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Pepperdine University  
Graduate School of Education and Psychology

WOMEN LEADERS IN HEALTHCARE: GOING BEYOND THE GLASS CEILING

A dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Education in Organizational Leadership

by

Cortney Baker

December, 2015

Andrew Harvey, Ed.D. – Dissertation Chairperson

This dissertation, written by

Cortney Baker

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

Doctoral Committee:

Andrew Harvey, Ed.D., Chairperson

Kay Davis, Ed.D.

Kent Rhodes, Ed.D.

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## DEDICATION

I am incredibly thankful to everyone who has been on this journey with me. First of all I want to dedicate this dissertation and all that I have done and achieved in life to my family, starting with my mom, dad, June, Terry, and my extended family, all of whom have helped shape me on this journey. I also want to thank my loving and amazing family. I couldn't have done it without the love and support from Jason, my incredibly supportive husband, and our loving and accepting children Landon, Grace, and Reagan. Thank you for understanding that "mommy had to study" over the last few years. You are priceless and I cannot thank you enough.

But more than anything, I dedicate this final product to three people who have been such an impact in my life. First, and foremost, Jesus. Thank you for your saving power that has brought me back from the brink of a pulmonary embolism and a stroke that almost kept me from even beginning this doctoral journey. You have healed and restored, and to you I owe all the glory and honor.

Second, again, I want to thank and dedicate this to my incredible husband. You have been with me through so many trials and tribulations, and I can honestly say that I could not have done it without your love and support. I love you and the family that has been by my side every step of the way.

Last, I want to dedicate this final product to my sister who left to be in Heaven when I was 16 years old. Kim, you have shaped my journey and it has been hard to do it without you by my side. I love you and will see you again. But next time you had better be singing and dancing!



## ACKNOWLEDGMENTS

First, I want to acknowledge all of my Pepperdine Gap 2012 cohort members who have made this journey so memorable. You will always be so special to me and I am appreciative of the time that we spent together: learning and not so learning! Next I want to say thank you to the Pepperdine Gap 2014 cohort that embraced me during the semester that I had to repeat as a result of health conditions. Thank you all for being so open and receptive to the new kid on the block. Thank you, too, to the women that were part of this study. You were all so incredibly open, honest, and inspirational. I thank you for sharing your journeys with me.

Next, I want to say thank you to my doctoral committee that has helped me so much along this journey. My Chair, Dr. Harvey, thank you for always being so responsive to all of my emails and questions. You never let 24 hours go by without getting back to me. For that, among so many other things, I am eternally grateful. To Dr. Davis, who is without a doubt a qualitative guru, thank you for helping me along my journey when I needed your expertise and guidance. And, last but not least, thank you to Dr. Rhodes, my fellow Texan, for your commitment and assistance to seeing me through this process. I am so grateful to you all for the help, commitment, and support that I have gotten from you on this road. I know how busy you all are and I genuinely want to thank you for always putting your students' needs first. You are all amazing instructors and I am so grateful and honored to have had your help, guidance, and leadership.

## VITA

### Education

Doctor of Education in Organizational Leadership, Expected December 2015  
Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA

Master of Science in Communication Disorders and Sciences, 2001  
Southern Illinois University, Rehabilitation Institute, Carbondale, IL

Bachelor of Science in Communication Disorders and Sciences, 1999  
Southern Illinois University, Carbondale, IL

### Leadership Experience

Chief Executive Officer/Owner/Chairman of the Board

02/2003-Present

Therapy Management Service, dba KidsCare Therapy, Addison, TX

### Responsibilities

- Participate in the tactical and strategic planning for the organization
- Set and ensure strategy and vision of company is being communicated and implemented
- Envision company growth and determine goals to measure corporate progress and improvement
- Monitor and direct all corporate actions to ensure appropriate, legal, and ethical functioning of KidsCare Therapy staff and therapists.
- Ensure corporate compliance with all current policies and procedures, as regulated by the Texas Department of Aging and Disability Services (DADS).
- Ensure documentation of services is provided accurately, as regulated by KidsCare Therapy corporate policies and procedures
- Maintain and conduct bi-monthly meetings with the Board of Directors
- Use hiring trend data in establishing priorities and developing strategies and objectives
- Analyze patient satisfaction reports and documentation to determine goals and strategies for corporate direction
- Review and approve all KidsCare Therapy collateral, for marketing purposes and otherwise, to determine appropriate representation of the agency
- Develop and implement leadership curriculum and facilitate trainings and discussion groups for management personnel.
- Manage, guide and oversee
- Perform professional presentations for local and national conferences, as well as to senior staff and directors
- Work with legislators, Health and Human Services Committee, and key contacts to ensure continued funding exists for pediatric home health care in Texas
- Maintain continuing education qualifications to ensure compliance with Texas licensure as a Speech-Language Pathologist.

## **Accomplishments**

- Founded a 10 patient home healthcare company in Dallas, TX and grew organization into an enterprise that currently services over 1700 patients across the state of Texas
- Grew a \$15,000 investment into organization that has \$20 million/gross annual revenue
- Increased service line from providing speech therapy services to providing speech, physical, and occupational therapy services and case management
- Developed an organization committed to ethical service with 99% patient satisfaction rating
- Developed E-recruiting programs to reflect college programs and philosophy.
- Transformed formerly adverse office environment to one that is collaborative, friendly, and innovative.

## **Student Consultant**

Placencia Medical Center, Placencia, Belize 2014

## **Guest Instructor**

Southern Illinois University, Carbondale, IL

## **Volunteer**

Keck Medical Center of University of Southern California, Los Angeles, CA 2014

## **Affiliations**

Leadership Texas- 2014 graduate  
 American Speech-Language Hearing Association- member  
 Texas Speech-Language Hearing Association- member  
 Home Therapy Advocates for Kids- member  
 Texas Association for Home Care and Hospice- member  
 Open Table: bring those from poverty to wholeness- table member/mentor

## **Professional Development**

Myers Briggs Type Inventory (MBTI) Certified Practitioner 4/2015-Present  
 Myers Briggs

## **Honors and Accomplishments**

Texas Business Woman of the Year- Top 3 Finalist  
 International business consulting: China and Belize  
 Published author: Industrial and Commercial Training: Vol 46 No 6, 2014  
 Stereotyping and Women's Roles in Leadership Positions

## **Speaking Engagements: 2015**

Global Symposium on Women's Leadership: Riverside, CA (June 2015)  
 Women's Chamber of Commerce- Texas: Austin, TX (July 2015)  
 4th Annual Women's Leadership International Conference: Washington, DC (July 2015)  
 Entrepreneur Workshop: Dallas, TX (October 2015)  
 Leadership Launch: Dallas, TX (December 2015)

## ABSTRACT

Between 2004 and 2014, healthcare jobs were among the fastest growing occupations in the U.S, adding 4.3 million positions and expected job growth of 30.3%. The majority of the healthcare workforce is overwhelmingly dominated by women. However, when it comes to leadership positions, especially executive and board levels, females are considerably underrepresented. Interestingly, though, women, more than men, are reported to demonstrate traits such as transparency, compassion, and support for teamwork, which would benefit organizations as they venture into the future of healthcare delivery.

In recent years, women have made minimal entry into the highest ranks of managerial positions of healthcare in American corporations. The purpose of this phenomenological qualitative study was to identify experiences, barriers, and obstacles that women in healthcare organizations have overcome in their efforts to obtain successful leadership positions. Ten women in varying capacities of healthcare leadership positions from across the United States engaged in open-ended interviews to discuss what obstacles and adversities they have faced and conquered to advance to their levels of leadership. The data focused on career paths, obstacles, leadership qualities, demographics, and experiences. The participants identified their perceived leadership styles to be centered around the importance of communication and what they deemed soft skills, suggesting a different style from their male counterparts. The results of this study confirmed that even in the 21st century, career barriers such as family responsibilities, gender, lack of self-confidence, and current career challenges continue to exist for women seeking executive leadership positions in the healthcare field.

*Keywords:* women's leadership, healthcare, leadership barriers, obstacles

## **Chapter 1: The Problem**

### **Introduction to the Problem**

Women have made substantial progress in achieving leadership positions in today's business world. In fact, women in today's workforce account for more than 43% of all management occupations in the United States (U.S. Department of Labor, Bureau of Labor Statistics, 2015). However, when considering positions of the highest paid executives (such as chief executive officers, chief operating officers, board chairpersons, or presidents) of Fortune 500 companies, women only comprise 4.8% of those roles (Catalyst, 2014). As a result, it could be perceived that women are still navigating their way and attempting to succeed in a male-dominated world. The same holds true with regard to the healthcare industry—women continue to be the minority among executive level leadership roles (American College of Healthcare Executives [ACHE], 2012). As indicated by the statistics, women contribute to all levels of organizational profitability and productivity; however, only a small amount of them are employed in the top corporate positions (Carr, 2014).

Courageous women pioneers such as Marie Curie, Elisabeth Kubler-Ross, Dorothea Dix, and Florence Nightingale were innovative in transforming the field of healthcare. These women were able to respond to the most critical health dilemmas of their time with compassion, laying the foundation for 21st century models of care in the medical field (McDonagh & Paris, 2013). Consequently, because of their intrepid leadership and that of many other females, women presently occupy healthcare positions that are well beyond conventional roles of caretaker or clinician (Hoss, Bobrowski, McDonagh, & Paris, 2011).

Women have a pervasive presence in the healthcare industry, not only as consumers but also as a large majority of the labor pool as well. Women are often the volunteers and donors

who contribute to the enhancement of healthcare organizations. Moreover, they are consumers who have the authority to impact how care is provided; typically, women are the decision makers who provide guidance for their families' health care choices (McDonagh & Paris, 2013). In addition, women currently compose over 74% of the healthcare practitioners and technical occupations workforce. Over 90% of nurses and nurse practitioners are female, as are 36% of physicians, 65% of physician assistants, and 56% of pharmacists. However, the healthcare labor pool is not composed entirely of women; certain occupations are typically male-dominant, such as dentists, chiropractors, surgeons, and emergency medical technicians (U.S. Department of Labor, Bureau of Labor Statistics, 2015).

Evidence also supports the finding that women are necessary, highly productive leaders capable of producing high-caliber results (McKinsey & Company, 2015). In fact, a survey of over 7,200 leaders revealed that women in every position, from executive-level to front-line managers, were scored as better overall leaders when compared to their male peers (Zenger & Folkman, 2012). However, the current healthcare culture perpetuates a male leadership dynamic that is not supportive of women's advancement (McDonagh & Paris, 2013).

Despite the belief that women shattered the glass ceiling long ago, there is a noticeable absence of females among executive-level positions in healthcare organizations (McDonagh & Paris, 2013). A mere 11% of Chief Executive Officer (CEO) roles in healthcare are occupied by women: a percentage that has remained stable for decades (ACHE, 2012; Lantz, 2008). However, according to a 2012 study, a reported 37% of women healthcare executives aspired to be promoted to CEO positions in the following 15 years. The same study found that a total of 79% of women, as opposed to only 42% of men, agreed with attempts to increase the number of females that achieve executive-level healthcare positions (ACHE, 2012).

Healthcare institutions would benefit greatly from diversification of their top leadership talents to include contributions of women and clinicians (McDonagh & Paris, 2013), as the representation of women in executive-level management roles is inordinately low (ACHE, 2012). Benefits of executive-level healthcare teams that are inclusive of women include greater access to strategic, innovative thinking and a style that encompasses more female leadership characteristics (Barsh & Yee, 2015). Through greater inclusion of women, an added advantage could be greater access to the knowledge of clinicians, resulting in improved healthcare outcomes (Onie, Farmer, & Behforouz, 2012).

Every executive-level female in healthcare contributes her own unique set of characteristics, stories, experiences, and abilities to her organization. This dissertation presents the accounts of ten women who have beaten the odds and achieved executive-level success in the healthcare field and specifically identifies what obstacles they have worked to overcome in their career journeys. These women also identify what sort of leadership style they believe they demonstrate, how those styles have contributed to their success, and what lessons they have learned on their paths of career advancement.

### **Background of the Study**

The U.S. healthcare system is faced with many opportunities and some serious threats with regard to quality, access, cost, and infrastructure. The current U.S. healthcare system is in crisis, as it has been estimated by a variety of measures that the American health care system is the most expensive in the world (International Federation of Health Plans, 2012; Young, 2014). In comparison to other countries in 2012, the U.S. had the highest reported healthcare expenditure of its gross domestic product (GDP) than any other country (World Health Organization, 2015). Not only is the American healthcare system the most expensive, but also, in

a startling 2010 report that measured quality, equity, efficiency, access to care, and projected longevity, the healthcare system in the United States ranked surprisingly last in all areas assessed when compared to Britain, Canada, Germany, New Zealand, Australia, and the Netherlands (Fox, 2010). Times have changed drastically and leaders in healthcare are now required to play a more demanding and vital role (Porter-O'Grady, 2003). The insistence on unprecedented change and powerful leadership to navigate the much-needed transformation is strong and pervasive (Lantz, 2008). Furthermore, there is agreement that the clinicians and management staff should reflect the clinical needs and cultural variations of the gender and ethnic populations that they serve (Dreachslin, 2007)

In Gawande's (2010) *The Checklist Manifesto*, the journalist and surgeon argued that medical innovation is not so much about finding new interventions, but rather about properly executing the ones that currently exist. The idea is speculative, but if women and clinicians were included on the forefront of executive leadership teams that determine proper protocols, would their presence help to bring new clinical perspectives and transform the U.S. healthcare system? Along with questions of cost-containment and quality, it is time to take a more considerate regard to approaching gender disparity in the leadership administration of healthcare organizations (Lantz, 2008).

Women make up the majority of healthcare workers and are advancing into management positions in the healthcare industry. Women are currently achieving more access to positions of mid-level management and leadership, but only as a result of the sheer number of women contributing to the healthcare labor force (Neubert & Palmer, 2004). Although females compose the majority of the healthcare workforce, the industry continues to operate as a patriarchal system where male characteristics and values are normative (Sebrant, 1999). So, what



characteristics contribute to the success of women when attempting to climb the corporate ladder in a male-dominated work setting, such as the healthcare industry? What are some of the obstacles and experiences that these women have overcome to achieve executive-level success in healthcare? What makes these successful women different from other women who attempt to succeed, but do not? What are these women like? This study attempted to identify the answers to these questions through a qualitative, phenomenological analysis.

The research question in a qualitative study typically begins by asking *how* or *what* could be implied by the research findings (Creswell, 2014). The qualitative method of research is optimal for analyzing a topic in detail. For the purposes of this research study, it was deemed imperative that a qualitative, phenomenological approach be utilized to better understand the lived experiences of executive-level women in healthcare (Richards & Morse, 2013). Because there is a lack of executive-level females in the healthcare field, it is important to learn what characteristics make women successful from the ones who have succeeded. It is also important to identify the obstacles that they have overcome in their journeys and identify strategies that they used to excel despite those barriers. Phenomenology provided a lens with which to capture the women leaders' experiences, skills, characteristics, and stories. By conducting this analysis through the phenomenological lens, the researcher was able to study this population's stories and experiences, which are difficult to measure.

### **Problem Statement**

A recent study conducted by the ACHE (2012) confirmed two troublesome facts regarding the gender gap among healthcare management; not only does the disparity continue to exist, but also very little has been done to narrow the gap since 1990 when the first study on the subject was conducted. In fact, it was determined during the 2012 study that there was a

decrease, although minimal, in the number of females in comparison to males who obtained CEO positions within the study group since 2006, when the previous ACHE study was conducted.

In healthcare, as with the case of many other workforce sectors, a large proportion of male executives are employed in top-level roles, and many women work in middle management positions (Weil & Mattis, 2001). In both sectors, substantially more males than females have obtained positions in upper-management, but the proportionate amount of males in executive-level positions is greater in healthcare. Despite the fact that equal levels of experience and education were reported in 2011, women earned an average of approximately \$134,100 annually, whereas men reported an average annual earnings of \$166,900; hence, women reportedly earned \$32,800 less annually than their male counterparts, which is equivalent to 20% less (ACHE, 2012).

The conventional ladder of career advancement has not been favorable for women with regard to promotion and advancement. Eagly and Carli (2007a) described a maze of obstacles and the seemingly insurmountable task of overcoming all of these barriers in an effort to attain career growth. Although these obstacles vary by individuals and settings, they appear to fall into four distinct categories: (a) discrimination, bias, and prejudice; (b) resistance; (c) leadership styles; and (d) family responsibilities. Reportedly, women are often grounded in middle-management roles and find it difficult to get promoted to higher-level positions or to the executive suite (Hoss et al., 2011; Lantz, 2008). However, a limited number of women leaders in healthcare has overcome the odds, faced risks, accepted the challenges, and succeeded in making a significant impact.

The overarching intention of this study was to present the stories and experiences of 10 successful, executive-level women in healthcare positions throughout the United States, with

specific emphasis on what challenges and obstacles they have worked to overcome in their professional journeys. Other research has been conducted on women in business leadership, but these studies have not focused specifically on the field of healthcare. The findings from this study will contribute to the healthcare realm by potentially helping other women in the field identify tactics and strategies to conquer the barriers and limits that they may face.

The data identified in this study will likely result in the integration of awareness of the gender disparity that exists in healthcare. Examining the participants' experiences through a qualitative, phenomenological approach allowed each of the women leaders being studied an opportunity to assume the role of an expert regarding her own experience. The qualitative format allowed for an open dialogue, where the female executives were provided the chance to share their stories via open-ended responses.

### **Purpose**

The purpose of this qualitative phenomenological study was to identify the barriers, obstacles, personality characteristics, experiences, and leadership styles of women employed in executive-level leadership positions in healthcare organizations. As a result, this study will help identify the factors women have worked to overcome and how they handled such obstacles in order to achieve leadership positions within the healthcare industry. These findings can potentially encourage other women in the healthcare field to continue to work toward executive-level positions by demonstrating that these roles are obtainable. Consequently, this study will also present the lived experiences of women so that strength and courage can be drawn from their stories.

## Importance of the Study

Over the course of history, women have made the transition from the predominant roles of mother and homemaker to one where they have been integrated into the mainstream workforce (Fagenson, 1993; LaRosa, 1990). In 2013, nearly 67 million women were working in the U.S., equating to approximately 47% of the general workforce (U.S. Department of Labor, Bureau of Labor Statistics, 2015). However, in 2006, only 2% of women held CEO positions with *Fortune* 500 companies, and women's representation in these companies only increased by 0.7% between 2002 and 2005 (Catalyst, 2007). One can conclude that even though professional women in the workforce are at equivalent levels to men in mid-level management in many companies, women's advancement into senior executive roles has been disparate (Carli & Eagly, 2001; Catalyst, 2007; Heilman, 2001; Lantz, 2008)

Societal norms in the workplace, which have traditionally been regarded as masculine, contribute to and play a role in influencing a woman's career (Babcock & Laschever, 2007; Catalyst, 2007; Evans, 2000; Ridgeway, 2001; Sebrant, 1999). These male-dominated norms have resulted in the construction of barriers and a power imbalance for women when attempting to further their careers. Looking closely at this patriarchal authority is critical when analyzing how women have succeeded in overcoming these obstacles.

The underrepresentation of women in top-level positions is predominant across industries and occupations, regardless of the number of females that are employed in their companies' management roles (Catalyst, 2007; Goodman, Fields, & Blum, 2003). Despite the fact that previous research has investigated the relationship between women and leadership, minimal literature has discussed the characteristics of successful executive women among healthcare organizations. An analysis of the perspectives of women who have successfully climbed the

corporate ladder in the healthcare field may provide a new, broader understanding and perspective for women seeking equality within executive level healthcare positions. The information obtained in this study may provide education and encouragement for women so they can more closely identify and change workplace norms that challenge progression for females.

### **Research Questions**

This study explored the obstacles and experiences that successful executive-level women have overcome to advance their careers in the healthcare field. The research also investigated the leadership characteristics, traits, and experiences of females employed in executive-level leadership positions in the healthcare industry. The purpose of this qualitative phenomenological study was to address one central research question: What are the experiences that executive-level women have encountered during their career journeys in the healthcare industry? This research question was addressed through two sub-questions:

- RQ1. What obstacles, if any, have executive-level women encountered during their career journeys in the healthcare industry?
- RQ2. What leadership characteristics do executive-level women in healthcare organizations self-report that they demonstrate?

### **Operational Definitions**

Definitions of terms are provided in the study as the terms are introduced, and are also presented in this section. When definitions of terms are presented when they appear in the text, they become grounded in the literature (Moustakas, 1994). Definitions of terms used throughout this study include:

**Agentic:** This term denotes any self-directed action aimed at personal development or personally chosen goals (“Agentic,” n.d.). The focus on autonomy or self.

Agentic characteristics: Characteristics that are typically ascribed to male behaviors such as strategic decision making, delegating, disciplining, punishing, problem solving, self-confidence, aggression, and competitiveness (Eagly & Carli, 2007a).

Agentic perspective: The ability to demonstrate control over the quality and nature of one's own life through the aspects of self-regulation, forethought, intentionality, and self-reflection regarding one's functional capabilities and qualities, as well as the purpose and meaning of one's life pursuits (Bandura, 2001).

Bracketing: The removal of preconceived ideas or personal experiences as much as possible during the interview and data analyses processes. Bracketing is done with the researcher's intention to allow the essence of the experience to identify the data in pure form. (Creswell, 2013; Leedy & Ormrod, 2010)

Communal characteristics: Behavioral characteristics that are typically ascribed to female behaviors such as being understanding, helpful, recognizing and rewarding, supporting, communicating, and informing (Eagly & Carli, 2007a).

Double-bind:

(1) A psychological impasse created when contradictory demands are made of an individual... so that no matter which directive is followed, the response will be construed as incorrect. (2) A situation in which a person must choose between equally unsatisfactory alternatives; a punishing and inescapable dilemma. ("Double Bind," 2000, para. 1)

Gender: Identifying oneself through one's sexual identity, with relation to society or culture ("Gender [Sociology]," n.d.). Gender refers to social and psychological conceptions of

what it means to be a man or a woman and is a term used to explain one's beliefs about sex-based categories (Valian, 1999).

Gender roles: "The shared beliefs that apply to individuals on the basis of their socially identified sex" (Eagly & Johannesen-Schmidt, 2001, p. 783). Gender roles are ideas that define one's concepts of how women and men are expected to behave (Valian, 1999).

Gender-role spillover: Gender-role spillover occurs when gender-based expectations carry over into one's workplace expectations for behavior. The concept of gender spillover implies that gender roles may corrupt organizational roles to a varying degree, resulting in individuals having varying expectations for male and female leaders (Eagly & Johnson, 1990).

Gender schemas: Gender schemas refer to instinctive hypotheses regarding the traits, preferences, and behaviors of girls, boys, women, and men (Valian, 1999).

Glass ceiling: The concept of a glass ceiling indicates the invisible barriers that prevent able, willing, and ambitious women from rising to positions of authority in many organizations ("Glass Ceiling," n.d.).

Healthcare executive: A healthcare executive is a person employed by a healthcare organization whose primary job functions are to influence the strategies, development, growth, and operations of the organization. These positions must take part in the organizing, leading, planning, staffing, and controlling functions of the organization. Positions may include, but are not limited to, any C-suite executives (Chief Executive Officers [CEOs], Chief Financial Officers [CFOs], Chief Operating Officers [COOs], Chief Information Officers [CIOs], Chief Development Officers [CDOs], Chief Human Resource Officers [CHROs], Chief Medical Officers [CMOs], Chief Nursing Officers [CNOs], Chief Development Officers [CDOs], etc.),

Administrators, Executive Directors, or any specialty management positions of comparable authority (ACHE, 2015).

Open-ended questions: Open-ended questions are utilized during phenomenological research; the interviewer asks the interviewee a question, and the interviewee is able to respond as he/she likes. Open-ended questions are also referred to as open, unstructured, or qualitative questions.

Phenomenology: Phenomenology refers to the study of structures of various types of consciousness as they have been lived from the view of the first person. These may include experiences such as perception, memory, thought, emotion, imagination, social activity, or desire (“Phenomenology,” n.d.). It is a philosophical approach to research where life experiences are studied. In a phenomenological study, those that are being observed are at the center of the research and use their own voices to relay their experiences in life (Creswell, 2014; Moustakas, 1994). From the perspective of a phenomenological approach, a reflective and descriptive experience may be elicited from the interviewee (Richards & Morse, 2013).

Qualitative research: The qualitative approach to research generally considers words and stories rather than numerical data. Qualitative research is concerned with answering *how* and *why* questions. This approach is different from quantitative research, which typically answers *what*, *where*, and *when* questions (Butin, 2010).

Stereotypes: Stereotypes are often oversimplified, rigid, exaggerated beliefs that are applied to either individuals or entire social categories of people. Stereotypes form the foundation of prejudice, which is then utilized as a justification for attitudes, beliefs, and discrimination (Crossman, 2015).



## **Limitations and Delimitations**

This study consisted of a select group of 10 females that currently hold an executive-level leadership position (CEO, COO, CFO, CIO, CHRO, CMO, CNO, CDO, Partner, Senior Vice President, Vice President, Administrator, or Executive Director roles) within an organization that supports the healthcare industry. It was required that these females have been employed in an executive-level position for a minimum of 3 years prior to the onset of this study. The sample was delimited to the United States. The tool of this study consisted of face-to-face or telephone interviews that were all audio recorded. A major delimitation of this analysis is that traits of executive-level male leaders were not being studied at this time. Another delimitation of this study was that all of the female participants described their ethnicity as White and/or Caucasian. As a result, it is not specified whether the traits and obstacles identified were solely specific to female executive-level leaders or all executive-level leaders in healthcare, regardless of gender or ethnicity.

The researcher's experiences in an executive-level position in healthcare may have had the potential to bring a bias to the qualitative research being examined. However, the researcher's background with regard to the process of interviewing, data collection, and qualitative analysis, as well as the interviewer's familiarity with executive-level healthcare professionals, should alleviate researcher bias or considerations related to the study.

Although studies of this nature have been conducted previously, it is the opinion of the researcher that they were limited to explorations of racial differences (Barone, 2012; Carr, 2014). The current study was open to considering women of various races throughout Texas, Oklahoma, Virginia, and California and was not limited to age, race, nationality, religion, or any other

factors that may hold back qualified contenders who have achieved executive-level leadership success.

### **Assumptions of the Study**

Six assumptions were made in this study. These were: (a) participants' descriptions of their experiences were honest and genuine; (b) the researcher would not allow any suggestive bias regarding or influence on the responses of the participants; (c) that, as a result of the literature review, gender would reportedly be a significant inhibitor to the career advancement of the participants; (d) the reporting of the stories and lived experiences of a representative sample of 10 women employed in executive-level positions in healthcare would contribute to a growing body of knowledge regarding the topic; (e) the participants, although from various backgrounds, would share enough commonalities on their journeys to justify this study; and (f) this study is verifiable and repeatable.

### **Organization of the Study**

This study comprises five chapters. The first chapter provides an introduction to the study and identifies the importance of the investigation. The first chapter also includes the background, operational definitions, assumptions, research questions, limitations, and delimitations of the study.

Chapter 2 contains a literature review, providing the reader with background information related to gender diversity in the field of healthcare in the United States, with particular emphasis on the journey that women have encountered regarding obstacles in the workplace. Chapter 2 also explores the theoretical framework for the study. The review also provides a detailed description of gender and leadership characteristics, concepts, and a focus on current leadership theories and models.

Chapter 3 presents the study's methodology and provides an overview of the research design. Chapter 3 also describes how interviews were conducted and how they corresponded to the research questions. Chapter 4 presents the research data, a review of the findings, and an analysis of the material. Chapter 5 contains the conclusion, recommendations, implications of the study, and future research considerations.

### **Summary**

In the introductory chapter, the researcher discussed that although women compose nearly half of the United States' workforce, gender inequality continues to exist with regard to women occupying the positions in the top echelon of organizations. This disparity also continues to exist in the field of healthcare, where 74% of the labor force is female. The researcher presented a brief review of the current research that has been conducted with regard to the gender gap differences that exist among healthcare executives.

This study reviewed the personal and workplace obstacles that 10 executive-level women have overcome on their career journeys. The experiences and characteristics of these successful executive women in healthcare organizations are presented.

## **Chapter 2: Literature Review**

### **Introduction to and Organization of the Chapter**

The objective of this qualitative, phenomenological study was to identify obstacles that 10 successful, executive-level women in healthcare have overcome in their leadership journeys. There is substantial research available discussing women and the gender disparity that exists in the business world; however, the research is sparse when it comes specifically to women in executive-level leadership roles in the healthcare industry.

In an effort to obtain a thorough understanding of the problem and importance of this study, the history of women's journey in the workplace will be discussed first. Next, the current literature regarding gender and leadership characteristics will be reviewed. Then, the theoretical framework that has been applied to this study will be presented. Fourth, leading theories of leadership will be reviewed, followed by a discussion of implications for women in leadership. Last, the implications for women in leadership positions in healthcare will be reviewed.

### **Women in the U.S. Workforce: The Journey**

The workforce is a vital industry that brings together the impact of all social, political, historical, and demographic forces that collectively affect a population (Toossi, 2002). A strong, growing workforce is a primary contributor to the economic growth and prosperity of any nation. The story of the changes in the labor force in the U.S. demonstrates dramatic change.

The number of women in the United States' paid workforce has been steadily increasing since the early 1800s, with a rapid increase occurring after the time of World War II. In 1900, fewer than two in 10 workers were female (Goldin, 1990). However, during the time of World War II, widespread enlistment of men in the armed forces left massive holes in the industrial work force. As a result, women were required to fill those holes. In just 5 short years, between

1940 and 1945, the labor force in America grew from being 27% female to almost 37% female. By the year 1945, nearly one in four married women was employed outside of the home (History Channel, n.d.).

In the 1920s, women in the U.S. were granted the right to vote; in 1972, Title IX of the Education Amendment barred sex discrimination in education programs for entities receiving federal assistance. Despite the fact that educational opportunities had improved, employment and career choices were still restricted by gender. The transformation of women's employment happened in various phases. Until 1920, the expansion occurred only in single women's employment. From the 1920s until the 1940s, married women's paid employment rose slowly, but accelerated after World War II. Households with single income earners continued to be the norm during the 1960s, with the division of labor dictating that women should be homemakers and men should be the breadwinners of the family (Goldin, 1990).

The number of females in the workforce in America has grown at an incredibly rapid pace since the time of World War II, and today nearly 50% of the workforce is composed of female laborers. The increase in the number of females in the workforce for the last 2 centuries has been the direct result of economic changes such as the Industrial Revolution, the increase in white-collar employment, education advancements, the shortened workday, and declines in fertility rates (Goldin, 1990). Although women progressed in many new career paths throughout the 1970s and 1980s, leadership in employment settings continued to be dominated primarily by men. Even with the career advancements of 1980s-era executives, access to top-level employment positions seemed to be just out of reach for women (Eagly & Carli, 2007b).

An article published in the 1986 *Wall Street Journal* gave an answer as to why top-level positions seemed explicitly denied to women. This phenomenon was termed the *glass ceiling*

(Hymowitz & Schellhardt, 1986). The glass ceiling concept was created to describe the invisible and factitious limits established in the business world that have prevented women from obtaining promotions to high leadership positions as well as upper management. In terms of climbing the corporate ladder into higher-level leadership roles, the ceiling indicates that a barrier exists and stands in the way of how high someone can climb before bumping into an obstacle of some type. To describe the ceiling as glass indicates that the obstacle is transparent, yet not apparent to the observer, although it is very real. It also signifies that what is seen on the opposite side is evident but inaccessible to those looking through it. The concept of a *glass ceiling* is most often used in business environments where it is believed, whether rightly or not, that White men are firmly established in the upper ranks of an organization's hierarchical power and that breaking through to that level is nearly impossible for minorities or women (Boyd, 2012).

In 1991 the U.S Department of Labor (DOL) formally addressed the problem, stating that the glass ceiling indeed existed and was composed of barriers that were founded on attitudinal or organizational bias, barring capable individuals from promotions into positions of management. As part of Title II of the Civil Rights Act of 1991, Senator Bob Dole introduced the Glass Ceiling Act. The Civil Rights Act of 1991 was signed by President George H.W. Bush, which created the Glass Ceiling Commission to study the phenomenon experienced by women. The 21-member bipartisan, multi-ethnic, gender-diverse commission was responsible for creating recommendations on the issue for leaders of the business world as well as the government (U.S. Glass Ceiling Commission, 1995).

The commission released their report in 1995, confirming the presence of the invisible, very real obstacles that prevented qualified minorities and women from advancing through the ranks of organizations to achieve top executive-level positions. The chairperson for the Glass

Ceiling Commission, Robert Reich, reported that this invisible ceiling was not only a social injustice for a great amount of the working population, but also indicative of a problem that affected American businesses by keeping some of the most talented and qualified applicants from top-level roles solely because of their race or gender (U.S. Glass Ceiling Commission, 1995).

The report disclosed that, at the time, women composed nearly 46% of the total labor force and were obtaining over half of all master's degrees. However, 95% of top-level senior managers were men, and the female managers' salaries equated to less than 70% of their male peers' wages. Nonetheless, the report found that serious obstacles to promotions remained, "such as persistent stereotyping, erroneous beliefs that 'no qualified women or minorities are out there', and plain old fear of change" (U.S. Glass Ceiling Commission, 1995, p. v). Central to these beliefs was the perception that it would be too uncertain to invest in a female to do the job for fear that she would quit working when it came time to raise a family. As one executive told the commission, "As long as I can get a satisfactory man who will work full-time for life (and I assume as much for all men), I'll take him every day of the week over a much better woman," (Schwartz & Zimmerman, 1992, p. 17). In the mid-1990s and 2000s, the barriers and methods of exclusion slowly began to change, as women began to be more accepted in positions of higher authority—just not those at the highest level (Eagly & Carli, 2007b).

## **Overview of Gender**

Women activists from as far back as the 1800s, such as Susan B. Anthony and Elizabeth Cady Stanton, helped pave the way for labor efforts aimed at securing women's rights, such as the creation of the Women's Trade Union League (WTUL). In 1903 the WTUL was formed as a result of a meeting with the American Federation of Labor (AFL), when it became apparent to them that the AFL had no desire to include women in the organization. From the inception of the

WTUL, the organization's agenda was to improve working conditions while also providing working women with educational opportunities. The organization was able to achieve its greatest successes from 1907 to 1922, when it fought for an established minimum wage, an 8-hour workday, the abolition of child labor, and an end to night work for women ("Women's Trade Union League [WTUL]," n.d.). Today, women in corporate America reap the benefits for which these pioneers fought because fewer barriers exist in social and work roles. However, even though much progress has been made, barriers continue to exist for women in the workplace.

The terms *boy/girl*, *male/female*, and *man/woman* clarify people's identities based on their reproductive capabilities; however, these terms should not imply that the personal characteristics of that specific group are due to their biological capabilities (Valian, 1999). The term *sex difference* should be utilized to refer to the difference directly linked to reproductive or chromosomal status. The term *gender*, however, was passed down through writings to demonstrate the differences in power and circumstance between men and women (Fawcett, Featherstone, Fook, & Rossiter, 2000; Fenstermaker & West, 2002; Gherardi, 2003).

Gherardi (2003) referred to gender as "the ways in which human beings present themselves, self-represent themselves, and are perceived by society; as a relational concept subsumed by a dyadic code that entails constant relation and tension" (p. 212). Gender is a tool that presents the cultural and social realities of women's historical experiences (Gherardi, 2003). Fenstermaker and West (2002) described gender as:

an individual involved in virtually any course of action may be held accountable for her or his execution of that action as a woman or a man. Membership in one or the other sex category can afford a means of legitimating or discrediting one's other actions or any pursuit can be evaluated in relation to its womanly or manly nature. (p. 29)



As a result, gender differences are typically identified through the lenses of (a) anatomy, (b) cultural-social-political perceptions, and (c) the language-writings-systems of each sex (Gherardi, 2003). Expectations of gender and anticipated behaviors of each sex are programmed early in life, as early as kindergarten, and stem from the beliefs of society and parents (Babcock & Laschever, 2007; Valian, 1999).

### **Gender and Leadership Characteristics**

The division of labor based on sexual differences is one example of a social phenomenon (Valian, 1999). Most industrialized countries have workforces that are divided and sectioned according to gender. Men are often predominantly employed in the technical fields, natural sciences, mathematics, trade and administration fields (skilled workers), national defense, etc., whereas women play a dominant role in the health and service sectors, teaching, and retail trade markets (Due Billing & Alvesson, 1993). The division of gender in labor must be explored in relation to the selection of profession and education, and cannot be seen in isolation. There are definite, distinct differences between genders, but biological differences should not control one's destiny. However, neither should the social environment. Neither variable exists in isolation to determine one's behavior; instead, they both work together to influence it (Valian, 1999).

Many theories have been formulated to attempt to explain the variances in roles of men and women in the workforce and the perceived domination of men over women (Due Billing & Alvesson, 1993). The attempt to assign specific, defined leadership characteristics to each gender has also been an ongoing debate among researchers for many years. Some research suggests that there are particular leadership differences between the genders with regard to characteristics, traits, styles, and behaviors. Others believe that there are no set characteristics that tie directly to leadership characteristics, capabilities, and gender.

Gender stereotypes are commonly held beliefs about the characteristics of women and men, prescribe how both genders should act, and are pervasive, thoroughly documented, and nearly impossible to change (Hoyt & Johnson, 2011). Gender stereotypes center around physical characteristics, role behaviors, job positions, and personality traits, specifically, communal and agentic traits (Deaux & Lewis, 1984; Eagly, Wood, & Johannesen-Schmidt, 2004; Hoyt & Johnson, 2011). Valian's (1999) work posited that gender norms were created around reproductive qualities, tying the division of labor to gender standards and expectations. These perceived traits and standards of gender norms perpetuate the continuation of differing ways of treating men and women in the workplace.

It is this study's purpose to present both sides of the argument of whether men's and women's leadership behaviors and characteristics are similar or different, and provide evidence of how each view has the ability to affect females in their leadership advancement. The author made no attempt to choose one belief over the other, but rather strove to present a description of how each view has the potential to impact women's leadership journeys. However, it is important to note that gender roles are closely linked to gender stereotypes, which are the consensual expectations of behavior as identified by an individual's sex (Hoyt & Johnson, 2011).

**Reasons to expect gender differences exist in leadership.** Throughout the systematic study of neuroscience, the scientific community has expressed great interest in determining the differences between the brains of females and males, as well as identifying other psychological and behavioral implications thereof (Hardies, 2011). The viewpoint that psychological gender differences exist between females and males is the dominant theme that persists in the popular media (Hyde, 2005). The 1992 book *Men Are From Mars, Women Are From Venus*, which asserted that a great many psychological differences exist between males and females, became

one of the best-selling books of the 1990s and earned the author the title of leading relationship expert in the world (Gray, n.d.). A great number of researchers and writers claim that clear differences exist between males and females' styles and behaviors. Women are generally attributed with demonstrating communal qualities, which are identified as showing concern for other people, nurturance, sensitivity to others, warmth, and helpfulness (Deaux & Kite, 1993; Heilman, 2001). Men, in contrast, are stereotypically defined as having agentic characteristics, demonstrating such traits as independence, confidence, assertiveness, and rationality (Deaux & Kite, 1993; Heilman, 2001; Hoyt & Johnson, 2011). As a result, it is more accepted socially for women to display the emotion of sadness than it is for a man, and it is more accepted socially for men to demonstrate feelings of anger than it is for women (Plant, Hyde, Keltner, & Devine, 2000).

The same researchers who believe that these differences in characteristics, behaviors, and traits exist between genders also believe these differences are reflected in the management and leadership styles demonstrated by men and women. Whether or not women and men operate differently in positions of leadership is a topic that brings much debate. As females are increasingly obtaining leadership roles that men have traditionally occupied, the possibility that female leadership behaviors are different than males continues to draw attention. Although general consensus acknowledges that women encounter more obstacles in achieving leadership roles than men, especially for male-dominated leadership roles, there appears to be much more disagreement about the behavior of men and women once they obtain such positions (Eagly & Johannesen-Schmidt, 2001). So what exactly are these gender differences in leadership styles?

Aspects of gender roles and positions that are applicable to leadership, again, refer to behavioral attributes that are deemed as either agentic or communal qualities. Agentic leadership

characteristics, which are commonly attributed to males, chiefly describe controlling behaviors that can be explained in such terms as ambitious, dominant, aggressive, competitive, daring, independent, and self-confident. In an employment environment, someone displaying agentic behaviors may speak assertively, actively influence others, compete for attention, initiate activity that is directly related to assigned tasks, and make problem-focused suggestions. Communal attributes, typically associated with women, are primarily focused on the well-being of others. Some of these attributes can be described as affectionate, gentle, helpful, kind, nurturing, sensitive, and sympathetic. In an employment setting, communal behaviors may include characteristics such as speaking tentatively, accepting the direction of others, showing support for or soothing others, and helping to resolve relational or interpersonal dilemmas (Eagly & Johannesen-Schmidt, 2001).

Several theories support the rationale for why differences exist between female and male leaders, even for those leaders who occupy lateral organizational positions. One such theory acknowledges the possibility of gender differences that are ingrained in behavioral tendencies and personality characteristics, which are variations that are validated by socialization or organizational selection (Eagly & Johannesen-Schmidt, 2001). Another theory that supports the differences between gender behaviors in leadership emphasizes the importance of childhood occurrences of sex-segregated playgroups, where boys and girls use different methods of interacting with and influencing one another (Maccoby, 1988). This theory postulates that the differences between female and male minds—which are the sources of feelings, thoughts, behavior, and abilities—can only be understood when one considers a person's socio-cultural context (Hardies, 2011). Consequently, it is conceivable that sex-differentiated previous experiences as well as biological sex differences result in women and men being thought of as

different behavioral types of people, despite the fact that they are occupying the same managerial position.

**Reasons to expect that genders are similar in leadership.** Although identifying and describing psychological gender differences began around 1879 with the beginning of formalized psychology (Shields, 1975), a handful of researchers were busy considering the possibility that the genders had more similarities instead (Hyde, 2005). Thorndike (1914) held the belief that psychological gender differences were too insignificant to be deemed of any importance. Hollingworth (1918) found little evidence of differences between genders after conducting a review of the available research. After reviewing the data and considering the scientists' views, Woolley (1914) stated:

The general discussion of the psychology of sex, whether by psychologists or by sociologists show such a wide diversity of points of view that one feels that the truest thing to be said at present is that scientific evidence plays very little part in producing convictions. (p. 372)

Currently, social scientists typically claim that no reliable differences exist in the debate over gender and leadership characteristics (Eagly & Johnson, 1990). Thorough research conducted by others has drawn similar conclusions (Due Billing & Alvesson, 1993; Hyde, 2005). A study conducted by Bartol (1978) examined gender differences in leadership and concluded, "In most cases, there are either no differences or relatively minor differences between male and female leaders on leadership style, whether the leaders are describing themselves or being described by their subordinates" (p. 806). Another study conducted in 1988 reached the following conclusion with regard to whether or not male and female managers differ; "they differ in some ways and at some times, but for the most part, they do not differ" (Powell, 1998, p. 165).

Valian (1999) stated that everyone has both masculine and feminine traits to some degree and people demonstrate different traits depending upon the situation at hand.

In the groundbreaking book, *The Psychology of Sex Differences*, Maccoby and Jacklin (1974) performed a meta-analysis that examined more than 2,000 studies of differences in gender over the domains such as abilities, personality, memory, and social behaviors. According to their findings, many unpopular beliefs of psychological gender differences were dismissed as unsubstantiated, such as the belief that girls were deemed more socially interactive than boys, that girls' self-esteem is lower than boys', that boys were considered better at higher-level thinking and processing, that girls excel more at simple and rote tasks, and that girls are not motivated to achieve. Maccoby and Jacklin's research verified that gender differences existed only in the areas of verbal ability, mathematics, visual-spatial ability, and aggression. In general, their research found substantial evidence for similarities between genders (Hyde, 2005).

Once Hyde conducted another thorough meta-analysis of differences among gender in 2005, she developed the *Gender Similarities Hypothesis* based on the results of her findings; these findings result in a stark contrast to the theory that claims psychological differences exist between genders. Hyde's results concluded that 78% of all differences in gender fell in the minimal or close to zero range, with only the exception of motor performance. As a result, she concluded that the inflation of psychological differences between genders has more serious repercussions than academic matters; these overinflated claims actually affect men and women alike in areas such as parenting, work, and relationships. It is easy to forget the fact that although differences in gender do exist between the sexes, albeit minimal, they are in fact more similar to each other than they are different (Valian, 1999).

Various theories have attempted to explain when variations between female and male managers are not found to exist. The first, and most apparent, is that real differences are not substantial (Due Billing & Alvesson, 1993). The lack of differences has also often been attributed to the fact that men have been in these leadership roles for a long period of time; therefore, they have defined the behaviors and styles to which people have adapted, and it is assumed that women have nothing exclusive or different to contribute (Due Billing & Alvesson, 1993; Eagly & Johannesen-Schmidt, 2001). A third reason that could be attributed to the similarities between genders' leadership styles is because attitudes and behaviors are framed and questioned in ways that do not specifically capture the female outlook (Due Billing & Alvesson, 1993).

### **The Glass Ceiling versus the Labyrinth**

The term *glass ceiling* suggests that invisible factors (as opposed to overt discrimination) are responsible for keeping women from making their way to the upper echelons of the corporate ladder. Ceiling is a term that denotes permanence, as a ceiling is unlikely to disappear. Therefore, it is assumed that these invisible factors will not vanish magically, either. The term glass ceiling also suggests that a woman's employment accomplishments are equal to or greater than her male peers' accomplishments (Valian, 1999). Despite one's competence, the implied ceiling is a barrier that intentionally bars women from career advancement. These unseen obstacles will not cease to exist on their own. Any objective differences in a woman's career performance are not enough to explain the differential in promotion rates, rank, or compensation rates that women experience as a gender group.

In a 2004 *Wall Street Journal* article, a special follow up to the original *glass ceiling* article, was printed. "Through the Glass Ceiling" was published and written by the lead journalist

who had introduced the metaphor of the glass ceiling in 1986. The article was written about women who were quickly rising or those who had succeeded in making it to the top of their industry. The front page contained 50 women's smiling faces, but the article did not describe one woman who was struggling in or frustrated by not being able to make it to the top of her organization or industry. Instead, the article presented a clear message that the glass ceiling and barriers that accompanied it were things of the past. The article implied that the barrier had seemingly been broken (Hymowitz, 2004).

However, this was not the case. The situation had morphed from women not being able to obtain advanced employment positions to one where women were not able to obtain roles in the upper echelons of organizations. Even with continuous change for the better, the obstacles that women have faced have only become surmountable by some women, some of the time; some women have been able to achieve the paths to the top of the career hierarchy. These routes, albeit sometimes cumbersome and subtle while other times blatantly obvious, can often contain numerous barriers (Eagly & Carli, 2007b). Belief in the existence of the glass ceiling as a deterrent that keeps women out of positions of upper authority now strikes most employers as unfair; the barriers that women face are no longer absolute. The metaphor of the glass ceiling and its applicability to women in the workforce today has fallen short in multiple areas.

### **Theoretical Framework**

While there is no theoretical framework that applies directly to this study of women in executive-leadership positions in healthcare, Eagly and Carli's (2007a) framework was utilized to identify and describe the four main obstacles that women face in the workplace. In comparison to the glass ceiling theory that describes an artificial, invisible barrier that keeps women from upper-level advancement, Eagly and Carli's works have identified four distinct, pronounced



barriers (referred to as the *labyrinth*) that women must overcome to successfully climb the corporate ladder. The metaphor of the labyrinth symbolizes the complex causes of women's current circumstances as leaders. The barriers are classified as: (a) discrimination, bias, and prejudice; (b) resistance; (c) leadership style; and (d) family responsibility.

**Discrimination, bias, and prejudice.** The first barrier identified describes the discrimination, bias, and prejudice that women face in the workplace (Eagly & Johannesen-Schmidt, 2001; Eagly & Karau, 2002; Hoyt, 2013). Women have been able to achieve most leadership positions that are either lower- or mid-level, and some have successfully navigated their way to the top levels of organizations. However, although opportunities have expanded for women in recent years, it continues to remain uncommon to see women in higher-level positions (Eagly & Carli, 2007a).

Most of the progressive steps toward chief executive positions were closed to women until federal legislation was passed in the 1960s. Prior to that time, sex-based discrimination was not only deemed acceptable, but also incorporated into the legal code. After the passing of the Title VII of the Civil Rights Act of 1964, women's opportunities expanded as employment discrimination based on race, sex, national origin, color, and religion became illegal (U.S. Equal Employment Opportunity Commission, n.d.). Despite the passing of the law, compliance did not happen instantly. Although some organizations opened positions to women voluntarily, others only complied when they were challenged with legal action (Valian, 1999).

The landmark legislation of the Civil Rights Act of 1964 was passed over 50 years ago. As a result, discrimination in the U.S. should be a memory of the past. However, the support for equal opportunity may waver when it comes to women gaining equal access to authority, pay, and power in the workforce (Eagly & Carli, 2007a).

Discrimination and workplace bias influence the evaluation of women's job performance as well as career placement (Ayman, Korabik, & Morris, 2009). Discrimination occurs when women who have equivalent qualifications as their male peers are offered and receive fewer leadership opportunities. This bias pertains particularly to the expectation that women should demonstrate perceived male behaviors and characteristics. As a result, this bias can lead to potential discrimination regarding the perception of women's performance and leadership selection (Ayman et al., 2009; Eagly & Johannesen-Schmidt, 2001).

In an effort to provide strong tests of discrimination, social scientists have conducted studies of men and women with equal qualifications to determine how they fare in obtaining employment, earning promotions, and receiving compensation (Eagly & Carli, 2007a). According to a study conducted in 2012 by the U.S. Bureau of Labor Statistics, women who were employed either salaried or full-time in the U.S. in 2012 reportedly earned an average of approximately 81% of the median earnings that men reported. According to the same study, in 2012, women across all races received compensation that was less than that received by males of their same race. Of women who were employed in fields of business, management, and financial operations positions, those who were chief executives reported median weekly earnings of \$1,730, whereas men employed in these roles reported median weekly earnings of \$2,275: a difference of \$545 weekly, equating to \$28,340 difference in annual compensation, or roughly 24% less (U.S. Census Bureau for the U.S. Bureau of Labor Statistics, 2013). The fact that a wage gap exists implies that discrimination affects compensation.

Prejudice has the potential to emerge when perceptions held concerning a group in society that come into conflict with attributes that are necessary for success in specific classes of social roles (Eagly & Karau, 2002). Individuals are typically classified according to gender first,

resulting in a group of characteristics and traits being associated with that person. Understanding how people arrive at these perceptions requires an understanding of the psychology of prejudice. Because it appears that few people in the U.S. intend to discriminate knowingly and blatantly, the psychology of prejudice is subtle (Eagly & Carli, 2007a). However, prejudice and bias still exist, as the connection between characteristics, traits, and gender is the foundation for placement in a job, division of labor, and evaluation of performance (Catalyst, 2007; Eagly & Karau, 2002; Heilman, 2001).

It has been well established that women as a group earn lower wages and slower promotions than their male counterparts (Casserly, 2013; Eagly & Karau, 2002). In fact, in a study conducted by the U.S. Census Bureau (as cited in Casserly, 2013) found that in every single state in the United States, women earned lower overall hourly compensation than men. For over a decade, the comparison of average of full-time employed men's wages and women's earnings has demonstrated that women continue to nationally earn a range of 64-85 cents on the dollar (or an average of 77 cents on the dollar) when compared against the earnings of Caucasian men.

The attitudes that govern prejudiced beliefs toward women leaders are directed by unconscious and conscious mental views regarding men, women, and leaders. Individuals typically correlate different traits and characteristics with women and men, and men are more often linked to traits that connote leadership (Eagly & Johannesen-Schmidt, 2001). Prejudiced actions, thoughts, and behaviors toward women leaders come from the contradictory beliefs that women demonstrate characteristics that are typically considered communal and leadership roles require more agentic qualities (Eagly & Karau, 2002).

Communal associations convey a concern with the compassionate treatment of others. Women elicit communal associations of being especially affectionate, helpful, friendly, kind, and sympathetic as well as interpersonally sensitive, gentle, and soft-spoken. In contrast, agentic associations convey assertion and control. Men elicit agentic associations of being especially aggressive, ambitious, dominant, self-confident, and forceful as well as self-reliant and individualistic. (Eagly & Carli, 2007a, p. 86)

These associations of gender with specific qualities form the foundation of stereotypes (Catalyst, 2005). The prejudice, bias, and discriminatory practices that are typically associated with executive-level female leaders are generally linked to a structure of stereotypical beliefs regarding differences between women and men. Many studies have validated the assertion that perceived masculine characteristics and traits are more often linked to leadership than traits that are considered feminine (Eagly & Carli, 2007a; Eagly & Karau, 2002; Valian, 1999).

Women in employment settings who demonstrate agentic qualities face a catch-22. If they demonstrate characteristics that make them appear qualified for roles in leadership, they achieve competence ratings on performance reviews that are equal to those of agentic men; however, these women suffer social repercussions and backlash (Rudman & Glick, 2001). Particularly, women who are agentic are considered socially deficient in comparison with men. This perpetuation of prejudice beliefs has the capacity to result in discrimination in hiring as well as promotions for women (Rudman, 1998).

**Resistance.** Because gender is the first feature that others notice about an individual, that identification automatically results in tying preconceived ideas, or stereotypes, to that person. These stereotypes and the resulting prejudice add to workplace discrimination for women.

Consequently, people's stereotypes regarding women and leaders result in resistance to women leaders by making contradictory demands of women (Valian, 1999).

Female leaders are supposed to fulfill the female gender role of being nurturing, selfless, and warm while also fulfilling the leadership role by demonstrating competence, assertiveness, and dominance. If women leaders demonstrate communal characteristics then questions are often raised about their leadership competence. Female leaders that typically demonstrate communal characteristics may be judged as not being agentic enough. However, female leaders who demonstrate largely agentic qualities may receive disapproval for lacking characteristics and qualities that are considered communal. As a result of these competing demands, women often feel the need to outperform men in an effort to be viewed as equally competent (Eagly & Carli, 2007a).

Female leaders face a dilemma, or what researchers have referred to as a *double bind* (Catalyst, 2007). Female gender roles dictate that women are supposed to behave in communal ways, whereas leadership roles stipulate that leaders behave agentially (Catalyst, 2007; Rudman & Glick, 2001). Women who demonstrate communal behaviors are warm and helpful, and avoid being overly dominant or assertive. Communal women make no overt attempts to influence those around them and do not promote or obviously display their achievements. These expectations result in a double bind for female leaders, as highly communal women may be chastised for not acting agentially enough. However, women leaders who demonstrate agentic characteristics may face resistance for not behaving communally enough (Eagly & Carli, 2007a).

Influence, which is the ability or power to affect others' behaviors or beliefs, is a necessity for leadership to be effective. As a result of the impact of the double bind, it should not be surprising that people may not be accepting of a woman's leadership, especially when the

setting is masculine. This resistance results in obstacles being created within the labyrinth to women seeking positions of leadership in organizations. Sometimes women face resistance because they lack a communal nature, resulting in people not liking them. Sometimes communal women face resistance because they are seen as lacking competence, resulting in people not respecting them. Therefore, for women in leadership to gain influence and be liked and respected requires a difficult balancing act (Eagly & Carli, 2007a).

Resistance is based on females being authentic and true to themselves. Resistance is derived from the difficulty that female leaders experience between navigating as their true, authentic selves and not appearing to others as too sweet or too abrasive (Chandler, 2011). Attempting to successfully demonstrate both characteristics can be challenging, as women are required to constantly consider their actions and behaviors. This concept was reinforced by Frankel (2004), who stated that females may experience resistance when they attempt to break out of society's defined social roles and act in a more self-actualizing way.

**Leadership styles.** Countless studies have affirmed that people attribute different traits and characteristics to males and females, and men are more commonly linked with traits that connote leadership than women (Eagly & Carli, 2007b). "Female leaders' efforts to accommodate their behavior to the sometimes conflicting demands of the female gender role and their leader role can foster leadership styles that differ from those of men" (Eagly & Johannesen-Schmidt, 2001, p. 785). As a result, gender roles have various implications for male and female leaders' behaviors, not only because male and female roles vary, but also because there are often discrepancies in the dominant communal characteristics typically correlated with females and the mostly agentic characteristics that are correlated with and perceived as necessary to successful

leadership (Eagly & Johannesen-Schmidt, 2001). Thus, people typically have comparable views and beliefs about leaders and men but differing views of women in leadership (Schein, 2001)

Female leaders often have difficulty cultivating an effective and appropriate leadership style for themselves—one combining the agentic qualities that people generally think leaders should possess in effort to be successful with communal characteristics that are preferred for women to demonstrate (Eagly & Carli, 2007b). Catalyst (2007) conducted a review of Fortune 1,000 female executives; a total of 96% of them stated that it was vital or fairly imperative that they create for themselves and demonstrate a leadership style with which male managers would be comfortable.

There seems to be a popular consensus that a distinct female leadership style exists. A review of 45 studies found that, in general, women leaders have a tendency to demonstrate more transformational leadership characteristics than male leaders, specifically when demonstrating encouragement and support for subordinates. Women also engaged in rewarding behaviors more often, which happens to be one aspect of transactional leadership. Men were reported to engage more frequently in behaviors such as corrective and disciplinary actions, which are more transactional behaviors. Women were also reportedly less likely to demonstrate behaviors consistent with laissez-faire leadership: a leadership style that takes minimal responsibility for managing. Women also appeared to be more collaborative and participative than men were reported to be (Eagly & Carli, 2007b).

In conclusion, the transformational leadership style, along with positive incentives and the rewards that are associated with transactional leadership, has been found to be more suitable for leading organizations in the 21st century. Research demonstrates that women and men do demonstrate differing leadership styles. Women's approaches tend to be less transactional and

appear to be more transformational than men, and transformational leadership is reportedly a generally more effective style (Chandler, 2011; Eagly & Johannesen-Schmidt, 2001).

**Family responsibility.** Family needs represent the final workplace barrier for professional women. Females continue to perform the largest portion of the responsibilities at home related to household duties and taking care of children (ACHE, 2012). Females are typically the primary ones responsible for scheduling appointments for family members, arranging children's activities, and caring for sick or elderly members of the family. Eagly and Carli (2007a) stated that females "provide the glue that holds families together by maintaining connections with extended family, preparing celebrations for family events, sending cards, visiting with neighbors, and so on" (p. 49).

According to time diary studies, for every hour that men devote to household responsibilities per week, women reportedly spent 1.7 hours, almost twice that of men, during the exact duration of time. Although housework responsibilities are currently shared more equally than at any other previous time, there continues to be a striking difference between each gender's time spent on domestic work. Women also provide more childcare than fathers do; however, many do not realize that in the U.S. both fathers and mothers spend more time providing childcare than previous generations. Despite the fact that men are increasingly sharing in child rearing and domestic responsibilities, these factors continue to contribute to women having less access to power and authority in society and the workplace (Eagly & Carli, 2007a).

Parenthood and marriage place differing demands on men than women. Women in managerial and professional positions often have the most intense time conflicts between their families and job because of the long hours their jobs can require (ACHE, 2012; Eagly & Carli, 2007b). Employment demands—such as phone calls, emails, and some weekend work—often



encroach into personal lives. For many women, job obligations and responsibilities conflict with family demands. Consequently, women experience employment that is less continuous, in turn lessening their career chances for advancement among the professional ranks (Eagly & Carli, 2007a).

A significant percentage of females set aside time for family responsibilities by relinquishing their jobs completely. One study that was conducted in 2005 determined that 37% of females that obtained either professional or graduate degrees or undergraduate degrees with honors dropped out of their employment voluntarily at some point in their career. This percentage of women stands in contrast to that of similarly qualified men, which was reportedly 24%. For mothers with one or more children, the number rose to 43%. The primary reason that females reported taking time away from their careers was to spend time with their family; however, men reported that it was to switch careers (Hewlett & Luce, 2005).

Generally a woman's prime years for child bearing often coincide with the crucial years for working toward establishing a favorable career, which can exacerbate the cost of suspending employment. Even for women who have exceptional educational credentials, it often requires hard work to regain career momentum (Eagly & Carli, 2007a). Of those women who attempt to regain employment, only approximately one in four succeeds in finding a job; a fraction of those who do successfully find positions are employed in full-time, professional settings (Hewlett & Luce, 2005).

### **Theories of Leadership**

Leadership is not a concept that is new to literature studies. In fact, the studies of leadership can be followed back to as early as the days of Cesar and Plato, and even the early Egyptian empires (Bass, 1981; Shediak, 2014). For the past 60 years there have been close to 70

various categorization systems created to define and explain the dimensions of leadership.

Leadership is a highly prized, highly sought-after commodity. Some researchers have conceptualized leadership as an information-processing perspective, whereas others believe it is a behavior or trait. Although there are various ways to conceptualize leadership, the following components are identified as essential: (a) leadership involves influence, (b) leadership is a process, (c) leadership requires a group setting, and (d) leadership involves shared goals (Northouse, 2013). Therefore, leadership can be described and defined as “a process whereby an individual influences a group of individuals to achieve a common goal” (p. 5).

The concepts of management and leadership are different, although they are often used interchangeably. The overarching function of management is to provide consistency and order to organizations; in contrast, leadership’s primary function is to produce movement and change. In short, leaders are responsible for altering the way people think about what can possibly be achieved (Northouse, 2013).

Leadership is increasingly crucial for organizations in today’s global market. Environmental and organizational changes and demands placed on workers make it even more imperative that leaders take a primary role in their institutions. Leadership demands of organizations will require that leaders be ready, willing, and able to change and evolve to meet the continuously developing needs of their industry. As a result, increased significance will be put on the individual responsibility of leaders within the workforce. As organizations continue to evolve and become more complex, more emphasis will be placed on leaders at all levels to accomplish tasks effectively, and high-level leaders will be needed to motivate, encourage, and inspire employees.

Although early models of leadership typically focused on hierarchal structures, individual leaders, and tasks, leadership theories and characteristics have transitioned away from these models to focus more on behaviorally-based methods. Leadership theory has also evolved to place more value and greater emphasis on the study of successful interpersonal skills. Although traditional leadership theories have been based upon a male model, effective leadership characteristics are not considered gender specific. The current literature indicates that both males and females can lead effectively even if differences exist regarding the presence of gender specific characteristics. As a result, it is essential to identify what leadership is as well as the successful characteristics of leadership (Northouse, 2013).

The following sections present a thorough, though not exhaustive, review of leadership theories and concepts. Particular emphasis has been placed on presenting current models that are more closely aligned with behaviorally and emotionally based frameworks.

**Trait approach to leadership characteristics.** The trait approach has been identified as one of the earliest organized ways to attempt to study leadership (Fleenor, 2011; Northouse, 2013). This approach focuses on the personal attributes possessed by the leader and includes such factors as values, competencies, and physical and personality characteristics. Although early research on the trait approach focused on identifying characteristic differences between followers and leaders, researchers concluded that few traits distinguish the two groups. Recently there has been a renewal of interest in and refocusing on the trait approach to leadership, possibly as a result of the emergence of the five-factor model of personality (Fleenor, 2011).

Many popular leadership books have continued to identify traits that are deemed necessary for effective leaders. In 1989, Gardner published research based upon a large number

of leaders, concluding that some characteristics appeared to enable leaders to be successful, regardless of the situation. The following traits were identified:

- Ability to motivate others
- An understanding of followers and their specific needs
- Resolution and courage
- Action-oriented judgment and intelligence
- Willingness and eagerness to accept responsibility
- Skill in dealing with people
- Self-confidence
- Physical stamina and vitality
- Competency of tasks
- Trustworthiness
- Decisiveness
- Assertiveness
- Need for achievement
- Flexibility/adaptability

The trait approach differs from most other leadership models because it does not consider the followers' traits or the situation (Fleenor, 2011; Northouse, 2013). The approach does not indicate any ideas or principles regarding what sort of leader would be most effective or beneficial in a specific situation, or what a leader should do in a particular set of circumstances. Rather, the trait approach suggests that individuals with designated leadership traits or profiles would be better suited for managerial positions in organizations. As a result, it is not uncommon

for personality assessment instruments to be used in hiring practices to identify the right people for the organization (Northouse, 2013).

One of the considerations of identifying lists of traits such as this is that the identified features that are correlated with successful leaders are most often considered *masculine characteristics* (Fleenor, 2011). Leaders, in general, are seen as behaving more agentially than communally, regardless of their gender (Eagly & Carli, 2007a). “Reportedly, when men and women are asked about the other gender’s characteristics and leadership qualities, significant patterns emerge, with both men and women tending to see successful leaders as male” (p. 2).

**Servant leadership characteristics.** The concept of servant leadership appears contradictory, seemingly running against traditional beliefs concerning what leadership is about. Servant leadership, originally described and discussed in Greenleaf’s (as cited in Northouse, 2013) writings, has been a model of interest to scholars studying leadership for the past 40 years. The concept of servant leadership emphasizes that leaders nurture their followers, empathize with them, and attend to their concerns. As a result, servant leaders are characterized by putting their followers’ interests first, even before their own. Servant leaders lead ethically in ways that support the best interests of the organization, the surrounding community, and the greater society (Northouse, 2013). Greenleaf (1970) provided the following definition of servant leadership:

Servant leadership begins with the natural feeling that one wants to serve, to serve *first*.

Then conscious choice brings one to aspire to lead... The difference manifests itself in the care taken by the servant—first to make sure that other people’s highest priority needs are being served. The best test...is: do those served grow as persons; do they, *while being served*, become healthier, wiser, freer, more autonomous, more likely themselves to

become servants? *And*, what is the effect on the least privileged in society; will they benefit, or, at least, will they not be further deprived? (p. 15)

Servant leaders have a social responsibility to care for the less fortunate, in addition to serving those that work in their organization (Northouse, 2013). Servant leaders value community for its many opportunities to provide in-person experiences for individuals to obtain personal growth, interdependence, trust, and respect (Greenleaf, 1970). Greenleaf (as cited in Spears, 2002) identified and described 10 traits or characteristics that are necessary for servant leadership development. These characteristics help identify or conceptualize the model of servant leadership.

1. Listening: Listen intently to others by hearing what they have to say and being open and receptive to them.
2. Empathy: Try to empathize and understand others by attempting to view the world from the vantage point of someone else.
3. Healing: In order to heal others, one must first learn how to heal oneself. Healing is crucial for transformation and integration, as servant leaders help themselves and others overcome personal struggles.
4. Awareness: Building awareness of one's self strengthens the servant-leader by making him/her attuned to his/her social, political, and physical environments. Awareness provides the servant leader the ability to step aside and see his/her perspectives and himself/herself in a greater context.
5. Persuasion: Communication that is clear, persistent, and seeks to convince rather than coerce or force compliance.

6. **Conceptualization:** Encourages leaders to be a visionary for an organization by thinking beyond day-to-day realities. Conceptualization allows for creative problem solving and big picture thinking.
7. **Foresight:** The ability to look at past events and lessons to analyze and predict what is likely the consequence of future decisions.
8. **Stewardship:** Taking responsibility for the role as the leader that one has been entrusted with by carefully managing the individuals and organization one leads.
9. **Commitment to the growth of others:** Believing that each follower is a special, unique individual that holds intrinsic values beyond the tangible contributions he/she is able to commit to the organization. Servant leaders are dedicated to the personal, spiritual, and professional development of each member in the organization.
10. **Building community:** A community is identified as a group of members with common goals and interests. They feel a connection of relatedness and unity. Building community allows followers to engage in something valuable to them that is greater than themselves (Greenleaf, n.d.; Northouse, 2013).

Gender issues and the workplace have not been analyzed empirically in the literature regarding the domains of servant leadership (Barbuto & Gifford, 2010). However, one study by Barbuto and Gifford (2010) found no distinct differences reported between communal or agentic leadership behaviors and followers' satisfaction with leadership.

**Authentic leadership characteristics.** Authentic leadership emerged in the 21st century as a response to what George (2003) called “the current leadership crisis” (p. 9). This approach, among the newest in the studies of leadership, focuses on leaders who exhibit integrity, ethics, values, and purpose, and who steward well the legacy inherited from predecessors. There is

currently no single, widely accepted definition of what characteristics an authentic leader demonstrates; however, varied definitions have been proposed, each coming from a varying viewpoint with a different emphasis (Northouse, 2013). Two common approaches to leading authentically, Terry's and George's authentic leadership approaches, attempt to detail the perspectives that are unique to leading authentically.

***Terry's authentic leadership approach.*** Terry's approach uses a formula, or guide, to demonstrate to leaders how they can practice authenticity (Northouse, 2013; Terry, 1993). Terry's approach is action-oriented and centered on practice, focusing on the leader's actions, the leadership team, or the situation in which the particular organization is located (Northouse, 2013). In all situations where leadership is needed, Terry stated that first the leader must ask questions to find out what is *really* going on to determine the situation (Northouse, 2013; Terry, 1993). Second, the leader must ask, "What are we going to do about it?" (Northouse, 2013, p. 255). The leader's challenge is to distinguish between inauthentic behaviors and actions and authentic ones, and then commit to doing what is the appropriate, authentic thing to do.

Terry developed a tool that called the Authentic Action Wheel to help leaders identify and address the underlying dilemmas within organizations. The wheel is composed of six components: the top contains *Power*, *Mission*, and *Meaning*; the bottom contains *Resources*, *Existence*, and *Structure*. *Fulfillment* is found in the wheel's center, representing the completion of the process (Northouse, 2013). In order to answer the questions that Terry posed, the leader is supposed to identify the dilemma on the wheel and then choose an appropriate response to the dilemma (Northouse, 2013; Terry, 1993).

***George's authentic leadership approach.*** George's (2003) approach focuses on the authentic leadership characteristics that are required of leaders, describing fundamental qualities



of leading authentically and how individuals can develop these attributes. George based his theory on research he conducted through interviews with 125 successful leaders, determining that authentic leaders knew their purpose, demonstrated a true desire to know themselves, led from their core values, and believed it necessary to serve others. Authentic leaders all demonstrate five specific characteristics: (a) they know and have an understanding of their purpose; (b) they are strongly compelled to follow their value of doing what they believe is the appropriate, correct thing to do; (c) they establish relationships built on trust; (d) they act on their values and demonstrate self-discipline; and (e) they act from their heart and have a deep passion for their mission (George, 2003; Northouse, 2013).

George's (2003) approach outlined five distinct, important features that he believed authentic leaders must possess. When leaders are disciplined and predictable in their behavior it results in those around them having a sense of security. Developing an authentic leadership stance is a process that takes a lifetime, and is impacted by each person's individual life story and circumstances.

Despite the fact that recent leadership research has focused greatly on the concept of leading authentically, there continues to remain a paucity of studies examining gender roles in leadership authenticity. The question of how authenticity and gender are correlated remains a topic that needs more exploration because most research assumes that authenticity is gender-neutral (Liu, Cutcher, & Grant, 2015).

**Transformational leadership characteristics.** In 1978, leadership was conceptualized as either transactional or transformational (Bass & Riggio, 2006; Burns, 1978). Transactional leadership was described as leading through social exchange. A transformational leader, however, was described as one who was able to inspire and stimulate his/her followers to achieve

extraordinary results, while during the process developing his/her own personal leadership potential. These leaders were reportedly able to challenge and persuade their followers while also providing mentorship, support, and coaching. Transformational leaders empower their followers by responding to their individual needs and are also able to align the goals and objectives of the followers, the group, and the organization (Bass & Riggio, 2006).

Transformational leaders go beyond setting up simple exchanges and agreements with their peers and followers. They are able to achieve powerful results by demonstrating at least one of the four outlined descriptors of transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Bass & Riggio, 2006).

***Idealized influence (II).*** Leaders who demonstrate idealized influence act in ways that others desire to emulate. These leaders are trusted, respected, and admired; they become role models for their peers and subordinates. Such leaders are viewed as determined and persistent. Two aspects of idealized influence include the leader's specific, actual behaviors as well as the elements that the followers attribute to the leader. Leaders with a high amount of idealized influence are willing to be persistent and take risks. They have high ethical and moral standards and can be counted on to do what is right by consistently making the best decisions (Bass & Riggio, 2006).

***Inspirational motivation (IM).*** The leaders who demonstrate inspirational motivation are transformational leaders who provide challenge and meaning to their followers' work, while also inspiring and motivating them. They demonstrate a commitment to the shared goals and vision of the organization, displaying optimism, enthusiasm, and team spirit. The attributes of idealized influence combined with inspirational motivation typically form the basis for charismatic-

inspirational leadership. This factor is associated with the behaviors identified and described in charismatic leadership theory (Bass & Riggio, 2006).

***Intellectual stimulation (IS).*** Leaders demonstrating intellectual stimulation support their followers' creativity by questioning assumptions and attempting to address previous situations in a variety of new, fresh ways. These leaders do not criticize individual members' mistakes publicly. Followers are included in the process of finding solutions and are encouraged to address problems with new approaches. The leader supports the followers' ideas, even in times when they differ from his/her own (Bass & Riggio, 2006).

***Individualized consideration (IC).*** Transformational leaders support their followers' needs for growth and achievement by engaging with them as teachers, coaches, or mentors. Individualized consideration refers to the recognition that everyone's needs and desires are different and the leader encourages these differences in a supportive environment. Leaders engage in two-way conversations and listen attentively. These leaders develop their followers by delegating tasks but also providing direction or support to assess progress (Bass & Riggio, 2006).

The vast majority of notable transformational and charismatic-transformational leaders in the past have been men. Several come to mind without much thought—Nelson Mandela, Martin Luther King, Jr., Mohandas Gandhi, Jesus, John F. Kennedy, and even infamous ones like Adolf Hitler, Osama Bin Laden, and David Koresh. In contrast, only a small number of female charismatic leaders come to mind, such as Mother Teresa, Eleanor Roosevelt, and Margaret Thatcher. However, if charismatic-transformational leadership's characteristics are analyzed, women might very well be more likely to demonstrate characteristics and behaviors more often and be better at leading transformationally than their male counterparts (Bass & Riggio, 2006).

## **Women in Leadership**

Gender and the differences between the way males and females lead have captivated the interest of writers in the popular press (Hoyt, 2013). Some of these differences have been described and explained as females being inferior to men, with the argument being made that women did not possess the traits and requirements for success in managerial positions (Henning & Jardin, 1977). Other researchers have swung the pendulum of beliefs in the complete opposite direction, stating that they believed that women demonstrated superior leadership characteristics, in comparison to men (Book, 2000; Helgesen, 1990).

Currently, there are a number of highly effective executive-level female leaders such as Hewlett-Packard's CEO Meg Whitman, Southwest Airlines' President Emeritus Colleen Barrett, Facebook's COO Sheryl Sandberg, and PepsiCo's CEO Indra Nooyi. The primary focus of whether there are leadership style differences between females and males is often incorporated into the bigger question of why female professionals continue to be underrepresented in elite leadership roles in America (Hoyt, 2013).

As women are occupying organizational leadership positions more often than they have in the past, questions have surfaced regarding whether or not they lead in a different way than men do. Academic researchers generally have not reached a consensus; many disagree that gender has any influence on/correlation to one's leadership effectiveness or style (Dobbins & Platz, 1986; Powell, 1990; van Engen, Leeden, & Willemsen, 2001). In a stark contrast to stereotypical expectations, women were not considered to lead in ways that appeared to be less task-oriented and more interpersonal than men in organizational studies and research (Eagly & Johnson, 1990). These differences were only perceived in experimental settings or settings where social roles regulated behaviors. The only powerful conclusion the analysis did find, however,

was that across settings women reportedly led in a more participative, or democratic, way than men. Van Engen and Willemsen (2004) found similar results in a meta-analysis conducted on leadership research between 1987 and 2000.

As stated previously, research has suggested that many women demonstrate transformational leadership qualities. A 1996 study by Bass, Avolio, and Atwater concluded that women more than men tend to demonstrate behaviors that are consistent with transformational leadership, especially individualized consideration, whereas men tend to display transactional leadership qualities more often than women. Carless (1998) conducted a study describing leadership styles through the construct of transformational leadership. According to Carless's findings, both males and females reported that females demonstrated a more transformational style than men, displaying such behaviors as participative decision-making, nurturing, consideration, and charisma. Carless attributed these findings to her belief that leadership development for girls and women is a socialization process, arguing that women are innately drawn to relational leadership skills and behaviors that appear to be most consistent with transformational leadership. Carless concluded that, overall, female leaders were characterized as being more inclusive and participative whereas their male peers were perceived as controlling, task-oriented, and directive. Another study validated these differences, suggesting that women in leadership positions appeared to most likely consider valuable the relational elements of their roles more than it seemed the men did (Boatwright & Forrest, 2000).

Women may experience differences in career advancement and applied leadership as a result of gender disparity, altering their leadership development. Gender differences may affect the opportunities and circumstances necessary for leadership development. As a result, in efforts to be promoted in the workplace, female leaders may be required to go to greater lengths than

their male colleagues. This can include adjustments and changes to work behaviors, potentially resulting in role conflict (Hoyt, 2013).

### **Implications for Women in Leadership**

Women in the corporate world continue to experience an enormous gender gap for senior-level leadership roles (Yee, 2015). Although there have been vast improvements in the disparity during recent decades, female leaders still have quite a long way to go (Hoyt, 2013). Currently, American females earn approximately 60% of awarded bachelor's and master's degrees, earn more than half of the doctoral degrees, and compose almost half of the American workforce (Hoyt, 2013; U.S. Department of Labor, Bureau of Labor Statistics, 2015). In American organizations, women have a strong leadership presence, representing approximately 40% of all managerial and professional positions (U.S. Department of Labor, Bureau of Labor Statistics, 2015). Despite these statistics, however, women continue to lack representation in the top positions of U.S. corporations, as they reportedly lead only seven of the Fortune 500 companies and hold top leadership roles in only 10 of the Fortune 501-1000 companies (Catalyst, 2005; Hoyt, 2013).

Research has identified and generalized that most people maintain assumptions about others that are biased largely by gender-specific stereotypes (Barbuto & Gifford, 2010; Ely, 1995). These stereotypic beliefs overflow into the working world, resulting in threats to the evaluation and advancement of women leaders. As a result, certain behaviors are deemed accepted and expected based on the leader's gender. Gender stereotypes can result in a strong, although invisible, barrier to women in leadership roles and the organizations in which they are employed. The impact of these stereotypes and the resulting bias is often underestimated. In fact, research shows that women consistently identify gender stereotypes as substantial obstacles to

their career advancement (Catalyst, 2007). Gender stereotypes typically represent women as not possessing the necessary qualities for effective leadership, resulting in assumptions and false perceptions that women leaders do not have the needed characteristics and traits when compared to men in important ways (Catalyst, 2005).

Because leadership talent is a vital, rare, and prized commodity, companies cannot afford to refrain from capitalizing on any division of the talent pool (Catalyst, 2005). Gender stereotypes and bias must be addressed directly to ensure that the corporation's leadership talent is successfully identified and utilized. Regardless of how much women have accomplished or the strength of their levels of skill, education, qualifications, preparation, and training for corporate leadership roles, if companies do not recognize and consider the effects of stereotypes and bias, they will persist in failing to hire and promote high caliber female talent (Catalyst, 2007).

With the possible exception of the performing arts, every prestigious and high paying profession in the U.S. is dominated by men, both in terms of sheer numbers and who wields power. Anyone entering the field of academia, law, or business is joining a field where the highest level positions are disproportionately occupied by men and the positions in the lowest level are inordinately staffed with women (Valian, 1999).

A 2009 analysis of college-aged women showed that despite women's current abilities and social progression, there was no evidence that positively affected their views or outlooks of women in leadership positions (Hoss et al., 2011; McEldowney, Bobrowski, & Gramberg, 2009). Similar to women during the 1990s, women enrolled in college today who demonstrate the desire to become leaders in their careers continue to believe and feel that their talents, strengths, abilities, and attributes are not adequately considered when compared to those of their male

peers. As a result, these women are left with feelings of inadequacy, uncertainty, and insecurity (McEldowney et al., 2009).

The analysis showed that male domination is not a thing of the past, and it continues to play a crucial role in the consequences of discrimination. When male participants tried to dominate or assume unofficial leadership roles, participants felt less secure, had lower self-esteem, and experienced less overall respect. (Hoss et al., 2011, p. 62)

To become leaders, women must make their way successfully through the labyrinth of barriers and dead ends. Ideally men and women would have paths to leadership that are equivalent; however, that is not the case. Many books have been written offering advice for women on how to advance their careers, but that advice is often conflicting. Two approaches are generally promoted—to act feminine or to act masculine. These one-sided methods fail to consider the double-bind dilemma.

There is still a pervasive belief in business that females do not fit the ideal criteria or image of what a leader should look like (Catalyst, 2007). Because individuals have the tendency to view males as stereotypical leaders, women's leadership behaviors are generally compared to masculine norms. As a result, it is difficult for a woman to measure up. "Even when 'feminine' leadership behaviors are perceived positively—such as when women are complimented for being team-oriented and sensitive to others' concerns—women's styles are still labeled as 'unique' and 'different' from the (presumed) leadership norm" (p. 9).

Although research conveys that organizational contexts and specific situations affect and influence leadership styles, individuals have a tendency to accept the belief that leadership styles are founded upon fundamental, inherent, and deep-rooted traits and characteristics that are



unchangeable. As a result, women are often considered abnormal, even if they exhibit behaviors that would be deemed acceptable if expressed by a male leader (Catalyst, 2007).

### **Implications for Women in Healthcare Leadership Positions**

“A healthcare organization (HCO) is a formal legal entity that reaches across the panorama of medicine, other clinical disciplines, as well as business to identify and deliver care to its community” (White & Griffith, 2010, p. 3). HCOs can be described as organizations with lines of authority and environments that hold individuals accountable for specific activities. A high level of content knowledge is necessary in these highly regulated environments, which require a great deal of empowerment and independent thinking (White & Griffith, 2010). As a result, the possibility of being able to deliver safe and reliable healthcare has far exceeded individual abilities (Gawande, 2010), creating the need for complex system processes, team-based specialty services, and a commitment to providing ethical services (Gilbert, 2007).

Healthcare systems can be described as (a) competitive, (b) political, (c) complex, (d) highly technological, and (e) simultaneously personal (White & Griffith, 2010).

Breakthroughs in medicine and science are occurring constantly. However, with each of these breakthroughs, HCOs face the obstacles of balancing the demands of meeting greater consumer expectations and affording the rising costs of operating facilities. HCOs must maintain sound financial management while balancing patient safety and quality in a rapidly changing environment. The healthcare setting demands focus on (a) strong collaborative employee relationships; (b) profit improvements; (c) managing controllable debt; (d) assuring compliance with applicable laws and regulatory requirements; (e) providing safe, quality care; (f) increasing growth and volumes; (g) low employee turnover; (h) ensuring a highly productive workforce; (i) superior customer reviews and ratings; and (j) providing a work environment that is satisfying

for the staff (Rowitz, 2006). Due to this increasing level of complexity in healthcare, HCOs would benefit from greater diversity among their leadership staff (McDonagh & Paris, 2013).

Leaders must display five key skills in complex environments: (a) an understanding, or personal mastery of the environment; (b) mental models, including a broad view of various cultures; (c) shared vision, including mental images of a future state; (d) working together as a team; and (e) systems thinking inclusive of all relationships and dynamics (Rowitz, 2006). Research has shown that behavioral characteristics and educational requirements required for executive-level leadership are not gender-specific; however, women are not accounted for in these positions in the same numbers as their male counterparts (Carli & Eagly, 2001; Catalyst, 2005; Goodman et al., 2003; Heilman, 2001). This is also true for senior-level executive leadership in healthcare settings (ACHE, 2012).

Women have maneuvered through the male-dominated world of healthcare for centuries and continue to deal with stereotypes and obstacles in asserting their influence and leadership. Despite the knowledge that females are the largest consumers of healthcare and compose over three-quarters of the healthcare labor force, females persist in being significantly under-represented in executive-level leadership positions in this field (Hoss et al., 2011). In fact, according to a recent study by the ACHE (2012), females reportedly represented a mere 11% of CEOs: a statistic that has not changed much at all over the past several years. Despite the fact that they are primary contributors to the field of healthcare, women continue to face barriers in career advancement.

The healthcare industry is projected to add over four million jobs between 2012 and 2022, more than any other industry, and is projected to be among the fastest growing industries in the American economy. Healthcare jobs are divided into five distinct categories: hospitals,

healthcare practitioner offices; residential and nursing care facilities; home healthcare agencies; and other laboratory, outpatient, and other ambulatory care services. More than 15.8 million people were employed in jobs in these industries in 2013. In 2013, hospitals employed the largest number of people in the healthcare setting, employing approximately 39% of the total healthcare labor pool (Torpey, 2014). In 2014, women made up nearly 76% of the healthcare industry workforce (U.S. Department of Labor, Bureau of Labor Statistics, 2014).

The ACHE (2012) has tracked and compared career advancement and attainment in healthcare by women and men since 1990. Its 2012 report, which is the most recent study conducted, showed that women achieve CEO positions among HCO positions at half the rate of males and were reportedly compensated approximately 20% less than men were overall. The report went on to say, “despite the persistence of this gap, women in this sample of healthcare managers are in a better position relative to women in general business who in 2011 earned 28 percent less than men” (p. 2).

Powerful leadership and substantial change are necessary requirements to transform the United States’ healthcare system (Lantz, 2008). Obtaining a balance of genders in the top echelons of healthcare leadership is likely to be an important contributing factor to effectiveness and innovation in the industry (Hoss et al., 2011). Although women have made tremendous progress in terms of gender equality when it comes to issues such as harassment and overt discrimination, these changes by themselves are insufficient to face the challenges of career development and advancement and the ability to access leadership roles (Coffman, Gadiesh, & Miller, 2010). The causes of gender disparity among leadership in healthcare are multifaceted and can include the following:

1. Leadership bias and management structures may favor a masculine style and approach.
  2. Recognition of the importance of gender differences in developing a multi-cultural organization with improved performance is lacking.
  3. Individual barriers block the drive of women leaders and create barriers for future leaders.
  4. Strategic focus is lacking as well as dedicated support to address the gender disparity.
- (Hoss et al., 2011)

**Navigating to the top.** Although progress in remedying the disparity between women and men in the ranks of healthcare leadership has been slow, some women have successfully navigated through the labyrinth of obstacles and dead ends to achieve executive-level positions in healthcare. According to Eagly and Carli (2007a), women are capable of achieving these positions by authentically balancing communal characteristics and behaviors with agentic traits. They argue that as leadership roles are transforming into more of a *good coach* or *good teacher* model, these models are actually more accepting of women's styles than previous models. As a result, this cultural shift makes women's paths to leadership easier. "Simultaneously women have already changed substantially in personality, abilities, education, career ambition, labor force participation, and job preferences. These changes reflect women's accommodation to their new roles and opportunities" (p. 182).

### **Summary**

External and internal obstacles exist for women seeking executive-level positions in the field of healthcare. Although no theoretical framework exists for analyzing these barriers for women in healthcare, Eagly and Carli's (2007a) framework that identified four main categories

of obstacles for women in the workplace was utilized. These obstacles were identified as:

(a) gender discrimination, bias, and prejudice; (b) resistance; (c) leadership style; and (d) family responsibilities.

It is clear that barriers continue to be present for women in executive-level roles; however, research does not clearly validate any specific gender characteristic limitations for senior leadership positions. It remains unclear if there are actual gender differences that have important implications for leadership, although literature is supportive of the notion that these differences do exist (Babcock & Laschever, 2007; Eagly & Johnson, 1990). These stereotypes and cultural perceptions may also result in women's feelings of isolation and being alone when they are employed in executive-level leadership roles (Evans, 2000).

The leadership disparity among women leaders is a phenomenon that occurs around the world, where females are disproportionately centered in lower-authority and sub-level leadership roles than males are (Powell & Graves, 2003). This gender disparity exists in many industries, but is especially prominent in male-dominant industries. One common explanation for the existence of the disparity is that females, more so than males, are willing to leave their employment, although no consistent studies or research evidence is supportive of that claim (Eagly & Carli, 2004). However, greater evidence has been found that females encounter larger, more pronounced deficits after leaving their employment positions because they are more likely than men to leave their positions for reasons related to family issues (Keith & McWilliams, 1999).

Leadership and the study of leadership have gained the attention of researchers across the world. Leadership is often considered to be a complex, multi-dimensional phenomenon that is difficult to define, study, or guide (Northouse, 2013). The leadership models and theories

presented in this literature review were in no way exhaustive; however, they are current models that encompass contemporary trends. The theories and models presented herein attempted to describe ways for leaders and organizations to create and produce the best possible results.

It is no secret that successful organizations require sound, effective leadership, and the healthcare environment is composed of complex organizations requiring such leadership. The healthcare industry faces the challenges of meeting consumer expectations in an ever-evolving field while also balancing rising costs. A commitment to safety, quality, and sound financial management are all requirements of leaders in the healthcare industry.

Although healthcare is a field in which women represent approximately 76% of the workforce, an overwhelming majority, females are substantially underrepresented among top-level leadership positions, especially at the executive and board levels (Fontenot, 2014).

Although reportedly thousands of women each year seek administrative and clinical management positions, men still occupy the overwhelming majority of executive offices. As a result of this disparity, it is not surprising that healthcare leadership is often considered a male-dominated field.

### **Chapter 3: Methodology**

The purpose of this study was to examine the obstacles, if any, that successful females employed in executive-level healthcare roles have faced and identify how they were able to overcome them. A comprehensive literature review related to women's journeys in the workforce, leadership theories, and a description of the healthcare industry with emphasis on the fact that even though the field is predominantly female, males dominate the leadership ranks provides the foundation of this research. This theoretical framework provides guidance in categorizing and classifying obstacles and challenges that females encounter with regard to advancement in their careers in the workforce.

When beginning any research project, it is important that the researcher understand not only that a variety of methods are available, but also that in each there is a specific relationship among each research question, method, and result. Qualitative inquiry allows the researcher to work with complex, unstructured data from which new understanding can potentially be derived. A phenomenological study is a perspective of qualitative research that allows for a reflective, descriptive, engaging, interpretive mode of inquiry from which the significance of the participants' experiences can be considered (Richards & Morse, 2013). Phenomenological methods attempt to investigate conscious experiences directly through a specific form of personal introspection as opposed to inferentially obtaining data through observation or cognitive exploration. This results in an understanding of the essence and structure of a phenomenon for an individual or a group (Moustakas, 1994).

In this chapter the researcher provides a complete, detailed explanation of the:

- (a) research questions; (b) research design and sources of data; (c) research population and sampling plan; (d) data collection strategies; (e) data collection procedures; (f) study validity and

reliability; (g) ethical considerations; (h) human subjects considerations; and (i) data analysis procedures. The overall research questions are vital to the study and guided the research; as such, the researcher used these questions to ensure that sufficient data were collected.

### **Research Questions**

This study explored the obstacles and challenges that successful executive-level women have overcome to advance their careers in the healthcare field, as well as identify the self-reported leadership characteristics, traits, and experiences of females employed in executive-level leadership positions in the healthcare industry. The purpose of this qualitative phenomenological study was to address the central research question which is what are the experiences that executive-level women have encountered during their career journeys in the healthcare industry? This research question was addressed through two sub-questions:

- RQ1. What obstacles, if any, have executive-level women encountered during their career journeys in the healthcare industry?
- RQ2. What leadership characteristics do executive-level women in healthcare organizations self-report that they demonstrate?

These questions were addressed using an interview protocol and demographic questionnaire (See Appendix A and B).

### **Research Design and Sources of Data**

This study focused on the experiences of successful executive-level women in healthcare. Because the goal was to understand their *lived experience*, a phenomenological approach was used. A small sample of women were interviewed in order to explore the experiences of successful women in healthcare and gain insight into their own unique obstacles and challenges they have overcome in their career journeys. Most qualitative researchers report that they are



fascinated by what information is conveyed to them by interviewees (Marshall & Rossman, 2014).

Qualitative inquiry is about attempts to understand a phenomena and the discovery of a defined experience (Creswell, 2013). In the process of engaging in qualitative research, collecting data is not done in isolation from data analysis (Richards & Morse, 2013). There is a multitude of ways in which data can be gathered and managed, but qualitative research is about discovery; there is no rigid sequence of collecting and analyzing data. The most popular reason for using a qualitative approach to research is that it provides flexibility for a study that will involve interviewing a population (Marshall & Rossman, 2014). Qualitative research is generally accomplished by utilizing four common approaches: personal interviews, observation of subjects, analysis of text and documents, and recording and transcribing (Silverman, 2014). This study included personal interviews.

For this study, qualitative interview questions were asked as open-ended questions for the goal of obtaining new information through candid, authentic responses (Creswell, 2014). Phenomenology allowed for the description of the interviewees' perceptions, motivations, and experiences (Moustakas, 1994). Phenomenology refers to an individual's perceptions and meaning of circumstances and events, in comparison to the event as it existed outside of that person (Leedy & Ormrod, 2010). In this study, the individuals' perceptions, experiences, beliefs, understandings, and perspectives regarding their journeys were the primary sources of information and knowledge. From the data obtained from the participants, the researcher believes that this information contributes to the current, existing body of knowledge regarding the journeys of females into executive-level leadership positions, with particular emphasis on women in executive roles in healthcare.

## **Research Population**

The target population in this study was delimited to executive-level women in healthcare who were employed in Texas, Oklahoma, California, and Virginia. Because the researcher has professional networks and colleagues in those states, this study focused on executive-level women in healthcare in these particular states. According to the American Hospital Association, there are an estimated 1,200 hospitals in those four states; however, it is not known specifically how many executive-level women are employed in HCOs in those regions. For the purposes of this study, it was estimated that there was a sample population of approximately 385 female executives in healthcare positions in those regions.

Women in executive-level leadership positions in a healthcare setting who had been in an executive leadership role for a minimum of 3 years were the targeted population for this study. This selection allowed the researcher to assess the obstacles that women experienced in their leadership journeys while further identifying the participants' experiences and characteristics. This allowed the researcher the ability to obtain a deeper understanding by identifying participants that shared common characteristics directly related to the purpose of this study (Merriam, 2009).

HCOs include organizations that provide healthcare and healthcare related services (White & Griffith, 2010). For the purposes of this study, the healthcare setting was defined to include hospitals, academic medical facilities, home healthcare agencies, and any entity that supported one of these entities. The HCOs considered for this study were operational throughout California, Texas, Oklahoma, and Virginia. Because this research design used a non-probability sampling method, the information obtained from this study cannot be generalized to a larger population.

## **Sampling Plan**

A sample of 10 executive-level women in healthcare were identified using a snowball sampling strategy. Personal contacts and colleagues were utilized to identify participants for the study. However, people with whom the researcher had a personal relationship were excluded from the research. The potential participants were contacted via electronic mail and informed about the study and invited to participate.

Prior to the researcher contacting any potential participants, The Institutional Review Board (IRB) at Pepperdine University reviewed and approved the study (See Appendix C). Following approval, a three step process occurred for identifying the participants.

- Step One: The researcher made initial contact with the participants via electronic mail to introduce the researcher, explain the research study criteria, and requested the executive-level female to participate in the study (See Appendix D)
- Step Two: The second communication contained correspondence thanking the participant for agreeing to participate in the study and asked what day and time would be most convenient for them to be interviewed. A demographic questionnaire and information sheet (See Appendix E) were provided.
- Step Three: Once the date and time were determined and agreed upon by the researcher and participant, confirmation of the interview was provided to the participant (See Appendix F).

## **Data Collection Strategies: Individual Interviews**

Previous research has used various methods for collecting data on women's leadership in executive-level positions. There is no single best method identified for the collection of data, as data collection in qualitative research can take many forms. Almost all forms of qualitative

inquiry use some form of interview strategy (Richards & Morse, 2013). Phenomenological researchers depend predominantly on lengthy interviews of approximately 60-90 minutes with a carefully selected group of participants (Leedy & Ormrod, 2010).

This study involved 10 participant interviews in total (one face-to-face interview and nine telephone interviews) as the participants were located in various regions throughout the United States, making face-to-face interviews unfeasible for some participants. All of the interviews conducted were audio recorded. In a phenomenological interview, the participants often work together with the researcher. The researcher is required to listen closely as the participants explain their experiences related to the phenomenon (Leedy & Ormrod, 2010).

It was anticipated that the interviews would be approximately 60 minutes in length. If the interviews were shorter, it was possible that not enough valuable data would be collected. If the interviews were longer, the researcher risked the possibility of reducing the number of participants that were willing to participate because the study would be too time consuming. The researcher conducted a pilot interview with a colleague that fit the participation criteria of the study to determine the approximate length of the interview; the pilot interview that was conducted lasted approximately 50 minutes. However, the data obtained from the pilot study were not included in the final study data. The average length of time for the interviews for the study was approximately 60 minutes.

A typical interview resembles the format of an informal conversation, with the researcher looking for meaningful, although sometimes subtle, cues in the participants' responses, expressions, and tangents. The researcher is required to listen intently while the participant does most of the talking (Leedy & Ormrod, 2010). The inclusion of open-ended interview questions provided a chance for the researcher to analyze new ways of looking at and understanding the

current topic (Cohen & Crabtree, 2006). Throughout the processes of interviewing and data collection, the researcher was able to generate useful and respectable qualitative conclusions. After the data were collected, analysis of the content was conducted: a crucial part of the study. The data were reviewed and analyzed in effort to discover trends, or common themes.

### **Data Collection Procedures**

The research data were collected by gathering the information presented from the interviews and the demographic questionnaires that were completed by the participants. All of the participants allowed their interviews to be audio recorded. To ensure data accuracy, the researcher personally transcribed each of the interviews using HyperTranscribe software.

### **Study Validity and Reliability**

Despite the fact that some qualitative researchers have stated that *validity* is not the correct terminology for qualitative research studies, these same researchers have also stated that some type of qualifying measure was necessary for their studies (Golafshani, 2003). Validity can be described as “being sure of the strength and accurateness of one’s conclusions” (Butin, 2010, p. 102). Validity, often referred to in qualitative studies as credibility, refers to determining that the findings are really about what they appear to be about.

Qualitative researchers are primarily concerned with descriptive validity, which Maxwell (2002) defined as the accuracy of the data. It was imperative that the data accurately reflect what the participants have done or said. Also of utmost importance was that the transcription reflected accuracy in what was said during the actual research or interview (Thomson, 2011). “Descriptive validity forms the basis on which all the other forms of validity are built upon” (p. 78).

Interpretive validity was also a consideration in this study. Interpretive validity ensures that the researcher reports the participants’ meanings of the behaviors, events, and experiences. It

was important that the interpretations not be based upon researcher's perspective, but on the participants' (Thomson, 2011). The researcher ensured the validity of this study by being the only source that transcribed the data. Doing so allowed the researcher the opportunity to control for any variance of having another source potentially transcribe the interviews incorrectly. Also, by personally transcribing the data the researcher became more familiar with the data.

Reliability, which is often referred to as dependability or consistency in qualitative research, takes into consideration whether the results are consistent with the collected data. Despite the fact that qualitative researchers cannot always capture an objective truth, there are strategies that can help the researcher increase the credibility of the study (Merriam, 2009). To ensure internal study validity several processes were used.

To ensure a valid interview protocol, a request was sent to a panel of three experts via email to review, comment, and validate the interview protocol. Included with the correspondence was an explanation of the study, the study's research questions, the interview protocol, and a request for recommended changes. The panel of experts consisted of three women with doctoral degrees in the field of organizational leadership studies. The experts were specifically asked to review the content and flow of the interview questions. The panel of experts consisted of Dr. Joan Millsbuffehr, who obtained her Ed.D. in Institutional Leadership from Pepperdine University in 1989; Dr. Brenda Shull who obtained her Ph.D. in Organization Development in 1990 from the University of Texas; and Dr. Jennifer Green-Wilson, who obtained her Ed.D. in Executive Leadership in 2010 from St. John Fisher College. These women had content expertise regarding leadership and were also familiar with the healthcare industry.

To expedite the review process, each expert was provided an electronic questionnaire (SurveyMonkey) in which she was asked to read and rank each question in one of three

categories: (a) accepted/requires no modifications, (b) valid but requires modifications, and (c) remove/irrelevant. For questions that were deemed valid but required modifications, the expert was asked to provide a suggestion of how she determined the question should be worded. If two of the three experts determined that a question was acceptable with no modifications, the question was accepted as part of the interview protocol.

Recorded interviews were transcribed directly by the researcher. Each audio recording was compared against the transcribed data to ensure accuracy. It was sometimes necessary for the researcher to ask for clarification to ensure an understanding of the participants' narratives at certain times during the interviews. Notes were made at the time and incorporated into the transcribed interview transcript.

Reliability of the interpretation process was ensured through a variety of processes. First, the researcher used a qualitative software tool (HyperResearch) as a way to document the coding process. A code-book was created and transcripts were coded and reviewed multiple times. In addition, a peer researcher (Patricia Hohlbein, Ed.D.) reviewed the coded transcript for coding consistency.

### **Ethical Considerations**

A research study's validity and reliability depend largely upon the researcher's ethics (Merriam, 2009). According to Patton (2002), the researcher's credibility "is dependent on training, experience, track record, status, and presentation of self" (p. 552). Credibility also includes "intellectual rigor, professional integrity, and methodological competence" (p. 570). In all research, these qualities are crucial to ensure the ethical stance of the researcher and the integrity of the study (Merriam, 2009).

It was important to examine a variety of issues when considering the ethical situations that can arise when conducting a study. Some of these considerations include treatment of data, treatment of participants, privacy, possible legal issues, possible intellectual property issues, anonymity, confidentiality, honesty, security of data, and citing all sourced materials, among other things.

The researcher explained to the participants in this study that they were not required to answer any or all of the questions, and that they were able to stop their involvement in the study at any time. The researcher explained to the participants why the study was being conducted, how the data would be stored, and how the data would be used in the research. Respondents were given all the details in writing in the information sheet so that they would be comfortable participating in this study. The researcher ensured total privacy and confidentiality for all of the participants.

### **Human Subject Considerations**

Participants' identities as well as interview information that was obtained have been and will continue to be treated as private, confidential information. It is the researcher's belief that nothing in this study could be construed as misleading or deceptive. Data from the study were coded to protect privacy of identifying information. Data have been reported in aggregate. The participants were given pseudonyms, and no individual's identity or facility in which she is employed has been named in any way. There were and are no anticipations of legal, economic, social, or physical risks to any of the participants. Confidentiality has been maintained in all written correspondence, including emails, and all participants have been formally reassured of their confidentiality. Also, in an effort to protect the participants' confidentiality, the researcher accommodated the participants' desires to schedule their interviews at convenient times. This



allowed each participant the ability to be more comfortable in determining when and where she chose to share her stories and experiences with the researcher.

The participants' socio-demographics have been reported in aggregate. Readers of this study may be able to determine the identity of the executive-level women in healthcare that participated in this study based on their unique experiences, individual challenges, or specific barriers that they relayed, although this was not anticipated. The researcher will be the only person to have access to the data, which has been kept secured. The confidential documents will not be destroyed until 5 years after the conclusion of this research project.

There was minimal physical discomfort for the participants having to sit for the duration of the interview; however, because the participants chose the time and location that the interview was conducted, this discomfort was minimized. Legal risks to the participants were not anticipated as a result of the fact that no personal names, names of organizations, or personal information regarding the participants is provided in the study results; doing so also minimized the legal risk for Pepperdine University and the researcher.

Each of the participants was provided an information sheet as part of her informed consent process. The information sheet was not required to be signed and returned to the researcher, which was added protection for confidentiality of the participant's identity.

### **Data Analysis Procedures**

In an effort to identify common perspectives on executive-level women's leadership journeys in the healthcare industry, the responses to the open-ended questions were organized into dominant themes according to their underlying meaning as opposed to the repetition of specific words or phrases. Statements that have the same underlying meaning but different wording were categorized together. An analysis of the frequency of themes allowed the

researcher to determine the relative frequency with which specific experiences, issues, obstacles, or barriers occurred for the participants on their career journeys.

The research involves open-ended interview questions. Using an open-ended technique allows the interviewer the ability to exercise some discretion over the questions asked, and probes were used to ensure that a thorough amount of data was collected. The data was accumulated, analyzed, and identified, and trends that existed from the collected data were determined. From the interview transcripts, the researcher coded the data to identify consistencies, patterns, or trends in the stories that women have experienced during their leadership journeys to executive-level positions in the healthcare setting, as well as to identify the leaders' overall self-reported leadership styles. This study used analytic induction logic of inquiry; it was anticipated that implications would arise from participants' narratives, which allowed the researcher to find trends and patterns in the information to help categorize and understand the phenomenon of women executive leaders in the healthcare industry (Creswell, 2014). The deduction enabled the transformation of evidence collected from the participants' explanations (Creswell, 2013).

The transcription was completed and the data was coded. Codes are generally devices, themes, or words used to identify trends or generalities (Cohen & Crabtree, 2006). The purpose of a code was to condense data or summarize it: not to reduce the quality of the data. The researcher sorted through each of the interviews looking for similar phrases or themes that were relayed by the participants.

The researcher analyzed the data searching for units of meaning that are reflective of various aspects of the participants' experiences. HyperResearch qualitative software was utilized for the analysis process. Results were reported by individual topics using qualitative

interpretation of ideas and thematic review. All participants received a thank you letter for their participation in the research. In addition, the participants were instructed that they would receive a summary of the study findings as well as a complete copy of the dissertation, if they so desired (See Appendix G).

### **Summary**

Much research has been conducted on the topic of women in leadership roles and the gender disparity that exists in the top ranks of corporations; however, there has been a lack of information in the literature that discusses how women in healthcare have overcome obstacles and navigated through the labyrinth to obtain executive-level positions.

A qualitative phenomenological study was used to identify the barriers and challenges that executive-level women have overcome in their career journeys in healthcare. This chapter explained how qualified participants were identified and provided the interview protocol that was utilized. This chapter also presented the methodology, research design, research population and sample procedures, as well as issues of data collection and instrumentation. The latter part of the chapter covered data analysis procedures, validity, reliability, and ethical considerations.

## **Chapter 4: Findings**

The purpose of this qualitative phenomenological research study was to examine the lived experiences of women who had successfully climbed the corporate ladder and achieved executive-level leadership success within the healthcare industry. Analyzing the lived experiences of others allowed the researcher to explore the individual reflections, feelings, memories, perceptions, and judgments of female executives in healthcare. This chapter provides the results of the study by presenting the results of the research, the data analysis, and interpretations of the executive-level women's interviews.

Data for this research were obtained via interviews that addressed the central research question and two sub-questions. Seven guiding interview questions were used for collecting data to answer the central question and two sub-questions (See Appendix A). The seven broad-based questions were used to lead the interview, but also allowed the women to provide in-depth answers without imposing undue influence (Moustakas, 1994). Each interview question was focused on identifying what obstacles, if any, the executive-level women had encountered on their career journeys in healthcare. The participants were also asked to identify what leadership characteristics and traits they believe they demonstrate and that have made them successful on their career paths.

The current phenomenological study involved 10 participants who were interviewed. One participant was interviewed in person at her office, which was the natural setting of her choice. Due to geographic distance, the nine other participants were interviewed via telephone. On average, the interviews took approximately 60 minutes to conduct. All of the participants were willing to be audio recorded; therefore, the interviews were conducted, audio-recorded, and then transcribed by the researcher in HyperTranscribe. Once transcribed, the source files were then

uploaded into HyperResearch, a qualitative data analysis software for aiding analytic coding. Working from the transcripts, the participants' responses were grouped into themes that were reflective of the research question. Although the lived experiences of the participants were varied, some emergent themes arose after analysis of the data.

This chapter provides the results of the analysis and a discussion of the findings, including narratives of the participants' lived experiences. This chapter is arranged in sections. First, a brief description of the women is provided, including their demographics. Next, the analysis of the findings is discussed, followed by a summary of the results.

### **Demographics of Participants**

To comply with the confidential nature of the study and to protect the identity of each participant from potential disclosure, the participants' names, specific geographical location, and company identifications were not reported. Further, data for age, education, and personal background information have been reported in aggregate.

1. Participant A0618: A Vice President and Chief Development Officer employed as an executive for 12 years
2. Participant B0625: A Chief Executive Officer employed as an executive for 3 years
3. Participant C0630: A Chief Financial Officer and Vice President employed as an executive for 18 years
4. Participant C0702: A Partner employed as an executive for 5 years
5. Participant D0702: A Chief Executive Officer employed as an executive for 13 years
6. Participant E0703: A Chief Nursing Officer employed as an executive for 10 years
7. Participant F0706: A Chief Medical Officer and Associate Dean employed as an executive for 18 years

8. Participant G0713: An Executive Director employed as an executive for 16 years
9. Participant H0713: A Chief Executive Officer employed as an executive for 13 years
10. Participant I0716: A Chief Nursing Officer employed as an executive for 12 years

The semi-structured nature of the interviews meant that the participants' information was not always discussed in the order suggested by the interview protocol. As a result, the results of the participant answers have been arranged by demographics and associated research question. To reduce researcher interpretation and to allow the voices of the participants to be heard, quotes from the participants' interviews have been included.

Table 1 provides information regarding the executive-level leaders' background demographics. Research has demonstrated that life factors such as marital status and motherhood influence the decision-making of executive women (Hewlett & Luce, 2005). It was reported that all of the executives were married, but one was divorced and then remarried. One participant had no children (10%), one participant had one child (10%), five participants had two children (50%), two participants had three children (20%), and one participant had six children (10%). The participants' age breakdown was as follows: one participant was between the ages of 30-39 (10%), two participants were between the ages of 40-49 (20%), five participants were between the ages of 50-59 (50%), and two participants were between the ages of 60-65 (20%).

**Ethnicity and geography.** All of the participants categorized themselves as being either White or Caucasian on the demographic questionnaire that was completed and returned prior to the interview. Although a few of the respondents talked about relocating for employment reasons, they were all currently employed in the United States, which was a requirement for participation in the study. The participants were located in: Texas (1), Virginia (1), Oklahoma (2), and California (6).

**Education, employment setting, and role/title.** The executive-level women's education was reported on the demographic questionnaires, but also discussed during the interview. The women reported their education levels to be as follows: medical doctor (1), doctoral degree (1), undergraduate degree (3), and graduate degree (5). They types of degrees received are presented in Table 1.

Table 1

*Degrees Received*

level of degree	field	percentage of respondents
undergraduate	communications	10%
	accounting	10%
	nursing	10%
graduate/masters	nursing	30%
	healthcare administration	10%
	business administration	10%
doctoral	nursing	10%
	medical doctor	10%

The types of facilities in which the participants of the study were employed varied as well. These women were employed in the following settings: home health agency (1), accounting firm (1), hospital (4), and academic medical facility (4). Although the researcher did not actively attempt to vary the interviewees' roles, the study's participants were diverse. They were employed in the following roles: Vice President/Chief Development Officer (1), Partner (1), Executive Director (1), Chief Financial Officer (1), Chief Medical Officer (1), Chief Nursing Officer (2), and Chief Executive Officer (3). The participants reported varying lengths of employment in their roles (from 1 year to 20 years), however, the average length in the position was 5.86 years. Although the amount of time that they had been in their roles varied, all of the participants were employed in executive-level leadership roles for a minimum of 3 years.

As part of the demographic questionnaire, the participants were asked to rate their level of happiness in their lives on a scale from 1-10, with a score of 1 equating to being completely unhappy and 10 equating to being perfectly happy. The women reported their happiness, on average, as an 8.4. The individual ratings were: 5 (1 participant), 7 (2 participants), 9 (5 participants), and 10 (2 participants).

### **Analysis of Findings**

**Journey into healthcare.** The career journeys of the women that were interviewed were varied and diverse from each other. Four of the women began their healthcare career journeys working from the bottom up.

- I started (in organization) as a Certified Nurse Assistant in 1986 (Subject D0702)
- My first position in healthcare was when I was 16 years old and I was washing dishes in a hospital kitchen. I was a dietary aid (Subject E0703)
- Well my first career journey was making auger plates in college and being a lab tech (Subject F0706)
- For part-time employment I began working at a hospital. I began at a ground level position in a part-time capacity. I was a guest relations representative (G0713)

The other women interviewed began their healthcare career journeys after finishing their bachelor's degrees. All but two of the participants knew that they had a desire to work in healthcare prior to entering the field.

**Challenges.** All of the participants spoke of unique challenges they had encountered on their career journeys. The overall theme was that they experienced challenges or obstacles related to being a female, as well as family challenges and challenges with confidence. Many



expressed being currently challenged. Each of these challenges is analyzed further in the following sections.

**Challenges: Gender.** Four of the women that were interviewed came from the same healthcare system, although they worked in different hospitals within that system. Each of these four women stated that the system was progressive and supportive of the advancement of women; therefore, they did not feel that they had experienced gender bias in their career journeys. However, one participant did state that advancement in the organization could potentially be affected because the current top two executives in the organization are male. She stated, “Our CEO came from finance, so she could follow in his footsteps, unless she’s held back because she’s a woman. I don’t know” (Subject A0618).

The six other women discussed gender bias and the challenge of being female in the upper echelons of the male-dominated healthcare field. Two of the women spoke specifically about the network that men have and how they utilize that network to help promote and advance one another: “I think in my current organization there is definitely a good ol’ boys club mentality” (Subject G0713) and another:

Well, the biggest challenge I have is the good ol’ boy country club. The good ol boy’s protect themselves. They promote each other. They are very, big egos, and you as a female, have to work harder. Yeah, and it’s a very big obstacle just because the men will always stick together. (Subject H0713)

Another theme that was brought up regarding gender was the inappropriate use of women using their feminine qualities to advance themselves in the work setting.

I feel very strongly that I’m not going to use my gender to get ahead. I’m going to earn my place equal and alongside. I don’t want to be put down because of my gender, and I

don't want to be pushed ahead because of my gender, but I want equal opportunity alongside anybody else. I just don't want there to be an issue. (Subject C0702)

The other obstacle for a female and for myself is that you have to make sure that you don't use any feminine, and that's hard to explain, but you don't use any feminine characteristics to get the work done. And what I mean by that is that I've worked with a lot of female executives that are flirtatious, their appearance is something I wouldn't feel comfortable wearing to work. I always go on interviews wearing a pant suit, and I think that's a challenge for me, because I am petite. And not that I want it, but I get a lot of attention. I really work hard to ignore the attention. (Subject G0713)

**Challenges: Family.** Of the 10 women that participated in the study, 90% of them had children. Of those that were parents, all of the participants spoke of family responsibilities and commitments as being one of the challenges they encountered in their career advancement; however, due to the certain stages of life the women were in, the challenge of balancing a family with a career was different depending on the age of the children. The youngest participant in the study also had the youngest child, who was 6 months old. She spoke very candidly about the difficulties she had with trying to coordinate family responsibilities with owning a growing business, especially since two of her three children required special medical attention.

Do I really want to be at home all day every day, or three days a week, that's a constant struggle for me. I don't have the magic answer. I know in my heart that I want to be there for my kids because in the blink of an eye they'll be grown. And I think even after the elementary stage, they'll be a lot more independent, where they won't need me as much. And I can work more, because I love working. I love what I do and we don't have any

goal to sell [the company] any time soon. So we just want to grow where we are. But now I have a 6 month old. (Subject I0716)

Of the nine participants that spoke of the challenges of balancing a family with a growing career, eight women spoke about the importance of having a supportive husband. Two of the women discussed that they had switched caregiver roles with their husbands so that they could be supported in furthering their careers.

You really need to have a spouse who can be so flexible and so available. Which I have. I have been so fortunate. My husband is a high school teacher. We switched caregiver roles 10 years ago when I came back and I started going through the ladder with the catholic health system. He and I had the deliberate conversation, and we said, ok, obviously I have the much higher earning potential than he does, we need to switch caregiver roles. And that was really hard for me to do. I love being a caregiver. . . For a female to advance, it's not impossible, but you've got to be such an equal partnership, but it takes a unique partner. (Subject C0702)

And:

We thought it was a huge growth opportunity. My husband, when my oldest daughter was born, we made the decision that he would be a stay at home dad. At the time we had a 3 year old, a 2 year old, and newborn twin girls. (Subject G0713)

One of the women spoke of the challenges that she had gone through of getting divorced while receiving a promotion and obtaining her doctoral degree at the same time.

I must say that I have an amazing husband. I think there were sacrifices in my life because I did go through a divorce during my doctoral education and because I was pursuing the advancement of strong and healthy women that that was threatening, to the

marriage. And that was unfortunate. But I'm married to a wonderful man who embraces all that I am. (Subject D0702)

**Challenges: Confidence.** Of the 10 executive-level women in healthcare that participated in the study, half of them discussed the challenges that they have dealt with previously and continue to deal with in regard to feeling a lack of self-confidence, whether at home or in the work setting. Their responses were honest and candid in sharing what they had experienced in life. One spoke about not feeling confident in knowing the data, with regard to her lack of knowledge of the financial skills that were required of someone at her level. Another spoke about her lack of confidence at home because she did not feel like she was knowledgeable about what her children were experiencing in school. The following response was given when asked by the researcher what her leadership weakness was:

There's something called the imposter syndrome, and as women leaders one of the things that we typically deal with, we deal with this feeling of "I'm a fake." [We tell ourselves] "I don't really have the talent necessary for the position that I find myself in" and "it's just a mistake that I'm here." So now and then [I have] that little sort of doubt. (Subject D0702)

The imposter syndrome (also called the imposter phenomenon) is a term that was first identified by psychotherapists Pauline Clance, PhD and Suzanne Imes, PhD (1978). Persons dealing with the imposter syndrome experience intense feelings and beliefs that they do not deserve their achievements, worrying that they will be exposed as a fraud in their accomplishments. When imposter syndrome was first described, Clance and Imes believed it was unique to high-achieving women. However, recent research has determined that both genders can have the undesirable experience of dealing with it (Sakulku & Alexander, 2011).

According to Weir (2013), many people who experience feeling like imposters were reared in families where achievement was largely emphasized. Particularly, being raised by parents who sent mixed messages, alternating between criticism and over-praise, can increase risks of individuals feeling like they're imposters; societal stresses and pressure adds to the problem. As a result of this participant's feelings of lack of worth for her position as CEO of a major hospital, the researcher suggests further studies be conducted on high-achieving women in healthcare and how many of them deal with feeling that they are not worthy of their career accomplishments.

The following response was given to the researcher's question about her leadership weakness:

A lot of it was my own confidence. You know, being in a predominantly male room, I find myself, you know, writing. . .well I had several good friends that of course were the guy executives and I would write notes to them with my ideas instead of speaking up on my own. I had a hard time speaking up with my own voice. Because I didn't want to be labeled with stupid ideas or whatever. I had a hard time finding my confidence. . . But finally one of them said, "Stop it, stop it. If you have an idea then say it. Say it. I'm not your voice." But to this day, when you're the only female in the room you find yourself apologizing or speaking with qualifiers, "I don't know if this is right, but. . ." (Subject C0702)

***Currently challenged.*** Eight of the 10 women expressed that they were currently experiencing challenges, although for various reasons. Three women discussed how they had reached the pinnacle of their careers and did not know where they saw themselves advancing to move forward in their careers. One spoke about the obstacle that she was experiencing by the

fact that her family was so content that she did not see it possible to advance in the career opportunities that had been presented to her, which would possibly require more travel or even relocation.

One of the women spoke about currently looking for a new career opportunity and how she was currently facing challenges with that obstacle:

I think I have to take responsibility for that. I think part of my career progression is that I'm not, I'm very assertive in the workplace, I can make a decision and I move on. I take responsibility for it. But I can tell you, out in interviews people that know me will say that I'm tough, but I'm fair and what not. But right now my thing is that I can't boast about myself. I have been told by executive recruiters that I am too humble. So that's my own fault, because that's not who I am. So that's, in the last few months I have gotten a little bit better, but over the last 4 or 5 years when I've been out interviewing, even when I've had positions, that was always an issue for me. (Subject H0713)

When asked whether she felt that her lack of being able to boast about herself was related to confidence, she stated that she did not believe so.

## **Mentorship**

Mentorship is defined as having a wise and trusted counselor or teacher who is able to act as an influential supporter or senior sponsor ("Mentorship," n.d.). Professional mentorship relationships vary from having someone help with obtaining a job or acting as a reference to providing career advice and assistance. When asked about their career journeys and if they had had any career mentors, 80% of the women spoke about receiving mentorship from males; 40% of the women spoke about receiving mentorship from females. Fifty percent of the women spoke about how they had experienced no women mentors or how they had negative relationships with

women who had demonstrated behaviors that they have chosen not to emulate. “When you get into the upper echelons of healthcare administration, there aren’t many females. The one’s I’ve encountered have not always been someone you want to emulate. So while they were mentors, they weren’t always positive mentors” (Subject C0702). “I’m not sure I’ve had a female mentor, though. I’ve had good friends that have traveled the path with me, but I’m not sure I’ve had any female mentors” (Subject F0706). Another subject stated:

I haven’t had mentors, but I have had tormentors; many of them were women. Nurses eat their young, they’re kind of like sharks. When I was an OR nurse and was being trained, they would leave parts of the education out of how to do a procedure or how to set up a room. They wanted to be the hero in the physician’s eyes. It was about building relationships and not necessarily hiding information. That happened a lot. It happened a long way throughout my career even when I reported to associate admins that were female. They didn’t want to share. (Subject H0713)

### **Leadership Strengths and Styles**

According to Eagly and Carli (2007a), it is often believed that women lead in a way that is more democratic and collaborative than men do. Therefore, the researcher wanted to identify leadership characteristics, attributes, and styles that executive-level women in the field of healthcare attribute to themselves. The participants spoke about the importance of good communication, understanding soft skills, having passion for what they do, and working well with teams. However, they also discussed the importance of delegation, visioning, being determined, and being decisive. Table 2 presents a summary of the findings.

Table 2

*Leadership Strengths and Styles*

Participant	Personal Leadership Strengths
A0618	Accepts challenges Accepts responsibility Adapts to change Hard worker (puts in hours needed) Hires the right people Identifies/recruits strong teams
B0625	Accepts change Clear/transparent Decisive Makes decisions Moves forward Not intimidated Open/honest Organized Politically astute Pulls right people together Supportive of team
C0630	Candid feedback Compromising Delegating Develops strong relationships/teams Enthusiastic Good change agent Innovative Listens Passionate Understands importance of mentorship Understands soft skills Visionary
C0702	Compassionate Not a micro-manager Sees big picture Team player (never says, "That's not my job") Volunteered to do every job
D0702	Creative Decision maker Diligence Guides and inspires others Innovative Optimistic Persistent Sees challenges as opportunities Strategic planner Strong implementation skills Visionary

(continued)



Participant	Personal Leadership Strengths
E0703	Being visible Determined Fair/honest Hard worker Maintains good connections with people Strong emotional intelligence Transparent communicator
F0706	Allows autonomy Good listener Good team player Honest: "Person of my word" Inclusive Kind Looks for opportunities
G0713	Collaborative Determined Humble Independent Not weak/not a pushover Self-sufficient Sticks to her guns when it's important Strong
H0713	Assesses positives and negatives Determined Fiercely independent Good decision maker Hold others accountable Likes people See big picture Strives to be better Strong in finance
I0716	Accepts others Assertive Calm Determined Good communicator Good judge of character Sees big picture Strategic planner

### Personal and Professional Regrets

When the women were interviewed for the research, each participant was asked if she experienced any personal or professional regrets that they wanted to share with the researcher.

Out of the 10 women that were interviewed, four of the women stated that they had no personal regrets; six women stated that they had no professional regrets. Four of the ten participants stated

that they had personal regrets; four of the 10 stated they had professional regrets. The following sections present a summary of their responses.

**No personal regrets.** Of the women that spoke of personal regrets, two participants spoke of wishing that they had advanced their education and two participants spoke of family challenges. When asked if she had any personal regrets, one respondent stated:

I don't. I'm thankful that I got my education when I was young and had time to commit to it. The other thing I did when I was early in my career was I achieved my professional certifications and my fellowships and my societies. It would have been difficult down the road so I'm glad I did that early. Every career move and step, it was part of a bigger plan. I don't regret that, I embrace that. I don't regret the time in New Orleans, but it was a difficult year. Some people would have viewed the job I took here in Oklahoma as a lateral, if not even a step back just with regard to titles, but for us what it was a chance to stabilize the family. And then over 9 years it's grown from 2-3 promotional opportunities. I don't regret any of that. I think I don't have any regrets or do-overs. (Subject G0713)

Another participant stated:

I do wish I had tried to handle those years better, with my daughter, maybe they wouldn't have lasted as long. Now granted, she doesn't have any lasting effects from it. She's healthy now, psychologically and physically. But I wondered if I should have stepped down, but the thought of, but my goal was to be controller by the time I was 30, God I'm so type A, I did it, I made it, and I wasn't going to step down. My next goal was to be CFO. I don't know, maybe I shouldn't have been so focused. I do wish I had handled those middle years. . . I maybe could have stepped back for a year, or maybe I could have done something that would have put me in the home more. It's hard to say regrets. I do

wish I had thought through some different options. But everyone is happy, healthy, and good to go today. So I'm thankful for that. (Subject C0702)

One participant stated:

I probably would have considered getting my master's earlier. I don't have my master's now, but it's not something that has held me back. But I do wish that I would have done that early in my career so I would have had that done and over with. (Subject C0630)

**No professional regrets.** Some subjects relayed that despite the obstacles and challenges they had encountered, they had no professional regrets:

No, I feel really good about that. I will say that I have applied for positions in (the healthcare system) that I have not gotten. That sometimes was devastating. And at the time, you don't know where you are going and what the next step will be and you kind of feel defeated, but each of the times that the decision was made and I wasn't the right fit or I didn't get the job I always maintained my confidence in myself and looked at how can I grow. And take the feedback that's provided to me. I even applied for a CEO position a year before I got this one and it wasn't the right timing, it wasn't the right fit. I didn't necessarily agree at the time. It was very difficult for me to accept that, but looking at it now, it was the right decision. (Subject D0702)

Another participant stated:

I think back at (the hospital), I probably regret, you know I put my hat in the ring for the VP of patient care. I should have been more assertive at the time, saying, you got to at least let me interview. But I didn't at the time. I knew I was a young mom and when the CEO says you're just too young. . .but 6 months later when the new person was about to be onboard, he pulled me in his office and said, "You've done a great job, and I'm

regretting. . .” So he did say in a very nice way that he regretted not letting me interview. But on the other hand, the doctors weren’t ready for it and I wasn’t going to be successful if the doctors thought they had to have somebody from the outside. (Subject E0703)

## **Summary**

This chapter presented the results that were obtained from the qualitative phenomenological study of the lived experiences of 10 executive-level women who had reached the upper echelons of healthcare employment. Also presented were the demographic data and themes derived by the analysis of the study as they related to the open-ended interview questions. The challenges that the women executives identified in the study were related to gender, family, self-confidence, and being currently challenged due to various reasons, but predominantly because they had reached the pinnacle of their success.

The information obtained in this inquiry will be of value to women who desire to obtain executive-level leadership positions within the field of healthcare. This study also provides additional information to the existing body of knowledge regarding the career paths that women have taken to achieve positions in the upper echelons of healthcare. The following chapter provides a discussion of the findings, conclusions, and considerations and recommendations for future research.

## **Chapter 5: Study Discussion and Conclusions**

Women have been an increasing presence in the workforce since the time of World War II, when men were leaving their positions and women were needed to fill in the industrial gaps. Despite the fact that women have been an increasing presence in the workforce, they continue to be underrepresented in the upper echelons of management and leadership. The same is true with regard to the healthcare industry, a major industry within the United States economy.

The purpose of this qualitative phenomenological study was to explore the lived experiences of women in executive-level leadership positions in healthcare and identify the obstacles and challenges, if any, that have impacted their career journeys. Lived experiences allow the researcher to explore individual feelings, memories, perceptions, reflections, and beliefs on being a female executive in healthcare, which were taken from the specific experiences of women who have lived those experiences. In order to gather the data needed for analysis, one central research question guided the study, which was addressed through two sub-questions.

The phenomenological design provided a theoretical anchoring for the study of 10 individuals and the experiences they have lived through the context of a single phenomenon (Creswell, 2013). In a phenomenological study the researcher is the vehicle of inquiry (Richards & Morse, 2013). However, data are collected through the observation of participants, by conducting personal interviews, via questionnaires, through focus groups, and by analyzing individual case studies (Patton, 2002). After considering the potential methods of data collection, the personal interview was chosen as the data collection method for this study.

Personal interviews allowed for the assimilation of the participants' experiences into both structural and textural descriptions of one single phenomenon (Creswell, 2013). According to

Richards and Morse (2013), the use of individual interviews is deemed appropriate when the researcher has personal knowledge and an understanding of the research topic. Zikmund (2003) relayed that interviewing participants allows for the gathering of precise and complete information. The benefit of conducting personal interviews was that the participants had control over the location, which increased involvement and allowed for greater candor.

### **Data Source and Delimitations**

The interview protocol contained seven guiding questions. Due to geographic restrictions, nine of the participants were interviewed via telephone. One participant was interviewed in her place of business, which was the location of her choice. The interviews were all audio recorded and then transcribed using HyperTranscribe software. All interviews were completed in approximately 60 minutes. Once the data were transcribed, the transcriptions were reviewed to identify themes and to attach codes to those themes using HyperResearch qualitative software.

The delimitations associated with this study were as follows:

1. Participants were delimited to those women who were currently or previously employed in an executive-level healthcare role.
2. Participants' responses were based on their own personal lived experiences with the phenomenon of being an executive-level leader in the healthcare industry.
3. Participants' experiences and data were based on their individual memories and recollections and are assumed to represent an honest, credible reflection of their career journeys.
4. Executive-level women in healthcare who lacked a minimum of 3 years of leadership experience were not included in the current research study. However, these

individuals may have pertinent information regarding the obstacles and challenges of the industry.

The population utilized for this study was composed of women that were employed in executive-level healthcare positions as CEO, CFO, CMO, CNO, VP/CDO, Partner, and Executive Director. The women worked in various organizations, including hospitals, academic medical facilities, a home health agency, and an accounting firm. They resided in four different states (California, Oklahoma, Texas, and Virginia). All women were college-educated and had a minimum of a bachelor's degree.

### **Findings**

The dilemma that the current study explored was that although women comprise over 74% of the healthcare workforce, a disparity continues to exist in the number of women that reach the upper echelons of leadership positions in the healthcare industry (U.S. Department of Labor, Bureau of Labor Statistics, 2015). According to Eagly and Carli (2007a):

Contemporary women still face many challenges, especially in relation to male-dominated leadership roles. They must be brave, resourceful, creative, and smart to be successful, because they can face the most elaborate of labyrinths on their path to leadership. The women who find their way are path breakers of social change, and they usually have figured out how to negotiate the labyrinth more or less on their own. (p. 199)

The research questions explored the lived experiences of executive-level women in healthcare in relation to their perceptions of the situations, conditions, or circumstances of their journeys in obtaining and sustaining an executive position in the industry. Findings are grouped

according to the theoretical framework of Eagly and Carli's (2007a) labyrinth that identified the barriers that women must navigate to reach the upper echelons of organizational leadership.

**Discrimination, bias, and prejudice.** The first barrier identified by Eagly and Carli (2007b) was that women experience discrimination, bias, and prejudice in the workplace, preventing them from advancing to top level leadership positions across many industries. The discrimination, bias, and prejudice associated with executive female leaders are linked to a belief structure of stereotypes that internalizes differences for women and men and acts as an external barrier (Eagly & Carli, 2007b). Because individuals typically categorize others by their gender first, a specific set of traits and characteristics is then assumed. This relationship between traits, gender, and characteristics is the foundation for job placement, division of labor, and performance evaluation (Catalyst, 2005; Eagly & Carli, 2007b; Eagly & Karau, 2002; Heilman, 2001). When women are viewed as displaying too many agentic qualities and not acting communally enough, they are considered to be acting outside their gender norm and are judged negatively (Babcock & Laschever, 2007; Eagly & Carli, 2007b; Rudman & Glick, 2001; Valian, 1999). In general, women are reportedly found to be stereotyped, discriminated against, and even penalized in interviews for demonstrating agentic behaviors (Valian, 1999).

Upon conducting the research and analyzing the data, it was evident that the four women employed in the same healthcare system found that their company culture was supportive of the advancement of females in the upper-level leadership ranks. However, the other six women that were interviewed stated that they had experienced some level of discrimination, bias, and prejudice in the workplace, whether in the past or current. One participant spoke of an initiative that her employer had for the advancement of women, but the committee that was spearheading



the cause was a group of all White males. She stated that when she attempted to give input to the members of the committee it was not received well.

However, in conducting the research, it was interesting to note that women are not only not supported in their career advancement by men, but also often not supported by other females as well. This was a theme that emerged during the discussion regarding lack of female mentors and participant's reports of not being supported in their career advancement. Forty percent of participants spoke of having had the assistance and support of a female mentor. Sixty percent of the female executives discussed either the lack of female support in the upper echelons of healthcare or the experience of having women torment them, thus providing them with examples of how not to behave.

**Resistance.** Resistance, as discussed by Eagly and Carli (2007b) relates to females being authentic and true to themselves, representing both an internal and external barrier. Resistance is something derived from the difficulty that females experience in charting the waters between being their authentic selves and not exhibiting behaviors that are too agentic or too communal (Eagly & Carli, 2007a). Resistance can be related to the real or perceived conflict that women experience with their career commitments or responsibilities. As a result, women often experience a double-bind: the prescription for female roles states that they need to demonstrate communal characteristics, but most leadership roles stipulate that the leader needs to demonstrate agentic traits.

The women participants in this study did not indicate or express that they experienced difficulty navigating the waters of balancing their communal qualities of being female and also leaders. However, one theme that did appear in the research was that half of the executive-level women spoke about feeling challenged by their lack of self-confidence at one time or another

during their career journeys into leadership in healthcare. Further research is suggested to identify if confidence is connected to communal characteristics that are typically attributed to female traits.

**Leadership styles.** In addition to how others perceive leadership styles regarding to gender, how women develop and view their own leadership style and competence can be an internal barrier (Eagly & Carli, 2007b). Typically, women are forced to compare their motivation, competence, and style to a male model (Coughlin, Wingard, & Hollihan, 2005). This provides an unfair disadvantage for women, and it also has the ability to prevent females from achieving their career aspirations (Eagly & Carli, 2007a).

The results of studies on gender and leadership styles vary. Some research supports the finding that a difference exists, and other research demonstrates that no differences in leadership characteristics exist. Researchers and theorists are currently debating if any gender differences exist in leadership, and, if they do exist, what those differences are (Eagly & Carli, 2007a; Eagly, Johannesen-Schmidt, & van Engen, 2003).

Based on the response of the participants of this study, eight women stated that they believed that males demonstrate different leadership styles and characteristics than women. The remaining two participants explained that they did not believe the differences were related to gender, stating that they instead believed the differences were related to personality types. One of the women (F0706) talked about how she previously had to coach her male superior to explain how his message was being relayed to his female subordinates. Four of the women (A0618, B0625, C0630, and E0703) spoke about how women are seen as being more emotional than men in their leadership styles. The participants also discussed how allowing emotion to be shown in

situations (such as meetings) can negatively impact women and their credibility in the workplace.

**Family responsibilities.** The challenges and obstacles that women experience when attempting to balance the needs of a family are another workplace obstacle. This is partially the result of the historic role that women have taken when it comes to the home and family responsibilities, especially with respect to childrearing (Eagly & Carli, 2007a). Women in the 21st century remain responsible for the largest portion of home responsibilities. Ultimately, women experience more time pressures between their professional and personal lives than men do. This conflict is of greatest intensity for women with professional careers (Eagly & Carli, 2007b).

Support systems were reported as another challenge. Unlike some men that have stay-at-home wives, women who reach the upper echelons of their careers may not have that same level of support. Women may be balancing executive leadership roles at work and home responsibilities more than their male counterparts (Walsh, 2001). Walsh (2001) noted that although statistics do not currently exist for this phenomenon, interviews with female and male executives demonstrate that males are beginning to take more supportive roles for their female executive spouses; however, differences still exists.

The findings of the current research support the data that family responsibilities continue to be a source of conflict to professional women when balancing a busy career and home life. However, eight of the 10 women spoke about the support that they had for their family responsibilities because of their supportive spouses. Two of the women stated that they had switched caregiver roles with their husbands as a result of their professional roles in advancing

careers and increased earning potential. One participant stated that she chose not to have children, which enabled her to focus on her career instead.

### **Leadership Characteristics**

Transformational leadership is currently conceived as the most effective leadership style and is characterized by (a) “idealized influence, (b) inspirational motivation, (c) intellectual stimulation, and (d) individualized consideration” (Bass & Riggio, 2006, pp. 5-7). Idealized influence is a trait that helps establish employees’ meaning and importance in the workplace. Inspirational motivation is the leader’s ability to have a vision of the future and to be able to effectively communicate that vision to others in the organization (Ayman et al., 2009; Bass & Riggio, 2006). Intellectual stimulation is characterized by the leader’s ability to stimulate his/her followers to be creative and innovative thinkers and approach old situations in new, dynamic ways. Individualized consideration occurs when transformational leaders give individual, special attention to each person’s needs for growth and achievement by acting as a mentor or coach (Bass & Riggio, 2006).

The executive-level women that participated in this study all identified personal leadership styles and characteristics that were consistent with being transformational leaders. Although many did not know the names for the different types of leadership styles, when asked what they felt their leadership strengths were, many discussed the importance of being supportive of their teams. The importance of demonstrating strong people skills was a theme that ran throughout all of the participants’ discussions of their leadership strengths. The women also described strong people skills and the importance of team building and exhibiting good listening skills as characteristics typically demonstrated by female leadership.

## **Recommendations for Future Research**

Although this study was beneficial in providing insight into what challenges and experiences executive-level women in healthcare have overcome, the results from this study cannot be generalized. It is recommended that additional studies be conducted to add a deeper understanding of the barriers that executive-level women leaders experience. Future recommendations for research include the following:

1. This study was limited to 10 women in executive-level leadership positions. A larger study is recommended to provide more data so that more women's experiences could be appreciated.
2. This study considered women of varying ages from 36 to 60+. As a result, their experiences and challenges were different because of their different life stages. It is recommended that women of the same age bracket be studied to determine if their challenges are more closely related to one another.
3. The purpose of this study was to focus on women, in general. Further research could be conducted that would take into consideration whether additional obstacles and challenges are present for minority women.
4. Some women in this study felt they were given opportunities for advancement as opposed to applying for positions. It is therefore recommended that a future study more fully analyze the phenomenon of whether women ask for advancement or wait to be invited.
5. Throughout the course of conducting the research, it became evident how many executive-level women experienced a lack of self-confidence, which they identified

- as an obstacle that they have experienced. Future research is recommended to analyze the relationship and correlation between communal characteristics and confidence.
6. During the interview with one of the women, a CEO of a hospital, she stated that she sometimes experiences a lack of self-confidence and suffers from imposter syndrome. She worries about feeling inadequate for her position and being found out that she is not qualified for her role. Further research is recommended to analyze imposter syndrome in high achieving women.
  7. The purpose of this study was to analyze what challenges that women have experienced in their career journeys in healthcare. It is recommended that a study be conducted to compare and determine what challenges, if any, that men have experienced in their journeys to executive-level leadership in healthcare.
  8. Throughout the course of this research, it was determined that 11% of women have reached CEO positions in healthcare. Future research is recommended to determine if women aspire to be in CEO roles in healthcare at the same ratio as men do.
  9. Throughout the course of conducting the research, it became evident that executive-level women are sometimes the factors that stand in the way of career progression for other executive-level women. It is recommended that further research be conducted to identify if female executives are more or less supportive of their female colleagues. A study that analyzes this topic would potentially help women identify behaviors that are non-supportive, if they exist.
  10. Future research is recommended to determine ways that organizations, and men in particular, can mentor and encourage advancement for women in the workplace.

## Conclusions

Women have made great, courageous strides in gaining some level of equality in the workforce over the past few decades. However, as evidenced by the findings of this study, disparity continues to exist in the upper levels of leadership regarding how many women fill positions in executive suites. Based on the findings of this research, this phenomenon appeared to be consistent with two of four of Eagly and Carli's labyrinth (2007a), as outlined in the theoretical framework. The following five conclusions were drawn from the ten women participants who shared their experiences as executive women in the healthcare industry.

**Conclusion 1: Some women in the 21st century, discrimination, bias, and prejudice are still experienced while climbing the corporate ladder in the healthcare industry.** The first conclusion drawn in this study was based on the six female participants who had experienced some form of discrimination, bias, and prejudice during their career journeys. As a result, the research demonstrated that some women still experience some level of discrimination, bias, and prejudice while climbing the corporate ladder in the 21st century in the healthcare industry. According to the research conducted in this study, this level of discrimination was not solely conveyed from males in the workforce; many of the participants spoke about having women who prevented them from exceling in their journeys of career advancement.

The other four women did not experience discrimination and prejudice on their career journeys. Although they were not employed in the same hospitals, they were all a part of the same hospital system. Each of them attributed their success in their careers to the fact that the organizational culture was supportive of the advancement of women and had many women leaders in top positions. As a result, it was concluded that for these women, organizational culture can have a direct relationship to the career advancement of the women employed.

The implications for practice for this conclusion are that women need to have access to more skilled, supportive leaders who are willing to mentor them at all levels. Women need to seek out mentors, both male and female, who can help them see their potential and work toward career advancement in the ranks of organizations. To that end, women need to be supportive of other women's advancement and help provide mentorship to younger women who are currently navigating through the challenges of climbing the corporate ladder. Women, as found in this study, reportedly tend to keep other women from success and advancement within organizations.

Another implication for practice is that organizations need to realize that if they are not supportive of high potential female employees in their organization then they risk losing them in their talent pool. Employer mentorship programs for women with advancement potential could possibly help keep female talent engaged in their current organizations. Employers are encouraged to ask women with high potential if they are interested in advancement and make attempts to support them on their career journeys of navigating through the obstacles and challenges of the workplace.

Implications for scholarship are that more research and information needs to be conducted to determine what discrimination, bias, and prejudice does to keep qualified women from achieving higher levels in the workplace. The current research concluded that of the 10 women that were interviewed, more than half of them reported that they still deal with levels of discrimination, bias, and prejudice. Scholarly research should be conducted to determine how much of that discrimination, bias, and prejudice is from men holding women back in the workplace and how much of that is attributed to other women keeping their female peers from career advancement.



**Conclusion 2: For some women, the phenomenon of resistance is not always experienced while climbing the corporate ladder.** According to Eagly and Carli's (2007a) framework, women are often met with resistance when they attempt to climb the corporate ladder. This resistance reportedly is a result of women feeling the need to balance communal characteristics of being female with agentic characteristics that are most often attributed to qualities perceived as being a strong, effective leader. However, the results of this study concluded that the participants did not report experiencing difficulty balancing their communal characteristics with agentic characteristics. The women participants did not feel they had compromised, or been inauthentic, to themselves in effort to accommodate behaviors that were considered to be consistent with male leadership.

As the researcher, it was promising to hear that the women interviewed had not compromised their authenticity to conform to the expected behavior roles of agentic (masculine) leadership traits. However, it was not evidenced anywhere in the findings of the literature review how many women had felt the need to conform their styles to expected leadership traits, resulting in feelings of the double-bind. It is recommended that more research be conducted on women who have felt the need to change and adapt their leadership style, to traits that are perceived as being more agentic, in effort to successfully navigate the labyrinth of climbing the corporate ladder.

Implications for practice for this conclusion are that women reportedly lead in a more transformational style than men. As research has developed in the field of leadership, communal characteristics such as teamwork, collaboration, support, and listening have become more emphasized as important traits for strong leaders to demonstrate. As a result, women who exhibit characteristics such as these, or other communal characteristics, may be promoted into higher

level leadership ranks in their organizations. Career rewards, promotions, or advancements in the workplace for women who are able to lead in a way that is authentic to their true style may result in women not having to alter and conform their leadership styles to that which is considered more agentic; therefore, decreasing the amount of women that face the double-bind.

Implications for scholarship are that further research is also recommended to be conducted to examine women leaders who inherently display agentic characteristics and how they are perceived by their peers and subordinates. In the personal experience of the researcher, when displaying agentic leadership characteristics as a female, other females have criticized and complained that communal characteristics were not displayed enough. It is the belief of the researcher that this is the other side of the double-bind.

**Conclusion 3: The women in this study who have attained great career success were not immune to struggles with self-confidence.** Although the research found that none of the participants reportedly struggled with feelings of resistance during their corporate climb, the study found that five of the participants reportedly struggled with lack of self-confidence at some point during their journey. Some of the women reported that it was a continuous battle. Prior to the onset of the study, it was the researcher's belief that oftentimes women who have reached the pinnacle of their success are perceived to *have it all together* and are self-confident. However, it was concluded that half of the women participants who have attained great career success and outwardly appear to be self-confident are internally struggling with self-doubt and lack of confidence.

For the researcher, this was the most enlightening conclusion of the study. Throughout the review of the literature, the topic of high-achieving women and their personal internal struggles with confidence had not surfaced. Even after the literature review and interviews had

concluded, the researcher began to research confidence and the imposter syndrome to attempt to find more information. It is the belief of the researcher that this information is sparse because women are not encouraged to discuss or place value on their journeys.

With regard to implications for practice, struggles and challenges with confidence in high-achieving women has far reaching implications for women, for both current and future generations. Women who have daughters need to encourage and inspire their children to see their full potential and achieve their desires in spite of life's obstacles and challenges. It is the belief of the researcher that women in today's society have been told that they can *have it all*, and when they are not able to successfully balance their career advancement with all the other challenges they are dealing with they feel that they have failed. However, it is the belief of the researcher that women (and their future generations) need to see their obstacles and challenges not as excuses or reasons to hold them back, but as reasons they have become successful in achieving and overcoming.

Implications for scholarship are numerous. First, it is recommended that future research be conducted to analyze how many high-achieving women struggle with lack of self-confidence. Second, further research is recommended to analyze why women who have outwardly reached the pinnacle of career success but continue to struggle with feelings of self-doubt, being found out that they do not really deserve their current career positions, and that they are a fraud. It is recommended that further research be conducted on the ramifications of imposter syndrome, for women who deal with it as well as how it can possibly impact future generations of females.

**Conclusion 4: Balancing family responsibilities with career advancement in the 21st century remained a challenge for these women.** This conclusion was reached for this study even though it had been reported in the literature how men are helping with family

responsibilities in the home more than at any other time in history (Eagly & Carli, 2007a). These women expressed difficulties balancing career advancement with demanding family responsibilities. This was evidenced by the fact that all nine of the women that had children reported balancing family responsibilities as being a challenge that they had experienced when climbing the corporate ladder. The participants ranged from having no children to rearing six children. Because of the struggles and experiences the women reported during their interviews, it was concluded that balancing family responsibilities continues to remain a challenge for women in the 21st century when climbing the corporate ladder.

Implications for practice for this conclusion are that spousal support and strong support systems in place help alleviate some of the burden of responsibility on women when attempting to advance their careers; in fact, all of the women with children referenced in their interviews that they were able to further careers as a result of the support that they had with rearing their children. However, even with additional support, family responsibilities were still considered a challenge for the women interviewed when growing their careers in the healthcare industry.

The scholarly implications for this conclusion are numerous. First, it is recommended for women who have built strong support systems to help with family responsibilities be interviewed specifically to determine how they have successfully grown their careers and families simultaneously. This would potentially give other women encouragement, ideas and advice on how they can raise a family while successfully navigating the labyrinth of growing a career.

It would also be valuable for women to learn what implications other mothers have dealt with from those who have put their careers on hold to raise a family, and vice versa. The idea of having to *compromise* family for career or career for family potentially has emotional and mental ramifications that have not been previously considered. Scholarly implications for the impact of

family responsibilities on high-achieving women would include researching and identifying how many women chose to derail their careers in effort to support their growing families. Further research should be conducted to determine how many women had put the needs of their family first and to what degree they had put their career growth on hold. Research should include what the emotional and mental responses were for the mothers who made the decision to support their families over advancing their careers.

Scholarly research should also be conducted to determine what emotional and mental implications have been experienced when mothers have chosen to put their career growth ahead of their family needs. It is hypothesized that those decisions have had drastic emotional and mental impacts on women, as well as their children. Further research should be conducted to determine what ramifications, both positive and negative, have been experienced by women and families of executive-level women who put more attention and focus on growing their careers than their families.

**Conclusion 5: Although career success had been attained for these women in the upper echelons of healthcare leadership, this success did not prevent the participants from experiencing current or future challenges on their career journeys.** This conclusion was based on the fact that eight of the women reported that they were currently in challenging situations, although for varying reasons. One challenge that had not previously been foreseen or considered by the researcher was that women reported they were currently facing obstacles as a result of their age. Women spoke candidly during their interviews about feeling that they had reached the pinnacle of their careers, but were faced with unknown circumstances regarding how to advance since they were not near retirement age. This is not something that the researcher

considers gender-specific to women, but is something that is potentially attributed to high achievers, regardless of their sex.

Implications for practice for this conclusion include the belief of the researcher that no matter what career stage a person finds themselves in, challenges will be a part of the journey. High-achieving professionals typically have achievement and advancement ingrained within themselves. Since American workers, both male and female, are employed beyond what had previously been identified as retirement age, it would be beneficial for organizations to identify programs to retain their leaderships' top talent while helping to grow their future leadership pool. These programs could include mentoring younger, high-potential employees through providing career advice. A program of this type could possibly improve employee engagement, particularly the engagement of younger generations.

Implications for scholarship are that beneficial information could possibly be obtained if future research was conducted on how current employees are successfully navigating through their career challenges as they age. It is hypothesized by the researcher, but company culture and employee engagement would be directly impacted by identifying how organizations are successfully retaining positive high-achieving contributors to their leadership ranks, despite the leader's age.

Another suggested research study would be to analyze how other women leaders have successfully diversify their talents and interests as they have aged. The women participants in the study spoke candidly in their interviews about how committed they were to their work and reported that they did not know what to do to keep involved in their employment since they were at a crossroads in life. Identifying ways that high-achieving women have engaged in other life ventures (such as volunteering, providing non-profit support, mentoring, etc.) would be of

interest to those women who have come to similar circumstances and not considered other options available to them.

**Conclusion 6: The women in this study expressed clear distinctions in their leadership practices from male counterparts.** Although the existence of differences between male and female leadership traits are often debated in present-day research, the perceptions of the women in this study reiterated to this researcher that male and female characteristics are different. According to this study, the participants maintained the belief that women demonstrate more communal leadership traits and characteristics than their male counterparts. This study further reinforced Eagly and Carli's (2007a, 2007b) work regarding females and the belief that females demonstrate differing leadership characteristics and traits than males.

### **Summary**

The number of females in the United States' workforce has grown at an incredibly rapid pace since World War II. Despite the belief that women shattered the glass ceiling a long time ago, there is a noticeable absence of females employed in the healthcare industry in executive level positions. The current study was conducted to further contemporary understanding of what obstacles and challenges are faced by women in the 21st century when climbing the corporate ladder in healthcare. As a result, a qualitative phenomenological approach was used to obtain a greater understanding from the individual participants.

While this study has limitations, the data that were collected and analyzed from the interviews of 10 executive-level women in healthcare found that current obstacles and challenges do, in fact, continue to exist for women in today's workforce. This study detailed six conclusions that were derived from the findings. As evidenced by the conclusions, discrimination, bias, and prejudice continue to impact some career journeys; balancing family responsibilities remains a

challenge for executive-level women in healthcare, and other factors attributing to the challenges women face on their career journeys included questioning their own self-confidence. Last, but perhaps most important, these women spoke of a clear distinction in their leadership practices from their male counterparts.



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## APPENDIX A

## Interview Protocol

Table A1

*Interview Questions*

Research Question	What are the experiences that executive-level women have encountered during their career journeys in health care?	
Research Question	Interview Question	
1. What obstacles, if any, have executive-level women encountered during their career journeys in the healthcare industry?	1.	Describe your career journey, beginning with your first position. A. Have you had any career mentors? 1. If so, how many and what was their gender?
	2.	What have you found to be the greatest obstacles or challenges you have encountered on your career path? A. If you have successfully overcome those obstacles, how did you overcome them? B. Do you feel that there are current challenges or obstacles that stand in the way of your career progression? C. Can you identify any gender-related workplace obstacles that have not been previously mentioned?
	3.	How do you balance your personal life with your professional life? A. In your journey was there a particular stage that gave more difficulty managing work-life balance?
	4.	Do you have any regrets or things that you would have done differently, either personally or professionally, if given another chance?
2. What leadership characteristics do executive-level women in healthcare organizations demonstrate?	1.	What personal traits or characteristics would you attribute to your success? A. How would you describe your leadership style? 1. What do you think are your leadership strengths? 2. What do you think are your leadership weaknesses?
	2.	Do you think men and women have different leadership styles or characteristics? A. If yes, what do you think those differences are?
	3.	What advice or words of wisdom would you give to other women in healthcare that aspire to be in an executive-level leadership position?

## APPENDIX B

## Demographic Questions

## Personal Demographic Questionnaire

Working Research Title: Women Leaders In Healthcare: Going Beyond the Glass Ceiling

1. What type of facility are you currently employed? ☐ Hospital ☐ Academic medical facility ☐ Home health agency ☐ Hospice agency ☐ Nursing Home  
☐ Other: \_\_\_\_\_
2. What is a best estimate of the number of employees of the facility? \_\_\_\_\_
3. What is your current position/title: \_\_\_\_\_
4. Length of time in current position: \_\_\_\_\_
5. What is the total number of years that you have been employed in any executive-level leadership position (CEO, CFO, COO, CMO, CNO, CIO, CHRO, CDO, President, Senior Vice President, Vice President, Executive Director, or Administrator)? \_\_\_\_\_
6. What is your age bracket: 20-29; 30-39; 40-49; 50-59; 60-65; 65+? \_\_\_\_\_
7. What is your ethnicity? \_\_\_\_\_
8. What is your level of education? ☐ Undergraduate ☐ Graduate ☐ Doctoral  
☐ MD/DO
9. In what field did you receive your highest level of education? \_\_\_\_\_
10. Identify special certifications and/or professional licenses? \_\_\_\_\_
11. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
12. Do you have children? ☐ No ☐ Yes (if yes, how many/what are their ages?) \_\_\_\_\_
13. On a scale from 1-10 (with 1 being unhappy and 10 being very happy), how happy are you with your current work/life integration? \_\_\_\_\_
14. Any additional comments that you would like to add (optional): \_\_\_\_\_

## APPENDIX C

## IRB Approval

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

June 3, 2015

Cortney Baker

Protocol #: E0615D02

Project Title: Women Leaders in Healthcare: Going Beyond the Glass Ceiling

Dear Ms. Baker:

Thank you for submitting your application, *Women Leaders in Healthcare: Going Beyond the Glass Ceiling*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Harvey, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

**Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

In addition, your application to waive documentation of informed consent has been **approved**.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the

Institutional Review Board (IRB) at [gpsirb@pepperdine.edu](mailto:gpsirb@pepperdine.edu). On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

A handwritten signature in cursive script, reading "Thema Bryant-Davis".

Thema Bryant-Davis, Ph.D.  
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives  
Mr. Brett Leach, Compliance Attorney  
Dr. Andrew Harvey, Faculty Advisor

## APPENDIX D

### Initial Email to Potential Participants

Hello!

I hope this email finds you well. My name is Cortney Baker and I am a doctoral student at Pepperdine University in the Graduate School of Education and Psychology; I am conducting my dissertation research on executive-level women in healthcare and would be honored for you to consider participating. The purpose of this study is to learn more about the leadership journeys of executive-level women who have overcome obstacles in their journeys toward leadership in the healthcare setting. My goal is to identify what, if any, obstacles, barriers, and experiences you have overcome in order to obtain successful careers, as well as determine what leadership style and characteristics you believe you lead with. I would love and appreciate the opportunity to interview you to learn more about your experiences if you meet the qualifications of the study and are willing to participate. Your participation is optional and you can opt out at any time for any reason.

The qualifications for participation in my study are:

1. You have been employed in a healthcare organization (such as a hospital, academic medical facility, home healthcare agency, nursing home, or community mental health center or any supportive organization of such an entity that is operational throughout the United States) in one of the following positions: CEO, COO, CFO, CIO, CHRO, CMO, CNO, CDO, Partner, Senior VP, VP, President, Administrator, or Executive Director.
2. You have been employed in one of the above-stated positions for a minimum of the last 3 years.

3. The organization in which you are employed has a minimum of 100 employees.
4. The organization receives a minimum of \$10 million in gross annual revenue.
5. You feel that you have overcome barriers or obstacles in effort to obtain your leadership position as a woman in healthcare
6. You are willing to share both general and specific details regarding your journey to your executive-level leadership position.

I will provide an information sheet outlining my study. Your identity and the organization(s) you work for will remain confidential.

You may respond to this email with either a yes or no that you meet the criteria and are willing to participate. At that time I will send you a brief demographic questionnaire, provide you with an informed consent, and we can work together to set up a time and location for your interview that is convenient for you. I can come to the location that works best for you or we can organize a time to conduct the interview via video conferencing software.

I look forward to hearing from you and potentially working together on this project!

Sincerely,

Cortney Baker



## APPENDIX E

### Information Sheet

My name is Cortney Baker, and I am a doctoral student in Organizational Leadership at Pepperdine University. I am currently in the process of recruiting individuals for my study entitled, “Women Leaders in Healthcare: Going Beyond the Glass Ceiling” (the professor supervising my work is Dr. Andrew Harvey). The study is designed to investigate challenges and obstacles, if any, that women have overcome in their career journeys in healthcare. I am inviting individuals who have achieved executive-level success in the healthcare industry to participate in my study. Please understand that your participation in my study is strictly voluntary. The following is a description of what your study participation entails, the terms for participating in the study, and a discussion of your rights as a study participant. Please read this information carefully before deciding whether or not you wish to participate.

If you should decide to participate in the study, you will be asked to participate in an interview, conducted either in person or via video conferencing software. The interview is anticipated to last approximately 60 minutes and can be done at a time and location that is most convenient for you and your schedule. The interview will be either video or audio-taped, depending upon the method that the interview is conducted.

Although minimal, there are potential risks that you should consider before deciding to participate in this study. These risks include the fact that some of the research questions may make you feel upset or uncomfortable, although they are not designed to do so. In the event you do experience any level of being uncomfortable, you are able to refrain from answering any question that you do not feel comfortable with, or to stop the interview altogether at any time.

Although there are no personal potential benefits to you for participating in the study, you will, however, be adding to the current body of knowledge that exists regarding executive-level females in the healthcare industry. No compensation or remuneration will be given for participating in the study.

If you should decide to participate and find you are not interested in completing the interview in its entirety, you have the right to discontinue at any point without being questioned about your decision. You also do not have to answer any of the questions in the interview that you prefer not to answer--just state that.

If the findings of the study are presented to professional audiences or published, no information that identifies you personally will be released. To minimize the risks to confidentiality, coding techniques will be utilized and the storage of data will be secure in a place that only the researcher has access to. Your information and data will be handled as confidentially as possible. The data will be kept in a secure manner for at least five years at which time the data will be destroyed.

If you have any questions regarding the information that I have provided above, please do not hesitate to contact me at the phone number provided below. If you have further questions or do

not feel I have adequately addressed your concerns, please contact Dr. Andrew Harvey via email at [REDACTED] or by phone at [REDACTED]. If you have questions about your rights as a research participant, contact Dr. Thema Bryant-Davis, Chairperson of the Graduate & Professional School Institutional Review Board at Pepperdine University, via email at [REDACTED] or at [REDACTED].

By replying to my email and stating that you are willing to participate in the research study, you are acknowledging that you have read and understand what your study participation entails, and are consenting to participate in the study.

Thank you for taking the time to read this information, and I hope you decide to complete the interview. Please remember to respond to the email whether you decide to participate in the study or not. You are welcome to a brief summary of the study findings in about 1 year.

Congratulations on your career accomplishments and I hope to work with you in the future!

Sincerely,

Cortney Baker, M.S., CCC/SLP  
Doctoral Candidate  
Pepperdine University  
Graduate School of Education and Psychology  
[REDACTED]

## APPENDIX F

## Confirmation Letter

Dear Participant,

This email confirms our FACE TO FACE OR TELEPHONE interview scheduled for DATE and TIME. This interview is scheduled to last approximately 60 minutes and will entail open-ended questions regarding your career journey in executive-level healthcare. If you have any further questions or need to reschedule, please contact me directly either by email or phone at [REDACTED].

I look forward to working with you soon,

Cortney Baker

## APPENDIX G

## Thank You Letter

Dear Participant:

Thank you for taking time out of your day, and busy schedule, to participate in my dissertation research study regarding executive-level women in healthcare. Your answers, albeit they will remain confidential, will serve to contribute to the growing body of knowledge regarding women in executive-level leadership positions in the healthcare setting.

After the study is complete, I will be more than happy to send you a copy of my dissertation at your request. Please let me know if that is something that you are interested in. I value your time and thank you for your participation in this study.

Sincerely,

Cortney Baker