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EXISTENTIAL–EXPERIENTIAL VIEW OF SELF-SOURCED (IN) AUTHENTIC HEALTHCARE IDENTITY

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In the healthcare context, both nurses and doctors derive their professional identities from diverse backgrounds, thus resulting in two distinct professions. Becoming a leader and forming a leader identity that is separate from a strong professional identity is a difficult task. However, assuming a leader identity is considered an important aspect of actually *being* a leader, not just a professional with a leader position. The current article explores authenticity in generic healthcare leader identity formation by utilizing the concept of professional identity. Instead of committing to the humanistic ontological roots of the authentic leadership construct, the research analyzes the concepts of self and authenticity from an existential–experiential perspective. A conceptual framework of self-sourced healthcare identity formation, including leader identity and professional identity, is presented. The framework shows how leader identity originates in the leader's experiencing self-in-situation, which is understood as the source of authenticity. The experiencing self, or the self as a subject, is differentiated from the experienced self, or the self as an object, by which professional identities are formed. The conceptualization provides a way of understanding and developing leadership in fields consisting of strong professional identities. The applications of the framework are also discussed.

Healthcare organizations address the demand to develop services by emphasizing on human resources. Among key human resources, nurses and doctors dominate healthcare worldwide (World Health Organization, 2012, 2014). Both nurses and doctors generate their identities from educational curricula that result in two distinct professions. Learned work practices and complementary roles maintain the distinctions (Ferlie,

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Fitzgerald, Wood, & Hawkins, 2005). Because of the self-governing processes of professional identity formation, nurses and doctors may have different attitudes toward role changes (Powell & Davies, 2012), they may regard the meaning of team work differently (Morgan & Ogbonna, 2008; Powell & Davies, 2012), and may have dissimilar opinions about what is considered evidence and appropriate research in healthcare (Ferlie et al., 2005). The boundaries between doctors' and nurses' professional identities are experienced as complicating work (e.g., Powell & Davies, 2012). If profoundly unrelated meanings characterize the professional identities of nurses and doctors, it has a negative effect on knowledge sharing (Ferlie et al., 2005; see also Powell & Davies, 2012), which is a critical element in patient care and safety (see Ferlie et al., 2005).

It has been argued that professional expertise no longer ensures successful leadership in healthcare (e.g., Collins-Nakai, 2006; Honour, 2013). Traditionally, however, a leader position in healthcare requires professional expertise. Healthcare professionals assume that professional expertise guarantees an understanding of followers' work (Koskiniemi & Perttula, 2013). However, achieving a leader position based on professional expertise might result in leaders who follow occupational traditions, including the crucial elements of professional identity, and do not lead healthcare expertise in general. Empirical studies (Currie, Koteyko, & Nerlich, 2009; Keighley, 2003; Morgan & Ogbonna, 2008; Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010) have shown that in healthcare, the nursing profession is generally dominated by the medical profession. The role of expressing professional identity in a leader position poses a challenge to both nurses and doctors. The more deeply professionals define themselves as leaders, the more they seek to learn about being a leader (McDaniel & DiBella-McCarthy, 2012).

An exploration of the source of generic leader identity is needed to understand how nurses and doctors can work coherently in a healthcare work environment. The theoretical examination and conceptualizations presented in the current study are relevant not only to healthcare but also to other fields involving strong professional identities. The nature of leadership in and between professions might differ, depending on whether one or more influential professional identities operate in the same work community.

Researchers have developed various leadership constructs and arguments to describe vital elements in explaining and carrying out a successful leadership practice (e.g., Cooper, Scandura, & Schriesheim, 2005). Authentic leadership (AL) is a relatively new leadership construct that has been carefully analyzed conceptually (e.g., Avolio & Gardner, 2005; Avolio, Walumbwa, & Weber, 2009; Gardner, Avolio, Luthans, May, & Walumbwa, 2005; Ilies, Morgeson, & Nahrgang, 2005; Luthans & Avolio, 2003; Neider & Schriesheim, 2011; Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008) and widely applied in empirical studies (e.g., Cerne, Dimovski, Maric, Penger, & Skerlavaj, 2014; Hannah, Walumbwa, & Fry, 2011; Hmieleski, Cole, & Baron, 2012; Jensen & Luthans, 2006; Laschinger, 2014; Leroy, Anseel, Gardner, & Sels, in press; Waite, McKinney, Smith, & Meloy, 2014; Walumbwa, Wang, Wang, Schaubroeck, & Avolio, 2010; Woolley, Caza, & Levy, 2011). AL, as a leadership construct, is commonly interpreted as consisting of four components: balanced processing, internalized moral perspective, relational transparency, and self-awareness (Avolio et al., 2009). The AL construct has been examined in, for example, telecom firms (Walumbwa et al., 2010), the service industry (Leroy et al., in press), hospitals (Laschinger, 2014), military squads (Hannah et al., 2011), and universities (Rego, Vitória, Magalhães, Ribeiro, & Cunha, 2013).

To capture the essential elements in professional identity and leader identity formation, the present research focuses on authenticity in the healthcare work environment. However, baselines for authenticity are distinct from those presented in the AL construct (e.g., Walumbwa et al., 2008).

A leadership construct is relevant to a healthcare setting only if it reflects the leader identity of both doctors and nurses beyond their professional identities. The current article does not commit to the AL construct as comprising four established conceptual components (Walumbwa et al., 2008). Arguments have been posed questioning the presuppositions of authenticity in positive psychology (Seligman, 2002), positive

organizational scholarship (Cameron, Dutton, & Quinn, 2003), and humanistic psychology (Maslow, 1993; Rogers, 1961), which together form the theoretical basis of the AL construct. While authenticity, as presented in the AL construct, mostly follows the humanistic tradition (Ladkin & Taylor, 2010; O'Connell, 2014), the understanding of authenticity offered in the current article is grounded in existentialism.

The theoretical goal is to explore the role of authenticity in healthcare leader identity as an existential–experiential phenomenon that requires parallel analyses of the concepts of self, leader identity, and professional identity. The existential–experiential perspective understands the self in two ways: as an experiencing self (the self as subject) and as an experienced self (the self as object). The experiencing self—the self as subject—is considered to be the source of authenticity and described in the next section. Comparisons with the experienced self—the self as object—are made in the discussion section.

The selected existential–experiential perspective allows exploring leadership in fields of strong professional identities in new ways. The specific research objectives are to conceptualize (a) how leader identity is grounded in the authenticity of an experiencing self; and (b) how healthcare leader identity formation is reflected by healthcare professional identities.

The Self as a Source of Authenticity

The concept of authenticity has roots in both humanistic and existential theories. Rogers (1961), a proponent of humanistic psychology, understood authenticity by the term *fully functioning person*, which refers to an ideal life situation in which a person can choose freely based on subjective experiences. Approaching the Rogerian concept of a fully functioning person, Maslow's (1993) humanistic presentation of actualization rests on the inner motive of becoming everything one can be, that is, the person one essentially is. Maslow (1993) and Rogers (1961), among other advocates of humanistic psychology (e.g., Bugenthal, 1965), highlighted the role of personal development in realizing the sense of a unified, integrated self. Interpreted from a humanistic ontological viewpoint, authenticity means the experiential discovery and fulfillment of a person's innate self. The true, inner self is both the origin of personal authenticity and the goal of a personally authentic life (Maslow, 1993; Rogers, 1961). Most of the AL theories conceptualize the self and authenticity from the humanistic viewpoint (Ladkin & Taylor, 2010; O'Connell, 2014) by describing AL as behaving according to one's true, authentic self (Avolio & Gardner, 2005; Gardner et al., 2005) and becoming more aware of different aspects of the self (Walumbwa et al., 2008). Based on the AL literature (Avolio & Gardner, 2005; Luthans & Avolio, 2003; Walumbwa et al., 2008), the authentic self of a leader has specific contents that are not only good to discover but also create goodness when followed.

While humanistic tradition maintains that the person has a kind of self regardless of the world in which the person lives, the main ontological presupposition of existentialism is that a person is not separated from the world but is living-in-the-world (Heidegger, 1962). According to existential understanding, persons are responsible for determining their life by making life choices. A person performing an authentic existence has the freedom in every situation to choose as a living-in-situation (Cooper, 1990; Heidegger, 1962; Lawler, 2005). Unlike the humanistic interpretation, existential theory does not posit that any internal, predetermined self exists or must be followed in making life choices in order to become authentic (Lawler & Ashman, 2012).

Existential theory views human existence as both authentic and inauthentic. The principal distinction between the two is that only in authentic existence is there awareness of the meaning of one's existence (Reynolds, 2006). Existential theory assumes that persons are embedded in the world, so various daily external influences disturb their simultaneous awareness of the sense of living and authenticity (Algera & Lips-Wiersma, 2012). Because belonging to the world comes ontologically before anything else, existential theories claim that inauthenticity is an inevitable condition of an authentic existence (Heidegger, 1962; Reynolds, 2006). Awareness of inauthentic existence enables one to become aware of the authentic self (Reynolds, 2006), which is the human experience of living the authentic life.

The view advanced by existentialism (Cooper, 1990; Heidegger, 1962) maintains that the self is an

experiential human agent operating in each person in every actual relation-in-the-world. The self acts according to the situation that the self experiences, and in every actual relation-in-the-world, the self acts as a source of authenticity. In the current research, the self, as understood in existentialism, is regarded as the self as subject. After combining the existential and experiential perspectives, the self as a subject is defined as an experiencing self-in-situation. Consistent with existential conceptualizations of being-in-the-world (see Heidegger, 1962), the hyphens in "self-in-situation" indicate that the self as subject cannot be separated from the situation the self is in, as well as being cannot be separated from the world in which the being happens (Heidegger, 1962). The adjective "experiencing" in "experiencing self-in-situation" does not carry hyphens as long as it serves as an adjective. To be a verb, for example, in "experiencing-in-situation" the hyphens would be mandatory in accordance with existentialism (see Heidegger, 1962).

The definition of the self as a subject does not hold any features or content that would imply that a person reflects having some sort of self. Therefore, the self is not similar to self-concept. Erikson's (1968) classic theory of the concepts of ego-identity and self-identity clarifies this view of the self: A person's self-identity emerges from seeing the experiencing self as an object that crystalizes and becomes more coherent over time. A person's self-identity can be paralleled to the experienced self or the self as an object. In contrast, ego-identity refers to the integrative functions performed by the conscious inner agent (Erikson, 1968)—the self as a subject. As mentioned earlier, the self as a subject, or experiencing self-in-situation, cannot be separated from the situation the self as a subject experiences. The same does not hold true for the self as an object or the experienced self in situation. The self as an object is regarded as separate from the situation as it contains some kind of content prior to the situation of which the self as an object becomes part. The content of the self as an object guides perceptions in a situation whereas the self as a subject, the experiencing self, lets the situation itself guide the generated perceptions.

Making personal choices and living under multiple external influences are endemic to the experiencing self's perceived daily life. The self as subject maintains the human presence of experiencing the making of personal choices. If one considers that a person cannot experience the self as present in a situation, the choices that the person makes are not literally his or her choices. Being present as self-in-situation is the unconditional prerequisite of authenticity. Experiencing without restrictions imposed by external pressures and expectations and being open to the environment as it presents itself is authentic experiencing, and behaving according to the experiences is authentic acting. Authentic experiencing and acting are separate so that the former does not posit the latter but the latter posits the former.

Being an Authentic Leader

In healthcare, AL was first acknowledged a decade ago when the American Association of Critical-Care Nurses (2005) identified it as a factor in establishing healthy work environments. Wong and Cummings (2009b) presented the first empirical findings obtained from applying the AL in healthcare. Since then, studies (Laschinger, 2014; Laschinger, Wong, & Grau, 2012; Waite et al., 2014; Wong & Laschinger, 2013; Wong, Laschinger, & Cummings, 2010) have indicated that AL yields varied positive outcomes among healthcare personnel. So far, research has focused on AL components' impact on nurses' work. Although the knowledge is still partial because of the lack of research on doctor leaders, the AL construct has been seen as promising for developing better healthcare leadership (Wong & Cummings, 2009a; Wong et al., 2010). Wong and Cummings (2009a) argue that nursing leadership needs AL's emphasis on positive psychological capacities, ethical and moral behavior, and the development of positive leader–follower relationships.

Although theoretical foundations of AL are often identified in positive psychology and positive organizational scholarship (e.g., Ilies et al., 2005; Luthans & Avolio, 2003; Wong & Cummings, 2009a; see also Gardner, Cogliser, Davis, & Dickens, 2011), a recent critique (Algera & Lips-Wiersma, 2012; Lawler & Ashman, 2012) contends that authenticity has been attached to the leadership construct without sufficient consideration of the ontological roots of the concept of authenticity. Algera and Lips-Wiersma (2012) and Lawler and Ashman (2012) observe that contemplation of the authentic human and authentic being has been

set aside to focus solely on authentic leader/leadership. According to critiques (Algera & Lips-Wiersma, 2012; Lawler & Ashman, 2012), it is important to understand one's authentic being before constructing an AL construct. Algera and Lips-Wiersma (2012) theoretically examine authenticity from an existential perspective and propose a way for all organization members, not just leaders, to be authentic. Algera and Lips-Wiersma (2012) criticize the AL construct as too leader-centric and the concept of authenticity as a permanent, positive quality of leaders as unrealistic. They argue that from an existential perspective, an authentic person does not necessarily behave more ethically than the inauthentic person. Discussing AL literature, Algera and Lips-Wiersma (2012) observe that "because much of this literature is framed in the tradition of Positive Organizational Psychology, it does not usually question how inauthenticity arises in the first place" (p. 120).

Lawler and Ashman (2012) apply a Sartrean perspective to authenticity and criticize the way authenticity has been attached to leadership without first considering what authenticity is and what presumptions the selected concept of authenticity introduces. Lawler and Ashman (2012) note that "authentic leadership appears to be a construct with no philosophical root and, despite its presupposition of a normative ethic, it does not provide one" (p. 333). While ethics, morality, and actions according to the true self are central topics in AL, Lawler and Ashman (2012, pp. 340–341) further argue that the interest in authenticity in leadership should open up dialogue about the value systems in which leaders and followers operate instead of identifying fixed, specific values and behaviors as the right ways to express the authentic self.

Indeed, the related concepts of self and authenticity have not been thoroughly examined in the AL literature. For example, by taking a humanistic view of the inner self in determining authentic action and remembering that the inner self does not change during a person's life course (Maslow, 1993), does AL theory assume that authentic leaders are born to be leaders while also discussing the development of authentic leaders? Setting the focus inside the person to be acquainted with the personal essence, and accordingly to live it through, does not leave much room for the development of leader identity in situations.

From an existential–experiential perspective, the authenticity of leaders is a question of the extent to which, and the circumstances in which leaders can be authentic in their work. It is important not to view the authentic as synonymous with the genuine and positive and, correspondingly, with positive leadership. From an existential–experiential perspective, the authentic actions of a leader are neither positive nor negative, neither genuine nor false in and of themselves. The key to authentic acts is a leader's ability to sense a situation and recognize an appropriate way to express the experiencing presence of one's self-in-situation to others.

The question then arises of how authentic leader acts are related to behavior grounded in the experiences attached to working in a profession. If healthcare leaders are firmly identified with their profession, there is a risk that they will ignore their actual personal experiences as leader**s**. The phenomenon of authenticity challenges doctors and nurses working in leader positions to think and behave as leaders. Existential–experiential authenticity requires one to remain open to the possibilities perceived in a situation and to be attentive to experiencing beyond previous experiences. As a result, authenticity is apt to challenge the habits, traditions, and conventions that are common in professional acts. Seeing matters in new ways and as they are in immediate situation**s**, not as they have been in similar situations, is a starting point for developing and creating the new. The perspective might precipitate useful rethinking of one's profession-related healthcare leader identity.

Because existentialism assumes that authentic behavior is disturbed by multiple external pressures as a result of living-in-the-world (Heidegger, 1962), healthcare leaders are presumed to sometimes or often behave inauthentically due to expectations set by the profession and the organization. Instead of merely avoiding inauthentic leader acts, it would be more useful to make sense of them. Learning by understanding oneself as an experiencing actor in different work settings presents an opportunity to develop a leader identity grounded in the phenomenon of authenticity. Existential–experiential authenticity creates the potential for both nurse and doctor leaders to find a balance between their dual roles. The potential does not offer unbroken authenticity in healthcare work settings (Algera & Lips-Wiersma, 2012) but neither is it an argument against authenticity.

The Self Compounded With Healthcare Identities

Recent theories (Oyserman, 2009a, 2009b; Oyserman, Elmore, & Smith, 2012) present identities as the multiple meanings attached to a person, such as traits, roles, and social relations. By assimilating the past, present, and future, identities are dynamically constructed in the life context (Oyserman, 2009b; Oyserman et al., 2012). Based on identities, individuals make meaning of situations, focus their attention, organize experiences, and form assumptions about themselves (Oyserman, 2009a, 2009b). How a person experiences himself or herself might vary depending on the identity assumed (Lord & Hall, 2005; Oyserman, 2009a). Only one identity can be activated at one time in any situation, but moving between identities is easy, depending on situational clues (Amiot, de la Sablonnière, Terry, & Smith, 2007; Day & Harrison, 2007). Identities are not usually completely independent of each other (Oyserman et al., 2012), rather, they interact with each other. Therefore, an already existing identity can influence or intersect the development of a new identity (Amiot et al., 2007). In the present conceptualization, identities are objects of human experiences performed by the self as a personal actor. Identities exist as a multidimensional filter through which the self acts in a given situation.

To expand the exploration of the self as a source of authenticity in healthcare leadership, simultaneous analyses of the concepts of self, professional identity, and leader identity are needed. Both professional and leader identities follow the same logic and are continuously formed in a person's objectifying understanding of the self, in the present case, working in healthcare.

Although formed in context, professional and leader identities are structured by person-based interpretations. In healthcare, the professional identity of doctors and nurses must be analyzed separately, but analyzing leader identity is a unified task in both.

PROFESSIONAL IDENTITY AS A STARTING POINT BEFORE BECOMING A LEADER

The professional identities of doctors and nurses include experiences that define them as professionals. Education (Hood, Cant, Leech, Baulch, & Gilbee, 2014; Monrouxe, Rees, & Hu, 2011), interaction with colleagues, and work in daily settings (Hood et al., 2014; Pratt, Rockmann, & Kaufmann, 2006) provide the context that forms the professional identities of nurses and doctors.

Doctors' professional identity is heavily developed during their education and early career (Crossley & Vivekananda-Schmidt, 2009; Monrouxe et al., 2011). From the very beginning, a doctor's identity provides a way not only to perceive himself or herself as a doctor but also to distinguish himself or herself from other professional groups. Doctors want to be autonomous in their work (McDonald, Waring, & Harrison, 2006; Morgan & Ogbonna, 2008; Powell & Davies, 2012). They feel fully aware of their role and are somewhat reluctant to change roles or tasks (Powell & Davies, 2012). Doctors believe that they hold a key position and have professional experience in making decisions about and coordinating patient care (McDonald et al., 2006; Snelgrove & Hughes, 2000). They do not consider themselves as dominated by other healthcare professions (Nugus et al., 2010); instead, the doctors tend to place themselves at the top of the healthcare professional hierarchy (Morgan & Ogbonna, 2008; Snelgrove & Hughes, 2000) because of their ultimate responsibility for the patient (Nugus et al., 2010). Doctors do acknowledge the importance of teamwork among professionals (Morgan & Ogbonna, 2008) but still interact more with colleagues than with members of other professions (Morgan & Ogbonna, 2008; Reeves et al., 2009). They feel that the culture in healthcare organizations maintains the existing boundaries between professionals (Morgan & Ogbonna, 2008).

Experiencing and acting in nurses' work environment affect nursing students' initial formation of the identity of a professional nurse (Hood et al., 2014). In addition, expectations for future professional lives, which are presented to nursing students, serve as a professional identity filter (Cowin, Johnson, Craven, & Marsh, 2008; Hood et al., 2014). As part of a nurse's identity, caring and being there for the patient (Currie et al., 2009) are essential. Nurses feel that they have the necessary skills and training to practice quality patient care (Morgan & Ogbonna, 2008) and that they are patient advocates (Morgan & Ogbonna, 2008;

Snelgrove & Hughes, 2000). Nurses value interprofessional teamwork and are willing to work with members of other professions to achieve shared goals (Morgan & Ogbonna, 2008; Nugus et al., 2010; Reeves et al., 2009) but feel that there is a potentially harmful boundary between them and doctors (Powell & Davies, 2012). Because nurses, also senior nurses, experience a lack of influence over doctors (Currie et al., 2009; Powell & Davies, 2012), having a strong character is important for nurses in situations when their voice needs to be heard on behalf of the patient (Powell & Davies, 2012, p. 810). In general, nurses do not accept the dominance of doctors (Nugus et al., 2010). Nurses feel that they sometimes are more qualified to deliver quality care than doctors because of the time they spend with patients (Morgan & Ogbonna, 2008). Human dignity and equality in patient care are fundamental professional values for nurses (Rassin, 2008; Vuckovich & Artinian, 2005). Finally, nurses have a desire to realize the values related to their profession (Ravari, Bazargan-Hejazi, Ebadi, Mirzaei, & Oshvandi, 2012).

As the empirical findings above indicate, the hierarchies and interprofessional boundaries between doctors and nurses are mediators among new generations of nurses and doctors and work to form their professional identities. However, the tendency is not straightforward but appears to be context-sensitive. For example, the distribution of power has been found to differ in community health and acute hospital services (Nugus et al., 2010).

When a nurse or doctor enters a leader position in healthcare among professional colleagues, the construction of a leader identity becomes a question. What, if anything, happens to professional identity in a leader position? A vital part of the development of leader identity is that a professional starts to think of himself or herself as a leader (DeRue & Ashford, 2010; Lord & Hall, 2005), which means that a generic healthcare leader identity is formed alongside the professional identity.

MOVING FROM BEING A PROFESSIONAL TO BEING A LEADER

The research on leadership development has suggested that, instead of searching for leadership traits or practicing any preformed set of leadership skills, the focus should be on constructing lasting, internalized leader behaviors (Lord & Hall, 2005). According to Day and Harrison (2007), leader identity works in a spiral-like fashion. It promotes the pursuit of leadership challenges and possibilities to use leader skills, which in turn further develops leader competence and skills. Personal motivation and interest in leadership practices are seen as notable issues in leader identity development (Chan & Drasgow, 2001; DeRue & Ashford, 2010). Moreover, meta-analyses of leader identity have shown that, when a person experiences himself or herself as a leader, the motivation to lead and seek developmental opportunities is increased (Day & Harrison, 2007; Kark & van Dijk, 2007; Lord & Hall, 2005, see also Chan & Drasgow, 2001). Thus, by not constructing a leader identity, a healthcare professional in a leader position neither feels like a leader nor has the desire to engage in leadership.

A leader identity can be either enhanced or restricted by the social context of the healthcare work environment. According to DeRue and Ashford (2010), the mechanism is highly influential: The more an employee is collectively endorsed to be part of one group, whether as a leader, follower, or member of a particular professional group, the stronger and more stable the related identity becomes. When the professional identity of doctors and nurses precedes the situational need to form a healthcare leader identity, the doctor or nurse faces challenging dynamics. The strong, collective interpretation is to maintain professional identity in a leader position (Witman, Smid, Meurs, & Willems, 2011); the alternative is a personal motivation to engage in leadership. In a healthcare leader position, the experiencing self has to be attentively present if the dynamics appear to favor leader identity formation over maintaining the professional identity. Because endorsing an employee as a leader is important in the leader identity development process (DeRue & Ashford, 2010) an employee must have support in being a leader, if not from followers inside the profession, then, for example, from healthcare management.

As noted, certain features create gaps between the nurse and doctor professions. Similarly, gaps can also exist between leaders and professionals (Witman et al., 2011). Witman et al. (2011) noticed that doctor leaders face a challenging task to balance the distinct worlds of

their profession and healthcare leadership. According to their study (Witman et al., 2011), it is important for the staff to identify the doctor leader as either one of the leaders or one of us, that is, the medical staff. If not viewed as part of the medical staff, the doctor leader risks losing the power to influence colleagues, which rests on being perceived as a great doctor, but not as a leader.

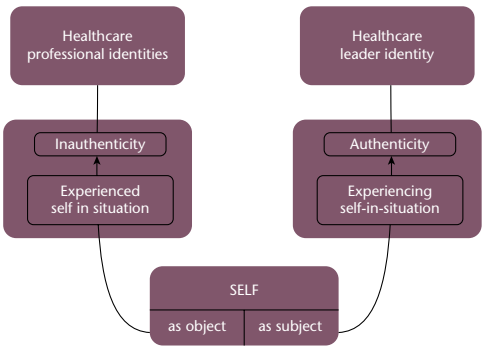
It is fair to expect that as a leader, a nurse or doctor should situate his or her profession within the healthcare organization not by highlighting professional differences but by identifying the importance of each profession and each individual. If the professional identity dominates over the leader position, identifying the significance of each profession and individual might be difficult.

Results

The aim of the current article was to explore the concept of existential–experiential authenticity in healthcare leader identity. The research objectives were twofold: (a) to identify how leader identity originates in the authenticity of an experiencing self; and (b) how healthcare leader identity formation is reflected by the healthcare professional identities. The focus was on the existential–experiential view of authenticity in leader identity, instead of the humanistic–positive interpretation of the AL construct. To accomplish the research objective, the concept of self was introduced and combined with the concepts of (in)authenticity, healthcare professional identity, and healthcare leader identity. The connections between the concepts in accomplishing the research task are presented in the conceptual framework of self-sourced (in)authentic healthcare identity formation as depicted in Figure 1.

In Figure 1, authenticity refers to the ontological existential–experiential phenomenon without any predefined content or components. To clarify the phenomenon of authenticity, the concepts of self as an object and self as a subject are distinguished. According to the conceptual framework, the potential variations in the content of authenticity in healthcare leader identity are infinite. Therefore, a leader identity labeled as authentic based on its content does not exist. The relations of the concepts presented in the framework are discussed next.

Figure 1. Conceptual Framework of Self-Sourced (In)Authentic Healthcare Identity Formation



Discussion

In the presented framework, authenticity is actualized in the leader's personal choices made in the presence of the experiencing self-in-situation, or, the self as subject. The self as a subject is a source of authenticity in all personally decided acts of leadership. A leader's authenticity and ability to make personal choices are mutually reinforcing. Authenticity is the source of personal choices, which make authenticity clearer to a leader. Authenticity, as sourced by the self as subject, is needed for a leader's decisions to be ontologically personal. Being present as a self-in-situation enables a leader to remain open to the beliefs, goals, and working practices valued by both healthcare professions and the majority of individual professionals. The same logic applies to being able to recognize the differences between both professions and professionals.

When considering the authenticity of the experienced self or self as an object (also referred to as the concept of self-identity), the answer is not as straightforward as for self-as-subject. It is evident that, even though the experienced self is inauthentic, the experiencing self remains in every situation the potential source of authenticity. The self as an object without the self as the subject does not exist ontologically. The (in)authenticity of the experienced self can be roughly assessed by its structure of meanings. The richer and more open and flexible the meaning structure of the experienced self-in-situation is, the greater the potential the experienced self offers for authentic healthcare

identity. In contrast, inauthenticity appears closed, unchanged, and a rigid structure of meanings.

In the conceptual framework, the role of (in)authenticity is crucial in healthcare identity formation. The distinction between professional and leader identities is useful in a healthcare setting because the formation of the two identities differs. The formation of the healthcare leader identity requires the presence of self-in-situation, which is grounded in the existential–experiential view of the self-sourced authenticity of identities. Thus, authenticity participates in identity formation as a leader experiences the daily work settings and avoids his or her self-reflective interpretations formed by personal and collective knowledge. The formation of healthcare professional identities shows that, without an existential orientation, the experiential view creates inauthenticity when the term "self-sourced" reflects the subject's detachment from the situation, not living-in-the-situation. This part of identity formation implies the influence of the given collective structure of meanings adopted by healthcare professions and various situations external to work settings.

The core of the conceptual framework is the dual understanding of the self as both subject and object. In the identity formation of leaders with a strong professional background, it is crucial that the objectifying act of self occurs. The vital distinction between professional identity and leader identity formations occurs when the objectifying acts take place. In professional identity formation, the self is objectified at the beginning, whereas in leader identity formation, objectifying acts take place later and concern the experiences formed in particular work situations by the self as subject. The formation of experiences in particular work situations becomes possible when a leader can be present in the work situations without perceiving himself or herself as some kind of leader. In the formation of leader identity, reflective self-interpretative acts occur after, not before, one gains personal experiences working as a leader.

In the professional identity formation, the content of the identity is defined from outside the person rather than by the person himself or herself. Tradition and education have created relatively strong views of what it means to be a doctor or nurse and how doctors and nurses are expected to behave as professionals. The professional identity of a doctor or nurse is not created mostly by himself or herself in the situations he or she operates at work. Instead, when acting as a nurse or as a doctor, the experiencing happens through already existing image of the self as a professional, and the self as object, which guides and restricts the experiencing by its content established by external sources. In addition to tradition and education, the external sources that form professional identities can be continuing education, major networks, stakeholders, and everyday working practices and routines. Consequently, different professional identities are relatively inaccessible to other groups, creating difficulties in achieving shared understanding. The more rigid and specific the contents of education, tradition, and other establishing features in a profession are, the less the experienced self is open to change, and the less authentic the related professional identity becomes. Therefore, although the professional identity is ontologically inauthentic because of its self-sourced nature as the self as an object, it can be evaluated empirically as more or less (in)authentic.

The presented framework is applicable not only to healthcare but also to other fields in which strong professional identities play significant roles in everyday work. The longer a profession has existed and the higher requirements for specialized knowledge in the profession, the more likely the evolution of a strong corresponding professional identity. In addition, professionals who work in a field of high expertise, even without a long professional tradition, are expected to have strong professional identities because of their special skills, knowledge, and work practices. For example, knowledge-intensive professions require specialized skills and knowledge in their area of expertise. Knowledge workers prefer autonomy, value their own knowledge, and do not like to be managed (Davenport, 2005). For example, lawyers, teachers, and social workers can be regarded as knowledge workers as well as healthcare professionals. The strength of a professional identity becomes clear when it faces expectations to change. New or changed expectations challenge the existing image of the self as a professional, that is, the professional identity. The key is to not reject new ideas, which are offered by the environment or colleagues, just because they are unfamiliar.

Existential–experiential authenticity in leadership should not be considered as a theory, a trend, or a set of certain kinds of behaviors. In essence, it is about being a human in the work environment and having the courage to trust one's own experiences even though they might be different from those of the majority. Questioning existing norms and actions happens by observing fresh approaches served by situations in which employees and leaders operate. Take, for example, a situation in which a leader seeks to develop the work climate. Instead of discovering developmental activities by using benchmarking, the authentic leader creates suitable developmental activities by sensing the work community's needs as such needs appear in interactions with employees.

Conclusion

The current article presents an existential–experiential conceptual framework to explore the ontological role of authenticity in the formation of leader identity in healthcare. The conceptual analysis has made the humanistic–positive approach utilized inmost research on the AL construct as complementary. The two perspectives, existential–experiential and humanistic–positive, are not contradictory but differ in the ontological preconditions given to the self as a source of authenticity. In the humanistic–positive perspective, the self is understood as essentially innate and good, whereas in the existential–experiential perspective, the self as subject is considered experiencing self-in-situation and the self as object is considered experienced self in situation. Despite the abundance of relatively solid empirical results related to the AL construct, there is a lack of empirical research clarifying and testing existentially oriented conceptual frameworks of authenticity in leader identity and professional identity formation. The existential–experiential ontological framework contributes to filling the gap in research on authenticity in leadership.

When authenticity exists in a leader position, regardless of the field of expertise, the leader can be present in-the-situation and, consequently, experience and act to achieve solutions without influence from environmental pressures. Especially in work settings where multiple professions work together toward the same goal, and the pressures leaders encounter are both hard and varied, the meaning of authenticity in leadership becomes vital.

The relevant question for organizations is how freely leaders can behave according to personal experiences that originate in experiencing self-in-situation. If that freedom is limited, fully authentic action is an ideal, not a realistic, aim. Even though the authentic acting would be limited by rules, norms, or pressures to behave as the organization and colleagues expect, limited authentic acting does not prevent authentic experiencing. When authenticity in leadership and the related leader identity is needed, the organization must be careful what kind of message it sends about leadership needs and expectations. If, for instance, the selection of leader trainees in an organization is based more on knowledge related to professions than leadership skills, the message to leader candidates is that the work context will remain generally the same and that there is no use in seeking to shift from a professional identity to a leader identity.

Authenticity appears only in the leader's acts as realized in the presence of the self-in-situation or self as subject. The self as subject is responsible for all experiencing, similar to a personal agent that performs conscious functions and thereby makes a person an existential–experiential creature. Every person remains potentially authentic throughout the life course and in every life setting because the self as subject remains intact to the end of the human life.

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