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SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN UNDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA

By

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DECLARATION

Student Number: 95027158

I declare that:

“Self-perceived leadership development of peer tutors in undergraduate health care studies at a university in South Africa”,

is my original work and that this work has not been submitted for any other degree at any other institution. All sources that have been used or quoted have been indicated and acknowledged by means of complete references in text and the bibliography.

03 March 2021

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Signed **Dated**

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ABSTRACT

Introduction:

Peer tutors are often seen by peer students as leaders. The role of peers in the development, learning, transition and success of fellow students is widely documented in literature on education and leadership. In spite thereof, minimal research has been done on the development of health care students' teaching and leadership abilities through involvement in tutor training programmes. The researcher believes that leadership skills of peer tutors develop through enhancing learning experiences of tutees and by introducing them to the leadership model of Kouzes and Posner - The Five Practices of Exemplary Leaders.

Aim:

The aim of this study was to describe the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a particular university.

Methodology:

A triangulation mixed method design was used to collect complementary quantitative and qualitative data with equal contribution. The study sample consisted of the tutors appointed for a specific academic year at a selected university, to tutor theoretical modules as well as practical skills. Data collection was done by means of a structured self-report instrument completed in the beginning and end of the tutoring programme, an unstructured focus group and narrative descriptions by the tutors.

Findings:

The data provided an answer to the question; what are the peer tutors' perceptions of their own leadership development during participation in the tutor training programme in undergraduate health care studies at a university, by describing the self-perception of their leadership abilities. Although the Leadership Practices Inventor - Self results showed a difference, but not always a statistical significant increase in their leadership abilities, when combined with the results from the qualitative data, the study showed that the participants exhibited great growth in their leadership abilities with regards to The Five Practices of Exemplary Leaders: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act and Encourage the Heart.

Key terms: leadership, leadership development, peer tutors, tutor training programme

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LIST OF ABBREVIATIONS / ACRONYMS

ABBREVIATION/ ACRONYM	MEANING
ACGME	Accreditation Council for Graduate Medical Education
CPR	Cardiopulmonary Resuscitation
IQR	Interquartile Range
LPI	Leadership Practices Inventory
LPI-Self	Leadership Practices Inventory – Self
SANC	South African Nursing Council
STEM	Science, Technology, Engineering and Math
OSCE	Objective Structured Clinical Examination

CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION, BACKGROUND AND LITERATURE REVIEW

Peer tutors are globally utilized in higher education, and specifically in health care studies, as a means of extending learning opportunities to other students. This is often done to help facilitate student learning of some of the practical skills in undergraduate health care studies (Rudland & Rennie, 2014:4). Health care peer tutors are expected to have mastered and transfer certain skills and to act as leaders among their peer student communities, but according to Clarence (2016:39), they are often not well trained and supported themselves.

Peer tutors are often acknowledged as peer leaders. In a study done by Keup (2016:37), student respondents indicated that peer leaders could be described as students who have been appointed to be mentors or peer tutors to other students. Their positive role in the development, learning, transition and success of fellow students is documented in literature on education and leadership (Keup, 2016:33). Although there is plenty of literature available on these topics, minimal research has been done about specialised tutor training programmes to develop health care students' teaching abilities and their leadership behaviours (Bouthillette, 2016:4; Doublestein & Ciervo, 2013:2). Leadership development should be part of undergraduate health care studies, since health care professionals are expected to not only have transferable skills and competencies, but they also need to excel in leadership, management, communication and critical thinking (Jorge, Coelho, Paraizo & Paciornik, 2014:306).

Leadership is a concept that is hard to define, but there is some agreement on the characteristics or attributes associated with leadership. These characteristics include, but are not exclusive to, commitment, caring, cooperative, problem solving skills, imaginative and having the ability to influence others (Kouzes & Posner, 2017:30; Hastings & Kane, 2018:11). Yukl (2013:18) states that "leadership has been defined in terms of traits, behaviours, influence, interaction patterns, role relationships, and occupation of an administrative position". Kouzes and Posner (2017:xi) define leadership as the ability to mobilise people "to transform values into actions, visions into realities, obstacles into innovations, separateness into solidarity, and risks into rewards".

In the health care setting, leadership is about the moral influence of one individual on others to change reactions, attitudes or behaviours to uphold or advance the core values of the health care profession (Gabel, 2014:848). Leadership development will improve the leadership skills of future health care leaders which are needed to bring about change in today's health care environment (Doublestein & Ciervo, 2013:1). Leadership development should be the product of a series of well-coordinated activities intending to develop individuals, by assisting them to learn from their work and from their superiors. Leadership development should also be integrated into everyday practices and therefore become a part of the culture of any organisation (Dalakoura, 2010:438).

Opportunities to practice leadership skills will strengthen one's self-perception as a leader and therefore increase the level of leadership abilities (Miscenko, Guenter & Day, 2017:606). Self-perception plays an important role in leadership development as it can lead to motivated individuals who will seek out leadership developmental experiences and opportunities to practice these leadership behaviours (Miscenko et al., 2017:606). Peer tutors can be guided towards these improved leadership behaviours by implementing The Five Practices of Exemplary Leaders of Kouzes and Posner (Kouzes & Posner, 2017:11-20).

According to Boelens, De Wever, Rosseel, Verstraete and Derese (2015:85), it should be a priority at any university to teach peer tutors to stimulate active and self-directed learning in students and to assume a leadership role. The development of leadership skills can lead to an increase in perceived authority among fellow students and ultimately this can improve knowledge and skill transfer to peer students, as well as personal growth and satisfaction for the peer tutors. Bouthillette (2016:6) showed in her study that universities using peer tutors, often only focus on the applicable skills that the tutors need to facilitate, while more research is needed on empowering tutors with leadership skills.

In this study, health care peer tutors have been involved with tutoring their peers on specific skills for several years, but the focus on leadership development was only introduced recently. The tutors have always received training on the skills that they were tutoring, but recently added was structured tutor training, as well as a workshop on implementing the transformational leadership model of Kouzes and Posner, The Five Practices of Exemplary Leaders (Kouzes & Posner, 2017:11-20). Support was available to the tutors throughout the academic year related to the specific skills, their roles as tutors and as leaders. This support was provided by academic staff with experience in these areas.

The assumption was that leadership skills of peer tutors can be developed through training of specific skills, with additional structured workshops on tutoring and a leadership model, as well as their experiences of the tutoring of their peers. The purpose of this study was therefore to describe the self-perceived leadership development of these peer tutors in the health care teaching environment.

1.2 PROBLEM STATEMENT

As peer tutors are being placed in leadership positions, leadership skills are imperative to increase knowledge and skill transfer amongst undergraduate students. Although peer tutors are being used as teaching partners at universities and they are being seen as leaders in their student communities, very little is known about their development as leaders (Bouthillette, 2016:6).

The perception of one's own leadership abilities has an influence on how one acts as a leader. Research shows that people with a strong believe in their own leadership abilities are more likely to pursue action, contribute more effort towards those actions, and will persevere to a greater degree in the face of obstacles (Anderson, Krajewski, Goffin & Jackson, 2008:595). It is therefore valuable to measure self-perception of one's leadership abilities.

In the particular setting of this study, peer tutors were being utilised in undergraduate health care programmes in the skills laboratory where specific procedural skills were being taught, as well as in tutoring programmes for academic modules. These tutors participated in training programmes that used to focus only on the mastering of clinical skills or academic performance. Recently training on tutoring abilities and leadership development has also been introduced.

The researcher observed that tutoring abilities were impacted negatively when tutors' leadership skills were not well developed or if they had a poor self-perception thereof. This might lead to a reduced ability to transfer skills or knowledge to peer students and might ultimately lead to poor patient outcomes. Thus, an increased focus on tutor leadership development in addition to the focus on their knowledge and clinical skills might lead to better tutoring abilities and skills outcomes of the tutors and tutees, as well as improved academic programme output and eventually improved outcomes for patients and communities.

This study therefore intended to describe the peer tutor's self-perceived leadership development as a first phase of a larger study to determine outcomes of leadership development of peer tutors.

1.3 RESEARCH QUESTION, AIM AND OBJECTIVES

The following research question was answered by this study: What are the peer tutors' perceptions of their own leadership development during participation in the tutor training programme in undergraduate health care studies at a university?

The aim of this study was to describe the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university.

The objectives of this study were:

- Objective 1 (phase 1): To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies.
- Objective 2 (phase 2): To describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies.

1.4 DEFINITION OF KEY TERMS

1.4.1 Leadership

According to Kouzes and Posner (2017:26), "leadership is a relationship between those who aspire to lead and those who choose to follow" and the ability to mobilise people "to transform values into actions, visions into realities, obstacles into innovations, separateness into solidarity, and risks into rewards" (Kouzes & Posner, 2017:xi). In this study leadership referred to the relationship between the appointed peer tutors and their fellow students where the tutors are expected to lead the tutees to academic growth.

1.4.2 Leadership development

The term "leadership development" often includes efforts to develop individual leaders as well as to build collective capacity for leadership within an organisation (Frich, Brewster, Cherlin & Bradley, 2015:656). Individual leadership development focusses on the expected behaviours, skills and competencies of the individual leader (Dalakoura, 2010:433).

Kouzes and Posner (2017:302) state that “leadership is an observable pattern of practices and behaviours, and a definable set of skills and abilities. And any skill can be learned, strengthened, honed, and enhanced, given the motivation and desire, along with practice, feedback, role models and coaching.”

Kouzes and Posner (2017:302) believe that leadership can be learned by anyone with a strong believe that he/she can learn and grow. In this study the tutors were exposed to leadership development opportunities based on the transformational leadership model of Kouzes and Posner (2017:11-20) to prepare them as tutors, while support was available throughout the period of tutoring to practice their leadership skills. The tutors were expected to report on their own perception of their leadership development during the tutoring programme.

1.4.3 Peer tutors

Topping (1996:322) has for many years been at the forefront of developing the concept of peer tutoring and he defines peer tutors as “people from similar social groupings who are not professional teachers helping each other to learn and learning themselves by teaching.” This definition is echoed by Benè and Bergus (2014:783) and Rudland and Rennie (2014:4). Peer tutors are usually fellow students who have less knowledge than faculty lecturers, and they usually have little to none teaching experience (Benè & Bergus, 2014:783).

The health care students in this study were from different disciplines at the faculty, including medicine, nursing, physiotherapy, occupational therapy, radiography, sport sciences, dentistry and dental hygiene. In this study, peer tutors refer to third and fourth year health care students who were appointed for an academic year to tutor their fellow undergraduate students in either academic or practical modules. Tutoring took place in a small group format and the peer tutors were placed in a leadership position with the task to facilitate procedural skills or theoretical knowledge.

1.4.4 Self-perception

Self-perception has been described as the personal view that an individual has of him-/ herself and is based on the personal sense of one’s experience, or how he/she perceives oneself (Aguirre-Raya, Castilla-Peón, Barajas-Nava, Torres-Rodríguez, Muñoz-Hernández & Garduño-Espinosa, 2016:167). In this study the peer tutors’ perception of their own leadership development was measured by using the Leadership Practices Inventory–Self (LPI-Self) self-report instrument (Annexure A: Data Collection Instrument), as well as a focus group discussion and written narratives from the tutors.

1.4.5 Tutor training programme

A *programme* is “a plan or scheme of any intended proceedings (whether in writing or not); an outline or abstract of something to be done. Also: a planned series of activities or events; an itinerary.” (Oxford English Dictionary, 2020a) *Training* can be described as “sustained instruction and practice (given or received) in an art, profession, occupation, or procedure, with a view to proficiency in it.” (Oxford English Dictionary, 2020b).

In the context of this study a tutor training programme is defined as a plan with a series of activities and sustained instructions and practices with the view to increase the skills and leadership proficiencies of the peer tutors while they contribute to improved performance of fellow students. Further discussion of the peer tutoring programme follows in the description of the context of this study.

1.5 CONTEXT

The context of this study was where tutoring programmes were being utilised at the Faculty of Health Sciences at a university in Gauteng, South Africa. Academic modules were presented and clinical skills were being taught to undergraduate students who studied in various health-related fields such as medicine, nursing, physiotherapy, occupational therapy, sport sciences, radiography, dentistry and dental hygiene.

To enhance the learning experience of the students and to alleviate the lecturers’ workload, twenty-four peer tutors were employed to facilitate practice sessions for skills and to enhance academic performance of students. The peer tutors participated in a tutor training programme before and during their facilitation of different teaching modules.

1.6 ASSUMPTIONS

All research is reinforced by a paradigm or the researcher’s philosophical worldview. A paradigm can be explained as “a way of looking at natural phenomena - a world view - that encompasses a set of philosophical assumptions and that guides one’s approach to inquiry” (Polit & Beck, 2017:738).

This study was guided by a pragmatic paradigm with a mixed methods design. Pragmatism offers a practical and outcome-oriented method of inquiry that is based on action and leads (Johnson & Onwuegbuzie, 2004:17). Pragmatism promotes combining research approaches to find the best possible answers to important research questions. Therefore, quantitative

and qualitative methods were used in this study to gather knowledge to solve a specific problem.

Johnson and Onwuegbuzie (2004:24) are of the opinion that a research paradigm consists of a set of beliefs, values and assumptions that researchers has in common regarding the nature and conduct of the research. The beliefs include, but are not limited to, ontological, epistemological and methodological beliefs.

1.6.1 Ontological assumptions

Ontological assumption focusses on what the nature of the reality is (Polit & Beck, 2017:9). Ontology becks the question "What is reality?" It is concerned with the reality of human experiences.

In this study there was both an objective and subjective environment. The objective side referred to the practical skills that the tutors needed to master. The subjective environment referred to the concept of leadership development. The assumption was that leadership can be learned, strengthened, or enhanced (in this study referred to as developed) as indicated by Kouzes and Posner (2017:302). The reality in this study was further that the best description of the peer tutors' leadership development would be their own self-reports.

1.6.2 Epistemological assumptions

Epistemology asks the question: "What is the relationship between the inquirer and those being studied?" (Polit & Beck, 2017:9). It is concerned with the study of what we know and of how we came to know it. According to Polit and Beck (2017:9-10), epistemology is a theory of knowledge that investigates how the researcher establishes rapport with participants to gain insight into their world and obtain knowledge.

In this study the pragmatic paradigm allowed for measurement, interaction and narrative writing as tools of obtaining knowledge and understanding. The assumption was that combining research methods would give the best results, as the sample group was small. A structured self-report instrument, an in-depth unstructured focus group discussion and personal written narratives of their experiences were used for measurement, observation and triangulation of the data describing the tutors' perceptions of their own leadership development.

1.6.3 Methodological assumptions

Methodology refers to the process and procedures for gathering and analysing data, therefore it defines the way the research is conducted (Polit & Beck, 2017:735). In-depth information about the participants' own perceptions as tutors in leadership roles was obtained by an unstructured focus group at the end of their tutoring time and also from personal written narratives. Due to the importance of self-perception of their leadership development, information was also collected by using a self-report instrument before and after participation in the tutor training programme. Using mixed methods with a small sample group gave a better description and understanding of the self-perceived leadership development of the peer tutors.

1.7 DELINEATION AND DELIMITATION

This study focused specifically on the development of leadership behaviours of the tutors that were appointed to tutor health care students at a specific university. This study was limited to this one specific setting with a small sample size as there were usually only twenty to thirty tutors appointed in an academic year. As it was a small sample size, a descriptive study was planned, which cannot be generalised.

1.8 SIGNIFICANCE

Peer tutors in higher education are perceived as leaders by their fellow students, but the training that they have received until recently, only focussed on skills development with a newly introduced segment on individual leadership development. This study was expected to serve as the basis for a follow-up study to determine the impact of leadership development of peer tutors on the clinical knowledge and skills retention in peer undergraduate health care students, as well as the effect on health outcomes of patients in clinical practice.

1.9 THEORETICAL FRAMEWORK

The transformational leadership model of Kouzes and Posner (2017:11-20), The Five Practices of Exemplary Leadership, served as the theoretical framework of this study. According to Kouzes and Posner (2017:26), "leadership is a relationship between those who aspire to lead and those who choose to follow." Leadership can be a one-on-one or a one-to-many relationship, and regardless of the number, a leader must learn to mobilize others towards shared aspirations (Kouzes & Posner, 2017:26). The researcher focused on the five specific practices or behaviours of exemplary leaders, namely:

- Model the Way: Leaders clarify their values and then set the example for others to follow.

- Inspire a Shared Vision: Leaders envision the future and enlist others in a common vision by appealing to their shared aspirations.
- Challenge the Process: Leaders search for opportunities, experiment and take risks.
- Enable Others to Act: Leaders foster collaboration and strengthen others to act.
- Encourage the Heart: Leaders recognise contribution and celebrate values and victories (Kouzes & Posner, 2017:13-20).

The Five Practices of Exemplary Leadership model is considered to be clear, evidence-based and easy to be implemented by anyone willing to create transformation through leading (Kouzes & Posner, 2017:13).

1.10 RESEARCH DESIGN

According to Polit and Beck (2017:164), a research design is an overall plan for addressing a research question and explains the basic approach that a researcher accepts to gather evidence that is relevant to the research question, precise and interpretable.

A convergent or triangulation mixed methods research approach was considered to be the most appropriate research design for this study. Mixed methods research is defined as research where the researcher combines quantitative and qualitative research techniques, methods, approaches and concepts into a single study (Johnson & Onwuegbuzie, 2004:17). In this study, data was triangulated by collecting both quantitative and qualitative data simultaneously (concurrently) and with equal contribution (weight).

Since the sample size for the study was small and leadership development is an abstract concept that is difficult to measure, the approach of Johnson and Onwuegbuzie (2004:14-15) was considered to be appropriate. Mixed methods research often provides a more workable solution and produces a superior product by drawing from the strengths and minimizing the weaknesses of both quantitative and qualitative research (Johnson & Onwuegbuzie, 2004:14-15).

Data collection happened by means of a structured self-report instrument (see Annexure A: Data Collection Instrument) that was developed and validated by Posner and Kouzes (Posner & Kouzes, 1988:483-496). Data was collected concurrently by conducting an unstructured focus group and collecting written self-report narratives.

1.11 METHODS

Methodology refers to the research methods that are used "to structure a study and to gather and analyse information relevant to the research question" (Polit & Beck, 2017:743). Methodology includes the context, population, sample, data collection and data analysis of a study (see Annexure B: Summary of Research Phases). The following section provides an overview of the methods used, with more detailed discussions to follow in Chapter 3.

1.11.1 Population, sampling method and sample size

In this study, the population was the group of peer tutors that was chosen from the students that were enrolled for their third and fourth years of undergraduate studies at a selected university in South Africa, during a particular academic year.

Sampling involves the process of selecting a portion of the population that is representative of the entire population (Polit and Beck, 2017:743). Since twenty-four tutors were appointed in this academic year, total sampling was used to include all the tutors in the study who were willing to participate. Inclusion criteria for this study were a participant appointed as a tutor in the skills laboratory or for an academic module, and willingness to participate voluntarily. The tutors were informed about the study and invited to participate during their orientation. If they were interested, they were requested to give their names and contact details to the secretary of the skills laboratory, who in turn gave it to the researcher who contacted them for further arrangements.

1.11.2 Data collection and organisation

Due to the small sample size and the subjectivity related to leadership development, the decision was made to obtain data using quantitative and qualitative methods to enhance the rigour of the findings.

To collect the quantitative data, an existing structured self-report instrument in the form of a questionnaire was used. Structured self-report instruments offer an accurate way to quantify subjective experiences (Polit & Beck, 2017:175) and in this study it quantified the perceptions of the tutors. The Leadership Practices Inventory (LPI-Self) self-report instrument was developed and validated by Posner and Kouzes (Posner & Kouzes, 1988:483-496) and can be seen in Annexure A. It is one of the most popular leadership assessment instruments used, which was validated to measure the effectiveness of leaders and level of commitment, engagement, and satisfaction of those that follow (McMaster, 2015:n.p.). The LPI-Self has proven proficient in assessing individuals' leadership behaviours and in providing feedback

that is useful for developing and enhancing leadership capabilities (Posner, 2016:16). The self-report instruments were completed before the commencement of the tutoring programme and the leadership workshop, and also at the end of the tutoring period.

To collect the qualitative data, the researcher conducted an unstructured focus group at the end of the tutoring period. Unstructured focus groups often begin with an informal, broad and open-ended question and subsequent questions and are more focused and guided by the responses to the broad question (Polit & Beck, 2017:509). The researcher chose this approach as it is more conversational and interactive; and allows for the participants to tell their story and reveal more depth.

The focus group was facilitated by an experienced independent facilitator who is familiar with the leadership model's content. The researcher was present during the focus groups and took field notes to capture additional information such as non-verbal communication or responses of the participants. The leading, open ended question was: "How do you perceive your own leadership development by participating in the tutor training programme? This question was followed by probing questions, guided by the participants' responses (see Annexure C: Interview Guide). The focus group was audio recorded with the permission of the participants.

The peer tutors were also asked to compile a written narrative of no more than one page to describe their experience and perception of their leadership development during participation in the tutor training programme, which they submitted to the researcher.

1.11.3 Data analysis

The self-report instrument included closed ended questions and was analysed by using descriptive statistics as a means of data reduction with the assistance of a statistician (see Annexure D: Letter from Statistician). Descriptive statistics are used to describe and summarise data by converting and condensing the data into an organised, visual representation, or picture, in a variety of ways, so that the data have some meaning (Polit & Beck 2017:726). A descriptive study illustrates a phenomenon without inflicting changes on an environment or situation.

Qualitative data analysis commenced with the transcribing of raw data from the focus groups and using a coding scheme to identify themes and subthemes. A theme is a theoretical entity that brings meaning and identity to recurring experiences and its variant manifestations; as

such a theme unifies the nature of the experience into a meaningful whole (Nowell, Norris, White & Moules, 2017:8). This process incorporates data reduction that involves reducing the dimensionality of the qualitative data by using exploratory thematic analysis and memoing (Johnson & Onwuegbuzie, 2004:22). The same method was applied to analysing the qualitative data from the written narrative reports. Findings from the quantitative and qualitative analyses were consolidated to create new meaning as described by Johnson and Onwuegbuzie (2004:22). In this study the integration was done to describe the self-perceived leadership development of the tutors during participation in the tutoring programme, based on the self-report questionnaires, the focus group discussion and the narratives.

1.11.4 Rigour

Rigour can be defined as the degree to which research methods are scrupulously and meticulously carried out in order to recognise important influences occurring in the process of conducting the research. It is a set of criteria investigators use to assess the quality, trustworthiness and value of research (Liu, 2017:1512).

1.11.4.1 Validity and reliability of quantitative data

Validity in the context of this study refers to the degree to which the self-report instrument measured what it was supposed to measure. Validity is concerned with the soundness of the study's evidence, in other words whether the findings are unbiased and well grounded (Polit & Beck, 2017:160). *Reliability* refers to the "accuracy and consistency of information obtained by a study" (Polit & Beck, 2017:160). That means a research instrument can be considered reliable if it yields similar results on separate occasions.

To ensure proper validity and reliability, the researcher used the self-report instrument of Kouzes and Posner (2003). Because of the LPI-Self's demonstrated psychometric properties, including its strong *reliability and validity*, educators and practitioners (Foli, Braswell, Kirkpatrick & Lim, 2014:76; Warde, Vermillion & Uijtdehaage, 2014:460) are confident in using the LPI-Self to further understand what it takes to be an effective leader (Posner & Kouzes, 1988:495). It was therefore considered a suitable instrument to be used in this study.

1.11.4.2 Trustworthiness of qualitative data

According to Polit and Beck (2017:747), trustworthiness is "the degree of confidence qualitative researchers has in their data and analyses, assessed using the criteria of credibility, transferability, dependability, confirmability, and authenticity."

Credibility deals with the question: How congruent are the findings with reality? The researcher promoted confidence by ensuring that the study actually measured what it was supposed to, by accurately recording the phenomena as described by Shenton (2004:64). The researcher further ensured that participants feel free to share their experiences by establishing good rapport with them, in order to develop a trusting relationship. The researcher was able to draw conclusions about what constitutes the truth, by using multiple data sources – an unstructured focus group, personal narratives and self-report instruments.

Transferability refers to the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck, 2017:747). The purpose of the study was not generalisation, but to make it possible to repeat the study in a different setting. Thick description was therefore used to provide enough data to make it possible to transfer the study to another context.

Dependability asks the question whether the findings of a study can be repeated with similar participants and in a similar context over time (Polit & Beck, 2017:559). In this study the researcher ensured dependability by using multiple methods of data collection. The research design and its implementation were thoroughly described to enable other researchers to fully understand the methods and their effectiveness as described by Shenton (2004:71).

Confirmability requires the data to represent the information that were provided by the participants during the focus group and with the written narratives and that the interpretation of that data was not invented by the researcher (Polit & Beck, 2017:560). The researcher's bias was reduced with data triangulation through the use of multiple data sources.

Authenticity transpires when the feelings, emotions and experiences of the participants are truthfully and faithfully described to show a range of realities (Polit & Beck, 2017:560). The unstructured focus group and narratives were transcribed verbatim and coded precisely to reflect the participants' experiences. All data will be stored for 15 years and will be available on request for scrutiny.

1.12 ETHICAL CONSIDERATIONS

Polit and Beck (2017:139) refers to the ethical principles of the *Belmont Report* that includes beneficence, respect for human dignity and justice. The researcher adhered to these principles to protect the ethical rights of the study participants in this study. The researcher

complied with the obligations of clinical investigators and all other pertinent requirements in the Declaration of Helsinki (see Annexure E: Declaration of Helsinki).

This researcher obtained approval from the Research Ethics Committee of the Faculty of Health Sciences of the university (see Annexure F3: Ethics Approval) before commencing with data collection. Permission to conduct this study at this specific university was also obtained from the relevant head of department (see Annexure F1: Deputy Dean of Education). Permission was granted by the authors of the instrument for the use thereof in the study (see Annexure F2: Wiley & Sons Publishers).

1.12.1 Beneficence

Beneficence is an ethical principle that aims to ensure maximum benefit and minimize harm for study participants (Polit & Beck, 2017:720). The right to freedom from harm and discomfort (non-maleficence) implies that researchers should not expose study participants to unnecessary risk, harm or discomfort. The qualitative component of this study included in-depth exploration of the study participants' personal experiences of their leadership development journey; the researcher therefore took care to be sensitive to the possible intrusion on people's psyches. There was no risk of physical harm and discomfort expected, but should any emotional discomfort have been observed, the student would have been referred for counselling to the faculty's student counsellor. No harm or discomfort were observed or reported during the study.

The right to protection from exploitation meant that participants needed to be assured that their participation would not be used to exploit them – in others words the information that they provided would not be used against them (Polit & Beck, 2017:139). The participants in this study were informed of their required time and effort as well as the potential benefit to them.

1.12.2 Respect for human dignity

Respect for human dignity is the second ethical principle of the Belmont Report and includes the right to self-determination and the right to full disclosure (Polit & Beck, 2017:140).

The right to self-determination means that participants can voluntarily decide whether to take part in a study without fearing prejudicial treatment. This includes the participant's right to ask questions, to refuse to give information and to withdraw from the study at any time (Polit & Beck, 2017:140). The researcher did not use any form of coercion tactics on participants.

The right to full disclosure required the researcher to describe the nature of the study, the rights of the participants to refuse participation, the benefits and possible risks as well as the researcher's responsibilities (see Annexure G: Participant Informed Consent).

Participants' informed consent was based on the principle of self-determination and the right to full disclosure. The researcher intended on obtaining informed consent (see Annexure G: Participant Informed Consent) from each participant to participate in the focus group discussion, written narrative reports and completion of the LPI-Self. The informed consent stated the purpose, the duration, the benefits, the possible disadvantages to and the roles of the participants in the study. Participation in the tutor training programme was compulsory for tutors, but they had a choice whether they wanted to participate in this study.

1.12.3 Justice

Justice in this study was ensured through *the right to fair treatment*. Fair treatment was achieved by selecting study participants based on the requirement of the study and not unfairly include or exclude particular individuals or groups that may benefit from the study as described by Polit and Beck (2017:141). Participants for this study were chosen on the grounds that they were already appointed as peer student tutors at the university.

The right to privacy was ensured by keeping data confidential (Polit & Beck, 2017:141). All personal information was withheld when reporting on any results and participants were assigned a number to ensure they could not be identified in the study. Complete confidentiality cannot be assured during the focus group discussion, even though the names of the participants were not used.

1.13 DISSEMINATION OF RESULTS

The results of this study were disseminated by giving feedback to the undergraduate peer tutors who participated in the tutor training programme. Feedback of the study results was given to the management of the institution and the researcher would like to see that the leadership programme becomes a permanent part of the tutor training programme. A copy of the dissertation was sent to The Leadership Challenge, Wiley Publishing Company. This dissertation is available online as well as in print from the university. The researcher plans to publish an article based on this study in an accredited journal.

1.14 SUMMARY

This chapter provided an overview of the study. Chapter 2 consists of an in-depth literature review, which is followed by the methodology of the study in Chapter 3. The research findings will be presented in Chapters 4 and 5 respectively, and finally the integration and conclusion will follow in Chapter 6.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 provided an overview of this study and a description of the problem, the research question, aim and objectives. It also clarified the key concepts, indicated the context of the study and introduced the research methods and design. Chapter 2 provides a more comprehensive literature review and description of the concepts of leader, leadership, leadership development and peer tutoring.

2.2 LEADERSHIP

2.2.1 Defining leaders and leadership

A leader is someone whose directions others would willingly follow (Kouzes & Posner, 2017:39). Kouzes and Posner (2017:31) state that there are four essential characteristics that people want in a leader namely: honesty, competency, forward-looking and inspiring. Social responsibility, innovation, self-management and task orientation are also considered key competencies for a leader in health care according to Lega, Prenestini and Rosso (2017:94). Leaders provide a focus for common objectives and actions and set the strategy and decision making direction for their subordinates to follow. They learn from challenging work, from solving complex problems, and from heading a team, and they use this knowledge to nurture team communication and improve team performance (Day, Fleenor, Atwater, Sturm & McKee, 2014:66).

Leaders transfer their own experience and knowledge to their followers, and in addition, leaders' own skills, knowledge and insights are further developed as a result of sharing their experiences with others. By developing the performance of others, leaders are enhancing their own ability to deal with tasks they currently do, which can allow them to pursue higher leadership responsibilities (Dalakoura, 2010:435).

Leadership is a process and according to Kouzes and Posner (2017:26), it "is a relationship between those who aspire to lead and those who choose to follow" and the ability to mobilise people "to transform values into actions, visions into realities, obstacles into innovations, separateness into solidarity, and risks into rewards" (Kouzes & Posner, 2017:xi). Leadership can be a one-on-one or a one-to-many relationship and regardless of the number, a leader

must learn to mobilize others to want to struggle for shared aspirations (Kouzes & Posner, 2017:26).

Northouse (2016:6) stated that through all the research done on leadership; four elements form an integral part to the definition of leadership: (a) leadership is a process, (b) leadership involves collaboration with a group; (c) leadership involves the exercise of influence; and (d) leadership involves the realisation of goals. Yukl (2013:18) on the other hand states that "leadership has been defined in terms of traits, behaviours, influence, interaction patterns, role relationships, and occupation of an administrative position".

According to Kouzes and Posner (2017:149), the study of leadership is the study of how a person leads others through misfortune, uncertainty and other significant challenges. It is about leaders who triumph against overwhelming odds, who take initiative when there is inaction, who confronts the conventional order and who mobilize individuals and institutions in the face of rigidity. It is also a study of how people in times of complacency actively seek to disrupt the status quo and awaken others to new possibilities (Kouzes & Posner, 2017:149).

In the context of the ever changing health care sector, leaders in health care should be prepared to face emerging issues, to make the difference and to take good decisions (Lega et al, 2017:94). A definition for health care leadership, which embrace a systemic view, has been identified according to Lega et al (2017:95) as ''…a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: followers within the leader's own organisation, and influential players and other organisations in the leader's wider, external environment". While most health care professionals do not hold formal leadership positions, they nonetheless may work in settings that require leadership, where they need to exert social and ethical influence to achieve health care related or other socially desirable goals (Gabel, 2014:848) for the benefit of individual patients and populations (Hargett, Doty, Hauck, Webb, Cook, Tsipis, et al, 2017:69).

According to Doublestein and Ciervo (2013:1), a *skilled* leader is an individual who is an expert in strategic and methodical thinking, spends time looking to the future, understands diversity and its value to an organisation, and is a creative innovator. Skilled leaders also know how to bring about change that keeps everyone within an organisation focused and committed.

Skilled leaders are experts in strategic and methodical thinking. They are able to assess problems and apply innovative, purposeful and strategic solutions. Most skilled leaders have

broad-based knowledge across various disciplines to solve problems; something that requires deliberate and wilful thinking skills that can be learned (Doublestein & Ciervo, 2013:1).

Leaders spend time looking to the future. One of the most important characteristics of admired leaders is that they envision the future. If leaders cannot envision the future, short-term strategic plans may take organisations down paths that will render it unrelated. Strategic foresight is a leadership skill that looks to the horizon and identifies potential trends that lead to various possible outcomes. This skill comes from deliberate consideration of the future (Doublestein & Ciervo, 2013:1).

Skilled leaders understand diversity and its value to an organisation. These leaders focus on developing human capital within an organisation (skills, knowledge, and experience possessed by individuals) to create a culture that emphasises the shared vision, mission, goals and values. Skilled leaders know that organisations with cultures centered on common values will be healthy, successful and thriving (Doublestein & Ciervo, 2013:1). Skilled leaders are creative innovators. They know how to create disruptive innovations in order to create new markets and value systems that improve products or services in ways that are unexpected (Doublestein & Ciervo, 2013:2).

Finally, skilled leaders know how to bring about change that keeps everyone within an organisation focused and committed. Change is part of life and we can choose to either embrace or fight it. Leaders of change are skilled to move people and organisations to a place that they would not go on their own. Organisations within the health care sectors cannot afford to avoid change and become irrelevant. Change-averse organisations are plagued by their extreme stability to the point of becoming better and better at less and less until they excel at nothing (Doublestein & Ciervo, 2013:1).

Besides some definitional differences regarding leadership, academic resources used to teach leadership to college students, including Kouzes and Posner (2017) and Northouse (2016), conceptualise leadership as a process in which all individuals have the capability of developing and engaging in leadership whether they hold a formal position or not (Eich, 2008:176). In the post-industrial leadership paradigm, it is believed that leadership can be developed in students and in organisations. This is opposed to older perceptions of leadership as positional or as an inherent characteristic. It is now believed that all students who involve themselves in leadership education have the potential to increase their leadership skills and knowledge (Eich, 2008:176). Kouzes and Posner (2017:12) concur that

it is a myth that leadership is something that you are born with, and that some people have it, and some don't. It is not about one's personality or formal position, but about behaviour and skills which can be learned (Kouzes & Posner, 2017:13).

While formal leadership is based on an individual occupying a position through an appointment or election, informal leadership is based on an individual's ability to encourage others to alter their attitudes and/or conduct by identifying with the leader's personality and convictions, rather than by being influenced by his or her appointed or elected position (Gabel, 2014:848). Many health care professionals who do not have formal leadership roles will be called on to provide informal leadership at various times in their careers. Doctors, nurses or other medical professionals can thus exercise clinical leadership, which is ''about facilitating evidence based practice and improved patient outcomes through local care'' (Lega et al, 2017:95) without holding a formal leadership position. This highlights the importance that all health care professionals and specifically those in the early stages of their careers must be trained in the personal and interpersonal competencies necessary for effective leadership in both formal and informal roles.

Many forms of leadership exist, including authoritarian, democratic and group decision making, but Gabel (2014:851), Lega et al (2017:95) and Tropella and DeFazio (2014:59) state that there are three types of leadership commonly used in health care services: the servant form of leadership, transactional and transformational leadership.

The servant form of leadership, for example, is commonly associated with physicians and other health care professionals because of its focus on leaders' work for the people. Robert K. Greenleaf, who first formulated the concept of servant leader, described the term as follows: "The servant–leader is servant first.… It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead." (Greenleaf, 1970:4). There are numerous qualities associated with the servant–leader, such as the ability to listen, understand, influence, and communicate. Other qualities include accountability, humility, empathy, anticipation and awareness (Tropella & DeFazio, 2014:59). Servant leadership is intuitively appealing and its relationship orientation and emphasis on the core value of service to others suggest that informal leaders in the health care services would have an affinity for it (Gabel, 2014:851).

Transactional leadership is possibly the most common form of leadership employed in various types of organisational and health care settings. Transactional leaders essentially

influence and manage their subordinates' productivity, behaviour, and task completion by providing rewards and consequences (Sfantou, Laliotis, Patelarou, Sifaki-Pistolla, Matalliotakis & Patelarou, 2017:74). Transactional leadership proves to be reasonably effective empirically, although it would be of very limited value to informal leaders who do not and cannot employ tangible reinforcements or forcible behaviours to influence others (Gabel, 2014:851).

Transformational leadership is the most widely reviewed form of leadership, and it appears well suited to the health care environment and to the efforts of informal leaders. Transformational leadership is a form of social influence that has a broad applicability in health care services and is much better suited to the changing health care environment (Ross, Fitzpatrick, Click, Krouse & Clavelle, 2014:201). Leadership theories and models from the twentieth-century were often based around a top-down dictatorial and rigid approach which aimed to achieve maximum gains from economies and social systems and as such needed workers who were task-orientated (transactional leadership) (Miskelly & Duncan, 2014:39). However, the twenty-first century economic and social systems emphasise knowledge and health care is a knowledge-based industry. It is an industry filled with bureaucratic and hierarchical structures as well as complex processes and networks, and new leadership theories and models need to enable and support flexibility, knowledge, problem-solving, teamwork, modernisation and change in order to meet the demands and pressures inherent within these structures (Miskelly & Duncan, 2014:39).

Transformational leadership practices originated from the concept of *transforming leadership* that was first described by James M. Burns in 1978 in his theory of leadership (Giddens, 2017:117, Ross et al, 2014:202). His theory was extended by the work of Bernard Bass in 1985 (Ross et al, 2014:202) who defined the term transformational leadership and how it could be measured. Bass proposed a theory that portrays how leaders influence and move their followers and organisations by transforming them. The theory of transformational leadership, was further developed by Bass and Avolio (Bass & Avolio, 1993:118-121) who described it as a leadership style that inspires and empowers followers to achieve extraordinary outcomes while transcending individual self-interests, aligning objectives and goals of the followers, the leader, groups and the organisation.

As early as 1989, Roueche, Baker and Rose (1989:24-25) examined and categorized exemplary community leaders also using transformational behavioural attributes. They identified five themes for their analysis of transformative leaders: leaders (a) believe in

teamwork and shared decision making, (b) value people both as members of the team and as individuals, (c) understand motivation, (d) have a strong personal value system and, finally, (e) have a vision of what their colleagues can become. They concluded that leaders are most effective when they empower others (Roueche et al, 1989:25).

Transformational leadership is principle-driven, relationship based, and empirically supported, and it has been shown to have a number of positive outcomes, such as an increase in subordinates' satisfaction with their leaders, and the improved motivation and performance of staff (Ross et al, 2014:202; Gabel, 2014:851). Specifically to health care services, transformational leadership is associated with a better sense of leader effectiveness, a reduction in burnout and higher rates of employee retention, and job satisfaction (Giddens, 2017:118; Ross et al, 2014:202). Furthermore, transformational leadership can lead to improved organisational strategies and better patient outcomes compared with other forms of leadership in health care (Ross et al, 2014:202).

Transformational leaders have the power to develop and support future generations of health care leaders with the aptitude to create effective strategies to some of the health care profession's most critical issues. The four core principles of transformational leadership are (1) idealized influence, (2) inspirational motivation, (3) intellectual stimulation, and (4) individualized consideration (Giddens, 2017:118; Bass, 1999:11). These principles reflect leaders' commitment to higher ethical standards and values, their ability to demonstrate, communicate, and inspire others with these values, along with their demonstrated interest in the achievements, success, and development of those they supervise (Gabel, 2014:851).

Kouzes and Posner were influenced by the theories of Bass and Burns and developed their model of leadership development based on this earlier transformational leadership style (Ross et al, 2014:202). This model is based on the assumption that transformational leaders have the ability to influence others by transforming their behaviour without necessarily being in positions of authority (Kouzes & Posner, 2017:12). Kouzes and Posner (2017:13-19) identified five exemplary practices that leaders were modelling when they were getting extraordinary things done in organisations. Such leaders can inspire others to follow them by displaying characteristic leadership behaviours. They referred to these practices as: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act and Encourage the Heart (Kouzes & Posner, 2017:12):

- The practice of Modelling the Way refers to understanding one's own values and beliefs and leading from those guiding principles. This practice involves being open

to discussing these values, standing up for them, and demonstrating a commitment to them through action (Kouzes & Posner, 2017:69-70, 91-92).

- Inspire a Shared Vision incorporates the strength of the leader's belief system into developing an organisational vision. Through this practice, leaders generate excitement and engagement in constituents around a united vision. Leaders also enlist others in working toward a united goal for the future (Kouzes & Posner, 2017:115, 140).
- Challenge the Process: leadership is about change and extraordinary leaders must be able to innovate and improve the organisation. In order to challenge the process, leaders must be able to search for opportunities to address constant shifts in an organisation's environment. Leaders must be prepared to face the possibility of failure, which is part of taking chances. Challenging the process includes accepting failures as opportunities for learning and continuous improvement (Kouzes & Posner, 2017:167, 191).
- Enable Others to Act: exceptional leaders know they can't make extraordinary things happen by themselves. They are experienced at building effective teams and promoting teamwork and collaboration. This involves creating a culture of trust and respect among all followers and sharing power with whomever is best suited to perform the necessary tasks (Kouzes & Posner, 2017:217).
- Encourage the Heart illustrates the very people-centered approach of The Five Practices of Exemplary Leadership Model. Engaged leaders recognise the importance of acknowledging and rewarding the efforts of individuals and teams and do so on a regular basis. Understanding the significance of heartfelt gratitude and recognition for hard work is invaluable in maintaining organisational morale and staff engagement (Kouzes & Posner, 2017:268).

While the concept of leadership is hard to define, most of the researchers agree that leadership consists of certain sets of characteristics or attributes (Hastings & Kane, 2018:10). These characteristics include, but are not limited to, commitment, empathy, collaboration, problem solving skills, initiative and the ability to influence others towards particular goals, values or outcomes (Hastings & Kane, 2018:10; McSherry & Pearce, 2016:12).

2.2.2 Leadership in health care

The importance of effective leadership in health care is difficult to overemphasise, as leadership not only improves major clinical outcomes in patients, but also improves provider

well-being by promoting workplace engagement and reducing burnout (Hargett et al, 2017:69).

In health care professionals, leadership involves the appropriate and ethical influence exerted by one individual to alter, modify, or change the reactions, attitudes, or behaviours of other individuals to maintain or further core values of all health professions (Gabel, 2014:848; Hargett et al, 2017:69). These core values such as beneficence, non-maleficence, independence, impartiality, and confidentiality, have been emphasised for many generations in numerous oaths and declarations in the health care field, for instance, the Declaration of Geneva (World Medical Association, 2017) and the General Ethical Guidelines for the Health Care Professions (Health Professions Council of South Africa 2016:2-3). The South African Nursing Council (SANC) reflects these ethical values in their Code of Ethics (South African Nursing Council, 2013:4-5).

Most health care professionals will apply leadership at some point in their careers in their practices, workplaces or communities without being appointed to a leadership position (informal leadership), but some will be appointed to formal leadership positions with great responsibilities (Lega et al, 2017:95; Gabel, 2014:848). These formal or positional leadership roles in health care may take many forms, including academic dean, hospital manager, medical staff president, academic department chair, training director and more (Gabel, 2014:848). Some overlapping qualities and characteristics of formal and informal leaders in health care services were identified by Gabel (2014:850) as the following:

- Demonstrate a strong commitment to the values and principles of medicine and health care;
- Demonstrate a strong commitment to the mission of the organisation;
- Demonstrate the ability to communicate their values and principles to others;
- Demonstrate the ability to communicate directly and clearly, to listen, and to include others in problem solving;
- Demonstrate the ability to inspire and motivate others to share their commitment to principle driven goals and objectives;
- Serve as a model for others, regardless of position;
- Demonstrate strong personal qualities of honesty, integrity, focus, and perseverance;
- Demonstrate the ability to recognise others for their accomplishments and contributions;
- Build relationships based on trust and genuine concern;

- Demonstrate the ability to recognise differences in perspective, to negotiate differences, and to help resolve conflicts;
- And take pride in their own accomplishments and value the recognition of others but do not require personal recognition for their mission-driven efforts.

According to Frich et al (2014:656), high-quality health care increasingly relies on teamwork, collaboration, and interdisciplinary work, and physician leadership which are essential for optimizing health care systems. This view is shared by the Accreditation Council for Graduate Medical Education (ACGME), whom has established common programme requirements for training residents and physicians. These include skills in interpersonal communication, leadership, quality improvement, and system-based practice (Accreditation Council for Graduate Medical Education, 2018:1-27).

In line with their American counterparts, the Royal College of Physicians and Surgeons of Canada, has developed the CanMEDS Physician Competency Framework that identifies and describes seven functions for physicians: medical expert, communicator, collaborator, leader, health advocate, scholar, and professional (Frank, Snell & Sherbino, 2015:n.p).

The CanMEDS competency framework is used for improving patient care by enhancing physician training. Since its formal adoption by the Royal College in 1996, CanMEDS has become the most widely accepted and applied physician competency framework in the world (Frank et al, 2015:n.p.). Based on this, experts are calling for leadership development to strengthen practicing physicians' leadership skills and competencies, performance improvement and system-based practice (Frich et al, 2015:656).

However, nurses make up the majority of the health care workforce worldwide and nursing leadership is critical to the success of current health care systems (Tropello & DeFazio, 2014:60). To that extend the American Association of Colleges of Nursing maintains that all baccalaureate nursing graduates must possess leadership skills that "emphasise ethical and critical decision-making, initiating and maintaining working relationships, and mutually respectful communication and collaboration within inter-professional teams" (American Association of Colleges of Nursing, 2008:13).

In South Africa, the philosophy of the SANC is underpinned by the National Strategic Plan for Nurse Education, Training and Practice of South Africa (Department of Health, 2013:17), in which the importance of nursing and midwifery education is highlighted to enable nurses and

midwives to provide competent patient care, meet the health needs of South Africans, engage in policy debates and provide leadership for change. Furthermore, the National Strategic Plan (Department of Health, 2013:38) states that leadership and management are fundamental for good health outcomes, and depend on adequate numbers of managers, adequate competencies of managers, functional support systems and enabling work environments. These leadership competencies should be specified for different levels of the health system and programmes or courses should be multi- and interdisciplinary (Department of Health, 2013:38).

2.3 LEADERSHIP DEVELOPMENT

2.3.1 Defining leadership development

Although some literature draws a distinction between leader development (building individual competencies) and leadership development (building collective capacity), the term "leadership development" often includes both efforts to develop individual leaders as well as to build collective capacity for leadership within an organisation (Frich et al, 2015:656). Individual leadership development focuses on the expected behaviours, skills and competencies of the individual leader (Day et al, 2014:64, Dalakoura, 2010:433), whereas organisational leadership development can encourage several key functions within organisations such as performance improvement, succession planning and achieving organisational goals (Frich et al, 2015:656, 672) and inherently involves multiple individuals (Day et al, 2014:64). Leadership development encompasses almost every form of growth or stage of development that promotes, encourages, and assists in one's leadership. This idea includes how one thinks about leadership, leadership practice, skills, efficacy, and personal leadership identity (Eich, 2008:179). According to Fitzpatrick and Modic (2016:561) leadership development in health care should prioritise the development of effective team building, translating vision into strategy, communicating vision and strategy, managing conflict, and managing the focus on patients and customers.

Leadership development should be the product of a series of well-coordinated activities intending to develop individuals, by assisting them to learn from their work and from their superiors. A critical success factor of effective leadership development is to integrate a development programme into everyday practices (Dalakoura, 2010:434) as part of longer-term development initiatives rather than short-term training interventions with limited success (Day et al, 2014:64). Ha and Pepin (2018:38) agree that leadership develops over time, through stages, with experience and continued educational support, with a mix of intentional and non-intentional leadership learning activities.

Day et al (2014:70) highlights the role of process in leader and leadership development. Specifically, process factors are those that shape the rate or pattern of development over time. In general, these factors can emerge through organisational practices such as mentoring and coaching, 360-degree feedback, self-other agreement, the use of narratives, leadership training, job assignments and action learning among others (Fitzpatrick & Modic, 2016:561; Day et al, 2014:70).

2.3.2 Leadership development programmes

Developing leadership in undergraduate students is one of the primary goals cited in the mission statements of many universities throughout the western world (Grunwell, 2015:82). Moreover, the development of leadership in students has become an increasingly emphasised component of the university experience in order to develop citizens who can engage successfully in the leadership process and contribute to the growth of society (Eich, 2008:176).

Some leadership development models for health care professionals focus on competencies required to fill leadership roles in a given organisational setting such as initiative, self-awareness, deliberate communication, technical and conceptual knowledge, and skills needed in leadership roles (Bennett, 2017:20; Frich et al, 2015:656).

However, the majority of leadership programmes still only focus on skills training and theoretical knowledge, while fewer programmes actually concentrate on personal growth and awareness (Frich et al, 2015:656). Also, leadership development programmes largely employ lectures, seminars, and group work rather than the broader set of teaching tools available for leadership development, including developmental relationships (mentors, coaching, service learning, clinical practice, peer preceptorship), assignments (action-based learning projects, simulation), feedback processes (performance appraisal, 360° feedback), and self-developmental activities (Ha & Pepin, 2018:38, Frich et al, 2015:671).

Because of this, many promising student leadership programmes have failed to incite significant change in their participants due to their lack of suitability to the university culture (Grunwell, 2015:84). The outcomes indicate that using teamwork and multiple learning methods in leadership programmes are likely to have the largest impact in the area of leadership development for health care professionals. These methods may be more expensive and time-consuming to undertake, but real progress will likely require such

resources, and sub-level efforts may continue to have a limited effect on the leadership development of undergraduate students (Frich et al, 2015:672).

Grunwell (2015:83) stresses the importance of higher education institutions in guiding the next generation of leaders towards the common good, while shaping the quality of their leadership at an undergraduate level. Students who will be taking on leadership positions in their careers should first develop their leadership abilities concurrently with the theory learned in higher education. To become a better leader, the importance of developing greater self-awareness, having positive mentors, and actively engaging in leadership behaviours should be acknowledged by higher education institutions (Day et al, 2014:69). This is also true for health care professionals where the preparation for leadership roles and responsibilities have become increasingly important due the increasing complexity in today's complex health care environment (Buckwell-Nutt, Francis-Shama & Kellett, 2014:18). Grunwell (2015:85) also stated that high-quality programmes must strive to align participant interest and programme curriculum, and that voluntary programme enrolment would be ideal, unlike in organisations where leadership training is often mandated.

To this extend, Hargett et al (2017:76) developed a leadership model that is specifically useful for teaching leadership skills to health care workers. The model is based on the core principle of patient centeredness and the core competencies of integrity, teamwork, critical thinking, emotional intelligence and selfless service (Hargett et al, 2017:69). This model is extremely helpful for learners to grasp the new concepts, to make sense of lessons learned through their experiences, and provides a basis for learner assessment and program evaluation (Hargett et al, 2017:70).

As mentioned before, leadership development needs to begin with development of student leaders. In their research on leadership development programmes offered at higher educational institutions, Kiersch and Peters (2017:151) found that students who participated in leadership training programmes were significantly more likely than non-participants to demonstrate long-term improvements in their sense of self-understanding, sense of ethics, willingness to take risks, civic responsibility, multicultural awareness, and community orientation. Eich (2008:176-187) studied the characteristics of what he defined as high-quality leadership programmes within higher education institutions, which had significant positive outcomes on student learning and leadership development. He concluded that through the application of these attributes, spread across three clusters of programme focus, leadership programmes could be enhanced for improved student outcomes (Eich, 2008:180).

In the first of three 'clusters' of attributes, participants established a learning community whereby they recognised the value of having experienced practitioners model effective leadership behaviours during programme facilitation and the benefits of cultivating meaningful relationships and a supportive culture within the training environment (Eich, 2008:180).

In the second cluster namely student-centered experiential learning experiences, Eich explains how effective programmes present opportunities for participants' self-reflection, both individually and collectively (Eich, 2008:182). Through dialogue and practical application, students learn to use presented material effectively, reflecting on their experiences and taking notes for future improvement. The role of prompt and constructive feedback in student leadership development has been found to be a vital part of quality instruction at the undergraduate level, as well as a highly desirable component of student leadership programmes (Eich, 2008:182).

Eich's last identified cluster of attributes of high-quality programmes declares that programmes must continuously grow and develop (Eich, 2008:184). Effective programmes must be both flexible to accommodate participant interests, while modelling the leadership values they present, explicitly stating their mission and values (Eich, 2008:184-5). By employing procedures for continuous improvement, programme facilitators can ensure that the information presented remains relevant, while ensuring the best chances for future participant successes through encouraging feedback from students upon completion of the programme (Eich, 2008:185).

Kiersch and Peters (2017:161-2) on the other hand suggested that the following principles should guide the process and delivery of the leadership development experience, rather than specifying leadership-specific content:

- Heavy emphasis should be placed on hands-on activities and simulations as primary tools of student leadership development, especially in early stages of such development.
- Purposeful reflection should be incorporate into leadership 'experiences' (including in-class activities) and students' ongoing leadership development journey to aid growth and self-awareness.
- A conceptual framework should be provided for hands-on learning, utilizing a range of delivery media (e.g., lecture, text, video) and sources (e.g., lecturers, community

leaders), allowing students to build knowledge of leadership and see themselves as leaders.

- And lastly, students should be given the opportunity for out of class, service learning experiences that allow them to practice and apply their developing leadership in a way that benefits some greater good.

2.3.3 Importance of leadership development in health care

All health care professionals take a leadership role at some point in their career and the aim of any medical school is to prepare students to practice health care in an ethical, competent and socially responsible manner (Jorge et al, 2014:306). Miskelly and Duncan (2014:39) also indicated that to overcome the challenges of today's health care environment, leadership models and theories need to empower health care professionals with proficiency in problem-solving, flexibility, learning, teamwork innovation and change. It is therefore very important to produce professionals who have an overall vision and the capabilities that span a variety of processes rather than just knowledge of medical skills and procedures. Warde et al (2014:460) found that, at the completion of a leadership course, health care students possessed qualities that characterize effective and resilient leaders; they were more mindful, related to each other effectively, and coordinated their activities well with one another. To achieve this goal, a curriculum supported by leadership programmes that help students develop critical analysis, resolve problems and lead people is essential (Jorge et al, 2014:306).

Lega et al (2017:99) and Hargett et al (2017:70) however found that guidelines to develop health care leaders are missing and that nurses and physicians alike lack specific education on leadership and management to prepare them for their current and future personal and professional leadership challenges in clinical settings. Buckwell-Nutt et al (2014:18) agreed that nursing education programmes provide limited opportunities for students to experience the role of expert and to develop leadership skills in a clinical setting, with many programmes relying on a single leadership course prior to graduation.

Health care students and trainees represent a unique opportunity to foster professional socialisation. They need and benefit from educational leadership activities as they need to be prepared, encouraged and enabled to play leadership roles in future (Lega et al, 2017:99). They need to be able to make delicate decisions as the very future of the health care profession is placed at risk if the next generation of leaders cannot be identified, developed

and empowered (Lega et al, 2017:99). According to Doublestein and Ciervo (2013:2), some of the more significant benefits of developing trained leaders in health care are:

- Trained leadership overcomes normal dysfunctions — new patient safety standards dictate strong patient care teams. Properly trained health care leaders create higher performing teams that rise above dysfunctions that often hamper quality patient care.
- Increased customer satisfaction — trained leaders create increased customer satisfaction, they elevate followers to a higher operating plane, raise others' moral and ethical behaviour, heighten positive emotions and physical well-being, and they improve performances, whether their 'customers' are patients, peers or the allied health team.
- Increased dedication — trained leaders work harder and are more dedicated to their organisation and its values and goals. These leaders gain a positive view of the future and envisage visions that others enthusiastically desire to join.
- Creating preferred futures — trained leaders scan the horizon for driving trends that would either positively or negatively affect the profession. They develop strategies that either reinforces the possibility of creating a positive future or strategies that avoid negative ones.
- Increased return on investment to stakeholders — trained leaders produce teams that are based upon trust and high-trust organisations outperform those that are low-trust. Health care can be revolutionized if health care workers can participate in the improvement of the health of patients, engagement of team members and organisational effectiveness.

2.3.4 Measuring leadership development

The conceptualisation of leader effectiveness is very challenging and among researchers there are many arguments to find out what leadership effectiveness is and how it should be measured (Madanchian, Hussein, Noordin & Taherdoost 2017:1044; Northouse, 2016:372; Bass, 1999:14; Posner & Kouzes, 1988:484). Northouse (2016:372) stated that leadership effectiveness is measured by the accomplishment of goals or objectives within a leadership background. In other words, leadership is considered to be effective when the individuals in the position of leadership are able to impact on a group to perform their roles with positive organisational outcomes (Madanchian et al, 2017:1044).

In the health care setting, effective leadership has a great impact on reducing mortality rates, improving patient outcomes, providing quality care and ensuring patient safety, by inspiring, retaining and supporting experienced staff (Ha & Pepin, 2018:37; McSherry & Pearce,

2016:12). Transformational leadership is strongly related to the implementation of effective leadership that establishes this culture of patient safety and quality care (Sfantou et al, 2017:74; Giddens 2017:119). For these reasons it is important to measure leadership effectiveness to ensure the development of leadership abilities of all relevant health care workers.

One of the most common outcome measures to evaluate an effective leader is examining the consequences of said leader's actions. Madanchian et al (2017:1045-6) identified through their research such measures of leadership effectiveness that examine specific leader outcomes as follows:

- Group performance and success of group goals: it is a strong indicator whether leaders are able to influence their subordinates and lead them to achieving the goals of the organisation. These are usually objective group performance measures such as achieving sales, profit margins and productivity.
- Subordinate leader effectiveness evaluations: this involves the evaluation of leader effectiveness by asking followers to assess how well the leader performs and accomplishes specific outcomes according to the goals of the organisation.
- Increase subordinate job satisfaction and performance: leaders are considered effective if they are able to influence and raise the performance and job satisfaction of subordinates.
- Advanced subordinate commitment: enhanced organisational outcomes develop when employees are committed to the organisation as a result of an effective leader.
- Improved decision making: the effective leader can make excellent decisions and can thereby also increase productivity and commitment from subordinates.
- Improved group performance: this is another outcome of a leader's actions that has been identified as an indicator of an effective leader. Specific measures may include the ability of the leader's organisational unit to reach its goals and also employee retention.

Effective leaders also have specific attributes, show specific behaviours and create situations that are best for an organisation using specific skills and processes (Madanchian et al, 2017:1047). Foli et al (2014:76) described competence, knowledge, teaching skills, communication and support as ideal leadership attributes amongst students, emphasising the value of transformational leadership in preceptor relationships.

The Five Practices of Exemplary Leaders of Kouzes and Posner, identified such leadership practices which leaders use to achieve extraordinary results (Posner, 2013:576). Each of these practices consists of reasonably specific, concrete, and measurable attributes and behaviours that relate significantly to such outcomes as the leader's credibility, employee morale, retention, and productivity (Posner, 2013:576). In short, these practices are as follows (Kouzes & Posner, 2017:13-19):

- *Model the Way:* leaders clarify their personal values by finding their voice and affirming shared values and then set the example for others to follow, aligning actions with the shared values of a team.
- *Inspire a Shared Vision:* leaders envision the future by imagining exciting possibilities and enlisting others in a common vision by appealing to their shared aspirations.
- *Challenge the Process*: refers to practices that search for opportunities by seizing the initiative and by looking outward for innovative ways to improve or experiment and take risks by constantly generating small wins and learning from experience.
- *Enable Others to Act:* leaders foster collaboration by building trust and facilitating relationships and strengthen others by increasing self-determination and developing competence.
- *Encourage the Heart:* leaders recognise individual contribution, by showing appreciation for individual excellence, or to celebrate the values and victories by creating a spirit of community.

The LPI was originally developed by Posner and Kouzes (1988:483-96) and is based on these five practices that leaders were modelling when they were getting extraordinary things done in organisations. It is based on qualitative and quantitative research of everyday actions and behaviours of exemplary leaders in a variety of settings and the feedback from the instrument is being used to assess leaders' skills to improve their leadership abilities (Kouzes & Posner, 2003:9).

The LPI requires the user to rank the frequency of their use of specific leadership behaviours on a Likert scale of 1-10. This instrument consists of 30 statements describing various leadership behaviours. Responses to six statements are used to compute five leadership scales: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act and Encourage the Heart (Posner & Kouzes, 1988:485). Respondents indicate the extent (frequency) to which they engage in the behaviour described using a ten-point scale, with 1 indicating 'almost never' and 10 indicating 'almost always' (Posner, 2013:578).

In a study to explore the differences in the Leadership Practices Inventory subscales among groups of medical residents based on specific residency and demographic characteristics and various types of peer teaching experiences, Bennett (2017:64) found significant relationships between leadership practices and overall peer teaching, tutoring, and groups based on an internal medicine residency program. Bennett's study (2017:114) revealed that among medical residents, overall peer teaching and tutoring specifically were associated with an increase in most, but not all, of the leadership domains identified by Posner and Kouzes (1988:483-96).

In another study, Blackwell, Katzen, Patel, Sun and Emenike (2017:49) introduced the Preparation in STEM (Science, Technology, Engineering and Math) Leadership Program at a university in New Jersey, with the purpose of creating a centralized training program for peer leaders which included assessments to evaluate peer leaders' knowledge and leadership practices over time. These assessments were done with the use of the LPI of Kouzes and Posner (2003). Academic peer leader positions in this study ranged from tutoring in one-on-one or group settings to facilitating small group study sessions, leading large review sessions or providing in-class learning support. Blackwell et al (2017:62) found higher scores for the LPI with the mid-programme assessment than for the post-programme assessment. The decrease could indicate increased self-awareness of one's practices or a change in how peer leaders understand each behaviour to which they responded (Blackwell et al, 2017:62).

In this study the LPI was used to describe self-perceived leadership of tutors in undergraduate health care programmes.

2.4 PEER TUTORING

2.4.1 Defining peer tutoring

Many researchers (Bouthillette, 2016:4; Benè & Bergus, 2014:783; Rudland & Rennie, 2014:4) have accepted in the last decade the definition of peer tutoring as described by Topping (1996:322) to be the golden standard. Topping (1996:322) defined peer tutors as "people from similar social groupings, who are not professional teachers, helping each other to learn and learning themselves by teaching". According to Topping (1996:322), peer tutoring is characterised by specific roles, and that at any given time, someone will have the position of tutor, while others will take on the role of tutees (peer students). Topping and Ehly (1998:1) further defined peer tutoring, also known as peer-assisted learning, as "the acquisition of knowledge and skill through active helping and supporting among status

equals or matched companions". It can incorporate everything from teaching, mentoring and counselling to behaviour modelling.

In more recent years, peer teaching is defined as an educational approach that encourages the development of knowledge through the support of peers who share many commonalities, such as being enrolled in similar courses or programs, but at different stages of learning (Alfaro, Larouche, Ventura, Hudon & Noel, 2019:770). Benè and Bergus (2014:783) indicated that peer tutoring draws on the social and cognitive similarities between learner and tutor and can be attractive to health care learning institutions faced with a growing number of students but an unchanging faculty size. Peer tutors can give lectures on assigned topics, lead problem-based learning sessions and provide one-on-one support to classmates, and therefore ensures that teaching and learning methods become more student-focussed (Williams & Reddy, 2016:23). Cognitive similarities are the result of peer tutors having a better understanding of the prior knowledge and learning experiences that tutees might have and a better understanding of the learners' challenges with learning new concepts within a faculty (Al Kawas & Hamdy, 2017:39; Benè & Bergus, 2014:786).

2.4.2 Benefits and disadvantages of peer tutoring

Due to the continuous transformation of the health care industry, current university students are required to successfully obtain and maintain skills throughout their education in order to keep up with industry and community expectations (Williams & Reddy, 2016:23). One of the many teaching and learning methods used by tertiary health care institutions is peer tutoring. Unlike conventional teaching methods whereby students are taught by professionals in their respective fields, peer tutoring incorporates the student into the teaching process and promote a more social, comfortable and safe educational environment (Al Kawas & Hamdy, 2017:39; Williams & Reddy, 2016:23). A large number of tutors are not professional tutors, but are rather students themselves, usually postgraduate, but in some cases senior undergraduate students. Their position as students themselves comes with advantages and disadvantages in terms of participating in a tutorial programmes responsible for enhancing students' knowledge and skills and therefore success at university (Clarence, 2016:41).

The growing interest in peer tutoring can relate back to the many benefits for all parties involved. One of the major benefits for universities is the alleviation of the lecturer's workload in view of the ever increasing numbers of health care students (Al Kawas & Hamdy, 2017:39; Rudland & Rennie, 2014:7). Because of this large class teaching that is becoming increasingly more common in many higher education institutions, the contact between tutors

and students in smaller, more intimate learning environments becomes increasingly more important and valuable (Clarence, 2016:41). Peer tutoring is thus implemented to improve teaching quality and to help to do more with fewer resources.

In terms of advantages for the tutees, peer student tutors are closer in experience to the tutees, so students tend to feel more comfortable sharing their struggles with tutors. Peer tutors have been found to be more supportive and encouraging and reduce learner anxiety through their ability to serve as role models (Benè & Bergus, 2014:786). Given the narrow distance between tutees and tutors who recently experienced the curriculum themselves, peer tutors can provide more relevant advice and a more effective learning environment to the tutees (Alfaro et al, 2019:770; Rudland & Rennie, 2014:6). If tutors are able to develop open relationships with students, they may be able to bring students' concerns to lecturers, who may not be able to readily access this information if they are teaching large classes where they do not know each student personally (Clarence, 2016:41). Rudland and Rennie (2014:6) concur that one of the perceived advantages of peer tutoring was identifying areas that required greater emphasis by staff in the formal curriculum. Thus peer tutoring in health education can alleviate the faculty teaching burden by focussing on potential gaps in the curriculum while also assisting students in preparation for assessments (Sammaraiee, Mistry, Lim, Wittner, Deepak & Lim, 2016:297).

Peer tutors and by extension peer leaders gain as much, if not more, value from the experience than the students they serve. Students in leadership roles report development in their communication skills, increased interaction with faculty staff and peers, critical thinking, development of problem-solving skills and an awareness and appreciation of diversity (Keup, 2016:32). In a study conducted by Frade and Tiroyabone (2017:123), it was reported that South African peer leaders also showed significant gains in the development of their own skills, of which the top three identified skills were interpersonal communication, leadership and teamwork.

As peer tutors act as role models for junior students, tutoring enhances their own intrinsic motivation, and prepares health care students for their future role as educators and leaders (Al Kawas & Hamdy, 2017:39). Evidence also suggests that being a peer tutor can lead to increased knowledge of the content area, skills competencies and self-confidence as well as knowledge of how to teach and engagement with the learning environment (Al Kawas & Hamdy, 2017:39; Rudland & Rennie, 2014:4). Peer tutoring can also encourage academic

careers as tutoring increases their understanding and awareness of facilitation, teaching and assessment (Burgess, McGregor & Mellis, 2014:116).

Health care graduates are expected to be skilled in lifelong learning, a characteristic that peer tutoring can help develop through gaining competence in reflecting and expanding on their own knowledge. As health care providers they will also be expected to supervise, teach, facilitate, assess and provide feedback to colleagues and to contribute to the teaching of future generations of health care providers (Burgess et al, 2014:115-6). Additionally, peer tutoring enhances teamwork skills and teach tutors to identify their personal strengths and weaknesses (Benè & Bergus, 2014:783). These are all competencies that are "identified as twenty-first century learning objectives for college and that are also highly desirable skills among employers" (Blackwell et al, 2017:52). Participation in peer tutoring is an effective and efficient way to introduce and foster all these core professional skills that may not be included in formal health care educational programmes (Burgess et al, 2014:115-6).

There are however some disadvantages to having students act as peer tutors and giving them the shared responsibility for improved student success. The main disadvantage is that, as students themselves, tutors are still developing their own knowledge, skills and personalities and therefore they may not be fully able to break down difficult concepts, unpack and explain dense knowledge clearly, or create relevant learning activities that help students engage with their learning in meaningful and context-relevant ways (Clarence, 2016:41-42). Other perceived disadvantages are that tutees are sometimes given incorrect information and they are sometimes subjected to poor teaching methods (Rudland & Rennie, 2014:6). It is also common for peer tutors to lack confidence in their abilities to successfully teach, and they welcome training related to their teaching role (Benè et al, 2014:783). A further disadvantage, especially with more experienced or older tutors, is that they may take on a too authoritative role in tutoring, acting as more of a lecturer than a peer tutor. An academically sound peer tutor development programme is thus essential in supporting tutors with learning how to facilitate rather than lecture, and with growing their confidence by further developing their disciplinary knowledge and personalities necessary for introducing students into a community of practice (Clarence, 2016:42).

Apart from the mentioned benefits and disadvantages of peer student tutoring, tutees have also indicated that tutors need to have certain competencies to be able to tutor effectively. Boelens et al (2015:2) identified five tutor competencies which are essential for effective tutoring. Tutors should be able to engage in active learning, self-directed learning,

collaborative learning, contextual learning and interpersonal behaviour (Boelens et al, 2015:2). Burgess, Goulston and Oates (2015:8) also found that good knowledge of theory; empathy and respect for tutees and patients; understanding of the curriculum; meaningful feedback and a keen interest in teaching were identified as positive examples set by tutors.

2.4.3 Leadership development of peer tutors

According to Keup (2016:37), a student peer leader can be described as an undergraduate student who has been selected to serve as a mentor or peer educator to other students through a position within a school-run organisation. In other words, peer leaders are students who have been selected, trained, and designated by a campus authority to offer educational services to assist peers toward the achievement of educational goals (Skipper & Keup, 2017:95). Peer leaders in higher education are often given important teaching and learning responsibilities e.g., peer tutoring, but their training or professional development and support opportunities vary greatly, and more often than not peer tutors are not well supported in their roles (Clarence, 2016:39). Peer leaders who are not trained cannot sufficiently assist students and may not even be fully aware of their roles and responsibilities, which are highlighted during training (Frade & Tiroyabone, 2017:122).

In a study done by Frade and Tiroyabone (2017:117) at six South African universities involving 466 participants, only 63.3% of the academic peer leaders reported having received initial training. Similarly, only 63.4% of the academic peer leaders reported having received ongoing additional training and sustained support (Frade & Tiroyabone, 2017:117). This highlights the fact that many South African peer leaders are placed in positions for which they receive minimal training. This lack of training can hinder the quality of peer-mediated interventions and adversely affect student engagement in peer-led activities.

In order to create and sustain teaching and learning environments that are better able to facilitate students' engagement with knowledge and learning, the role of peer tutors needs to be recognised differently (Clarence, 2016:39). Frade and Tiroyabone (2017:115) suggest that intentional and ongoing training is critical for developing the capabilities and skills required for successful peer leadership, and by extend peer tutoring, and further state that training should be intentionally designed to adequately prepare peer leaders for their roles and responsibilities. Clarence (2016:39) found discrepancies in the types of professional or educational support, training and development offered to tutors by their universities and lecturers in South Africa. While some educators advocated skills in leadership, communication, and trust building as important skills, others have suggested that knowledge

of learning theory and practicing teaching in a simulated setting are necessary to prepare tutors to facilitate peer students (Benè & Bergus, 2014:785).

According to Bright (2019:1), opportunities to practice and develop leadership skills are often limited for undergraduate health care students even though leadership theory is introduced in baccalaureate level in for example the nursing curricula. Other researchers have also cited a lack of opportunities for students to practice leadership skills and to engage in the process of organisational change (Bright, 2019:2; Towle, 2015:160).

Burgess, Van Diggele and Mellis (2015:615) found that by actively involving students in leadership practices like peer tutoring, they were able to not only engage with the students, but also develop their leadership skills within the student community and contribute to the promotion of a culture of excellence in teaching within the health care profession. The development of leadership skills among senior students has been identified as one significant justification to incorporate peer teaching into health care educational facilities (Bennett, 2017:47). Peer leaders who are involved in peer tutoring furthermore reported an increase in the leadership skills of critical thinking, problem solving and the ability to work under pressure (Skipper & Keup, 2017:97) and an increase in their ability to manage group dynamics and facilitate learning (Blackwell et al, 2017:52). Tutoring during simulation can also increase leadership development with clinical practice and ultimately, peer leadership provides opportunities for senior students to “learn, experience, analyse, and develop” leadership skills (Brown & Rhode, 2018:54). This facilitation of learning experiences for peers with whom they can socially identify, creates an ideal leadership opportunity for senior students in the safe, supportive and multifaceted environment of human patient simulation (Brown & Rhode, 2018:53).

According to Clarence (2016:40) there are two significant, but often ignored parts of tutor development in higher education that need attention, namely the role of the lecturers that tutors work for and with, and the need for a support and development programme for tutors.

Lecturers and tutors should work together as partners in designing and providing effective teaching and learning environments for students, thus lecturers have a responsibility in helping tutors realise their partnership role in ways best suited to the teaching and learning objectives of the department and academic discipline. Tutors need guidance and ongoing interaction from lecturers on how to facilitate learning successfully within the specific disciplinary or departmental context in which the tutoring occurs (Clarence, 2016:40).

There is a need for a support and development programme for tutors that are coherent, underpinned by relevant theory and research in higher education (Clarence, 2016:40). Such a support and development programme needs to cumulatively build peer tutors' knowledge, skills and characters in relation to their work with tutees. This kind of cumulative development can however not happen in ad hoc generic workshops on aspects of tutoring that happen outside of academic disciplines and departments. These programmes should also pay attention to who the tutors are, the kinds of experience and knowledge they bring into tutoring with them, and the ways in which they need to be supported taking into account both their psycho-social and academic needs (Clarence, 2016:41).

2.5 SUMMARY

In conclusion, literature indicates that health care leadership development programmes are associated with significantly increased self-assessed knowledge and expertise among health care students, however, few studies have examined the impact on broader outcomes at an organisational or system level (Frich et al., 2015:672). The practice of involving advanced students in mentoring, teaching, and leading beginner students in combination with a narrative academic approach, offers a cost-effective and efficient way to reinforce learning, provide support for beginner students, develop leadership skills among advanced students, and strengthen health care educational programmes overall (Bright, 2019:2).

The literature suggests important gaps, including a lack of programmes that integrate non-physician and physician professionals, a limited use of more advanced training tools such as interactive learning and feedback in order to develop greater self-awareness, and an overly narrow focus on individual-level rather than system-level outcomes (Frich et al, 2015:672).

If an organisation can develop leadership at all levels, then its people would act more like owners and entrepreneurs rather than just hired employees. They would take initiative to solve problems acting with a sense of urgency and a willingness to experiment; willingly accept accountability for meeting commitments, and share a common goal, philosophy and language of leadership. Chapter 3 will discuss the methodology used in this study.

CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Chapter 2 reviewed literature on leadership, leadership development and peer tutoring. In Chapter 3, the research question is reinstated followed by a description of the research design. Next, a discussion of the research methods follows. This includes the context of the study, sampling procedures, data collection and instruments. The data collection and analysis procedures used in this study are also reviewed. The chapter concludes with a description of measures used to enhance the rigour of the study.

3.2 RESEARCH QUESTION, AIM AND OBJECTIVES

Peer tutors in higher education are perceived as leaders by their fellow students, but the training that they have received until recently at this specific university, only focussed on skills development with a new segment on individual leadership development only being introduced recently. To be able to develop a well-designed tutor training programme for future, the following research question was answered by this study: What are the peer tutors' perceptions of their own leadership development during participation in the tutor training programme in undergraduate health care studies at a university?

The aim of this study was to describe the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university.

The objectives of this study were:

- Objective 1 (phase 1): To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies.
- Objective 2 (phase 2): To describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies.

3.3 RESEARCH DESIGN

According to Polit and Beck (2017:164), a research design is an overall plan for addressing a research question and explains the basic approach that a researcher accepts to gather evidence that is precise, interpretable and relevant to the research question. Since leadership development is an abstract concept that is difficult to measure and describe and the sample size for the study was small, the approach of Johnson and Onwuegbuzie (2004:14-5) was considered to be appropriate.

This approach is a convergent or triangulation mixed methods research approach that was chosen to be the best research design for this study. Mixed methods research is defined as research where the researcher combines quantitative and qualitative research techniques, methods, approaches and concepts into a single study (Johnson & Onwuegbuzie, 2004:17).

Data triangulation is the use of various sources of data to validate conclusions (Polit & Beck, 2017:725) and due to the small sample size and subjectivity related to leadership development, the decision was to obtain data using quantitative and qualitative methods to enhance the rigour of the findings. Polit and Beck (2017:584) agree that the principle of a convergent design is to obtain different but complimentary data about the central phenomenon under study and then the goal is to converge on the truth about the research problem.

To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies (Objective 1), quantitative data was collected with the use of a self-report instrument. For Objective 2 – to describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies – qualitative data was collected in the form of an unstructured focus group discussion and personal narratives written by the participants. All the data were triangulated to provide results of equal weight for this study.

3.3.1 Mixed methods research

Mixed methods research often provides a more workable solution and produces a superior product by drawing from the strengths and minimizing the weaknesses of both quantitative and qualitative research (Johnson & Onwuegbuzie, 2004:14-5). According to Johnson and Onwuegbuzie (2004:18), researchers should collect multiple data using different strategies, approaches, and methods in such a way that the resulting mixture or combination is likely to result in complementary strengths and non-overlapping weaknesses. Effective use of this

concept is a major source of justification for mixed methods research because the product will be superior to mono-method studies (Johnson & Onwuegbuzie, 2004:18). The strengths and weaknesses of mixed methods research were well described by Johnson and Onwuegbuzie (2004:21) as illustrated in Table 3.1 below:

Table 3.1
Strengths and Weaknesses of Mixed Research

Strengths	Weaknesses
* Words, pictures, and narrative can be used to add meaning to numbers. * Numbers can be used to add precision to words, pictures, and narrative. * Can answer a broader and more complete range of research questions because the researcher is not confined to a single method or approach. * A researcher can use the strengths of an additional method to overcome the weaknesses in another method by using both in a research study. * Can provide stronger evidence for a conclusion through convergence and corroboration of findings. * Can add insights and understanding that might be missed when only a single method is used. * Qualitative and quantitative research used together produce more complete knowledge necessary to inform theory and practice. * Can be used to increase the generalisability of the results.	* Can be difficult for a single researcher to carry out both qualitative and quantitative research, especially if two or more approaches are expected to be used concurrently; it may require a research team. * Researcher has to learn about multiple methods and approaches and understand how to mix them appropriately. * Methodological purists contend that one should always work within either a qualitative or a quantitative paradigm. * More expensive. * More time consuming. * Some of the details of mixed research remain to be worked out fully by research methodologists (e.g., problems of paradigm mixing, how to qualitatively analyse quantitative data, how to interpret conflicting results)

Johnson, R.B., Onwuegbuzie, A.J. 2004. Mixed methods research: A research paradigm whose time has come. Educational researcher. 33(7):21

Although the researcher was well aware of the weaknesses of a mixed methods design, the strengths of the design still established suitable motives for using this specific design for this study. The researcher drew strengths from both quantitative and qualitative research by adding the use of written narratives to enhance the data collected by the self-report instruments to describe the participants' journey of leadership development. By also using the transcribed data from the discussion group, the researcher was able to triangulate the data to answer a broader and more complete range of research questions. Since the sample group was small, a mixed methods design provided insights and understanding that might

have been missed if only a single method was used. It also provided stronger evidence for a conclusion through convergence and corroboration of findings.

Moreover Johnson and Onwuegbuzie (2004:22) describe five major reasons for conducting mixed methods research: a) triangulation (i.e., seeking convergence and corroboration of results from different methods and designs studying the same phenomenon); b) complementarity (i.e., seeking elaboration, enhancement, illustration, and clarification of the results); c) initiation (i.e., discovering paradoxes and contradictions that lead to a re-framing of the research question); d) development (i.e., using the findings from one method to help inform the other method); and e) expansion (i.e., seeking to expand the breadth and range of research by using different methods for different inquiry components). In this study the researcher chose a mixed method design for the reasons of triangulation and complementarity. Because of the small sample size the researcher wanted to validate and converge as well as enhance and illustrate the results to better clarify and describe the participants' perception of their leadership development.

3.3.2 Quantitative research

Quantitative research methods were used to inform the first objective - to describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies.

According to Polit and Beck (2017:741), quantitative research involves the investigation of phenomena that lend themselves to precise measurement and quantification and often involve a rigorous and controlled design. Quantitative research involves a formal, objective and systematic process to obtain information about a phenomenon. Most often the data that is gathered consist of numerical information that is obtained from a formal measurement and is analysed statistically (Polit & Beck, 2017:11).

Some of the strengths of quantitative data are described by Johnson and Onwuegbuzie (2004:19) as follows:

- Can generalise a research finding when it has been replicated on many different populations and subpopulations.
- Useful for obtaining data that allow quantitative predictions to be made.
- The researcher may construct a situation that eliminates the confounding influence of many variables, allowing one to more credibly assess cause-and-effect relationships.

- Data collection using some quantitative methods is relatively quick.
- Provides precise, quantitative, numerical data.
- Data analysis is relatively less time consuming (using statistical software).
- The research results are relatively independent of the researcher.
- Quantitative data may have higher credibility with many people in power (e.g., administrators, politicians, people who fund programs).

The quantitative data for this study was obtained by using the structured self-report instrument of Posner and Kouzes (1988:483-96). The instrument will be discussed under the heading of 'Data collection and organisation'.

3.3.3 Qualitative research

Qualitative research methods were used to inform the second objective – to describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies.

Qualitative research is the investigation of phenomena typically in an in-depth and holistic manner through the collection of rich narrative materials using a flexible research design (Polit & Beck, 2017:741). A qualitative design was chosen because it generates both in-depth and detailed information and was done with the use of an unstructured focus group and analysing personal narratives of the participants.

Some of the strengths of qualitative data are described by Johnson and Onwuegbuzie (2004:20) as follows:

- Is useful for studying a limited number of cases in depth.
- Is useful for describing complex phenomena.
- Provides individual case information.
- Can conduct cross-case comparisons and analysis.
- Provides understanding and description of people's personal experiences of phenomena (i.e., the "emic" or insider's viewpoint).
- Can describe, in rich detail, phenomena as they are situated and embedded in local contexts.
- Identifies contextual and setting factors as they relate to the phenomenon of interest.
- Can determine how participants interpret "constructs" (e.g., self-esteem, IQ).
- Can be used to collect data in naturalistic settings.

- Is responsive to local situations, conditions and stakeholders' needs.

3.4 RESEARCH METHODS

Methodology refers to the research methods that are used “to structure a study and to gather and analyse information relevant to the research question” (Polit & Beck, 2017:743). Methodology includes the context, population, sample, data collection and data analysis of a study.

3.4.1 Context of the study

The context of this study was the skills laboratory of the Faculty of Health Sciences at a university in Gauteng, South Africa. Students who studied in various health-related fields were using this skills laboratory for clinical skills training. Peer student tutors were utilised to assist with training of these students (tutees) as part of a tutoring programme.

To enhance the learning experience of the tutees and to alleviate the lecturers’ workload, peer tutors were employed to facilitate practice sessions for clinical skills and to enhance academic performance of students. The peer student tutors participated in a tutor training programme before and during their facilitation of different teaching modules.

The tutor training programme consisted of four components, of which the past tutor training programmes only included the first two components:

- **Recruitment component:** peer tutors, usually in their third or fourth year of studies, were selected and appointed according to the needs of the faculty and the recruitment policy of the university. There were seven tutors appointed at the skills laboratory and seventeen for other academic modules over the period of this study at the Faculty of Health Sciences. Thus, the total number of appointed tutors was 24.

- **Skills and knowledge training component:** in the skills laboratory peer tutors were trained to facilitate the transfer of clinical skills to peer students. These skills included: basic emergency care procedures (cardiopulmonary resuscitation and splinting) and general procedural skills (including intramuscular injections, intravenous therapy, venepuncture, arterial puncture, urinary catheterisation, manual defibrillation and skin suturing). With the academic modules, tutors were trained to use teaching skills to transfer academic knowledge in a particular basic sciences module, for example anatomy, or discipline-specific modules.

- **General tutor training component**: training focussed on the general principles of tutoring and learning for all tutors of the faculty, annually organised by the faculty. This was a two day course, presented by the department of Education Innovation, at the university. This course was compulsory for all newly appointed tutors.

- **Leadership development component:** peer tutors attended a leadership workshop, adapted from the Sigma Theta Tau International Leadership Programme, which focussed on The Five Practices of Exemplary Leaders as described by Kouzes and Posner (2017:11-20). The workshop was an interactive face-to-face opportunity for tutors to identify their own potential and to discuss ways for themselves to develop their own leadership skills. The workshop was presented by an independent presenter who was familiar with the leadership model as well as the Sigma Theta Tau International Leadership Programme. Further discussions on leadership development were incorporated in all scheduled meetings throughout the tutoring programme.

The last two components were added as part of the tutor training programme within the previous year. It was expected that the addition would contribute to leadership development of the peer tutors.

3.4.2 Population, sampling method and sample size

A population is the entire set of individuals or objects having some common, defining characteristics (Polit & Beck, 2017:739). In this study, the target population was the group of tutors who attended the initial tutor training programme at a selected university in South Africa, during a particular academic year (2019). The population was the same for both objectives of the study.

Sampling involves the process of selecting a portion or subset of the population that is representative of the entire population (Polit & Beck, 2017:743). Since twenty-four tutors were appointed in this academic year, total sampling was used to include all the tutors in the study who were willing to participate.

Inclusion criteria, in other words the criteria that specified the population characteristics (Polit & Beck, 2017:250). For this study a participant had to be appointed as an undergraduate peer tutor in the skills laboratory or for an academic module, and would

participate in all the phases of the study voluntarily. The tutors were informed about the study and were invited to participate during their tutor orientation or by means of e-mails. Those who were interested were requested to give their names and contact details to the secretary of the skills laboratory, who in turn gave it to the researcher to contact them for further arrangements. Based on the nature of the population, they were all above 18 years and fluent in reading, writing and speaking English.

Exclusion criteria specify the characteristics that a target population does not have (Polit & Beck, 2017:728). In this study, tutors who responded to the e-mail invitations and were post-graduate students or did not complete all components of the tutor training programme, were excluded.

A total of 12 tutors responded to the invitation and gave consent to participate in the study. All these tutors attended the general tutor training programme of the university as well as the leadership development workshops. Three were post-graduate students and was therefore excluded from the study. Two of the undergraduate tutors who initially gave consent to participate did not complete all phases of the study – one did not participate in the final unstructured group discussion and the other never handed in the required personal narrative.

This left the researcher with seven tutors who qualified for the study and were willing to participate by completing all phases of the study including tutor training, the leadership development workshop, the completion of the self-report instrument and personal narrative, as well as participating in the focus group discussion. These seven tutors were all undergraduate, third or fourth year students, and were appointed in the skills laboratory to facilitate peer tutoring of practical skills.

3.4.3 Demographic characteristics of participants

Of a total population of 24 eligible participants invited to participate, seven participated throughout. Their demographic details related to sex, age, year of study, programme enrolled for and years of experience are discussed in Chapter 4.

3.4.4 Data collection and organisation

- **Quantitative Data**

Data collection is defined as the gathering of information to address a research problem (Polit & Beck, 2017:725). To collect the quantitative data for the first research objective, a structured self-report instrument in the form of a questionnaire (see Annexure A: Data

Collection Instrument) was used to describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme. This structured self-report instrument was developed and validated by Posner and Kouzes (1988:483-96) according to their leadership model.

Structured self-report instruments offer an accurate way to quantify subjective experiences (Polit & Beck, 2017:175) and in this study it was used to quantify the perceptions of the tutors. The self-report instrument, Leadership Practices Inventory (LPI), was developed and validated by Posner and Kouzes (1988:483-69). It is one of the most popular leadership assessments instruments used today, which is validated to measure the effectiveness of leaders and level of commitment, engagement, and satisfaction of those that follow (McMaster, 2015:n.p.). The LPI-Self has been proven proficient in assessing individuals' leadership behaviours and in providing feedback that is useful for developing and enhancing leadership capabilities (Posner, 2016:16).

The LPI-Self is a registered tool of the Wiley Company, which granted permission to the researcher to utilize the instrument for this research study (See Appendix A). The subscales of the LPI-Self represent The Five Practices of Exemplary Leadership: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act and Encourage the Heart (Kouzes & Posner, 2013). Each of these subscales is represented in the LPI-Self through six items, delineated in Table 3.2.

Table 3.2

Item Numbers Associated with Each LPI-Self Subscale

LPI-Self Subscale	*Item Numbers*
Model the Way	1, 6, 11, 16, 21, 26
Inspire a Shared Vision	2, 7, 12, 17, 22, 27
Challenge the Process	3, 8, 13, 18, 23, 28
Enable Others to Act	4, 9, 14, 19, 24, 29
Encourage the Heart	5, 10, 15, 20, 25, 30

This tool can be employed online via the Leadership Practices website, but for the purposes of this research, it was distributed to health care student tutors via paper copy. Respondents were asked to score themselves from one to ten on each of the above items in the LPI-Self,

based on how frequently they engage in the particular behaviour, indicating a response of almost never as one, to a score of ten, indicating almost always. When adding the items for the subscale scores, each subscale has a potential range of six to sixty, providing interval data for analysis (Ross et al, 2014:203). The LPI-Self was completed twice – once *before* the tutoring year started and the commencement of the leadership workshop, and a second time *after* the tutoring year ended and the workshop and discussion group were completed.

- **Qualitative Data**

Concurrently, to collect the qualitative data for the second research objective to describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme, the researcher conducted an unstructured focus group after the tutoring period for the year has been completed. Unstructured focus groups often begin with an informal, broad and open-ended question and subsequent questions are more focused and guided by the responses to conversational and interactive; and allows for the participants to tell their story and reveal more depth (Polit & Beck, 2017:509). The researcher has chosen this approach as it is more conversational and interactive and allows for the participants to tell their story and reveal more depth.

The focus group was facilitated by an experienced independent facilitator who is familiar with the leadership model's context. The researcher was present during the focus group discussion and was taking field notes to capture additional information such as non-verbal communication or responses of the participants. The leading, open ended question was: "How do you perceive your own leadership development by participating in the tutor training programme? The question was followed by probing questions, guided by the participants' responses (see Annexure C: Interview Guide). The focus group was audio recorded with the permission of the participants. The peer student tutors also compiled a personal narrative of no longer than one page to describe their experience and perception of their leadership development during participation in the tutor training programme of that specific year.

3.4.5 Data analysis

- **Quantitative data**

The LPI-Self included closed ended questions and was analysed using descriptive statistics as a means of data reduction with the assistance of a statistician (see Annexure D: Letter from Statistician). The data from the questionnaires were captured in Excel and analysed in the statistical package R and visual representations were done.

Descriptive statistics were used to describe and summarise data by converting and condensing the data into an organised, visual representation, so that the data have some meaning. The descriptive statistics were computed and included frequency counts, means and standard deviations. The group (subscale) results were obtained by taking the average of the results for all the questions (items) that formed part of each subscale. For each item on the LPI-Self, descriptive results were calculated using the Wilcoxon Signed Rank Test, to evaluate the difference between the pre- and post-LPI-Self test results. This test was used to measure two nominal variables, 'before' and 'after', on one measurement variable which represents an individual (Polit & Beck, 2017:384,748). A significant difference exists where the p-value is less than 0.05 (Polit & Beck, 2017:385).

- **Qualitative data**

The unstructured focus group discussion was audio recorded and no names were used during the discussion to ensure confidentiality. To analyse the data, the raw data from the group discussion was firstly transcribed verbatim by the researcher to ensure thick description of information. The participants were numbered (P1-P7) during the process of data transcription. Once transcribed, the researcher used priori themes according to the leadership model of Kouzes and Posner (2017:13-20) to identify emergent themes of interest. The priori themes were:

- Model the Way
- Inspire a Shared Vision
- Challenge the Process
- Enable Others to Act
- Encourage the Heart

Meaningful sub-themes (emergent themes) were identified according to the priori themes and were guided by the research question. The priori and emergent themes, along with the participants' exact words, were entered into an Excel spreadsheet and was then colour coded to identify the categories. From there the final and sub-themes were determined. The same was done with the written personal narratives of the participants. The findings are discussed in Chapter 5.

- **Integrating quantitative and qualitative data**

Findings from the quantitative and qualitative analyses were consolidated to create new meaning as described by Johnson and Onwuegbuzie (2004:22). In this study the integration was done to describe the self-perceived leadership development of the tutors during the tutoring programme, based on the self-report questionnaires, the focus group and the personal narratives.

3.5 RIGOUR

Rigour can be defined as the degree to which research methods are scrupulously and meticulously carried out in order to recognise important influences occurring in the process of conducting the research. It is a set of criteria investigators use to assess the quality, trustworthiness and value of research (Liu, 2017:1512).

3.5.1 Validity and reliability of quantitative data

Validity and reliability increase transparency and decrease opportunities to insert researcher bias in research. These are important concepts in research, as they are used for enhancing the truthfulness of the assessment and evaluation of research work.

To ensure proper validity and reliability, the researcher used the existing self-report instrument (LPI-Self) of Posner and Kouzes (1988:482). The LPI-Self was developed by creating a set of statements describing essential leadership behaviours derived by documenting specific one-sentence descriptions of behaviour demonstrated in the personal-best leadership cases consistent with The Five Practices of Leadership (Posner, 2016a:2). Statements were collected, modified or discarded following lengthy discussions and iterative feedback sessions with respondents and subject matter experts, as well as through pragmatic analyses of the behaviourally-based statements (Posner, 2016a:2). Because of the LPI-Self's demonstrated psychometric properties - including its strong reliability and validity - educators and practitioners are confident in using the LPI-Self (Foli et al, 2014:76; Warde et al, 2014:460).

Validity is a quality criterion referring to the degree to which inferences (conclusions) made in the study is accurate and well-founded (Polit & Beck, 2017:747), whether the findings are unbiased and well grounded (Polit & Beck, 2017:160), or if an instrument measures what it asserts to measure (Polit & Beck, 2017:747).

Validity is an important characteristic of a measuring instrument. The research instrument (questionnaire) is required to correctly measure the concepts under study. It encompasses

the entire experimental concept and establishes whether the results obtained meet all of the requirements of the scientific research method (Mohajan, 2017:14). Validity in the context of this study refers to the degree to which the self-report instrument assesses individuals' leadership behaviours and is described in terms of face validity, content validity, criterion-related validity and construct validity.

Face validity refers to the extent to which a measuring instrument *looks* as though it is measuring what it is supposed to measure (Polit & Beck, 2017:728). It is helpful for a measure to have face validity if other types of validity have also been demonstrated, even though it is not considered to be strong evidence of validity (Polit & Beck, 2017:310). The LPI-Self that was developed by Posner and Kouzes (1988:484) based on a large number of interviews and observations, and respondents echoed the LPI-Self to have excellent face validity (Posner, 2016a:11).

Content validity refers to the degree to which a multi-item instrument has an appropriate set of relevant items reflecting the full content of the construct domain being measured (Polit & Beck, 2017:724). In other words, it is the extent to which the questions on the instrument and the scores from these questions represent all possible questions that could be asked about the content. Of the 650 personal best surveys and the additional 450 short form surveys that Posner and Kouzes (1988:484-5) collected originally, 80% of the behaviour and strategies described in these surveys, could be found in the five leadership practices as described in the LPI-Self instrument. The content validity is further demonstrated through confirmatory factor analysis in different studies (Posner 2016a:12).

Criterion validity is the extent to which scores on an instrument are an adequate refection of a criterion – in other words a "gold standard" measure (Polit & Beck, 2017:725). Not all measures can be validated in this way as there might not always be a "gold standard" to use as a criterion (Polit & Beck, 2017:311). This is true in the case of the LPI-Self as Posner and Kouzes (1988:483-4) state that the field of leadership lacks consensus on its definition and whether it can be measured. Hence, they developed their own measuring instrument based on the "personal best surveys" that they conducted. Criterion validity is further enhanced through factor analysis and regression analysis (Posner, 2016a:13).

Construct validity refers to the degree to which a measure truly captures the focal construct (Polit & Beck, 2017:723). The question being asked is basically "What attribute is really being

measured?" (Polit & Beck, 2017:315). Using a team of experts familiar with the concept is a way in which this type of validity can be assessed (Mohajan, 2017:18). The experts can examine the items and decide what that specific item is intended to measure. With regards to the LPI-Self instrument, Kouzes and Posner are considered to be experts in the field of leadership development and measurement thereof, and the validity of the instrument has been proven by the large number of studies where it has been used across disciplines and contexts (Posner 2016:13).

Reliability refers to the extent to which a measurement is free from measurement errors (Polit & Beck, 2017:742). That means a research instrument can be considered reliable if it yields similar results on separate occasions – in other words it concerns consistency. It is the absence of variation in measuring a stable attribute for an individual (Polit & Beck, 2017:303).

In this study the researcher made use of an existing self-report instrument which has been developed and verified by Posner and Kouzes (Posner & Kouzes, 1988:483-96) for which the reliabilities, as measured by Cronbach alpha coefficients, are consistently strong (Posner, 2016a:4). Over a period of time the internal reliability of the instrument has been substantial with consistent results across a wide range of sample populations in different disciplines and groups with different demographic characteristics (Posner, 2016a:4-5; Posner & Kouzes, 1988:495). In the normative database of studies done by Kouzes and Posner, LPI scores were also generally independent of various demographic characteristics (e.g. age, marital status, years of experience, educational level) and contextual factors (e.g. company size, functional area, length of service, line versus staff position) (Posner, 2016a:5).

3.5.2 Trustworthiness of qualitative data

According to Polit and Beck (2017:747), trustworthiness is "the degree of confidence qualitative researchers have in their data and analyses". Qualitative data are measured against different criteria than quantitative data. Guba (1981:80) constructed correspondent criteria by which qualitative data can be assessed for trustworthiness:

- credibility (in preference to internal validity) to measure the truth value;
- transferability (in preference to external validity / generalisability) to measure the applicability;
- dependability (in preference to reliability) to measure the consistency;
- confirmability (in preference to objectivity) to measure the neutrality.

Credibility deals with the question: "How congruent are the findings with reality?". Credibility is an important aspect of trustworthiness as it ensures that the study measures what it is supposed to and that the findings are congruent with reality (Shenton, 2004:64). The following methods were used by the researcher to increase the credibility of the study:

The adoption of well-established research methods: the researcher believes that she incorporated the correct operational methods for the concepts being studied.

The development of an early familiarity with the participants was assured by developing an early familiarity with the participants by means of prolonged engagement (Guba, 1981:84) and building a trusting relationship with participants, which ensured that participants felt free to share their experiences of their journey of leadership development.

Triangulation of data was also used by the researcher as another way of increasing credibility. As previously mentioned, triangulation may involve the use of different methods. According to Guba (1981:87) the use of different research methods and sources compensates for their individual limitations and utilizes their respective benefits (Shenton, 2004:65). The researcher was able to utilize this method to draw conclusions about what constitutes the truth, by using multiple data sources – an unstructured focus group, personal narratives and self-report instruments.

Tactics to help ensure honesty of informants when contributing to data was ensured by making sure that participants knew their participation was voluntary and they could terminate their contribution at any time during the study. The researcher made sure that participants felt no need to tell untruths. This was indeed the case with two participants who terminated their participation and did not complete all the phases of the data collection process.

Thick description of the phenomenon under scrutiny promoted credibility by providing a detailed description of the phenomenon as it conveyed the actual situation and context.

Transferability refers to the extent to which the qualitative findings can be transferred to other settings or groups (Polit & Beck, 2017:747). According to Shenton (2004:69), some researchers argue that since the findings of a qualitative project are usually specific to a small number of particular settings and individuals, it is impossible to demonstrate that the findings and conclusions are applicable to other environments and populations. Erlandson et

al as referenced by Shenton (2004:69) noted that many naturalistic inquirers believe that in practice even traditional generalisability is never possible as all studies are defined by the specific contexts in which they occur. A contrasting view would be of those who suggest that although each case may be unique, it is also an example within a broader group, and as a result, the prospect of transferability should not be immediately rejected (Shenton, 2004:69).

Nevertheless, the purpose of this study was not generalisation, but to make it possible to repeat the study in a different setting, a thick description was indeed used to provide enough data to make it possible to transfer the study to another context. According to Shenton (2004:70), it is imperative that an adequate thick description of the phenomenon under investigation is provided to allow readers to have a proper understanding of it, thereby enabling them to compare the cases of the phenomenon with those that emerged in their situations. The nature and extent of background information may vary according to researchers, but few would dispute the need for "a full description of all the contextual factors impinging on the inquiry" (Guba, 1981:86).

Dependability asks the question whether the findings of a study can be repeated with similar participants and in a similar context over time (Polit & Beck, 2017:559). In this study the researcher ensured dependability by using overlapping methods of data collection by means of an unstructured focus group and personal narratives. In order to address the dependability issue more directly, the processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work (Shenton, 2004:71). The research design and the implementation thereof were thoroughly described in this study to enable other researchers to fully understand the methods and their effectiveness.

Confirmability requires the data to represent the information that was provided by the participants during the focus groups and that the interpretation of that data was not invented by the researcher (Polit & Beck, 2017:560). The notion of confirmability is the qualitative investigator's comparable concern to objectivity. Steps must be taken to help ensure as far as possible that the researcher's conclusions are the result of the experiences and ideas of the participants rather than the characteristics and partialities of said researcher (Shenton, 2004:71). The role of triangulation in supporting such confirmability must again be highlighted to reduce the effect of researcher bias. In this study that was once again done by using multiple data sources and overlapping methods.

3.5 ETHICAL CONSIDERATIONS

Polit and Beck (2017:139) refers to the ethical principles of the *Belmont Report* that includes the principle of beneficence, respect for human dignity and the principle of justice. Embedded in these principles are the right to freedom from harm, discomfort and protection from exploitation, the right to self-determination and full disclosure and the right to fair treatment and privacy. The researcher adhered to these principles in order to protect the ethical rights of the study participants.

The researcher also obtained approval from the Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria (Ethics Reference No.: 277/2019, see Annexure F3) before commencing with data collection. Permission to conduct this study was also obtained from the relevant head of department (see Annexure F1: Deputy Dean of Education). Furthermore, participants gave informed consent to voluntarily participate in this study.

The ethical considerations for this study were discussed in detail in Chapter 1.

3.6 SUMMARY

Chapter 3 focused on the research design and methodology used to address the particular research question, aim and objectives. Although only a few tutors ended up participating in the study, the researcher was able to collect sufficient data by using a mixed method design in order to answer the research question. The results and findings will be discussed in Chapters 4 and 5.

CHAPTER 4
QUANTITATIVE RESULTS

4.1 INTRODUCTION

Chapter 3 provided an in-depth discussion of the research design and methods of this study on the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university. This chapter presents an overview of the respondents' demographic data followed by a description of the process used to analyse the quantitative data as well as the results of phase 1. Phase 1 intended to attain the first objective of the study: to describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies.

The LPI-Self was the structured self-report instrument utilized in this study as discussed in Chapter 3. The LPI-Self instrument was completed by the peer student tutors before the leadership workshop and also at the end of the tutoring period. Descriptive statistics were used to describe and summarise data by converting and condensing the data into an organised, visual representation or picture in a variety of ways, for the data to have meaning as described by Polit and Beck (2017:726). Inferential statistics were used to describe the difference between the results of the first and second sets of data.

4.2 DEMOGRAPHIC OVERVIEW

The response rate was 12 (50%) for the LPI-Self questionnaire, from a target population of 24 peer student tutors. Three (25%) of these tutors did not qualify as they ended up being post-graduate students and did not comply with the inclusion criteria. Two (16.6%) of the students did not complete the study – one did not attend the unstructured group discussion and the other did not complete a written narrative. In the end, 29% (n=7) of the invited health care peer tutors willingly participated in all the components of this study. See Table 4.1 for the demographic characteristics of the respondents.

Table 4.1

Respondents' Demographic Data

Age:	18-22 years old	5 (71%)
	Older than 22 years	2 (29%)
Race:	Black	3 (43%)
	White	4 (57%)
Gender:	Female	5 (71%)
	Male	2 (29%)
Nationality:	South African	6 (86%)
	Other	1 (14%)
Degree enrolled for:	MBChB	7 (100%)
Year of Studies:	Third year	4 (57%)
	Fourth year	3 (43%)
Experience in previous peer tutoring programmes:	Yes	4 (57%)
	No	3 (43%)
How many hours per month do you tutor?	Less than 5 hours	2 (29%)
	5-10 hours	5 (71%)

From the respondents who participated, 71% (n=5) were younger than 22, 29% (n=2) were older due to previous studies completed. The respondents were asked to indicate their race for the sake of completeness. Of the respondents 43% (n=3) were black and 57% (n=4) were white. Of the seven respondents, 71% (n=5) were female and 29% (n=2) were male. Among the respondents 86% (n=6) were South African and 14% (n=1) was a foreign national with a current study visa. Of the respondents 57% (n=4) were in their third year of studies and the other 43% (n=3) were in their fourth year, while 57% (n=4) had previous tutoring experience and 43% (n=3) had no previous experience. The respondents were also asked to disclose how many hours they tutored per month, of which 71% (n=5) tutored between 5 and 10 hours per month and the remaining 29% (n=2) tutored less than 5 hours per month.

None of the above demographic data, specifically previous tutoring experiences and the amount of tutoring hours seemed to have had any influence on the leadership development of the respondents while participating in this tutoring programme, as no other tutoring programme they were previously involved in included any leadership development training.

The demographic questionnaire can be viewed as part of Annexure G (see Annexure G: Participant Informed Consent).

4.3 RESULTS

The results were reviewed according to the subscale groups of questions according to the leadership model of Kouzes and Posner (2013:n.p.). The results were summarised and discussed by means of tables and supported by relevant literature.

4.3.1 Subscale 1: Model the Way

This subscale describes the respondents' inclination to lead from personal values and beliefs and to act as a role model consistent with these values and beliefs (Kouzes & Posner, 2017:14). The LPI-Self evaluates a person's ability to Model the Way with six items: setting a personal example of expectations; ensuring others are adhering to agreed-upon principles and standards; following through on promises and commitments; requesting feedback on how personal actions affect those around them; building consensus around common values; and being clear on personal viewpoint of leadership (Bennet, 2017:50)). The respondents were asked to rate the frequency with which they exhibit these behaviours. The difference in scores as they responded in the beginning of their involvement and at the end of the year is depicted in Tables 4.2 and Table 4.3 below.

Table 4.2

Subscale 1: Model the Way

Subscale 1	ID: Pre (N=7)	ID: Post (N=7)
Missing	0	0
min	5.5	6.0
max	8.00	9.33
mean (sd)	6.91 ± 0.92	7.60 ± 1.12
median (iqr)	6.83 (6.33, 7.67)	7.67 (6.92, 8.16)

Table 4.3

Paired Test Score for Model the Way

Question	p-value
Q1	0.5862
Q6	0.3447
Q11	0.8241
Q16	0.2034
Q21	0.8501
Q26	0.2807
Subscale Total	0.5862

Data in bold represents significant difference

The results for the Model the Way subscale pre-test (median=6.83, interquartile range (IQR)=6.33, 7.67) and the post-test (mean=7.67, IQR=6.92, 8.16) are statistically similar. When using the Wilcoxon test, it was found that there was no statistically significant difference in the pre- and post-test scores of the combined six relevant items, with a resultant p-value of p=0.5862. This could be an indication that the respondents rated themselves highly for setting examples and clarifying beliefs and values, even before the leadership workshop was held and before the tutoring sessions commenced.

This correlated with a study conducted by Foli et al (2014:78) in which the leadership development of nursing students was measured before and after leadership training and practice interventions. One possible explanation was that the students were already demonstrating relative competency of these leadership behaviours (Foli et al, 2014:81).

4.3.2 Subscale 2: Inspire a Shared Vision

Inspiring a Shared Vision attempts to describe the respondents' perception of their ability to gain support of others in working toward common goals (Kouzes & Posner, 2017:15). In this area, respondents were asked to report how commonly they exhibit the following behaviours: discussing future trends affecting activities, describing a compelling image of the future; appealing to others to share an exciting dream of the future; continually illustrating positive ways of how those goals can be realised; painting the "big picture" of what is aspired to and speaking about the higher meaning and purpose of one's actions (Kouzes & Posner, 2003:3). The results are indicated in Table 4.4 and Table 4.5 below.

Table 4.4

Subscale 2: Inspire a Shared Vision

Subscale 2	ID: Pre (N=7)	ID: Post (N=7)
Missing	0	0
min	4.00	5.67
max	7.33	9.00
mean (sd)	5.95 ± 1.10	7.31 ± 1.04
median (iqr)	6.50 (5.42, 6.50)	7.33 (6.83, 7.75)

Table 4.5

Paired Test Score for Inspire a Shared Vision

Question	p-value
Q2	**0.035**
Q7	**0.0498**
Q12	1
Q17	0.0585
Q22	1
Q27	0.0568
Subscale Total	0.0515

Data in bold represents significant difference

The overall results for the Inspire a Shared Vision subscale pre-test (median=6.50, IQR=5.42, 6.50) and post-test (mean=7.33, IQR=6.83, 7.75) demonstrated minor statistical differences. The p-value scores for two of the six items which included talking about future trends that influence how work gets done and describing a compelling image of what the future could look like were p=0.035 and p=0.0498 respectively. These p-values of less than 0.05 indicate a statistical difference between the pre- and post-test results. This is an indication that the respondents employed more of the relevant methods and behaviours by envisioning the future with shared stories and experiences after they participated in the leadership workshop and tutoring sessions.

The paired testing for the item of communication with conviction about what the future could look like, also showed a significant difference (p=0.02) in the pre- and post-test done by Foli et al (2014:79), using the LPI-Self to measure leadership development amongst nursing students. Frade and Tiroyabone (2017:125) also found that students who took part in peer leader activities, such as peer tutoring, reported higher incidences of leadership behaviours such as providing direction through persuasion, sharing ideas with others in writing and applying knowledge to real life settings. These behaviours contribute in inspiring a shared vision by creating a cause for commitment, appeal to common ideas and animating the vision

(Kouzes & Posner, 2017:110,119,129). Northouse (2016:173) agrees that transformational leaders should have a clear vision of the future that is simple, understandable, beneficial and compelling to followers.

4.3.3 Subscale 3: Challenge the Process

This subscale describes the respondent's tendency for risk-taking, developing innovative practices, and initiating change (Posner, 2016a:2). In order to assess their ability to Challenge the Process, respondents were asked to rate the frequency of the following behaviours: seeking out challenging opportunities; challenging people to try new things; searching for innovative ways to improve; seeing failures as learning opportunities; and taking initiative in anticipating and responding to change (Kouzes & Posner, 2017:16). The respondents' responses are captured in Table 4.6 and Table 4.7 below.

Table 4.6 Subscale 3: Challenge the Process

Subscale 3	ID: Pre (N=7)	ID: Post (N=7)
Missing	0	0
min	5.00	6.67
max	7.33	9.00
mean (sd)	6.12 ± 0.93	7.81 ± 1.01
median (iqr)	6.50 (5.25, 6.75)	8.00 (6.83, 6.75)

Table 4.7 Paired Test Score for Challenge the Process

Question	p-value
Q3	0.4982
Q8	**0.0498**
Q13	**0.0498**
Q18	0.089
Q23	0.1464
Q28	**0.0418**
Subscale Total	0.0592

Data in bold represents significant difference

The Challenge the Process subscale pre-test (median=6.50, IQR=5.25, 6.75) and post-test (mean=8.00, IQR=6.83, 8.67) demonstrated the largest statistical difference of all the subscales. The p-value scores for three of the six items included: challenging people to try out new and innovative ways to work (p=0.0498), actively searching for innovative ways to improve (p=0.0498) and taking initiative in anticipating and responding to change (p=0.0418). This is an indication that the respondents did not necessarily demonstrate these behaviours to challenge the process before participating in the peer tutoring programme. The

respondents learned a great deal from the leadership workshop with regards to searching for opportunities to grow, innovate, take risks and experiment even if it was outside their boundaries (Posner, 2016b:2).

These results correlate with a study done by Frade and Tiroyabone (2017:97) concerning the peer teaching experiences and self-reported leadership practices of medical residents. It was found that students made use of several leadership practices to challenge the process, which included: accepting challenges allowing team, members to make mistakes and learn from them, not being afraid to take risks, demanding improvement, providing constructive and timely feedback, promoting questions, and being open to suggestions. The respondents in this study learned they could challenge the process and the way things were being done by challenging their peers to find new and innovative ways of doing things and to take initiative even if not specifically asked to do so (Foli et al, 2014:81).

4.3.4 Subscale 4: Enable Others to Act

The Enable Others to Act subscale assesses the respondent's perception of their ability to build successful teams and promote collaboration among team members. This involves building relationships and trust and developing the competencies of others (Kouzes & Posner, 2017:194). The LPI-Self measures ability in this area by asking respondents to evaluate how frequently they display the following behaviours: developing cooperative relationships; actively listening to various viewpoints; treating others with dignity and respect; involving people in decisions that have an effect on them, providing people with some level of autonomy in deciding on how to do their work and consistently encouraging team members' professional growth and skills development (Kouzes & Posner, 2013:n.p.). The responses are indicated in Table 4.8 and Table 4.9 below.

Table 4.8

Subscale 4: Enable Others to Act

Subscale 4	ID: Pre (N=7)	ID: Post (N=7)
Missing	0	0
min	6.83	7.33
max	8.83	9.00
mean (sd)	7.95 ± 0.73	8.43 ± 0.56
median (iqr)	8.00 (7.58, 8.42)	8.50 (8.33, 8.75)

Table 4.9

Paired Test Score for Enable Others to Act

Question	p-value
Q4	0.4615
Q9	0.5887
Q14	0.7103
Q19	0.2878
Q24	1
Q29	0.3964
Subscale Total	0.3491

Data in bold represents significant difference

The results for the Enable Others to Act subscale pre-test (median=8.00, IQR=7.58, 8.42) and the post-test (mean=8.50, IQR=8.33, 8.75) are statistically similar and displays the smallest difference of all five subscales. When using the Wilcoxon test, it was found that there was no statistically significant difference in the in pre- and post-test scores of the combined six relevant items, with a resultant p-value of p=0.3491. This demonstrates that the respondents rated themselves comparably for fostering collaboration and strengthening others for the pre- and post-test.

This is in contrast with the studies of Foli et al (2014:78) and Ross et al (2014:204) which demonstrated Enabling Others to Act as one of the top transformational leadership practices in their respective studies. The reason for this could be that the respondents in this study already rated themselves highly in the pre-test as they already employed these leadership practices. Expecting high achievement and active teaching, like the respondents did in this study, helps others to help themselves and brings out the best in the tutees (Frade & Tiroyabone, 2017:97).

4.3.5 Subscale 5: Encourage the Heart

This last subscale considers the respondent's tendency to acknowledge the efforts of people and teams and to celebrate values and victories by creating a spirit of community (Kouzes & Posner, 2017:246). Assessment of Encourage the Heart is based on questions regarding the frequency of the following behaviours: praising people for their good work; making sure to let people know you have confidence in their abilities, ensuring people are creatively and publicly rewarded for their contribution; telling stories of encouragement about the good work of others and personally recognising people and ensuring accomplishments are celebrated

(Kouzes & Posner, 2013:n.p.). Table 4.10 and Table 4.11 below; reflect the outcomes of the responses.

Table 4.10

Subscale 5: Encourage the Heart

Subscale 5	ID: Pre (N=7)	ID: Post (N=7)
Missing	0	0
min	3.67	6.67
max	7.83	8.83
mean (sd)	6.69 ± 1.43	7.81 ± 0.87
median (iqr)	7.17 (6.50, 7.58)	8.00 (7.17, 8.42)

Table 4.11
Paired Test Score for Encourage the Heart

Question	p-value
Q5	1
Q10	0.0708
Q15	0.7981
Q20	1
Q25	**0.035**
Q30	0.14
Subscale Total	0.1077

Data in bold represents significant difference

The overall results for the Encourage the Heart subscale pre-test (median=7.17, IQR=6.50,7.58) and post-test (mean=8.00, IQR=7.17, 8.42) demonstrated insignificant statistical differences. Although the subscale pre- and post-tests show an insignificant difference in the scores, there was an increase in the p-value score for one of the six items. This was the item stating that respondents tell stories of encouragement about the good work of others (p-value=0.035). This is an indication that the respondents realised the importance of telling stories and sharing experiences as ways of encouraging tutees after they attended the leadership workshop as part of the tutoring programme.

In their study conducted with nurse leaders, Ross et al (2014:204) also found Enabling Others to Act as one of the top two leadership practices of successful nurse leaders. In the study done by Foli et al (2014:81) involving undergraduate nursing students, the researchers found that Encourage the Heart was an important factor for their respondents' peers who evaluated the students before and after a leadership programme was implemented.

Northouse (2016:175) states that it is natural for people to want support and recognition and leaders that are attentive to this need tend to reward others for their accomplishments.

4.4 SUMMARY

This chapter discussed the results of the quantitative phase of the study. Data was collected with the use of a structured self-report instrument, the Leadership Practices Inventory-Self of Kouzes and Posner (2013:n.p.) and the results were discussed according to the leadership practices subscales of the instrument. Chapter 5 discusses the findings of the qualitative data.

CHAPTER 5
QUALITATIVE FINDINGS

5.1 INTRODUCTION

Chapter 4 discussed the quantitative results from phase 1 of the study on the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university. This chapter presents the findings of phase 2. Finally, the priori and emergent themes that describe the participants' experiences of their leadership development is discussed.

The results of phase 2 aimed to answer the research question of objective 2 of this study: to describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies. The priori themes are based on the Five Practices of Exemplary Leaders of Kouzes and Posner (2017) as discussed in Chapter 2. Table 5.1 summarises the themes and sub-themes.

Table 5.1

Themes and Sub-themes

THEMES	SUB-THEMES
1. Model the Way	• Know your own leadership style
	• Being a role model
2. Inspire a Shared Vision	• Motivate tutees
	• Do not lose sight of the end goal
3. Challenge the Process	• Challenging experience
	• Continued learning experience
4. Enable Others to Act	• Let tutees learn from their mistakes
	• Building the self-confidence of the tutees
5. Encourage the Heart	• Encouragement of tutees
	• Encouragement of tutors

5.2 FINDINGS

The findings were reviewed according to each priori theme supported with verbatim quotations from the participants and related to the literature reviewed.

5.2.1 Theme 1: Model the Way

Leaders model the way by finding their voice and setting an example. Leaders are supposed to stand up for their values and should be clear on what those values and beliefs are. They must find their own beliefs and values and should then clearly and authentically give voice to those values and guiding principles (Kouzes & Posner, 2017:13). Leaders also know how to create a culture that emphasises the shared vision, mission, goals and values within an organisation (Doublestein & Ciervo, 2013:1). Within health care, leaders demonstrate a strong commitment to the values and principles of medicine and show the ability to communicate their values and principles clearly to others (Gabel, 2014:850).

However, leaders cannot simply force their values on others and expect commitment. Titles may be granted, but leadership is earned (Kouzes & Posner, 2017:13, 48). Powerful speeches and talking about common values are not nearly enough. Exemplary leaders know that it is their behaviour that earns them respect. Leaders set an example and build commitment through simple, daily acts that create progress and build momentum (Kouzes & Posner, 2017:14). According to Burgess et al (2015:8), tutors can set examples by having a good knowledge of theory, understand the curriculum, have empathy and respect for tutees and patients, and by giving meaningful feedback to tutees. People want to see that their leaders do what they say they will do. This comes down to credibility which according to Kouzes and Posner (2017:44) is the foundation of leadership. From this theme two sub-themes emerged: i) Know your leadership style and ii) Being a role model.

5.2.1.1 Know your own leadership style

Knowing your own leadership style emerged as the first sub-theme under the priori theme of Model the Way. The participants realised the importance of finding their own voice by learning their own leadership style and not to constantly compare themselves with other tutors or students. According to the participants:

> “In all of this I had learn to find my own, my own style of leadership not comparing myself to other people and being confident when speaking to my peers.” (P4)

> "I think a major thing is also learning your type of leadership, in what you're saying, that's something I learned as well. Uhm, when you see people, leaders, you usually see… through the dominant types, but then with this I needed to learn that, you know what – I'm not the dominant type." (P4)

> "I can't pretend with how I'm tutoring because people see obviously that I'm not secure within myself so I need to learn how to portray myself in a sense that makes me come through and also how the other person perceives me as well." (P2)

According to Kouzes and Posner (2017:54), values are your "personal bottom line". Values guides your actions and influence every aspect of your life, for example your moral judgement, the way you react to others and your dedication to personal and organisational goals. Purposeful reflection on values and actions can be used in the students' ongoing leadership development journeys to aid growth and self-awareness (Kiersch & Peters, 2017:161-2). Being clear about your values helps you perform better in difficult circumstances and it helps to explain the choices you make and why you make them. The participants agreed with the notion that leaders can only speak the truth when speaking in their own voice – by finding their own style of leadership and tutoring and not pretending to be something or someone else.

5.2.1.2 Being a role model

The second sub-theme that emerged was to be a role model to the tutees and also the other tutors. The participants in this study took being a role model very seriously. They agreed on three actions that encompass being a good role model, namely, leading by example, good communication and setting the standard for the level of excellence.

The participants mentioned many ways they tried to lead by example, whether it was with practical actions like being punctual and looking professional, or by guiding tutees in perfecting a new skill. The participants mentioned:

> "I've always tried to lead by example, whether it being punctual, trying to look professional, extending a helping hand or taking on an extra slot." (P1)

> "Although they may not say it they do look up to you and you should be able to guide them to become better at what they are learning and eventually become confident in their new skill." (P2)

> "…but you realise when you are there, you are literally their role model, 'cause you've experienced this." (P3)

Good communication skills were also mentioned as an important skill to have as leaders, even between the tutors themselves to confer about the tutoring process. This ultimately also increased the participants' self-confidence when it came to tutoring their peers. According to the participants:

> "From the get-go, we [tutors] met with each other and had a 'tutor chat'. It allowed us to get on the same page and have an opportunity for questions and feedback of our previous years' experience, especially being a tutor of your own year… " (P1)

> "I learnt to interact with different types of people, that different people need different approaches." (P4)

Setting the standard for the level of excellence is extremely important in becoming a health care professional as these health care students will one day become working health care professionals caring for their patients. According to participants:

> "Modelling the way when tutoring goes without saying because you will be setting the standard for the level of excellence that can be achieved. Although they may not say it, they do look up to you and you should be able to guide them to become better at what they are learning and eventually become confident in their new skill." (P2)

> "This year has shown me that I am capable of helping others and guiding them to be their best in the skills taught that may enable them to be the best health care practitioners they can be." (P3)

According to Kouzes and Posner (2017:75), the most significant signal-sending action leaders can take to demonstrate living their values are how they spend their time and what they pay attention to, the languages they use and the way they handle critical incidents. How

you spend your time and how you communicate to others show what is important to you as a leader (AlHaqwi, 2014:126).

The participants found that communication skills in leaders have a larger influence on the performance of others than just leadership skills alone (Schwing, 2020:16). Peer tutors have been found to be more supportive and encouraging and reduce learner anxiety through their ability to serve as role models (Benè & Bergus, 2014:786).

For leaders, setting the right example is so important because being a leader means you are always on stage, being watched and being talked about. And people are always testing your credibility – in other words what you say and do (Kouzes & Posner, 2017:91). Leaders must set the pace in living in accordance with shared values. If they do not live by the shared values themselves, they do not have any credibility when preaching them.

Exemplary leaders understand and are attentive to the language they use because they appreciate the power of words and communication. Words do not just give voice to one's mind-set and beliefs, they also evoke images of what people hope to create and achieve with others and how they expect people to behave (Kouzes & Posner, 2017:79).

The study participants showed through their actions and communication skills that they do perceived themselves as role models to the tutees and therefore strived to model the way by firstly knowing their own leadership style and then by setting good examples to their peers.

5.2.2 Theme 2: Inspire a Shared Vision

Leaders inspire a shared vision by envisioning the future and enlisting others in a common vision. Exemplary leaders are forward-looking – a quality that constituents clearly expect of leaders (Kouzes & Posner, 2017:97). They contemplate the future and envisioning the opportunities that are in store when they and their followers arrive at a set goal. Leaders are driven by their clear image of possibility and what their organisation could become, and they passionately believe that they can make a difference (Kouzes & Posner, 2017:97).

Yet visions seen only by leaders are insufficient to create an organised movement or to bring along significant change. A person with no constituents is not a leader, and people will not follow until they accept a vision as their own. They need to see their own ideals and aspirations, their hopes and dreams, incorporated and appreciated (Kouzes & Posner,

2017:107). The central task for leaders is to inspire a shared vision, not merely selling their own personal view of the world.

To enlist people in a vision, leaders must get to know their constituents and learn to speak their language. Enlisting others is all about igniting passion for a shared purpose and moving people to persist against great odds (Kouzes & Posner, 2017:119). People must believe that leaders understand their needs and have their interests at heart if they are to sign up for journeys into the future. Leaders uplift people's spirits with an ennobling perspective about why they should strive to be better than they are today (Kouzes & Posner, 2017:120). From this theme two sub-themes emerged: i) Motivate tutees and ii) Do not lose sight of the end goal.

5.2.2.1 Motivate tutees

Motivating peer students or tutees emerged as the first sub-theme under the priori theme of Inspire a Shared Vision. The participants mainly tried to motivate the tutees by sharing inspiring stories from their personal experiences and also by giving the tutees real life scenarios to think about.

Sharing stories from personal experience and real life scenarios was used by the senior students who already had some experience working with patients on the clinical platform. According to the participants:

> "I always tried to make learning the skills more meaningful by giving them scenarios in which they would find themselves in the position of the patient seeking service in the form of that particular skill, thus helping them realise the importance of not just learning the skill for the sake of passing a module, but more so for the sake of one day having to deliver good quality service to a patient." (P5)

> "I learnt to share stories of doing certain procedures (e.g. suturing, venepuncture, etc.) on live patients and how I remembered the checklist procedures which gave me more confidence and allowed me to be successful in performing such skills. This really worked for many and I think in a way reminded them why it is important to know those skills." (P3)

> "…what makes a great leader is recognising that each and every person is different in their approach to things. Working with different students has taught me that I have to adapt to their needs and make sure I communicate in a way that is effective for everyone." (P3)

According to Kouzes and Posner (2017:99), being able to envision the future is decidedly important and has an incredible impact on people's motivational levels and workplace productivity. Kouzes and Posner (2017:100) also emphasise the importance of looking back at past experiences when aiming for the future. Understanding the past can help you identify themes, patterns and believes that both underline why you care about certain principles and explain why realizing those goals is such a high priority to you. The participants agreed that by telling stories of real life incidences that happened to them in the past, it made the skills relevant and important for the tutees to master the specific skills. The participants mentioned:

> "I find that a lot of times, because as a fourth year we are in clinics a lot more, so by sharing stories from the clinics, what we see in the hospitals, then they do get a little more motivated and they do see, 'oh wait, this is something that I'm going to need later on – maybe next year – this is something that I'm going to need to apply later on'." (P5)

> "… 'cause it really comes down to making the skill relevant to the person. 'Cause a lot of them come in and their question is just "When are we gonna do this?"; "When am I gonna use this?" like, "What does this mean for me?" (P2)

By explaining the meaning and the relevance of the particular skills and drawing from their own past, the participants could motivate the tutees to try their best at learning new skills, and to then become the best health care professionals that they can be.

5.2.2.2 Do not lose sight of the end goal

Motivating tutees to not lose sight of the end goal emerged as the second sub-theme under the priori theme of Inspire a Shared Vision. Perfecting a skill to use the rest of your life is the most important thing – not just to pass an exam. The participants agreed that tutees often got so fixated on just passing the exams; they lost sight of the end goal. The participants tried to reinforce the idea of learning and perfecting a skill that tutees can use for the rest of their lives. They mentioned the following:

> "Regardless of whether the students we tutored were medical students or health allied students, they all had one goal in common and that was to become competent in carrying out the skills presented to them." (P3)

> "As a tutor who was once in the position of a learner trying to master the same skills, I thought it was important for me to inspire a shared vision, which for them all is to ultimately ace their OSCEs [Objective Structured Clinical Examinations). However, it was also crucial for me to convey to them that acing their examinations is not the main goal." (P5)

> "If you can allow people to see the end goal and be willing to work with you to achieve it, you have already done half the job. I felt it was very important when tutoring not to emphasise passing as the only goal, but rather the importance of learning a skill that you will be utilising for the rest of your life." (P2)

Leaders need to be able to imagine the end result and be able to communicate their vision to their followers in such a way to achieve their hopes and dreams while achieving the end goal (Kouzes & Posner, 2017:108). The participants realised that an important vision for the tutees was to pass the exams, but they needed to convey the message that learning these skills was not only important in the short run, but it was imperative for students to master the skills to become better health care professionals in the future. As Kouzes and Posner (2017:111) put it: "People have a deep desire to make a difference. They want to know that they have done something on this earth, that there's a purpose to their existence". For health care students the purpose of their training should be to learn lifelong skills that will help them be the best health care provider they can be.

5.2.3 Theme 3: Challenge the Process

"Challenge is the crucible for greatness" (Kouzes & Posner, 2017:16). Leaders are innovators, willing to step out into the unknown – not one person ever achieved their personal best by keeping things the same. Leaders do not sit and wait for good things to happen – they understand the need to search for opportunities by seizing the initiative and by looking outward for innovative ways to improve (Kouzes & Posner, 2017:16). Leaders seek to improve upon the status quo by searching for opportunities to grow and innovate, many of which are outside of their comfort zone (Posner, 2016a:2).

Innovation and change involve experimenting and taking risks and setbacks are looked upon as learning opportunities for both themselves and their followers (Posner, 2016a:2). Leaders need to create a climate for experimentation, recognition of good ideas and the willingness to challenge the system (Kouzes & Posner, 2017:16). From this theme two sub-themes emerged: i) Challenging experience and ii) Continued learning process.

5.2.3.1 Challenging experience

Leaders are willing to step out into the unknown. The work of leaders is change, and like mentioned before - the status quo is unacceptable to them. Almost all the participants in this study recognised tutoring as a personal challenge to them saying they challenge themselves by putting themselves into uncomfortable positions and surroundings in order to learn. The participants did not necessarily strive to bring about organisational change, as they rather found the challenge within themselves. They searched for opportunities to grow and improve themselves as described by Kouzes and Posner (2003:4), while also trying to make a difference in the lives of the tutees they tutored. The participants commented that:

> “My challenge to myself was to put myself intentionally into positions and surrounds where I would be uncomfortable, in order to learn to adapt and to learn to be an individual away from my peers.” (P4)

> “I decided to become a tutor because I realised that I need to do something outside of my comfort zone and in this way allow myself to grow.” (P2)

> “I felt insecure in my lack of leadership background, but the biggest thing I learnt was that you need to start somewhere, you need to take the leap to get somewhere.” (P4)

> “Challenging the process and attempting to change the status quo took some time for me because it required me to be willing to change myself.” (P2)

> “They say as human you go through different seasons as well. Currently I circulate between winter and spring. With my journey through the leadership position in the Prinshof skills lab I can say that I also experienced different seasons in my two years working as a tutor. I don't think it is possible to grow without going through the different seasons. It doesn't stop for me, although there only are four seasons.” (P7)

> "I did eventually step outside of my comfort zone and attempt to find new ways of teaching the same thing to different people who not only learn differently, but also present to the skills lab with different problems. Adapting to people was a skill that I acquired in this regard and I am very thankful for it." (P2)

According to Kouzes and Posner (2017:156), the strongest motivation to deal with challenge and the uncertainties of life comes from inside people and not from outside, in other words if people are going to do their best when challenged, they must be internally motivated. People need a reason to care, which leaders can make clear to them when explaining how new growth and innovation can benefit themselves, their community, their customers or their families (Kouzes & Posner, 2017:158). The participants of this study initially saw tutoring as a challenge, but applied anyway, since they saw it as an opportunity to get out of their comfort zones and to learn something new.

5.2.3.2 Continued learning experience

Leaders know well that innovation and challenge involve experimentation, risk and even failure. Experiments do not always work out as planned and people often make mistakes when they try something new. Leaders learn from their mistakes and encourage others to do the same. Leaders recognise that the key that unlocks the door to opportunity is learning, especially in the face of obstacles (Kouzes & Posner, 2003:4). According to the participants:

> "I do make mistakes as well and these are the biggest learning moments for me rather than failures, seeing and asking how I can try do better and allow myself to constantly grow in the process." (P1)

> "I for one despise the state of being stagnant – so I am constantly observing and trying to see ways of improving what has already been established." (P1)

> "…we [tutors] shared our tips and tricks to how to approach obstacles and gain confidence in front of your peers that may think of you differently because you are in this position." (P1)

> "It got quite tough for me when it came to being the leader in a small group where you have individual chats, but they need to be kept informative and short as to help them as much as possible, no room for small talk!" (P6)

Leaders approach each new and unfamiliar experience with a willingness to learn and an appreciation for the importance of learning, as well as the recognition that learning inevitably involves making some mistakes (Kouzes & Posner, 2017:184).

To develop a growth mind-set and to cultivate it in others, you need to embrace the challenges you face and when you experience obstacles you have to persevere (Kouzes & Posner, 2017:185). That is where the learning takes place. This was a sentiment that was whole heartedly shared by the participants of this study. They enrolled for the tutoring programme in order to learn something new, even if it was a big personal risk for some of them. They realised that they needed to take this risk, experiment with new skills and learning environment in order for them to become better tutors and leaders.

5.2.4 Theme 4: Enable Others to Act

According to Kouzes and Posner (2017:195), leaders can enable others to act by fostering collaboration and strengthening others. To accomplish these goals leaders must create a climate of trust and facilitate relationships with followers (Kouzes & Posner, 2017:197), enhance self-determination and develop competencies and confidence of their followers (Kouzes & Posner, 2017:220). From this theme two sub-themes emerged: i) Let tutees learn from their mistakes and ii) Building the self-confidence of the tutees.

5.2.4.1 Let tutees learn from their mistakes

Letting the tutees learn from their own mistakes emerged as the first sub-theme under the priori theme of Enable Others to Act. The participants saw the value in letting the tutees make mistakes and learn from them – even though it was sometimes hard for them having to watch the tutees try multiple times. With their leader's support, followers are set up to learn from experimenting and sometimes making mistakes. As Kouzes and Posner (2017:186) concur: "Mistakes are the pathway to great ideas and innovation". The participants mentioned:

> "However, I saw that there is so much value if you intentionally challenge the students to try for themselves but guiding them through the skills, and only if they failed about three times do you take over and demonstrate again." (P6)

> "…but as a tutor it was important to keep motivating them and encouraging them to learn from their mistakes." (P5)

> "What also challenged me a lot was to let others learn from their mistakes…" (P6)

> "…and enable their learning by first gauging their level of understanding and then adapting my teaching skills accordingly." (P5)

> "Personally, I struggled with challenging the process as well as enabling others to act, because in my thinking it is so much easier for me to do it myself, so therefore teaching others step by step time after time seemed tedious." (P6)

Leaders foster teamwork, build trust and create energetic teams. They actively involve others and understand that mutual respect is what sustains extraordinary efforts, making each person feel capable and powerful (Posner, 2016a:2). Exemplary leaders significantly increase people's belief in their ability to make a difference. They move from being in control to giving over control to others, becoming their coaches (Kouzes & Posner, 2017:220). The participants in this study had to learn to help others master new skills, develop existing talents and provide support for ongoing growth and change. This was hard to do for some of the participants, especially those who had academic tutoring positions before, as these entailed more teaching than facilitating skills and letting tutees learn from their mistakes.

5.2.4.2 Building the self-confidence of the tutees

The second sub-theme that emerged for Enabling Others to Act was to build the self-confidence of the tutees. Even if people know how to do something or perform a certain skill, a lack of confidence will stop them from doing it. Without sufficient self-confidence, people lack the conviction to take on new or tough challenges (Kouzes & Posner, 2017:239). The lack of self-confidence manifests itself in feelings of helplessness, powerlessness and self-doubt (Kouzes & Posner, 2017:239). To that extend the participants mentioned the following:

> "You realise that the other students really rely on you to boost their confidence in the skills they are practicing so you learn ways in which to approach them and things to say to all of them that will help when they are practicing." (P3)

> "…so reiteration, repetition, new explanations, relation to other known examples, one-on-one focus and encouragement … have been a few things I've picked up to help students develop their confidence." (P1)

> "Enabling others to work and achieve their goals was one of my favourite parts of tutoring. I learnt that sometimes when you help others you also help yourself in many ways and fostering trust between yourself and the people you work with is vital." (P2)

> "I need to be able to notice when things are not right and how to interject and help when needed. This also gives the students more confidence to come forward and ask questions. I learnt that I need to show that I am open to helping them and they can ask me what they are unsure of." (P3)

> "…therefore whenever a student has a "Eureka" moment, I like to then ask them to explain and guide their partner through the same thought process, so as to facilitate their learning as well. Not only does this build the student's confidence, but it also promotes self-leadership." (P5)

The participants realised that motivation and praise built trust between the tutees and themselves and it increased the self-confidence of the tutees to such an extent that it had a positive influence on their learning capabilities. By increasing the tutees' self-confidence, the participants gave them a chance to master difficult skills with the necessary fervour and thus increasing their chances of passing their exams and retaining their skills level beyond their student years. By building people's belief in themselves, leaders can bolster their inner strength to forge ahead in unchartered terrain and to make tough choices because they believe in their skills and decision-making abilities (Kouzes & Posner, 2017:239).

Being a peer tutor and subsequently a leader was a challenge to most of the participants, as they needed to step out of their comfort zones to allow for self-growth. The tutees had to accept challenges, not being afraid to take risks, and allow the tutees to make mistakes and learn from them without constantly intervening as described by Bennett (2017:97).

5.2.5 Theme 5: Encourage the Heart

According to Kouzes and Posner (2017:246), leaders can encourage the heart by showing appreciation for individual excellence and by celebrating the values and victories of their followers by creating a spirit of community. From this theme two sub-themes emerged: i) Encouragement of the tutees and ii) Encouragement of the tutors.

5.2.5.1 Encouragement of tutees

Exemplary leaders recognise and reward what individuals do to contribute to the values and vision of the organisation in the pursuit of achieving mutual goals (Kouzes & Posner, 2017:268). They express their appreciation and they enjoy being creative and spontaneous when saying thank you. The participants of this study used constant praise and verbal encouragement as ways of encouraging the tutees to do their best and to keep trying until they could perform the skills correctly. The participants mentioned:

> "Overall it is the praise you give the students when they are successful that motivates them the most. That is why walking around and making sure I assess everyone's work is so important." (P3)

> "Every time I have praised and encouraged someone I always see a slight change in their body language and sometimes a smile, which in turn gave me more confidence in my abilities." (P3)

> "I learnt how vital it is to encourage not only others but myself and I saw how words can go a very long way in helping people achieve their goals." (P2)

> "Lastly to encourage the heart; confidence is very important when you are learning new things and one requires a lot of encouragement." (P2)

> "…and celebrate the small wins, even if there is room for improvement elsewhere." (P6)

Leaders make people feel like winners and thereby encourage the heart to achieve even greater heights. They recognise everyone's contributions as valuable, creating a sense of community by celebrating the team's victories. Leaders create high expectations and

standards, holding people accountable to them by ensuring that rewards and performance are interconnected (Posner, 2016a:2).

5.2.5.2 Encouragement of tutors

The participants mentioned that positive feedback goes both ways – the better the tutees performed, the more the participants felt like role models, with feelings of increased confidence and affirmation of their knowledge as tutors. The participants mentioned:

> "I truly enjoy about being a tutor is seeing the student's face glow when they have that "Aha!" moment" (P5).

> "I must say that my favourite part about being a tutor is having a past student greet me and tell me that they did well in their examinations because of me. I find that very gratifying and serves as a confirmation that I am doing something right in my role as a tutor." (P5)

> "The tutoring process has helped me gain confidence in myself and has even helped me to reinforce the skills I learnt previously in the skills lab and carry them out with more confidence on real patients." (P3)

> "Constant affirmation when you see someone that struggled get better at practicing their skills creates a positive learning environment and the building of visual confidence is also affirming to our skills as a tutor." (P1)

According to Kouzes and Posner (2017:275), individual recognition increases the recipient's sense of self-worth and also improves their performance. In addition, public recognition of accomplishments builds commitment and shows a representation of how the organisation would like everyone to behave and demonstrate that it is possible to do so (Kouzes & Posner, 2017:275). By praising the tutees while they practice, the participants acknowledged their "small wins" and other students would see that and also put in even bigger effort as they could see that it was possible to do things well. Encouraging the tutees lead to them being more confident and in the end performing their skills even better and in turn the participants gained confidence in themselves and their tutoring abilities. As one said: "I find that very gratifying and serves as a confirmation that I am doing something right in my role as a tutor." (P5)

5.3 SUMMARY

This chapter discussed the data analysis and findings of the qualitative phase of the study. Data was collected in one unstructured focus group discussion and from personal narratives written by the participants. The researcher used priori themes according to the leadership model of Kouzes and Posner (2017:13-20) to identify emergent sub-themes of interest. The findings were discussed with direct quotations from participants and with reference to the literature review. The next chapter focuses on the integration of the quantitative and qualitative findings, as well as the recommendations from the study.

CHAPTER 6
INTEGRATION OF THE FINDINGS, CONCLUSION, LIMITATIONS, STRENGTHS AND RECOMMENDATIONS

6.1 INTRODUCTION

The quantitative results for this study were discussed in Chapter 4 and the qualitative findings in Chapter 5. In this chapter finding of both phases will be integrated followed by a conclusion and finally the recommendations, strengths and limitations of the study.

The aim of this study was to describe the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university. The objectives of this study were:

- Objective 1 (phase 1): To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies, which is described in Chapter 4 as the results of the self-report questionnaires completed at the beginning and the end of the tutor programme.
- Objective 2 (phase 2): To describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies, which is described in Chapter 5 as derived from the focus group and personal narratives done towards the end of the tutor programme.

The following section discussed the integration of the findings.

6.2 INTEGRATION OF THE FINDINGS

The findings from the quantitative and qualitative analyses were consolidated to create new meaning as described by Johnson and Onwuegbuzie (2004:22). Data was further interpreted according to The Five Practices of Exemplary Leaders Model to render it meaningful by explaining the results and comparing them to the literature reviewed. Data from the self-report instruments, the unstructured focus group and the personal narratives revealed some notable trends in peer leaders' self-perceptions of their leadership practices.

6.2.1 Model the Way

Model the Way is the first of The Five Practices of Exemplary Leaders. This practice is concerned with clarifying values and setting examples (Kouzes & Posner, 2017:46). The analysis of this study's quantitative data representing the subscale for Model the Way on the LPI-Self did not show any significant statistical differences between the pre- and post-test for the combined relevant items (p=0.5862).

On the other hand, the qualitative data that was collected by means of the focus group and the personal narratives clearly indicated that the participants took their responsibilities as role models very seriously. Four of the seven tutors stated that they always try to be a good role model by employing good communication skills, setting good examples and by setting the standard for the level of excellence for the tutees to become exceptional health care professionals. The participants also stated that they have learned a lot about their leadership styles and that it was important for them to find their own voices and not to pretend to be someone they are not. Leading by example, clearly defining values and goals, living from one's ideals, determination and passion for work, taking responsibility and guiding the team were also identified by Bennett (2017:96) as important aspects of Model the Way and leadership as a concept.

The difference in the results of the quantitative and qualitative data could possibly be explained by the participants' self-perceived high competency level in this practice as shown in the relative high result in the pre-test of the LPI-Self. The median score for the pre-test was 6.83 and the post-test had a median score of 7.67. This shows only a small difference for the Model the Way subscale in the pre- and post-test. These differences are an indication that the participants rated themselves highly for setting examples and clarifying beliefs and values even before the leadership workshop was held and before the tutoring sessions commenced.

6.2.2 Inspire a Shared Vision

Inspire a Shared Vision is the second subscale of The Five Practices of Exemplary Leaders. It relates to envisioning the future and enlisting others in a common vision by imagining exciting and ennobling possibilities and by appealing to shared aspirations (Kouzes & Posner, 2017:94). The quantitative data for two of the six items for this subscale showed a significant increase in the post-test results. These two items included talking about future trends that influence how work gets done (p=0.035) and describing a compelling image of

what the future could look like (p=0.0498). This is an indication that the respondents employed more of the relevant methods and behaviours by envisioning the future with shared stories and experiences after they participated in the leadership workshop and tutoring sessions.

The findings of the qualitative data corroborate that of the quantitative data as the participants mentioned that motivating tutees and inspiring them to keep the end goal in mind was a way for them to inspire a shared vision with the tutees. The participants would tell stories of their own experiences with patients and encouraged the tutees to see the relevance of the skills they were trying to master. The participants would also remind the tutees that the end goal is not just to pass the exams, but to perfect skills that would make them better health care providers in the future. It is important that transformational leaders have a clear vision of the future that is simple, understandable, beneficial and compelling to their followers, which is also described by Northouse (2016:173).

6.2.3 Challenge the Process

Challenge the Process is the third subscale for The Five Practices of Exemplary Leaders. Challenge the Process requires searching for opportunities by seizing the initiative and also experimenting and taking risks and ultimately learning from experiences (Kouzes & Posner, 2017:144). The results for this subscale revealed the largest statistical difference for the overall score of all the subscales. This is the result of the substantial difference in three of the six items' scores as seen by their p-values. These three items were: challenging people to try out new and innovative ways to work (p=0.0498), actively searching for innovative ways to improve (p=0.0498) and taking initiative in anticipating and responding to change (p=0.0418). The respondents demonstrate a significant increase in the frequency that they engage in this particular behaviour e.g. to challenge tutees to try out new ways of getting things done, responding to change (work outside of their comfort zone) and searching for ways to improve their tutoring.

Although these items on the LPI-Self refer to challenging the followers and circumstances, the qualitative data indicated that the participants' greatest challenge for them was the tutoring in itself. The main sub-themes that were identified for this priori theme was: a challenging experience and a continued learning experience. Four out of the seven participants felt that tutoring skills was a new experience for them and that they felt challenged by working with their peers in small groups. They also mentioned that they felt

insecure about their leadership backgrounds before the tutoring and leadership programme but saw the programme as a way for them to step out of their comfort zones to better themselves and their leadership abilities. The other participants saw the tutoring programme as a continuous learning experience and were willing to except their mistakes and learn from them.

The findings for the Challenge the Process subscale clearly demonstrate the importance for the participants to be able to take risks, to be innovative and to grow in the process, even if that means making some mistakes along the way as indicated by Kouzes and Posner (2017:185) and Northouse (2016:174).

6.2.4 Enable Others to Act

The Enable Others to Act subscale is the fourth dimension for The Five Practices of Exemplary Leaders. This practice is concerned with fostering collaboration by building trust and relationships and also with strengthening others by increasing self-determination and developing competence (Kouzes & Posner, 2017:194). The quantitative data for this subscale revealed statistically similar results for the pre-test (median=8.00, IQR=7.58, 8.42) and the post-test (mean=8.50, IQR=8.33, 8.75) and displays the smallest difference in the overall score of all five the subscales. The median for the pre-test score was very high (median=8.00) which is an indication that the respondents rated themselves highly for the frequent use of these behaviours. As facilitating practical skills was what the tutors were employed for, they already employed the actions of developing skills and self-determination.

The qualitative data corroborated these results as the participants mentioned that they had to let the tutees learn to do the skills by themselves, even if they made mistakes at first. The participants also mentioned the importance of building the self-confidence of the tutees in order for them to be able to believe in their abilities. The participants used constant praise and motivation as a way of building confidence and trust with the tutees. By building people's faith in themselves, leaders can bolster their inner strength to forge ahead in an unfamiliar environment and to make tough choices because they believe in their skills and decision-making abilities (Kouzes & Posner, 2017:239).

6.2.5 Encourage the Heart

Encourage the Heart is the fifth and last subscale of The Five Practices of Exemplary Leaders. Encourage the Heart relates to showing appreciation for individual excellence and celebrating the values and victories by creating a feeling of community (Kouzes & Posner, 2017:246). The quantitative data did not show a significant difference in the pre-test (median=7.17, IQR=6.50, 7.58) and post-test (mean=8.00. IQR=7.17, 8.42) scores. One of six items however showed a significant difference with a p-value=0.035. This was the item related to telling stories of encouragement about the good work of others. Northouse (2016:175) states that it is natural for people to want support and recognition and leaders should be attentive to this need and reward others for their accomplishments.

The sub-themes that were identified for Encourage the Heart were the encouragement of the tutees and also the encouragement of the tutors themselves. The participants recognised the value of constantly praising the tutees while they were practicing and thereby celebrating their “small victories”. This led to the tutees displaying even greater efforts to better their skills. Three of the seven participants also mentioned that encouraging the heart goes both ways. They felt that they performed well as tutors when tutees mastered skills well and if they passed their exams. The participants found it gratifying and a boost to their own confidence when they saw tutees have a breakthrough moment. According to Kouzes and Posner (2017:275), individual recognition increases the recipient’s sense of self-worth and also improves their performance, and in this study, it was true for both the tutees and the tutors.

6.3 CONCLUSIONS

This study set out to describe the self-perceived leadership development of peer tutors in undergraduate health care studies at a university in South Africa. As discussed in the literature review (Chapter 3), peer tutors are being placed in leadership positions and leadership skills are imperative to increase knowledge and skill transfer amongst undergraduate students. But although peer tutors are being used as teaching partners at universities and they are being seen as leaders in their student communities, very little was known about their development as leaders and very little was intentionally done to improve their leadership abilities.

In this study, health care peer tutors have been involved with tutoring their peers on specific skills for several years, but the focus on leadership development was only introduced recently. The tutors have always received training on the skills that they were tutoring, but

recently added was structured tutor training as well as a workshop on implementing the transformational leadership model of Kouzes and Posner, The Five Practices of Exemplary Leaders (2017). The peer tutors were supported on their journey throughout the academic year in relation to the specific skills and their roles as tutors and leaders.

The researcher observed that tutoring abilities were impacted negatively when tutors' leadership skills were not well developed or if they had a poor self-perception thereof. This might lead to a reduced ability to transfer skills or knowledge to peer students and this might ultimately lead to poor patient outcomes. The researcher believed that leadership skills of peer tutors can be developed through their training of specific skills, with additional structured workshops on tutoring and a leadership model, as well as their experiences of the tutoring of their peers. The assumption was made that an increased focus on tutor leadership development in addition to the focus on their knowledge and clinical skills might lead to better tutoring abilities and skills outcomes of the tutors and tutees, as well as improved academic programme output and eventually improved outcomes for patients and communities. The purpose of this study was therefore to describe the self-perceived leadership development of peer tutors in the health care teaching environment.

The following research question was answered by this study: *What are the peer tutors' perceptions of their own leadership development during participation in the tutor training programme in undergraduate health care studies at a university?* The aim of the study was to describe the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university. Objective 1 (phase 1) was: *To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies*. Objective 2 (phase 2) was: *To describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies*.

Since leadership development is an abstract concept that is difficult to measure and describe and the sample size for the study was indeed small, the approach of a convergent or triangulation mixed methods research study was chosen to be the best research design for this study, combining quantitative and qualitative research techniques, methods, approaches and concepts into a single study. Data triangulation was used to combine various sources of data to validate conclusions and enhance the rigour of the findings. The principle of the

convergent design was to obtain different but complimentary data about the central phenomenon under study. The goal is to converge on the “truth” about the research problem.

To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate health care studies (objective 1), quantitative data was collected with the use of a self-report instrument. For objective 2 – to describe the peer tutors’ experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies – qualitative data was collected in the form of an unstructured focus group discussion and personal narratives written by the participants.

Although the researcher was aware of the weaknesses of a mixed methods design, the strengths of the design still established suitable motives for using this specific design for this study. The researcher drew strengths from both quantitative and qualitative research by adding the use of written narratives to enhance the data collected by the self-report instruments to describe the participants’ journey of leadership development. By also using the transcribed data from the discussion group, the researcher was able to triangulate the data to answer a broader and more complete range of research questions. Since the sample group was small, a mixed methods design provided insights and understanding that might have been missed if only a single method was used. It also provided stronger evidence for a conclusion through convergence and corroboration of findings. The researcher wanted to validate and converge as well as enhance and illustrate the results to better clarify and describe the participants’ perception of their leadership development.

This data provided an answer to the question; what are the peer tutors’ perceptions of their own leadership development during participation in the tutor training programme in undergraduate health care studies at a university, by describing the self-perception of their leadership abilities. Although the LPI-Self results showed a difference but not always showed a statistical significant increase in their abilities after attending the tutor and leadership training programme, when combined with the results from the qualitative data, the study showed that the participants exhibited great growth in their leadership abilities. They valued the lessons that they have learned and was able to apply new skills and knowledge with regards to leadership when they were tutoring their peers.

6.4 LIMITATIONS OF THE STUDY

Several limitations were ascertained during the study. Firstly, the findings were from a study from only one faculty of one university. This led to a small population and an even smaller sample size, which may have reduced the influence of the results of the study. The sample of this study was not representative of the population and as such the generalisation of the current study findings is limited.

Secondly, it is problematic to compare the results of this study with other intervention studies involving leadership programmes presented to peer student tutors, which differed in their theoretical background or used different instruments or outcome variables.

Thirdly, there was a lack of randomisation in this study. This was considered unavoidable for ethical reasons. It was indefensible to provide some participants with leadership training and not to others, just for the sake of randomisation.

Fourthly, the researcher based this study on the use of one of the most commonly used instruments to increase the participants' self-awareness and identify areas for improvement as a leader by measuring how often they practice exemplary leadership behaviours. The use of only one questionnaire raises the question whether this instrument covered the full extent of leadership behaviours. Although self-reporting questionnaires are valuable instruments, sole reliance on one questionnaire can be a limitation, as the potential for subjective and reporting bias exists. Although the validity and reliability of the LPI-Self has been extensively corroborated, it remains a subjective instrument that measures the participants' perceptions of their leadership behaviours.

6.5 STRENGTHS OF THE STUDY

The aim of the study was to describe the self-perceived leadership development of peer tutors in undergraduate health care studies during participation in the tutor training programme of a selected university. This was accomplished by the researcher, and even though the samples size was small, the objectives of the study were met by using a mixed methods research design.

Another advantage of this study was the fact that the participants benefited hugely in a personal capacity from attending the leadership workshop and being able to practice their leadership behaviours in a safe environment while conducting peer tutoring. This was clear

from the verbatim quotations from the participants and the personal narratives from the students.

6.6 RECOMMENDATIONS

Based on the findings of this study, the researcher suggests recommendations for education institutions and for research.

6.6.1 Recommendations for education institutions

The following recommendations are made to education institutions:

- Opportunities for peer tutoring should be encouraged as part of leadership development.
- Best practices should be established for peer tutor leadership training that can be assessed rigorously and implemented across multiple disciplines and various higher education institutions.
- Leadership training programmes should be well-planned as part of tutoring programmes to include training such as tutoring, 360-degree and action learning, and should incorporate pedagogical and leadership theories, models, approaches and research findings.
- Leadership practices of tutors should be monitored through self-report techniques as well as peer review.

6.6.2 Recommendation for research

Recommendations for research include the following:

- This study could serve as a basis for a larger study involving other faculties and even other universities to get a more comprehensive population, a bigger sample size and more generalizable results.
- Experimental studies with randomisation should be conducted on leadership development of health care students during involvement and participation of different opportunities during their studies.
- The study could be repeated with the addition of peer review of the peer tutors' leadership practices to be compared to their self-perceived leadership development.
- To overcome the possible subjectivity and bias of the self-report questionnaire (LPI-Self), the study should be repeated utilising the LPI 360 assessment that goes a step further by illuminating the effectiveness of a leader and by measuring the level of commitment, engagement, and satisfaction of the individuals they lead.

- The participants should be followed up over time to describe their leadership development over time

6.7 SUMMARY

The focus of the study was on the self-perceived experiences of tutors of their leadership development during involvement in a tutoring programme. The programme included training on the procedures or skills that they would tutor, as well as on tutoring and the Five Practices of Exemplary Leaders of Kouzes and Posner (2017). The study is concluded by the following two quotations from participants:

> "Being a skills lab tutor has both challenged and helped to build my leadership potential."

> "The 5 practices of exemplary leadership have come in very handy on not just in the setting of tutoring but also daily when interacting with others. I am glad that I was able to learn these practices and put them into play because being a leader in your own life is very important."

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ANNEXURE A:

DATA COLLECTION INSTRUMENT

THE LEADERSHIP CHALLENGE® A Wiley Brand

BY JAMES M. KOUZES & BARRY Z. POSNER

INSTRUCTIONS:

Write your name in the space provided at the top of the next page. Below your name, you will find thirty statements describing various leadership behaviors. Please read each statement carefully, and using the rating scale on the right, ask yourself:

"How frequently do I engage in the behavior described?"

When selecting your response to each statement:

- Be realistic about the extent to which you actually engage in the behavior.
- Be as honest and accurate as you can be.
- DO NOT answer in terms of how you would like to behave or in terms of how you think you should behave.
- DO answer in terms of how you typically behave on most days, on most projects, and with most people.
- Be thoughtful about your responses. For example, giving yourself 10s on all items is most likely not an accurate description of your behavior. Similarly, giving yourself all 1s or all 5s is most likely not an accurate description either. Most people will do some things more or less often than they do other things.
- If you feel that a statement does not apply to you, it's probably because you don't frequently engage in the behavior. In that case, assign a rating of 3 or lower.

For each statement, decide on a response and then record the corresponding number in the box to the right of the statement. After you have responded to all thirty statements, go back through the LPI one more time to make sure you have responded to each statement. *Every* statement *must* have a rating.

The Rating Scale runs from 1 to 10. Choose the number that best applies to each statement.

RATING SCALE	1–Almost Never 2–Rarely	3–Seldom 4–Once in a While	5–Occasionally 6–Sometimes	7–Fairly Often 8–Usually	9–Very Frequently 10–Almost Always

When you have completed the LPI-Self, please return it to:

_____

_____

_____

Thank you.

LPI: LEADERSHIP PRACTICES INVENTORY SELF

Your name: _____

To what extent do you engage in the following behaviors? Choose the response number that best applies to each statement and record it in the box to the right of that statement.

1.	I set a personal example of what I expect of others.	
2.	I talk about future trends that will influence how our work gets done.	
3.	I seek out challenging opportunities that test my own skills and abilities.	
4.	I develop cooperative relationships among the people I work with.	
5.	I praise people for a job well done.	
6.	I make certain that people adhere to the principles and standards that have been agreed upon.	
7.	I describe a compelling image of what our future could be like.	
8.	I challenge people to try out new and innovative ways to do their work.	
9.	I actively listen to diverse points of view.	
10.	I make it a point to let people know about my confidence in their abilities.	
11.	I follow through on the promises and commitments that I make.	
12.	I appeal to others to share an exciting dream of the future.	
13.	I actively search for innovative ways to improve what we do.	
14.	I treat others with dignity and respect.	
15.	I make sure that people are creatively recognized for their contributions to the success of our projects.	
16.	I ask for feedback on how my actions affect other people's performance.	
17.	I show others how their long-term interests can be realized by enlisting in a common vision.	
18.	I ask "What can we learn?" when things don't go as expected.	
19.	I involve people in the decisions that directly impact their job performance.	
20.	I publicly recognize people who exemplify commitment to shared values.	
21.	I build consensus around a common set of values for running our organization.	
22.	I paint the "big picture" of what we aspire to accomplish.	
23.	I identify measurable milestones that keep projects moving forward.	
24.	I give people a great deal of freedom and choice in deciding how to do their work.	
25.	I tell stories of encouragement about the good work of others.	
26.	I am clear about my philosophy of leadership.	
27.	I speak with genuine conviction about the higher meaning and purpose of our work.	
28.	I take initiative in anticipating and responding to change.	
29.	I ensure that people grow in their jobs by learning new skills and developing themselves.	
30.	I get personally involved in recognizing people and celebrating accomplishments.	

LPI: LEADERSHIP PRACTICES INVENTORY SELF

ANNEXURE B:

SUMMARY OF RESEARCH PHASES

Summary of Research Phases

	PHASE 1	PHASE 2
Research Objective	To describe the self-perceived leadership abilities of peer tutors during their participation in the tutor training programme in undergraduate healthcare studies.	To describe the peer tutors' experiences of their leadership development during their participation in the tutor training programme in undergraduate health care studies.
Population	Group of peer tutors, chosen from students that were enrolled for their 3rd and 4th years of undergraduate health care studies.	Group of peer tutors, chosen from students that were enrolled for their 3rd and 4th years of undergraduate health care studies.
Sampling	Total sampling was used to include all seven appointed tutors in the study.	Total sampling was used to include all seven appointed tutors in this study.
Data Collection	Structured self-report instrument (LPI-Self of Kouzes and Posner) before the leadership workshop and at the end of the tutoring time.	• Unstructured focus group • Narrative to describe their experience and perception of their leadership development.
Data Analysis	Descriptive Statistics	• Transcribing of raw data from the focus groups. • Developing a coding scheme to identify themes and subthemes. • Content and Thematic analysis followed.
Rigour	Quality indicators: Validity and Reliability	Quality indicators: Credibility, Transferability, Dependability, Confirmability, Authenticity.

ANNEXURE C:

INTERVIEW GUIDE

Interview Guide

For the study of Wanda van der Merwe, titled:

SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN UNDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA,

the following questions served as an interview guide during the unstructured focus group:

The leading, open ended question will be:

How do you perceive your own leadership development after participating in the tutor training programme?

Possible Probing Questions:

1. Describe your own experiences of your leadership development during the tutor training programme.
2. Describe how you have been a role model for your tutees.
3. How did you go about to inspire your tutees to have common goals?
4. Describe the challenges you have encounter during this time.
5. How did you manage to enable other students to act?
6. Describe how you encouraged and commended your tutees?
7. Describe the influence of this tutoring opportunity on your own leadership development.

ANNEXURE D:

LETTER FROM STATISTICIAN

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Denkleiers • Leading Minds • Dikgopolo tša Dihlalefi

DEPARTMENT OF STATISTICS

Date: 7th May 2018

This letter is to confirm that ***Ms. Wanda van der Merwe***, studying at the University of Pretoria, discussed the project with the title "***Self-perceived leadership development of peer tutors in undergraduate health care studies at a university in South Africa***" with me.

I hereby confirm that I am aware of the project and also undertake to assist with the statistical analysis of the data generated from the project.

The sample will consist of a Total population sample of 24 undergraduate peer tutors enrolled in their 3rd or 4th year of studies.

The data analysis will consist of a mixed methods design which consist of data collected with a quantitative approach which will then be enriched by collecting additional data in a qualitative manner. Since the sample size of the study is small and leadership development is an abstract concept which is difficult to measure, the addition of the qualitative data collection might reveal unrealized associations and perceptions. A mixed methods approach will not just address one specific issue but will rather answer the question by seeking for rich and comprehensive information.

The quantitative data collection will consist of structured self-report instruments that was developed and validated by Kouzes and Posner. The results obtained from these self-report instruments (which will be collected at two different time points) will be evaluated using descriptive statistics which will aim to describe the self-perceived leadership development of peer tutors. The descriptive analysis will also aim to investigate if any differences exist between the three timeframes.

The qualitative data collection will consist of unstructured focus groups as well as self-report narratives which will be investigated in order to determine/find any themes and subthemes which plays a role in the tutors' leadership development perception.

Ms. Tanita Cronje
Department of Statistics
Internal Statistical Consultation Service
tanita.cronje@up.ac.za

ANNEXURE E:

DECLARATION OF HELSINKI

Special Communication

World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects

World Medical Association

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964, and amended by the:
29th WMA General Assembly, Tokyo, Japan, October 1975
35th WMA General Assembly, Venice, Italy, October 1983
41st WMA General Assembly, Hong Kong, September 1989
48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996
52nd WMA General Assembly, Edinburgh, Scotland, October 2000
53rd WMA General Assembly, Washington, DC, USA, October 2002 (Note of Clarification added)
55th WMA General Assembly, Tokyo, Japan, October 2004 (Note of Clarification added)
59th WMA General Assembly, Seoul, Republic of Korea, October 2008
64th WMA General Assembly, Fortaleza, Brazil, October 2013

Preamble

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data.

   The Declaration is intended to be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs.

2. Consistent with the mandate of the WMA, the Declaration is addressed primarily to physicians. The WMA encourages others who are involved in medical research involving human subjects to adopt these principles.

General Principles

3. The Declaration of Geneva of the WMA binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act in the patient's best interest when providing medical care."

4. It is the duty of the physician to promote and safeguard the health, well-being and rights of patients, including those who are involved in medical research. The physician's knowledge and conscience are dedicated to the fulfilment of this duty.

5. Medical progress is based on research that ultimately must include studies involving human subjects.

6. The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments). Even the best proven interventions must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality.

7. Medical research is subject to ethical standards that promote and ensure respect for all human subjects and protect their health and rights.

8. While the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects.

9. It is the duty of physicians who are involved in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects. The responsibility for the protection of research subjects must always rest with the physician or other health care professionals and never with the research subjects, even though they have given consent.

10. Physicians must consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research subjects set forth in this Declaration.

11. Medical research should be conducted in a manner that minimises possible harm to the environment.

12. Medical research involving human subjects must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional.

ANNEXURE F:

PERMISSION LETTERS

ANNEXURE F1:

DEPUTY DEAN OF EDUCATION

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

20/05/2019

The Chair
Research Ethics Committee
Faculty of Health Sciences
University of Pretoria

Ethical approval for student participation in research project

This serves to confirm that I am supportive of the following registered for the MNurs, Nursing Management (VGK Dissertation 890):

Wanda van der Merwe u95027158

who has applied for ethical approval for a project entitled:

SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN UNDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA

I have no objection to her requesting the third and fourth year MBChB student tutors to participate in the study by completing an anonymous questionnaire and participating in a focus group discussion.

Kind regards

Prof D Manning
Deputy Dean: Education

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE F2:

WILEY AND SONS PUBLISHERS

WILEY

July 20, 2018

Wanda Van der Merwe
University of Pretoria, Prinshof Campus
Pretoria South Africa 0084

Dear Ms. Van der Merwe:

Thank you for your request to use the LPI®: Leadership Practices Inventory® in your research. This letter grants you permission to use either the print or electronic LPI [Self/Observer/Self and Observer] instrument[s] in your research. You may ***reproduce*** the instrument in printed form at no charge beyond the discounted one-time cost of purchasing a single copy; however, you may not distribute any photocopies except for specific research purposes. If you prefer to use the electronic distribution of the LPI you will need to separately contact Joshua Carter (jocarter@wiley.com) directly for further details regarding product access and payment. Please be sure to review the product information resources before reaching out with pricing questions.

Permission to use either the written or electronic versions is contingent upon the following:

(1) The LPI may be used only for research purposes and may not be sold or used in conjunction with any compensated activities;
(2) Copyright in the LPI, and all derivative works based on the LPI, is retained by James M. Kouzes and Barry Z. Posner. The following copyright statement must be included on all reproduced copies of the instrument(s); "Copyright © 2013 James M. Kouzes and Barry Z. Posner. Published by John Wiley & Sons, Inc. All rights reserved. Used with permission";
(3) One (1) **electronic** copy of your dissertation and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data must be sent **promptly** to my attention at the address below; and,
(4) We have the right to include the results of your research in publication, promotion, distribution and sale of the LPI and all related products.

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T +1 415 433 1740
F +1 415 433 0499
www.wiley.com

Permission is limited to the rights granted in this letter and does not include the right to grant others permission to reproduce the instrument(s) except for versions made by nonprofit organizations for visually or physically handicapped persons. No additions or changes may be made without our prior written consent. You understand that your use of the LPI shall in no way place the LPI in the public domain or in any way compromise our copyright in the LPI. This license is nontransferable. We reserve the right to revoke this permission at any time, effective upon written notice to you, in the event we conclude, in our reasonable judgment, that your use of the LPI is compromising our proprietary rights in the LPI.

Best wishes for every success with your research project.

Cordially,

Ellen Peterson
Permissions Editor
Epeterson4@gmail.com

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ANNEXURE F3:

ETHICS APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

20 July 2020

Approval Certificate
Annual Renewal

Ethics Reference No.: 277/2019
Title: SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN UNDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA

Dear Mrs W Van der Merwe

The **Annual Renewal** as supported by documents received between 2020-06-19 and 2020-07-15 for your Research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2020-07-15.

Please note the following about your ethics approval:
- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2021-07-20.
- Please remember to use your protocol number (277/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria
The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel +27 (0)12 356 3084
Email: deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Announcement and instruction to all researchers

from the Faculty of Health Sciences Research Ethics Committee

This is an update following previous instructions from the Research Ethics Committee, accounting for recent announcements by government in relation to COVID-19 on 24 May 2020.

All researchers must minimise the risk of transmission at research sites and in studies involving human participants approved by the Research Ethics Committee. To this end,

1) all non-therapeutic or non-interventional research data gathering involving contact with human participants remain suspended, with the exception of studies involving telephonic or other online/remote methods of data collection;
2) research that is entirely situated in a laboratory is permitted provided that COVID-19 precautionary measures are in place;
3) research that is merely utilising existing records or data is permitted provided that COVID-19 precautionary measures are in place;
4) emergency research related to COVID-19 is permitted after ethics approval;
5) everyone should endeavour protecting research participants, personnel and students in reducing the risk of transmission of COVID-19.

For therapeutic and clinical research trials:

1) each research study or study site must maintain a plan to minimise exposure to COVID-19 risk for all parties involved in the study, including but not limited to research participants, researchers and student researchers;
2) Whenever feasible, in-person visits should be substituted with telephonic visits;
3) Principal investigators and study sites should maintain measures to ensure that there is no interruption of required medication/essential treatment and monitoring of adverse events;
4) Researchers and study sites should develop a 'COVID-19' template register in case retrospective contact tracing becomes necessary;
5) New enrolments into clinical trials remain suspended. Potential exceptions to this announcement should be discussed with the chair or a deputy chair of the REC;
6) Serious adverse events at an UP-site should be reported on the PeopleSoft system within 72 hours as usual.

Research Ethics Committee
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Lefapha la Disaense tša Maphelo

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

3 June 2019

Approval Certificate
New Application

Ethics Reference No.: 277/2019
Title: SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN NDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA

Dear Mrs W Van der Merwe

The **New Application** as supported by documents received between 2019-05-06 and 2019-05-29 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-05-29.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-06-03.
- Please remember to use your protocol number (277/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

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ANNEXURE G:

PARTICIPANT INFORMED CONSENT

Participant's information & informed consent document

STUDY TITLE:

SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN UNDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA

SPONSOR:

Principal Investigator: Wanda van der Merwe

Institution: University of Pretoria

DAY TIME AND AFTER HOURS TELEPHONE NUMBER(S):

Daytime numbers: 082 788 7879

Afterhours: 082 788 7879

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

				:
dd	**mm**	**yy**		**Time**

Dear Participant

Dear Mr. / Ms. ..... Date of consent procedure …...../…...../….....

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study is to describe leadership development of peer tutors in undergraduate health care students. By doing so we wish to learn more about peer tutors' self-perception of their leadership development.

3) EXPLANATION OF PROCEDURE TO BE FOLLOWED

This study involves taking part in a tutoring programme which will include workshops on leadership development. You will be taught how you could implement a leadership model in your tutoring classes. You will be asked to complete a self-assessment instrument on the progress of your leadership development, before and after your tutoring time. You will also be asked to compile a written narrative, of no more than one page, about your experiences at the end of your tutoring time. There will also be a focus group discussion involving the other peer tutors in your group.

4) RISK AND DISCOMFORT INVOLVED.

The only possible risk to you will be your time. The leadership workshop will be about 2 hours long. The unstructured focus group will be approximately 1-2 hours long. Each self-assessment instrument will take approximately 30 minutes to complete and this will be done on 2 separate occasions. You will be able to write the narrative on your own time. **5) POSSIBLE BENEFITS OF THIS STUDY.**

The benefits of this study will be an increase in leadership development that can be utilized in tutoring classes as well as in other aspects of the participant's life.

6) I understand that if I do not want to participate in this study, I will still be allowed to participate in the peer tutoring classes that I was appointed for by the University.

7) I understand that I may, at any time, withdraw from this study.

8) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been granted

by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

9) INFORMATION

If I have any questions concerning this study, I should contact:

Mrs Wanda van der Merwe Tel : 012 356 3296 or Cell: 082 788 7879

10) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

11) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read, in a language that I understand, the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

12) CONSENT TO RECORD FOCUS GROUP DISCUSSION

Do you agree that the focus group discussion can be audio-recorded? Yes ☐ No ☐

I have received a signed copy of this informed consent agreement.

.....	.....	.....
Participant signature	Participant name	Date
.....	.....	.....
Investigator signature	Investigator name	Date
..		
.....	.....	.....
Witness signature	Witness name	Date

Demographic Questionnaire

Please complete the following Demographic Questionnaire by circling the most applicable answer. All information obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

1. Age: What is your age?
    a. 18-22
    b. Older than 22

2. Gender: What is your gender?
    a. Male
    b. Female
    c. Other

3. Nationality?
    a. South African
    b. Other (please specify)_____

4. For which Degree are you enrolled?
    a. MBChB
    b. Other (please specify)_____

5. Year of Studies?
    a. Third Year
    b. Fourth Year

6. Have you been involved in any previous tutoring programmes?
    a. No
    b. Yes (please specify)_____

7. Involvement: In which ways are you involved on campus?
    a. Academic or professional organization
    b. Campus activities or event attendance
    c. Leadership or mentoring program
    d. On-campus employment
    e. Other student club
    f. Please specify if answer is YES to any of the above:
    _____

8. Employment: How many hours do you tutor/mentor peer students per month?
    a. Less than 5
    b. 5-10
    c. 10-20

Thank you for your participation.

ANNEXURE H:

STORAGE OF RAW DATA

Principal Investigator's Declaration for the Storage of Research Data and/or Documents

I, the Principal Investigator, Wanda van der Merwe, of the following study titled:

SELF-PERCEIVED LEADERSHIP DEVELOPMENT OF PEER TUTORS IN UNDERGRADUATE HEALTH CARE STUDIES AT A UNIVERSITY IN SOUTH AFRICA,

will be storing all the research data and/or documents referring to the above mentioned study at the following non-residential address:

Skills Laboratory, Faculty of Health Sciences,
University of Pretoria,
Bophelo Street, Pretoria.

I understand that the storage for the abovementioned data and/or documents must be maintained for a minimum of 15 years from the end of this study.

START DATE OF STUDY: February 2018 END DATE OF STUDY: April 2021

SPECIFIC PERIOD OF DATA STORAGE AMOUNTING TO NO LESS THAN 15 YEARS:

Begin storage date	End of storage date
December 2019	December 2034

Wanda van der Merwe