have clouded the replies provided. Educating hospital managers in these circumstances provided an additional challenge to the outcome of the research.

1.9 LAYOUT OF RESEARCH REPORT

The study consists of 9 Chapters:

- Chapter 1 provides an overview of the topic, formulates the problem, discusses the purpose and scope of the study, the research methodology and the outline of the study.
- Chapter 2 outlines leadership, the organisation and the relationship of both with coaching.
- Chapter 3 describes the history of coaching in South Africa.
- Chapter 4 describes the differences between coaching and executive coaching as well as their different applications.
- Chapter 5 describes the healthcare context vis a vis mentoring and coaching in South Africa.
- Chapter 6 describes the concept of an executive coaching model for healthcare in South Africa
- Chapter 7 describes the research methodology used to gather the data informing the outcomes of the study.
- Chapter 8 describes the findings and recommendations of the study.
- Chapter 9 contains a discussion of the analysis, recommendations and conclusion of the study.

Chapter 2 describes the context within which executive coaching takes place, exploring the role of the organisation. The relationship between leadership and performance is described and developed to explain the meaning and significance of leadership.

CHAPTER 2

LEADERSHIP, THE ORGANISATION AND THE RELATIONSHIP WITH COACHING

2.1 INTRODUCTION

This Chapter seeks to explain the integral and mutually inclusive relationship between leadership and coaching within an organisation. Issues such as the relationship between leadership and performance, leadership styles, value systems and culture are explored and linked.

2.2 RELATIONSHIPS BETWEEN LEADERSHIP AND PERFORMANCE

As early as the 1990s, management theorists began recognising the relationship between managerial attitudes, organisational structure and employee performance (Gibson, Hogetts & Herrera, 1999). The flatter organisational structure with broader spans of control and fewer layers of management was analyzed as well as the relationship between the formal and informal relationships of both employees, technology and structure. Similarly, Gibson et al (1999) laud the work of Worthy in particular as having been a pioneer in bringing understanding to the manager and subordinate inter-relationship dynamic.

In keeping with Gibson et al (1999), Greiner (1998) argued that management practices themselves brought about change as stimulus and events in the organisational environment unfolded. Thus, management problems did not remain on a continuum, but transcended the various growth or retardation stages described. Challenges varied as times changed. What remained constant, however, may have been managerial attitudes and the response of employees to same. Similarly, as an organisation grew, new challenges related to communication and co-ordination emerged.

In support of the arguments of Gibson et al (1999), Sutton (2004) described research conducted by the McKinsey consultancy that asserted that a single study was sufficient proof that any company that managed talent would show superior results in the long term.

In addition to the management of talent, Cyert and Hedrick (2001) described two additional views, namely behavioural and managerial. The behavioural approach made factual analyses of organisational processes which were incorporated into the organisational model, while the managerial incorporated empirical observations of organisational behaviour. The authors questioned, however, whether any organisational theory which dealt with the maximisation of profit or growth alone could be used to describe organisational conditions in deference to actual decision making processes.

2.3 THE DEVELOPMENT OF THE "FIRM" FROM A SINGLE MINDED PROFIT CENTRE TO A DYNAMIC ORGANISATION

Drucker (1987) described the development of the business enterprise away from the traditional view of the "firm" to the evolution to an enterprise. Organisations developed and were no longer run by owners but by shareholders. What in older institutions could be explained as different rules and procedure, became known in the new institution as management.

This institution extended to both the profit and non-profit sectors, even extending into society. Most citizens of the world derived an income as well as status from an organisational association, reinforcing the role of the organisation. Drucker defined new pluralism as multi-dimensional, governmental and non-governmental, providing for all aspects of life in addition to basic needs and services (whether commercially based or otherwise). To survive in this context, management, in turn, had to reconcile concern for the common good with the pursuit of the goals and objectives of the relevant organisation (Drucker,1987). This reconciliation would of necessity include all stakeholders in the management process, while observing job creation and wealth generating capacity. To exercise power legitimately, management had to be accepted as a profession, in the view of Drucker (1987), and work would be needed on the preparation, testing and selection of top management. Once placed, it would be

imperative to monitor and evaluate any management structure in order for credibility to be maintained.

Credibility in this context would extend to corporate social responsibility and would require the organisation to extend beyond the original purpose or motive (profit or non-profit). The challenge posed by the amount of information available and the way in which an organisation responded to this would largely determine success or failure as traditional organisational structure gave way to channels of information and knowledge management. Drucker (1987) argued that the success of management had not changed the work of management, but significantly changed its meaning, making it a distinct and powerful facet of society. As such management in general and leadership in particular could not survive without change and growth. It is argued that coaching provides the context for this growth both individually and from the organisational perspective.

In keeping with the view of Drucker (1987), Morgan (2000) contended that despite how an organisation may have been structured on paper, every stakeholder had an implicit picture of that organisation, in effect a mental image. Not only would an organisation be seen in different ways by one (1) person, but that person may have seen the organisation in different ways in different scenarios. This view gave momentum to a new understanding of the organisation, and in so doing revealed new ways of managing and designing organisations.

Similarly in the view of Mintzberg (1998), as organisations struggled to create organisational capabilities that reflected rather than diminished environmental complexity, good managers would gradually stop searching for the ideal organisational structure to impose on a top down basis. The focus would shift to building up an appropriate set of employee attitudes and skills and linking these with carefully developed processes and relationships. Organisations which had succeeded generally exhibited the following characteristics:

i. A well-developed and communicated, clear and consistent corporate vision.
ii. Effective human resource management systems and tools which served to broaden individual perspectives and develop symbiosis with corporate goals.
iii. Integrated individual and group thinking which supported the organisational agenda.

In keeping with the views of Mintzberg (1998) and Morgan (2000), Drucker (2006) considered the manager to be the dynamic, life-giving element in every organisation. In his view, leadership and management were synonymous, as without leadership, the manager would remain without the necessary resources and would be unable to achieve the goals and objectives of the organisation. The manager was defined as that person giving direction to all tasks and processes, in turn, inspiring the perpetuation of the organisation. Notwithstanding the basic characteristics of the manager, the manager could improve his performance in all areas by way of learning, be it situational, experiential or formal. The processes of coaching in general and executive coaching in particular, lent themselves to the development of new skills and competencies (Alexander & Renshaw, 2005).

2.4 INTRODUCING EMOTION INTO THE WORKPLACE CONTEXT

Fineman in Clegg (1996) postulated that organisational writers had been slow to incorporate the concept of emotion into their thinking, although in his view, the organisation would not exist were it not for emotion. During the course of the text, the various concepts linked to emotion that the leader must consider, will become increasingly clear and will demand consideration. Fineman in Clegg (1996) described the traditional view of the workplace where male Western cultural beliefs were rooted in the belief that organisational order and manager / worker efficiency were rational and in no way linked to irrational or emotional behaviours. It would follow that a well-functioning organisation would be one where feelings were managed, designed out of processes or removed. Organisational theory in this milieu would be comprised of behaviour control and cognitive processes linked thereto. This would be in keeping with the machine-like organisation where uniformity of behaviour was regarded as crucial to the profitable manufacture of goods or supply of services.

Rational assumptions on human conduct continued to shape a whole range of organisational management issues (Clegg, 1996). Human beings would make decisions which would optimise their gains in relation to specific goals. By following a process of careful search and assessment of information, the optimum means to achieving the goals would be adopted. Impulse and emotion would not be part of the process described. Fineman in Clegg (1996) challenged this traditional view, arguing that the emotional challenge to rationality came in three distinct forms:

i. That emotions would interfere with rationality;
ii. That emotional processes could serve rationality; and even
iii. That emotions and cognitive processes were inextricably linked and that rationality was a myth.

Key to interrogating organisational leadership was understanding the wisdom that different perspectives provided. Coaching and executive coaching provided the context for the learning of new behaviours and competencies, linking emotions with cognitive processes (De Haan & Burger, 2005).

2.5 CORPORATE GOVERNANCE AND DIVERSITY

Pfeffer (1996) described how over the past decade, organisations had been seeking economic success, all the while ignoring the organisational culture in favour of seeking solutions to competitive challenges that regarded the organisation as a portfolio of assets that could be traded, outsourced or downsized. In his view, effectively managing people could produce greatly enhanced economic performance. Throughout the course of this thesis, the influence that leadership can have on creating the conditions described by Pfeffer (1996) will be argued, demonstrating the importance of creating, in the first instance, a sound organisational culture.

The alignment described is easier described than accomplished, as Pfeffer (1996) asserted , given that few organisations developed a set of consistent practices. In an environment where corporate social responsibility and sound corporate governance was in stages of infancy, most organisations were, as yet, not culturally mature enough to make changes in their alignment, even when discovered. Although many organisations spoke about trust and included the value in their published set of values (and even reflected trust in their mission statement), few “walked the talk” (Pfeffer, 1996: 100). According to Pfeffer (1996), only a limited few were prepared to evaluate all of their business practices in terms of whether these were consistent with their corporate values.

Pfeffer (1996) used the example of a corporation that, by encouraging creative thinking, brought about the exploitation of a commercial opportunity that resulted in significant profits to shareholders ultimately. On the face of it, there appeared to be little prior review, planning and approval and yet the outcome was exceptional.

2.6 SOLUTIONS TO ORGANISATIONAL PROBLEMS

A new paradigm, which Ackoff (2003) termed synthetic thinking would, in his view, provide greater understanding by thinking about and designing a system that derives the properties and behaviour of its parts from the functions required of the whole. In this way, strategic behaviour starts to develop that would, in turn, influence the functioning and culture of the organisation at all levels. The new paradigm as envisaged by Ackoff (2003) originated from the concept of the learning organisation (Senge, 2000). Based on the work of Senge (2000), Ackoff (2003) reinforced the sentiments of Drucker (2006) by emphasising the need to understand a system as opposed to knowing it in the technical / process sense. The focus lay then with a social system, a community, and with the social strata that may or may not inter-relate. The co-dependency of the various layers of the community would provide opportunities for growth and development for all members if approached with enlightenment. Enlightenment would, in the view of Ackoff (2003), be a product of leadership, forthcoming from inspiration and the pursuit thereof. The leader would produce the vision, inspired through an organic process with clear community involvement. In order to actualise the vision, the leader may or may not draw on his own managerial abilities, drawing on good managers, perhaps, to give effect. The key to formulating effective strategy lay with an understanding of the system and the belief that an organisation had to be continually learning (Senge, 2000).

Understanding of the system was thus developed by looking extrinsically and intrinsically at the organisation and developing a vision within the emerging culture and environment. Following this synthesis, strategy would be drawn to bring the community of the organisation closer to the vision. Coaching tools and techniques applied for the improvement of team and individual performance as well as at executive level would provide the platform for change (Grant, 2003). As such Ackoff (2003), Grant (2003) and Drucker (2006) built on the five (5) disciplines seen as central to the concept of the learning organisation as defined by Senge (2000), namely systems thinking, personal mastery, mental models, building shared vision and team learning.

2.7 LEADERSHIP STYLES DURING TIMES OF CHANGE

McCall (1993) dealt with change and the leadership style or styles necessary to deal with the challenges of change. He listed the types of leaders; transformational, charismatic, inspirational, visionary and empowering and questioned the usefulness of categorising for one or other scenario given the challenges of change. Suggesting a crisis in leadership, McCall (1993) called for closer examination of whether organisations merely did not act on the information available as opposed to a lack of leadership, *per se*. The technical solutions generated by formal planning, forecasting and other managerial approaches had, in his view, failed, further widening the chasm between leadership and management. In the view of McCall (1993) however in keeping with that of Ackoff (2003), it was a given, however, that an organisation would have to be open to recognising leadership talent in this way and then nurturing it. If neglected, this talent would become mediocre, talented individuals would ignore fatal flaws in the organisation's resource base, and earlier mistakes would be compounded.

Leadership, in McCall's view (1993), was not some esoteric characteristic that was acquired at birth. He postulated that leadership could be learnt by developing skills, attitudes and values. While personality traits may assist the learning process and some people may have more potential than others, leadership skills would be learned over time. A leader would still have to learn to direct and align people accordingly, while behaving ethically in terms of recognized principles of governance. The only personal traits that would benefit any leader would be the ability to manage and deal with stress and continually learn. That said, it would be undesirable for a leader to be threatened by ambiguity, to crumble in the face of adversity, or to lose confidence when faced with difficulty (Cope, 2004). Executive coaching would reinforce learning principles, reinforcing and both developing new skills (Cope, 2004).

In describing the activities of the leader, McCall (1993) went on to elaborate on the necessity for direction and described giving direction as being more than simply visioning. McCall (1993) spoke of environmental knowledge and awareness, customer awareness and knowledge and the ability to mobilise people to become aware of the same and then act on dealing with the challenges that arise. The notion that visioning was surreal and unattainable for anybody besides the gifted was deferred as unrealistic. McCall's suppositions (1993) resonated with the coaching dialogues of Whitmore (1996), Alexander and Renshaw (2005), Cope (2004),

Flaherty (1999) and Galwey (2002) who emphasised the ability to develop awareness on all levels through the medium of executive coaching.

2.8 THE ETHICS OF LEADERSHIP AND THE "VALUE" OF VALUE SYSTEMS

Management, in essence, involved setting goals and objectives, creating the relevant budget *vis a vis* the objectives, creating plans to achieve the objectives, organizing the implementation of the goals and objectives and then monitoring all the processes described to ensure progress (Kotter, 1996). The divide between management and leadership, as it were, became distinct when dealing with transformation, as leaders were central to significant change. However, in order to guide change, an organisation needed both leadership and management and the key elements of such a combination were to be found in persons who were trusted by stakeholders at large as well as persons who shared a common goal in this context. Hattingh (2005) affirmed that management should be seen as a job and not as a means to reward individuals by giving status and perks. Leaders, by contrast, had a vision for the organisation and inspire employees. In the view of Hattingh (2005), all managers should be leaders in order for the organisation to flourish. The greatest opportunity, in the view of Hattingh (2005), lay with managers being able to create opportunities for employees to learn.

The European view of governance (Handy, 2002) regarded the organisation as a community, with employees having the right, for example, to have a seat on the Board. In this context, a sense of security and loyalty wass generated which, in turn, also safeguarded the assets of the community. The stakeholders regarded the preservation of wealth as a duty in order for it to be passed to future generations. In the British model there was less transparency and in the view of Handy (2002), this needed to change to be in keeping with governance initiatives worldwide. This could change the perceptions of the general population to regarding management and organisational leadership as ethical, as per the American model.

The American model required that accountability be adopted by all employees, who would, in turn, validate the results of the organisation before presenting same to all stakeholders. The practice of including employees as shareholders would encourage these trends.

Sosik (2005) conducted a study in five organisations to examine linkages between the personal value systems of managers and performance. In effect, positive leadership was inextricably linked to sound values as well as performance. The research indicated that leadership could be linked to performance outcomes and indeed back to values. The ability of a leader to influence others was directly relevant to his value system. Charismatic leaders with strong values (often found within religious organisations) were able to influence behaviour and also determine performance.
Values, in turn, can also be examined during the leadership process and were not confined only to the leader. The study conducted by Sosik (2005) was undertaken within the technology industry, deemed to be more turbulent as a result of the constant change culture.

Behavioural tendencies of charismatic leaders provided inspiration to motivate employees to action, behaving as role models. Charismatic leaders were sensitive to the environment and changes in the environment, were sensitive to unconventional behaviour, took personal risks, and designed and articulated their vision for the organisation. Sosik (2005) examined, in particular, the dimensions of inspirational motivation and idealised influence. Inspirational motivation was defined as involving communicating high performance expectations through projecting a powerful, confident and dynamic presence. Idealised influence was defined as displaying exemplary personal achievements, character strengths and related behaviour, in effect, being a role model for employees. Such styles extended beyond the individualistic corporate model to the altruistic, promoting social and ethical collective action. Both the corporate and the social models resulted in an improved effort toward challenging goals, a more cohesive team, commitment to the vision of the leader, and strong admiration and respect for the leader (Sosik, 2005). The degree to which outcomes were achieved depended on the degree of charisma that the leader displayed as well as his personal value system. Sosik also referred to research that suggested that externally observed values directly affected individual behaviour by encouraging employees to act in accordance with their own values (Sosik, 2005). The charismatic leader would not only project their own values but also observe changes in the environment and respond accordingly to suit the situation. The success of being open to environmental forces would be determined by the extent to which the leader would be open to change and how the leader's traditional value set could be manipulated.

This reinforced the role of a positive and inspirational value system on the part of the leader. High performing managers who were open to change, worked collectively, believed in self-enhancement (openness to learning) and displayed traditional values, would inspire employees to greater performance and, in turn, improved organisational outcomes. Sosik (2005) postulated that future research should examine how cultural differences relate to values and charismatic leadership using a more diverse sample of leaders and employees in various industries and countries. Future research should also in the view of Sosik (2005) examine factors such as stress, organisational culture and organisational structure, in addition to focusing on leadership and values.

Kakabadse, Kakabadse and Lee-Davies (2005) described a leadership process model which describes the differences in approach between visioning and divisioning and how making the choice between the former and the latter may determine outcomes. Kakabadse et al questioned whether visioning was a process or an intrinsic leadership trait, current or futuristic in nature. When defined as an action or process, visioning indicated a sense of the future, as opposed to an analytical activity. The full extent of visioning would involve complete strategic direction and all relevant organisational processes, creating the future, as well as shaping it (Kakabadse et al, 2005).
The ability to create the future was one of seven parts of a great leader in addition to "the strength to surface sentiments, a wisdom for pathways through paradox, a flair to engage through dialogue, a discipline to communicate, a passion for results and staying power" (Kakabadse et al, 2005: 237).

When a leader took responsibility for visioning, he took responsibility for everything that visioning involved, not simply creating strategic direction based on knowledge of the organisation. Kakabadse et al (2005) described the process as definable in terms of charismatic leadership theory. The components of the style would be the communication of the vision and possessing a charismatic personality in order to implement the different processes of the vision. Charismatic leadership was not so much defined by the behaviour of the leader, in the view of Kakabadse et al (2005), but in the perception of charisma and influence held by employees and other stakeholders. Thus, certain defining actions could result in the process being perceived as charismatic and value driven. These actions were:

i. Framing the organisation's mission around appealing goals and values;
ii. Incorporating positive values with anecdotes;
iii. Highlighting key beliefs;

iv. Employing analogies and metaphors when communicating verbally;
v. Experimenting with various rhetorical techniques when communicating; and
vi. Allowing own emotions to surface (Kakabadse et al, 2005).

The successful visionary leader would design the future and the means to getting there while espousing the meaning in terms of human capital and profits continually. The leader would take responsibility for ensuring that each employee derived meaning and moral value for money from the experience. Emotional intelligence on the part of the leader could assist in the process, gaining employee commitment to the cause.

The research conducted aims to make the connections between leadership and the alignment of organisational values and objectives, using the medium of coaching in general and executive coaching in particular.

2.9 DEFINING LEADERSHIP

The most recent definition of leadership within the context of coaching accrued to Magee (2004) who asserted that most leaders were blessed at birth with an active conscience and an active knowledge of right and wrong was present in all positive leaders. Magee (2004) defined a leader as a person for people even though the style of leadership may vary, but where the common thread was the unique ability to see the humanness in each individual, to personally connect, to contribute as well as participate, and to create the space for safety and growth. Magee (2004: 27) drew on the words of Lao Tzu that "As for the best leaders, the people do not notice their existence. When the best leaders' work is done, the people say, 'we did it ourselves'.", and explained that successful teams and organisations worked through a great leader rather than for a great leader. This process was possible (Magee, 2004) because the leader effectively communicated a vision, wisely delegated and inspirationally motivated the team to move as one. The positive leader was distinguished by the process of influence as much as the final outcome (Magee, 2004).

Akin to the view of Magee (2004), leadership was defined based on the capacity of the leader to infuse meaning and impact on performance (Podolny, Kurana & Hill-Popper, 2004). Leadership, according to Mintzberg (2004), stimulated teamwork, was long-term in nature and built trust. Leadership stimulated, set direction, and supported the direction setting of others, leadership provided leadership appropriately.

In the view of Mintzberg (2004), leadership could not be separated from management, and when it was, the result was mundane and un-stimulating in all aspects of organisational existence.

Mintzberg's view (2004) derived from an earlier opinion expressed with Westley (Westley & Mintzberg, 1989), describing the concept of visionary leadership in a manner more suited to strategic management, which was termed strategic vision. Akin to other theorists cited, Westley and Mintzberg (1989) made the assumption that visionary leadership was dynamic as opposed to linear, taking into consideration both content as well as context insofar as product, market, issue and organisation were concerned. The visionary style, however, was not limited to one milieu, but took on the form of a drama, repeating in order to develop strategic perception through practice. By way of representation, the vision was given life, articulated and communicated both verbally and in the actions (non-verbal responses) of the leader. The manner in which the vision was communicated was key as invoking an emotional response created a bridge between the leader and employees, in turn.

2.10 LEADERSHIP AND CULTURE

The dissection of culture became popular in the 1980s, according to Mintzberg (2004), and Goshall (1998). Culture permeated many critical aspects of decision-making and was therefore central to leadership in any successful organisation. To ignore culture was to ensure disaster and Mintzberg et al (1989) describe strong culture, in particular, as deserving of the status of ideology. Strong organisational culture would be rooted in the sense of mission, the traditions and challenges of the entity, and reinforcement through various forms of identification such as branding. As opposed to believing that organisations were driven by product and the processes that determined product, a theory emerged that supported organisations being driven by power. In the view of the authors, such theory began to question the motives for organisational existence and in turn the purpose. Again, the examination of the structure of the organisation became interesting.

Culture, in effect, brought to the surface the emotional part of organisational life (Clegg, 1996). According to Peters and Waterman (1982) the key to corporate success was a strong unified culture. Top managers could build a strong culture by articulating a set of values which were subsequently reinforced by way of formal

policies, informal norms and jargon. Higher commitment would lead to greater productivity and ultimately greater profits.

Central to sustaining the organisation demanded of the twenty first century, would be a permeating culture of leadership, not only at the helm of the organisation, but at every level (Kotter, 1996). Managers themselves would need to develop leadership skills in order to cultivate the learning organisation referred to by many current-day publications. Leaders would be identified, not by the positions that they held, but by their capacity to deal with complex and changing environments on a continuous basis and their skill in advancing organisational transformation. Kotter (1996) referred to leadership habits such as risk taking, humble self-reflection, the solicitation of opinions, careful listening and openness to new ideas.

2.11 WOMEN IN LEADERSHIP ROLES

Specific to the healthcare industry, Robinson-Walker (2004) addressed the challenges for women in leadership roles. In the United States, as late as 1999, women were not present in senior management positions to the extent expected given that 85% of healthcare workers were female. Wirth (2001) established that globally women only made up 20% of the workforce when it came to managerial positions. Fortunately this was not the case in South Africa, where, due to the successful implementation of affirmative action and progressive gender equality policy, women were well-represented at senior management level, particularly in the public health sector (HST, 2007).

The case described in the United States by Robinson-Walker (2004) attributed the absence of women in leadership roles to so-called feminine values of responsibility, connection and inclusion. These traits were in contrast to the traditional leadership model, although not inherently different to modern leadership concepts, as discussed in this paper. The perceived ability of women to consult more extensively, reach consensus and encourage participatory decision-making indicated a movement towards modern leadership traits. Women were perceived to value connectivity and similarity rather than difference, as advocated by men. Robinson-Walker (2004) also examined the communication styles of the sexes, with men generally communicating to conclude tasks and women communicating to fulfil the social-emotional function.

For women, perceived success was based on trust, and communication sustained this feeling.

McColl-Kennedy and Anderson (2005) debated the merits of a recent study that claimed that women leaders placed value on building and developing relationships with their subordinates in order to achieve outcomes. McColl-Kennedy and Anderson (2005) stated that no study to date had indicated either positively or negatively as to whether female managers created organisation-based self-esteem or commitment.

The way that females and males managed differently, had been studied extensively and acknowledged (McColl-Kennedy and Anderson, 2005). Women were generally accepted to be relationship-builders, focusing on mutual empathy and empowerment, as opposed to men, who focused on self-gratification, autonomy, competition and independence. McColl-Kennedy and Anderson (2005) postulated that effective managers did not work in isolation from their employees.

Similarly, specific to the issue of gender and grooming women for leadership positions, Robinson-Walker (2004) suggested that women be actively groomed for leadership positions. Based on the outcomes of the research of Robinson-Walker (2004), women who were extensively mentored were promoted more often and earned higher incomes than their peers. While most mentors were men, men fulfilling this role reported that they were comfortable working with women who were secure in their positions, as they themselves had high self-esteem, professional wives or daughters.

In order to overcome a stereotype of women being less competent and therefore less suited to leadership roles, Robinson-Walker (2004) outlined the attitudes and skills necessary for women to overcome the stereotype:

i. Be competent;
ii. Indicate a comprehensive knowledge of the facts as well as detail;
iii. Be organised, methodical and disciplined;
iv. When delivering work, speak confidently without copious reference to paper;
v. Use language that is authoritative, definite, and articulate well; and
vi. Avoid stumbling over phrases and punctuating by “ums” and “ahs”.

Women in leadership roles succeeded for the reasons described above because they were also able to develop employee competency and build confidence. The gender of the subordinate was, however, important in the discussion and was the focus of the study by McColl-Kennedy and Anderson (2005). The study took the form of a survey of 139 sales representatives of a global pharmaceutical company in Australia, and 98.6% of the candidates responded. The reporting relationships were mixed in terms of gender, and the variables modelled were subordinate-manager gender combinations (gender), leadership style (leadership), experienced frequency of optimism (optimism) and frustration (frustration), organisation-based self-esteem (esteem) and organisational commitment (commitment). The outcomes reflected the lack of a direct relationship between gender and leadership style. What was relevant however, was the gender combination of manager and subordinate as this impacted on other variables.

The most favourable set of probabilities for positive emotions, self-esteem and commitment, were to be found between the female subordinate and the female manager with a transformational leadership style. Without any particular reference to gender, leadership style, frustration, optimism and self-esteem had greater influence on commitment. The study demonstrated that female managers produced the highest levels of optimism in their subordinates, irrespective of gender. The highest levels of frustration were experienced when male subordinates were teamed with male managers. Male subordinates experienced the highest levels of self-esteem when teamed with a female manager. The highest levels of commitment were experienced when the manager was female. McColl-Kennedy and Anderson (2005) recommended that management training focus on developing training programmes that developed so called "female" management qualities like nurturing, relationship-building and being sensitive to the emotional context of the employee. Different gender combinations and leadership styles created different outcomes for the organisation.

In the South African healthcare context, differences identified provide rich material for interaction, learning and growth, particularly in the executive coaching arena (Rosinski, 2003). Participants to executive coaching relationships could be invited to embrace cultural diversity and to leverage cultural differences to the advantage of both the growth of the leader as well as the organisation (Rosinski, 2003). An executive coaching intervention under such conditions would present unique challenges for the coach (Triputti, 2007). These unique challenges would extend to "identity loss" as defined by Carruthers (2007: 8) and stereotyping and "self limiting

beliefs" as defined by Vuocolo (1997) and Akande (1994). The model conceptualised for an executive coaching intervention in private healthcare, and discussed extensively in Chapter 6 makes provision for the identification and resolution of self limiting beliefs when and whether identified in either gender.

2.12 GROOMING LEADERS

While assessing and reassessing the environment and gathering support for organisational processes, an attitude of continuous learning was also crucial (McCall, 1993). This learning would not necessarily take a formal approach, but would be seated in the ability to assess and adapt to changed circumstances, whether by formal or informal processes. It follows then that true leaders would have the attributes to change and adapt as quickly as the context within which they found themselves. Organisations, on the other hand, would identify those with potential and then nurture them carefully in the same way that any precious resource would be nurtured (McCall, 1993).

McCall (1993) suggested that organisations use assignments and projects to nurture and develop leadership so that in "small bites", the organisation would be able to assess the short- and medium-term ability of the leader. McCall (1993) went on to suggest that leaders be selected as role models who would reflect the diversity and change required of the organisation. Learning by example and the ability and freedom to make mistakes would create trust in the approach suggested. In keeping with McCall (1993), Ackoff (2002) suggested a definition of creativity: "Creativity involves a three-step process: identify assumptions that you make which prevent you from seeing all the alternatives; deny these constraining assumptions; explore the consequences of the denials …" (Ackoff, 2002: 5). McCall (1993) and Ackoff (2002) underpinned the principles of coaching in developing leadership skills and competencies.

Similarly Hattingh (2005) emphasised that leadership must create a culture of continuous learning and set the example. The manager should be more like a coach than a person giving instructions, and must encourage people to think creatively. All employees should feel that they have a contribution to make, with the emphasis on teamwork. Part of teamwork would involve sharing knowledge and creating a culture of learning. Learning would involve a two-way process directed between both the

manager and the employee. Task management would be effected simultaneously with relationship management. Consultation was key to ensuring that both parties feel a sense of empowerment and responsibility during the execution of a project (Hattingh, 2005).

2.13 CONCLUSION

Seeger (2003) concluded that the most difficult situations often generated the best leaders, and the quality of leadership in such situations influenced the outcome. In the healthcare industry, in particular, leaders have been chosen on the basis of criteria other than their leadership skills, something that the environment was changing (McAlearney, 2005). Leaders selected for the healthcare industry had to be successful in difficult times (Nwabueze, 2001). Seeger (2003) sought clarity as to what the characteristics of a successful leader were. In doing so, Seeger (2003) examined the roles of the Polar explorers and determined that good leadership made the difference. Preparation through the effective and efficient use of resources paved the way for a "happy" team in the case of Amundsen (Seeger, 2003) as opposed to Scott, who failed as a leader due to poor planning, leaving too narrow a margin of safety and limiting the effectiveness of the team by using poor equipment, methods, and leadership techniques. Shackleton, in the view of Seeger (2003), had been able to keep the team focused, optimistic about survival, and working as a team toward the goal of reaching their homes safely for almost two years when the team was constantly wet, cold, hungry and in imminent danger. Thus, leaders had to be visible and set the example, remain optimistic, but take a balanced view all the same, be fair and minimize status, master conflict and be willing to take risks, all the while building the confidence of the team and not losing sight of the objectives set (Peltier, 2001). Ultimately, the leader had to remember that leadership was a responsibility and not a privilege (Seeger, 2003). The leader was responsible for constantly learning and developing both themselves as well as the team, as well as seeking out new leadership potential.

Leadership skills could be cultivated. Leaders could be groomed by being identified in the first instance by other insightful leaders. For an organisation to succeed an open culture which encouraged learning and innovation was essential. In a symbiotic environment, new leaders would rise to the surface and contribute with ease.

The argument for coaching in general and executive coaching in particular will be made as a certain means by which to cultivate leadership skills and exceptional outcomes.

Chapter 3 describes the history of coaching in South Africa against the backdrop of developments in Europe and the United States.

CHAPTER 3

THE HISTORY OF COACHING IN SOUTH AFRICA

3.1 INTRODUCTION

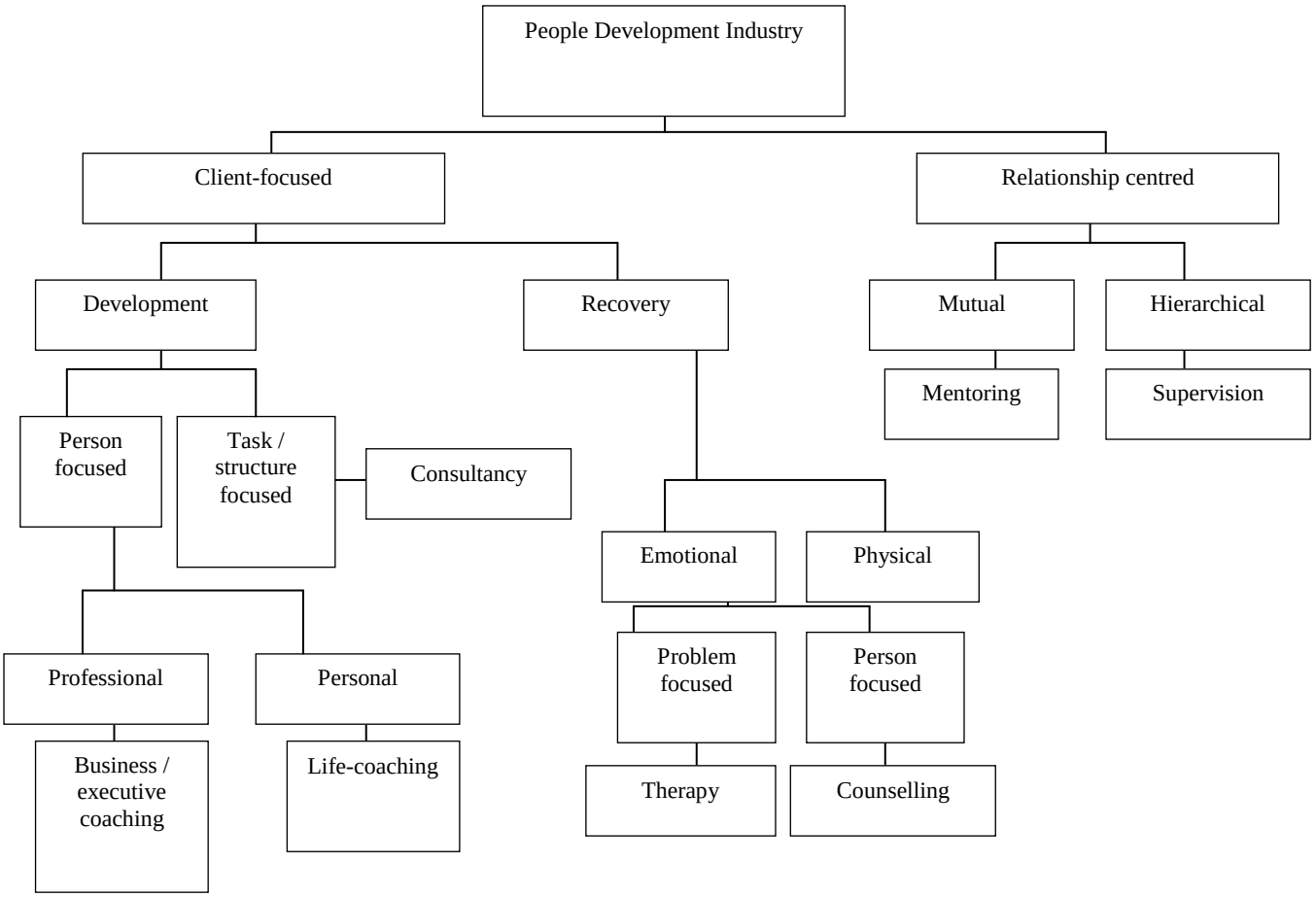
Per Walker (2004), coaching as an intervention started around 1980. This Chapter explores the development of coaching both in South Africa as well as the source of its origins and the association of coaching with other human development interventions. The fundamental differences between mentoring and coaching were also analysed and extrapolated to as far as relevant in the South African context.

3.2 THE EVOLUTION OF COACHING AS A DISCIPLINE

Coaching as a discipline was new in relation to other people development interventions. Coaching per se was drawn from the insights of a range of professionals, psychotherapists, educators, sports coaches and business consultants (Walker, 2004). Akin to the way that counselling developed in the 1960's, the discipline of coaching as an independent intervention emerged in Europe and the United States of America in the 1980's (Walker, 2004).

The diagram below describes how the people development industry has developed and stratifies business/ executive coaching, life coaching, therapy, counselling, mentoring and supervision, in as far as this is possible (Walker, 2004:18).

Figure 3.1 : Inductive classification of people development industry



Source: Walker, 2004:18

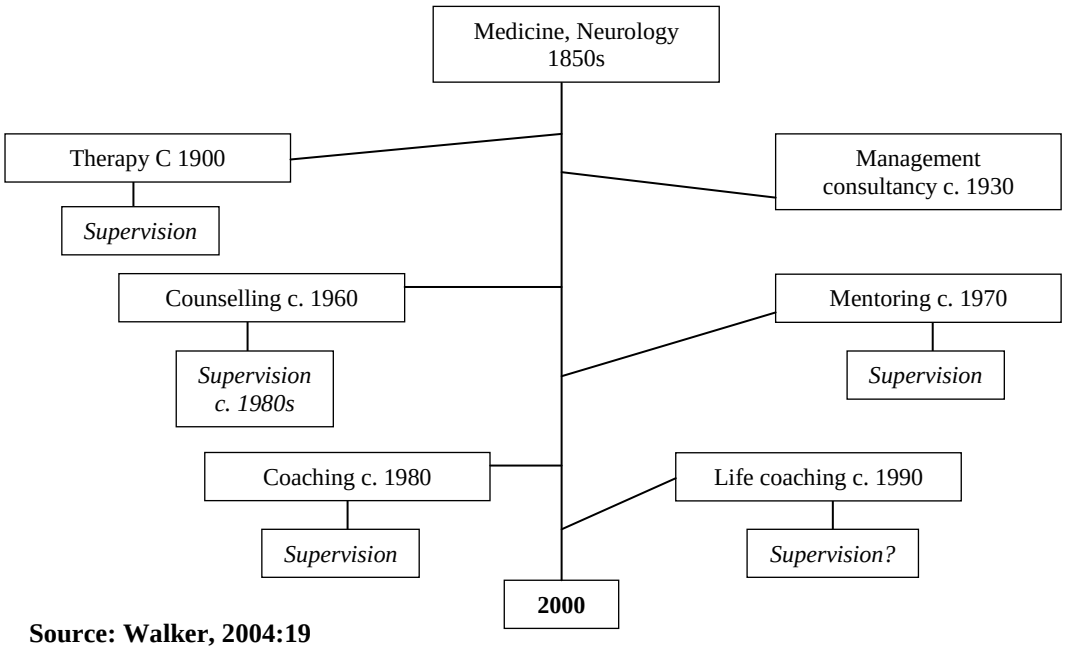
Walker (2004) also provided a useful interdisciplinary model of people development where the innate differences between outcomes orientated foci and process orientated foci were described. This interdisciplinary model provided a useful reference tool for practitioners identifying which intervention would be most appropriate whether in the case of an individual or a team and also at the appropriate level within the organisation.

The tools provided by Walker (2004) formed a critical base from which to assess and create a situational analysis, which was one of the pillars of this research. In assessing the current status of executive coaching in healthcare, the ability on the part of the researcher would be determined by the ability to distinguish between organisational interventions. As such the outcomes would be clear and provide an accurate picture of the status quo in respect of executive coaching.

Walker's model would be used to provide the research participant with insight and the ability to identify clearly which intervention, if at all had been used in that particular set of organisational circumstances.

In Walker's historical classification (2004: 19) provided for ease of reference below, developments were described chronologically ranging from the 1850's and the development of modern medicine to the most recent development which was that of life coaching around 1990.

Figure 3.2: The historical evolution of the various disciplines



Source: Walker, 2004:19

Whereas the older disciplines as described by Walker had been supervised and accredited, coaching remained largely unsupervised and unaccredited in South Africa providing significant opportunity for the professionalisation of the coaching industry in this country (Rostron, 2006).

Rostron (2005) traced coaching back to Aristotle and Socrates but conceded that the coaching terminology originated in the world of sport. Current day coaching had evolved from initiatives driven during the 1970's and 1980's when large organisations began to move away from rigid hierarchical structures to structures and systems which encouraged participation amongst employees and teams (Rostron, 2005). Training focused on teamwork and empowerment was directed at individuals within the organisational context (Rostron, 2005). In the 1990's however, organisations

began to focus on change as well as aligning personal development and growth with organisational change. Organisations had become value and purpose driven as opposed to rule and hierarchy bound, inspiring changes in the interventions also, hence the development of coaching particularly in the South African context. The South African context had created the impetus and opportunity for other forms of change in a number of industries, not least the people development industry given the speed of legislative and political change (Rostron, 2005).

Rostron (2005) asserted that the field of professional coaching emerged as a natural response to the demands and approaches of management of life and business in the 1980's. Similarly, Hudson (1998) described the complexity of society and the rate of change in the 1980's, individuals increasingly asking for help within the organisational context around matters such as:

- personal development;
- career planning;
- transitions and organisational mergers;
- individual and team performance;
- retrenchment and personal marketing following retrenchment;
- stress and burnout;
- leadership training;
- scenario development and building; and
- individual and organisational renewal.

With the reduction in the number of middle managers in the 1970's and 1980's (Hudson, 1998), entrepreneurial leadership influenced and shaped the growing profession of coaching both in the United States, the United Kingdom and Europe. This was also encouraged by the need for a more self-motivated, challenged and imaginative workforce in these countries (Rostron, 2005). Similarly, work with individuals and systems in the late 1980's accelerated a move to corporate coaching (Hudson, 1998). The views of Hudson (1998), and Rostron (2005), resonated with the model of Walker (2004).

During the 1980's employees began questioning organisations about who could be used as a resource during times of personal turbulence and organisations began to recognise the need to support individuals (Van Rensburg, 2005). The practitioner most suited to providing support at this juncture was identified as "the coach".

Coaching was also seen as a method of developing skills and competencies and executive coaching developed from this view in the late 1980's (Van Rensburg, 2005)

3.3 MENTORING VS COACHING – DIFFERENCES AND DISTINGUISHING CHARACTERISTICS

3.3.1 INTRODUCTION

Hughes (2003: 8) postulated that the concept of the mentor appeared for the first time in Homer's "The Odyssey". Homer described in the book how he himself was an old and deeply respected man into whose hands Odysseus had placed the kingdom of Ithaca, while Odysseus went off to fight the war with Troy. The character "Mentor" had the task of raising Telemachus, the son of Odysseus. In the event of Odysseus not returning from the war, Telemachus would become king, and so appeared the first mentor in literature as we know it. In this context, the mentor represented a person in whom trust was placed to hold the space of another. The mentor however was not just a guardian but also a guide who instilled knowledge and provided guidance on a journey to a clearly specified destination. While on the journey the mentor may also have inspired the "student" to reflect inwardly so as to enrich the process. The process then was experiential, and not simply the passing of knowledge from sage to student.

O'Reilly (2008) in current times, explained that having or acting as a mentor in the workplace did not involve an exchange of money. A mentor provided free advice and a relationship based on mutual respect, and could be sought within the particular field or industry.

3.3.2 MENTORING

Hughes (2003) provided clear insight into what mentoring was not. In summary mentoring was not teaching, coaching, being a best friend, or eldering. In the teaching relationship, data and information would be exchanged, but rarely knowledge. In the coaching relationship the coach sought to understand how the coachee learnt, in order to determine whether the coach can add value. A great coach would know that every coachee could not be coached as their own method of

exchanging skills and practices would not meet all learning styles. In the case of the best friend, the relationship was emotional and mutual.

In the mentoring relationship, the mentee's questions formed the basis of the dialogue. Eldering in turn involved a relationship where one person had been granted authority to provide advice and assist with the maturity process. Unlike mentors, elders had responsibilities to a wide number within the "tribe".

Hughes (2003) and Tracey (2008) identified the functions a mentor performed:

1. Asked questions that guided the mentee to the deepest possible learning about themselves and enabled the mentee to set goals.
2. Conducted a dialogue where both parties gained essential knowledge and the mentee was able to overcome obstacles.
3. Required that both parties commenced the work together as apprentices in the Zen context with the "mind of a beginner" (Hughes, 2003: 10).
4. Included the three (3) ways of learning in order to identify the knowledge, skill and expertise required:
    a. Data – Information – Knowledge.
    b. Seeking – Journeying – Listening – Exchanging - Integrating.
    c. Breaking away – Pausing – Integrating.
5. Required that both parties agree how the process would end and discussed issues beyond boundaries. The relationship assumed that when the mentee had found the answers within, the relationship would end.
6. Each party would be able to answer with an open mind as to whether the person was best suited to forming the questions and assisting with the dialogue of the process in order to find the answers that would best enhance self-awareness in the pursuit of happiness.

Similarly, O'Reilly (2008) and Coxon (2008) supported creating a mentoring programme provided the purpose of the programme was understood. Guidelines and membership policies should be understood. O'Reilly (2008) emphasised the voluntary nature of the programme and indicated that the programme should consist of a supportive group of professionals who sought to help others coming into the particular profession. In keeping with the view of Hughes (2003), O'Reilly (2008) emphasised the value of regularly scheduled meetings. The relationships created in the mentoring programme should be fostered by members checking in for feedback.

Mentor and mentee should meet one-on-one and also meet outside of the workplace at industry related functions to share networking opportunities. As in the view of Hughes (2003), O'Reilly (2008) also emphasised the importance of the educational component during the mentoring process.

Tracey (2008 further elaborated on the value of the mentor promoting the concept of borrowing wisdom and in so doing saving years of time of frustration and misguided effort. Tracey (2008) advocated choosing a mentor based on character and competence as well as the willingness of the mentor to assist the mentee in achieving goals.

3.3.3 DIFFERENTIATING BETWEEN MENTORING AND COACHING INTERVENTIONS

Meyer and Fourie (2004: 112) discussed 10 options which clearly differentiated between the two interventions and describe the settings most appropriate to the use of each intervention. Similarly, DeLong, Gabarro and Lees (2008) advocated the use of mentoring to develop talent particularly in professional service firms.

Table 3.3: Application of mentoring and coaching options

Mentoring and coaching options	When to use
Informal mentoring	When the onus is on the mentee to informally select a mentor that s/he could learn from.
Formal mentoring	When you want to use a third party or a mentor to structurally develop an employee for a higher-level position; very appropriate for accelerated development and employment equity
Coaching	When you want to help an individual to develop specific skills to do his/her job better.
Executive coaching	When you want to provide specialist coaching and advice to an executive in order to improve his/her management skills.
Co-active coaching	When a partnership is formed between an individual and a coach in order to develop life and work skills.
Team coaching	When a team needs coaching to improve their teamwork and group cohesion with the aim of performance improvement.
Professional mentoring	When a professional body appoints a mentor to help a mentee to develop in a specified capacity to achieve the professional standards of a

	profession.
Reverse mentoring	When the roles of mentor and mentee are reversed for a specific purpose in order to help the mentor to understand the mentee better; very useful in cross-cultural mentoring relationships.
Multiple mentoring	When a mentee has more than one mentor to help him/her to accelerate development by developing a broader and wider set of skills that cannot be learned from one individual only; very useful for employment equity.
Electronic-supported mentoring	When it is not always possible for the mentor and mentee to meet face-to-face, electronic-supported mentoring can be used; useful when the mentor and mentee are in different locations, even in different countries.

Source: Meyer and Fourie, 2004:112 –113

As in the view of Meyer and Fourie (2004), Delong et al (2008) advocated the use of mentors who were credible and highly respected in the particular industry. The process was also one where the mentee was expected to attract the mentor through their own eagerness to learn as well as track record. Saluzzo (2007) placed as much responsibility on the mentee as on the mentor, vesting responsibility for action with the mentee and emphasising the need to clearly measure goals during the course of the process.

In essence mentoring goes to transferring technical skill whether managerial or task orientated. The depth or efficiency of the skill was dependant on the mentor and the inherent ability of the mentor as far as the skill or knowledge was concerned. The mentor was central to the extent to which the skill was developed as seldom did the skill transfer extend beyond the ability of the mentor. Subsequent to the mentoring intervention, the mentee may develop the skill, but the skill was transferred in the purest sense of the action in this context. The mentor and mentee/ protégée may be similar in their approach to work and learning style. In the case of coaching the ability to develop the skill lay with the coachee. The coach used a process to extract the skill or insight from the coachee or client. The learning style of the coach had to be diametrically opposite to that of the coachee/ client to facilitate the learning and develop the insight required for the process to be meaningful and provide a return for the client. Inherent in both processes were the "helping" component although per the model of Walker (2004) described earlier, the boundaries for the coach were clearly defined and were restricted to development from a detached perspective. The "helping" relationship was restricted to that of empathy.

The process of mentoring then per Meyer and Fourie (2004) was that of transferring and exchanging information over an extended period of time and would be one of a number of tools to aid personal and professional development within the workplace. Mentoring would be value-orientated as well as career-orientated, in order to assist the recipient with progression and development within the particular context.
The mentor could also use coaching techniques to stimulate a change in leadership behaviour on the part of the mentee. Coaching would be provided in this context with due regard to other forms of psycho-social support, such as counselling, support and role modelling (Meyer & Fourie, 2004). The role of the mentee was also crucial, given that the person had to take charge of their own development and also see value in learning from others.

Similarly, Birchfield (2003) defined coaching as equipping the individual to deal with career and life issues, while mentoring assisted executives to solve specific industry or job-related challenges both for the individual and the organisation. Coaching centred on the individual, albeit in the organisational context, providing a tool for understanding and tapping motivation, directing through questioning, but allowing for personal responsibility.

In keeping with the views of Hughes (2003), and Meyer and Fourie (2004), Weafer (2006) intimated that the market determined the difference between mentoring and coaching. In particular, a mentor was hired to pass on particular skills, as opposed to a coach, who was brought in to bring a new perception, allowing more potential to be unlocked and new realisations and insights to be created. A mentor would be involved in transferring job-specific skills or culture-specific knowledge to someone junior who was not in their direct line of management within the organisation. The mentor would have specific knowledge of the role, skills, structure and organisational culture. A coach would not require the same knowledge, but would focus on the client's perception of the challenges being faced. From this perspective, the coach would facilitate the client unlocking their own insights and realisations in order to accomplish more. The coach would focus on the client and the client would focus on the role. True mentoring, in the view of Weafer (2006), was also focused down the chain of command, as opposed to coaching, which could be applied to peers also.

Similarly Hughes (2003), and Meyer and Fourie (2004) defined mentoring as a dynamic and reciprocal relationship in a working environment where a more

advanced and wiser employee assisted a less experienced person with potential to develop in a particular direction. The key elements of the relationship were:

- A dynamic relationship which grew.
- A reciprocal relationship.
- A relationship founded in the workplace.
- The mentor as "wise".
- The mentor assisting the mentee to develop.
- The mentee having the potential to develop.
- The mentor being a third party outside of the normal channel of command.
- The purpose of the development was clearly defined.

3.3.4 ASSESSING WHETHER AN ORGANISATION IS READY FOR A MENTORING/ COACHING INTERVENTION

The culture of the organisation would exert influence over mentoring relationships and hence it was critical that mentoring relationships be openly and clearly defined for the following reasons:

- People would be developed and empowered, which could be threatening to certain sectors of the organisation.
- Mentoring was about change and as individuals within the organisation changed, they could have a wider impact on processes and systems, which the organisation may not be ready for.
- Mentoring and coaching was perceived as a threat or intrusion to decision-making.
- As outcomes were be difficult to predict, uncertainty may create dynamics between teams (Meyer & Fourie, 2004).

The commitment of senior management to the mentoring programme was an essential component in the view of Meyer and Fourie (2004). Meyer and Fourie (2004) also argued that unless the organisation could answer in the affirmative and provide evidence to support the answers to the following questions, the organisation may not be fertile ground for mentoring or coaching interventions:

- "Do your managers believe in mentoring and coaching?
- Do managers understand the difference between mentoring and coaching?
- Are there good role models in your organisation who could be good mentors or coaches?
- Have you attended a conference or workshop on mentoring and coaching?
- What informal mentoring or coaching already occurs within your organisation?
- How successful are the current attempts at implementing mentoring or coaching?
- What are the shortcomings of your current approach to mentoring or coaching?
- Has the decision to adopt mentoring or coaching been taken at a senior management level?
- Has the decision to adopt the programme been clearly communicated throughout the organisation?
- What is the purpose of the mentoring or coaching intervention?
- What would be the benefits of mentoring and coaching for those involved?
- Do your training and skills development programmes have mentoring as a core element?
- Is there support for this programme in terms of time, staff and resources?
- Do you have a mentoring steering committee?
- Is this going to be a once-off or ongoing programme?
- Who are the potential participants?
- Do you evaluate the effectiveness of mentoring and coaching in your organisation?"

In keeping with the view of Meyer and Fourie (2004), Zacchary (2007) defined eight (8) hallmarks of a mentor culture within an organisation.

- That of an organisation which supported accountability and provided a means for providing feedback evaluation and benchmarking. The mentoring programme itself would clarify roles, goals and responsibilities, manage expectations encourage accountability.
- The mentoring programme would be aligned with the organisational culture (values, mission and goals) and not perceived as an extraneous programme based on lip service to development.
- The programme would be designed to identify stakeholders and key messages that should be communicated. Feedback would be invited so

as to determine what was working as well as to ensure a constant flow of information to make improvements.

- People within the organisation itself would be enthusiastic about participating in mentoring relationships. Mentoring per se would be incorporated into the training and development programme and there would be flexibility in the manner in which mentoring relationships were conducted, be they by email, over the telephone or in person.
- As in the case of coaching, confidentiality would be honoured and the participants would have access to psychological counsel.

In conclusion, Ensher and Murphy (2007) described the defining moment in mentoring when the mentor played a key role in a decision impacting on the career of the mentee and indicated that this support was the key to positive learning opportunities.

3.3.5 CONCLUSION

Coaching was concerned primarily with performance and the development of particular skills. The process presupposed that learning objectives had been defined and were relevant to particular situations in the workplace that, by virtue of their nature, provided the opportunity for "real-time" learning.

While coaching provided day to day professional skills in the workplace which may have extended to leadership styles and team dynamics, mentoring provided a medium to long term solution across a pre-determined range of competencies . Coaching was provided on a one to one basis while mentoring may have been provided by a range of appropriate role players. Coaching provided growth for the individual within a particular timeframe and results were measured via the organisational performance appraisal system.

Mentoring created standards and best practice, whilst coaching developed intra-personal competencies. The mentor may have been present for the mentee in a defining moment of their career, whereas the coach would not be physically present.

Differentiating between the interventions of mentoring, coaching and executive coaching was the critical platform. Organisational readiness determined the appropriate intervention/s. While a number of interventions could be used, each had to be appropriate in order to achieve the desired result.

3.4 COACHING IN SOUTH AFRICA

Sievers in McLoughlin (2006) re-emphasised that coaching was a young industry globally, and more particularly in South Africa. The current debate around coaching in South Africa centred around whether coaching was a profession, a set of skills or a form of expertise intrinsically related to other disciplines (McLoughlin, 2006). The debate extended to whether coaching stood independently as a discipline or whether it was directly connected to organisational development, management consulting, leadership development and human resource management. It was argued that all of these assertions were factual making coaching as an intervention significantly powerful and useful both in the personal development context as well as within professional development in an organisation. In industries plagued by stakeholder challenge and strategic disconnect, such as healthcare (McAlearney, 2005), where coaching had not been applied to any significant extent, the question arose as to how the potential of the intervention could be both explored and applied to create value, return on investment and develop people to their fullest potential. The research would seek to answer this question in providing an executive coaching model for healthcare in South Africa, given the "youth and newness" of the intervention in South Africa.

Coaching had in effect integrated a number of models from the psychological, systemic and organisational professions (Walker, 2004). Rostron (2005) while recognising the value of coaching as an independent profession did however acknowledge that while coaching was not psychotherapy, coaching was indeed therapeutic in the vernacular sense, and this could be confusing to both client and practitioner. Coaching also drew on the techniques used by psychotherapists with the distinction being that the techniques were used to develop potential as opposed to treating pathology (Rostron, 2005). Similarly, Sieler (2003) postulated that if coaching was to gain credibility as a profession, it had to be informed by theory. Sieler (2003) advocated the discipline of ontology as a sound substantive theoretical basis for professional coaching, given that the theory and methodology of ontological coaching enabled a coach to observe and work constructively with what were, in the

view of Sieler (2003) the three (3) essential domains for human existence – language, emotions and body.

As opposed to the international context described above, per Rostron (2007), the South African coaching fraternity was divided into three (3) provinces. Coaching was considered more elitist and a developing profession as opposed to mentoring which was practiced across different levels. COMENSA (The Coaching and Mentoring Society of South Africa), a Section 21 Company, which started five and a half years ago (as at 2005), was comprised of stakeholders at different levels, namely corporate, service providers, practitioners and interested parties. In Johannesburg, Standard Bank, ABSA and Pick n' Pay were involved as corporates and participated in setting standards as well as corporate requirements for coaching, in particular executive coaching. The contributions of corporate members filtered through to practitioners and trainers within the South African Region. COMENSA had considered it essential to enlist the contributions of the purchasers of the service. In addition, the Gordon Institute of Business at the University of Pretoria was hosting the various corporate members of COMENSA on a regular basis to interrogate coaching practice and perception in South Africa. Universities such as RAU, WITS, UCT, Da Vinci and Stellenbosch were in discussion with COMENSA via their Business Schools around developing the profession. Through these discussion forums COMENSA was building on what it termed the four (4) pillars of the profession, ie measurable results, value for money, standards and ethics. A common definition of the term "Coach" was also being developed. The profession was also in need of empirical research in order to develop credibility (Rostron, 2007).

Internationally coaching was represented by the EMCC (European Mentoring and Coaching Commission), the Chartered Institute of Personnel, and the Coaching Unit at the University of Sydney. The EMCC enlisted the membership of practitioners only as opposed to COMENSA which enlisted the membership of all stakeholders. In the United States, the International Coaching Federation was working on developing coaching as a profession. The greatest developments in coaching were taking place in Europe (including the United Kingdom), Australia and South Africa (Rostron, 2007).

In South Africa, COMENSA organized a coaching event for members every second month, to build best practice. Various sub-committees of COMENSA worked on issues such as:

- a moral and ethical code;
- research and definitions;
- supervision;
- corporate governance; and
- standards and criteria for continuing professional development (Rostron, 2007).

In the South African context, the marketplace was demanding criteria for coaches as well as requirements pertaining to the continued professional development of coaches. Three (3) other organisations in South Africa were also working towards developing coaching as a profession, namely the Association of Psychologists, the South African Council for Coaching (Johannesburg based) and the UCT (University of Cape Town) Centre for Coaching (Rostron, 2007).

COMENSA was currently working with Colleges of Further Education and Training as well as the Coach Trainers Association of South Africa to develop an NQF (National Qualifications Framework) framework for accreditation with the SETA (Sector Education and Training Authority). COMENSA was also encouraging diversity amongst the local membership to draw on the experiences of other racial groupings, based on the largely Eurocentric approach imported into coaching. The possibility of training new managers to work inside organisations as coaches within the "Manager as Coach" model was being investigated by COMENSA and also supported the drive to encourage greater participation in the Body. COMENSA encouraged the use of the scientist practitioner model as advocated by David Lane, whereby intellectual capital was developed. The development of the model was explored in July 2007 in New York when the World Council of Personnel Bodies met to create a group of themes that needed to be researched in order to develop coaching as a profession. Following the New York Convention, White Papers were developed and presented in Dublin in 2008 in a collaborative process in order to build consensus through scenario planning. Scenarios were built around neuro-linguistic programming (NLP) and all variants of coaching from life coaching through to executive coaching (www.coachingconvention.org) (Rostron, 2009). This had assisted in the South African credentialing process which COMENSA had been undertaking.

3.5 COACHING IN SOUTH AFRICAN CORPORATES

There was no empirical data regarding the implementation or outcome of any coaching interventions. The extent to which executive coaching had been implemented within the corporates would be described with reference to the interventions of Standard Bank, Old Mutual and Unilever. There was no data available regarding a coaching intervention in any healthcare facility besides that of Dovey (2002) which involved a team coaching intervention in the primary healthcare setting of the Eastern Cape Province Public Sector.

3.5.1 Coaching at Standard Bank

Horner (2006) described the intervention deployed by Standard Bank. Standard Bank began designing a solution to address the challenges faced in 2005 under the leadership of Dolny and Saley (Horner, 2006). The turn of the millennium raised a number of concerns within Standard Bank. When the Bank successfully defended a hostile takeover, it was discovered that the leadership profile was perceived to be traditional, rigid and instructional. A 360 degree leadership development assessment of senior leaders was undertaken and the perception confirmed. An audit of people development interventions at Standard Bank revealed that leadership development was taking place on an ad hoc basis, coaches were being hired without reference to any framework. The Bank was faced with expediting the promotion of young Black managers in order to fulfil constitutional imperatives along with commitments made in the 2003 Financial Sector Charter (Horner, 2006). Recognising the need to invest in employees to resolve the problems being faced, the Bank made two (2) decisions which would ultimately result in a comprehensive coaching and mentoring framework. The mentoring framework would be available at all levels of the organisation, while the coaching framework would be based on a three-tiered system as proposed by Horner.

The three-tiered coaching framework would effectively function as follows:

- On-the-job performance coaching would be available to all those who carried out performance appraisals. The nature of such coaching would be skills orientated and more directive.
- Team coaching, training in the delivery of coaching tasks for managers and peer coaching training would be delivered after the model of

Nancy Kline's Thinking Partnerships (Kline, 1999). Such coaching would be directed at building cultural and organisational alignment.

- Leadership development would be honed through executive coaching. Requiring greater skill of greater complexity, such coaching would be directed at outcomes such as leadership competencies and behavioural change.

The Standard Bank Coaching and Mentoring Framework was launched as recently as July 2006, indicating the stage at which executive coaching was (Horner, 2006).

3.5.2 Coaching at Old Mutual

In the case of Old Mutual, one of the largest insurance companies in South Africa and one of the largest financial institutions in the world (Horner, 2006), 120 leaders from the Employee Benefits team were invited to participate in a coaching initiative in order to secure meaningful organisational culture change in 2005. Participation was voluntary and 86% of the leadership took up the coaching initiative. Feedback received from the Old Mutual process highlighted that executive coaching was an effective process for developing new leadership behaviours. Within the context of a high performance culture, the development of high performance leadership capacity was critical. Coaching was therefore a critical success factor for the Old Mutual change programme and one of the cornerstones of the organisation's new economy leadership (Horner, 2006).

3.5.3 Coaching at Unilever

In the case of Unilever, a Fast Moving Consumer Goods corporate, coaching and executive coaching had been introduced initially in the business outside of the African operations in the late 1980's. In subsequent chapters the use of executive coaching in Unilever North America is discussed in relation to the way in which same was used to effect integration post a merger with Best Foods. In the South African business however, coaching was used from the early 1990's to realign skills and attitudes post restructuring (Wilkins, 2006). As opposed to Standard Bank where a unit was designated to implement coaching, Unilever engaged the services of Hay, an international consultancy based in London, United Kingdom. Hay launched the initiative and monitored same both locally and in other Unilever African operations.

Capacity built in the local operation was subsequently used for local executives either facing retrenchment, redeployment or re-skilling.

3.5.4 Corporate coaching in South Africa in summary

In summary, executive coaching had been approached from different angles by corporate South Africa, sometimes from the perspective of an internal service provider, but in the case of the corporates described, using external expertise co-opted through a structured intervention with specified outcomes such as organisational alignment and culture change.

3.6 EXECUTIVE COACHING IN HEALTHCARE IN SOUTH AFRICA

Executive coaching had been a once-off experience for Hospital Managers within Netcare (Pty) Ltd. Netcare initiated an executive coaching programme as part of their leadership development programme in 2005 with the plan being to develop internal coaches (Rostron, 2006).

As discussed in the Chapter on coaching per se, the work of Dovey (2002) was the only data recorded within the healthcare sector.

This research would seek to construct empirical data for the healthcare industry and build a model for executive coaching in healthcare in South Africa. Building on the argument of Meyer (2006), coaching skills would be critical for any leader to thrive in a knowledge age where constant learning was imperative. It was widely acknowledged (Rostron, 2006) that the traditional model of healthcare where the leader directed and the employee followed would not produce successful outcomes for the organisation. In the new healthcare paradigm, employees and leaders were partners who shared in the discussion, analysis and solutions to bring about strategic change resulting in organisational success.

3.7 CONCLUSION

Coaching in general and executive coaching in particular created the context for conversations of immense potential. In the ensuing chapters it will be argued that

leadership and coaching are symbiotic processes, each providing for the other. The doyennes of coaching inter alia, Whitmore (2002), Walker (2004) and Alexander and Renshaw (2005) purported that coaching was about unlocking potential to maximise performance, growing both the leader as well as the organisation simultaneously. These symbiotic processes created the context for organisational development and successful outcomes for the sector.

A groundbreaking McKinsey study conducted in 1997 identified the war for talent and the changing world of work where employees chose their employers and not *vice versa*. In the healthcare industry in particular, global trends had shown that health professionals were choosing their employers and that the race to be the employer of choice was on. The McKinsey research showed that an organisation that invested in developing its talent was employing a key factor for success, in the absence of this approach, the best and brightest went elsewhere (Alexander & Renshaw: 2005).

Chapter 4 describes the difference between coaching and executive coaching and the relative application of each in the corporate environment.

CHAPTER 4

EXECUTIVE COACHING AND COACHING – DIFFERENCES DEFINED

4.1 INTRODUCTION

Executive coaching and coaching, in order to be effective, had to be applied in direct relation to the need identified. The "diagnosis" of the need for the intervention had therefore to be accurate and appropriate for the greatest value to be secured. This Chapter addresses the fundamental differences between the interventions of executive coaching and coaching. Once the differences were defined, the various applications were detailed to provide guidance to the coach in the appropriate context.

Following the hierarchical nature of the organisation, coaching is described first, followed by executive coaching. In essence, coaching was applied before the executive level hierarchically (Buys, 2007).

4.2 COACHING FROM THE MANAGERIAL PERSPECTIVE

The Harvard Management Mentor Guide (2004) described coaching as an opportunity to contribute to another person's development, an opportunity which would present as a matter of course for any manager, once the necessary awareness had been created. Coaching, from the managerial perspective, was a two-way partnership where both parties shared knowledge and experience in order to maximise the coachee's potential and achieve goals. Coaching was a means for learning and development, which also provided guidance towards goals. Coaching involved the mutual sharing of experiences and opinions to create agreed outcomes. The process of coaching involved inspiring and supporting another person.

Coaching (Harvard, 2004) was not:

- An opportunity to correct someone's behaviours or actions.
- Directing someone to do something to meet goals.
- Being the expert or supervisor with all the answers.
- About trying to address personal issues.

Common coaching situations arose when a new member of the team needed direction, a direct report was ready for new responsibilities, a problem performer needed guidance, and an employee needed positive feedback and recognition (Anderson & Anderson, 2004). Coaching was particularly suited to situations when the manager believed that working together in the coaching context would lead to improved performance:

- To maximise individual strengths and build on existing skills.
- To overcome personal obstacles, such as the fear of public speaking.
- To reach full personal potential through continuous learning.
- To attain new skills and competencies in order to become more professionally effective.
- To prepare for new responsibilities and acquire leadership skills.
- To manage personal constructs as well as time management.
- To clarify and work toward performance goals (The Harvard Management Mentor Guide, 2004: 5).

Coaching within managerial competency should be an ongoing process, where the manager sought to understand the coachee's skill level and behaviour patterns. Once the coach had an understanding of the aforementioned, professional growth would be facilitated through the creation of a comfortable environment, within which action plans were developed (Harrison, 2004). While managers often felt tension between the roles of evaluator and coach, the two roles were interrelated. The key to managing the two roles was to create an atmosphere of trust. Employees sought help and learnt best from managers who showed interest in their long-term development and who provided support and autonomy (The Harvard Management Mentor Guide, 2004). Employees opened up to managers who were trustworthy and trust made coaching possible. The act of coaching itself increased trust, and effective coaching was an upward spiral with trust as the foundation (The Harvard Management Mentor

Guide, 2004). The role of trust and other core values will be discussed extensively in this Chapter.

Per Whitmore (2002), broader business and social conditions also made coaching a valuable skill for the manager. In Whitmore's opinion, (2002) and in keeping with the views of Anderson and Anderson (2004), a listening, learning and coaching culture provided the best context for dramatic change within an organisation. Organisations that adopted a more supportive, people-oriented culture where coaching was inherent, would experience a general sense of acknowledgement at all hierarchical levels. As managers listened to staff and acted on what they heard, employees would be happier and perform better. Coaching secured a value-based future that could not be prescribed by an external authority (Schein, 2004). Performance would always be optimal when staff, shareholders, directors and customers shared the same values, and performance could best be optimised in the manager-employee relationship.

Meyer and Fourie (2004: 24) reinforced the views of Harvard (2004) and Whitmore (2007) regarding the changing role of the manager, from the historical perspective of "controller" to that of modern day coach. The manager played a central role to the optimal use of coaching in an organisation, displayed appropriately below by Meyer and Fourie (2004). Table 4.1 clearly defines the changing role of the manager as coach.

Table 4.1: The shifting role of the manager: From controller to coach

Manager as a Controller	Manager as a Coach
The manager sets objectives for the team to achieve.	The coach helps the team to set mutual objectives.
The manager compiles a plan to be executed by employees.	The team compiles the plan jointly, while the coach facilitates the process.
The manager closely supervises the work of the employees.	The coach works with the team and only checks work when it is really necessary.
The manager is automatically the chairperson of a meeting.	Any employee who takes ownership of a particular project can be the chairperson of a meeting.
Employees get in trouble when they make mistakes.	Mistakes are seen as learning opportunities.
Scientists or specialists are responsible for innovation.	Employees are encouraged to be innovators.
The purpose of control is to discipline employees.	The purpose of control is to ensure that all objectives are achieved.

The major form of communication is top-down.	All lines of communication are open.
Employees are blamed for defects.	The source of defects is a system or process not working properly.
Managerial control lies in power.	Managerial control lies in empowerment.
Information is the prerogative of management.	Employees have access to information.
Management makes decisions on their own.	Employees are empowered to make their own decisions.
The hierarchy emphasizes position and status.	A flat structure emphasizes vertical and horizontal co-operation.
Management is about execution.	Coaching is about development.

Source: Meyer and Fourie, 2004:24

From Table 4.1 it was evident that the role of the manager changed from being purely directional to that of being inclusive and developmental. While the manager remained accountable for the outcomes, the processes by which the outcomes were achieved were constructed from within the team. The relationship between the manager and the members of the team was not one-directional, but inter and intra-directional encouraging communication. Each member of the team was encouraged to participate and to construct and deliver outcomes as opposed to relying on the leader in the traditional sense for same. Using this approach the collective energies and skills of all members of the team were resourced as opposed to relying on the skills and energy of one person. Members of the team were encouraged to participate thereby growing confidence and encouraging development. This approach resulted in a positive result for both the team member, the team and the organisation (Buys, 2007).

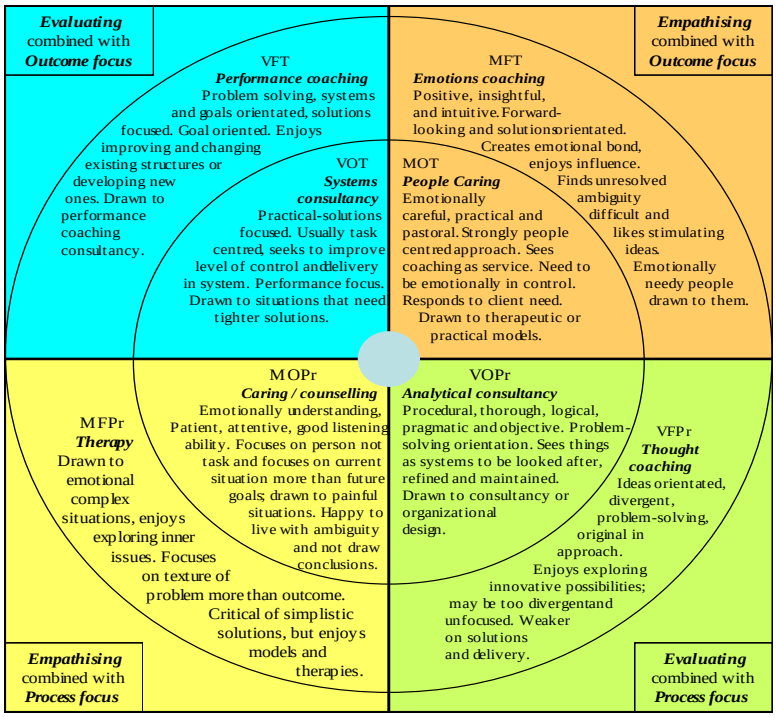
Extending beyond the functional role (Meyer & Fourie, 2004: 24) the developmental roles of the manager ultimately influenced the performance and growth of the employee as previously also defined by the Harvard Group (2004) and Whitmore (2002). In dealing with the specifics of the coaching relationship as defined by Cope (2004) and Alexander and Renshaw (2005), the table provided by Meyer and Fourie (2004) provided guidance and context for the ordinary dynamics of the manager/ subordinate relationship. The specifics of the coaching relationship are discussed subsequently in paragraph 4.5 of this Chapter.

4.3 COACHING FROM THE PERSPECTIVE OF THE ORGANISATION

Within the organisational context, a number of coaching interventions could be applied along with other organisation development interventions (externally or internally sourced). In order to best contextualise coaching within the people development interventions, Walker (2004) generated an interdisciplinary model of people development which provided boundaries for general coaching interventions but did not delve into the arena of executive coaching. Figure 4.1 was useful for the purposes of the research at hand in that it contextualised performance coaching, an area of coaching central to coaching within the organisational context, and defined previously by Meyer and Fourie (2004). What was more useful was that the model set performance coaching aside from "emotions coaching" as defined by Walker (2004), clearly excluding life coaching as it was commonly termed from the organisational framework. Walker's model (2004) clearly isolated performance coaching and reinforced the theory of Whitmore (2002) and the definitions of Meyer and Fourie (2004) around the manager's role in same.

From Figure 4.1 it is evident that Walker (2004) therefore defined coaching in the organisational context as a problem solving intervention, with sound foundations in evaluation, making connections between synergies (systems and goals) but ultimately seeking to construct solutions which improved and changed/developed existing structures as well as the people who functioned within same. No theory around executive coaching was presented, in order to further define the clear boundary of coaching as a skill set for the manager.

Figure 4.1: An interdisciplinary model of people development



Dimensions	***High***	***Low***
Empathy	M – eMpathy. Close proximity to other people	V – eValuation. Remote proximity to other people.
Logic	F – Forming. Sees the connections between people / things.	O – Ordering. Sees things in themselves.
Control	T – Outcome. Seeks to manage parameters.	Pr – Process. Seeks to respond to parameters.

Source: Walker, (2004:24).

Similarly as in the case of Walker (2004), Whitmore (2002) described coaching as an activity that focused on future possibilities and not past mistakes. While the dictionary definition of coaching, in the view of Whitmore (2002), served a descriptive purpose, for Whitmore (2002), coaching was really about the way in which the outcomes were created, as opposed to the fact that outcomes were created in any event. Coaching delivered results as a result of the relationship between the two parties and the means and style of communication used. The material used during the process was generated by the coachee, albeit stimulated by the coach. Whitmore (2002) reinforced the view of Walker (2004) as described in Figure 4.1 and furthermore subscribed to the understanding of Galwey (2002) that coaching was about unlocking potential to maximise performance, but helped the employee learn as opposed to teaching the employee (Whitmore, 2002). Fundamentally Walker (2004) then differed from Whitmore (2002) and Galwey (2002) in that he did not define as such a learning experience during the coaching process, but rather semantically a process of growth and even change. Intrinsically however, all three (3) views supported the coaching process as one of development, ultimately improving organisational outcomes (Buys, 2007).

In keeping with the views of Meyer and Fourie (2004), Whitmore (2002), and Galwey (2002), Alexander and Renshaw (2005: 14 - 15) concurred and defined coaching as:

- "An enabling process to increase performance, development and fulfilment.
- The art of facilitating the performance, learning and development of another.
- Primarily a short-term intervention, aimed at performance improvement or developing a particular competence.
- To provide help and support for people in an increasingly competitive, pressurised world in order to help them develop their skills, improve their performance, maximise their potential, and to become the person they want to be."

Coaching therefore was designed and executed within the organisational context, by either the manager, or the agent of the manager/ organisation.

4.4 THE CHARACTERISTICS OF THE COACH AND THE ETHICAL CHALLENGES – ALIGNING PERSONAL GOALS WITH ORGANISATIONAL GOALS

As extrapolated above, coaching on the part of the manager took place within the organisation for the purposes of development. Such development sought to develop the employee within the context of an organisation ultimately set also to develop and make progress. Performance coaching thus sought to align personal/ professional goals with organisational goals and values and create synergies as well as future purpose (Buys, 2007).

Much focus had been placed on the passage of the employee, without examining the role of the coach. Within the organisational context as described by Walker (2004) in Figure 4.1, the manager as coach faced innumerable challenges as the human and professional face of the employee presented and had to be managed. Figure 4.1 (Walker, 2004) provided clear guidance for the boundaries of the manager, who was not qualified to examine aspects beyond performance coaching for professional reasons. Should the manager extend the boundaries, the role extended to the areas of therapy and psychology within which the manager was neither mandated nor qualified to delve.

In establishing boundaries, Meyer and Fourie (2004: 82) and Buys (2007: 47) subscribed to the profile characteristics of coaches based on the competency list of the International Coach Federation, as follows:

"The ability to:

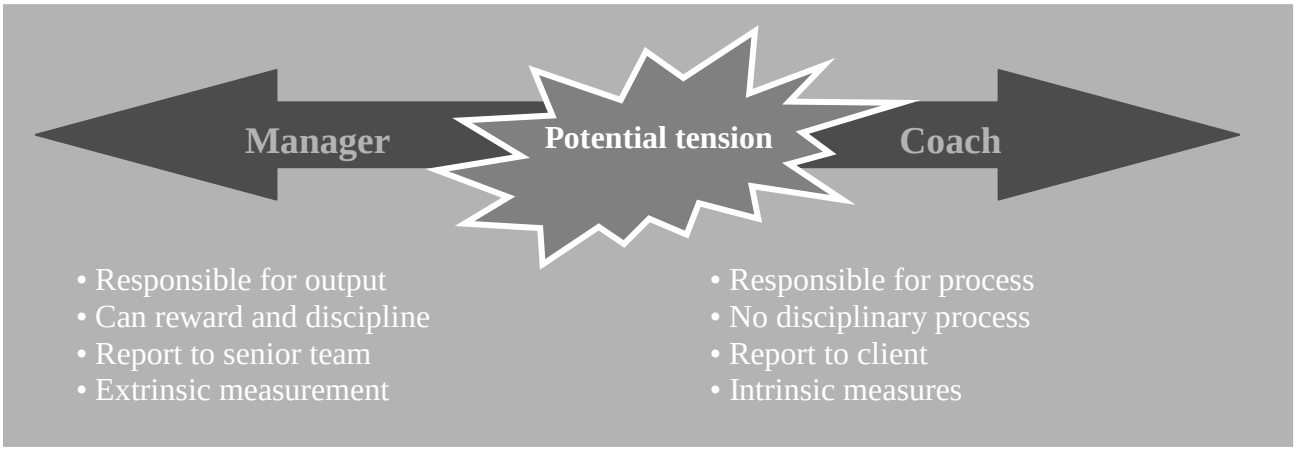
- Be ethical in business;
- Understand the differences between coaching, mentoring, counselling, psychotherapy and consulting;

- Know when to refer the coachee/ mentee (used interchangeably in this context) to other disciplines for help;
- Understand how to effectively discuss work-related issues and make connections within these guidelines;
- Reach agreement on parameters within the coaching relationship;
- Establish trust and credibility with the mentee and manager;
- Show genuine interest and concern for the welfare, wellbeing, learning style and perceptions of the mentee;
- Be fully "there" when in consultation with the mentee;;
- Be open to not know everything and be flexible, including risk-taking;
- Use humour effectively;
- Orchestrate a high sense of enquiry and problem-solving techniques;
- Demonstrate confidence and create energy and lightness;
- Attend to the client's agenda and listen with real interest to understand his/her perspective;
- Integrate the ideas and connections with the real time issues of work and outcomes;
- Ask questions in order to create power and momentum towards solutions, and evoke discovery, insight, commitment to action and the confidence to challenge assumptions;
- Demonstrate clear communication in terms of sharing and providing feedback, reframing, articulating, understanding, defining outcomes, using appropriate language to help illustrate a point or paint a verbal picture;
- Integrate and accurately evaluate multiple sources of information and make interpretations that help to gain awareness to focus on desired results;
- Create ongoing learning opportunities, promote active experimentation and self-discovery, and encourage personal stretching and growth;
- Manage the process, and evaluate and measure the outcomes based on the actions taken by the mentee."

McLeod (2003) addressed the practicality of the principles identified by Meyer and Fourie (2004), and identified a number of coaching pitfalls and provided advice on how to avoid traps, asserting that coaches could become focused on performance, leadership and success to the extent that their humility became corrupted.

Where the coach began to feel protective and/or attracted to the coachee, counter-transference and inspiration began to manifest (McLeod, 2003). The quality of the coaching intervention was obviously reduced and may have led to inappropriate questioning techniques or forms of assessment being deployed. The use of supervisory coaching and other therapies was advocated when counter-transference manifested sporadically, although termination of the coaching contract was essential if the syndrome persisted (McLeod, 2003: Buys, 2007: Starr, 2003) as referred to in Figure 4.2.

Figure 4.2: Manager as coach tension



Source: Cope, 2004:231

The views of Cope (2004) and Peterson and Hicks (1996) provided a valuable platform for the dynamics of the coaching relationship. When the coach was prepared adequately on the performance level for the intervention, the way was paved for coaching interventions where the outcome was potentially more significant for the organisation, and particularly the executive coaching context.

For Cope (2004), change was a non-negotiable outcome of the coaching process. If the client did not think, feel or behave differently at the conclusion of the intervention, the investment of time and energy wuld have been in vain. During and after the intervention, the client must have derived value from the change. Coaching must also have been sustainable, enabling the client to function independently. "Only where the change, value and sustainability have been fully addressed can the coach walk away with some satisfaction at having delivered an ethical and responsible service" (2004: 17).

The boundaries set by Walker (2004) in Figure 4.1 sought to reinforce the importance of the awareness and knowledge of the different people development interventions and where the boundary lay for each of those. But where the manager focused on performance coaching and clearly defined the boundaries of that form of coaching, the intervention would remain relevant to problem solving, systems and goal orientated and solutions focused. Ethical challenges would of consequence be limited and the true purpose of the intervention would be achieved enabling growth as well as an improvement in the performance of the employee (Buys, 2007).

4.5 OPPORTUNITIES FOR COACHING IN THE WORKPLACE

Building on the work of Walker (2004), it was clear that innumerable opportunities for coaching presented in the workplace. For the coach themselves, it was critical that a more optimistic view of the dormant capability of people be adopted (Whitmore, 2002). Whitmore (2002) identified broad categories of 10 opportunities which were deemed obvious for the application of coaching in the workplace and which according to Buys (2007: 3) could improve performance by as much as 85% as well as sustain such performance:

- "Motivating staff
- Delegating
- Problem-solving
- Relationship issues
- Team-building
- Appraisals and assessments
- Task performance
- Planning and reviewing
- Staff development
- Team work."

Whitmore (2002) argued that while managers must recognize the potential that lies within each and every employee and treat them accordingly, it was even more important for each individual to recognize their own potential. Coaching was tailor-made to build employees' self-belief. For the manager, building others' self-belief

demanded that the desire to control and be regarded as superior be released. If managers bore these principles in mind and acted on them persistently and authentically, Whitmore (2002) asserted that they would be amazed at the improvements in both employee performance and relationships . Coaching for a manager was not merely an intervention, but a way of managing, a way of treating people, a way of thinking, and a way of being . For a manager to be a true coach, coaching demanded of the manager the highest qualities of empathy, integrity and detachment .

Whitmore (2002) contended that if managers managed by coaching principles, tasks would be done to a higher standard and people would be developed simultaneously. Coaching optimised the adage that people were our greatest resource and was the management style of transformed organisational culture (Whitmore, 2002: Buys, 2007). People in any organisation demanded to be treated differently. As skills within organisations became more specialised and technically complex, coaching would become a prerequisite for managers (Whitmore, 2002: Buys, 2007).

Akin to the views of Whitmore (2002) around potential and coaching opportunities in the workplace, looking after talent became even more important in a climate of constant change and uncertainty (Alexander & Renshaw: 2005: 26). In the opinion of Alexander and Renshaw (2005), coaching bridged the gap between the challenges of personal emotional change during turbulence and knowing that people cared in the coaching context. Operating in a manipulative and autocratic environment where no coaching took place would have a damaging effect on personal performance and health (Alexander & Renshaw, 2005). As was presenting in the South African public health sector in the present times, absenteeism, recruitment challenges and the movement of trained professionals abroad, would be limited or even stemmed by investing in coaching in order to develop scarce resources such as healthcare professionals in general and healthcare managers in particular (HASA, 2008).

From an individual perspective, each person had enormous potential, but with that also came the ability to interfere with the actualisation of that potential. Limiting beliefs or assumptions were forms of interference, as were negative inner dialogues, confusion, feelings of being overwhelmed, fear and the inability to focus. External factors such as leadership, excessive workload, lack of communication and unclear expectations could also impact on the actualisation of potential. Coaching assisted in

eliminating interference so that performance started to match potential and vice versa (Alexander & Renshaw, 2005).

Similarly and in support of the views of Whitmore (2002), and Alexander and Renshaw (2005), the ability to raise the performance of a team and to seek long-term goals for the team to work towards was an important element of being a good manager (Eaton & Johnson, 2001). Through coaching, staff could be developed to take on greater responsibility and the manager was provided with the time to manage. Coaching was the art of improving the performance of others (Eaton & Johnson, 2001). As a coach, the manager helped develop employees through a process of mutually assessing performance, discussing the current context, defining achievable objectives, exploring new initiatives, and supporting the coachee in their plan of action. Coaching referred to a specific skillset, but as opposed to other interventions was concerned with current change as well as long term learning as it was an unending process, each new achievement forming a platform for the next challenge (Eaton & Johnson , 2001: Buys, 2007).

Supportive of the view of Whitmore (2002) and Walker (2004), and in the view of Eaton and Johnson (2001) and Cope (2004), for any single coaching goal there was a process of six (6) basic stages, as follows:

1. Definition – the coach and coachee determined what the performance goals are.
2. Analysis – both coach and coachee gained an understanding of the present reality.
3. Exploration – The options to achieving the goals set were explored.
4. Action – Timeframes were assigned to the achievement of goals.
5. Learning – Agreed actions were implemented.
6. Feedback – Progress was reviewed in the next coaching session.

The role of the coach was described as one where the coachee learnt from mistakes, identified performance targets, and took responsibility for implementing the first step towards the conclusion of the process. The coach was not prescriptive, but assisted the coachee to choose the best route for success. Coaching was used to teach

coachees to adopt a positive attitude to learning through encouraging open dialogue (Eaton & Johnson, 2001).

By coaching, managers made more time available, improved staff performance and by so doing, enhanced the productivity of the organisation. Coaching and delegating more but supervising less, boosted productivity and enabled the team to fulfil potential. By asking probing questions that solicited thinking on a different level and giving feedback, staff were encouraged to become more aware of strengths and weaknesses. As staff learnt to build on their strengths and develop new skills, they developed the ability and initiative to take on new challenges, raising the level of performance of the team and within the organisation also (Eaton & Johnson, 2001).

A further opportunity for coaching within the workplace was that of team coaching. Team coaching could be used to foster mutual learning and support, and to create new initiatives (Eaton & Johnson, 2001). Each opportunity for coaching was examined within the broader context of building skills, developing projects, solving problems, developing careers, overcoming conflict, re-motivating people and generating creative ideas within that framework. The framework provided by Eaton and Johnson (2001) built on the work of Walker (2004) discussed previously in this Chapter and which simplified the context within which performance coaching should take place.

4.6 OPPORTUNITIES FOR COACHING IN THE SOUTH AFRICAN HEALTHCARE CONTEXT

In the South African public healthcare sector, low morale and general dissatisfaction amongst the workforce had been identified as key factors driving the migration of this class of skilled labour to “greener pastures” overseas (Van Deventer, 2005: 17). In support of the aforementioned, Alexander and Renshaw (2005) referred to the research conducted by Sheffield University in 1998 , the findings of which showed that job satisfaction was a very reliable predictor of profitability. The research also showed that positive morale controlled general behaviour and influenced the efforts of less satisfied workers, ultimately encouraging higher productivity. Alexander and Renshaw (2005) suggested that organisations focus more on the attitudes of the

workforce in order to perform better and further postulated that coaching dealt directly with attitudes, thereby ensuring that people derived fulfilment at work.

The workload associated with healthcare in the public healthcare sector in South Africa had resulted in an above-average number of health professionals presenting with burnout and other stress related illnesses (Shisana, Hall, Maluleke, Chauveau & Schwabe, 2004). In the coaching context, Alexander and Renshaw (2005: 43) described the scenario as one of juggling different parts of life in "a frantic quest for some tranquillity and equilibrium …".

"Stress levels are high, tempers are short, there is no white space in the calendar and time appears to be running out. Clients report how they struggle to get to the finishing line late on a Friday evening. They then experience the wrath of their partner's frustration as they collapse for most of the weekend …" (Alexander & Renshaw , 2005).

In a focus group discussion conducted at St Mary's Hospital in June 2006 with 15 medical practitioners (Zingoni, 2006), this tone and sentiment presented more often than not. The practitioners recalled feeling overwhelmed by operational demands and torn between their families and service to a community devastated by the HIV/AIDS pandemic (Shisana et al, 2004: 846). As additional evidence supported the extension of these notions to other categories of healthcare worker, coaching became more attractive in all areas and particularly the following topics, as articulated by Renshaw and Alexander (2005: 47).

In the health sector in general, and for managers in particular, the challenge for managers as coaches was twofold (Meyer & Fourie, 2004). The manager had to guide the team in terms of strategy and the implementation of objectives, while creating an environment where performance is encouraged. The role of manager extends then to both strategist and motivator (Meyer & Fourie, 2004: Buys, 2007).

Given the challenges faced in healthcare, Eaton and Johnson (2001) postulated that emotional intelligence was a prerequisite to success within an organisation, as opposed to academic learning. A successful coach would strive to develop self-

awareness, self-regulation and self-motivation in both the individual and the team, thereby encouraging emotional intelligence. For the coach, a high degree of emotional intelligence was required. The coach had to demonstrate qualities of motivation, empathy, sensitivity and influence and be a role model (Eaton & Johnson, 2001) as well as develop emotional intelligence in others. The manager could develop and/or improve emotional intelligence in the team by asking searching questions that prompted the team to reflect on experience and learn from it.

By giving feedback that enabled the individual to see themselves from the perspective of others defensive thinking was discouraged. The process ensured that people took responsibility for their own actions and results, and created awareness of political sensitivities involved in projects (Eaton & Johnson, 2001: Goleman, 1995).

Similarly, Norton (2003) described emotional intelligence as the raw, almost basic material of leadership that provided the capacity and capability for human beings to change and grow.

Whitmore (2002) described how Maslow, besides contributing work on the hierarchy of needs, had contributed through the goal of humanistic psychology towards influencing business and the way business perceived personal development. Goleman (1995) built on this trend by introducing the concept of emotional intelligence, which soon became a non-negotiable for business. Supportive of the views of Goleman (1995), business had recognized, also in the view of Whitmore (2002), that a business person could not be focused on personal achievement in the material world and become a well-integrated person, a good parent and a respected member of society, without due regard to developing emotional intelligence (McAlearney, 2005).

4.7 THE BENEFITS OF EXECUTIVE COACHING FROM THE ORGANISATIONAL PERSPECTIVE

Within the context of strategy, executive coaching served a vital role in providing time to think (Alexander & Renshaw, 2005). Coaching at this level enabled high-level business thinking and strategising to take place and, given that time for thinking and planning were crucial to success, augured well for the coaching argument (Alexander & Renshaw, 2005 : O'Neill, 2000).

Coaching assisted in creating positive meaning from random life events, which led to resilience creating an upward mobility that enabled people to overcome obstacles and improve their performance (O'Neill, 2000). The way that a leader behaved was a critical determinant of the culture of the organisation.

The way in which a leader behaved affected both own as well as team performance. Coaching at executive level used leadership frameworks such as 360 degree feedback to enable an individual to modify behaviour where necessary (Alexander & Renshaw, 2005).

A coaching culture as depicted in Table 4.2 within an organisation could lead to a dynamic environment where people valued each other in tangible ways, played to their strengths, exchanged feedback, had clear expectations, roles and responsibilities, continued to learn, enjoy their work and relationships, achieved high performance and outstanding results (Alexander & Renshaw, 2005). In the view of Alexander and Renshaw (2005: 369) a coaching culture would resemble the following:

Table 4.2 An executive coaching culture

Vision High performance / people development as competitive advantage **Strategy** Behaviours linked to execution of strategy **Leadership Style/ Support** -Role modelling -Communication -Participation	**Attitudes / Skills** -Development programmes -Colleague feedback -Personal development plans -Workshops -Implementation plans -Management follow-up -On-going support -Review and reinforcement **SuperCoaches** -Specialist internal coaches

	-Culture development
Linked to Performance Management	-One-to-one coaching practice
-Objectives	
-Appraisal	**Continuous Improvement**
-Reward	-Measurement
	-Best practice
	-Communication
	-Success stories
	-Refinement

Source: Alexander and Renshaw, (2005: 369) (adapted)

Similarly, Sievers (2006) asserted that good coaching at the executive level relentlessly tracked the outcomes the client had suggested, which was one of the aspects that differentiated executive coaching from coaching in general. From a position of unconditional positive regard, the executive coach held the client to the selection and commitment of the outcomes.

This view was critical in relation to return on investment which was central to executive coaching. Integral coaching per Sievers (2006) dealt with four (4) areas namely behavioural, intentional, cultural and social. Integral coaching also addressed within the executive context multiple forms of intelligence, *viz*, cognitive, emotional, spiritual and cultural intelligence.

From the organisation's perspective, the coach had to be well matched and in order to deliver return on investment, the organisation had to be coachable (Sievers, 2006). Executive coaching was an enabler for leadership development, in which specified leadership competencies were developed in accordance with the leadership framework of the organisation (Sievers, 2006). Sievers (2006) explored various coaching topics, and highlighted the areas of direction, learning and development which were of particular relevance to executive coaching as referred to in Table 4.2 above.

In the area of leadership, which is what this research focused on, Alexander and Renshaw (2005) questioned the value of coaching in providing the leader with feedback and providing invaluable information as to how the leader was perceived, as well as perceived him/herself. Using the insight from feedback tools such as 360 degree feedback, the coach could help the leader adapt his/her leadership style appropriately to support the success of the organisation (Alexander & Renshaw , 2005). The insights of Alexander and Renshaw (2005) echoed the work of Wasylyshyn (2003) which was also supportive of particular feedback in terms of the 360 degree model.

Strategic coaching provided an invaluable opportunity for the organisation to pause and provide time for thinking. Coaching made it possible, in the view of Alexander and Renshaw (2005) and O'Neill (2000), for strategising to take place on the premise that time for thinking and planning were crucial to success (Alexander & Renshaw , 2005).

Similarly, Kline (1999: 18), while emphasising the essence and value of thinking particularly at strategic level, also drew attention to the value of incisive questions and the value of an incisive question in removing limiting assumptions and encouraging fresh thought.

- "If you were to become Chief Executive Officer, what problem would you solve first and why?
- If you knew that you were vital to the organisation's success, how would you approach your work?
- If things could be exactly right for you in this situation, how would things have to change?
- If you were not to hold back in your life, what would you be doing?
- If you knew that you were as intelligent as your superiors, how would you present yourself to them?
- If you trusted that your excellence would not put others in your shadow, what would your goals be?"

This in turn emphasised the importance of executive coaches who created relationships in which the client found the courage to question the basic pre-suppositions from which she or he had been working (O'Neill, 2000: Peltier, 2001). The executive coach also had to have the ability to listen for the client's passion, to break conversational patterns which trapped the client (reinforcing the ability to question basic pre-suppositions), to recognise environmental dynamics and the ability to build trust (Meyer & Fourie, 2004).

Executive coaching therefore focused on the development of an individual at the executive level, the process constantly contextualising the organisational objective. The process was one of continual alignment to ensure a return on investment for both the executive as well as the organisation.

4.8 EXECUTIVE COACHING AND EXECUTIVE COACHING MODELS

4.8.1 Introduction

Coaching models were applied to either executive teams or executives themselves. It was however critical to measure the value added for the team led by the executive. The 2009 Sherpa Executive Coaching Study (Sherpa, 2009) expounded on the fact that every crisis called for great leadership and that executive coaching was an essential development tool for leaders at every level. Executive coaching created positive changes in business behaviour in a limited time frame (Sherpa, 2009). The results of the survey which drew from the experience of 1500 participants with an error margin in the results of 2.6% (Sherpa, 2009) accurately identified changes and trends in industry executive coaching practice. Among executive coaches, a majority favoured standard processes along with executives themselves (Sherpa, 2009).

4.8.2 The impact of executive coaching on the team

When coaching the executive members of an organisation through culture change, the coach should ensure that all participants were clear about what was required from the

change and committed. A team of "master coaches" would be trained to institute a thorough programme of maintenance and reinforcement from the first day of the intervention. Each supervisor would benefit from a basic coaching programme to ensure that the language of the intervention was common. Staff, in turn, would be exposed to the principles of coaching so as to feel comfortable with the change in approach on the part of management (Whitmore, 2002 : Schein, 1990).

For any executive coach, it was critical to assess the opportunities within any process, during which, needs should be summarised for maximum benefit (McCleod, 2003). Various techniques such as break-away groups, group presentations and brainstorming sessions could stimulate these interventions and drive the process forward. McLeod (2003) also referred to Whitmore's GROW model (2002) as an intervention useful in assessing the team context.

McLeod (2003) referred to research conducted by Lamont (2002) that suggested that managers could be a hindrance to performance and that by enlisting the involvement of the team, profound solutions could be generated as a consequence of coaching. Coaching in this context produced more efficient results in the organisations where it was deployed, as opposed to other interventions, provided that values were shared. If the overarching philosophy or value system within the organisation encouraged the best from all employees, the scope for improvement was significant.

In support of Whitmore (2002), Alexander and Renshaw (2005: 360) described six (6) dimensions for team coaching, given that teams today were fraught with stress and fire-fighting activities:

1. "Determining vision and direction.
2. Establishing goals and action plans and reviewing same on a regular basis.
3. Agreeing roles and levels of accountability.
4. Developing an effective working process.
5. Creating effective working and inter-personal relationships as well as social time together.

6. Understanding motivation and fulfilment linked to individual and collective meaning and purpose as a group."

Within the context of coaching for managers, team coaching became almost a *fait accompli*, as for the manager to succeed, the team had to succeed also.

For Whitmore (2002) akin with the principles of Alexander and Renshaw (2005), value was added on the basis of the same principles that applied to individuals, ie., using the GROW model described in paragraph 4.8.2.

Whitmore (2002) therefore asserted that coaching held multiple benefits for the organisation. Besides the executive deriving personal growth from the intervention of executive coaching, coaching was infinitely more than a tool that managers could use in a variety of situations, such as planning, delegating and problem solving. Coaching was a different and optimistic way of approaching people and treating them. Coaching required that the manager suspend limiting beliefs about people (including self), abandon old habits and discard redundant ways of thinking (Whitmore, 2002).

Perhaps Whitmore's most profound statement was that "coaching is a nicer way to do business" (2002: 170). Besides the executive deriving personal growth from the intervention of executive coaching, coaching was certainly a tool that managers could use in a variety of situations, such as planning, delegating and problem solving.

4.8.3 Coaching at executive level

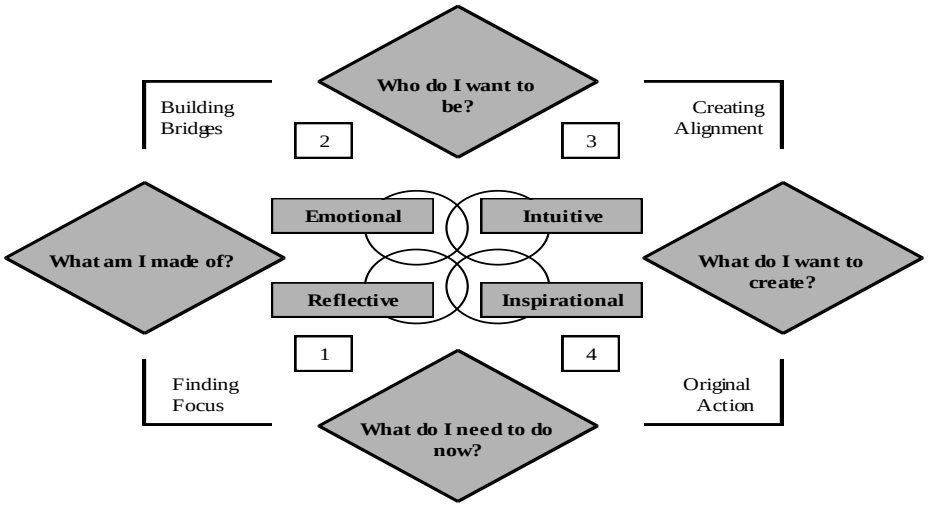
Hargrove (1999: 47) advocated what is termed "masterful coaching" for executives, effectively changing the context for coaching at that level. Whereas coaching for performance and other disciplines of coaching addressed progress, executive coaching addressed winners and superior performers, senior employees seeking an edge or advantage. Executive coaching was about creating the impossible future, not just filling gaps in competency. Executive coaching explored powerful new possibilities for leaders and their organisations and promised to deliver extraordinary and tangible results, bringing people into alignment with their greatest aspirations, while linking them with the needs of their organisations. Executive coaching also clearly transcended the coaching context in preparation for a higher level, including

constructs such as emotional intelligence. In order to deliver strategic value for an organisation, an executive coaching intervention must go beyond supporting an individual's achievement of specific goals (Anderson & Anderson, 2004). Successful coaching engagements at the executive level created positive change for all individuals within the organisation as:

- "Change was targeted to meet the development needs of both the individual and the strategic needs of the organisation.
- Change that occurred as a result of coaching was sustained.
- The outcomes of the coaching engagement laid foundations for the continued development of the client, even in the absence of the coach.
- Change continued to evolve and add value beyond the individual who experienced the coaching (Anderson & Anderson, 2004: 18)."

As opposed to other forms of coaching, which were transactional in nature, executive coaching was transformational (Anderson & Anderson, 2004), guiding the client to tap into deeper levels of insight to support larger and more complex outcomes. This required working with four (4) levels of insight, namely reflective, emotional, intuitive and inspirational insight (Anderson & Anderson, 2004). Anderson and Anderson (2004: 30) advocated the use of a model as described in Figure 4.3 to develop insight at the level described.

Figure 4.3: The Leading with Insight™ Model



Source: Anderson and Anderson, (2004:30).

Each quadrant explored a deeper level of client development and supported the realization of increasingly complex coaching goals. The first quadrant focused on personal effectiveness and enabling clients to find their focus. The second quadrant supported clients in enhancing the effectiveness of interpersonal relationships through the development of emotional intelligence. The third quadrant assisted the client to focus on achieving goals involving teams, groups and the organisation at large supported by the development of their own intuitive insight.

In the final quadrant clients were inspired to achieve goals they may not have imagined when they first began the coaching conversation. For the leader, coaching conversations revolved typically around organisational mission, vision, goals, values, role modelling behaviours, values, inspiring and motivating (Downey, 2004). The cyclical form of the model advocated by Anderson and Anderson (2004) was replicated by all theorists of executive coaching and was also therefore replicated in the model developed as a consequence of this research.

Downey's view (2004) held that coaching formed part of the leadership role, as effective leadership was dependent on the personality of the leader. Downey (2004) asserted that when there was alignment between what inspired the leader, the role being played and the objectives of the organisation, people at all levels of the organisation gave of their best freely, communication became easier and great results were achieved.

Following from the model of Anderson and Anderson (2004), McLeod (2003) advocated coaching from the perspective of servant leadership. McLeod (2003) referred to the great leaders of our time and named Mahatma Ghandi, Mother Theresa of Calcutta and Nelson Mandela, all icons who had played significant roles in South African society, also. McLeod (2003) defined the leadership of these great people as inspirational from a state of humility, leaders who were optimistic about the human spirit, held clear and inspiring visions of where they were headed and who led by example. For the coach, the lessons to be learnt from these great leaders were:

- "Helping people to be their best.
- Being tolerant of errors and viewing mistakes as opportunities for sustained learning.

- Encouraging and offering choices.
- Helping people to create imagination, vision and direction.
- Placing others in positions of primary importance.
- Understanding the greater good and stepping aside when necessary.
- Uncorrupted by fawning and idolatry and humble.
- Always a student of learning." (McLeod: 2003: 208)

The lessons advocated in the process of executive coaching were mirrored in the model of Anderson and Anderson (2004).

Extending the concepts of intuition, reflection and inspirational practice derived from the model of Anderson and Anderson (2004), Grant (2001) indicated the increased interest in using executive coaching to enhance work performance and life experience. In the view of Grant (2001), executive coaching interventions had typically used techniques with their foundation in cognitive and behavioural psychology. Although executive coaching focused on attaining goals, self-reflection and insight were key components for the executive. Grant (2001) described the constructs of coaching as those of being a collaborative relationship between two parties with the primary focus on creating solutions. The coach followed a process of questioning that prompted the client to re-examine assumptions and by so doing develop a greater understanding.

The cognitive-behavioural model of executive coaching (Grant, 2001) posited that there were four (4) facets of human experience which needed to be purposefully regulated in order to improve the attainment of goals namely, the environment or situation, thoughts, feelings and behaviour . Executive coaching interventions that dealt with all of the aforementioned domains would be more effective than others, in the view of Grant (2001). Again, the model postulated by Grant (2001) found synergy with the concepts of intuition, reflection and inspiration, and the ability to create alignment as advocated by Anderson and Anderson (2004) and McCleod (2003).

Hargrove (1999: 75) in Table 4.3 advocated a five (5) step process to masterful coaching for leaders; and took the context and process already discussed by Grant (2001), McCleod (2003) and Anderson and Anderson (2004) to the level of the executive and the team.

Table 4.3 The five step process to masterful coaching for leaders

Step 1 :	Enrol leaders in an extraordinary coaching relationship
Step 2 :	Coach the executive to design an "impossible future" for themselves and the organisation
Step 3 :	Gather and provide 360 degree feedback on the premise that in order to reinvent the organisation you must reinvent yourself first
Step 4 :	Engage in Strategic Planning with the Executive and the Team
Step 5 :	Coach executive effectiveness through monthly follow up on goals, priorities and high-level actions

Source: Hargrove (1999: 75)

Through following the process advocated by Hargrove (1999), the leader declared an extraordinary future that they were passionate about. This led to the articulation of their personal leadership and business challenges, and to creating a roadmap with the Masterful Coach by their side. Leaders also worked with the coach to create a source document that expressed their vision (goals), teachable points of view, key initiatives and key actions. The source document became a tool for other leaders in the organisation to use in translating the vision, mission and values. The source document also became a roadmap for the coaching relationship. Hargrove (1999) then focused on process essentially, while acknowledging the concepts of intuition, reflection, inspiration, and the ability to create alignment as advocated by Anderson and Anderson (2004), McCleod (2003) and Grant (2007).

Similarly, O'Neill (2000) considered that coaching high-powered executives required something special as well as something extra. Executive coaches had to be partners, whose emotional investment in business outcomes equalled that of their clients.

The executive coach had to have the strength and courage to face an organisational leader in times of crisis and speak the unadulterated truth. For O'Neill (2000: 7), executive coaching had four (4) essential ingredients:

1. "Having a results orientation to the leader's problem.
2. Partnership.

3. Engaging the executive in the specific leadership challenged being faced.
4. Linking team behaviours to organisational goals, and encouraging that executives set specific expectations for their teams."

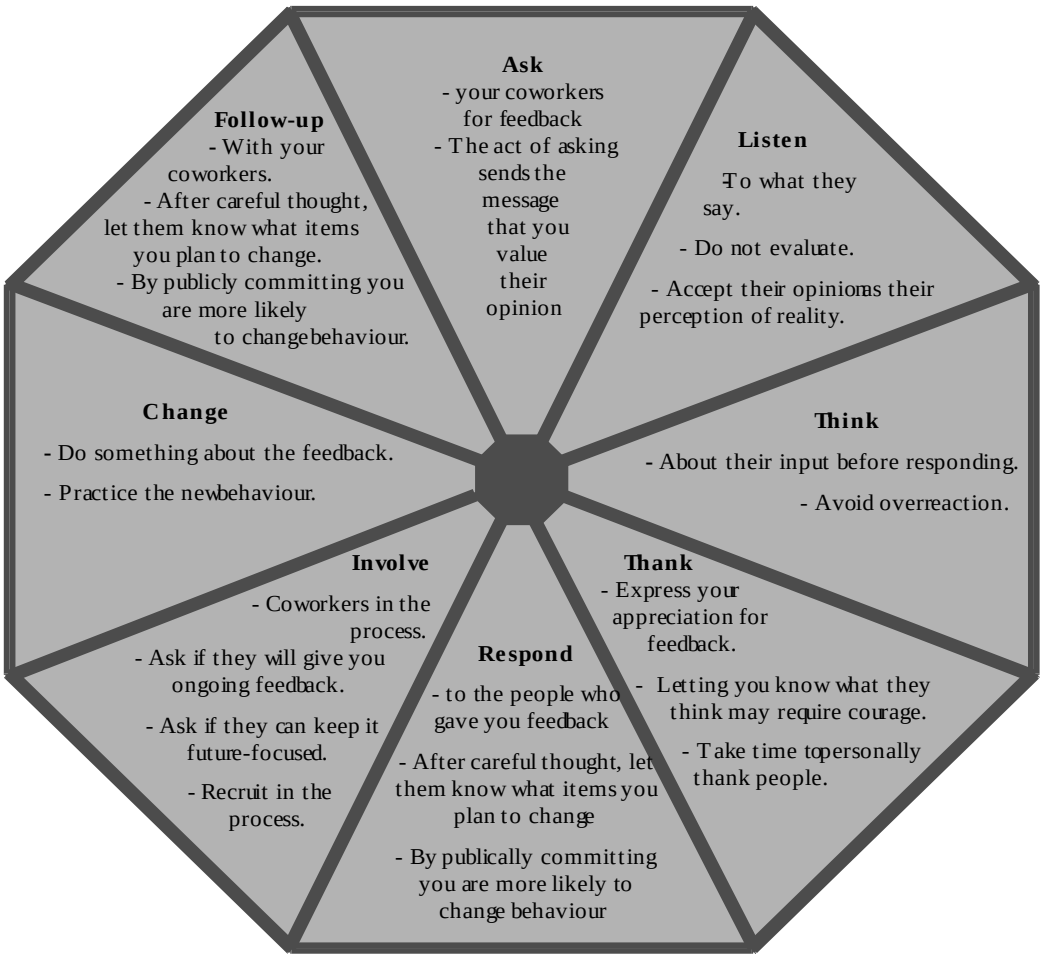
As such, O'Neill (2000) subscribed in essence to the content and process advocated by Hargrove (1999).

For the leader, coaching created the platform for building a stronger team, coaching attracted talent and sustained a network of support (Peterson & Hicks, 1996). As coaching strengthened capacity and produced better results, additional talent was attracted to the organisation. Growth and opportunity also increasingly differentiated organisations. Peterson and Hicks (1996) asserted that successful coaches created career opportunities that led to new challenges. As people moved on to new challenges, support grew for shared vision developed in the coaching context. These views were supported in turn in the models of Hargrove (1999) and Anderson and Anderson (2004).

Sharkey (2003) in turn contended that leadership was not learned primarily in the classroom but learnt in the workplace. Action learning, feedback and coaching were all used to help leaders develop through practical experience and leadership was built through leaders facing challenges and learning from experience. In the experience of Sharkey (2003), leaders often referred to mentors and/or coaches as having been central to their personal development, and understood that to be successful, coaching and receiving feedback were essential. Whilst many leaders understood the importance of coaching and feedback for themselves, they fell short on providing coaching and feedback to their teams (Sharkey, 2003), a concept also supported by Hargrove (1999) and Grant (2001).

Sharkey (2003: 70) advocated using a behavioural executive coaching model as an internal coaching tool based on experiences at General Electric. Figure 4.4 details the model and process used.

Figure 4.4: The behavioural executive coaching model



Source: Sharkey, edited by Effron, Gandossy and Goldsmith, (2003:70).

Using data from a 360 degree feedback process implemented at General Electric between March 1999 and March 2002, Sharkey (2003) established that the feedback process had provided another platform which leveraged human resources within the organisation at a strategic level. Teams within the organisation began to work across organisational divides to source and maintain improvements. When leadership teams shared their development needs and used the coaching model and process described, they found that they had similar issues, gained value through sourcing suggestions for improvements from each other and received support for improvements generally.

Human resource professionals drove the approach and managed the sustainability of the intervention, proving for General Electric, in particular, that human resources could be a critical resource in globalization strategy, *per se*. The effectiveness rating

for each degree of follow-up provided invaluable insight into the value of feedback and follow-up as a leadership and coaching tool.

The critical lessons learnt from the General Electric exercise were, in the view of Sharkey (2003: 77), universally applicable:

1. "The use of a consistent 360 degree assessment tool across the organisation to accurately reflect leadership behaviours deemed important for success.
2. Linking coaching to the 360 degree process to ensure that actions were taken beyond what was usually expected.
3. Using human resource professionals already part of the organisation as coaches.
4. Ensuring confidentiality.
5. Driving an internal follow-up and feedback process by regularly evaluating the intervention.
6. Cascading the 360 degree assessment and coaching model throughout the organisation."

The views of Sharkey (2003) were echoed in the approaches discussed and advocated by the theories discussed. While the inclusion of the many executive coaching models appeared onerous, the assessment was critical as a point of reference for the research to be undertaken. Given that no empirical data existed in the South African scenario, as much information as was available was required to identify possible models or combinations thereof in executive coaching interventions applied locally. The models provided a valuable framework for the assessment to follow, and would be useful in coding data and credentialing the interventions.

In essence then, a cyclical process of executive coaching was advocated by the theories discussed. Central to the use of the cyclical process which followed the creation of awareness, the definition of issues, the attainment of goals, and reflection – was an environmental awareness built into the approach, which took into consideration:

(a) the environment both politically, socially and economically;
(b) the organisational context, values and culture; and
(c) the role of the team in sustaining change, transformation and learning.

Key to the coaching process and a thread linking through all the theories discussed, but yet warranting special mention, was the issue of values – their identification, clarification and application specifically.

In conclusion, Peterson and Hicks (1996) likened coaching to research and development, the purpose of which was to hone technical excellence and sustain competitive advantage. Coaching translated the adage that "people are the greatest asset" into a true return on investment (Peterson & Hicks, 1996: 9).

Purposeful coaching and development, in the view of Peterson and Hicks (1996: 10), directed energy within an organisation and generated systematic improvement in organisation-specific competencies. For coaching to create return on investment, coaching should be injected into every area of the organisation, at every level of leadership. Peterson and Hicks (1996: 11) considered coaching a leadership imperative based on four (4) organisational realities:

1. "Change was inevitable.
2. People had to learn and adapt quickly.
3. Employees wanted to grow.
4. People were the real source of competitive advantage and with new development became competent, aligned to the purpose and values of the organisation, self-directed and able to demonstrate personal responsibility; and adaptable, able to continuously learn and adapt as their roles and the needs of the organisation change."

The views of Sosik (2005) and Peterson and Hicks (1996) reinforced the development and progression of values and the importance of building value systems within the organisation.

4.9 MEASURING THE RETURN ON INVESTMENT DERIVED FROM EXECUTIVE COACHING

Meyer and Fourie (2004) asserted that as organisations started to use executive coaching as an intervention, the need would arise to develop the managerial skills of

the executive team. As this intervention would not only benefit the executive, but also the team of that person, the "sell" of the intervention could be enhanced given the cumulative benefits of same for the organisation. Ultimately, at executive level, coaching as an intervention with any value would be measured in terms of return on investment.

Sherpa (2009: 16) used the following formula to calculate the return on investment received from executive coaching.

1. "Estimate the total value of resolving an issue or issues. (example: Avoided USD 55 000 in turnover costs, increased productivity by USD 45 000 – Total benefit: USD 100 000)
2. Multiply this amount by the percentage of the improvement attributable to coaching. (example, 50% of the improvement came from coaching – coaching benefit USD 50 000 (#1 times #2: 50% of USD 100 000)
3. Factor in our degree of confidence in our estimates (example, we are 90% certain that our estimate in steps 1 and 2 are correct, therefore adjusted coaching benefit: 45 000 - #2 times #3: USD 50 000 times 0.9)
4. Subtract the total cost of coaching (say USD 15 000) (example, net benefit USD 30 000 - #3 minus #4)
5. Calculate ROI: Divide net benefit (step 4: USD 30 000 by coaching cost USD 15 000 therefore ROI = 200% (#4 divided by #3: 30 000/ 15 000 = 2.00)."

Anderson and Anderson (2004) in turn indicated that return on investment could be measured by using what they defined as an ROI Evaluation Toolkit. Anderson and Anderson (2004) developed a tool to measure the return on investment provided by executive coaching which is detailed in Annexure D.

The model of Anderson and Anderson (2004) provided a useful point of departure for assessing the value of executive coaching as the concepts were universally applicable with a variation of values such as hours of work and costs.

Further studies conducted in the United Kingdom under Whitworth and Shook (2003) in Meyer and Fourie (2004) albeit using a methodology other than that of Anderson and Anderson (2004), identified the following benefits resulting in a return on investment, almost six (6) times the cost of the actual executive coaching.

Table 4.4 Benefits to companies

Benefits to companies	Improvements
Productivity	53% of executives reported
Quality	48%
Organisational strength	48%
Customer service	39%
Reducing customer complaints	34%
Retaining executives who received coaching	32%
Cost reductions	23%
Bottom-line profitability	22%

Source: Meyer and Fourie, (2004:118).

Table 4.5 Benefits to executives

Benefits to Executives	Improvements
Working relationships with direct reports	77% of executives reported
Working relationships with immediate supervisors	71%
Teamwork	67%
Working relationships with peers	63%
Job satisfaction	61%
Conflict reduction	52%
Organisational commitment	44%
Working relationships with clients	37%

Source: Meyer and Fourie, (2004:119).

From a case study conducted in the South African subsidiary of Fraser Alexander, Meyer and Fourie (2004) identified several learning opportunities for South African companies *vis a vis* executive coaching. They identified that commitment from the senior team was essential, and that coaching should be applied from the top down to every individual. Coaching interventions should be aligned with the overall business strategy of the organisation, with clear goals and objectives having been set. In order to achieve optimal outcomes, work and life, goals should be integrated, although the process should be simply constructed to meet key goals. Feedback should be given regularly to monitor progress on a continuous basis. The intervention should be

designed so as to ensure sufficient benefits for both the individual, the team and the organisation, ultimately. In the absence of these factors, a return on investment for both parties would be questionable.

Ultimately, at executive level, coaching as an intervention with any value would be measured in terms of return on investment. Anderson and Anderson (2004) indicated that return on investment could be measured by using the evaluation tool detailed above. The evaluation tool was made up of a questionnaire which isolated choices around the executive coaching experience and intervention. Impressions and perceptions around the coaching process itself were assessed and suggestions for improving the process invited. Efficacy as a leader based on specific evidence was evaluated and collated with specific performance related outcomes inherent in the performance appraisal system against which the employee was ordinarily measured. The assessment tool also sought to evaluate the insights gained by the recipient of coaching insofar as challenges to be met regarding collaboration with peers and the impact of the actions of the individual on others. Within the context of the business the tool sought to assess how the coaching process encouraged the individual to look differently at business situations and how to engage more effectively within the work team to achieve goals. Communication skills were also assessed with a view to ascertaining whether both personal and team work had improved. The tool sought to provide concrete evidence of the assertions and apportion a financial value to the outcome. Thus, the tangible as well as the intangible assets were identified and quantified.

Similarly, Sievers (2006) advocated measuring performance in two ways, assessing the individual and the organisation as a whole. Meetings were conducted at specified intervals with the executive concerned, during which, feedback and review were shared (Sievers, 2006). Sievers (2006) used a Lickert Scale with terminology such as little progress through to some progress, and steady progress through to excellent progress. To measure the impact of the intervention, research interviews were conducted with clients and stakeholders to gather ratings on:

- The overall coaching experience.
- The quality of the coaching.

- Progress.
- The relationship with the coach.
- The importance of coaching.
- The financial impact of behavioural change.

Key to the implementation of any intervention, not least of all an executive coaching intervention, was the ability of the organisation to evaluate change in the context of a continuous process (Lane, 1992). Evaluation served to provide feedback on procedures adopted so that the process may be adapted (Lane, 1992). Where the outcome had been successful, the evaluation could consider return on investment. Lane (1992) suggested the following to consider before proceeding:

- If the programme had been a success, ascertain why and work from a position of strength for future programmes.
- If success was only complete in part, evaluate errors.
- If the intervention was a complete failure, consider the initial design of the programme.

Even when behaviour was deemed to have changed and success was reported, considerations should lead to assessing whether behaviour changed in the most efficient manner possible, not only for the individual, but also for the group. The establishment of new behaviour patterns opened up new situations and the possibility of new relationships, the implications of which had to be considered (Lane, 1992). Lane (1992: 177) deemed the following points noteworthy before proceeding to a revised intervention:

- "Can the level of intervention be optimised?
- Have new objectives arisen which require clarification and action?
- Have the implications of the new behaviour for all involved been considered?
- Has a programme to maintain gains and/or meet the new objectives been introduced?
- Has a post-intervention contract been established so that each participant is aware of his/her role in maintaining gains and in taking necessary action in the event of difficulties or further new objectives arising?"

On a cyclical basis, Lane (1992: 178) advocated following up on cases to assess the current situation, obtain data and provide feedback and advice to the team, and to update records and reconsider ideas. In the absence of such a process, the validity of work being carried out would not be established. Measurement followed definition, in the absence of which reflections and assessments would be subjective, as follows:

- "Have the gains been maintained?
- What changes have taken place?
- What can be learned from the follow-up data relevant to future programmes?
- Which areas need to be rethought and which can be consolidated?
- What information can be usefully fed back to participants? (Lane, 1992: 179)"

Table 4.6 below summarises the approach of Lane (1992: 180) to context focused analysis.

Table 4.6 Context-focused analysis

Summary of steps:	
PHASE ONE: Definition.	1. Obtain statement of the problem from those involved. 2. Clarify initial objectives of those involved. 3. On the basis of initial information received consider roles. **Theme:** A process of awareness aimed at achieving a shared concern.
PHASE TWO: Exploration.	4. Propositions of cause are generated. 5. Observation technologies are chosen. 6. Data is collected to test the propositions. **Theme:** The process is one of increasingly refined observations.
PHASE THREE: Formulation.	7. The adequacy of the propositions are checked. 8. A formulation and intervention propositions are established.

	9. Discussion with participants and redefinition of objectives takes place. **Theme:** The process is one of testing the propositions until an adequate explanation is available.
PHASE FOUR: **Intervention**	10. The procedures to be used are specified. 11. An intervention contract is established. 12. The agreed programme is enacted and monitored. **Theme:** The process is one of structured practice.
PHASE FIVE: **Evaluation**	13. Outcomes achieved are evaluated. 14. Any gains made are maintained, the programme optimised and new objectives which arise are tackled. 15. Re-evaluate, re-think and review outcome and ideas. **Theme:** The process is one of monitored achievement… WITHIN A SUPPORTIVE ENVIRONMENT.

Source: Lane, 1992:180

4.10 CONCLUSION

In conclusion, and in support of Sievers (2006: 161), "coaching is one of the most significant enablers for leadership development. As a mechanism for transformation it supports and underscores the development of human consciousness as a whole. Grounded in practicality and structured toward accountability, it uses the vehicle of relationship to achieve its goals."

In the healthcare context, the maintenance of standards and achievement of quality improvement was central to the achievement of strategy, both in the public and private healthcare sectors, as the patient voted ostensibly with their feet and sought the healthcare facility proven or perceived to be providing the best outcomes in the context of value for money (HASA, 2008).

An extensive awareness of different models albeit from the international context provided a solid framework for the development of an integrated model as well as for the research to follow.

Chapter 5 becomes specific to the healthcare milieu and describes the healthcare context around mentoring and coaching in South Africa.

CHAPTER 5

THE HEALTHCARE CONTEXT *VIS A VIS* MENTORING AND COACHING IN SOUTH AFRICA

5.1 INTRODUCTION

From sources outside of the South African context, it was evident that today's senior-level healthcare executives had no shortage of challenges to overcome (Hutton & Angus, 2003). Balancing the demands of multiple stakeholders, from government to patients to medical practitioners, to boards, could leave healthcare executives feeling overwhelmed and unable to keep up with the challenges of a rapidly changing environment (HASA, 2008). Meeting these challenges demanded a unique balance of technical and interpersonal skills, self-knowledge, and the ability to set and meet performance goals (McAlearney, 2005). Per Hutton and Angus (2003), an effective tool available to senior level healthcare executives was executive coaching. In the experience of Hutton and Angus (2003), in recent years, many executives had begun to use executive coaches to increase efficiency, develop leadership skills, and address specific personal or organisational goals. Professional executive coaches used feedback mechanisms, assessment tools and proven leadership models to help executives increase personal and professional awareness and identify and achieve goals. Coaches also introduced executives to new skill sets and techniques designed to help hone the approach to dealing effectively with challenge in a rapidly changing environment. The effects of coaching often spilt over to direct reports, who benefitted from improved guidance.

Executive coaching in the healthcare context was a more intensive, personal experience than most leadership skill assessments, given the environment. In the view of Hutton and Angus (2003), executive coaches working in the healthcare environment should be experienced in the field and have an excellent knowledge of the healthcare field.

While each industry or sector may argue that it was unique, the healthcare sector was as emotive (if not more than) as the education sector, with the added challenge of life-or-death situations, or choices that had far-reaching implications for families and

loved ones. Patients' decisions regarding the utilisation of healthcare services were primarily driven by their emotions and the desire to be healed at any cost (HASA, 2008).

The South African healthcare context faced a number of challenges which differentiated the particular context from that of the developed world, from whence the executive coaching data emanated. These challenges included the human immuno deficiency virus, the leadership challenges brought about by cultural diversity and legislated affirmative action initiatives as well as the changes to the legislative framework from the position of government (HASA, 2008). Delivering on expectations within South African healthcare would require innovative programmes and partnerships based on the optimal use of resources (HASA, 2008).

The private hospital sector played a substantial strategic role in South African healthcare and was fundamental to the delivery of healthcare services: treating approximately 3 million patients per year with over 1,5 million being in-hospital admissions (HASA, 2008). An effective private hospital sector made an important contribution on the one hand, addressing the healthcare needs of the country's employed population (HASA, 2008) as well as on the other providing Management Development Programmes to emerging managers within the country (HASA, 2008).

For the purposes of this research mentoring as a people development intervention was discussed in Chapter 3 and does not form part of the discussion in this Chapter.

5.2 THE CHALLENGE OF HIV/AIDS FOR HEALTHCARE IN SOUTH AFRICA

A significant challenge facing healthcare organisations in South Africa was that of HIV/AIDS prevalence among South African health workers. Shisana et al (2004) conducted a survey to determine HIV prevalence among South African health workers. Given that health workers were critical to the management of HIV/AIDS patients and the pandemic required a response at strategic, and therefore, executive level, both in the public and private sectors, the question of how to deal both internally, as well as externally, with the pandemic was raised. The HIV prevalence of 15.7% among health workers aged 18 years and older was high, *per* Shisana et al (2004), with serious implications for the health system. Sick healthcare workers

would not be able to carry out their responsibilities effectively, as they managed their own health challenges. Healthcare workers who were not infected would be required to manage the workload of their sick colleagues, placing an undue burden on an already overburdened public healthcare system, in particular. The issue of HIV in general and the effect that it had on healthcare organisations demanded a new intervention and coaching could be just the intervention to inject new life into a sector plagued by low morale and the inability to deliver on the national mandate. It would be the responsibility of the leadership to take the challenge further.

In support of the views of Shisana et al (2004), Ncayiyana (2004) reflected on the semantic ambiguity termed the concept of people's health. Ncayiyana (2004 : 1425) referred to the World Health Organisation definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", intimating that such definition cast a wide net, making the measurement of indicators within a health system nigh impossible. The proclamation by the South African Bill of Rights to the effect that everyone had the right of access to health services had formed the basis of healthcare post-1994 in South Africa. At the core of post-apartheid healthcare was primary healthcare.

Post-1994, funding had been redistributed amongst provinces from tertiary to primary care, bringing healthcare closer to rural populations. From the point of view of the eminent skill set in South Africa, which was largely concentrated within academic hospital complexes, many highly skilled medical brains (who played leading roles at strategic level) had left the country. Although the changes were meant to improve access for the previously disadvantaged, what had, in fact, happened was that maternal, infant and peri-natal mortality, child nutrition, the prevalence of tuberculosis, and life expectancy had all deteriorated. Unemployment and poverty, indicators established by the World Health Organisation as the greatest threat to "health", had also increased, despite economic improvements. As referred to previously, Ncayiyana (2004) highlighted the impact of HIV/AIDS, which he contended was largely responsible for the regression in health indices such as infant and child mortality, tuberculosis and life expectancy. Until and unless South Africa was able to deal with poverty and HIV/AIDS, the future of the health of people would remain bleak, further impacting on the developmental opportunities that seemed so apparent in 1994.

Mullan (2005) explored the immigration of physicians to developed countries from the developing world, which was defined, as including South Africa. In the research conducted, it was evident that the brain-drain, as termed by Mullan (2005), was limiting the ability of the source nation to respond to the HIV/AIDS pandemic, in particular. The solution postulated was an increased investment in the psycho-social and environmental wellbeing of medical practitioners.

Similarly, Padarath (2005) reflected on the National Health Act of South Africa and the importance granted to healthcare workers in terms of this legislation. The National Health Act created the foundation for a long-term Human Resources for Health plan, that identified priority areas for immediate action in 2005. Of the areas identified, was the critical shortage of health professionals in the public sector, in particular, medical practitioners. The 2005 South African Health Review, a review of the healthcare sector over the financial year 2004/2005, revealed that in order to implement the Operational Plan for Comprehensive HIV and AIDS Care Management and Treatment in South Africa alone, by 2009, South Africa would need approximately 3,200 medical practitioners, 2,400 professional nurses, 765 social workers, 765 dieticians, 112 pharmacists and 2,000 data capturers.
Unless factors contributing to shortages were addressed, the situation would not change and the outcome would be diabolical. Shortages were exacerbated by poor working conditions, poor job satisfaction, lack of skilled managers and the HIV/AIDS pandemic. Critical areas highlighted for urgent policy attention and implementation were human resource development, communication and improved leadership competencies to improve team motivation. The areas identified provided good material for executive coaching interventions at senior level and a variety of coaching interventions at other levels within healthcare.

No study of South African healthcare would be complete without contextualising the effect that HIV/AIDS has had on that system. According to the Population Bulletin of 2005 (2006: 9), the AIDS pandemic would halt population growth for the period 2006 – 2021, despite high fertility. South Africa was projected to add fewer than 1 million people to its 2005 population of 47.4 million in 15 years.

If the country had escaped the AIDS pandemic, the United Nations estimated that South Africa's 2020 population would be 63.1 million. Between 2000 and 2005, high AIDS mortality among young and middle-age adults meant that people aged 20 to 49 accounted for almost 60 percent of deaths. The public health sector had felt the

impact of HIV directly through the expense of medical treatment, supplies and staffing, and indirectly through the falling numbers of trained medical providers and increasing stress on health systems struggling to respond to the epidemic. In South Africa, 14 percent of staff, mostly nurses, died of AIDS between 1997 and 2001. AIDS undermined morale as workload and stress increased and healthcare workers witnessed the high mortality of children, young adults and colleagues (Padarath, 2005).

In the workplace in general, and healthcare organisations in particular, the scourge of HIV/AIDS had demanded a specific response, as both procedural and conversational aspects of work became affected. Procedurally minimum standards, as documented by the International Labour Organisation, had enforced:

- "careful handling and disposal of needles and any other sharp object (sharps);
- Hand washing before and after a procedure;
- Use of protective barriers – such as gloves, gowns, masks – for direct contact with blood and other body fluids;
- Safe disposal of waste contaminated with body fluids and blood;
- Proper disinfection of instruments and other contaminated equipment;
- Proper handling of soiled linen" (ILO, 2001: 39).

Although it may be argued that such practices were always in place within healthcare settings, the psychological burden of dealing with infectious waste / material, where personal contamination will result in life changing circumstances, was severe. The psycho-social burden that resulted from dealing with HIV/AIDS patients was well documented in the South African context and reflected merely to complement the contextualisation of healthcare in South Africa.

In response to the immense challenge facing healthcare workers in dealing with HIV/AIDS in the Faith Based Healthcare Environment in particular, a pastoral counselling guide was issued in 2005 (Igo, 2005).

As opposed to being a counselling tool, the pastoral counselling guide did not prescribe for the client what the outcome should be, did not give advice, did not give own opinion and did make decisions for the client. Akin to coaching, the pastoral guide was a tool for the healthcare worker to use in self-coaching in the context of HIV/AIDS for self, or with others. The person affected was not prevented from

exploring their own thoughts and feelings. The person was encouraged to find a solution to their own challenge without sympathy as a response. This approach was taken on the basis that people did not require pity, but instead, for the pastoral coach to stand with them and to listen as they revealed what was within. The person affected by HIV/AIDS required respect and acceptance, trust and genuine compassion. They would then be able to tell their story. The process allowed the story to unfold at its own pace and in its own way. The client was allowed to experience healing and growth through a process of exploration about what was difficult and a barrier in life. Pastoral practitioners applied insights from scripture and spirituality, psychology and common sense, sensitively (Igo, 2005).

Igo (2005) considered HIV/AIDS an important challenge and invitation for all faith-based healthcare organisations to learn how to listen more effectively. Listening to people living with the virus would grow understanding for what their needs were, rather than assuming them (Igo, 2005).

5.3 LEADERSHIP REQUIREMENTS FOR THE SOUTH AFRICAN HEALTHCARE SECTOR

5.3.1 Lessons from the American experience

McAlearney (2005) contextualised the issue of developing leaders in healthcare organisations in the United States. In the view of McAlearney (2005), the issue of developing leaders had gained increasing attention in recent years, especially given that the industry in the United States was a $1.7 trillion industry and in a state of constant and rapid change. This context demanded strong leadership. In the United States, healthcare executives typically responded to numerous stakeholders, clinical and non-clinical employees, patients, physicians, boards of directors, and the community. In the South African situation, Government would be included as a stakeholder, given the changes taking place both legislatively and economically. Within healthcare organisations, strategic goals appeared diverse, ranging from quality of care, to customer service, to organisational performance and community service. Healthcare organisations were also subject to cyclical changes in both the legislative and market environments, requiring executives “to appropriately respond while leading their organisations with unflagging energy, enthusiasm, and integrity” (McAlearney, 2005: 494). McAlearney (2005) asserted that in healthcare

organisations, mentoring and leadership were no less important than in other industries.

McAlearney (2005) described how little research had examined how healthcare organisations could promote and expand their managerial talent. Using a qualitative methodology, McAlearney (2005) conducted interviews to ascertain leadership development practices, including mentoring for middle and senior-level healthcare managers. Using quantitative methodology, McAlearney surveyed Chief Executive Officers at hospitals across the United States and examined mentoring experiences, leadership development opportunities offered, as well as opportunities pursued by Chief Executives, themselves.

Healthcare leaders could serve as important mentors and role models for the employees they hoped to develop (McAlearney, 2005). In this context, the study examined management learning principles in the workplace. The issue of how to structure such opportunities within the healthcare sector was a practical and real concern for healthcare organisations. The issue for this research was to develop a model for executive coaching in healthcare in South Africa as clearly informal mentoring had been applied to a limited extent. As no empirical data could be sourced to suggest that either coaching or executive coaching had been applied as an intervention in the sector, the sector specific model could have universal appeal.

For the interviews conducted as part of McAlearney's research (2005), broad topics such as general descriptions of leadership and leadership development opportunities, general views about leadership development programmes, perspectives about opportunities and challenges for different individuals in healthcare leadership; were explored with the opportunity for specific personal input (McAlearney, 2005: 497) as follows:

- "Could you please describe the leadership development programme at this institution? (clinical, administrative) – get historical perspective
  - What are/were the components of the leadership development programme in this organisation?
  - How is it related to other activities/ programmes?
  - Why was the programme initiated?
  - How was it introduced?
  - Where is the programme connected within the organisation?

- Is the human resources department involved? (if so, How? How much?)
- How are individuals selected to participate in the leadership development programme?
- Are assessment tools used? If so, which ones?)
- How are management learning and adult learning principles used in this programme?
- Does this programme work to incorporate external leadership development activities such as conferences and seminars? (if so, how?)
- Does this organisation have a formal mentoring programme?"

The questions raised by McAlearney (2005) serve as a foundation for the research to be conducted and would be included as areas for coding during the email as well as telephonic interview process.

The results of the qualitative research conducted by McAlearney (2005) produced results indicating that few healthcare experts could describe having participated in formal leadership development programmes, and none reported that they had been mentored, or participated in a mentoring programme. The quantitative research revealed that the Chief Executive Officer however, had participated in a number of developmental experiences, in some instances sourcing mentors (24% of hospital managers) and coaches (20% of hospital managers). .

Mentoring and coaching was seen as a relatively new initiative on the part of healthcare organisations and where diversity and the representation of women and minorities in leadership positions was concerned, particular interest was expressed (McAlearney, 2005). A general sense was that the more senior the executive, the greater the application of mentoring and the greater the responsibility in this context (McAlearney, 2005). From the research conducted, healthcare leaders clearly articulated the need for leadership development within the following parameters:

- Senior leadership being committed to leadership development.
- The designation of a senior employee as the Chief Learning Officer to assist in focusing leadership development activities.
- The joint development of administrative and clinical leadership through mentorship pairings.

- Integrating mentoring, talent management and coaching with leadership development.
- Promoting the importance of development, evaluating programme outcomes and continually motivating the case for investment in leadership development.
- Interest in leadership development, diversity enhancement and succession planning being promoted at Board level (McAlearney, 2005).

McAlearney (2005) ascertained that executives who had joined the healthcare industry from other sectors considered the industry to be 15 years behind other industries. The outcomes of this research by McAlearney (2005) showed that the future presented many opportunities for healthcare organisations in the United States to improve leadership capacity through mentoring, coaching and other leadership development activities .

5.3.2 Learning from the British experience

Nwabueze (2001) advocated the inculcation of the Japanese 5-S model as valuable to providing leadership in general, and total quality management in healthcare. Using the Japanese 5-S model, Nwabueze (2001) conducted a survey of 50 chief executives within the British National Health Service and identified significant leadership requirements including good communication skills, good planning skills, focus, strong ability to command, being a good listener, being enthusiastic, being a good organiser and being people orientated with a high level of integrity

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From the requirements identified the synergies with executive coaching outcomes became clear. Good listening skills for example, also identified in the works of Hughes (2003) and Hutton and Angus (2003) were cited as critical along with good communication skills and a high degree of integrity.

5.4 HEALTHCARE – A UNIQUE RESPONSE TO CHANGE IN ALL RESPECTS

Hartman and Crow (2002) explored development in healthcare during periods of change. Using an analysis of comments from managers and executives in healthcare organisations in the United States, insights were provided into strategic management

needs. With the context of the survey, Hartman and Crow (2002) asserted that there was widespread support for the premise that healthcare managers and healthcare executives needed continuous skills development to cope with challenges in that industry.

The dynamic nature of the industry was particularly challenging and required advanced executive expertise. Similarly as reinforced by the research of McAlearney (2005), Hartman and Crow (2002) established that management approaches used by many healthcare organisations lagged behind other industries .

Hartman and Crow (2002) established that the healthcare industry warranted being singled out, as internationally providing healthcare was becoming increasingly problematic . As was the case in South Africa, continued consolidation among healthcare organisations had created a complex, rapidly changing and competitive environment extrinsically, while intrinsically, healthcare executives had to balance quality of life issues with stakeholders issues "in a way that no other managers are required to do" (Hartman & Crow, 2002: 360), given the "patient and empathetic component". A number of executives interviewed by Hartman and Crow expressed explicitly the need for coaching and mentoring as formalised processes, in order to formulate new approaches to strategy development and implementation, and a revised sense of vision (Hartman & Crow, 2002).

Savage (2001) promoted investing in coaching to increase organisational productivity in the nursing management context. In the study conducted by Savage (2001), when coaching was included in management development programmes, the retention rate for nursing managers increased by 39%. In the South African context, at the Nursing 2006 conference, Hertzog (2006) referred also to the role of nursing leadership to influence and recreate the future for junior ranks. Hertzog (2006) reiterated that nurses in leadership positions would become more important in the South African context, playing a more visible role in stakeholder management and leadership development across the scope of the hospital management team, given the inherent skillset.

Spear (2005) questioned how healthcare professionals could ensure that the quality of their service matched their knowledge and aspirations. Spear (2005) made reference to the existing performance mechanisms in the American healthcare systems, which rewarded practitioners for the number of patients they treat as opposed to team and

organisational outcomes . In the view of Spear (2005), quality was sacrificed in deference to volume .

Improvements could only be achieved, Spear (2005) argued , if the gap between the American system's performance and the skills and intentions of the people who work in the system were established. The problem derived from the system's complexity, which created many opportunities for ambiguity in terms of how an individual's work should be performed and how the work of many individuals should be successfully integrated (Spear, 2005). The problem also stemmed from the way that healthcare workers reacted to ambiguities when encountered. Healthcare workers tended to work around problems, despite confronting them continuously (Spear, 2005).

Spear (2005) referred to the experience of industry leaders such as Toyota and a number of airlines, who had demonstrated that it was possible to manage the contributions of thousands of specialists in such a way that their collective effort was capable and reliable, both in the short- and long-term. Spear (2005) detailed a model for delivering operational excellence, the underlying intervention of which was coaching and mentoring from junior through to senior levels.

As Spear (2005) described, typically, care was organized around function in hospitals. Hospital systems often lacked reliable mechanisms to integrate the individual elements into the coherent whole required for safe, effective, care. The result was ambiguity over responsibility and breakdowns occurred. Spear (2005) gave the example of the wrong drug being delivered or a patient being left unattended and doctors and nursing beginning to improvise. "They rush orders through for the right drugs, urge colleagues to find available room for patients, or hunt down critical test results. Unfortunately, once the immediate symptom is addressed, everyone moves on without analysing and fixing what went wrong in the first place. Inevitably, the problem recurs, too often with fatal consequences" (Spear, 2005: 82). The answer lay, in the view of Spear (2005), not in installing a common set of tools and procedures broadly and quickly, but in individual, team and organisation-wide interventions, based on coaching and mentoring , given that the healthcare system was populated by highly intelligent and well-intentioned people.

5.5 COACHING MODELS - THE SOUTH AFRICAN HEALTHCARE RESPONSE

5.5.1 Introductory remarks

But what of the South African experience of coaching tools and interventions in the healthcare sector? As indicated previously, there was no documented empirical data available regarding coaching in either the public or private healthcare industries in South Africa. Only a handful of authors had approached the fringes of the coaching intervention, and in these limited circumstances applied some of the principles to the clinical setting.

5.5.2 Reflective practice and coaching interventions in the clinical setting

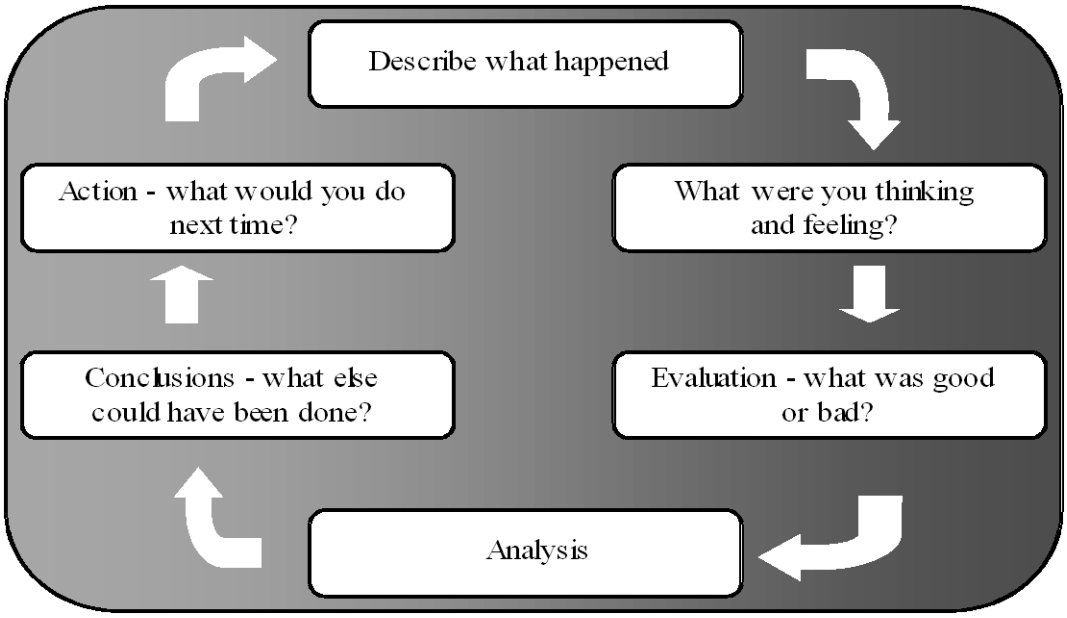
Van Deventer et al (2005) advocated the use of the learning plan as a reflective tool for trainers of family medicine registrars. This model incorporated mentorship, with the reflective phase of coaching *per se*, and was used for individual patient encounters, general academic needs or for documenting critical incidents (such as adverse events). All the reflective tools were used to compile the eventual learning plan, which was a perpetual and dynamic learning journal ultimately.

As such, Van Deventer (2005) advocated the use of a journal to encourage reflective practice. Akin to the views of Cope (2004), Anderson and Anderson (2004), Alexander and Renshaw (2005), Grant (2003) and Harrison (2004), reflective practice was critical to progress at the executive level.

Van Deventer et al (2004) advocated using the reflective process, as prefaced by the Flemish model in the compilation of the Performance Management Contract, provided the document was completed as a collaborative exercise in the coaching context. The extension of the model to private and academic medical practice was also advocated. Underlying the reflective model was the experiential learning model, as advocated by Whitmore (1996), literature that was intrinsic to many executive coaching models, and moved from the premise that initial assessment of learning styles was key to the conclusion of any coaching contract.

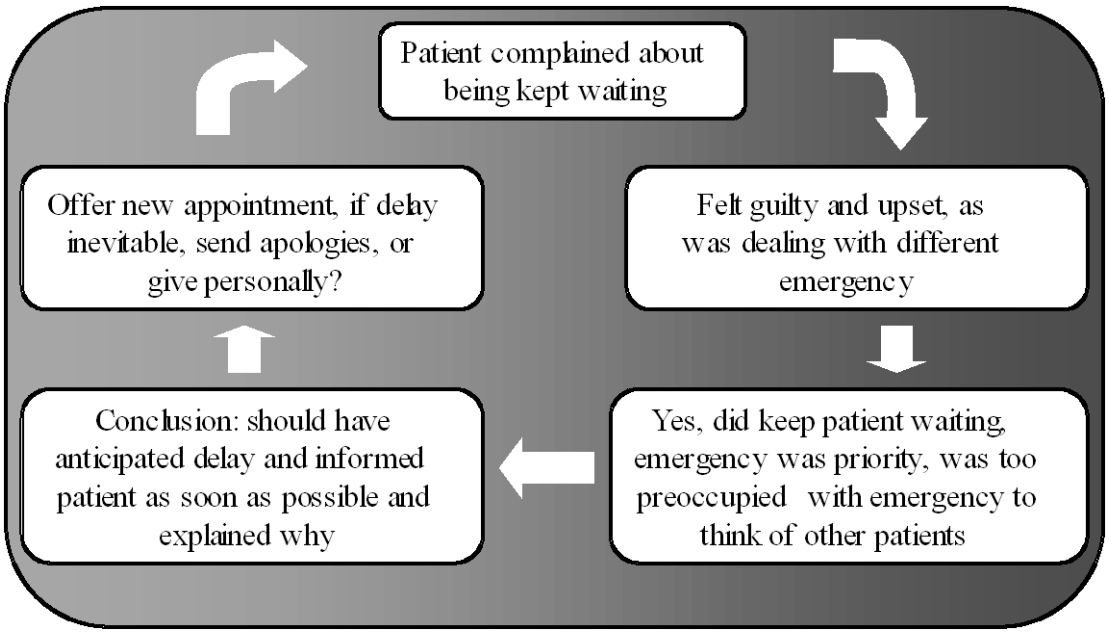
Similarly, Gibbs (2005) encouraged reflective practice in the positive sense and opened the discussion for how reflective practice could become standard professional practice, leading to high quality care and encouraging future learning. Gibbs (2005) averred that the majority of medical practitioners continually reflected on their daily professional lives and clinical practice, critically analysing and evaluating their own decision-making, their interactions with their patients and also with their colleagues. If constantly reflecting, learning should occur from every opportunity presenting, consequently fine-tuning medical practice. In the experience of Gibbs (2005), practitioners reflected on the negative or that which required remedial action, rather than recognizing positive observations as equally effective for quality learning and practice. The observations of Gibbs (2005) were key concepts in coaching conversations and also pointed to the use of same by the nursing profession to develop undergraduate students. In nursing, reflective practice was closely aligned to critical thinking and evidence-based practice (Hertzog, 2006). Reflective practice was an integral part of the assessment process, both from the external as well as the internal perspective, and key to leadership and empowerment. It followed that reflective practice developed important qualities that, in turn, developed competencies. The practice of reflection was used extensively in executive coaching to enable the executive to make sense of what had transpired in a given situation, which may have been directly relevant to the coaching process or adjacent to an issue under evaluation. Hence the Gibbs' model (2005) as detailed below was incorporated into the proposed conceptual executive coaching model for healthcare in South Africa also. Gibb's model (2005) followed the same step-wise process as the conceptual model.

Figure 5.1 Gibbs' modification of Kolb's experiential learning cycle



Source: Gibbs, 2005:5

Figure 5.2 Application of the reflective learning cycle



Source: Gibbs, 2005:6

As opposed to the model of Van Deventer (2004) which focused on the external application, from the internal perspective, Gibbs (2005: 6) advocated certain stages of reflective practice:

- "The reflective practicum; the environment in which learning occurs, the practice, the hospital, or the academic environment.
- The development of tacit knowledge; that knowledge which we cannot verbalise but occurs through events simply happening.
- Knowing in action; the knowledge that is personal to the practitioner in how he carries out tasks, the knowing is in the action of which we perform. This is the very personal part of reflection.
- Reflection in action; the way the practitioners uses knowledge, experience and judgement to guide decisions is real life clinical situations as they are happening.
- Reflection on action; this reflection occurs after the event, consciously taken, often documented and for most the main component of reflective practice.
- Operative attention; the practitioner is in a state of readiness to learn, to apply and experiment with new information."

In dealing with reflective practice, Ellis (2005) postulated that burnout in medical practitioners had little to do with environmental conditions and much to do with self-esteem. Ellis (2005) advocated getting to know yourself and making use of professional coaches in order to do so, thereby being challenged to go deeper and avoid the traps of keeping stresses and emotions on the theoretical and intellectual level.

Similarly, Bond (2003) described the frustration of doctors who did not express their opinions of patients holistically in writing and by so doing, frustrated their own efforts at reflection and regenerated learning. In response to Bond (2003), Alper (2005) explored reflective practice and the benefits that reflection had for the individual doctor.

Couper (2005) described the problem of burnout amongst doctors as being residual in doctors themselves seeing themselves as invulnerable. Couper (2005) extrapolated the myths of medical practice, that doctors did not get stressed, did not get sick, knew everything, showed uncertainty as a sign of weakness, and never revealed emotions. Couper (2005) expounded that it was largely in the helping professions that burnout occurred, professions in which the carer was constantly attending to others. The difficulty arose out of maintaining boundaries between the different roles and responsibilities and allowing certain roles to dominate. This appealed to the ethos of

coaching where work-life balance, or integration, was fostered. Medical practitioners, per Couper (2005), dealt with a number of paradoxes, healer vs. businessperson, everyone's friend vs. no-one's friend, compassionate vs. frank / honest, kind vs. firm, knowledgeable vs. humble / teachable, available vs. private, celebrity vs. servant, good income vs. time to enjoy one's income; and belonging to community v.s belonging to family. Couper (2005) advocated developing strategies in consultation with a coach to avoid burnout, amongst these strategies reflecting and debriefing, and journaling on a daily basis. In the process of reflecting, Couper (2005) asserted that it was important to clarify goals. To take time to reflect on goals and personal purpose, and to ensure congruence between the individual and the achievable. In testing boundaries, the opportunity presented at which to learn how to deal with tension.

5.5.3 A case study in coaching – the Eastern Cape Project (2002)

The work of Dovey (2002) is the only data published on any study conducted around executive coaching in South Africa. Dovey (2002) reported the outcomes of a collaborative learning project aimed at developing the leadership capacity in district health management teams in the Eastern Cape Province of South Africa. The research endorsed the role of leadership coaching in the development of, and ability to, leverage strategic knowledge resources that resided within and between team members. Dovey (2002) based the approach on the concept of work-based learning, a concept also central to executive coaching. Participants to the study were empowered to address a key strategic problem / challenge within the healthcare sector. The team at the coalface, as it were, was responsible for providing the underpinnings, building alliances, breaking down barriers, and facilitating insights into the task of implementation.

Dovey (2002) elucidated on the political and social context of the study, explaining how South Africa's recent history had had a profound impact on the complexity of problems presenting, in particular, in respect to human resources. The annual World Competitiveness Report had consistently rated South Africa at the bottom of the list *vis a vis* human resources. Policies of apartheid had systematically denied black South Africans any number of development opportunities. In the view of Dovey (2002), the human resources situation had exacerbated since 1994, when affirmative action policies had placed black South Africans in senior positions in state and private

sector organisations. As a consequence of their poor preparation for these positions, many leaders were failing to manage or lead their constituencies effectively.

Dovey (2002: 522) described the quandary as follows:

"A feature of the strategic incapacity of South African organisations, including the national government, is their inability to develop high quality strategic plans that, subsequently they are unable to implement. This is due to contextual constraints that make the politics of implementation of strategic plans complex and very difficult to manage. The deficit in the procedural and strategic knowledge bases of senior management in the state sector is possibly the most important problem with respect to the inability to implement. These knowledge bases are always linked in a fundamental way to the solving of problems *in situ* and their development is strongly dependent upon appropriate experience that has been guided by informed and insightful mentors. Such experience and guidance has not been part of the new leadership's formal, or informal, preparation for management roles."

In the study conducted by Dovey (2002), district health teams were made up of between 12 and 20 professional staff from regional hospitals, local health clinics, environmental health areas, local government, pharmacies and co-ordinators of various of health programmes. In collaboration with the district health management team, participants decided on a problem / challenge to be addressed in the work-based project context. Each project was perceived as one of a number of cycles of sustained strategic action aimed at resolving the particular problem identified. Each project team had a coach, to whom access was guaranteed. Each district also received at least one visit from the coach during the implementation phase of the project.
Using an action research approach, self-reflective practices required for the generation, conversion of knowledge, refinement of strategic action and alignment of action to mission, were facilitated. Each district health management team undertook a collaborative study of their collective actions, followed by a strategic action process characterised by reflection, discussion and shared responsibility for team learning. Each step in the strategic action process created its own outcomes.

Core values were established, constituting a code of conduct for the team (Dovey, 2002). District management teams were analysed contextually and people were recognized as the key determinant of success or failure. As a result of this outcome,

team leaders focused on processes of enablement, encouragement and empowerment, in keeping with transformational leadership theory.

Despite having been advised to choose each project on the basis that the project should be measurable, realistic and achievable, most teams chose unrealistic objectives (Dovey, 2002). Dovey (2002) attributed this to a previously superficial strategic process, as well as an external locus of control in the team context. As a result of the process, following formal evaluation and coaching interventions, the strategic cycles began to exhibit strong teams, that focused on achieving organisational results and learning by the process. The learning developed from, initially; setting unrealistic objectives, poor insight into strategic options, little cognizance being taken of contextual analyses; and poor management of time frames. From the individual perspective, Dovey (2002) described the development of a sense of social agency, or internal locus of control. The teams also recognized that workplace problems were shared problems and could be resolved through collaboration. Through committed coaching and the use of an innovative work-based learning methodology, leadership capacity was developed (Dovey, 2002).

5.6 A PASTORAL APPROACH TO COACHING AROUND HEALTHCARE CHALLENGES

Igo (2005) dealt with the facets of coaching in the pastoral context, reinforcing the need for healthcare workers to listen with empathy, practice the art of silence and actually hear what was behind what patients and colleagues said. Igo (2005) advocated asking open-ended questions from a personal grounding of empathy, acceptance, genuineness, confronting as well as understanding one's own feelings and thoughts. In the same way that coaches were grown, Igo (2005) advocated active listening through taking an interest in what the other person was saying, looking at the person and showing that what was being said was being followed; and using all the human senses to pick up on verbal and non-verbal communication. The art of powerful pastoral questioning formed a mental checklist in order to facilitate the flow of the "story" and was never delivered in the form of an interrogation. Igo (2005: 66) suggested the following base for questioning as a structure and framework for the pastoral coaching context:

- "Why does this person need help at this particular time?
- What has happened that made them ask for help now?
- How long have they been living with this particular problem?
- What is it that they really want to express?
- Who or what has brought them comfort in the past?
- How have they coped with their problem up to now?
- Who forms their support network?
- What spiritual resources have they got or do they need?
- How best could I help them to help themselves?
- What is this person's problem?
- When and how did it begin?
- Who is involved?
- What are they looking for?
- How best can help and support be given?"

The process of pastoral coaching was in parallel with coaching according to Igo (2005), requiring:

- "Open questions as opposed to closed questions.
- Questions of clarification.
- Questions in search of specific detail.
- Questions in search of specific meaning.
- Questions in search of options and personal strengths.
- Encouragement.
- Reflecting back, clarifying and summarizing.
- Focusing" (Igo, 2005: 80).

As was common to coaching, it was critical that the pastoral coach build a relationship of trust, explore the present situation, understand the context, as well as how to move forward, plan for action and set goals; and review strengths and how to build on same (Igo, 2005). In planning for action and setting goals, it was important that the pastoral coach deploy action-orientated skills such as problem-solving, goal-setting, the use of role plays, homework and reflection; and also evaluate milestones in the process (Igo, 2005). Confidentiality was a given, as was setting up a support network, much as a coach would advocate.

5.7 CHALLENGES FOR MEDICAL PRACTITIONERS

In this context, and given the pressures of South African healthcare, Anthony (2005) examined the culture of healthcare where unrealistic expectations on the part of patients had created a cadre of medical practitioners who believed that they were infallible. The consequence of this was that doctors were unprepared for the emotional consequences and a general conspiracy of fear pervaded much of the culture. New doctors quickly learnt that errors were not condoned by the medical profession. There was little teaching about error, how to deal with it at a personal level, or demonstration from mentors about the emotional impact of error based on own experience (Anthony, 2005). Anthony (2005) advocated talking honestly about the emotional impact in the coaching and/or mentoring context in order for doctors to come to terms with their own fallibility, and following, becoming more humane and better fulfilled as practitioners.

Couper (2003) described the need for mentoring by doctors to nurses and other health workers in primary healthcare settings. Couper (2003) contextualised the need in describing the workplace context where skills were in short supply and the workload exceeded the number of hours available in which to deliver care. Primary Healthcare Clinics were run by professional nurses with varying degrees of training in primary healthcare. Most nurses did not have managerial skills and had functioned outside of their scope of practice simply to provide patient care to the community, who without them would have nothing whatsoever. Their focus primarily then was on providing care and not on evaluating the context, planning ahead and ensuring sustainability. Their own development needs were neglected in favour of providing basic care. Although the clinics were supported by visiting doctors from either the district or district hospital, these visits were not planned on a daily basis, given resource constraints. Evidence suggested (Couper, 2003: 12) that the visiting doctor should play a mentoring and coaching role and include in the intervention the following themes:

1. “Management support.
2. Skills development
3. Orientation.
4. Assistance with equipment.
5. Convergence and better ways of working.

6. Familiarity with cultural and community requests / preferences.
7. Intra-team respect.
8. Evaluation of attitudes within the team.
9. Teamwork.
10. Relationship continuity and support.
11. Networking and co-ordination."

Couper (2003) identified the need for the role of the doctor visiting the Primary Healthcare Clinic to expand and to be optimised within the context of coaching and mentoring. Couper (2003) furthermore challenged medical schools and district authorities to train doctors so as to capacitate them for such roles, and suggested additional studies examine the positive effects that such interventions would have on teamwork and relationships.

5.8 CONCLUSION

Healthcare systems that were serious about transforming themselves had to harness the energies of their clinicians as organizational leaders (Mountford & Webb, 2009). In support of Anthony (2003) and Couper (2003), Mountford and Webb (2009) advocated that for formal leadership development programmes, healthcare organisations should consider introducing processes tailor-made to participants, particularly processes such as executive coaching.

Buchan (2004) deliberated that many of the organisational performance measures in health were unique and this, in turn, demanded a unique approach *vis a vis* the human resource management function. Performance in the health sector could only be fully assessed with indicators that were sector-specific. Indicators had to measure clinical activity or workload (staff per bed and patient acuity), measures of output (number of patients treated) and measures of outcome (mortality rates, post-surgery complications). The challenge lay in bridging a knowledge gap, between general evidence of human resource management inputs and performance, and health sector-specific evidence. In the often politicised health sector, linked and coordinated human resource interventions would be more likely, in the view of Buchan (2004), to achieve sustained improvement in organisational performance, than would single or uncoordinated interventions.

Gibbs et al (2005: 6) advocated the following approaches to coaching in the healthcare sector, based on experimental learning theory:

- "Planning specific learning opportunities in particular settings.
- Opening opportunities for reflection during the learning process and after events identified by the practitioner.
- Encouraging conceptual thinking and enquiry through questions and alternatives.
- Promoting feedback and the testing of insights by sharing understanding."

Mountford and Webb (2009) provided a poignant conclusion in asserting that to achieve the best and most sustainable quality of care, a commitment to building high-performing organisations had to complement traditional clinical skills. By providing executive coaching, healthcare providers would enhance their skills significantly, ultimately benefiting the patient.

Chapter 6 discusses an integrated model for executive coaching in healthcare in South Africa.

CHAPTER 6 – AN INTEGRATED MODEL FOR EXECUTIVE COACHING IN HEALTHCARE IN SOUTH AFRICA

6.1 INTRODUCTION AND BACKGROUND TO THE INTEGRATED COACHING MODEL

The views of McAlearney (2005), Rostron (2007) and Hartman and Crow (2002) which were the only sources of reference to executive coaching in the healthcare industry internationally as well as locally advocated strongly for a dedicated model of executive coaching for the healthcare industry.

The unique nature of the environment demanded specialist experience to bring value to the executive coaching experience (Rostron, 2007). On this premise an integrated model for executive coaching in healthcare in South Africa was constructed. Each model described in Chapter 4 is referenced in the construction of the integrated model.

6.2 COACHING FRAMEWORK AND META MODEL

The model is contained at Annexure "A", although discussed and the content and process elucidated on in the ensuing chapter. The model emanated from the literature review presented in Chapters 1 to 5 and contains the elements of the literature review in an integrated format, from a content as well as process perspective.

6.2.1 Introduction

The foundation of the model is that of a step-wise process within a cyclical model. The circular construction of the model indicates the influences from the systems which the leader exists within. On a personal level the leader was influenced by their own reality and the day to day challenge in managing the demands of leadership and personal life challenges. On a personal level the leader was also influenced by the dynamics of the team (Buys, 2007), the organisational dynamics and those created and inflicted by the environment.

In the coaching process, the model integrates all the approaches discussed in the previous Chapters , to create a step-wise model, albeit it informed by the cyclical and systemic influences discussed in the preceding paragraph.

6.2.2 Philosophies underpinning the model

This form of coaching transcends the coaching context in preparation for a higher level of performance, achievement and awareness, also described by Goleman (1995) and Hargrove (1999) as emotional intelligence. The incorporation of the construct of emotional intelligence also followed the model of Anderson and Anderson (2004) which developed insight at four (4) levels, namely those of reflection, emotion, intuition and inspirational insight. The model of Anderson and Anderson (2004) also, as in the model being described, took a cyclical form and was thus akin to most executive coaching models.

In essence these constructs spoke to the value and interpretation assigned to reflection and making meaning of events so as to draw value inferences and generate growth. These constructs were followed through during the coaching process as the model encouraged active reflection and the construction of meaning. As per the Harvard model (2004) the integration of personal and organisational purpose was paramount within the executive coaching context.

The relevance of the individual as a leader per Buys (2007) and the value of the individual was underpinned by virtue of the leader being central to the model and the cog around which the wheel may turn.

The model used such constructs to create both the reality and the outcomes for the leader, all the while mindful of the context (Whitmore, 2002: Anderson & Anderson, 2004: O'Neill, 2000).

6.2.3 Theories underpinning the model

The primary theories underpinning the model were those of:

- Existentialism (Nietzsche, 2006); (Whitmore, 2002) in order to identify purpose and meaning in life, to alleviate suffering in all the contexts described and to enable the individual to live a more fulfilled and joyful life (Meyer & Fourie, 2004).
- The Systems Thinking and Ecological Systems as conceptualised by Senge (2000) and further underpinned by the Buddhist Wheel of Life (Poussin, 1897) and the Golden Wheel of Islam (Haeri, 1993).
- The GROW model as defined by Whitmore (1996), which guided the flow of the process and ensured that the process was made up of a logical start, process flow and conclusion step. The logic of the model was also derived from the stages described by Eaton and Johnson (2001) and Cope (2004) and Hargrove (1999) in their executive coaching models.
- Competency based organisation and job design (Mathis & Jackson, 2006) and the organisation development theory of Greiner (1998).
- The approach of Downey (2004) who advocated at executive coaching level that the coaching intervention be 80% non-directive and 20% directive in order to encourage the degree of reflection and insight required of an executive. The approach of Downey (2004) was echoed by Hargrove (1999) who described coaching at the executive level as "masterful coaching", addressing the issues faced by achievers and superior performers, senior employees seeking an edge or advantage.

6.2.4 Ideas, beliefs, experiences and personal values underpinning the model

The model was also supported by ideas gained from experience and which were contained in the learning journal constructed during the compilation of this thesis.

Some constructs also remained unaccounted for and were therefore implicit based on past studies and discussions.

Support for executive coaching as an intervention was also prefaced by Whitmore (1996) as being a nicer way to work and remained consistent with modern management techniques which advocated feedback such as contained in 360 degree models (Wasylyshyn, 2003).

Notwithstanding the concept of any model, in the executive coaching process the client was always responsible and accountable (O'Neill, 2000). Incisive questions formed an intrinsic part of the process, enabling each stage of the model to progress logically to the next (Kline, 1999).

The value of incisive questions could not be overemphasized in moving the coaching process from one stage to the next, as the coach empowered and enabled the client to question basic pre-suppositions and to make progress (O'Neill, 2000: Peltier, 2001).

It followed that integrity and honesty were inextricably linked in any people development setting. Following the model of Walker (2004) the responsibility placed with the coach was clear, akin to the responsibility of any counsellor or psychologist entrusted with the development of a human being. While Walker (2004) described the inter-relationships between problem solving interventions in the organisational context, the outcomes created as a result of executive coaching separated the process of executive coaching from the other development interventions given the strategic context.

Cope (2004), and Peterson and Hicks (1996), extrapolated on the value of making connections and building relationships. Building on the issues of integrity (Peltier, 2001: Cope, 2004), Peterson and Hicks (1996) took the value of making meaningful connections to the extent of placing fundamental emphasis on sustainable outcomes and independent functionality of the client post the executive coaching process.

McAlearney (2005) dealt with the matter of excellence in the executive coaching context emphasizing that at executive level, excellence was a pre-requisite for the coach in directing the process, developing the questions, and moulding the outcomes. This was a view also underscored by O'Neill (2000) who insisted that for the process

to be authentic coaching at this level had to involve high level business thinking and strategy building as well as implementation. As opposed to the use of performance management frameworks at the performance and team coaching level, executive coaching used leadership frameworks such as 360 degree feedback (Alexander & Renshaw, 2005). The evaluation of emotional intelligence (Goleman, 1995) formed part of the leadership framework.

In evaluating the executive coaching experience it was essential to source feedback on the presence and overt application of the ideas, beliefs, experiences, values and ethics described (Sosik, 2005). Such feedback provided additional material for the development of the coach and measured the impact of the model and the delivery of same in the coaching context.

6.2.5 The coaching model

The coaching model is termed the "CEDAR" model and describes the development of the individual figuratively from a seed to a tree.

The coaching process is divided into five (5) stages which form part of a cyclical process and also intend to close a process. The influence that the leader exerts on the behaviours and decisions of the team and the organisation in turn (Boyatzis et al, 2006) are explored and reflected on throughout the intervention. Similarly, in the model of Schein (1990), the work was not limited to the intervention at hand but was systemic and considered the consequences for other parts of the system. Each stage has a procedural element but also draws on various tools in order to move the process within the cyclical wheel forward.

The five (5) stages are as follows:

- Contracting
- Exploring
- Defining
- Actioning; and
- Reflecting.

6.2.5.1Contracting

The first stage of the model opens the entire process and is made up of a greeting and welcome. The purpose of this stage is to set the client at ease and to start to create the space for dialogue. A situational conversation is key to clearing the space of any environmental noise which may inhibit participation. At this point the time frame for the initial session as well as subsequent sessions is decided and contracted.

The tools which may be drawn from include topical events, drawings and an introductory letter (Appendix C).

The purpose of the initial session, once the climate has been constructed for the dialogue, is to start the process of definition in terms of what the client wishes to explore within the process. Given that the context is that of executive coaching, the issue would be professionally related and could be linked to any challenge or development area identified by the client.

At the close of the session, the client is tasked with defining the issue and presenting same at the next session.

6.2.5.2Exploring

The second stage of the model seeks to explore the issue defined perhaps in a single phrase by the client.

The process reviews the homework exercise, discusses insights gleaned from the exercise, and reflects on the homework insights as relevant to goals and the coaching issue. The responsibility of the coach during the process was to question what informs the client and to provide insightful questions around this (Rosinski, 2003).

The tools which would be used during this stage of the process would include visualisation, the construction of collage, the completion of a learning styles inventory (Kolb, 1976), career assessments via an industrial psychologist, and personality profiling using for example the Myers-Briggs profiling tool (McCleod, 2003). Exercises such as writing obituaries, rewriting the client's Curriculum Vitae and completing the Wheels of Life would also add substance to the exercise. The cultural orientations framework and the seven (7) levers and tools (Rosinski, 2003) could also add content to the dialogue during this stage of the coaching process.

The exploring stage of the model is interchangeable and cyclical within the "defining" stage of the model as both processes seek to create clarity and purpose for the remainder of the process (O'Neill, 2000). This stage of the process may take more than one session and after each session, homework is contracted so that definition is clearly explored and satisfies the developmental goal of the client.

6.2.5.3Defining

The third stage of the process which remains interchangeable with the second (Exploring), pursues the process of definition.

The journey or process follows the following steps:

- Suggesting the use of a tool to gain insight and heighten definition (McCleod, 2003).
- Prompt discussion on insights and reflections from homework, reversal and redefinition (Alexander & Renshaw, 2005).
- Asking about what the client is experiencing during the process as well as what is going well (Rosinski, 2003) (Jackson, 2005).
- Exploring and defining barriers to action (Rosinski, 2003).
- Exploring limiting assumptions (Kline, 1999).
- Looking at life from the point of view of death (Flaherty, 1999).

The tools used would include:

- Finding the limiting assumption/s and then defining the positive opposite with the client's own words (Kline, 1999).
- Asking incisive questions which enable the freeing of assumptions in order to generate new ideas towards achieving goals (Kline, 1999) (Hargrove, 1999).
- Applying the insights gained from the learning styles inventory (Kolb, 1976).
- Applying the VISA model (Nel, 2006).
- Dialogue around appreciation and reflecting on what has transpired.
- Compiling a personal mission statement (Alexander & Renshaw, 2005).

- Reviewing personal and organisational ethics and culture, and conducting an exercise which identifies synergies and incongruencies (Whitmore, 1996).
- Securing independent feedback from five (5) referees (Peterson & Hicks, 1996) (Sharkey, 2003).
- This process would derive from constructing development plans (Eaton & Johnson, 2001). The behavioural executive coaching model as advocated by Sharkey (2003) also integrates 360 degree feedback as advocated by Wasylyshyn (2003) and discussed in the underpinning belief to the executive coaching model for healthcare.
- Conducting a SWOT analysis of the issue and the client's relationship with the context (Anderson & Anderson, 2004 : Downey, 2004).

The combination of process and tools in this third stage, enables the client through a number of sessions (if relevant) to understand and define the issue and the context surrounding the issue so that action can be taken.

6.2.5.4Actioning

The fourth stage of the coaching process is termed actioning as this stage takes the process towards completion. The issue/s have been explored and defined and it remains for the client to commit to action.

The client defines an action for each definition, constantly referring to the definition so as to keep the action clear and relevant. The "SIMPLE" process as defined by Jackson and McKergow (1998: 80) was used as follows:

- "S" stands for solutions and not problems.
- "I" stands for in between the action is the interaction.
- "M" stands for make use of what is there.
- "P" stands for possibilities from the past, present and future.
- "L" stands for language simply stated.
- "E" stands for every case is different.

The RIVAS contract (Wilkins, 2007) provided a further framework for capturing the process around action and the SMART (Wilkins, 2007) criteria of simple, measurable, achievable, realistic and timebound were applied. Where the client is enthusiastic

about creating a visual contract, a picture may be sourced or a collage created. Whatever form the contract may take, the contract is intended as a measure of progress against the action taken and any action outstanding in the process of achieving the desired outcomes. The RIVAS contract was similar to the performance goals matrix as detailed by Downey (2004).

The performance goals matrix of Downey (2004) is used specifically to monitor a coaching intervention at executive level by defining and listing learning goals, performance goals linked to learning goals and the measures of success of behaviour associated with the aforementioned goals. The Downey model (2004) also required time lines by which to monitor progress as did the RIVAS contract previously described.

Over the requisite number of sessions, the client pursues, per the contract the action, reporting back in the coaching session, and being tested via the coach's questions as to whether action is indeed being achieved (Grant, 2001). This process can also be contracted so that the desired action is defined in terms of a finite timeframe, and the process does not drag on or exist within a never ending cyclical process and becomes more linear in form, hence ensuring that the goal is indeed reached.

6.2.5.5Reflecting

The final stage of the coaching process is called reflecting and is essentially to reflect back on the achievements of the coaching dialogue as well as the process. The reflective stage is not engaged until the outcomes have been achieved, so as to keep the process clean and free for environmental noise, in the event of the outcomes/ actions not having been fully explored and defined.

The reflective process involves:

- Summarising activities.
- Discussing and agreeing insights
- Agreeing support.
- Talking about the issue of commitment to the change that has taken place, about being human and prone to fallibility but also being aware of same and taking remedial action quickly, and about learning and change always being possible. This reinforces learning and changes

that have taken place and creates the space for celebration of these developments in a manner designed by the client (McCleod, 2003).

- Reflections and affirmations are reinforced with positive statements and thinking on the part of the coach (Kline, 1999).
- The client is thanked and the positive experience of the process affirmed.

Tools useful at this stage of the coaching process are:

- The narrative letter (White, 2000).
- A relationship assessment in the form of a questionnaire to invite feedback (Anderson, 2004).
- An assessment of the extent to which mutual respect, freedom of expression and mutual learning has been reinforced (Flaherty, 1999).
- A values exercise (Whitmore, 1996 : Whitworth & Shook, 2003).

The purpose of the exercise in full is for the coach is to focus on helping the leader optimise performance and potential. The leader should also be able to behave more congruently within the organisation, in synergy with the organisational values and develop own ability to influence others and manage strategic and operational challenges:

- To be more intentional, resilient, self directed, aware and purposeful.
- To better manage their performance and change context.
- To align and focus energies and create synergistic congruence.
- To create supportive and enabling structures (through active reflection) in order to sustain the change sustained throughout the coaching process as well as influences from the environment.

6.3 THE COACHING MODEL AND THE RELEVANCE TO THE HEALTHCARE SECTOR

6.3.1 Reflections and summation

The South African healthcare sector was populated by a variety of leaders, young, new and wise and seasoned (HASA, 2008). As discussed in Chapter 5, the sector

faced an onslaught from a variety of sources, some external and some internal. What was clear was that an outdated mode of thinking would not meet the challenges posed. Leaders would have to be developed in a revised way and every personal resource would have to be drawn on.

The model focused extensively on reflection, which was a tool seldom if ever used in the industry. The model also focused on self limiting beliefs and sought to define and redefine the context continuously for the individual so as to ensure that the leader was not mal-aligned and sidetracked by irrelevant environmental factors.

As argued by McAlearney (2005), coaching within the healthcare sector should be pursued by qualified coaches with industry experience so that the context was fully examined.

The model also drew on various religious perspectives constructing an integrated model in that respect during the exploratory phase. This was particularly relevant for South Africa in general and the industry in particular where cultural diversity was well established and part of everyday operations both from the perspective of the patient as well as the leader. The possibility of self limiting beliefs holding back the development of emerging leaders was also explored through the use of the model and this had significance for the South African context in particular.

6.4 THE COACHING MODEL AND THE RESEARCH METHODOLOGY

Where executive coaching had been used as an intervention within the industry to develop leadership competencies, the research explored the applicability and usefulness of the model and this is discussed in Chapter 7 which follows. The outcomes were reflected in the findings and explored so as to conduct an assessment of the assumptions made and referred to in this thesis.

CHAPTER 7

RESEARCH METHODOLOGY, TECHNIQUES, PROCEDURES AND PROPOSITIONS

7.1 INTRODUCTION

This Chapter describes the research design and methodology, including the population, data collection and analysis. A multi-method quantitative and qualitative descriptive and exploratory research design was used to investigate the extent to which executive coaching has been used as an intervention in the private healthcare sector, and to what end. Descriptive and exploratory studies are perfectly linked to a deductive approach to research, where quantitative and qualitative techniques (from primary data) were used to collect data (Saunders, Lewis & Thornhill, 2007).

The epistemology applied combines interpretivism with pragmatism, ontology and subjectivism (Saunders et al, 2007) which is relevant to business and marketing research as it deals with business situations which are complex but unique, and those situations which are a function of a particular set of circumstances and individuals. The interpretivist approach asks of the researcher to be empathetic and enter the world of the research subjects and to understand that world. By understanding the detail of the situation the researcher gains in understanding the reality (Saunders et al, 2007). Working from the perspective of grounded theory, pragmatism works from the premise that the most important determinant of the research philosophy adopted was the research question (Saunders et al, 2007). Thus mixed methods, using qualitative and quantitative methods within one study as is indicated, were highly appropriate and possible within the confines of a single study, and were supported entirely by the epistemology described.

7.2 AIM AND PURPOSE OF THIS RESEARCH

The aim of the research was twofold: firstly to examine the extent to which executive coaching had been provided to the private healthcare sector in South Africa, to establish whether executive coaching had improved personal leadership performance and/ or organisational performance, and secondly to develop a conceptual model for

executive coaching in healthcare in South Africa. Within the context of organisational performance, return on investment was also evaluated. The research was made up of a literature study (Chapters 2 to 5) in the first part, the concept of a model for executive coaching in healthcare in South Africa (Chapter 6), and quantitative and qualitative data collection and analysis in the second part which included the testing of the feasibility of the model developed from the literature study – thereby adopting a deductive approach (Saunders et al, 2007).

The objectives of this research were to answer the following fundamental questions in terms of executive coaching:

Objectives of Literature review:

i) How had coaching evolved internationally as a discipline?

ii) How had coaching evolved in South Africa?

iii) How had executive coaching evolved and been offered to the private healthcare sector in South Africa?

iv) Was the relationship between leadership and coaching symbiotic or mutually exclusive, and how did management come into the equation?

Objectives of empirical research:

v) Will an executive coaching model specific to private healthcare deliver outcomes for leaders who have had coaching as opposed to leaders who have not been exposed to a healthcare specific model for executives (involving thus the testing of the feasibility of the model)?

vi) Does executive coaching in private healthcare create a positive return on investment?

7.2.1 Propositions

7.2.1.1 Proposition 1

There is a positive improvement in the performance of those leaders who have had coaching at the executive level in the South African private healthcare context. (Refer to Chapter One paragraph 1.5.2 for the underlying theory of this proposition).

7.2.1.2 Proposition 2

An executive coaching model specific to private healthcare will deliver better outcomes for leaders who have had coaching as opposed to leaders who have not been exposed to a healthcare specific coaching model. (Refer to Chapter one paragraph 1.5.2 for the underlying theory of this proposition).

7.3 POPULATION, SAMPLE FRAME, SAMPLING AND SAMPLE SIZE

7.3.1 Population

The population used was the healthcare sector in South Africa. From the population of all hospital managers both public and private, a sample of 226 hospital managers was drawn to include the private sector in its entirety which was a total of 226 hospitals. As stated previously the databases of HASA and the 2009 Healthcare Review (2009: 101) were used to source the names and contact details of the 226 hospital managers. The quantitative research was applied to all 226 hospital managers.

7.3.2 Sample frame, sampling and sample size

The sample frame comprised of the list of the 226 hospital managers. The qualitative element of the research was determined by whether any form of executive coaching has been deployed in the private health sector. On the assumption from the literature review that no data existed, the entire private healthcare sector was explored provided that the entities approached were de facto organisations registered via legislation of the South African Government to provide healthcare. Thus, the sample size included all organisations within the private healthcare sector as follows. The entire sample was invited to participate in the research, and the eventual sample size was determined by the response rate.

Table 7.1: Distribution of hospitals, beds and theatres by ownership, 2007

Hospital Group	Number of hospitals	% of hospitals	Number of beds	% of beds	Number of theatres	% of theatres
Clinix	4	1.9	511	1.9	10	1.0
Independent	64	25.0	3 417	12.3	125	12.9
Joint Medical Holdings	4	1.9	367	1.3	20	2.0
Life Healthcare	56	25.9	7 300	26.4	257	26.5
Medi-Clinic	44	20.3	6 401	23.2	234	24.2
Melomed	3	1.4	351	1.3	12	1.2
Mining	5	2.3	1 470	5.3	16	1.7
Netcare	46	21.3	7 769	28.1	294	30.4
Total (8)	226		27 586		968	

Source: HASA, 2009

The Hospital Association of South Africa was contacted to ensure that every member of the sample had been selected for the research as this would allow the results to be generalised to the target population and would prevent subjectivity and bias (Burns & Grove, 2001).

7.4 RESEARCH DESIGN

Multi-method and mixed methodology research design, including qualitative and quantitative data collection were used.

From the website database of the Hospital Association of South Africa it was established that 226 private hospitals were licensed to operate in South Africa. Using the isalient website the questionnaire was made available electronically. The research questions were open-ended and exploratory and generated additional information during the telephonic interview process, described subsequently in this paragraph. The questionnaire was piloted, feedback was received and the necessary technical

adjustments made whereafter and supported by two emails inviting participation, the updated version of the questionnaire was despatched to all 226 hospital managers. Of the 226 hospital managers contacted via email, eight (8) had to be contacted via fax also as the email addresses proved inaccessible. The identical letter of invitation sent via email was subsequently sent via fax. Where appropriate and requested, personal contact by means of a telephonic interview was used to finalise the ROI questionnaire and to test the conceptual model.

A structured questionnaire was designed after the literature review and is attached as Annexure "C". In the questionnaire, the researcher asked open-ended and closed questions to find out what hospital managers knew and had experienced about executive coaching as it pertained personally and organisationally.

The questionnaire allowed for objective data from the hospital managers and by administering the questionnaire electronically via email eliminated diversion from the topic, and prevented bias and subjective judgements from the researcher. All the hospital managers were asked the same questions, which allowed for objective comparison of results (Brink, 1996) (Saunders et al, 2007) and ensured consistency of responses.

As per Brace (2004) the two generally recognised types of error namely sampling and non-sampling errors could be contained. The sampling error was reduced by increasing the size of the sample to the maximum number of hospital managers in this case 226 hospital managers.

The non-sampling errors of coding, data entry process and mistakes made when the answers were provided (Brace, 2004) posed the greatest challenge and every attempt was made to obtain the most accurate data to address the objectives of the study. The interview schedule at Annexure "C" was compiled with this firmly in mind and these principles and cautions were applied and tested vigorously when the electronic version of the questionnaire was compiled and posted on the isalient website.

It was acknowledged that hospital managers were being used on a voluntary basis, to answer in their own time, questions which may have been of little interest to them, questions which dealt with their own feelings and emotions about issues they had never consciously considered, and data collected through an interview would never be

completely accurate (Brace, 2004). In an attempt to counteract that scenario, the mixed methods of delivering an electronic questionnaire as well as the follow up telephonic interview were used.

7.5 RESEARCH PROCESS

Permission was sought from all the eight (8) major hospital groupings prior to the hospital managers being contacted and asked to complete the questionnaire.

After the questionnaire had been designed, it was piloted with the Regional Human Resource component of the Coastal Region of Netcare. Feedback around issues of clarity was received and the questionnaire was adjusted on that basis. The feedback received during the pilot study related to the absence of a description of the proposed model. The questionnaire was then adjusted to include a visual of the model as well as a description of the process which the model followed.

7.5.1 Quantitative research

The Hospital Association of South Africa (HASA) website which contained a list of all member hospitals, the names of their hospital managers as well as their contact details was used to access the information necessary for the dissemination of the questionnaire. This source of information provided the details of 220 Hospitals. Of the 226 private hospitals in South Africa, six (6) of these were not members of HASA and their details were extracted from the Healthcare Review (2009) which contained details of every hospital in South Africa, both private and public. The questionnaire was designed on the isalient website, and then tested by the designer as well as the author.

Thirty six hours prior to communicating with all 226 hospital managers identified via the HASA website and the 2009 Healthcare review, a personalised email was sent to each respondent requesting their participation in the research. This was done in order to verify all the email addresses and identify any communication issues via the electronic medium.

Of the 226 hospital managers, eight (8) email addresses were returned with a message to the effect that the contents were undeliverable. Those eight (8) hospital managers

were then contacted telephonically and fax details sought in order for the message to be transmitted via fax. This enabled the hospital manager concerned to complete the questionnaire online but the initial communication tool was via fax.

Of the 218 hospital managers who received the email and the eight (8) who received the invitation by fax, inviting/ requesting their participation in the research, 192 responded positively wishing the author well and indicating that they would participate in the research. This represented an 88.07% response rate to the initial email.

Thirty hours after the despatch of the email requesting the hospital managers' participation in the research, a personalised email was sent to the 218 hospital managers whose email addresses had not returned undeliverable status messages and a personalised fax in the form of a letter (containing details identical to those in the email message) to the eight (8) hospital managers for whom email could not be used. Both forms of communication contained the link to the internet-based source of the questionnaire (the primary research tool).

Following the distribution of the email based questionnaire and the analysis of the findings, an interview was conducted with the 15 hospital managers who had indicated that they would value the executive coaching experience detailed in the questionnaire. This formed part of the qualitative research component.

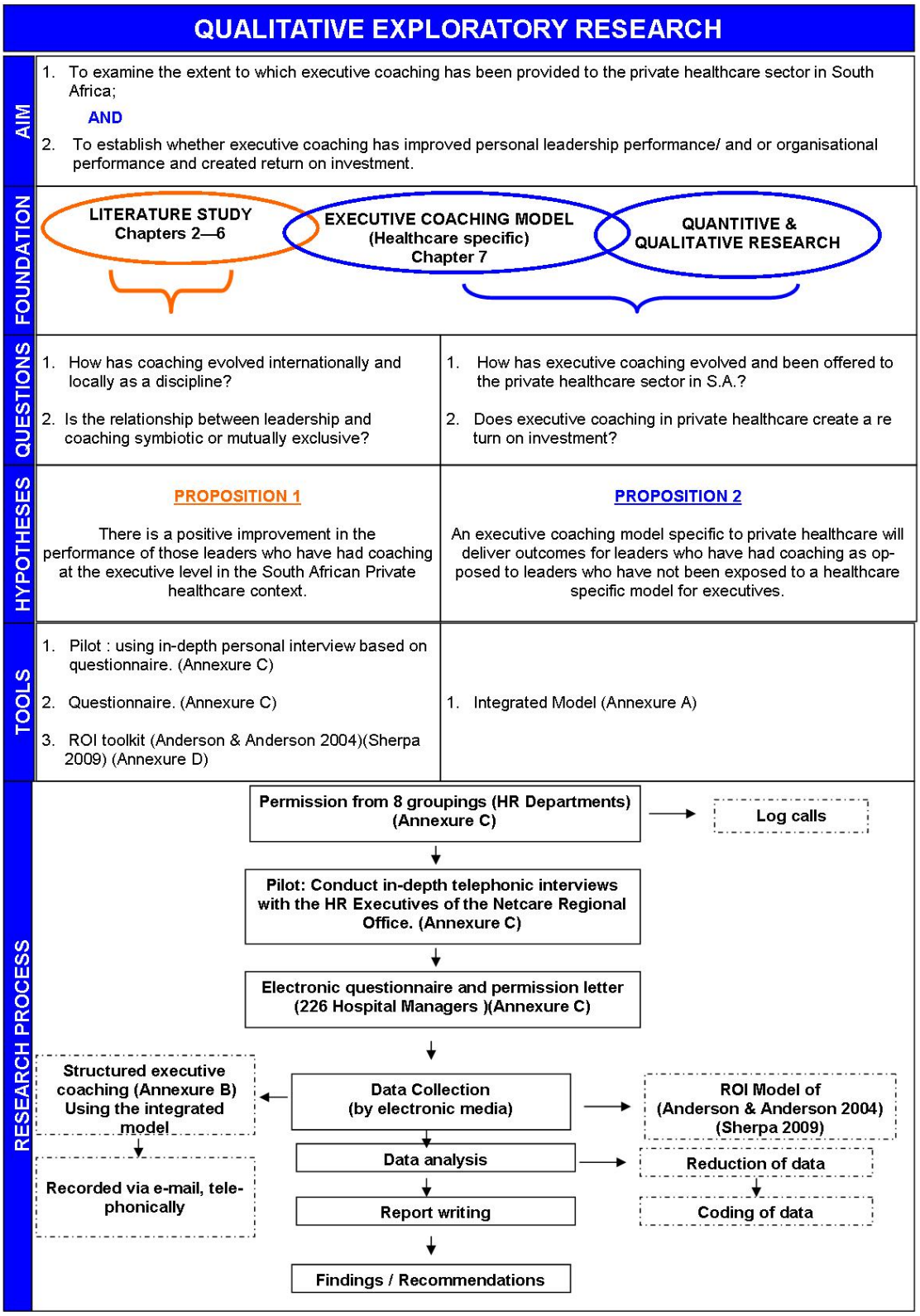
7.5.2 Qualitative research

When a respondent answered in the affirmative to having received executive coaching, the ROI Toolkit (Sherpa, 2009) (Anderson & Anderson, 2004) contained at Annexure E was supplied, followed by an invitation to experience the model, contained in the electronic questionnaire as well as at Annexure C (and described in Chapter 6). The data provided by the hospital managers during the telephonic interview process and which dealt with the testing of the conceptual model, was qualitative and largely descriptive as well as not readily available in pre-determined categories.

The responses provided during the telephonic interview were then transcribed to include all possible context such as setting and social context given the nature of the research. Thick description (Leedy, 1993) was used to capture imagery, interpretative comment and contextual knowledge given the subject matter and the importance of

measuring the relative return on investment both for the subject personally as well as for the organisation. Figure 7.1 describes schematically the research design and process.

Figure 7.1 Research process



From Figure 7.1 it can be seen that the research process was divided into eight (8) sub-processes as follows:

1. Permission to conduct the research was sought in the first instance from the eight (8) private sector groups which own the majority of the 226 private hospitals registered to provide healthcare in South Africa. This set the foundation for further distribution of the questionnaires and also the pilot study.
2. A pilot study using the questionnaire in unadulterated form was conducted with the Human Resource component of the Netcare Coastal Region so as to refine the content and test for ambiguity or lack of clarity insofar as the content of the questionnaire (Annexure "D') was concerned.
3. Thirty six hours prior to the email containing the link to the electronic questionnaire (internet based) being sent, an email (218 hospital managers) and a fax (eight (8) hospital managers) was sent inviting and requesting participation in the research.
4. Following the introductory/ invitational emails and faxes sent, the link to the questionnaire was sent with a covering letter of introduction.
5. Where responses are made in the affirmative in respect of hospital managers having received executive coaching or wishing to experience the model (15 hospital managers) telephonic contact was made and the 15 hospital managers exposed to the model as well as to the ROI toolkit (Annexure "D") .
6. The questionnaire and ROI toolkit were designed in an internet based format so that responses were returned electronically and could be collated, coded and analysed electronically. Once all the responses had been received by the relevant deadline the data analysis began.
7. Further contact was made by telephone in order to test the model and request the completion of the ROI Toolkit (Annexure "D").
8. In both email contacts hospital managers were invited to communicate with the author should any questions or issues for clarity become apparent during the process. One (1) respondent requested clarity

around the definition of Executive Coaching per se. A response was sent via email and this was acknowledged as having been satisfactory.

7.6 DATA COLLECTION METHODS, TECHNIQUES AND PROCEDURES

7.6.1 Introduction

The data was collected using the process detailed in Figure 7, and described in the last quadrant. A detailed description of the process is contained at paragraph 7.5 above.

7.6.2 Data collection instruments

Data was collected via an internet based questionnaire (quantitative) and a telephonic interview (qualitative) which tested the integrated model specifically and also applied the ROI tool.

Critical to the design of the questionnaire was a review of the literature and the discussion of ideas at colloquia at the University (Saunders et al, 2007) thereby applying a deductive approach.

7.6.3 Data analysis techniques

As both quantitative and qualitative data was gathered, different methods were used to analyse the data. The different methods are described below.

7.6.3.1 Quantitative data analysis techniques used

SPSS version 15.0 (SPSS Inc., Chicago, Illinois) was used to analyse the data. Frequency tables and bar charts were generated to describe the responses to the questions in terms of frequency counts and relative percentages. Responses were cross –tabulated by gender and Pearson's chi square tests were used to assess if there was any association between gender and response. A p value <0.05 was considered as statistically significant.

The Pearson's chi square test was used to assess association between row and column variables in the cross-tabulation of categorical variables. As the variables were categorical, the chi square test was the appropriate test applied. Given that this test required a sample size of 20 or more the tables where the sample size was greater than 20, for example 79, the assumptions were met and the test was valid. Where the sample size was less than 20 the Fisher's exact test was used.

Quantitative analysis was applied to questions (1) to (10) of the electronic questionnaire distributed via email as well as to the ROI questionnaire.

7.6.3.2 Qualitative data analysis techniques used

From the basis of a deductive position, existing theory was used to shape the approach used for both the qualitative research process as well as the data analysis.

Working from construct summaries, notes taken during the interviews around the executive coaching model were transcribed and categorised representing the context of the research as well as the objectives. Key themes were identified and conclusions drawn. Data was therefore explored systematically and rigorously per Saunders et al (2007).

Notes were transcribed during the interviews using thick description (Leedy, 1993) and from those notes themes were identified. Each interview was recorded separately so as to identify the respondent and ensure validity and reliability of the data collected (Saunders et al, 2007). Quotes relevant to the themes were also transcribed verbatim in order to facilitate their use as substantiation during the analysis and interpretation of the themes. In the final analysis, 33 themes were identified, of which 9 themes were directly relevant to the content and 24 to the content again ensuring validity and reliability of the data collected (Saunders et al, 2007).

7.7 ADVANTAGES AND DISADVANTAGES OF USING INTERNET BASED QUESTIONNAIRES AND TELEPHONIC INTERVIEWS

The pilot study was conducted on a personal basis although the questionnaire was used in the same format. Once refined, the regional human resources team was

thanked for their contribution and the changes made were also explained. The regional team then re-completed the questionnaire and indicated that it was more user friendly and easily understood.

The use of the internet and electronic mail (Yenza, 2008) (Sainsbury, Ditch & Hutton, 1993) provided the researcher with a range of new opportunities for finding information, networking, conducting research and collating the results. The challenge however lay with the ethics of conducting research online, physical access and the skill required on the part of the participant to use the technology itself, the accuracy and reliability of information obtained and the medium of communication itself.

The advantage of an online medium was the low cost delivery and return (given that the infrastructure of computers and networks already existed in 218 out of the 226 hospitals), wide potential coverage, ease of completion, submission and data capture (Sainsbury et al, 1993) (Selwyn & Robson, 1998). The willingness of hospital managers to participate mitigated for the method and adequate introduction of the subject matter was done (Yenza, 2008).

A personal call was made to each one of the hospital managers before sending the electronic questionnaire in the first place to establish a relationship as well as given additional credibility to the completion of the questions (Thomas & Purdon, 1994). The initial contact besides establishing the relationship between the researcher and the respondent also allowed for data to be collected from a geographically scattered sample more cheaply and quickly (Thomas & Purdon, 1994). Electronic mail also avoided the traditional biases around race, gender, age and sexuality (Selwyn & Robson, 1998).

The critical problem traditionally raised by electronic media based surveying being that of obtaining representative samples (Thomas & Purdon, 1994), was eliminated by contacting all 226 members of the sample (all hospital managers in the entire private sector) from within the larger health sector population. Random sampling was not used.

Computer assisted questionnaires enhanced the quality of survey data by eliminating the routing of problems within the questionnaire, eliminating the possibility of an

interviewer not asking the question in the first place, and questions being customised (Sainsbury et al; 1993).

The questionnaire was designed to take between 30 to 45 minutes in total, but given the medium could be completed at a time/ times convenient to the respondent. This dispelled the disadvantage of traditional techniques which needed to be long enough to gather the required data but also did not impose too heavily on the time of the respondent (Sainsbury et al, 1993 : Selwyn & Robson, 1998). As opposed to a face to face interview which would rarely follow the course intended as the respondent would change their view about earlier answers (Sainsbury et al, 1993), the electronic questionnaire allowed for reflection on the part of the respondent and therefore potentially greater depth to the answer (Selwyn & Robson, 1998).

As with any method, and as also discussed earlier, given the topic, hospital managers may have struggled with compiling an answer which matched or "fitted" (Sainsbury et al, 1993) and may even have guessed an answer if unsure (Saunders et al, 2007). Using electronic mail avoided the conventional constraints of spatial and temporal proximity between the researcher and the respondent and offered the advantage of providing already transcribed data (Selwyn & Robson, 1998). The electronic questionnaire reduced the problem of interviewer effect, thereby alleviating some of the interpersonal problems commonly associated with interviewing techniques (Selwyn & Robson, 1998). The clear disadvantage would be the loss of opportunity to deal with any nuances or reflections expressed, at that time although this was mitigated by the follow-up telephonic interview.

A further disadvantage was potentially the lack of "face to face" contact although this was mitigated by telephonic contact. This had the potential to contribute to constraints around validity and reliability of the data collected (Walther, 2010). This would take the possible form of the person behind the desk not necessarily being the person to whom the email request was directed. Within the corporate context however, this was obviated by verifying via the internet database that the internet protocol address matched the initial email address to whom the invitation to participate in the research had been sent. Each Hospital Manager participating verified that their internet access as well as email usage was password protected and that their password was confidential to them and for personal use only. This validated the data and also created reliability in what data had been collected (Saunders et al, 2007). In the events where data was collected telephonically the identity of the

respondent was validated prior to the telephonic interview being conducted (Walther, 2010).

The greatest weakness in this method was potentially the refusal of participants to participate in the research, thereby creating potential distortion of the data outcomes (Gobo, 2001). This was mitigated by sending an invitational and introductory email to all hospital managers ahead of the actual despatch of the electronic questionnaire (Gobo, 2001). A written as well as verbal undertaking as to the confidentiality of the data was advocated at the outset and this was included in the research process. This was applied to both the internet based questionnaire as well as the telephonic interview when the model was tested and the ROI questionnaire served.

A possible weakness may also have presented in the form and language used given the multi-cultural profile of the respondent base. This was dealt with by providing spaces for written comment at the end of each part of the questionnaire to allow for comment on the part of the hospital manager. The pilot study also served to eliminate ambiguity and improve clarity of content of the questionnaire.

Discourse regarding the subject may have presented from a range of perspectives given the recent introduction of executive coaching to the South African context. This may have created feelings of inadequacy which Gobo (2001) advocated dissipating by using well-prepared language which clearly displayed the content of the question in the second instance and the nature of the research in the first (with which the pilot study assisted). The enthusiastic responses received from all the hospital managers who responded indicated that there was no discourse regarding the subject.

7.8 VALIDITY AND RELIABILITY

In order to ensure reliability and the degree of consistency with which the data collection instrument produced the same results every time it was implemented in the same situation, the identical questionnaire was sent to each hospital manager. The data collection instrument, in this case the questionnaire was therefore accurate and stable in order to reflect true scores of the attributes under investigation (Brink, 1996). To ensure reliability the researcher pre-tested/ piloted the questionnaire with the Human Resource Executives of the Netcare regional office in KwaZulu-Natal (Brace,

2004). This was done to identify vague and unacceptable questions, thus ensuring validity.

7.8.1 Construct validity

Abstract concepts were measured adequately and logically and relationships between variables identified with the instrument based on theory and clear operational definitions. Construct validity included the definition of variables in line with existing literature or theory and differentiated between hospital managers who had experienced executive coaching and those who had not (Burns & Grove, 2001). In this research the questionnaire was based on the literature reviewed and the relevance to the variables in the content. Hospital managers who had not experienced executive coaching were not invited to use the ROI toolkit or invited to experience the integrated model.

7.8.2 Content validity

The tool was evaluated for content validity to ensure that all the components of the variables to be measured were included in the questionnaire without neglecting important components (Brink, 1996). To meet this criterion, relevant literature was reviewed before developing the instrument and all necessary content was included. Research objectives were constantly referred to and propositions also identified in order to ensure congruence and relevance.

7.8.3 Internal validity and reliability

In order to measure internal validity and reliability, the researcher was observant of the following factors, which could have provided false or negative measurement in the variables of the study.

The potential or envisaged constraint due to a lack of “face to face” contact was mitigated by two (2) forms of interaction in any event in that initial telephonic contact was made as well as a subsequent interview conducted telephonically also. Data was ostensibly linked directly to each respondent and could therefore be validated and considered reliable (Saunders et al, 2007). Given the confidentiality had been contracted prior to the respondent participating in the research, there was no reason for the respondent to manipulate any response, either via the internet or via the

telephonic medium. The issue of consent has been discussed previously but for the purposes of this Chapter is also again confirmed.

Consent was explicitly sought at the onset of the data collection process, and re-confirmed throughout interaction, either by way of the internet database or telephonically with the researcher. Each participant was also debriefed by way of an invitation to contact the researcher for information during or subsequent to the data collection process. The interaction in this regard is discussed in Chapter 9. The requirement of debriefing was thus met.

7.8.3.1 Setting and reliability

The research was conducted in the privacy of the hospital manager's office by assumption that this would create the environment for honest and unbiased responses. Within the context of the setting, the validity of the data was established by verifying the email address with the internet protocol address (Walther, 2010). By conducting telephonic interviews subsequent to the initial data collection the reliability of the data collected was further tested, as has been discussed in 7.7 above. Further discussion in this regard follows in paragraph 9.4 below.

7.8.3.2 History

Given the popularity and hype around executive coaching the mere sentiment could have created some bias during the process and skewed responses. A clear statement of the purpose and goal of the study was made at the outset in the letter of introduction (Leedy, 1993). Saunders et al (2007) also referred in this context to subject or participant error where the time and juncture at which a survey was completed may in their view have been affected by the ensuing sentiment of the participant at that moment. Bias may also have crept in where answers were affected by organisational culture or prevailing management styles (Saunders et al, 2007). The questions posed were clear and unambiguous and were tested during the pilot study to ensure that they did not generate emotion in the respondent as opposed to encouraging direct answers. None of the historical factors identified presented at any juncture.

7.8.4 External validity

The ability to generalise the findings of the research to other members of the population rather than the sample (Burns & Grove, 2001) (Saunders et al, 2007) created external validity. The outcomes of the study had extended generalizability within the Health Sector. Leedy (1993) also suggests a consistent trail of logs (reflected in Figure 7.1 also) justifying each step in the research process and dealing with alternatives. In this research the options of the ROI toolkit and the opportunity to experience the integrated model dealt with the view of Leedy (1993).

As the "sample" extended to the entire private sector population concern over data validity were also obviated. The access to the entire population spread over the entire country obviated skewing on gender, race or any geographical basis. The sampling was therefore fully representative as has been previously discussed and the data may be applied to the remainder of the health sector population viz the public and non-governmental sectors.

The Internet provided the method by which responses were reached and recorded extensively and verified electronically also as previously discussed. This was further followed up telephonically and the identity of each respondent confirmed pre and post the research. The issue of potential identity deception and therefore invalid data is therefore excluded.

7.9 ETHICAL CONSIDERATIONS

To ensure that the research was conducted within an ethical framework, the principles of seeking permission to conduct the research, beneficence, respect, privacy and confidentiality and the right to fair treatment, were observed (Saunders et al, 2007).

Before any individual was contacted, permission was sought in writing from the respective corporate human resources functionary (Saunders et al, 2007). After obtaining permission, the hospital managers were contacted telephonically to confirm their contact details before being invited to participate in the research. The researcher communicated the benefits (in the form of general and generic feedback on the outcome of the research) to the hospital managers. The researcher also undertook to

avoid misuse of the relationship established with the hospital managers by not asking intrusive or sensitive questions and not disclosing any information to other hospital managers at any stage. Hospital managers received questionnaires privately and by virtue of the language and tone used were treated with respect and dignity (Polit & Beck, 2006 : Saunders et al, 2007).

In conducting this research, the hospital manager's privacy was maintained in the first instance for the pilot study during contact with the Human Resource Executives by conducting individualised interviews and omitting personal details in the interview schedule and not being forced to answer questions (Polit & Beck, 2006 : Saunders et al, 2007). As the interviews took place in the privacy of the hospital manager's own environment, and hospital manager's names were not contained in the notes. The interview schedules were assigned numerical numbers (the internet protocol addresses) for tracking purposes only. The interview schedule and completed interview schedules were kept in a safe place to which only the researcher and her personal assistant had access.

For the purposes of the electronic survey, hospital managers were identified only via their internet protocol addresses. The responses were checked for authenticity and for validity against the internet protocol addresses and this ensured that each respondent only completed the questionnaire once online. The 15 hospital managers who indicated that they would want to participate in the testing of the integrated model were identified with their prior permission having been sought, via their internet protocol addresses.

Using the same format the responses collected during the telephonic interview process were recorded against the internet protocol identification only and no name was recorded. In so doing complete confidentiality was ensured, as the identity of the hospital manager was only known to the researcher during the telephonic interview.

The right to fair treatment was maintained by selecting all available hospital managers not based on racial, social or cultural bias. The effect of social desirability bias (Brace, 2004) could not be assessed although it is assumed that in the case of the 226 hospital managers, that completing the questionnaire privately eliminated same. In keeping with strict ethical practice no questionnaire received electronically was forwarded and/ or shared with any third party save for the purposes of data

transcription where the researcher requested her personal assistant to collate responses and transcribe the notes taken (Saunders et al, 2007).

7.10 PROBLEMS EXPERIENCED WITH THIS RESEARCH

7.10.1 Sample size

The size of the sample (226 hospital managers) was difficult to manage administratively initially as following up on the contact details of the hospital managers was time consuming and involved numerous contacts in some instances to make direct contact with the hospital manager.

7.10.2 Use of the internet medium

The website chosen to host the questionnaire was blocked by some corporates as it was an unfamiliar site. When this was identified it was incumbent on the researcher to contact the relevant webmaster to open access to the site so that hospital managers could make the link via their normal corporate internet access protocols.

7.10.3 Understanding of the concept of executive coaching

In two (2) out of the 149 hospital managers (out of a total of 226 requests sent) the concept of executive coaching was entirely new and unheard of. Email contact was made with the researcher and the concept defined. In both cases the response was appreciated and both hospital managers completed the questionnaire.

7.11 CONCLUSION

The use of both quantitative and qualitative research methods, as well as triangulation proved to provide a volume of data suitable for analysis. The results of the research are discussed in Chapter 8.

CHAPTER 8 – RESEARCH RESULTS

8.1 INTRODUCTION

In order to explore the quantitative and qualitative research proposed after the conclusion of the literature study, a questionnaire to be transmitted via electronic media as well as a telephonic interview format were compiled. The methodology served to explore specifically the aims of the research namely:

- An examination of the extent to which executive coaching had been provided to the private sector in South Africa and whether this had improved personal leadership performance and/or organisational performance and created return on investment; and
- To test a conceptual model for executive coaching in private healthcare in South Africa.

The research questions which were linked to the aims of the research further explored the evolution of coaching as a discipline both locally and internationally. The relationship between leadership and coaching was also explored by way of the literature study as was the evolution of coaching.

Two (2) propositions emerged from the data and were thus explored by way of the quantitative and qualitative research process, namely:

- Proposition 1 – There is a positive improvement in the performance of those leaders who have had coaching at the executive level in the South African Private healthcare context.
- Proposition 2 – An executive coaching model specific to private healthcare will deliver outcomes for leaders who have not been exposed to a healthcare specific model.

The research process was able to explore the aims, research questions and propositions by way of a literature study in the first instance (Chapters 1 to 6) and quantitative and qualitative research in the second instance (Chapter 7). The results of the quantitative and qualitative data analysis are discussed below.

8.1.1 Quantitative data

SPSS version 15.0 (SPSS Inc., Chicago, Illinois) was used to analyse the data. Descriptive and multivariate statistical analysis were done. Frequency tables and bar charts were generated to describe the responses to the questions. Each question was also cross-tabulated against gender and Pearson's chi square tests were used to assess the association between gender and response. Gender was requested in the questionnaire initially for demographic purposes but later tested as the results seemed significant, a characteristic which is discussed subsequently.

The Pearson's chi square test was used to assess association between row and column variable in a cross-tabulation of categorical variables. As the variables were categorical, the chi square test was appropriate although it was premised on the assumption that not more than 20% of the cells expected counts were less than 5, which required a sample size of greater than 20 in total. For the tables where the sample size was 79 the Pearson's chi square assumptions were met and the test was valid.

A p value <0.05 was considered as statistically significant.

Where the sample size was only 16, the assumptions were not met and Fisher's exact test was used. Fisher's exact was therefore not used as a post hoc test, but as a significance test which was used in place of the Pearson's chi square test when the assumptions were not met.

ROI values were summarized for the group of hospital managers who had received executive coaching as a whole using mean, standard deviation and range.

8.1.1.1 Results

One hundred and forty-nine responses were received out of 226 sent out. This resulted in a response rate of 66%. This was slightly below the valid response rate level of 70% considered as adequate for surveys in order to reduce non response bias but nevertheless it is considered adequate for the purposes of this study.

One-way frequencies of responses to all the questions are presented in Tables 8.1 to 8.5.

Table 8.1: Gender distribution

		Frequency	Percent
Valid	F	61	40.9
	M	88	59.1
	Total	149	100.0

From Table 8.1 it is evident that the sample shows a relatively balanced gender distribution with 59% males and 41% females in the study.

Table 8.2: Exposure to Executive Coaching

		Frequency	Percent
Valid	Y	79	53.0
	N	70	47.0
Total		149	100.0

From Table 8.2 it is evident that 53% (n=79) had ever had executive coaching.

Table 8.3: The use of executive coaching and the benefits derived

Refers to Question		Frequency	Percent	Valid Percent	Cumulative Percent
Did you pay for your executive coaching yourself?	Valid E	57	38.3	72.2	72.2
	Valid S	22	14.8	27.8	100.0
	Total	79	53.0	100.00	
	Missing	70	47.0		
	Total	149	100.0		
Did your coach use a coaching model?	Valid N	30	20.1	38.0	38.0
	Valid Y	49	32.9	62.0	
	Total	79	53.0	100.0	
	Missing	70	47.0		
	Total	149	100.0		100.0
	Valid Y	49	100.0	100.0	100.0
Was the model explained to you?	Valid Y	49	100.0	100.0	100.0
Did the executive coaching process follow the model?	Valid Y	79	53.0	100.0	100.0
	Missing	70	47.0		
	Total	149	100.0		
Did you benefit from the	Valid Y	79	53.0	100.0	100.0
	Missing	70	47.0		

experience of executive coaching?	Total	149	100.0		
Did your employer benefit from the experience of executive coaching?	Valid Y Missing Total	79 70 149	53.0 47.0 100.0	100.0	100.0
Do you feel that your team benefited from your experience of executive coaching?	Valid N Valid Y Total Missing Total	1 15 16 133 149	.7 10.1 10.7 89.3 100.0	6.3 93.8 100.0	6.3 100.0
Would the application of this model add value to any executive coaching process?	Valid N Valid Y Total Missing Total	1 14 15 134 149	.7 9.4 10.1 89.9 100.0	6.7 93.3 100.0	6.7 100.0

Of the 79 hospital managers who had had executive coaching, in 72% of situations the employer had paid for the intervention and in 28% of situations the hospital manager had paid for themselves to have the coaching. 62% of hospital managers responded that their coach had used a coaching model. All 49 hospital managers whose coaches had indeed used a coaching model indicated that the coaching process had followed the model. All 100% of those who had experienced executive coaching reported that they had benefited from the experience and intervention fully as had their employers and their teams. 93.8% of the hospital managers who responded to the question as to whether in their experience the conceptual model would add value to any executive coaching process considered that this would indeed be true and all responded that they would like to experience the model.

Table 8.4: The recipients of executive coaching –gender distribution

	Have you ever had executive coaching? (N)	Have you ever had executive coaching? (Y)	Total	Pearson's chi square	P value
Gender F – Count	37	24	61	7.755	0.005
% within Gender	60.7	39.3	100.0		
Gender M – Count % within	33	55	88		
Gender	37.5	62.5	100.0		
Total – Count	70	79	149		
% within Gender	47.0	53.0	100.0		
	Did you pay for your executive coaching yourself? (E)	Did you pay for your executive coaching yourself? (S)	Total	Pearson's chi square	P value
Gender F – Count	15	9	24	1.509	0.206
% within Gender	62.5	37.5	100.0		
Gender M – Count % within	42	13	55		

Gender	76.4	23.6	100.0		
Total – Count	57	22	79		
% within Gender	72.2	27.8	100.0		
	Did your coach use a coaching model? (N)	Did your coach use a coaching model? (Y)	Total	Pearson's chi square	P value
Gender F – Count	13	11	24	3.387	0.050
% within Gender	54.2	45.8	100.0		
Gender M – Count % within	17	38	55		
Gender	30.9	69.1	100.0		
Total – Count	30	49	79		
% within Gender	38.0	62.0	100.0		
	In your experience, would the application of this executive coaching model add value to any executive coaching process? (N)	In your experience, would the application of this executive coaching model add value to any executive coaching process? (Y)	Total	Fisher's exact p	
Gender F – Count	1	7	8	1.000	
% within Gender	12.5	87.5	100.0		
Gender M – Count % within	0	8	8		
Gender	.0	100.0	100.0		
Total – Count	1	15	16		
% within Gender	6.3	93.8	100.0		
	If provided with the opportunity, would you like to experience executive coaching using this model? (N)	If provided with the opportunity, would you like to experience executive coaching using this model? (Y)	Total	Fisher's exact p	
Gender F – Count	0	7	7	1.000	
% within Gender	.0	100.0	100.0		
Gender M – Count % within	1	7	8		
Gender	12.5	87.5	100.0		
Total – Count	1	14	15		
% within Gender	6.7	93.3	100.0		

There was a significant association between gender and whether any hospital manager had had executive coaching (p=0.005) as male hospital managers were more likely to have had executive coaching. There was no association between gender and who had paid for coaching (p=0.206) as the percentages of self payment and employer payment were similar between the genders. There was borderline significance in the association between gender and whether the coach had used an executive coaching model (p=0.050). Males were more likely then females to report the use of an executive coaching model. There was no difference (p=1.000) between the genders in terms of whether in the experience of the hospital managers, the application of the specific executive coaching model would add value to any executive coaching process and whether the hospital manages would if provided with the opportunity, like to experience executive coaching using the model.

Table 8.5: Analysis of the questionnaire of Sherpa (2009) and Anderson and Anderson (2004) in respect of the Return on Investment

N	Valid	79
	Missing	70
Mean		102.11
Std. Deviation		17.567
Minimum		52
Maximum		240

The mean ROI for the 79 responses was 102.11%. The standard deviation was 17.6% and the range was from 52% to 240%.

From the findings of the quantitative analysis, it was clear that executive coaching delivered a positive improvement in the performance of those hospital managers (leaders as defined in Proposition 1) but given a response rate of 34.9% (79 out of 226 hospital managers) the mean ROI of 102.11% cannot be generalised and is divergent with the qualitative results which did not measure return on investment per se.

8.1.2 Qualitative data

From the feedback gathered on the testing of the conceptual integrated model and recorded using thick description the following data summarised in Annexure E was sourced. The model was tested by way of exploratory research via the telephonic medium.

8.1.2.1 Results

Of the 15 hospital managers who participated in the testing of the model, 33 themes were identified from their responses. The 33 themes were identified from the responses transcribed verbatim in the form of direct quotes pertinent to either the process or the content of the model. Where a quote could be ascribed to 90% and more of the respondents this quote was designated as a theme. The themes were divided between the coaching process (9 themes) and the content of the coaching intervention (24 themes). Each theme linked back to the various constructs in the

theory discussed in Chapter 4 and integrated in Chapter 6 during the discussion of the conceptual model. This summarised the deductive position taken, whereby existing theory was used to shape the approach adopted to the research process as well as to aspects of the data analysis, in this instance the qualitative research. Two (2) Research propositions which emerged from both the theory and the data are discussed subsequently in Chapter 9.

The pattern of the data which emerged from the research was able to test the adequacy of the framework as a means to explaining the findings. As per Yin (2003) the use of the research processes (electronic questionnaire and telephonic interviews) was underpinned by specifying theoretical propositions before the data was collected and analysed.

The themes identified apply to a minimum of 90% of the 15 hospital managers in the case of the process of the conceptual model (and where this percentage is greater this is indicated), and to 100% of the 15 hospital managers who participated in the testing of the conceptual model as far as the Content of the Model is concerned.

8.1.2.2 Themes emanating from the Process of the Model

8.1.2.2.1 Theme 1 – Logical process

All (100% of) hospital managers described the executive coaching process as logical. Quotes ascribed included:

"Simple and easy process to follow"
"Makes sense and logical"
"A logical feedback loop for communication"

8.1.2.2.2 Theme 2 – Contextualises leadership framework and tools universal to the leadership context

All (100% of) hospital managers described the process as one which contextualised the leadership framework. There was no ambiguity as to processes relevant to team or performance coaching.
Quotes ascribed included:

"Logical communication framework"
"A logical conversation"
"Clear measurable outcomes within a clear framework"
"Easy to match with the leadership journey"

8.1.2.2.3 Theme 3 – Examines balance in the workplace

All (100% of) hospital managers described the conceptual model as a process to recognise the various facets of workplace life and the role of the executive in creating balance and synergy between the various facets.
Quotes ascribed included:

"Clearly compartmentalises the facets of workplace life"
"Clear distinction between the workplace life cycle"
"Clear measurables for each context – leader, team and organisation"
"Easy to measure how leadership, team and organisational goals inter-relate and synergise"

8.1.2.2.4 Theme 4 – Valuable tools and feedback at each stage of the process

Ninety (90) % of hospital managers described the process as valuable in providing tools in the team context for developing themselves to both give and receive feedback in particular. The views expressed resonated with the theory of the value of sharing mutual experiences, feedback and opinions in order to create agreed outcomes on a wide variety of business related topics. All (100%) of hospital managers expressed the value of the process as a feedback tool in itself as previously discussed in the earlier themes.
Quotes ascribed included:

"Superb process for giving and receiving feedback"
"Foolproof process for giving and receiving feedback"

8.1.2.2.5 Theme 5 – Space to identify, analyse and reflect

One hundred (100) % of hospital managers described valuing the space created by the process to identify issues, analyse these issues and reflect on the implications of same.

Quotes ascribed included:

“Provided time to think and define issues”
“Logical process created clear spaces to define issues”
“The process allows you to clearly define your actions and to develop clear solutions”
“Taking the time to look back, yet within the safety of a framework was invaluable and something I will always use now that I have the structure at hand”
“I realised the immense benefit that reflection has for me and my team”
“I realised how positively contemplative thought impacts on me and therefore on my team”

8.1.2.2.6 Theme 6 – Space to experiment in a safe environment

The space to experiment in a safe environment was verbalised by all (100%) of the hospital managers who participated in the research. The critical importance of contracting the privacy and confidentiality ensured that, as in the de facto executive coaching experience, the leader would have such an environment
Quotes ascribed included:

“I trusted the process completely because it made sense and was logical”
“I was fully confident that the information shared was protected”
“At no stage did I feel that I was being judged or exposed”
“I never felt vulnerable during the process”

8.1.2.2.7 Theme 7 – Universal applicability to team context

All hospital managers (100%) described the process as providing significant value to their team context in that the feedback and assessment tools could be applied.
Quotes ascribed included:

“I look forward to applying these tools to my team”
“I am grateful for a process that provides clear feedback “
“Using the assessment tools gave structure to giving meaningful feedback”

8.1.2.2.8 Theme 8 – Useful reference framework

Ninety (90%) of all hospital managers gleamed numerous reference works as a result of their participation in the research. When requested the full reference listing was provided (5 hospital managers), although in the case of the remainder of the participants (10 hospital managers) references were provided selectively when a hospital manager experienced interest in a particular tool or theory.
Quotes ascribed included:

"Extensive reading list and resources greatly appreciated"
"Comprehensive list of references greatly appreciated"

8.1.2.2.9 Theme 9 – Measurable outcomes

All (100%) of hospital managers described the outcome/s as measurable and quantifiable. This was verified by the quantitative data analysis process relevant to the value of the return on investment and described in paragraph 8.1.1.1 proving convergence of the quantitative and qualitative data sets in this instance and therefore also supporting the first proposition (discussed subsequently in Chapter 9).

8.1.2.3 Themes emanating from the Content of the Model

8.1.2.3.1 Theme 1 – Identifies leadership style

The private healthcare industry in South Africa faces constant change (HASA, 2009) and all hospital managers expressed interest in identifying their leadership styles during times of change. The tools used during the executive coaching process and described in Chapter 6 were used to identify leadership styles and particularly those deployed during times of change. This theme describes also the experience of the conceptual model in its entirety (as discussed in Chapter 6) as well as the themes of process insofar as they relate to the process of evaluating leadership style and discussed previously. The hospital managers who participated in the research found exploring the theory of the aforementioned styles invaluable.
Quotes ascribed to the creation of the theme included:

"Knowing what my leadership style is gives me a solid base from which to move

forward”

“I have a foundation and I can build on it – my leadership style with its inherent strengths and weaknesses provides me with workable material to create an exciting future for myself as well as my team”

8.1.2.3.2 Theme 2 – Identifies leadership influence profile

Taking the hospital managers through the executive coaching process exposed them to tools which identified their leadership influence profiles. As such they were able to build on their awareness vis a vis their leadership styles and identify their ability to influence. Synergies between leadership ethics and executive coaching outcomes were created by way of the executive coaching process and created the opportunity for the hospital manager to learn building on the awareness already created Themes such as transparency in governance,, linkages between personal value systems, and values and organisational outcomes also appeared during the research and strengthened the platforms of awareness created during the executive coaching process.

Quotes ascribed to the creation of the theme included:

“I know who I am and how I influence others, both positively and negatively – invaluable knowledge for taking my team to the next level”

“Building on the ability to give feedback, I can also assess where I stand in terms of my values relative to the organisational goals and values, and define a clear path to creating meaningful change for my team and for my organisation’

8.1.2.3.3 Theme 3 – Identifies leadership behaviour

Closely linked to themes 8.1.2.3.1 and 8.1.2.3.2 were themes emanating from awareness created for the hospital managers during the executive process around the identification of leadership behaviour. Once baseline behaviour was identified in the sample of hospital managers, the process of executive coaching was used to develop a skill set which contained a unique balance of technical and inter-personal skills, self-knowledge and the ability to set and meet performance goals. Again, the creation of awareness facilitated change where appropriate to leadership behaviour, which impacted extensively on Theme 4.

Quotes ascribed to the creation of the theme included:

"I am aware of my behaviour now and how this impacts on my team"
"The awareness created has enabled me to develop both my professional-specific as well as inter-personal skills and I understand the value of doing this on a reflective and ongoing basis"
"Conducting these baseline assessments enabled me to re-evaluate my own performance and develop more meaningful performance goals for both myself and my team, which has motivated us all tremendously"

8.1.2.3.4 Theme 4 – Examines behaviours and impact of behaviour on team

The literature discussed in Chapter 4 identified no shortage of challenges for hospital managers during periods of change and transition. The executive coaching process created awareness of behaviour and how behaviour impacted on the hospital manager's team in all instances. Tools were provided to facilitate balancing the demands of multiple stakeholders during the executive coaching process and provided valuable support to all hospital managers who participated in the research enabling a unique balance of technical and inter-personal skills, self knowledge and the ability to set and meet performance goals mindful of the context. This theme extended to the recruitment process with an awareness being created in all the hospital managers who participated, that traditional task ability would no longer suffice. Additional skills, which are discussed in subsequent themes, were identified as critical.
Quotes ascribed to the creation of the theme included:

"I clearly understand the need to balance the demands of multiple stakeholders, my doctors (clients), my team (internal clients), the hospital staff and most importantly – our patients – so that all the roleplayers function effectively and quality healthcare is provided"

8.1.2.3.5 Theme 5 – Examines behaviours and impact of team behaviour on organisation

The following sub-themes were examined by the hospital managers and discussed extensively during the executive coaching process:

(i) The development of executive talent from the perspective of reward
(ii) Executive burnout in the sector.

(iii) The need to develop emotional intelligence.

(iv) The need to develop sustainable leadership in an industry adversely affected by the "brain drain" and the power stress relationship.

Again, awareness created platforms for discussions and sustainable initiatives on the part of the hospital managers. All hospital managers agreed that unique approaches were required to deal with the unique situation that they found themselves in, in the South African healthcare context

Quotes ascribed to the creation of the theme included:

"I get so overwhelmed by all the demands of private healthcare that I often forget to take a step back and look at the situation from the various perspectives, the content of the model enabled me to do this"

"I realised that rewards can be more satisfying when they are non-monetary, this reflective process enabled me to make meaning of what I do and to develop my emotional intelligence and my awareness of the various underlying factors that affect our industry such as over-inflated egos, political challenges and the need to be cost-effective"

"I wish our company would reward us for participating in processes such as this one as the change that I have been able to bring to my situation both personally and in terms of the contribution of my team has been more valuable than any monetary reward, the pressure just came off"

8.1.2.3.6 Theme 6 – Develops gaps in leadership behaviour

Theme 6 was contextualised extensively by Theme 5 with the exception of a specific gap analysis process being applied to identify behaviours which required adjustment and development. These processes were synonymous with the tools and techniques which were discussed extensively in Chapter 6 which described the conceptual model. Hospital managers identified the process and content of the model as being consistent and easy to apply to both themselves and their teams in the executive context.

Quotes ascribed to the creation of the theme included:

"Understanding the gaps in my behaviour has enabled me to make meaningful personal change and this is impacting very positively on the performance of my team"

8.1.2.3.7 Theme 7 – Clearly defines process to closing gaps in leadership behaviour

As discussed in Theme 6 above, hospital managers identified the process and content of the model as being consistent and easy to apply to both themselves and their teams in the executive context. Limiting beliefs and assumptions were identified during the process. Assumptions about own style and behaviour were reviewed. The hospital managers identified linkages between team behaviours and organisational goals.
Quotes ascribed to the creation of the theme included:

"The tools provided have been invaluable in helping me develop myself as well as my team. We understand our context so much better and are able to understand our development areas"
"I valued the opportunity to explore my limiting beliefs and assumptions. I was under the impression that some hurdles were just meant never to be overcome and knowing that I can think differently about my challenges is empowering"

8.1.2.3.8 Theme 8 – Reviews insights, creates "time to think" – reflection and "making meaning of"

The work of Kline (1999) was shared extensively during the theoretical discussions around this theme. Hospital managers appreciated the essence and value of time for thinking at the strategic level. Part of the thinking process also involved postulating around the value of insightful questions on the part of the executive coach, and then subsequently using this technique on the part of the hospital manager to stimulate creative thinking within the executive team.

This theme was considered one of the core themes by hospital managers participating in the research, in all instances novel yet obvious. The theme stimulated a fresh approach to the thought processes of both the executive (in this case the hospital manager) as well as within the team context at the hospital.

Based on the work of Kline (1999), hospital managers were stimulated to question basic pre-suppositions from which they had been working. In all instances hospital managers found these exercises invaluable especially when linked to reflective

thought processes and taking the time to make meaning of complex situations involving numerous role players.

Feedback reinforced the ability of the process to break conversational patterns which had previously trapped the hospital managers.
Quotes ascribed to the creation of the theme included:

"The best time out and the best contribution to a personal stock take – the impact it has had on me and on my team will show in our annual performance review as everyone is energised"
"Who ever has time to stop and think – and then when you do you realise how much you have been missing because you haven't done exactly that"

8.1.2.3.9 Theme 9 – Develops visualisation

The work of Anderson and Anderson (2004) was used extensively to enable the hospital managers to experience the executive coaching process as transformational. The "Leading with Insight" model (Anderson & Anderson, 2004) and discussed extensively in Chapter 4, provided the hospital managers with the ability to tap into deeper levels of insight to support larger and more complex outcomes. Four (4) levels of insight were developed in the hospital managers who participated in the testing of the conceptual model, namely reflective, emotional, intuitive and inspirational. Developing the four (4) levels of insight created the platform for enhanced visualisation in the workplace context. All hospital managers experienced an enhanced ability to think positively of immediate, medium and long term future scenarios.

Hospital managers experienced the process and theory as influential in their view of change per se, also creating futures that they were passionate about. Hospital managers felt more confident of their abilities to manage change in order to meet the needs of the teams they led as well as the organisations they represented, even in the absence of the executive coach.
Quotes ascribed to the creation of the theme included:

"The most rewarding exercise for me was imaging the future in my context. It took me from a place of analysis paralysis through to a set of new possibilities"

8.1.2.3.10 Theme 10 – Explores barriers to action "self limiting beliefs"

This theme was linked directly with Themes 6 and 7 and is discussed within those themes also for completeness.
Quotes ascribed to the creation of the theme included:

"Initially I battled to see where I was stuck. I had accepted my "weakness" as just that. The exercise broke through the barrier and I was able to see the issue from an entirely new perspective which was a career changing experience for me"

8.1.2.3.11 Theme 11 – Defines barriers to action

This theme was linked directly with Theme 10. The use of development plans and SWOT analyses were used to define barriers to action for the hospital managers. Linked with the themes around self-limiting beliefs (Theme 10) the tools referred to provided the mechanism for breaking away from barriers and creating revised and creative platforms for the hospital managers to identify new realities. This process linked directly with the visualisation techniques discussed in Theme 9 and the awareness processes and theory discussed in the first 3 themes discussed within the context of content.
Quotes ascribed to the creation of the theme included:

"Using the tools provided enabled me to identify new realities which I had not conceptualised before and which I thought were only there for others with different abilities to mine"

8.1.2.3.12 Theme 12 – Develops questioning and listening behaviours in leadership context

All hospital managers appreciated the opportunity to develop questioning and listening behaviours in their leadership context. All hospital managers explored the questioning and listening techniques provided and considered these techniques as an additional part of their newly acquired skill-set. Where hospital managers had applied

the questioning and listening behaviours with their teams, they shared situations of open and transparent participation in both day to day conversations, performance discussions and strategic planning sessions.
Quotes ascribed to the creation of the theme included:

"Learning how to listen was one of the most empowering activities of my leadership tenure. I could sense and experience first hand the appreciation of my team as I stopped providing answers and listened for their answers. This changed the entire dynamic within the team"

8.1.2.3.13 Theme 13 – Teaches use of models to develop team synergy and listening technique

All hospital managers indicated that the use of tools and models had provided them with new mechanisms to create conversations around day to day conversations, team interactions and planning sessions which impacted on organisational performance. The tools and models deployed were discussed in the content themes discussed in paragraph 8.1.2.2 above.
Quotes ascribed to the creation of the theme included:

"We were able to use a model as well as all the new tools to work in a new way. This changed the way we related with each other and had a very positive improvement on our results also. Our conversations became less confrontational, more structured and more meaningful"

8.1.2.3.14 Theme 14 – Teaches feedback technique

All hospital managers placed value on the use of tools such as 360 degree feedback both during the coaching process as well as being consistent with modern management techniques which advocate regular and structured feedback. The relevance of providing apt and sensitive feedback was discussed extensively in Chapter 6 in the formulation and theory of the conceptual model and the fact that this kind of tool was regarded as valuable was regarded as significant for the Process themes also, in particular Themes 7 and 14.
Quotes ascribed to the creation of the theme included:

"Giving feedback was always a stressful and conflict inducing part of my leadership role to the extent that I shied away from it and reserved the occasion for feedback during performance reviews only. I learnt how to give feedback in a meaningful way, as the content itself was based on a solid foundation, using a method/ tool contracted up-front and in that way both parties enjoyed the journey and derived value from it"

8.1.2.3.15 Theme 15 – Reviews personal values

Hospital managers ascertained early on in the executive coaching process that a review of personal values was critical to the success of the process. For the hospital managers, coaching conversations revolved typically around organisational mission, vision, goals, role motivating behaviours, values, inspiring and motivating the team.
Quotes ascribed to the creation of the theme included:

"Providing and reinforcing the structure of discussions around critical and pertinent issues such as organisational mission and values focused us again. We all reaffirmed our commitment to providing quality healthcare and to being aware of the value of compassion. This linked in with our newly acquired abilities to listen and to ask meaningful questions of ourselves and others – very inspirational indeed"
"It was exciting and extremely inspirational reviewing my personal values, many of which had become hidden under layers of complexity from too many years of not reflecting on what kind of a contribution I was actually making to myself, let alone others in the organisation"
"Discovering that we had so many values in common was hugely motivational, and then discovering the synergies between our values and those of our organisation – even more so"

8.1.2.3.16 Theme 16 – Reviews alignment of personal and organisational values

Building on Theme 15 hospital managers identified by way of the executive coaching process that any review of personal values preceded a review of the alignment of personal values with those of the organisation.
Quotes ascribed to the creation of the theme included:

"I realised for the first time in a long time that I was immensely proud to work for the company in the way that I did. I took quite a bit of time outside of the coaching

sessions recalling my interview with the company all those years ago and what both I and the company had achieved both separately and together during the time under review. I felt proud to have achieved what I have for myself as well as what I have achieved for the company"

"I took a lot of ethical issues for granted and assumed that I was in touch with my ethical framework. It was exciting revisiting these matters and assessing what had changed and what I could still change in order to make a meaningful contribution both to my own growth and that of my team"

"I realise that I have some tough decisions to make – I no longer feel able to make a contribution in the private sector and realise that I need a change. I will use many of the tools I have learnt about during the coaching process to guide me on this path and will certainly seek out a personal coach to assist me in making the changes in my professional life that are long overdue"

"I had become complacent in my thinking and had forgotten to look at the big picture. I was able to confirm my commitment to what my organisation wants me to contribute as a leader"

8.1.2.3.17 Theme 17 – Constructs development plans and facilitates management of performance context

Based on the theory hospital managers were by way of the executive coaching process encouraged to construct development plans. Quotes ascribed to the creation of the theme included:

"A new and unique, yet simple way of mapping out your path, monitoring your progress and determining the next step in your development as a leader"

"The development plans provide the structure for the content as well as the conversations which you as a leader need and want to have with your team"

8.1.2.3.18 Theme 18 – Constructs measurable outcomes in alignment with development plans – personal, team and organisational

Theme 18 links directly with the quantitative analysis compiled relevant to the return on investment for hospital managers who had experienced executive coaching. In all instances the return was positive with a mean of 102.11% showing congruence between the quantitative and qualitative analysis.

Quotes ascribed to the creation of the theme included:

"I can clearly see how my performance has an impact on my team – sharing this with them has changed the way they see me, and they feel (which is clearly being illustrated in the way that their performance has improved) that we are working together now with a common understanding of what we want and need to achieve"
"The way in which everything makes sense now and aligns is remarkable. We were working in a vacuum before and nothing seemed to gel"
"It made sense to keep assessing and aligning, that way we all knew we were making a real and meaningful contribution to the vision, mission and values of our company"

8.1.2.3.19 Theme 19 – Reviews outcomes

All hospital managers who participated in the testing of the conceptual model had completed the quantitative assessment regarding return on investment which has been discussed previously.

8.1.2.3.20 Theme 20 – Provides support framework for ongoing leadership development

All hospital managers who participated in the process found that they were able to apply the content as well as the process to their teams. All hospital managers indicated that using the model was a more congenial way to work and develop talent in their teams. The model provided structure to development conversations within the team and also created consistency in the approach that the leader in this case the hospital manager took to development issues. All hospital managers indicated that in the case of talented individuals the creation of a collaborative relationship and the questioning process both developed the leader as well as the coachee.
Quotes ascribed to the creation of the theme included:

"I have been able to establish a framework of reference that I will continue to build on. I don't feel alone in my role any longer as I know I have created a platform of engagement with my team which we will continue to reinforce now that we have structure against which to engage openly and in a meaningful way"
"We acknowledge above all else that we have created the time and space to engage meaningfully and the positive affirmation that this has generated cannot be lost at any cost"

"The process and content of the conceptual model enables us to interact in a mature and focused manner with clear feedback processes, thereby taking the ambiguity out of our leadership conversations"

8.1.2.3.21 Theme 21 – Develops individual insight into intentional focused leadership practice and self-directed leadership

All hospital managers indicated that in being exposed to the process and the tools offered, they had been able to further explore interventions useful to intentional and focused leadership practice.
Quotes ascribed to the creation of the themes included:

"I am focused and clear on my role and that of my team, understanding and appreciating the value of clear and meaningful communication against the structure provided has inspired me and I want to develop my skills further in this area"
"It was exciting synchronising the values and goals of our organisation with those of the team and gave to new meaning to our exciting and inspirational organisational culture where contribution is highly valued. It (the process) opened up new avenues for us as a team to make a meaningful contribution to ourselves as well as the company"
"I am clear in my role and my motives and the fact that I shared this with my team has opened new possibilities for me as a leader"

8.1.2.3.22 Theme 22 – Develops self awareness

All hospital managers indicated that in keeping with the process of the conceptual model self awareness was entrenched to the extent that hospital managers sought regular feedback following the testing of the conceptual model and extended their use of awareness tools such as relationship assessments, values exercises, learning styles inventories, personality style profiles, leadership style evaluation and cultural diversity barometers.
Quotes ascribed to the creation of the theme included:

"Initially, learning about myself was daunting, but I have come to appreciate this the most out of the entire process"

"I would never have imagined that taking time out was so valuable and would make such a significant contribution to my personal and professional wellbeing, I learnt to stand aside and look both inwards and outwards and to appreciate the time to do that"

"I have a toolkit that has empowered me"

"I will continue to build on the toolkit provided and grow my team"

8.1.2.3.23 Theme 23 – Aligns and focuses energy to create synergistic congruence

All hospital managers indicated that the process and content of the executive coaching intervention aligned and focused their energies in order to create synergistic congruence.

8.1.2.3.24 Theme 24 – Builds resilience and enables leader to manage own change processes

All hospital managers expressed experiencing an enhanced ability to manage change processes with data gathered from the team context. In the final analysis the research propositions which evolved during the course of the research are discussed and conclusions drawn. Based on the findings no changes to the conceptual model are envisaged as support for the both the process and the content of the model was clear.

8.1.2.3 Integration of Process and Content findings of the Model

Both the process and content themes supported all aspects of the conceptual model with the qualitative research in particular indicating in 100% of respondents that the team as well as the organisation benefited from the leadership having received executive coaching. This was further supported by 93.8% indicating that receiving the executive coaching using the conceptual model added value.

There were no disparate findings between the quantitative or the qualitative research results that indicated in any way that the model was incongruent with the healthcare context and that it not improve leadership performance, therefore supporting both propositions as well as the aim of the research.

8.1.2.4 Combined discussion of quantitative and qualitative research findings and confirmation of Propositions

Of the 149 responses received in relation to the quantitative research undertaken, 53% had received executive coaching and derived benefit from the experience, the nature of which will be discussed in a subsequent paragraph. Of the respondents who had indeed received executive coaching, 62% had experienced the intervention by way of a defined executive coaching model and all 62% had benefited from the process followed directly, as had their teams and in turn the organisation which they served. 93.8% of the hospital managers who responded also indicated that the conceptual model would add value to any executive coaching process. In assessing the value of the executive coaching process, 79 responses (a response rate of 34.9%) indicated that the return on investment could be measured at a mean of 102.11% displaying more than a 100% return on investment in relation to the intervention, and hence a positive outcome.

In keeping with the quantitative findings, the qualitative findings revealed that all 33 themes identified were synonymous with each other in terms of the process and content of the conceptual model. All themes supported the model unequivocally and reinforced the perpetuation of the model in the original format.

The themes supported a logical process and conceptualised the leadership framework. Valuable tools were provided at each stage of the process which supported feedback and were highlighted during the content themes also. The content themes in particular assisted in identifying leadership styles and behaviours as well as how these impacted on the team and organisational contexts. The process as well as the content of the conceptual model was able to clearly define process in closing gaps in leadership behaviour for the hospital manager. Both the process and the content themes indicated that insights were reviewed and that the "time to think" created was invaluable. By using visualisation by way of the process and content of the conceptual model, the hospital managers were able to explore self-limiting beliefs and define barriers to action beyond these self-limiting beliefs. The application of the conceptual model developed the ability of the hospital managers to question as well as listen within the leadership context. Models were explored and applied in order to develop team synergy.

Through applying the process of the conceptual model, and synonymous with the theme of logical process, personal values were examined and contextualised to both the individual, the team and the organisational context. The process and content themes also revealed that hospital managers were able to construct development plans both for themselves as well as for the management of the performance context. From the development plans, measurable outcomes were constructed, resonating with the outcome of the quantitative data findings in respect of the positive return on investment.

The application of the conceptual model and the resultant findings and themes showed that outcomes from the executive coaching process created the opportunity for review as well as provided a support framework for ongoing leadership development. Within the context of ongoing leadership development, the hospital manager also developed insight into intentional focused leadership practice and within that a greater sense of self awareness. This insight in itself enhanced the hospital manager's ability to deal with change faced personally, within the team and within and by the organisation.

The data, as discussed above revealed patterns and recognised relationships between categories. From the results of the qualitative data analysis Proposition 1 was tested as well as verified by way of all the themes verified as well as the quantitative analysis that examined return on investment, despite being tested constantly against alternatives. The view of Yin (2003) was followed whereby existing theory was used to formulate research questions and objectives as well as organise and direct data analysis. Proposition 2 was however not conclusively tested as no additional model was tested although the applicability of the model was tested in the quantitative analysis by way of questions 2 through to 10 which scored a 100% response in the affirmative.

8.2 Conclusion

This Chapter presented the results of the quantitative and qualitative data analysis and where appropriate triangulated same. The first research proposition was supported by both the quantitative and qualitative results reaffirming the value of triangulation. The two methods yielded congruent and comparable data insofar as the first research proposition was concerned and partially yielded congruent data insofar as the second data proposition was concerned, although in the absence of another executive coaching model the result was inconclusive. The qualitative data analysis reconciled

the contents of the literature study with the conceptual model and the results clearly displayed congruence with no divergence identified in any theme. The analysis and synthesis of the results confirmed the reliability and validity of executive coaching as an intervention at the executive level.

In the context of the study the second research proposition was partially supported as all hospital managers who participated in the research process experienced positive outcomes.

Chapter 9 concludes the research and makes recommendations based on the findings as well as illustrates the contribution of this research to the body of knowledge.

CHAPTER 9 – DISCUSSION OF ANALYSIS, RECOMMENDATIONS AND CONCLUSION

9.1 Introduction

The aim of the research was to examine in two parts, firstly - the extent to which executive coaching had been provided to the private healthcare sector in South Africa, and secondly – to establish whether executive coaching had improved leadership performance and/ or organisational performance and created return on investment.

As displayed by the results of the research, the first part of which was contained in the literature study, executive coaching had been provided only to the extent that 53% of the respondents responded in the affirmative. The research findings therefore correlated with the results of the literature study which revealed a very limited number of results in respect of healthcare worldwide and a limited number of results for industry in South Africa as a whole. The literature study also sought to answer, and answered conclusively the questions as to how coaching had evolved internationally and locally as a discipline and also that the relationship between coaching and leadership was symbiotic in nature.

The results of the quantitative research revealed that executive coaching indeed improved leadership performance – displayed by all respondents at a response rate of 100% to the question which dealt specifically with performance. The literature review in turn dealt with how executive coaching had been offered to an extremely limited extent to executives in private healthcare in South Africa, the only documented evidence of any offering to healthcare being that of Dovey (2002) who had piloted executive coaching in a primary healthcare setting in the public health domain of the Eastern Cape Province.

From the qualitative research 33 themes emerged all of which supported the contents of the literature study as well as reinforced Proposition 1 of the research methodology and in turn reinforced the conceptual model entirely. On the basis that a response rate of 100% was achieved in respect of all themes, the themes could be generalised and applied therefore to the context.

The correlation to the contents of the literature study and the conceptual model are integrated and discussed subsequently within the various themes that emerged, in the ensuing paragraphs.

Although the process themes are discussed independently initially within the content discussion synergies between process and content themes are highlighted where relevant.

9.2 Themes emanating from the Process of the Model and their relevance to the literature study and conceptual model

9.2.1 Theme 1 – Logical process

All (100% of) hospital managers described the executive coaching process as logical. The process was clearly distinguished from other coaching processes such as those of life and performance coaching (Walker, 2004), but supportive of the executive coaching models advocated by Anderson and Anderson (2004), Hargrove (1999) and Sharkey (2003) all of which were discussed in Chapter 4 within the literature review. The process of the model was therefore reinforced and supported by the research.

9.2.2 Theme 2 – Contextualises leadership framework

All hospital managers described the process as one which contextualised the leadership framework. There was no ambiguity as to processes relevant to team or performance coaching. The process followed within a contextualised leadership process, ie a process rooted within healthcare supported the views of Anderson and Anderson (2004). The relevance and value of the individual as a leader (Buys, 2007) was underpinned by the leader being central to the model and this was clearly identified and described by the hospital managers. This meant that the process was viewed as clear and unambiguous, clearly separating the role of the leader from the others in the organisation. The research confirmed the contents of the literature review and reinforced the value of the role of the leader in this context.

The tools and process specific to healthcare were supported in the theory by McAlearney (2005), Rostron (2007) and Hartman and Crow (2002) in that a specific model was advocated for the healthcare industry given the unique context. Rostron (2007) in particular indicated that the unique nature of the environment demanded

specialist experience to bring value to the executive coaching experience. Although the tools were universally applicable, when applied in the healthcare context to hospital managers by way of the research, the value of these tools as instrumental in guiding and directing change was unequivocal. The tools used as part of the model, therefore supported each step and stage of the model, reinforcing the relevance and value-add in turn.

9.2.3 Theme 3 – Examines balance in the workplace

All hospital managers described the conceptual model as a process to recognise the various facets of workplace life and the role of the executive in creating balance and synergy between the various facets (Walker, 2004). This was a view expressed in the work of Walker (2004) which clearly delineated the various themes of coaching and the need for balance between work and lifestyle activities. Following on from the second theme (Theme 2) this finding again supported the significance and value of the conceptual model in recognising the various facets of workplace life. This meant that the process of the model clearly separated issues enabling clearer understanding and greater definition.

9.2.4 Theme 4 – Valuable tools at each stage of the process

All hospital managers described the process as valuable in providing tools in the team context for developing themselves to both give and receive feedback in particular, a theme which resonated with the theory of Alexander (2005) in recognising coaching as a tool to address complex challenges. This meant that hospital managers were able to use the tools supplied with the model to their best advantage and to that of the team, thereby improving performance (further discussed within the content themes).

The views expressed resonated with the theory of the value of sharing mutual experiences, feedback and opinions in order to create agreed outcomes on a wide variety of business related topics (Harvard, 2004) (Anderson & Anderson, 2004) (Harrison, 2004) (Whitmore, 2002) (Schein, 2004) (Meyer & Fourie, 2004) (Walker, 2004) (Alexander & Renshaw, 2005) (McLeod, 2003) and (Eaton & Johnson, 2001). A detailed discussion and integration of these theories was discussed in Chapter 4 as well as used extensively to inform the conceptual model discussed in Chapter 6. The fact that these concepts were expressed during the research process re-affirmed the value of the model in addition to the findings of the literature review.

All hospital managers expressed the value of the process as a feedback tool in itself. This resonated with the views of Sosik (2005) who advocated that in evaluating the executive coaching experience it was essential to source feedback on the presence and overt application of the ideas, beliefs, experiences, values and ethics described. Such feedback would provide additional material for the development of the executive as well as impact the coaching context. Linking back to the logical process and flow identified by testing the conceptual model, the use of the model as a feedback tool was confirmed. Using the process therefore enabled the executive to deal with a number of situations around performance within the team context – in a focused manner, confident in the knowledge that by following the process, the outcomes would be more creative, better considered and certainly a contribution to improved performance and development on the part of the team member receiving the feedback.

9.2.5 Theme 5 – Space to identify, analyse and reflect

All hospital managers described valuing the space created by the process to identify issues, analyse these issues and reflect on the implications of same. The value created by the executive process was described both theoretically and in the conceptual model by the work of Kline (1999). As well as having been referred to extensively contextually in the literature review, the use of "time-out" and space to reflect was therefore a powerful and relevant concept within the model.

The data indicated a direct correlation between the theory of McLeod (2003) and Kline (1999). The theory of Kline (1999) has already been referred to in preceding paragraphs, but was integrated with the thinking of McLeod (2003) in that reflective processes reinforced learning and change that had taken place and also creating the space for the celebration of these achievements by the hospital managers. Reflective processes allowed for both careful consideration of key change issues (involving multiple stakeholders) as well as the celebration of gains made during change processes, many of which were described and specific to cultural diversity, generational communication, a decline in nursing standards, increased patient advocacy and greater demands from specialist doctors in providing better equipment and facilities against budgetary constraints. The reflective process, considered a key element of the model was strongly affirmed by testing the conceptual model.

9.2.6 Theme 6 – Space to experiment in a safe environment

The space to experiment in a safe environment was verbalised by all the hospital managers who participated in the research. The critical importance of contracting the privacy and confidentiality ensured that, as in the de facto executive coaching experience, the leader would have such an environment. The consequence of this theme, supported by the theory of Whitmore (1996) was that hospital managers felt free to contribute and take risks which it could be argued contributed to the quality of the outcomes experienced and which are discussed within paragraphs 8.1.2.3.1 to 8.1.2.3.34 while having space provided within a safe environment was in itself a valuable concept within the model, the implications for the content can also not be under-valued. All hospital managers found that having "space" promoted clearer thought processes, allowed for enhanced creativity and in so-doing had positive outcomes for team morale. The value of positive team morale during times of change is well documented and re-enforces the value of creating "space" and a "safe environment" as key sub-concepts and processes within the conceptual model.

9.2.7 Theme 7 – Universal applicability to team context

All hospital managers described the process as providing significant value to their team context in that the feedback and assessment tools could be applied. This is significant for a number of processes, not least of all performance management processes. Given that improved performance was clearly detailed as an outcome of executive coaching by lastly this research and firstly the literature review, the testing of the model also served to confirm the universal applicability of the process in the team context.

9.2.8 Theme 8 – Useful reference framework

All hospital managers gleamed numerous reference works as a result of their participation in the research. When requested the full reference listing was provided (5 hospital managers), although in the case of the remainder of the participants (10 hospital managers) references were provided selectively when a hospital manager experienced interest in a particular tool or theory.

9.2.9 Theme 9 – Measurable outcomes

All hospital managers described the outcome/s as measurable and quantifiable. This was verified by the quantitative data analysis process relevant to the value of the return on investment and described in paragraph 8.1.1.1. The significance of this finding is immense as it substantiates the first proposition and clearly indicates (as further substantiated by the discussion within the themes relevant to the Content) that executive coaching is an intervention that improves performance both for the leader, the team and the organisation.

9.2.10 Concluding remarks linking the Process themes to the Content themes

Where a process theme resonated with a content theme, this is specifically cited in the discussion that follows. All process themes resonated with the content themes insofar as they linked to that particular stage of the conceptual model and that discussion is integrated below. The findings of the quantitative research as well as the qualitative research are therefore integrated with the theory (Literature Study Chapters 1 through to 5) which conceptualised the model (Chapter 6).

9.3 Themes emanating from the Content of the Model

9.3.1 Theme 1 – Identifies leadership style

The private healthcare industry in South Africa faces constant change (HASA, 2009) and all hospital managers expressed interest in identifying their leadership styles during times of change. The tools used during the executive coaching process and described in paragraph 8.1.2.2 above were used to identify leadership styles and particularly those deployed during times of change. In Chapter 4, the work of McCall (1993) was used in particular to describe leadership styles best applied during times of change and McCall (1993) identifies styles which are transformational, charismatic, inspirational, visionary and empowering as useful. The hospital managers who participated in the research found exploring the theory of the aforementioned styles valuable. The context described by McCall (1993) resonated with the coaching dialogues documented in Chapter 4 of the literature review and described as such by Whitmore (1996), Alexander and Renshaw (2005), Cope (2004), Flaherty (1999) and Galwey (2002) and all developed awareness at the executive level through the medium of executive coaching. These coaching dialogues were experienced

positively during the coaching process by the hospital managers who participated in the testing of the conceptual model and reaffirmed the contents of the literature review as well as the content which emanated from applying the conceptual model. This means that the conceptual model could be applied generally within private healthcare and possibly given a support base of greater than 60% (in these cases 100%) to the general population of hospital managers in both public and private healthcare.

9.3.2 Theme 2 – Identifies leadership influence profile

Rostron (2006) identified the critical need for the private healthcare sector to respond to change and for leaders to be equipped with new and appropriate skills, a theme which was fully contextualised in paragraph 8.1.2.3.1 above and in the process theme discussion around the conceptual model being universally applicable to the team context (Theme 12). Taking the hospital managers through the executive coaching process exposed them to tools which identified their leadership influence profiles (Themes 4 and 5 of the process findings and discussion). As such they were able to build on their awareness vis a vis their leadership styles and identify their ability to influence. Synergies between leadership ethics and executive coaching outcomes were created by way of the executive coaching process and created the opportunity for the hospital manager to learn building on the awareness already created (Hattingh, 2005). Themes such as transparency in governance (Handy, 2002), linkages between personal value systems (Sosik, 2005) and values and organisational outcomes (Meyer & Fourie, 2004) (Kakabadse, Kakabadse & Lee-Davies, 2005) also appeared during the research and strengthened the platforms of awareness created during the executive coaching process. The contents of the literature study as well as the content revealed during the testing of the conceptual model affirmed the value of the model as universally applicable to hospital managers in the South African healthcare context, both public and private.

9.3.3 Theme 3 – Identifies leadership behaviour

Closely linked to themes 8.1.2.3.1 and 8.1.2.3.2 were themes emanating from awareness created for the hospital managers during the executive process around the identification of leadership behaviour (and linked directly to process Themes 2 and 7 which speak to the value of contextualising the leadership framework and exploratory tools providing feedback in a valuable context).

This theme was particularly appropriate to the findings of Dovey (2002) and Hartman and Crow (2002) (and discussed extensively within the literature review) indicating that healthcare was highly politicised and the change inherently re-active, forcing hospital managers to deal with high volume and innumerable challenges. Once baseline behaviour was identified in the sample of hospital managers, the process of executive coaching was used to develop a skill set which contained a unique balance of technical and inter-personal skills, self-knowledge and the ability to set and meet performance goals, themes identified in the international literature by Hutton and Angus (2003), McAlearney (2005) and Nwabueze (2001). Again, the creation of awareness facilitated change where appropriate to leadership behaviour, which impacted extensively on Theme 4. Again the universal applicability of the conceptual model was affirmed in all the process themes discussed.

The challenges of the implementation of a National Health Insurance (NHI) system presenting (HASA, 2009) are clear and include critical shortages of healthcare professionals (70 000 across the various categories), the increased burden of disease including HIV/AIDS (referred to in the introductory Chapters), and the introduction of public-private partnerships on a previously unprecedented scale. The extent of the change required is immeasurable and every hospital manager spoke during the coaching process of the need to be aware of leadership behaviour given the challenges. In the inevitable situation where leaders from both sectors of the industry (namely public and private) are expected to engage and build the industry through public-private partnerships, mature as well as responsive leadership behaviour would be key to the success of the change process. This theme would link directly with Theme 4 described below and would of essence be key to building the relationships required of the transformation which the NHI would bring to the South African healthcare sector beyond 2010.

9.3.4 Theme 4 – Examines behaviours and impact of behaviour on team

The literature discussed in Chapter 4 identified no shortage of challenges for hospital managers during periods of change and transition. The resilience and behaviour of the hospital manager during times of change impacted on the behaviour of the team, as discussed by Hutton and Angus (2003), Spear (2005) and Van Deventer et al (2005). The executive coaching process created awareness of behaviour and how behaviour impacted on the hospital manager's team in all instances. Tools (Theme 4 of the process themes) were provided to facilitate balancing the demands of multiple

stakeholders during the executive coaching process and provided valuable support to all hospital managers who participated in the research enabling a unique balance of technical and inter-personal skills, self knowledge and the ability to set and meet performance goals mindful of the context (Van Deventer et al, 2005). This theme extended to the recruitment process with an awareness being created in all the hospital managers who participated, that traditional task ability would no longer suffice. Additional skills, which are discussed in subsequent themes were identified as critical.

9.3.5 Theme 5 – Examines behaviours and impact of team behaviour on organisation

The following sub-themes were examined by the Hospital Managers and discussed extensively during the executive coaching process:

(i) The development of executive talent from the perspective of reward (Van Deventer, 2005).
(ii) Executive burnout in the sector (Shisana et al, 2004) (Padarath, 2005) (Igo, 2005).
(iii) The need to develop emotional intelligence (Eaton & Johnson, 2001) (Norton, 2003) (Goleman, 1995) (Whitmore, 2002) (Cope, 2004) (Peterson & Hicks, 1998).
(iv) The need to develop sustainable leadership in an industry adversely affected by the "brain drain" and the power stress relationship (Boyatzis et al, 2006) (Mullan, 2005).

Again, awareness (Theme 9 of the process themes linked directly to this content theme in that space to identify, analyse and reflect was provided by applying the conceptual model) created platforms for discussions and sustainable initiatives on the part of the hospital managers. All hospital managers agreed that unique approaches were required to deal with the unique situation that they found themselves in, in the South African healthcare context, approaches supported by the research of Buchan (2004) and Gibbs (2005). As such then, the contents of the literature review and the themes (in particular Themes 3 through to 5) which emanated from the content discussions of the conceptual model substantiate and affirm the conceptual model as a vehicle to manage complex change and the effect thereof on team and leadership behaviour in a positive manner. It follows that the conceptual model would also by virtue of the positives derived from the application thereof, contribute significantly to performance, both individually (on the part of the leader), for the team, and ultimately

for the organisation as a whole.

9.3.6 Theme 6 – Develops gaps in leadership behaviour

Theme 6 was contextualised extensively by Theme 5 with the exception of a specific gap analysis process being applied to identify behaviours which required adjustment and development. These processes were synonymous with the tools and techniques of Kolb (1998), Rosinski (2003), Peltier (2003) and Goldberg (1998) and which were discussed extensively in Chapter 6 (within the literature study) which described the conceptual model. Content themes were therefore continually underpinned by process themes identified and discussed in paragraph 8.1.1 reinforcing synergies within the conceptual model. Hospital managers identified the process and content of the model as being consistent and easy to apply to both themselves and their teams in the executive context.

9.3.7 Theme 7 – Clearly defines process to closing gaps in leadership behaviour

As discussed in Theme 6 above, hospital managers identified the process and content of the model as being consistent and easy to apply to both themselves and their teams in the executive context. Limiting beliefs and assumptions were identified during the process as described in the literature by Kline (1999), Nel (2006), Rosinski (2003) and Carruthers (2007). Assumptions about own style and behaviour were reviewed per the theory of Flaherty (1999), Galwey (2002) and Hargrove (1999). The work of O'Neill (2000) identified for the hospital managers, linkages between team behaviours and organisational goals, resonating also with the work of Boyatzis et al (2006) which dealt with the influence that the leader exerted on the behaviours and decisions of the team. Again, reinforcing the contents of the literature study, the applicability of the conceptual model was justified by virtue of the process described in par 9.2 above relevant to the process discussion around the conceptual model.

9.3.8 Theme 8 – Reviews insights, creates "time to think" – reflection and "making meaning of"

The work of Kline (1999) was shared extensively during the theoretical discussions around this theme. In keeping with the work of Kline (1999) hospital managers appreciated the essence and value of time for thinking at the strategic level. Part of

the thinking process also involved postulating around the value of insightful questions on the part of the executive coach, and then subsequently using this technique on the part of the hospital manager to stimulate creative thinking within the executive team.

This theme was considered one of the core themes by hospital managers participating in the research, in all instances novel yet obvious. The theme stimulated a fresh approach to the thought processes of both the executive (in this case the hospital manager) as well as within the team context at the hospital.

Based on the work of Kline, hospital managers were stimulated to question basic pre-suppositions from which they had been working (O'Neill, 2000) (Peltier, 2001). In all instances hospital managers found these exercises invaluable especially when linked to reflective thought processes and taking the time to make meaning of complex situations involving numerous role players (hence resonating with the concepts introduced by Rostron (2006) and McAlearney (2005).

Feedback reinforced the ability of the process to break conversational patterns which had previously trapped the hospital managers (Meyer & Fourie, 2004).

As such, the content of the literature study which had informed the conceptualisation of the model was affirmed and the conceptual model in turn reinforced.

9.3.9 Theme 9 – Develops visualisation

The work of Anderson and Anderson (2004) was used extensively to enable the hospital managers to experience the executive coaching process as transformational. The "Leading with Insight" model (Anderson & Anderson, 2004) and discussed extensively in Chapter 4 (within the literature study), provided the hospital managers with the ability to tap into deeper levels of insight to support larger and more complex outcomes. Four (4) levels of insight were developed in the hospital managers who participated in the testing of the conceptual model, namely reflective, emotional, intuitive and inspirational. Developing the four (4) levels of insight created the platform for enhanced visualisation in the workplace context. All hospital managers experienced an enhanced ability to think positively of immediate, medium and long term future scenarios.

Hospital managers experienced the process and theory as influential in their view of change per se, also creating futures that they were passionate about (Hargrove, 1999). Hospital managers felt more confident of their abilities to manage change in order to meet the needs of the teams they led as well as the organisations they represented, even in the absence of the executive coach. This concept within the theme is also supported by the work of Grant (2001) and McCleod (2003) which supports such techniques in order to create solutions (and which was contained in the literature study)).

Theme 9 was underpinned by Themes 3 through to 5 also, reinforcing the value of the conceptual model against the strong theoretical framework of the literature study.

9.3.10 Theme 10 – Defines barriers to action

The use of development plans (Anderson & Anderson, 2004) and O'Neill (2000) and SWOT analyses (Alexander & Renshaw, 2005) (as described and discussed in the literature study) were used to define barriers to action for the hospital managers. Linked with the themes around self-limiting beliefs (Theme 6) the tools referred to, provided the mechanism for breaking away from barriers and creating revised and creative platforms for the hospital managers to identify new realities. This process linked directly with the visualisation techniques discussed in Theme 9 (of the process discussion also) and the awareness processes and theory discussed in the first 3 themes discussed within the context of content.

This meant that once a barrier to action was identified, steps could be taken within the context of the model to address same. The conceptual model was therefore used to create movement and initiate change, albeit within a safe environment and from a sound platform of theoretical content and a valuable toolkit.

9.3.11 Theme 11 – Develops questioning and listening behaviours in leadership context

All hospital managers appreciated the opportunity to develop questioning and listening behaviours in their leadership context. The theory was premised (from the content of the literature study) on the views of Downey (2004) and Hargrove (1999) who advocated that in the executive coaching process itself, the intervention be 80% non-directive and 20% directive, encouraging the greater degree of reflection and

insight required of an executive. All hospital managers explored the questioning and listening techniques provided (from within the content of the literature study) by Downey (2004) and Hargrove (1999) and considered these techniques as an additional part of their newly acquired skill-set. Where hospital managers had applied the questioning and listening behaviours with their teams, they shared situations of open and transparent participation in both day to day conversations, performance discussions and strategic planning sessions.

The value of this revelation given the challenges of change facing South African healthcare cannot be underestimated, and as referred to in the Themes above provide sound platforms for the launch of change within the context of a new NHI for South Africa.

9.3.12 Theme 12 – Teaches use of models to develop team synergy and listening technique

All hospital managers indicated that the use of tools and models had provided them with new mechanisms to create conversations around day to day conversations, team interactions and planning sessions which impacted on organisational performance. The tools and models deployed were discussed in the content themes discussed in paragraph 8.1.2.2 above.

The model of Sharkey (2003) was used extensively and informed the experience of the hospital managers in their perception of this theme.

As with the reflective themes, the listening technique provided the environment within which difficult conversations could take place. The model therefore created seemingly obvious yet critically necessary opportunity for valuable conversation. In the change facing private and public healthcare given the introduction of a NHI, the ability to engage constructively (by listening and providing safe spaces) has not been underestimated and the conceptual model plays a key role in creating safe process as well as valuable content for such conversations. This in itself creates the platform for positive change and consequential improvement in the lives of all South Africans by virtue of better access to quality and affordable healthcare.

9.3.13 Theme 13 – Teaches feedback technique

All hospital managers placed value on the use of tools such as 360 degree feedback both during the coaching process as well as being consistent with modern management techniques which advocate regular and structured feedback (Wasylyshyn, 2003). The relevance of providing apt and sensitive feedback was discussed extensively in Chapter 6 in the formulation and theory of the conceptual model and the fact that this kind of tool was regarded as valuable was regarded as significant for the Process themes also, in particular Theme 4.

9.3.14 Theme 14 – Reviews personal values

Hospital managers ascertained early on in the executive coaching process that a review of personal values was critical to the success of the process. For any leader, coaching conversations revolved typically around organisational mission, vision, goals, role motivating behaviours, values, inspiring and motivating the team (Downey, 2004). While supported extensively by the literature discussed in Chapter 2, values and the role that values play in any leadership context, came strongly to the fore during the testing of the conceptual model. This reinforced the need for regular conversations between leaders themselves as well as their teams around values, which in turn would influence the outcomes, by way of enhanced performance – clear and relevant goals having been set.

The conceptual model clearly dealt with values and entrenched the need for review of same, both on the part of the leader and the team. The discussion around Theme 16 further demonstrates the critical role that the conceptual model assigns to conversations around values, during all organisational seasons.

9.3.15 Theme 15 – Reviews alignment of personal and organisational values

Hospital managers identified by way of the executive coaching process that any review of personal values preceded a review of the alignment of personal values with those of the organisation and likewise with the themes below, where personal ethics were examined.

The significance of this for the affirmation of the conceptual model cannot be underestimated given the change facing the healthcare sector in South Africa.

The insights built on the theory of Whitmore (1996) and Whitworth (2003) who advocated using values exercises to examine congruence between personal and organisational ethical frameworks, concepts which were discussed extensively during the literature review. Along with the process of the conceptual model, such content underpins the need to bind the various pieces of content against the backdrop of a sound foundation constructed specifically with congruence in mind. The conceptual model reinforced the need to establish congruence between personal and organisational ethics.

9.3.16 Theme 16 – Constructs development plans and facilitates management of performance context

Based on the theory of Anderson and Anderson (2004) and O'Neill (2000) (emanating from the literature review) hospital managers were by way of the executive coaching process encouraged to construct development plans. In keeping with the views of Hargrove (1999), Grant (2001), McCleod (2003) and Anderson and Anderson (2004) (also discussed extensively during the literature review) this led to an extension of the conceptual model and incorporated Hargrove's (1999) five step process to masterful coaching which essentially built on Themes 1 through to 8 ultimately structuring regular feedback to the hospital manager as well as the team. The content of the literature review was yet again reinforced in the application of the conceptual model, reaffirming the value of the integrated conceptual model.

9.3.17 Theme 17 – Constructs measurable outcomes in alignment with development plans – personal, team and organisational

This theme linked directly with the quantitative analysis compiled relevant to the return on investment for hospital managers who had experienced executive coaching. In all instances the return was positive with a mean of 102.11%.

The first proposition was therefore fully supported and the second partially supported in that the conceptual model indeed contributed positively to performance.

9.3.18 Theme 18 – Constructs measurable outcomes in alignment with development plans – personal, team and organisational

All hospital managers who participated in the testing of the conceptual model had completed the quantitative assessment regarding return on investment which has been discussed previously. In addition, the work and theory of Grant (2003), McCleod (2003) and Flaherty (1999) (from the literature study) was applied to extend the hospital managers' use of tools to review outcomes meaningfully and purposefully in alignment with team and organisational goals and objectives.

Again, the findings of the literature review and the testing of the conceptual model were integrated and substantiated by the research findings.

9.3.19 Theme 19 – Reviews outcomes

All hospital managers who participated in the testing of the conceptual model had completed the quantitative assessment regarding return on investment which has been discussed previously.

9.3.20 Theme 20 – Provides support framework for ongoing leadership development

All hospital managers who participated in the process found that they were able to apply the content as well as the process to their teams. In similar vein to the postulations of Whitmore (1996) (from the literature review) all hospital managers indicated that using the model was a more congenial way to work and develop talent in their teams. The model provided structure to development conversations within the team and also created consistency in the approach that the leader in this case the hospital manager took to development issues. All hospital managers indicated that in the case of talented individuals the creation of a collaborative relationship (Peterson & Hicks, 1996) (Sharkey, 2003) and the questioning process both developed the leader as well as the coachee (Grant, 2001).

The process and content of the conceptual model were again reinforced.

9.3.21 Theme 21 – Develops individual insight into intentional focused leadership practice and self-directed leadership

All hospital managers indicated that in being exposed to the process and the tools offered, they had been able to further explore interventions useful to intentional and focused leadership practice. This reflection resonates with the work of O'Neill (2000) (from the literature study) who posits that executive coaching per se engages the leader directly with the specific leadership challenges being faced as well as links leadership practice with the behaviours key to achieving organisational goals. The views of Meyer and Fourie (2004) (and from the literature study) also indicated that in order for executive coaching interventions to be successful the interventions should be aligned with the overall business strategy of the organisation.

Again the contents of the literature study were reinforced in the outcomes of the testing of the conceptual model.

9.3.22 Theme 22 – Develops self awareness

All hospital managers indicated that in keeping with the process of the conceptual model (and discussed with Theme 5 of the process findings above) which advocated reflection as the final step, reflective practice encouraged as well as entrenched self awareness. Self awareness was entrenched to the extent that hospital managers sought regular feedback following the testing of the conceptual model and extended their use of awareness tools (discussed extensively in the literature study) such as relationship assessments (Anderson & Anderson, 2004), values exercises (Whitmore, 1996) (Whitworth, 2003), learning styles inventories (Kolb, 1998), personality style profiles (Peltier, 2003), leadership style evaluation (Peltier, 2003) and cultural diversity barometers (Rosinski, 2003).

The conceptual model therefore again provided for the integration of concepts and processes critical to the successful management of change and enhanced performance.

9.3.23 Theme 23 – Aligns and focuses energy to create synergistic congruence

All hospital managers indicated that the process and content of the executive coaching

intervention aligned and focused their energies in order to create synergistic congruence. The processes within the intervention directly relevant to exploring and defining (stages 2 and 3 of the conceptual model) focused the hospital managers as such.

Given the processes of change facing the industry, empowering leaders by way of the conceptual model and the content gleamed from participating in the testing of the model, has contributed significantly in the positive to the approach that these hospital managers will take when faced with significant and overwhelming change.

9.3.24 Theme 24 – Builds resilience and enables leader to manage own change processes

All hospital managers expressed experiencing an enhanced ability to manage change processes with data gathered from the team context. This outcome resonated with the views of Meyer and Fourie (2004) who proposed that feedback given regularly during any process of change would benefit both the individual, the team and the organisation. In the presence of feedback on this basis, a return on investment for all parties would be guaranteed (Meyer & Fourie, 2004). Evaluation was fundamental to any form of measurement in the executive coaching context (Anderson & Anderson, 2004). In further support of the theory of Meyer and Fourie (2004), (Anderson & Anderson, 2004), Sievers (2006) indicated that change could only be measured by assessing performance in both the team and the leader's (in this case the hospital managers') context, further supporting from the theoretical perspective, the individual experiences (which led to the creation of this theme) and thus the ability to build resilience and manage processes of change within the private healthcare sector in South Africa.

Given the processes of change facing the industry, empowering leaders by way of the conceptual model and the content gleamed from participating in the testing of the model, has contributed significantly in the positive to the approach that these hospital managers will take when faced with significant and overwhelming change.

The conceptual model (premised on the findings of the literature study) is therefore a significant contribution to knowledge, providing the roadmap as well as the guidance to manage both performance and change within the industry.

9.4 Limitations of the research and implications thereof

Initially it was envisaged that some constraints would arise as a result of the questionnaire being distributed by email, in particular hospital managers receiving contact from an unknown person and regarding the email as spam. To preclude this from happening an introductory email was sent from the researcher's corporate address (as was the subsequent email) alerting the recipient to the email which would arrive within the next 48 hours. The researcher was introduced briefly and the corporate as well as personal credentialing done using this method. This ensured that good email etiquette was maintained.

The email was kept brief and to the point to prevent irritation on the part of the hospital manager opening the email in the first instance. Anonymity on the part of the researcher who was not known to all recipients (although the corporate entity and hospital from which the email originated were known) was envisaged as a barrier to entry although this emerged not to be the case in the final analysis.

The email addresses of the hospital managers were verified by way of an initial telephone call and introductions also done in this manner and hospital managers alerted to the imminent arrival of the initial email and later the email containing the link to the website where the questionnaire was located. The barrier of access to the website was precluded by making prior arrangements with the various hospital groupings which also showed appropriate email etiquette. Most fortunately in 90% of the cases there was direct access to email and/ or the internet and the questionnaire could be completed using the preferred medium which allowed for integrated data analysis.

The use of a website specifically designed to create a database facilitated the processing of the data in its entirety and simplified and verified the process keeping the data sacrosanct. The website also allowed for various formats of text precluding difficulties with data recording. A fee was paid for the use of the website chosen and this in turn resulted in a more efficient and user friendly methodology, evidenced as well by the ease of access and ease of data processing. There were a number of free use websites available, but none satisfied the stringent confidentiality as well as data security arrangements required. So while the methodology was cost effective in terms of distribution it was not free, and this in itself could have been a constraint for a

researcher without the financial means. The cost of telephoning 226 hospital managers was also substantial although not excessive and fortunately sponsored by the corporate entity which employs the researcher. This could also have been a constraint for a researcher without the means to make calls across the length and breadth of the Republic. Designing and administering the questionnaire also incurred a substantial cost and this could have precluded the use of this method for a researcher without the financial means.

The benefit and possible barrier in using this method was efficient administration, and the researcher was able to set up mailing lists and confirmation delivery lists which precluded duplication but ensured that the request for participation and actual questionnaire reached the respondent appropriately (in a user friendly format) and timeously. The monitoring of the return of the questionnaire was also automated as was the reminder, resulting in no respondent who had indeed submitted a reply being erroneously reminded, once again reinforcing email etiquette. The information as a result of using the medium was therefore corroborated, accurate and useful.

As email surveys and electronic methods of data collection become more prevalent, it is envisaged that this form of survey would be ignored to a greater extent as potential respondents view the contents as potential spam. As all respondents had a good command of the English language, there was no language barrier. The potential inability to use the electronic medium was also precluded by enquiring as to the existence of an email address for each hospital manager and then verifying the existence of the email address via the internet protocol application linked to the website used.

The greatest methodological constraint was the lack of face to face contact with the hospital managers who responded in general and those who participated in the testing of the conceptual model in particular. The data provided could however be validated as the website on which the data was collected validated the respondent's internet protocol address. As each respondent was a member of a corporate identity the ability to further justify that the respondent indeed used that exact internet protocol address was also validated in that each opportunity for access was password protected particular to that individual respondent.

The subject matter as evidenced in the findings was of great interest to all who participated hence the high return rate and it was unfortunate that due to geographical

constraints personal interviews could not be conducted. There is no doubt that this would have enriched the data substantially and allowed for further data to be collected and this would be an opportunity for further research. The telephonic contact made initially however proved invaluable in establishing the relationships and may also have contributed to the relatively high response rate, although this was not tested specifically. The telephonic contact verified the identity of the respondent as well as validated the email address as being that specific to the respondent themselves.

As the private sector was chosen as the sample, the remainder of the sector namely the public healthcare sector and the non-governmental sector were not included. Extending the research to the remainder of the sector would generate the same constraints ostensibly as the geographical layout of the Republic of South Africa would make the amount of travelling involved costly and time consuming. This was, as mentioned also a factor in making personal and physical contact with all the hospital managers who responded in any event.

The only limitation of the research was being unable to meet with all the respondents (the hospital managers) face to face. Time and distance precluded such contact, although the telephonic medium did provide the opportunity to build the relationship common to an executive coaching intervention. The telephonic contact was not optimal if considered against the basic premise of coaching which is the contracting and building of a relationship. It may be argued that a relationship may be built over the telephone, but in developing a person's potential the face to face dynamic is invaluable. Within the research environment however, this was deemed satisfactory as validity was indeed established as discussed.

As the content of the research had been contracted as being confidential in respect of identity, but that the content would be used in pursuit of the research conducted and this was made explicit and agreed at the onset of the communication both in person over the telephone and in writing via email, there was no doubt as to the reliability of the data and that the data had indeed been provided by the respondent. The data sourced as a result of the research, although posted to the database was not available for public inspection or comment and privacy was therefore protected. The expectation created that the respondent's contribution would remain private was maintained.

Not making contact in person precludes both the coach and the coachee (in this case

the hospital manager) from developing the kind of relationship which emanates from direct contact. In the situations which were used in this research none of the body language or nuances which derive from personal contact could be used as they were never witnessed directly.

The findings are therefore confined to the sample but provide lessons and guidelines for the remainder of the population namely the public and non-governmental sectors of healthcare in South Africa. The conceptual model may therefore be applicable in other settings within healthcare which provides an opportunity for further research.

9.5 Implications and opportunities for future research

With the introduction of the NHI imminent, applying the model developed in this study to the public health sector would be a superb opportunity to manage the changes inherent in that part of the healthcare sector at present.

The model is a simple and step-wise process easy adaptable and it would be valuable to see how the public sector would adapt it in a non-profit environment. The effect that the model would have on performance and the improvement of managerial performance which has clearly been identified as a priority by government, given the results of this study, could be extremely significant.

Specific recommendations for future research relate to the public healthcare sector where in recent years the lack of managerial competence has been regularly and vociferously identified.

It would be opportune given the lack of managerial competency identified in hospital managers in the public sector for further research to be undertaken which deals specifically with:

- An understanding of the principles of executive coaching and how these may be used to develop potential in leaders in healthcare (derived from the literature review);
- An application of the conceptual model initially on a pilot basis in the public hospitals where the quality of care and service delivery is deemed to be the most lacking;

- An evaluation following the application of the conceptual model to determine the extent to which the leadership has developed and also to determine what the return on investment has been in human resource terms as opposed to financial terms given that there is no financial "bottom line" in the public sector.

Essentially the objectives, aims and propositions of this study could be applied in the public sector setting and this is real opportunity for further research in the field of executive coaching in healthcare in South Africa, across the entire sector.

9.6 Towards refining the model

There was no indication that the model required refinement in any form, from a process or content perspective, and as such could be adopted as conceptualised. The model was however extended to include the five step process of Hargrove (1999) which dealt specifically with a feedback process between the Hospital Manager and the team.

Within the public sector context, given that no profit motive exists, calculations around return on investment would be confined to achieving perhaps more altruistic goals and the relative measurement thereof in value add to communities, as opposed to the private sector model which was able to measure profits and return on investment more traditionally in terms of established accounting and reporting models.

9.7 Specific recommendations on executive coaching in South Africa

The research conducted was a study in the field of Leadership, directed towards the development of systematic knowledge concerning the value of Executive Coaching in the South African healthcare sector.

Clearly executive coaching is in the developmental stages in South Africa, having been explored to a limited extent within the corporate sector and to a very limited extent in the public healthcare sector. COMENSA, the Coaching and Mentoring Society of South Africa is in the process of finalising a code of ethics, as well as norms and standards for the coaching fraternity, but these remain in discussion format

at the time of writing. This will place coaching in South Africa on an equal footing with coaching bodies in the rest of the world, but particularly countries such as the United States, Australia and the European continent and the conclusion of such consultative processes is eagerly anticipated and strongly recommended.

Clear ethical guidelines should be produced to guide the coaching fraternity and the credentialing of coaches pursued through reputable academic channels in order to give the intervention the credibility warranted and required.

Given the impact of the executive coaching intervention, the implementation of accreditation and credentialing as described will ensure a systematic approach to the implementation of the intervention across all industries and not only the healthcare industry.

From the experience of corporate South Africa, documented in this research, coaching can be recognised as a tool to empower and develop South Africans post-apartheid. Executive coaching has also from the South African experience detailed in the literature review been recognised as a tool to address complex challenges, making it particularly suitable for healthcare as the industry faces the introduction of the National Health Insurance (NHI) system.

9.8 Specific recommendations on implementing the model

The model was developed specifically for private healthcare given that the content also focused on the return on investment which is generally a for-profit concept, not used generally in the public sector where the primary motive is supposed to be service.

Thus, the measurement of return on investment would not be appropriate in the form provided for in the conceptual model, and would have to be revised to provide for the measurement of performance in terms of service delivery if applied to the public healthcare sector.

9.9 Summary and the contribution of this research to the body of knowledge

Building on the context described in paragraph 9.7, and premised on the literature review, the quantitative and qualitative research conducted as well as the testing of the

conceptual model, executive coaching was found to:

- Serve as a powerful tool to empowerment and development in Human Resources, post apartheid;
- Be a powerful tool to address complex challenges such as those being faced in the South African healthcare sector with the imminent introduction of National Health Insurance (NHI)
- Be appropriate and relevant to developing leadership within the private healthcare sector in South Africa based on the quantitative and qualitative research findings as well as the testing of the conceptual model.

At the time that the research commenced the concept of National Health Insurance had not been mooted in South Africa. The South African healthcare industry was under siege, designated as a money hungry service provided to only 7 million of the total population. The challenges posed in the political arena at that time caused distress and panic among many role-players who saw their profits under imminent threat. Change and the management thereof was critical in that set of circumstances. With the concept of National Health Insurance now a reality to be lived within the next five (5) years the pressure for healthcare executives to perform within the political context and to provide universal access to healthcare has become non-negotiable and obligatory. Change and the management thereof now faces the leader in the eye and survival will depend on the leader's capability to respond to the change. The conceptual model provides the framework for a reflective and responsive leader to be made in a relatively short space of time, as evidenced by the research.

As such, the contribution of the conceptual model developed in this study and the supporting literature study cannot be underestimated. Both contribute significantly to a body of knowledge within the milieu of South Africa to one of the greatest debates around change – and the transformation in so doing of the South African healthcare industry both public and private.

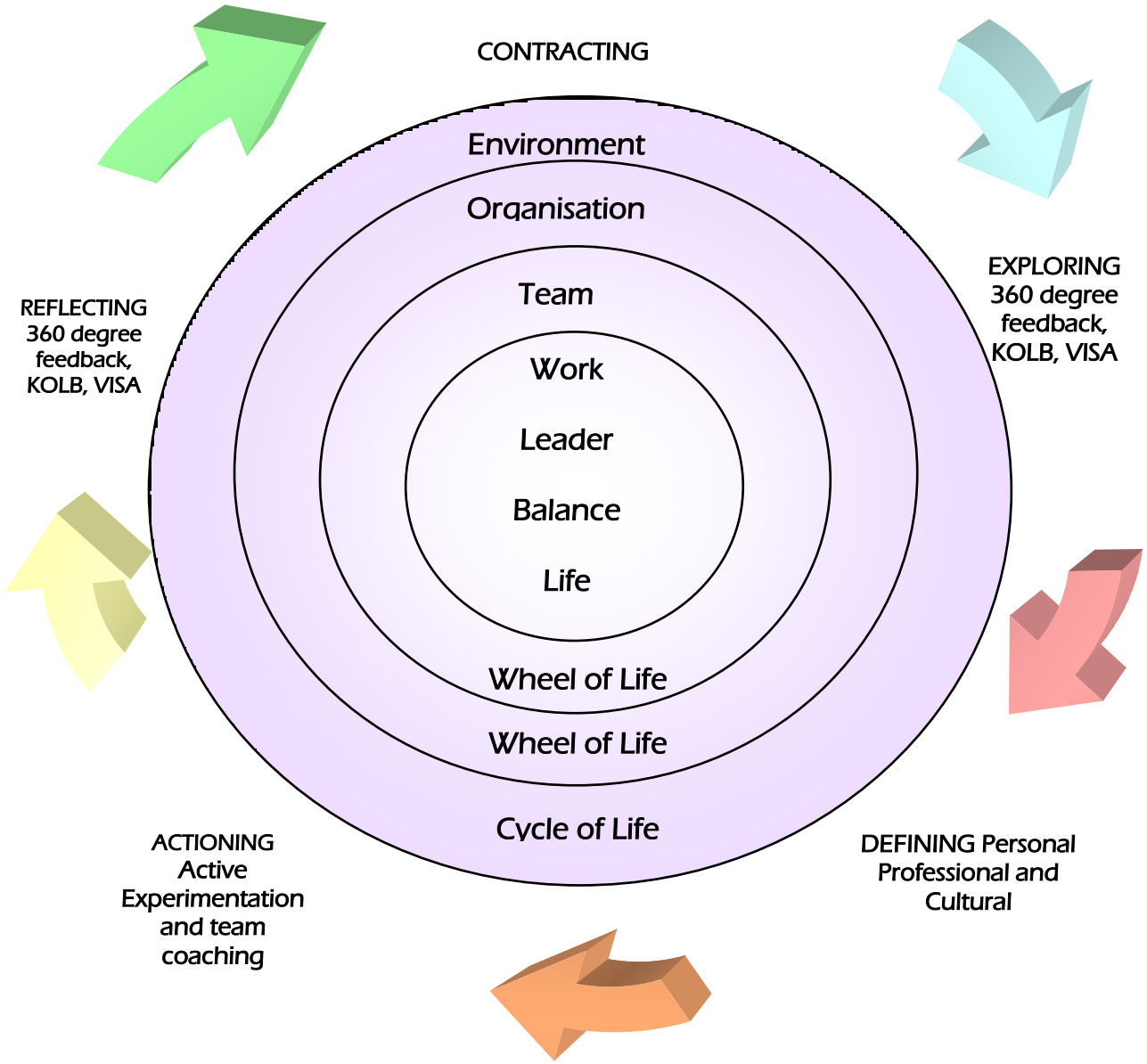
The research was premised on an extensive literature review which reviewed all executive coaching texts available until July 2009, hence making the research the most updated review of this literature internationally in general and in South Africa in particular.

The recommendation is that the conceptual model be applied within healthcare both public and private within the South African healthcare industry.

In keeping with the national imperative to empower, the model would be taught and re-taught to leaders on a not for profit basis. This would ensure that the contribution to knowledge was grounded in the true spirit of contribution – finally to enhance the lives of all South Africans through equitable and easier access to quality healthcare – but ultimately to improve the quality of life of all.

ANNEXURE A – AN INTEGRATED MODEL FOR EXECUTIVE COACHING IN HEALTHCARE IN SOUTH AFRICA

The model below has been designed especially for use in healthcare, and concentrates extensively on "reflection" and feedback.



ANNEXURE B – INTRODUCTORY LETTER TO EXECUTIVE COACHING CLIENTS

Augusta Waller Dorning
47 Gainsford Place, La Lucia, Umhlanga, 4051
adorning@kzn.netcare.co.za
(031) 268 5018 (w) 083 778 1154 (cell)

Dear (respondent)

RE:COACHING

Thank you for the opportunity of sharing in this executive coaching process with you.

The process has been designed specifically for executives working in the private healthcare sector, and your participation for the purposes of doctoral research is much appreciated.

During the process the total focus will be on you, what you want from your role, and what will help you achieve it so that you secure a return on the investment of your time and effort. It will be my responsibility to keep the content confidential, to keep you accountable in the process and to keep you moving toward your goals. I will provide the structure which is based on the model I will share with you. I will help you focus on your specific outcomes.

I commit to telling you the truth, to listening, communicating with you without judgement and accepting what you say without analysing you. With your permission I will also share my insight as appropriate. I commit to complete confidentiality.

A little about me. I am currently the General Manager of Netcare St Augustine's Hospital which is situated on the Berea in Durban. I was previously the Clinical Operations Manager at St Mary's Hospital and also served the Department of Health as Director: Labour Relations. I am in my third year of study towards a Doctorate in Business Leadership.

In order to facilitate the process ahead I would request that we commit to talking telephonically at time mutually suitable. We may also email, as you wish. I would

request that you record for your own benefit progress of the process, as we would review this at each meeting. With your permission, to facilitate my own learning, I may take notes during our meetings. The content of our meeting will not be reflected to maintain confidentiality. You may request a copy of these notes at any stage.

Yours Sincerely

AUGUSTA DORNING

FOR YOUR OWN USE:

I acknowledge receipt of the introductory correspondence. I accept the process and commit to completing it to the best of my ability.

SIGNATURE

DATE

ANNEXURE C

PART 1 – LETTER INTRODUCING STUDY AND REQUESTING PERMISSION – CORPORATE HUMAN RESOURCE EXECUTIVE/S

Dear (Respondent – name to be inserted and personalised)

I am a doctoral student with the UNISA School of Business Leadership under the guidance of Professor Lize Booysen. I am in the process of conducting research around executive coaching and through the database of HASA have identified you as a possible respondent. For your own interest I am also employed in the private healthcare sector with Netcare and I am the General Manager of Netcare St Augustine's in Durban.

I am making contact with you as the head of the corporate Human Resources Department in order to request your permission to make contact with all the Hospital Managers employed in the organisation. This however in no way obligates any Hospital Manager to complete the questionnaire (copy attached for ease of reference), although doing so would be greatly appreciated on my part. Completing the questionnaire will enable me to conduct research on a topic which has to date not been researched at all in South Africa or the world for that matter. On completion of my research if you so indicate I would be delighted to share the contents with you and your organisation.

The aim of my research is to:

1. Examine the extent to which executive coaching has been provided to the private healthcare sector in South Africa; and
2. Establish whether executive coaching has improved personal leadership performance and/or organisational performance.

Should any Hospital Manager wish to remain anonymous that will be respected. All information gathered will be treated in the strictest confidence and reserved for academic use.

Hospital Managers may complete the questionnaire and return it via email or electronically to adorning@kzn.netcare.co.za or fax it to (031) 201 4598 by 15 April 2009.

Thank you for taking the time to participate in this research, your time and contribution is greatly appreciated.

Yours sincerely

AUGUSTA DORNING

PART 2 - LETTER INTRODUCING MYSELF AND THE STUDY (QUESTIONNAIRE WITH PERMISSION TO CONDUCT RESEARCH ATTACHED IN SCANNED FORMAT)

Dear (Respondent – name to be inserted and personalised)

I am a doctoral student with the UNISA School of Business Leadership under the guidance of Professor Lize Booysen. I am in the process of conducting research around executive coaching and through the database of HASA have identified you as a possible respondent. For your own interest I am also employed in the private healthcare sector with Netcare and I am the General Manager of Netcare St Augustine's in Durban.

I have made contact with your corporate Human Resources Department and have secured permission to make contact with you. This however in no way obligates you to complete the questionnaire , although doing so would be greatly appreciated on my part. Completing the questionnaire will enable me to conduct research on a topic which has to date not been researched at all in South Africa or the world for that matter. On completion of my research if you so indicate I would be delighted to share the contents with you and your organisation.

The aim of my research is to:

3. Examine the extent to which executive coaching has been provided to the private healthcare sector in South Africa; and
4. Establish whether executive coaching has improved personal leadership performance and/or organisational performance.

Should you wish to remain anonymous that will be respected. All information gathered will be treated in the strictest confidence and reserved for academic use.

You may complete the questionnaire and return it via email or electronically to adorning@kzn.netcare.co.za or fax it to (031) 201 4598 by 15 March 2009.

Thank you for taking the time to participate in this research, your time and contribution is greatly appreciated.

Yours sincerely

AUGUSTA DORNING

QUESTIONNAIRE : EXECUTIVE COACHING IN PRIVATE HEALTHCARE

Closed Q's respondent number: _____

Please indicate whether you are a male or female respondent

Male ☐ **Female** ☐

1. Have you ever had executive coaching?

Yes ☐ **No** ☐ → Thank you for taking the time to Respond

If "Yes" please proceed to the next set of questions, thank you, if "No" you need not answer any further questions

2. Did you pay for your executive coaching yourself? **Yes** ☐

OR

Did your employer pay for your executive coaching? **Yes** ☐

3. Did your coach use a coaching model? If you are not sure please answer "No".

Yes ☐ **No** ☐

4. If your answer is "Yes", was the model explained to you?

Yes ☐ **No** ☐

5. If your answer is "Yes", did the executive coaching process follow the model?

Yes ☐ **No** ☐

6. Did you benefit from the experience of executive coaching?

Yes ☐ **No** ☐

7. Do you feel your employer benefited from your experience of executive coaching?

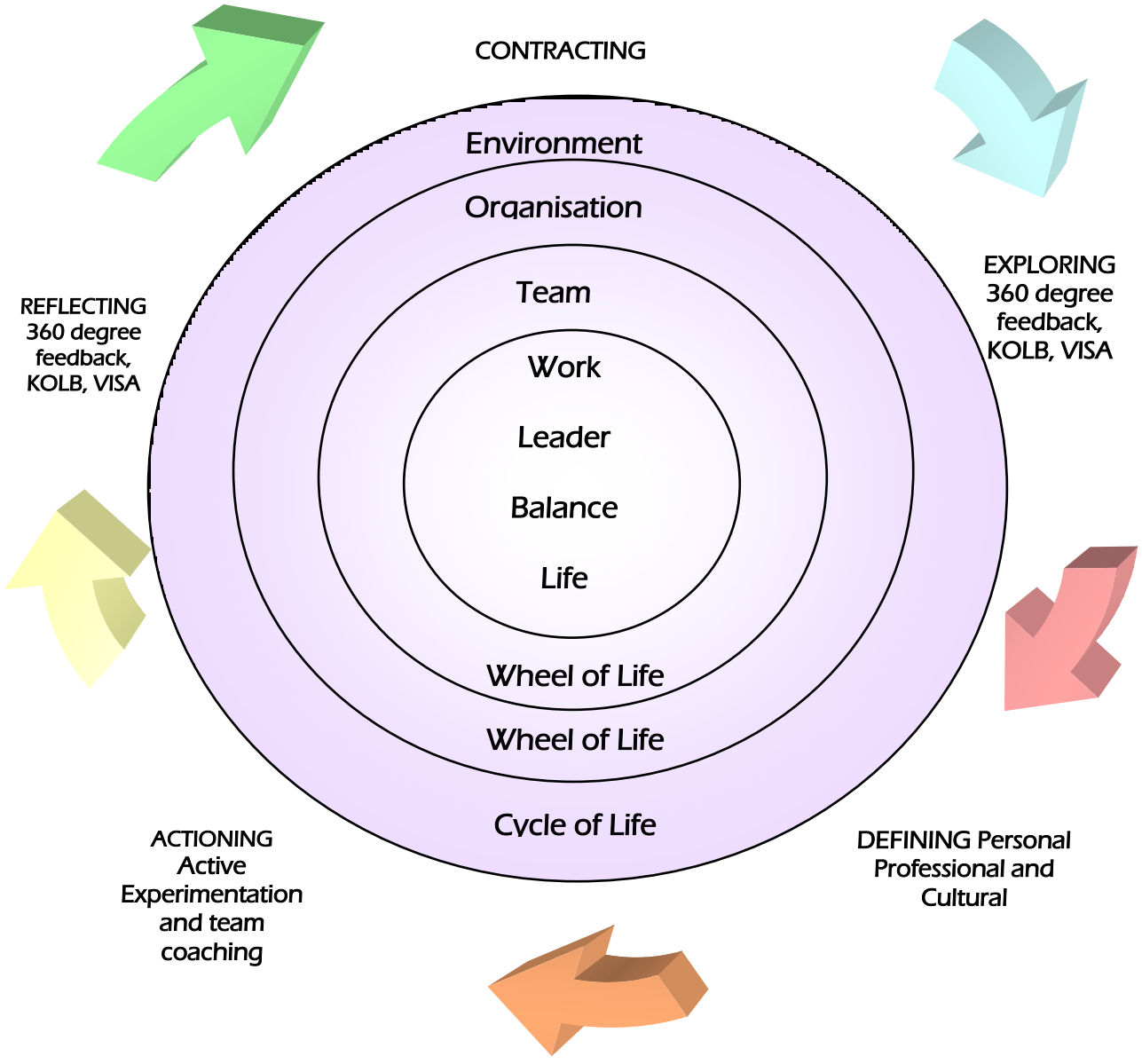
Yes ☐ **No** ☐

8. Do you feel that your team benefited from your experience of executive coaching?

Yes ☐ **No** ☐

N/A ☐ **(**If you have not direct reports)

9. The model below has been designed especially for use in healthcare, and concentrates extensively on "reflection" and feedback.



For ease of reference I have provided a narrative which explains each component of the model. The narrative is attached as Annexure "A".

In your experience, would the application of this executive coaching model add value to any executive coaching process?

Yes ☐ **No** ☐

10. If provided with the opportunity, would you like to experience executive coaching using this model?

Yes ☐ **No** ☐

Feel free to add comments or suggestions and same will be accredited in the research. Should you wish to receive feedback on the research conducted, feel free to indicate same below.

Please submit your completed schedule electronically or to adorning@kzn.netcare.co.za or by fax to (031) 201 4598. Thank you for taking the time.

The coaching model is termed the "CEDAR" model and describes the development of the individual figuratively from a seed to a tree.

The coaching process is divided into five (5) stages which form part of a cyclical process and also intend to close a process. The influence that the leader exerts on the behaviours and decisions of the team and the organisation in turn (Boyatzis et al, 2006) are explored and reflected on throughout the intervention. Similarly, in the model of Schein (1990), the work is not limited to the intervention at hand but is systemic and considers the consequences for other parts of the system. Each stage has a procedural element but also draws on various tools in order to move the process within the cyclical wheel forward.

The five (5) stages are as follows:

- Contracting
- Exploring
- Defining
- Actioning; and
- Reflecting.

Contracting

The first stage of the model opens the entire process and is made up of a greeting and welcome. The purpose of this stage is to set the client at ease and to start to create the space for dialogue. A situational conversation is key to clearing the space of any environmental noise which may inhibit participation. At this point the time frame for the initial session as well as subsequent sessions is decided and contracted.

The tools which may be drawn from include topical events, drawings and an introductory letter (Appendix B).

The purpose of the initial session, once the climate has been constructed for the dialogue, is to start the process of definition in terms of what the client wishes to explore within the process. Given that the context is that of executive coaching, the

issue would be professionally related and could be linked to any challenge or development area identified by the client.

At the close of the session, the client is tasked with defining the issue and presenting same at the next session.

Exploring

The second stage of the model seeks to explore the issue defined perhaps in a single phrase by the client.

The process reviews the homework exercise, discusses insights gleamed from the exercise, and reflects on the homework insights as relevant to goals and the coaching issue. The responsibility of the coach during the process is to question what informs the client and to provide insightful questions around this (Rosinski, 2003).

The tools which would be used during this stage of the process would include visualisation, the construction of collage, the completion of a learning styles inventory (Kolb, 1976), career assessments via an industrial psychologist, and personality profiling using for example the Myers-Briggs profiling tool. Exercises such as writing obituaries, rewriting the client's Curriculum Vitae and completing the Wheels of Life would also add substance to the exercise. The cultural orientations framework and the seven (7) levers and tools (Rosinski, 2003) could also add content to the dialogue during this stage of the coaching process.

The exploring stage of the model is interchangeable and cyclical within the "defining" stage of the model as both processes seek to create clarity and purpose for the remainder of the process (O'Neill, 2000). This stage of the process may take more than one session and after each session, homework is contracted so that definition is clearly explored and satisfies the developmental goal of the client.

Defining

The third stage of the process which remains interchangeable with the second (Exploring), pursues the process of definition.

The journey or process follows the following steps:

- Suggesting the use of a tool to gain insight and heighten definition.
- Prompt discussion on insights and reflections from homework, reversal and redefinition.
- Asking about what the client is experiencing during the process as well as what is going well (Rosinski, 2003) (Jackson, 2005).
- Exploring and defining barriers to action (Rosinski, 2003).
- Exploring limiting assumptions (Kline, 1999).
- Looking at life from the point of view of death (Flaherty, 1999).

The tools used would include:

- Finding the limiting assumption/s and then defining the positive opposite with the client's own words (Kline, 1999).
- Asking incisive questions which enable the freeing of assumptions in order to generate new ideas towards achieving goals (Kline, 1999) (Hargrove, 1999).
- Applying the insights gained from the learning styles inventory (Kolb, 1976).
- Applying the VISA model (Nel, 2006).
- Dialogue around appreciation and reflecting on what has transpired.
- Compiling a personal mission statement (Alexander & Renshaw, 2005).
- Reviewing personal and organisational ethics and culture, and conducting an exercise which identifies synergies and incongruencies (Whitmore, 1996).
- Securing independent feedback from five (5) referees (Peterson & Hicks, 1996) (Sharkey, 2003).
- Constructing development plans (Eaton & Johnson, 2001).
- Conducting a SWOT analysis of the issue and the client's relationship with the context (Anderson & Anderson, 2004) (Downey, 2004).

The combination of process and tools in this third stage, enables the client through a number of sessions (if relevant) to understand and define the issue and the context surrounding the issue so that action can be taken.

Actioning

The fourth stage of the coaching process is termed actioning as this stage takes the process towards completion. The issue/s have been explored and defined and it remains for the client to commit to action.

The client defines an action for each definition, constantly referring to the definition so as to keep the action clear and relevant. The "SIMPLE" process as defined by Jackson and McKergow (1998: 80) is used as follows:

- "S" stands for solutions and not problems.
- "I" stands for in between the action is the interaction.
- "M" stands for make use of what is there.
- "P" stands for possibilities from the past, present and future.
- "L" stands for language simply stated.
- "E" stands for every case is different.

The RIVAS contract (Wilkins, 2007) provides a further framework for capturing the process around action and the SMART (Wilkins, 2007) criteria of simple, measurable, achievable, realistic and time bound are applied. Where the client is enthusiastic about creating a visual contract, a picture may be sourced or a collage created. Whatever form the contract may take, the contract is intended as a measure of progress against the action taken and any action outstanding in the process of achieving the desired outcomes.

Over the requisite number of sessions, the client pursues, per the contract the action, reporting back in the coaching session, and being tested via the coach's questions as to whether action is indeed being achieved (Grant, 2001). This process can also be contracted so that the desired action is defined in terms of a finite timeframe, and the process does not drag on or exist within a never ending cyclical process and becomes more linear in form, hence ensuring that the goal is indeed reached.

Reflecting

The final stage of the coaching process is called reflecting and is essentially to reflect back on the achievements of the coaching dialogue as well as the process. The reflective stage is not engaged until the outcomes have been achieved, so as to keep the process clean and free for environmental noise, in the event of the outcomes/ actions not having been fully explored and defined.

The reflective process involves:

- Summarising activities.
- Discussing and agreeing insights
- Agreeing support.
- Talking about the issue of commitment to the change that has taken place, about being human and prone to fallibility but also being aware of same and taking remedial action quickly, and about learning and change always being possible. This reinforces learnings and changes that have taken place and creates the space for celebration of these developments in a manner designed by the client (McCleod, 2003).
- Reflections and affirmations are reinforced with positive statements and thinking on the part of the coach (Kline, 1999).
- The client is thanked and the positive experience of the process affirmed.

Tools useful at this stage of the coaching process are:

- The narrative letter (White, 2000).
- A relationship assessment in the form of a questionnaire to invite feedback (Anderson & Anderson, 2004).
- An assessment of the extent to which mutual respect, freedom of expression and mutual learning has been reinforced (Flaherty, 1999).
- A values exercise (Whitmore, 1996) (Whitworth & Shook, 2003).

The purpose of the exercise in full for the coach is to focus on helping the leader optimise performance and potential. The leaders should also be able to behave more congruently within the organisation, in synergy with the organisational values and develop own ability to influence others and manage strategic and operational challenges:

- To be more intentional and purposeful.
- To become self directed, self aware, self managed and self led.
- To better manage their performance context.
- To align and focus energies and create synergistic congruence.
- To build resilience and learn to manage their own process of change.

- To create supportive and enabling structures (through active reflection) in order to sustain the change sustained throughout the coaching process as well as influences from the environment.

Thank you for taking the time.

ANNEXURE D – MEASURING RETURN ON INVESTMENT

Please take some time to calculate the return on investment exercise which combines the models of Anderson and Anderson (2004) and Sherpa (2009). You may use whichever method is more appealing to you. Please describe why a particular method has been used in preference to the other. Thank you.

1. Estimate the total value of resolving an issue or issues. (example: Avoided USD 55 000 in turnover costs, increased productivity by USD 45 000 – Total benefit: USD 100 000)
2. Multiply this amount by the percentage of the improvement attributable to coaching. (example, 50% of the improvement came from coaching – coaching benefit USD 50 000 (#1 times #2: 50% of USD 100 000)
3. Factor in our degree of confidence in our estimates (example, we are 90% certain that our estimate in steps 1 and 2 are correct, therefore adjusted coaching benefit: 45 000 - #2 times #3: USD 50 000 times 0.9)
4. Subtract the total cost of coaching (say USD 15 000) (example, net benefit USD 30 000 - #3 minus #4)
5. Calculate ROI: Divide net benefit (step 4: USD 30 000 by coaching cost USD 15 000 therefore ROI = 200% (#4 divided by #3: 30 000/ 15 000 = 2.00)

Anderson and Anderson (2004) in turn indicate that return on investment can be measured by using what they define as an ROI Evaluation Toolkit. Anderson and Anderson (2004) developed a tool to measure the return on investment provided by executive coaching and which is detailed in Figure 4.7 below.

Figure 4.7: ROI evaluation toolkit

Your Initial Coaching Sessions

Please provide your initial impressions of coaching based upon your first four sessions. Place an "X" in the appropriate category for each item.

	1	2	3	4

	Strongly disagree	Disagree	Agree	Strongly agree
1. My coach and I set objectives for coaching.				
2. The expectations from the senior leaders for the coaching initiative are not clear.				
3. My coach and I connected and established rapport.				
4. I was sceptical that coaching was going to work for me.				
5. I was satisfied that the first three or four sessions provided a strong foundation for our coaching conversations.				
6. Conducting coaching over the telephone is very effective for me.				
7. The pacing of the coaching sessions is about right; not too fast or too slow.				
8. The personal assessment data were effectively explained to me.				

9. What suggestions do you have for improving the introduction and initiation of coaching?

(Write your response here.)

Initial Learning Gained from Coaching

Please reflect upon your initial experience with coaching and respond to the following items. Place an "X" in the appropriate category for each item.

	1	2	3	4
	Strongly disagree	Disagree	Agree	Strongly agree
10. I understand how to be more effective as a leader.				
11. I am gaining insights into personal challenges that I needed to make to be more collaborative with peers.				
12. I am learning about the impact my actions have on others.				
13. Coaching is opening up new ways for me to look at business situations.				
14. I understand how to work more effectively with my peers to accomplish business objectives.				
15. I am learning how to engage my work team more effectively to achieve goals.				
16. Coaching is enabling me to explore new ways to increase teamwork.				
17. I have begun to improve my communication skills.				

Capturing the ROI of Coaching Worksheet

Instructions: This worksheet is designed to serve as an interview guide for evaluators to assist coaching clients in evaluating the monetary impact of coaching. While not an exact science, this worksheet follows a well-established, conservative and credible approach to evaluation. Estimation is a necessary and accepted part of the ROI process.

1. Describe the performance improvements that you have realized as a result of coaching.
……
……
……

2. Identify the potential sources of impact of these improvements. (Please check that all apply):
   a. Increasing your personal productivity ……
   b. Increasing the productivity of your work group ……
   c. Increasing sales ……
   d. Reducing cost ……
   e. Increasing product quality ……....
   f. Reducing cycle time ……

3. For each item checked above, please complete one of the benefits calculations in the following section. Use one letter code for each response. Identify currency used in the analysis ……..
   Determine / use the standard values of the client organisation. If these are not known or available, use the following values in calculating the monetary benefits. If the benefits are not in US$, then convert the values to the appropriate currency. All benefits must be recorded in annualized numbers (i.e., a benefit that is recorded in monthly terms will be multiplied by 10.5 months to get the annualized number).

Compensation rate	= $75 USD
Hours per week	= 40 hours
Weeks per year	= 46 weeks
Months per year	= 10.5 months
Sales margins	= 20%
Cost of money	= 10%

Benefit Calculations: Please describe the benefit in the left margin.

Letter Code	Estimated monetary value of performance improvement	Estimate % of improvement due to coaching	State confidence in this estimate (on a percentage basis: 0% = no confidence; 100% = high confidence)	
_____ $	_____ x based on: Circle one	_____ % { Daily Weekly Monthly Quarterly Yearly	x _____ % x (_____) Annualising multiplier	= $ _____ Est. monetary benefit = _____ Annualised benefit
Letter Code	Estimated monetary value of performance	Estimate % of improvement due to coaching	State confidence in this estimate (on a percentage basis:	

	improvement		0% = no confidence; 100% = high confidence)	

_____ $	_____ x based on: Circle one	_____ % { Daily Weekly Monthly Quarterly Yearly	x _____ % x (_____) Annualising multiplier	= $ _____ Est. monetary benefit = _____ Annualised benefit
Letter Code	Estimated monetary value of performance improvement	Estimate % of improvement due to coaching	State confidence in this estimate (on a percentage basis: 0% = no confidence; 100% = high confidence)	
_____ $	_____ x based on: Circle one	_____ % Daily Weekly Monthly Quarterly Yearly	x _____ % x (_____) Annualising multiplier	= $ _____ Est. monetary benefit = _____ Annualised benefit

4. Determine the cost of the coaching
   _____ Professional fees
   _____ Cost of client's time to participate in coaching (hours x $75 or standard value)
   _____ Materials
   _____ Travel expenses
   _____ Telecommunications
   _____ Administration costs (includes cost of evaluation)
   _____ TOTAL

5. Calculate the ROI
   Tally the annualized benefits (A through F) = _____
   Enter the values into the formula:
   ROI = ((Benefits – cost) / Cost) x 100
   ROI = ((-) /) x 100 = _____

6. Identify the intangible benefits.
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

Source: Anderson and Anderson, 2004:209-213

ANNEXURE E – QUALITATIVE DATA ANALYSIS

Process Themes

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Logical	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Contextualises leadership framework	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Examines balance in the workplace	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Valuable tools at each stage of the process	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Valuable feedback processes at each stage	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Stages linked into each other - consistent flow of process	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Exploratory tools aided feeedback process	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Tools universal to leadership context	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Space to idenitfy, analyse and reflect	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Space to experiment in a safe environment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Reflective process easily applied in everyday leadership practice	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Universal applicability to team context	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Useful reference framework	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Valuable feedback tool	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Measurable outcomes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Content Themes

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Identifies leadership style	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Identifies leadership influence profile	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Identifies leadership behaviours	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Examines behaviours and impact of behaviours on team	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Examines behaviours and impact of team behaviour on organisation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops gaps in leadership behaviour	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Clearly defines process to closing gaps in leadership behaviour	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Reviews insights, creates "time to think" - reflection and "making meaning of"	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops visualisation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Explores barriers to action "self limiting beliefs"	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Defines barriers to action	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops questionning and listening behaviours in leadership context	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Teaches use of models to develop team synergy	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Teaches feedback technique	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Teaches listening technique	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Reviews personal values	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Reviews alignment of personal and organisational values	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Examines personal ethics	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Examines congruence between personal and organisational codes/ ethics	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Constructs development plans	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Constructs measurable outcomes in alignment with development plans - personal	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Constructs measurable outcomes in alignment with development plans - team	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Constructs measurable outcomes in alignment with organisational goals	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Reviews outcomes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Provides support framework for ongoing leadership development	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops individual insight into intentional focussed leadership practice	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops purposeful activity on the part of the leader	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops self-directed leadership	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develops self-awareness	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Facilitates management of performance context	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Aligns energy to create synergistic congruence	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Focusses energy to create synergistic congruence	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Builds resilience and enables the leader to manage own change processes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

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