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Impact of supervisors' person-centered listening on sense of belonging among occupationally minoritized healthcare professionals

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IMPACT OF SUPERVISORS' PERSON-CENTERED LISTENING ON SENSE OF BELONGING AMONG OCCUPATIONALLY MINORITIZED HEALTHCARE PROFESSIONALS

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by

Nelu Nedelea

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June Schmieder-Ramirez, Ph. D. – Dissertation Chairperson

This dissertation, written by

Nelu Nedelea

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 PHILOSOPHY

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DEDICATION

To my beloved wife, Olivia, and our precious daughters, Maya and Lara: Words cannot fully capture the depth of my gratitude for your endless love, sacrifice, and encouragement. You have been my stronghold, my source of joy and motivation. It is my profound hope that this achievement serves not only as a milestone in our lives but also as an inspiration for you to dream big, aim high, and embrace the boundless opportunities that life offers.

ACKNOWLEDGMENTS

First and foremost, I offer my sincerest gratitude to God, whose unwavering guidance and light have illuminated my path throughout this demanding academic journey. This dissertation stands as a testament to the faith and perseverance that have been my anchors in times of doubt and challenge.

I am immensely thankful to my mentor, Dulce Pena, who played a pivotal role in steering me towards Pepperdine University and this transformative PhD program. Dulce, your wisdom and belief in my potential have been instrumental in my pursuit of this academic endeavor.

To my doctoral committee: Dr. June Schmieder-Ramirez, Ph. D., Chairperson; Kent Rhodes, Ed. D. ; Charles Bray, Ph. D., I extend my heartfelt appreciation for your invaluable guidance, rigorous feedback, and unwavering support throughout this process. Your expertise and dedication have been crucial in shaping both my research and my personal growth.

I am also grateful to the entire faculty at Pepperdine University for fostering an environment of excellence, innovation, and collaboration. Your commitment to nurturing future scholars and professionals has profoundly impacted my academic journey and professional outlook.

Special thanks to my PhD colleagues, Jam Narte Harley and Scott Samara, for their friendship, support, and camaraderie along this challenging but rewarding journey. Your solidarity and encouragement have made all the difference, turning daunting obstacles into memorable milestones.

In closing, I acknowledge that this dissertation is not just a reflection of my work, but a tapestry woven from the contributions, support, and love of all those mentioned above and many others who have touched my life in significant ways. To all of you, I am eternally grateful.

VITA

EDUCATION

Pepperdine University — Los Angeles, CA
Ph.D. in Global Leadership and Change — Graduation: May 2024

La Sierra University — Riverside, CA
Master of Business Administration — Graduated: Summer 2018
Concentration: Healthcare Management

Loma Linda University — Loma Linda, CA
Master of Science in Chaplaincy — Graduated: Summer 2016
Concentration: Chaplaincy

PROFESSIONAL EXPERIENCE

System Vice President of Mission and Ministry, Mercy, Chesterfield, Missouri | October 2022 – Present

Head strategic and operational planning, development, and assessment for programs, policies, and processes related to mission integration, spiritual clinical caregiving, and workplace optimization. Support the Senior Vice President in incorporating organizational mission and values into daily operations for all individuals within the Mercy Health System.

- Defined strategic vision for 220+ team members across the Mercy System; drive integration and alignment by assessing spiritual/emotional support services of newly acquired hospitals to create improvement plans.
- Acted as business liaison for a third-party vendor partnership program, developing and delivering virtual chaplain services for healthcare institutions operating in four states.
- Served as Executive Sponsor for Mercy's human trafficking response education program, coaching and mentoring healthcare providers and hospital staff while forging solid partnerships with law enforcement agencies.
- Collaborated with foundation leadership at Mercy to secure funding for chaplaincy-related programs; analyze market/competitive trends to adopt improved compensation plans for spiritual care professionals.
- Directed the development, preparation, and submission of the biannual Vatican report, a high-level comprehensive report covering activities happening across the healthcare system.
- Expanded the Clinical Pastoral Education (CPE) program via Medicare reimbursements and independent licensing while developing comprehensive professional development pathways for spiritual care professionals.
- Organized regular employee events and conferences, including securing high-level guest speakers.
- Collaborate with senior leadership to integrate mission-focused strategies within the operational frameworks of Mercy Technology Services, Organizational Development and Change, and Clinical Excellence, ensuring consistency and alignment with organizational values.

Director of Mission Integration, Adventist Health, Roseville, California | May 2017 – October 2022
Administered mission integration and daily department operations for a multi-site healthcare system that included hospitals ranging from 28 to 515 beds. Chaired the COVID Resilience Committee and the Mission Life Committee that defined strategic direction and led large-scale campus transformation initiatives aligned with organizational mission and values. Presented to the Board of Directors regarding organizational culture.

- Guided large-scale transformation initiatives across the market, leading to a 155% increase in customer interactions and a 14% improvement in customer satisfaction scores within one year.
- Provided leadership for employee training while expanding the team from 4 to 18 members within 12 months, enhancing diversity and inclusion while significantly improving staff capabilities.
- Cultivated partnerships with external stakeholders such as the Western Diocese of the Armenian Church to train Armenian priests from the US and abroad to improve the patient experience and crisis response.
- Raised funds to open a clinical pastoral education center in 2022 at Adventist Health Glendale.
- Partnered with La Sierra University to offer an MBA program to hospital employees at reduced rates.
- Created and implemented Values in Practice, a staff engagement and retention tool, which enabled cash incentives for employees that are the most engaged in company values. Projected to reduce turnover to 14%, driving up cost avoidance for new hire training.
- Planned and executed two employee retreats, a camping retreat and family farm fun day; resulted in a 20% improvement in staff engagement, as well as a positive working culture.
- Spearheaded a Community Health Forum, connecting government officials and church leaders to establish plans for economic/community development initiatives. Paved the way for strategies to be put in place for managing the two biggest issues, poverty/homelessness and mental health by providing additional resources.
- Involved in coordinating and executing medical mission trips for employees twice a year.
- Led Covid-19 Resilience Committee to develop and deploy programs to reduced stress, burnout, and turnover for 3K employees.
- Started capital campaign of $480K to open a clinical pastoral education center in 2022.

Mission Leader Resident, Loma Linda University Health | Loma Linda, CA | May 2016 - April 2017
Provided emotional and spiritual support, stress management, and conflict resolution to various departments as part of one-year residency. Motivated employees to deliver top results by assessing engagement levels.

- Sparked 20% increase in stress coping skills in the emergency department in six months by collaborating with social workers and case managers to establish a culture of debriefing and building employee resiliency.
- Cultivated a more transparent organizational culture and reduced recruiting costs within the first year by designing and implementing new strategies for attracting, retaining, and grooming employees.
- Played critical role in driving continuous improvement by receiving Six Sigma training.
- Counseled emergency department during 2015 San Bernardino shooting.
- Led events related to National Day of Prayer in 2016 and 2017.

Student Council President, Loma Linda University | Loma Linda, CA | March 2014 – August 2016
As the orchestrator of the School of Religion's student activities, I oversaw the planning and execution of a variety of programs designed to foster intercultural understanding and unity among students of diverse faiths. My responsibilities included the prudent management of our annual financial plan, ensuring an equitable distribution of resources across events to optimize their impact. In collaboration with faculty and student leaders from various academic disciplines, we crafted and delivered initiatives that celebrated religious diversity and encouraged communal harmony. Highlights of my tenure include hosting a special worship gathering at the President's residence, coordinating enriching excursions to notable attractions like Disneyland and the San Diego Zoo, and guiding the student council through regular meetings that shaped the student experience.

Lead Pastor, Seventh-Day Adventist Church | Romania & Canada | September 2003 - March 2014
Recruited team of 30+. Secured partnerships with 35 institutions and successfully launched educational programs for the community. Spearheaded a project that aimed for a 20% reduction in school dropout rate. Managed 50+ volunteers, 20+ projects, and a $550K budget. Oversaw $300K church expansion that led to 25% increase in attendance.

- Coordinated $250K building project in Romania in two years.
- Built partnership with government agencies to provide support for the community, including implementation of programs such as stop smoking, depression recovery, nutrition/cooking classes, school food drive, feed the homeless, and international food festival.
- Developed and integrated iLearnStreet, a unique educational program for the community targeting youth and teenagers. Designed the program, recruited volunteers, and networked with individuals to build program participants. Secured partnerships with 35 institutions and 400+ participants.
- Coordinated and managed $300K church expansion project, including installation of elevator. Project was completed within established deadline and resulted in a 25% increase in church attendance.
- Established a growth-minded culture, which translated to 50% increase in financial performance within first year as Pastor, as well as 25% YOY growth each following year.
- Served as an active member of the K-12 Education Board, as well as Volunteer Director of Immigrant Services.

TEACHING EXPERIENCE

Guest Lecturer/Workshop Facilitator, Leadership Series, California State University, East Bay | October 2022
Provided an overview on personal leadership experience and engaged students in dialogue about leadership, purpose, and life-long goals.

Guest Lecturer, MBA Cohort, La Sierra University, California | February 2023
Presented on experiential learning, creativity, and ethics. Shared personal experiential learning during my Ph.D. journey, particularly the trip to Dubai and social-economical stratification in the United Arab Emirates.

SCHOLARLY CONTRIBUTIONS

Authored a chapter on The Impact of Spiritually Based Leadership on the Efficacy of Diversity, Equity, and Inclusion Initiatives, for the forthcoming *Encyclopedia of Diversity, Equity, Inclusion, and Spirituality (DEIS).*

LEADERSHIP AND SERVICE

Corporate Mission Strategy Team, Mercy | Chesterfield, MO | October 2022 - Present
As a member of the Corporate Mission Strategy Team for Mercy System I am at the heart of organizational development and strategic alignment with Mercy's core values. My role involves collaborating with other team members to shape and guide the integration of the mission across various functions and processes within the healthcare system. This contribution is crucial in ensuring that Mercy's services and internal culture resonate with its commitment to providing compassionate care and excellence in health services. My leadership role includes fostering a values-driven approach to healthcare administration and strategic decision-making.

Chaired Mission Life Committee, **Adventist Health Glendale | Glendale, CA | October 2020 – September 2022**
I was at the forefront of guiding the campus through a significant transformation initiative, ensuring alignment with the institution's core mission and values. This pivotal role involved strategizing and implementing changes that infused the organization's ethos into every facet of campus operations. Regular presentations to the Hospital Board were a key aspect of my responsibilities, where I communicated progress, garnered support, and reinforced the integral connection between the mission and the evolving organizational culture. This period of leadership not only strengthened internal cohesion but also enhanced the institution's external identity, reflecting a deep commitment to embodying the principles that define Adventist Health.

Community Health Needs Board Member, **Adventist Health Glendale | Glendale, CA | October 2020 – September 2022**
Within a collaborative workgroup, I participated in a detailed evaluation of local health needs, contributing to the ideation and formulation of targeted strategies and programs. Our collective efforts were instrumental in forging and nurturing partnerships across the community to facilitate the effective addressing of identified health concerns. My role in this team-centric approach underscored the importance of a united effort in healthcare initiatives, ensuring that our contributions were well-integrated and supportive of the overarching goal to enhance community health and wellness.

Chaired COVID-19 Resilience Committee, **Adventist Health Glendale | Glendale, CA | October 2020 – September 2022**
In this role, I orchestrated a comprehensive support structure aimed at enhancing staff resilience and well-being across a campus serving over 2,200 employees. Recognizing the critical impact of mental health on clinical outcomes, this initiative provided systematic debriefing and counseling services, alongside accessible coping resources, to mitigate the risks of medical errors attributed to burnout and stress. The proactive approach not only fortified the workforce's capacity to manage the high demands of healthcare environments but also underscored the organization's commitment to maintaining a robust, supportive, and sustainable work culture. This endeavor was crucial in promoting a healthier, more engaged, and efficient team, ultimately contributing to the overall quality of patient care.

Member of the Corporate Mission Sub-Committee, **Adventist Health | Roseville, CA | May 2019 – September 2022**
As a dedicated member of the Corporate Mission Sub-Committee at Adventist Health, I actively participated in shaping the critical roles and functions of chaplains and mission integration staff across the organization. My contributions were pivotal in enhancing the spiritual and emotional support infrastructure, ensuring that it is deeply woven into the fabric of the organization's care delivery model. This involved not only the development of role-specific competencies but also the strategic planning of ongoing professional development, fostering a culture that upholds the organization's values in every patient and employee interaction. My efforts supported the creation of a cohesive mission integration strategy that empowers chaplains and staff to effectively contribute to the holistic well-being of individuals and communities served by Adventist Health.

Member of the President's Council, **Adventist Health Bakersfield | Bakersfield, CA | May 2017 – December 2019**
In my role as a Board Member on the President's Council at Adventist Health Bakersfield, I was instrumental in steering the strategic direction for both the hospital and its community outreach initiatives. My responsibilities included providing governance oversight, contributing to policy development, and endorsing programs that align with the hospital's mission to promote health and wellness. With a focus on community-centric strategies, I worked collaboratively to address local health disparities and to support the integration of innovative health solutions that cater to the unique needs of the Bakersfield community. My commitment was to ensure that the hospital's initiatives not only met the highest standards of healthcare delivery but also reinforced its role as a pillar of support in the community.

Student Council President, Loma Linda University | Loma Linda, CA | April 2014 – August 2016
As the President of the Student Council at Loma Linda University's School of Religion, I spearheaded a range of activities designed to enhance the educational and social experiences of our diverse student body. My tenure was marked by a collaborative spirit, where I worked closely with faculty and other student leaders to initiate and establish innovative multicultural programs. These initiatives were aimed at fostering an inclusive community that celebrates diversity and encourages cultural exchange. By successfully launching these programs, we not only enriched campus life but also equipped students with broader perspectives and a deeper appreciation for global religious and cultural traditions.

Healthcare Executive Leadership Committee, Loma Linda University | Loma Linda, CA | March 2016 – April 2017
As a member of the Healthcare Executive Leadership Committee at Loma Linda University Health, I engaged in monthly strategic sessions, gaining insights from senior executives on navigating the complexities of the healthcare industry. This role allowed me to contribute to discussions on emerging challenges and to participate in shaping the organization's trajectory for growth and innovation. Through this mentorship and collaborative discourse, I acquired a nuanced understanding of healthcare management, which informed my approach to leadership and equipped me with the foresight to drive proactive changes in a rapidly evolving sector.

Board Member, B.C. Conference Education Board | British Columbia, Canada | January 2011 – March 2014
As a Board Member for Welcome Shuswap Immigrant Services and the B.C. Conference Of SDA, I was actively engaged in championing the integration of immigrants and refugees, ensuring they received the support necessary to thrive in their new community. My role entailed advocating for programs that facilitated cultural assimilation and language acquisition, while also focusing on educational initiatives that supported the K-12 sector. This dual commitment to enhancing the lives of newcomers and bolstering the educational framework reflects a dedication to social responsibility and community development.

Board Member, Welcome Shuswap Immigrant Services, Salmon Arm, BC, Canada | Jan 2012 – Jan 2013
My shared responsibility as member on the Board of Directors was to determine the work the Society will choose to do in the community, setting out policy to guide employees in their work, setting out a financial budget and overseeing spending as well as staffing. Shuswap Settlement Services Society offers services for immigrant and refugee newcomers, including settlement and integration, translation and interpretation, mentoring, job search assistance and guidance, volunteer matching, and peer support. Shuswap Settlement Services Society also provide outreach and education in the community through community development workshops on anti-racism, multiculturalism, diversity awareness, immigration, and human rights.

SOCIETY MEMBERSHIPS

Association of Professional Chaplains **|** 2020 - Present

RESEARCH INTEREST

- Organizational culture
- Organizational posttraumatic growth
- Leadership development
- Emotional intelligence
- Organizational performance

AWARDS

- Marquis Who’s Who in America – March 2024
- Who's Who Among Students Award – La Sierra University, March 2017
- President's Award – Loma Linda University, June 2016
- Mission Leader Scholarship – Loma Linda University, March 2014

SKILLS

Technical: Microsoft Office Suit, Mac OS, EPIC and other healthcare systems
Language: English, Romanian, French (beginner), and Spanish (beginner)

Leadership:
Strategic Leadership & Visionary Planning, Partnership Building, Cross-Functional Team Leadership, Program & Project Management, Customer & Community Engagement, Organizational Development & Change Management, Team Building & Goal Setting, Data-Informed Decision Making, Budgeting.

ABSTRACT

Significant gender and racial disparities are evident when comparing the composition of the U.S. healthcare workforce to the general U.S. population. Latinx individuals are underrepresented across all professions, while non-White individuals and women are occupational minorities in executive roles and in physician, surgeon, and advanced practitioner roles. Lack of diversity poses problems for underrepresented healthcare professionals, their organizations, and their patients. While diverse professionals experience various forms of microaggression, discrimination, prejudice, and diminished sense of belonging in their fields, these conditions can compromise communication among the various healthcare professionals involved with a patient, in turn, potentially threatening patient safety and diminishing the quality of care. Supervisors' behaviors affect the organization individually and collectively. Therefore, supervisors play central roles in whether an underrepresented individual feels a sense of belonging. This study investigated the impact of supervisor listening behaviors on diverse healthcare professionals' sense of inclusion. Data gathering occurred via semi-structured interviews with 14 physicians, advanced practitioners, or leadership-level individuals who are occupational minorities in their profession working and living in the United States. Participants were asked about their experiences of inclusion and lack of inclusion, the contributors to those experiences, and the role supervisors' behaviors, specifically listening behaviors, in those experiences. Study data were reviewed using content analysis. Study data were reviewed using content analysis. Study findings indicated that critical supervisory behaviors for enhancing inclusion among occupational minorities are seeking to understand and engage subordinates and actively supporting subordinates' development. Person-centered listening was found to improve inclusion through a variety of intrapersonal, interpersonal, team, and organization-level impacts. Based on these findings, organizations are advised to create and deliver person-centered listening based cultural sensitivity and inclusiveness training and to institute

accountability and enforcement measures to ensure that inclusion is actively and deliberately achieved.

Keywords: diversity, equity, inclusion, healthcare, leadership, listening

Chapter 1: Introduction

The U.S. healthcare industry has been facing ongoing disruptions that place increasingly heavy demands on healthcare organizations, healthcare leaders, and healthcare professionals. In addition to financial and competitive trends such as insurance reimbursements that fail to keep up with inflation (Bannow, 2017) and new market entrants such as digital health startups and big tech companies that are disrupting the industry (Ganguly & Kumar, 2022), healthcare providers themselves are constituting another significant industry challenge.

Staffing had been an increasing issue of concern in healthcare for various reasons. First, the U.S. population is aging and living longer, thus, increasing the demand for healthcare (U. S. Census Bureau, 2021). The increased demand complicates an existing staff shortage, particularly in rural areas (Michas, 2022). Michas (2022) reported that as of September 2022, rural areas accounted for 65. 6% of health professional shortages in primary medicine, compared to 29. 5% in non-rural areas. Staff shortages, especially when combined with increased demand, leads to excessive workloads, elevated stress, staff burnout, and difficulty providing high-quality care (Murthy, 2022). These working conditions can make attraction and retention of healthcare workers an ongoing challenge (Hines et al., 2020). Moreover, healthcare workers often receive less pay than workers with comparable education in other industries, further exacerbating the challenges of attracting staff (Gould et al., 2021).

Sexton et al. (2022) found in their 3-wave survey of clinical and nonclinical hospital-based healthcare workers in 2019 (N = 37,187), 2020 (N = 38,460), and 2021 (N = 31,475) that emotional exhaustion significantly increased every year. Sexton et al., additionally noted that emotional exhaustion was higher for nurses than for other provider roles. The Great Resignation, the wave of landmark levels of turnover affecting the entire global workforce during and following the COVID-19 pandemic, affected healthcare particularly dramatically (D. Gordon, 2022). The field reportedly lost 20% of its workforce, including 30% of nurses by 2022, largely due to burnout. Moreover, Mercer predicts that if these attrition trends are not corrected, the

U.S. healthcare industry will experience a shortage of 3. 2 million workers by 2026 (Bateman et al., 2021). For these reasons, it is critical to examine and improve healthcare organizations' ability to retain its workforce.

Across the healthcare workforce, a particularly valuable yet vulnerable segment consists of workers who, by virtue of their gender, ethnicity, or other personal characteristics, are already few in number within their profession. Taylor (2010) referred to such individuals as *occupational minorities*. In healthcare, Latinx individuals are occupational minorities across all professions, while non-White individuals and women are occupational minorities in executive roles and in physician, surgeon, and advanced practitioner roles (U. S. Census Bureau, 2018, 2020).

Although diverse professionals are in particularly short supply, they are vital components of the healthcare workforce because of the heterogeneous patient population being served (Weaver et al., 2021). Diversity among healthcare providers and staff yields benefits such as more equitable access to care, more culturally sensitive care, and improved representation in research because providers and healthcare teams have deeper understanding of their patients' needs and day-to-day experiences (Emery et al., 2018; Morris et al., 2020).

However, in addition to being few in number, occupationally minoritized employees reportedly experience various forms of microaggression, discrimination, and prejudice based on the results of several studies. Various terms are frequently used to refer to the unfavorable encounters that people may have as a result of their race or ethnicity. According to Murray-Garca et al. (2014), implicit prejudice refers to unintentional views toward a person or group that could lead to discriminatory conduct. Stereotyping is the practice of ascribing certain traits to every individual belonging to a group (Dovidio et al., 2008). Microaggressions are defined as brief remarks or interactions that send the wrong message to people because of their membership in a minority group. Examples of microaggressions include remarks that insinuate that Asians should return to their home countries or that Black individuals are prone to crime. Microaggressions are defined by their negative effects on the victim, even if they may not be the

perpetrator's goal (Sue et al., 2007). To improve patient care and create more sustainability in the healthcare workforce, working conditions for occupational minorities also need to improve. This chapter further describes the present study, which is dedicated to examining how working conditions for occupational minorities may be improved as a result of supervisor interactions with them.

Chapter Overview

In the present chapter, the study background and purpose are discussed. Significant gender and racial disparities are evident when comparing the composition of the U.S. healthcare workforce to the general U.S. population. Latinx individuals are underrepresented across all professions, while non-White individuals and women are occupational minorities in executive roles and in physician, surgeon, and advanced practitioner roles. Lack of diversity poses problems for underrepresented healthcare professionals, their organizations, and their patients. While diverse professionals experience various forms of microaggression, discrimination, prejudice, and diminished sense of belonging in their fields, these conditions can compromise communication among the various healthcare professionals involved with a patient, in turn, potentially threatening patient safety and diminishing the quality of care. Supervisors' behaviors affect employees both as individuals and en masse. Therefore, supervisors play central roles in whether an underrepresented individual feels a sense of belonging.

The problem background and problem statement guiding the study are explained in this chapter. Afterwards, the study's objectives and the research questions that informed it are provided. Key concepts are defined, and the significance of the study for both research and practice is discussed. The restrictions and limitations of the study are noted. The researcher's positionality is described, along with the assumptions it is predicated on. The structure of the remaining portion of the study is then discussed, along with the theoretical framework that guides this analysis. A summary closes the chapter.

Background of the Study

In the United States, non-white individuals are underrepresented in executive leadership positions in healthcare. Approximately 11% of hospital CEOs were people of color, compared to 38% of the general population within the U. S (U. S. Census Bureau, 2020). The percentage of people of color in executive leadership positions across all hospital and health systems roles was approximately 17%. Sharma et al. (2016) predicted that although 50% of the U.S. population will be non-White by 2050, the persistent racial and ethnic disparities evident in the healthcare workforce pose significant risks for patient care.

The reason for concern is that occupationally minoritized employees reportedly experience various forms of microaggression, discrimination, and prejudice based on various studies (Dovidio et al., 2008). Various terms are frequently used to refer to the unfavorable encounters that people may have as a result of their race or ethnicity. According to Murray-Garca et al. (2014), implicit prejudice refers to unintentional views toward a person or group that could lead to discriminatory conduct. Stereotyping is the practice of ascribing certain traits to every member of a group (Dovidio et al., 2008). Microaggressions are defined as brief remarks or interactions that send the wrong message to people because of their membership in a minority group. For instance, remarks that insinuate Asians do not belong in the United States or imply African Americans are criminals could fall under this category. Microaggressions are defined by their negative effects on the victim, even if they may not be the perpetrator's goal (Sue et al., 2007).

The many ways discrimination affects the experience of minority workers has been extensively studied and includes social isolation, lost work opportunities, lack of group identity, distress, dissatisfaction with one's job, lowered identification and affinity to the organization, and lowered sense of feeling good (Hennein et al., 2021). Other common results of discrimination include exacerbated isolation and diminished sense of belonging to one’s profession (Brunsma et al., 2017; Clark et al., 2012; Gay, 2004; Haskins et al., 2013; Smith et al., 2007; Torres et al.,

2010). For example, in a 2019 American College of Radiology national survey of radiologists and radiation oncologists, researchers found occupational minoritized workers face increased risks for poor treatment in their employment setting, which present obstacles to their recruitment, retention, and career advancement (Pandharipande et al., 2019).

Underrepresented medical students face disparity and prejudice at each stage of the path through continuing medical education (Fnais et al., 2014). Based on one investigation, Latinx, Native American, and Alaskan individuals applying to medical school are particularly underrepresented (Lett et al., 2019), with discrepancies of 60-70% less compared to the general U.S. population in the same age group. These findings suggest that the poor diversity of the medical workforce may occur far earlier--during the recruitment and retention of underrepresented students. For example, decisions about what applicants to interview are often based on accolades such as grade point averages, test scores, awards, and referral letters. Many underrepresented students lack these qualifications due to inequitable educational access and opportunities in elementary, secondary, and postsecondary school. Moreover, these discrepancies continue into medical school, with fewer Black medical students being admitted to honor societies than their counterparts (Boatright et al., 2017). Significant differences in average the US Medical Examination Step 1 scores are evident when examining scores by race and ethnicity, with white test-takers scoring higher than non-White test-takers (Williams et al., 2020). These test scores are used as the basis for residency decisions, even through research shows weak associations between the test scores and job performance in the clinic. A study by Poon et al. (2019) found that white orthopedic residency applicants were accepted at higher rates than Latinx pupils with numerous articles published and Black applicants with more volunteer hours. These various studies suggest that bias may be continuing to disadvantage non-white medical school applicants, students, and graduates.

Nwora et al. (2021) noted that simply receiving an interview despite the structural barriers facing non-White candidates simply is an achievement. Swapping out in-person

interviews with interviews on Zoom falls short of correcting the systemic racism that enable and encourage the implicit biases and oppressive structures that disadvantage students underrepresented in medicine. Consequently, Nwora et al. (2021) speculated that the change to utilize Zoom interviews would only exacerbate the many factors reinforcing the implicit biases complicating underrepresented students' paths to medical school. Moreover, Nwora et al. predicted that the move to Zoom methods would create new avenues for discrimination during the procedures governing residency applications, culminating in a proliferation of unanticipated consequences and problems for diversity efforts. Furthermore, Nwora et al., predicted that the elimination of recruitment activities that extend beyond interviews (e.g., experiences in clinics and dinners with application committee members) would additionally disadvantage diverse candidates in effectively competing for a place in medical school.

Carmichael et al. 's (2021) study of minoritized genetic counseling graduate students found that most minority students complete their education primarily under the guidance of white instructors and with white students due to the very small number of non-White genetic counselors. Carmichael et al. have named countless ways that underrepresented students' sense of inclusion in medicine was undermined by exchanges with other students, professors, providers, and healthcare staff. Study participants reported this undermined inclusion left them feeling "othered. " Some study subjects recall feeling culture shock operating within the racially monolithic environment of medicine. The feeling of not belonging was intensified by a series of microaggressions by other students and teachers. Two study subjects said they were mistaken for another minority student in their group. Hassouneh and Thomas (2017) referred to instances of being perceived first as an ethnicity and second as a person as "invalidation. " Other study subjects shared that they had been the recipients of more pointed statements. For example, an Islamic subject stated that other students told her they felt "intimidated" to make her acquaintance. Another student who was born in the U.S. was labeled as being a foreigner. Although the reported interactions might not have been intended by the speakers to be

humiliating or harmful, study subjects experienced them as microaggressions and reported experiencing a negative impact as a result.

Well-meaning comments by other students also reinforced the study subjects' feelings of being othered (Carmichael et al., 2021). For example, other students' overzealous comments about an underrepresented students' foods contributed to a group meal cemented their feeling of being different. Study subjects also reported that white students made invasive inquiries about their romantic relationships, which they felt were violations of the personal confidentiality that white students were granted. Such experiences are widely reported across various medical specialties. These experiences diminish minority students' sense of inclusion and belonging while intensifying their sense of isolation. Underrepresented students reported that these experiences attract an uncomfortable focus to their racial and ethnic identity as differentiators compared to their classmates (Brunsma et al., 2017; Clark et al., 2012; Gay, 2004).

Minoritization, discrimination, and exclusion has dramatic and concerning effects on healthcare, especially given that patient care relies on the effective communication and collaboration of cross-disciplinary teams (Nembhard & Edmonson, 2006). Healthcare teams not only face the difficult and rapidly expanding base of medical practice and knowledge, but also the expanding range of specialization that distributes essential knowledge across providers, and this knowledge then must be integrated to provide high-quality care and to improve care. Studies indicate that most errors in medicine originate in the healthcare team--specifically, within their interactions. These findings suggest that a fundamental contributor to problems with patient safety, medical errors, and adverse medical occurrences concern improper communication between health professionals (Lee & Doran, 2017; Nembhard & Edmonson, 2006). Various factors influence the nature of providers’ interactions and information exchanges. One dominant factor is the nature of providers’ relationships. Yet, discussions of interpersonal relations and communication are lacking in healthcare team literature. Lee and Doran (2017) proposed a theory and model to explain how relations among healthcare professionals affect

information exchanges, team performance, and ultimately patient safety based on their examination of studies across various medical and social science fields. The researchers concluded that perception, evaluation, and feedback, which emphasize relational communicative behavior and provider relations strongly influence the nature of interpersonal processes on healthcare teams and, in turn, patient outcomes.

People's lives are endangered when failures of process emerge, leading to an understandable avoidance of risk that diminish a team's eagerness to participate in the disorder and ambiguity that comes with generating and trying out new ideas. In addition, superior medical care requires sound interdisciplinary teamwork that effectively combines the know-how and experience of various providers. However, this goal is difficult to achieve in practice (Edmondson et al., 2003). Improving the quality of the care delivery process necessitates contrasting perspectives, each based on in-depth awareness of disparate facets of the process. Doctors have deep medical expertise, while nurses and medical staff (e.g. occupational therapists and nutritionists) gain a better understanding of the processes of day-to-day interactions with patients. Together they develop a more extensive collection of information. However, the knowledge is often not shared. One investigation found that although nurses observe various issues in the course of their work and employ some novel solutions to address emerging problems, they normally keep these experiences to themselves rather than share them with other providers (Tucker & Edmondson, 2003). Accordingly, although shared learning and knowledge sharing are critical for enhancing patient care, it generally fails to occur in healthcare without explicit structure and reinforcement.

The deeply ingrained hierarchies of professional status in the medical profession complicate open information sharing across professions. In other words, it is not typical for doctors to speak to nurses and nurses to speak to therapists, for example. These dynamics more deeply exacerbate conditions of minoritization based on occupation (Edmondson, 2003). Moreover, medical education that cutlivates orientations of autonomy further discourage

healthcare professionals from pursuing situations for peer learning, knowledge sharing, communication, distributed authority, collaborative problem solving and efforts to improve quality (Nembhard & Edmonson, 2006). The independence cultivated in medicine sadly can diminish quality care. A significant association was found between patient outcomes and degree of hierarchy in interactions with the healthcare team. A study conducted by the Institute of Medicine and cited by Nembhard and Edmonson (2006) indicates that deleterious patterns of communicating within hierarchies and arising from status differences are, in part, to blame for of the cause of several medical errors. An examination of medical malpractice cases nationwide revealed that the high-status doctors overlooked vital information provided by the low-status nurses. Furthermore, nurses refrained from communicating information critical for diagnostic and therapeutic purposes (Schmitt, 1990). In this status-conscious environment, opportunities to learn and process improvements may be overlooked due to collective reluctance to communicate information that could incur retribution from higher status professionals, even when such communication would enhance the quality of patient care.

Problem Statement

Simply adding more racial diversity to the workforce generally falls short of achieving actual success in the workplace (Ely & Thomas, 2020). Diversity absent genuine inclusion is empty. Instead, each employee needs to feel welcomed for who they are and feel like an actual and vital team member if the aims of diversity and inclusion are to be realized (McKinsey, 2020). In addition, studies show that although attention to diversity in occupational and social sectors has increased, most companies still find it difficult to actually experience the purported outcomes of DEI initiatives and reduce any unanticipated adverse impacts of these efforts on employee groups (Kuntz & Pandaram, 2022). An expanding literature suggests that the current dissonance when comparing the launch of DEI initiatives and realization of DEI aims are attributable to things like the organization culture and individual values concerning diversity as well as minority group status. Studies across industries indicate that employees who self-report

as being a racial minority often rank DEI efforts as highly important, demonstrate enhanced understanding of their employers' DEI efforts, exhibit strong allegiance to the aims of diversity, and feel a reduced sense of belonging (Kuntz & Pandaram, 2022).

The challenges of successful DEI efforts were only compounded as a result of the COVID-19 pandemic, revealing that achieving genuine inclusion is critical for building resilience, equity, and belonging within organizations. For example, the pandemic illuminated pre-existing health inequities, where underprivileged communities have been disproportionately impacted by the virus (Thomeer et al., 2023). The virus has had a disproportionate impact due to factors such as socioeconomic status, race, ethnicity, and healthcare accessibility. This has emphasized the significance of tackling systemic disparities in healthcare and advocating for fair distribution of health resources as a component of DEI initiatives.

The transition to remote work during the pandemic additionally inflamed discussions on accessibility and inclusivity (Ewers & Kangmennaang, 2023). Remote work has offered freedom to certain individuals, but it has also posed difficulties for others, especially those who lack access to dependable internet, appropriate work environments, or necessary accommodations for disabilities. Employers have had to modify their rules and practices to guarantee that remote work solutions are comprehensive and easily available for all employees.

The COVID-19 health crisis has had a greater negative effect on underprivileged communities, making existing inequities worse. Marginalized communities, including people of color, women, LGBTQ+ individuals, and other vulnerable groups, have experienced disproportionately greater levels of unemployment, income volatility, and financial adversity throughout the pandemic (Bitler et al., 2023). The importance of DEI efforts has grown in addressing these gaps and advancing economic empowerment and opportunity for everyone.

Mental health and well-being diminished as a result of the pandemic, particularly among marginalized communities that have experienced distinct stressors and difficulties (Luk et al., 2023). Communities like these have been disproportionately impacted by problems such as

social isolation, prejudice, and limited access to mental healthcare. The DEI initiatives have prioritized the promotion of mental health awareness, provision of support services, and establishment of inclusive environments that provide a sense of safety and support for persons seeking assistance.

Moreover, the COVID-19 pandemic occurred at the same time as a revival of racial and social justice movements, including Black Lives Matter. These movements have highlighted the problems of systemic racism and inequality and made them a prominent topic of public discussion. Organizations are under growing pressure to tackle diversity, fairness, and inclusion concerns both inside their own operations and in their interactions with the outside world (Yancey & Krome, 2021). This includes addressing issues relating to hiring procedures, workplace culture, and social responsibility.

Finally, the shift to virtual platforms for business, education, and social interaction has presented both advantages and difficulties for DEI initiatives (Katsabian, 2020). Virtual environments have the potential to enable more people to participate and access resources, but they can also worsen existing inequalities, such the digital gap and disparities in technology and resource access. The DEI programs have prioritized the utilization of technology to advance inclusion, accessibility, and a sense of belonging in online environments.

To combat the challenges of workplace inequity, Rice et al. (2021) concluded based on their studies of inclusiveness and its outcomes that organizational leaders, including supervisors throughout all levels of the organization, play central roles in spreading and demonstrating messages of organizational inclusiveness. Furthermore, they noted that supervisors' behaviors actually may supersede organizational practices and other characteristics regarding inclusivity. Rice et al. consequently urged organizations shift their focus from companywide policies and practices to supervisor behaviors, wherein leaders and managers become "key messengers of the organizational stance on inclusion" (p. 276). They further advised that organizations could

promote the chance of consistent demonstration of inclusion by providing managerial training on the topic.

While there may be many avenues for leaders to enhance employees' sense of inclusion, leaders approaches to communication—specifically, listening, may be a particularly powerful tool. King et al. (2012) asserted that listening is a central component of communication. Yet, whereas communication encompasses more activities, such as bidirectional information exchange, listening deals with the specific process and competencies needed to accurately understand someone, display that comprehension, and attaining the aims of listening. King et al. reviewed listening within healthcare settings as well as listening research across other settings and fields as a means for guiding a framework for effective listening by health professionals. The researchers additionally identified common themes across the literature as well as distinguishing elements of listening specific to healthcare settings. They defined a conversation within their research as bidirectional communication between a healthcare provider and a patient. The researchers' ultimate aim was to outline a framework for researchers and providers within the subspecialty of rehabilitation to use in their efforts to more effectively listen to patients.

Listening is a central component of person-centered healthcare, which endeavors to offer the type of support that catalyzes change in patients (Bruder & Dunst, 2005; Jones, 2011; Magnusson & Mistry, 2017). Person-centered healthcare is both multifaceted and occurs across disciplines such that patients are at the center of the healthcare delivery process (McCance et al., 2011). In person-centered care, the patient's desires and needs are considered to be utmost importance, as opposed to any systemic goals or needs (Moore et al., 2017). Furthermore, such care exhibits effective information sharing, honor for the patient's dignity, mutual trust, and engagement of the patient in care (McCance et al., 2011; Santana et al., 2018). The provider in such approaches takes care to demonstrate compassion, suspends judgment, and engages in active listening (Byrne et al., 2020). Person-centered care also is referred to as "patient/family-

centered care, relationship-centered/based care, and personalized care" (Santana et al., 2018, p. 430).

In person-focused care models, there's a basic presumption that great listening and bidirectional information exchange are possible. For instance, in family-centered care for children experiencing disability, Bruder and Dunst (2005) allude to the significance of dynamic listening. Listening is considered as basic to working in organization with recovery clients and giving adaptable and responsive care (King et al., 2002). It is imperative for parents of these children to communicate their care experiences with somebody who openly listens to their needs and concerns (King et al., 2007, 2012).

Listening has been defined in various ways in extant literature, and most of these definitions focus on the idea of exchanging information. Burleson (2011) reified listening as "a process that involves the interpretation of messages that others have intentionally transmitted in the effort to understand those messages and respond to them appropriately" (p. 27). Recently, the complex nature of the listening process is reflected in reifications that encapsulate far more than mere exchange of information. These recent definitions have incorporated emotional competencies such as empathy (Brown et al., 2020), emotional involvement (Brown et al., 2020), and authenticity (Floyd, 2010). The plethora of listening subtypes that have been identified, such as active listening (Brown et al., 2020), dialogic listening (Floyd, 2010), and mindful listening (Prince-Paul & Kelley, 2017), indicates that an comparative examination of these reifications of listening would be helpful, particularly as they concern the qualities of suitable, patient-oriented listening when practiced in healthcare settings—and how these differ from day-to-day dialogue.

Although the importance of listening has been established across various disciplines, listening has also been referred to as a paradox that is multivariate in nature. For example, listening is the focus of a wide number of studies, books, and other literature (Sinclair et al., 2016); yet, as a concept and practice, listening often is overlooked in studies and theory-making

(Bodie, 2011b; Itani et al., 2019) and particularly in the training of healthcare practitioners (Meldrum & Apple, 2020). Most notably, in theory and literature related to interpersonal communication, where one would expect rigorous examination of the listening construct, such investigation is thin (Jones, 2011). Furthermore, even though academics within the field of communication acknowledge the centrality of listening to effective dialogue (McKenna et al., 2020), healthcare practitioners generally fail to adequately understand the phenomenon, leaving the power and practice of listening underestimated and inadequately exercised (Kagan, 2008). Thus, although listening is believed to be an easy and simple practice, it actually is quite difficult and complex to effectively do (Meldrum & Apple, 2019, 2020). In sum, researchers agree that listening within the realms of person-to-person conversation, medical education, and healthcare practice is inadequately appreciated and investigated (Bodie, 2011a; Kelly, 2001; Meldrum & Apple, 2020). Listening is under-theorized (Bodie, 2011b; Bodie et al., 2008), overlooked (Itani et al., 2019), not well understood (Sinclair et al., 2016; Stickley & Freshwater, 2006), and generally insufficiently addressed when new healthcare practitioners are educated (Meldrum & Apple, 2020). Although listening is acknowledged to be a critical skill for healthcare providers (Meldrum & Apple, 2020), it is nonetheless devalued as a so-called soft and less vital aspect of medical practice, especially compared to the science of medical practice (Rees & Garrud, 2001).

The present study particularly focused on supervisors' person-centered listening. Person-centered listening involves actively seeking to understand, engage, and support subordinates by accepting one's own knowledge gaps (Jentz & Murphy, 2005; Kegan & Lahey, 2001), engaging in collaborative problem exploration with subordinates, providing structure for problem exploration (Jentz & Murphy, 2005), and engaging in deep listening (Jentz & Murphy, 2005; Rogers & Roethlisberger, 1991) and collaborative discussion (Jentz & Murphy, 2005). Person-centered listening has been associated with a variety of benefits, heightened performance among subordinates (Cardiff et al., 2018; McCormack & Dewing, 2019; Lynch et

al., 2018), more inclusive work climate (Harding et al., 2015), and improved job satisfaction and retention among subordinates (Choi et al., 2016).

Purpose Statement

Healthcare organizations have undergone significant adverse forces in recent years that have had extensive negative impacts on staff morale and retention. Among the many challenges are staff burnout, challenging workplace cultures, and underrepresentation of women and people of color, particularly in physician and higher level leadership roles. The purpose of this study was to examine the impact of supervisors' person-centered listening on occupationally minoritized healthcare professionals' sense of belonging.

Significance of the Study

Despite a sizeable body of literature on the rationale for diversity, traditional theoretical frameworks related to inclusion such as relational demography or attraction-similarity (Shore et al., 2010; Theodorakopoulos & Budhwar, 2015) generally focus on approaches for simply increasing minority representation in the organizations, versus processes for creating and propagating organizational inclusiveness up, down, and throughout healthcare organizations. A particular gap in the research concerns the roles managers, supervisors, and leaders need to carry out in order to propagate organizational inclusiveness. This study produced new knowledge specifically on how the way supervisors listen affect organization members' sense of inclusion. This study helped by investigating where room exists in extant literature for more research, yielding suggestions for healthcare institutions, healthcare leaders, and healthcare professionals as they endeavor to construct more supportive workplaces that lead to improved inclusion and, in turn, enhanced individual, group, and organizational performance.

Definition of Terms

This section outlines core definitions and terms that are of critical importance to the present investigation. Key terms are defined when the constructus important or at the core of the study are novel, rarely used, or vulnerable to different meanings or are obscure (Patton,

2014). In these instances, researchers must create unequivocal reifications of such terms so that reviewers and readers can accurately understand the study and the meanings intended by the principal investigator. Several terms are central to the present study:

- Advanced practitioner: healthcare providers who do not hold and/or are not licensed as a medical doctor (Chang, 2023). Advanced practitioners include healthcare workers including but not limited to physician assistants, nurse practitioners, and clinical nurse specialists.
- Sense of belonging: “the extent to which one feels accepted, valued and supported within their environment” (Lampinen et al., 2018, p. 469). In this study, sense of belonging and inclusion are used interchangeably.
- Diversity: achieving variety within a workforce related to employees’ demographic characteristics (e.g., age, sex, national origin, gender, sexual orientation), and “the varied perspectives and approaches to work that members of different identity groups bring” (Ely & Thomas, 1996, p. 80).
- Inclusion: the degree of feeling that one’s genuine being is welcome in the workplace, in turn, encouraging the worker to make meaningful and deliberate contributions to the organization (McKinsey, 2020; Miller, 1998). Inclusiveness has been associated with the extent that the company’s systems and procedures encourage employees’ feelings of fitting in within the workplace (Miller, 2021). In the present research, feeling they belong and feeling included are used interchangeably.
- Occupational minority: “a worker who is a numerical rarity in his or her occupation” owing to specific identity-related traits such as age, gender identity, national origin, ethnic identity, sexual orientation, ability status, or other defining feature (Taylor, 2010, p. 190). Occupational minorities are small in relative proportion “at the national (occupational) level, regardless of the actual composition of their workplaces” (p. 190).

Theoretical Framework

The theoretical framework guiding this study consists of inclusive leadership, leader-member exchange, social judgment theory, relational generation of workplace inequality, optimal distinctiveness, and ingroup–outgroup relations. These theories are described in the following sections. To begin this section, inclusive leadership is outlined, followed by each of the remaining theories in the framework.

Inclusive Leadership

Academics fail to agree on the elements and structure of inclusive leadership (Zhang et al., 2016). Prior attempts of understanding and reifying management that reflects inclusiveness—such as Carmeli et al. (2010) operated without sufficient theoretical frameworks. Consequently, past attempts failed to adequately distinguish it from related management orientations such as leadership is transformative or servant-oriented in nature (Randel et al., 2018).

In Randel et al. ’s (2018) examination, the researchers architected and clarified a more extensive construct to reflect the essence of inclusive leadership. In their work, they reified inclusive leadership to reflect a constellation of leader behaviors oriented toward meeting employees’ desires for both belonging yet separateness and individuality. Randel et al. ’s work resulted in the definition of five groups of behaviors—three of which create belongingness and two of which emphasize individuality. These dominant features of inclusive leadership—to act upon workers’ sense of both fitting in and being unique—suggest that the results of leadership could be quite variable because it affects how subordinates show up and contribute at work. Past research has concluded that inclusive leadership promotes follower behaviors such as exerting leadership and autonomy (Zeng et al., 2020), novel thinking (Carmeli et al., 2010), exercising innovation (Fang et al., 2019), and expressing and amplifying their own voice (Qi & Liu, 2017). Al-Atwi and Al-Hassani (2021) further proposed that employees’ perceptions of their

leaders' inclusive-leadership behaviors positively affects their own work performance by enhancing proficiency, adaptivity, and proactivity.

While Randel et al. 's work helped to advance conceptions of inclusive leadership, psychometrically viable measures of the leadership style remain outstanding. This gap in research could preclude deeper understanding and further development of this style of leadership. Al-Atwi and Al-Hassani (2021) endeavored to create and validate an inclusive leadership scale oriented around Randel et al. 's (2018) research.

Leader-Member Exchange

LMX theory is described as asserting leadership through an orientation of social exchange. Accordingly, LMX theorists investigate the creation of relationships between leaders and followers through the mechanism of give-and-take exchanges. Supervisors create distinctive connections with their direct reports. The quality of these connections can vary from very poor to optimal. Low-quality exchanges are conceptualized by an observance of formalized behaviors and lowered trust, mutual support, and supply of recognition and resources. More optimal levels of exchange are characterized by the relationship going farther than formalized roles and responsibilities to encompass higher trust, collaboration, and shows of mutual support. According to LMX theory, more optimal exchange relationships are associated with more effective leadership (Graen & Uhl-Bien, 1995). In turn, sound leader-subordinate relations produce high levels of mutual respect, trust, and appreciation. Within such relationships, supervisors can rely on subordinates to provide aid, volunteer for extra work, and offer helpful feedback. For their part, subordinates can rely on their supervisors for advice, help, and support that ultimately boost their careers (Graen & Uhl-Bien, 1995). In this way, LMX has been associated with enhanced subordinate job performance as well as citizenship behavior (Settoon et al., 1996; Sparrowe, 1994; Wayne et al., 1997, 2002).

Graen and Uhl-Bien (1995) examined LMX research proposed a three-part classification for LMX to include exchanges that promote respect, exchanges that promote trust, and

exchanges that promote obligation. Graen and Uhl-Bien (1995) concluded that building suitable exchange relationships within the leader-subordinate relationship “will not be made or accepted without (1) mutual respect for the capabilities of the other, (2) the anticipation of deepening reciprocal trust with the other, and (3) the expectation that the interacting obligation will grow over time” (p. 237). Deinesch and Liden (1986) concluded based on their examination that LMX can be characterized as a multidimensional variable that includes elements oriented around mutuality. The researchers elaborated that mutuality is rooted in social exchange and are created through elements that both parties in the relationship value and which enable both to affect. Deinesch and Liden (1986) further elaborated that three particular variables are central to examining the mutual exchange relationship present between a leader and subordinate: (a) each party’s contribution to the relationship and the goal-related value attributed to that contribution, (b) fidelity, meaning “the expression of public support for the goals and personal character of the other member of the dyad” (p. 625); and (c) attraction*,* the degree of appreciation and regard between the parties to the relationship. Deinesch and Liden (1986) further proposed that these variables help explain the aspects of human relationship that lead to the development of high-quality exchange relations.

LMX theory essentially proposes that “effective leadership processes occur when leaders and followers are able to develop mature leadership relationships (partnerships) and thus gain access to the many benefits these relationships bring” (Graen & Uhl-Bien, 1995, p. 225). Past research has associated high-quality interactions between leaders and followers with advantageous outcomes at the organizational level, including improved performance, enhanced worker satisfaction, and elevated worker commitment to the organization (Gerstner & Day, 1997). Nonetheless, what requires further illumination is what particular leader behaviors are involved in creating these strong bonds between leaders and their direct reports.

Social Judgment Theory

Social Judgment Theory refers to an internal process that takes place when a person hears an idea (Sherif & Hovland, 1961). The theory seeks to illuminate how people express, evaluate, and change their opinions based on past and present events and experiences. Sherif and Hovland (1961) added that core attitudes are central to an individual's self-identity and, thus, tend to be resistant to change.

The process that occurs when an individual encounters a message or situation is that the person judges the value of the message against their personally held views, and then reaches one of three decisions: acceptance, rejection, or non-commitment. This process of judgment occurs within the subconscious rather than the conscious mind, and the process initiates immediately when a message is perceived (Sherif & Hovland, 1961). Therefore, the outcomes of attempting to include an employee vary based on the employee's originating propensity to accept, reject, or not commit to those inclusion efforts. When inclusion attempts are perceived and the individual believes the environment or leader is generally inclusive, the attempt may be accepted and assimilated. However, when the individual believes the environment or leader is generally not inclusive, any subsequent inclusion attempts may be rejected. In this way, the individual's preferred or preexisting position serves as an anchor against which new information and situations are judged.

Relational Generation of Workplace Inequality

The theory of Relational Generation of Workplace Inequality (Tomaskovic-Devey, 2014) asserts that power and status differentials emerge as the result of the social interactions and relational dynamics between people within a system. For example, managers gain status and power due to (a) the resources and authority granted to them by their own managers and (b) the followership offered to them by their direct reports. In this way, there are no objectively determined minorities and majorities, leaders and followers, or skilled and unskilled workers.

Instead, these statuses must be not only claimed but also granted by others to have an effect. For example, Tomaskovic-Devey (2014) points out:

> Many claims are never made, are ignored, or are repressed. When faced with resistance to claims, actors may successfully mobilize discursive or collective power to compel that their claims be honored, validated, and respected. Once claims are endorsed by powerful others, resources are distributed and inequalities generated. (p. 67)

Accordingly, inequality exists where individuals within a social network have implicitly or explicitly granted certain individuals more rights, prestige, respect, and resources and other certain individuals fewer of these rights, prestige, respect, and resources. These claims and grants may be found in the beliefs, values, and actions reflected within the social network and its larger organizational or community context. Tomaskovic-Devey (2014) described this mechanism of claiming and granting that results in unequal distribution of power, prestige, and privilege as exploitation, and the accumulation of exploitation as opportunity hoarding. This dynamic can be particularly destructive within organizations, which tend to be the context for the pooling of resources in the form of capital, technologies, and other scarce assets.

Optimal Distinctiveness

Optimal distinctiveness theory (Brewer, 2011) asserts that individuals possess and must meet two basic needs: the drive to feel belonging and inclusion and the drive to feel unique. These needs coexist, compete with one another, and are situationally activated or deactivated. For example, participation in a highly belonging-oriented group (e.g., a church where everyone is welcome) satisfies the individual's desire for belonging but activates their drive to feel unique and different. To satisfy this competing drive, the individual subconsciously may then be driven to focus on how they are different from other members and additionally feel a sense of separateness from the group. This group also may fracture into subgroups, with subgroups attending to how they differ from other subgroups, such as what is observed within the student bodies of large public schools and the fracturing into cliques of popular versus unpopular students or athletic versus academic students. In contrast, participation in an exclusive group

(e.g., becoming a member of a very expensive and elite country club) may satisfy the individual's need for distinctiveness while activating the drive for inclusion. In turn, the individual and any smaller subgroups will subconsciously be driven to self-identify with the larger group. In general, people endeavor to strike a balance between their drives for uniqueness and belonging. This is commonly achieved by seeking membership in various groups or by seeking membership in a group that offers some fulfillment of both needs.

In-Group/Out-Group Relations

Ingroup and outgroup relations refers to the perceptions, beliefs, and behaviors related to the interactions between individuals based on social identity (Sherif & Sherif, 1965). An ingroup is the social group to which one psychologically identifies, whereas an outgroup is a social group to which one does not psychologically identify. The concept and dynamics of ingroup/outgroup relations aligns with innate human psychological drives to distinguish people into "us" and "them" taxonomies (Sapolsky, 2017).

Several behavioral and systemic implications emerge from ingroup/outgroup classifications (Sherif & Sherif, 1965). First, people generally prefer and treat preferentially those within their ingroup. This preferential treatment can take the form of more positive perceptions and evaluations, more resources, and more tangible and intangible benefits. In turn, outgroup members may be viewed with more suspicion and be granted fewer benefits and resources. At an extreme, it is this dynamic of classifying certain groups of individuals as "them" that results in othering and discrimination.

Research Questions

In this section, the guiding research question is presented. Then, this broad research question is further elucidated by stating research subquestions. Together, answering these questions help accomplish the purpose of the study. Moreover, the research question and subquestions offer disparate perspectives for examining the effect of person-centered listening on sense of belonging. The broad research question was: What is the impact of supervisors'

person-centered listening on sense of belonging among occupationally minoritized healthcare professionals? Two subquestions were examined:

1. What supervisor behaviors do occupationally minoritized healthcare professionals associate with feeling a sense of belonging?
2. What do participants report as the impact of supervisors' person-centered listening behaviors on their sense of belonging?

Limitations

Limitations are those issues that unexpectedly arise as well as other events that occur while the study is conducted and affect the study data. A limitation in the present investigation was researcher bias. The researcher has experiences, perceptions, and values related to supervisorial listening, and it is possible that these biases affected the collection and analysis of data. This limitation was controlled by subjecting the analysis to review by a second rater.

Another limitation was social desirability, meaning the participants may have been consciously or subconsciously motivated to answer in ways that make participants "look good" to others (Bryman, 2008). The researcher reduced this limitation by focusing on building good rapport with participants and striving to demonstrate a nonjudgmental attitude.

Delimitations

Delimitations refer to the researcher's design decisions that may affect the study data and findings. One delimitation of the present study involved the choice of research interviewing as the method of data collection. Specifically, interview data wre constrained to what the participants were aware of and what they were able and willing to report while in the research conversation. For example, interviews are particularly vulnerable to participant biases (e.g., social desirability as discussed in the previous section). A related delimitation was the use of self-reported data, which is heavily influenced by participant biases. In contrast, the collection of unobtrusive data (e.g., researcher observations or organizational documentation and statistics), would be less subject to participant biases. However, the study inherently relies upon

participants' perspectives, thoughts, and feelings; therefore, self-reported data was an appropriate choice.

Another delimitation concerned the use of convenience sampling, wherein participants were drawn from participants that were within the researcher's network. Convenience sampling has been criticized for its adverse impacts on external validity. However, convenience sampling is regularly used in research, and its feasibility benefits made the research possible to be conducted given the study's time frame and lack of funding.

A final delimitation was the study's reliance on a small sample. Qualitative interview research often relies on small numbers of participants due to the challenges of logistics, scheduling, and volume of data such studies produce (Brinkmann & Kvale, 2014). Nonetheless, drawing findings based on data collection from a small sample inevitably limited the range of data that could be collected and the ultimate transferability of the findings to other sites.

Assumptions

The assumptions of a study concern factors beyond the researcher's control that are presumed to persist during and beyond the conduct of the study (Patton, 2014). If these assumptions are violated, the research problem upon which the study hinges collapses, along with the rationale for conducting the study. A core assumption underlying the present study was that a lack of diversity will continue to persist for the foreseeable future. People of color comprise more than one third of the American population yet hold only 11% of hospital chief executives positions (U. S. Census Bureau, 2020). Moreover, only 17% of executive leaders in positions across all healthcare organizations were people of color.

A second core assumption was that lack of diversity poses problems for occupational minorities themselves, their organizations, and their patients. Past research has found that occupationally minoritized employees experience various forms of microaggression, discrimination, and prejudice (Dovidio et al., 2008; Pandharipande et al., 2019) as well as a diminished feelings that they belong in their field. These conditions can compromise

communication among the various healthcare professionals involved with a patient, in turn, potentially threatening patient safety and diminishing the quality of care (Edmondson et al., 2003; Lee & Doran, 2017; Nembhard & Edmonson, 2006; Tucker & Edmondson, 2003).

A third core assumption was that supervisors' behaviors have an effect at both the individual and collective level within their sphere of influence. In turn, supervisors play a central role in whether an underrepresented individual feels a sense of belonging. Various past researchers have concluded that direct supervisors act as agents of the organization and, thus, influence subordinates' conclusions about whether they belong in the organization (Douglas et al., 2003; Liden et al., 2004; Nembhard & Edmonson, 2006). Further, Rice et al. (2021) proposed that demonstrations of inclusion have a trickle-down effect, influencing other workers, thus producing a cumulative effect for the individual employee.

A fourth and final assumption was that the way the supervisor listens to the occupationally minoritized individual can affect the degree of inclusion they feel. Various past studies have concluded that person-centered listening by supervisors enhances subordinates' sense of inclusion by promoting open communication (Subrahmanyam, 2018), collaboration (Amin et al., 2018), and shared vision (McCormack & McCance, 2017).

Positionality

The outcomes of a qualitative study are inextricably linked with and affected by the researcher conducting it. Therefore, according to a post-positivist methodology, identifying the researcher's personal and professional experiences as well as their biases related to the study topic is essential (Camic et al., 2003).

Researchers are susceptible to prejudice in their professional activities. These biases can be mitigated through the peer review process. Below is a summary of the investigators background:

- Born and raised in Romania
- Immigrated to Canada and later to the United States

- Has an MS in Chaplaincy and an MBA in Healthcare Management
- Has 19 years of work experience in church setting and healthcare (Mission and Spiritual Care)

I am a strategy-driven leader with a consistent track record of helping companies across industries achieve their growth-oriented goals. During my career, I have focused on building partnerships with cross-functional stakeholders while keeping the organization's strategic narrative at the forefront. In addition, as a change agent, I am improving organizations' visibility by crafting new programs and driving cross-functional special projects.

My role at the time of this study is system vice president of mission and ministry at a large healthcare organization. In this role, I provide strategic and operational leadership for planning, developing, directing and evaluating programs and methodologies to integrate mission and spiritual care/spirituality into clinical caregiving and into work life. In this role, I am keenly aware of the need to incorporate diverse perspectives in the work we do, as that is the only path to organizational efficacy. In my previous role as director of mission and spiritual care, I managed all the daily operations of a multi-site healthcare organization, including community development and outreach, interdisciplinary rounding, palliative care, patient visitation, and staff debriefing. While at this organization, one of my initiatives was leading a team to high performance through special initiatives and growing the team from 4 to 18 members within 12 months. I purposefully recruited underrepresented healthcare professionals to better reflect our patients. The team developed a strong reputation within the organization, and we were regularly asked to lead other projects for the corporation. My professional experiences have demonstrated to me that it is essential to recruit and retain occupational minorities in order to achieve the highest level of patient care and satisfaction. It is this conviction, coupled with awareness and concern about persistent disparities in the healthcare workforce, that motivated me to conduct the present study.

Organization of the Study

This chapter presented an introduction to the dissertation, including the study background and problem statement, followed by a statement of purpose. The significance of fulfilling this purpose was then outlined. Key definitions, the underlying theoretical framework, and research questions were then discussed. Study limitations, delimitations, and assumptions of the study were acknowledged. Finally, the researcher's positionality. This chapter closes with an overview of the dissertation's structure and a chapter summary.

Chapter 2 presents an examination of literature central to the present investigation. The concept of person-centered leadership is examined before outlining descriptions and critiques of theory and studies on inclusion. Finally, occupationally minoritized healthcare professionals is discussed. Chapter 3 explains the methodology that will be employed in the study. After a chapter overview and introduction the research design is stated. Next, the intended processes for recruiting participants and collecting and analyzing data for this study are outlined. Chapter 4 reports the findings. Chapter 5 discusses the study findings.

Chapter 2: Review of the Literature

This study looks at how supervisors' person-centered listening affects occupationally minoritized healthcare professionals' sense of belonging. In this chapter, an examination of literature related to this study is presented. First, studies about person-centered leadership are examined, with a particular focus on listening as a function of person-centered leadership. Next, research on inclusion is presented. This section begins with a definition of inclusion followed by a discussion of its antecedents and influences. Next, inclusive practices and initiatives are described, and the importance of inclusion is explained. Finally, the impact of person-centered leadership on employees' sense of inclusion is considered. The final body of literature reviewed for this study is theory and research on occupationally minoritized healthcare professionals. This section begins with an overview of the demographics of the healthcare workforce, followed by a discussion of research on their experiences. The importance of inclusion for this body of workers in then reviewed, and impact of person-centered leadership and leader listening on occupationally minoritized healthcare professionals' sense of inclusion is considered. This chapter closes with a synthesis of the literature, presentation of a conceptual framework underlying this study, and chapter summary.

Person-Centered Leadership

Person-centeredness emphasizes an individual's potential to progress and that humans are always in a state of growth (Rogers, 1961). Central to the approach is the belief that people are trustworthy and can achieve self-actualization and health if given the right circumstances. These ideas are rooted on the belief that people have the inner resources to make positive changes.

Person-centered therapy was developed by Carl Rogers, a psychotherapist who believed based on his clinical experience that people possess the personal resources to achieve their full potential (including health) if they have one or more growth-promoting relationships (Rogers, 1961). The person-centered approach was developed from the concepts

of humanistic psychology. The humanistic approach considers that people are capable and independent, possessing the competencies they need to solve their difficulties, achieve their potential, and make positive shifts in their lives (Seligman et al., 2006).

Person-centered approaches hinge upon the creation of growth-promoting (helping) relationships, characterized as having unconditional positive regard, genuineness, and empathy (Rogers, 1961). Rogers explained that within these types of relationships, people develop self-acceptance; greater access to their full extent of thoughts, feelings, and experiences; and an internal locus of evaluation. In therapeutic settings, person-centered therapists focus on creating an effective helping relationship rather than focusing on diagnosing pathology. Although humanistic therapies are not widely practiced today, the concepts pervade therapeutic practice—particularly theories around forming a therapeutic alliance.

Applications of person-centeredness within organizational settings, particularly as it concerns leadership, focus on creating cultures of dignity, respect, compassion, caring and coordinated support (Masimula et al., 2020). These conditions tend to yield positive workplace cultures that foster, among other things, personal and professional growth.

Components of Person-Centered Leadership

Masimula et al. (2020) asserted that person-centered leadership is necessary for creating climates that are oriented around the worker. This style of leadership employs methods including empowerment, involvement, fortifying accountability, orienting the organization around workers' needs, creating efficient resource networks, and forming an organizational environment that is conducive to change (McCance & McCormack, 2017; World Health Organization, 2015). Leadership that is oriented to the personhood of workers also has been associated with company philosophies that encourage workers to bring their authentic selves to work in contrast to concepts of impression management and strong work-life boundaries (Plas, 1996). Instead, person-centered leadership encourages employees to express their talents, needs, and feelings in the workplace.

Self-awareness is a component of person-centered leadership, as is other-centered leadership, which enables employees and leaders to thrive and improve metrics at the organization level (Cardiff et al., 2018). In order to evaluate the performance in the workplace, leaders who are truly oriented toward others, mindful in their actions, and prone to express care and consideration are better equipped to collect data about themselves, peers, supervisors, and subordinates. By treating employees as more than just coworkers or nurses, these leaders foster a person-centered work environment. Instead, they value each employee as an individual, try to come to an agreement, express optimism, and work to make the workplace a safe place to work (Cardiff et al., 2018).

According to participants, leadership qualities like empathy, positive regard, mindfulness, and respect for others are necessary for establishing a welcoming environment in which workers gain a sense of motivation and mobilization. Self-reflection is important for developing these leadership attributes (Lynch et al., 2018). Healthy inner dialogue and reflective self-talk enhance leaders' self-oriented perceptions, emotions, and actions and, further, aid in reducing stress. Additional leader qualities exhibit awareness of self and their emotions. Moreover, they exhibit sound listening skills, inspirational leadership, inclusiveness, regarding for, and trust in workers.

Participants in McCormack and McCance's (2017) study characterized person-centered leadership as involving the expression of respect and dignity. Leaders that exhibit worker-centered styles should emphasize the oneness of the group's vision and goals and use these to create a context for worker transformation, in order to strike a balance between the needs of employees and those of the workplace (McCormack & McCance, 2017).

Person-Centered Leadership Compared to Inclusive Leadership and Leader-Member Exchange

Person-centered leadership, particularly with regard to listening, exhibits several areas of alignment with related leadership concepts such as inclusive leadership and leader-member

exchange. According to Carmeli et al. (2010), inclusive leadership is the capacity of the leader to hear, attend to, and show openness to the demands of followers. According to Randel et al. (2018), inclusive leadership is viewed as a multidimensional construct made up of three actions that members may use to feel like they belong:

1. Support for people on the team: Leadership practices that show consideration for the needs and feelings of the group members and address their overall contentment and well-being within the group (Arnold et al., 2000; Rhoades et al., 2001). Making members feel valued as a part of the group is the aim (Randel et al., 2018).
2. Monitoring the sense of justice: leaders' actions that provide group members the impression that they are treated fairly and without bias (Arnold et al., 2000; Moorman, 1991).
3. Making decisions in a shared way: By encouraging fruitful discussions to enhance decision-making and allowing all group members to express their perspectives, inclusive leaders foster a sense of belonging (Arnold et al., 2000). Members can then talk on how to incorporate the suggestions made as a result (Randel et al., 2018).

Leaders who practice inclusion additionally assist members in detecting a sense of uniqueness in two primary ways:

1. Diverse contributions are valued when group members are treated with respect and encouraged to listen to new ideas (Al-Atwi & Bakir, 2014; Carmeli et al., 2010). Supporting the individual distinctions that each member brings to the group and emphasizing the need for diverse inputs are two ways to foster contributions (Randel et al., 2018).
2. Leaders respect individuality by providing members with constructive criticism of their ideas and assistance to those who must carry out jobs outside of the norm (Madjar et al., 2002; Randel et al., 2018). Leaders must also provide followers the motivation they need to keep coming up with fresh ideas.

Related to leader-member exchange, leader listening appears to be reflected in Graen and Uhl-Bien's (1995) Leadership Making Model. This model explains the stages of relational development in leadership. The *stranger* phase aligns both with Dienesch and Liden's (1986) initial interaction and Graen and Scandura's (1987) role taking stages. The leader simply supplies the knowledge required to complete the assignment, and all other interactions between supervisor and subordinate are strictly contractual. A relationship-improvement offer must be made by one party (the leader or subordinate) and accepted by the other in order to go on to the next stage. When this happens, the relationship enters the acquaintance stage, during which the supervisor and subordinate engage in more social interactions. As the sharing of resources and knowledge increases, so do interpersonal relationships. Members of the dyad go into the mature relationship phase as mutual respect, trust, and responsibility grow between them. In turn, two-way interactions are sophisticated and incorporates emotions.

Lloyd et al. (2017) additionally determined based on their research that although listening and leader-member exchange are conceptually distinctive, a close link exists between the two. They explained that in every established leader-follower relationship, the effectiveness of listening and the effectiveness of member interchange are inextricably linked. The concept of leader-member interchange, which includes many elements of connection with employees, is quite wide. It is possible that listening is a more specialized element of those, and that is statistically consumed by its relationships with job results. It follows that managers who have good listening skills may create strong, positive relations with subordinates with relative ease and further encourage sound leader-member exchange. In turn, this could improve workplace outcomes like satisfaction with the boss, their relationship, and the job. To put it another way, leader-member interaction is a wide concept that incorporates things like views of leader support and the efficacy of interpersonal relationships. Consequently, this concept is built on and always refers to an existing relationship. Contrarily, within this theoretical framework, listening must be viewed as a particular receptive action that is critical at any stage of a

relationship. In the end, they identified the relationship between listening and leader-member exchange as a “chicken-and-egg” situation that cannot be resolved without more research.

Impacts of Person-Centered Leadership

Various studies have suggested that worker-oriented managers inspire their direct reports to accomplish objectives more effectively and efficiently (Cardiff et al., 2018; Lynch et al., 2018; McCormack & Dewing, 2019). This impact occurs because the associated respectful, empathic, and supportive climate tends to enable all individuals to grow and creating workplace cultures conducive for high performance (Harding et al., 2015).

Impacts of person-centered leadership also can be deduced from studies of transformational leadership, which includes concepts of person-centeredness. This body of research indicates that transformational leadership increases job satisfaction, lowers turnover, and increases retention (Choi et al., 2016).

In Cardiff et al. ’s (2018) study, the researchers observed a ripple effect, where person-centered leadership fostered mentoring, coaching, and collaboration throughout the workplace. Cardiff et al., elaborated that caring employees become more critical but also transparent and fair to one another, which improves workplace satisfaction and fosters positive intrapersonal and interpersonal skills. Cardiff et al. (2018) found that person-centered leadership increases staff willingness to take on more responsibility and become more involved in decision-making, despite participants' need for empowerment. In contrast, employee dissatisfaction, attrition, employee conflict, and organizational issues were noted as consequences of the lack of person-centered leadership. Cardiff et al. (2018) added that person-centered leaders facilitate employee self-actualization, empowerment, and well-being.

Mazetti and Schaufeli (2022) systematic review of 20 articles on leadership and work engagement demonstrated a positive correlation between work engagement and a variety of person-centered leadership styles. Transformational leadership was the framework that was used the most, while authentic, ethical, and charismatic leadership was used to a lesser extent.

Carasco-Saul et al. (2015) similarly concluded that the bulk of evidence on person-centered leadership indicates that these styles are associated with engagement and affects it directly or via mediation. DeCuypere and Schaufeli's (2019) study, which was a meta-analysis, examined a set of 69 research projects and determined significant positive associations between engagement and ethical (*k* = 9; ρ = . 58), transformational (*k* = 36; ρ = . 46) and servant leadership (*k* = 3; ρ = . 43), with more moderate correlations being revealed with authentic (*k* = 17; ρ = . 38) and empowering leadership (*k* = 4; ρ = . 35). This effect was mediated by resources concerning the job (e.g., autonomy, social support), organization (e.g., identification, trust), and person (e.g., self-efficacy, creativity).

Jentz and Murphy (2005) argued that leaders need to employ person-centered listening particularly when faced with complex challenges, as such approaches help validate and deepen leaders' understanding; test assumptions; avoid missteps; and assure that followers feel heard, understood, trusting, and willing to collaborate.

Listening as a Function of Person-Centered Leadership

When performed well, listening involves a sense of appreciating and being interested in another person; thus, effective listening aids in enhancing wellbeing at both a personal and interpersonal level (Bodie, 2012). Rogers and Roethlisberger (1952/1991) are credited with a pioneering essay published in the *Harvard Business Review*, which extolled the virtues of empathic listening as a hallmark of effective leadership (e.g., Drucker, 2004; Frey, 1993; Reave, 2005; Steil & Bommelje, 2004). However, the term and practice of listening lacks definition due to an absence of theory and specification within the disciplines of organizational psychology and management research (e.g., Bodie et al., 2012; Brownell, 1994). Bodie (2012) reviews many academic disciplines' approaches to listening research and contends that "listening" has to be incorporated into theoretical frameworks that are "capable of explaining how listening works and functions to the betterment of people's lives" (p. 121).

Process and Antecedents of Person-Centered Listening by Leaders. The majority of listening occurs in dyadic relationships, develops in a distinctive manner when interacting (Pasupathi & Hoyt, 2009), and may successively develop each encounter in a distinctive manner. Empathic listening, also known as "active listening," was developed based on Carl Rogers' (1951) discoveries in client-centered therapy (Rogers, 1959, 1975). It is characterized as an accepting and nonjudgmental method of seeing and reacting to an individual. Effective supervisor listening has also been defined in the leadership literature as the act of actively accepting employee perspectives and ideas (Spears, 1995) or as the readiness to do so (Bass & Avolio, 1994). It follows that person-centered listening by leaders involves *listening quality*, defined as whether the person believes they are being attended to, accepted, and appreciated by the listener (Barnlund, 1962; Stone et al., 2010; Lloyd et al., 2017; Tyler, 2011; Rogers, 1975).

Relatively few listening theories and frameworks are evident in extant literature, suggesting that listening is relatively under-researched (Bodie, 2011b). Formal frameworks that have been introduced include a systems framework (Bodie et al., 2008), a framework of affective, cognitive, and behavioral processes of listening (Gearhart & Bodie, 2011), an Interaction Adaptation Model of supportive listening (Jones, 2011), a Theory of Shared Communication (Giambra et al., 2014), and an Engagement Theory of Listening (Wolvin, 2020). These frameworks include depictions of how listening unfolds and reflect an attempt to synthesize works on systems model of listening (Bodie et al., 2008), affective, cognitive, and behavioral processes underlying active-empathic listening (Gearhart & Bodie, 2011). Other frameworks reflected relational and interactional viewpoints (Giambra et al., 2014; Jones, 2011).

The heuristic framework developed by Bodie et al. (2008) combined research results from other fields, including management and psychology, but not healthcare. He presented a systems model of listening that takes into account both personal and contextual elements, specifying comprehension and relationship-building objectives in addition to emotional

outcomes like motivation and empathy. The listening process itself, which entails attention, decoding or interpretation, and response planning, was also taken into account in this framework as well as human aspects (i.e., listening talents and skills, as well as state characteristics). The paradigm uses the perspective of the listener rather than seeing hearing from a relational perspective, disregarding listening characteristics.

Jones (2011) and Gearhart and Bodie (2011) both examined listening from the perspectives of cognitive, emotional, and behavioral processes. According to Gearhart and Bodie (2011), listening is a multidimensional construct made up of behavioral processes like verbal and nonverbal responses, affective processes like motivation to pay attention to others' messages, and cognitive processes like attending to, understanding, and interpreting messages. Based on interaction adaptation theory (Burgoon et al., 1995), Jones (2011) presented an interaction adaptation model of supportive listening. In this model, social interaction is used to regulate actions, and adaptation tendencies control exchanges while offering data on rapport as well as approval. This theory emphasizes the relational character of hearing by taking into account the emotive, cognitive, and behavioral aspects of the listening process when two individuals are involved.

The Theory of Shared Communication (Giambra et al., 2014), which focuses on parents' views of communication with nurses, takes into account the relational character of healthcare discourse. To achieve an agreed-upon comprehension of the child's treatment strategy, this approach focuses on communication activities including listening, questioning, and understanding verification. According to Giambra et al. (2018), communication is seen as having both relational and content components. Relational components deal with messages of dominance/power, receptivity, and trust, whereas content elements pertain to the messages that are being attempted to be delivered.

Wolvin (2020) outlined an Engagement Theory of Listening in a recent book chapter, which combines listening with engagement theory. This theory contends that listeners' levels of

participation in conversations with speakers vary, and that self-regulation determines these levels of participation. The importance of self-regulation as a meta-cognitive ability including self-monitoring in the listening situation is highlighted by Wolvin's theory. In order to listen effectively, one must keep an eye on their understanding and choose which precise communication tactics to employ. This theory therefore takes into account the functions of engagement, intent, and self-control.

Jentz and Murphy (2005) provided a five-step approach to person-centered listening:

1. Acceptance of knowledge gaps (Jentz & Murphy, 2005). Accepting and normalizing that their knowledge is incomplete and embracing confusion are critical starting points to listening and addressing unfamiliar problems. Being able to do this requires resisting the idea that they “should” know the answer and self-recrimination for not knowing. Leaders also should fight the urge to simply and quickly eradicate confusion (Kegan & Lahey, 2001).
2. Collaborative problem exploration. After leaders accept their state of not knowing, it is important to involve trusted others who do have insights about the issue or problem for the purpose of expanding the leader’s understanding (Jentz & Murphy, 2005). In doing so, it is important for leaders to demonstrate an attitude of calm, confidence, honesty, and receptiveness through statements such as, “This new information just doesn't make sense to me,” or “Before I can make a decision, I need help in understanding this situation and our options for dealing with it. ”
3. Structuring problem exploration. By providing the frame for examination, leaders can reassert their authority despite their state of not knowing (Jentz & Murphy, 2005). The framework should include specific steps, time frames, metrics, and assessment criteria. This framework establishes the conditions for a collaborative exploration as well as a sense of stability despite not having complete information.

4. Deep listening. Using the framework outlined in Step 3, the leader carefully listens to those assembled and reflects on what they share for the purpose of deep understanding (Rogers & Roethlisberger, 1991). This style of listening departs from typical transactional leader listening, which involves swift judgments about the speaker's message followed by vocal agreement or disagreement (Jentz & Murphy, 2005). In contrast, deep or person-centered listening begins with an open mind, followed by positioning oneself in speaker's perspective, reflecting on both their verbal and nonverbal communication (Rogers & Roethlisberger, 1991), and testing their understanding by paraphrasing the speaker's message. Thereafter, the revises their message if needed.
5. Collaborative discussion. As a final step, leaders think aloud, spurring collaborative discussion and learning (Jentz & Murphy, 2005). Through open dialogue where the leader continues to voice areas of not knowing, all individuals present continue to engage in a process of listening and learning.

Notably, the process Jentz and Murphy (2005) outlined is a formal and lengthy process of problem solving led by the leader. Jentz and Murphy pointed out this process requires significant unlearning and relearning and may be difficult to do with speakers who do not listen well or when the leader feels threatened. Another obstacle to person-centered listening by leaders can be how dramatically different it is from traditional leadership ideals such as heroic leadership or even ideas about how business conversations should unfold. Accordingly, Jentz and Murphy warned that care should be taken to balance person-centered listening with establishing leadership credibility.

Sensing, processing, and reacting are the three steps of conversational listening that make up competent listening (Bodie, 2011a; Drollinger et al., 2006). Sensing is the term used to describe listening actions that indicate attention to explicit and implicit information produced when someone else is speaking. To facilitate the creation of a narrative whole, processing

involves actions like synthesizing conversational information and memorizing conversational fragments. Last but not least, responding entails requesting clarification and demonstrating attention with both verbal and nonverbal cues.

Activity and empathy might differ for each set of actions. Activity is the level of listening engagement and attention to what the other person is saying and doing, and it shows up in a variety of verbal and nonverbal cues (such eye contact) and patterns of synthesis or memory of conversational elements. The empathic component of AEL is described in accordance with Rogers (1959) as "the ability to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings. . . as if one were the other person" (p. 210), despite the fact that there are many different varieties of empathy. This definition focuses on the empathetic tendencies in listening that are consistent with perspective taking, a skill that has been found to improve when people participate in different forms of internal dialogue both before and during conversation practice.

King (2022) summarized based on a critical review of 75 peer-reviewed journals published from 2010 to 2021 that effective listening is characterized by (a) engaged awareness, indicated by attentiveness, presentness, and emotional involvement and (b) a person-centered perspective, indicated by a non-judgmental, genuine, open, and attuned attitude. The intentional, relational stance of the engaged, person-centered listener creates a relational space that leads to relational outcomes including mutual understanding, mutual engagement, relationship building, and collaboration. Moreover, when an individual is listened to in this manner, the individual, in turn, feels trust, affirmation, validation, engagement, and satisfaction. While King's (2022) aim was to create a model for effective listening in healthcare between providers and patients, the critical review was based on articles dealing with listening in everyday interpersonal conversations (Bodie, 2011b) and many fields of human interaction and service delivery, including business (Itani et al., 2019), counselling (Bernhardt et al., 2020), and various fields of healthcare (Meldrum & Apple, 2020; Nicola-Richmond & Watchorn, 2018).

Given the range of papers consulted, it can be concluded that the framework outlined by King (2022) also is applicable to other listening interactions.

Importance and Outcomes of Person-Centered Listening by Leaders. Guidance on management (e.g.,Covey, 1989; T. Gordon, 1977; Steil & Bommelje, 2004), magazines for businesspeople, and academics in the field of leadership have advocated that listening should be considered central to effective management (e.g., Drucker, 2004; Ewing & Banks, 1980; Frey, 1993) because it allows for better comprehension of emotions and improved expression of care for employees (Gabarro, 1991). This has been supported by some empirical research, which, for instance, links supervisor listening to perceived employee relationship quality (Stine et al., 1995).

According to Bodie (2012) and Steil and Bommelje (2004), listening to employees has the positive potential to develop and maintain strong leader-follower relationships. As such, it may be one particular factor that promotes high-quality leader-member exchange, a phenomenon where leaders and their employees engage in ways that are characterized by high levels of trust, support, and collaboration. According to research by Drollinger et al. (2006), salespeople who listen actively and empathically may build and sustain more gratifying connections with customers.

Between interaction partners, empathy listening forges a link that develops over time into a relationship of trust and mutual understanding (Rogers, 1957, 1975). According to Rogers (1951, 1975), trustworthy relationships and mutual understanding are achievable when a person feels welcomed and cared for. When used in organizational contexts, listening may have impacts that are comparable in the interactions between supervisors and employees (e.g., Brownell, 1990; Reave, 2005). Rogers' research on empathetic listening might assist in clarifying what listening means in a corporate setting. The manager-subordinate attachment could have a significant impact on other outcomes related to work, such as attitudes and

behaviors, according to study results in the setting of the organization (Ellinger et al., 2003; Lloyd et al., 2014; Stine et al., 1995).

In this regard, Lobdell et al. (1993) demonstrated a favorable relationship between employee perceptions of leader responsiveness and support and perceived supervisor listening skills. Comparable research has indicated a connection between manager listening as well as perceived relationship quality between managers and workers (Stine et al., 1995). This connection might, in the long run, also affect more distant variables like employee perception of the atmosphere of company openness and support (Husband et al., 1988), general job satisfaction (Brownell, 1990; Ellinger et al., 2003), and organizational citizenship performance (Lloyd et al., 2014).

According to listening studies, there are beneficial relationships between listening and job outcomes such employee engagement (Lobdell et al., 1993), organizational trust, and performance (Stine et al., 1995), as well as perceived leadership effectiveness (Johnson & Bechler, 1998). Recent research by Lloyd et al. (2014) showed in two investigations that perceptions of supervisor listening affect three crucial job outcomes: emotional tiredness, organizational citizenship behavior, and intentions to leave. Together, these data points show that evaluating listening in the workplace may have potential similar to that found in clinical or psychological research, and as a result, has to be further defined in terms of its connections to related categories and results. We suggest that manager listening, through its associated concept leader-member interchange (Graen & Uhl-Bien, 1995), leads to favorable organizational outcomes.

Assessment and Research. The act of listening involves several different steps (Bodie et al., 2012). As a result, conceptualizations have varied in terms of underlying theory and assessment, ranging from investigating listening attitudes and abilities (e.g., Mishima et al., 2000) to actions (e.g., Bodie et al., 2012; Ramsey & Sohi, 1997). Few studies have combined

the study of leader listening with leadership styles; significant exceptions include Bechler and Johnson (1995), Johnson and Bechler (1998), and Kluger and Zaidel (2013).

Nonetheless, research is growing on the use of person-centered leadership. For example, Masimula et al. (2020) examined stakeholders' perspectives on how person-centered leadership may be used to change the culture of the workplace in nursing education institutions in South Africa. Lloyd et al. (2017) examined the quality of listening within the context of manager-direct report relationships using the construct of empathic listening (Rogers, 1957) occurring within the framework of LMX theory. Listening quality also has been assessed based on feeling understood and active-empathic listening (Bodie, 2011a; Drollinger et al., 2006). Lloyd et al. (2017) additionally assessed employees' satisfaction with the manager, interactional justice, and job satisfaction. Based on their survey study of 250 German employees from a variety of professions, Lloyd et al. found associations among perceived supervisor listening quality and supervisor's active-empathic listening as well as with employees' feelings of being understood. Study findings indicated that listening quality predicted employee job satisfaction, satisfaction with their supervisor, and interactional justice.

Inclusion

Whereas diversity examines the demographic characteristics (e.g., age, gender) of a workforce (Ely & Thomas, 1996), inclusion concerns how well workers "are allowed to participate and are enabled to contribute fully" (Miller, 1998, p. 151). Inclusion further has been reified to indicate the extent to which a person believes their authentic selves are welcomed at work, allowing them to offer their best in ways that are concerted and full of meaning (McKinsey, 2020). Rice et al. (2021) observed that inclusion has prompted academics and professionals to investigate the "how" and "why" rather than simply the "what" and "who. "

A term related to and used interchangeably with inclusion in this study is *sense of belonging*, which is reified to indicate the degree of feeling accepted, valued, and supported in one's setting (Lampinen et al., 2018). In the context of inclusive workplaces, sense of belonging

has lately been studied (e.g., Enwereuzor, 2021). According to academics, procedures and institutions that achieve a balance between assimilation into the larger company and being recognized as identifying with the group to satisfy the demand for belonging (Randel et al., 2018). These goals can be met by implementing initiatives that show a robust DEI strategy, such as diverse representation practices, effective procedures for dealing with discrimination, and systems for keeping leaders accountable for creating inclusive workplaces synergistic developments for diversity are valued.

Antecedents and Influences on Inclusion

According to research by Pugh et al. (2008), organizational policies, practices, and procedures both implicitly and overtly convey the organization's prioritization of developing and preserving diversity as well as eliminating prejudice. Pugh et al. added that these features of the organization can be used to measure organizational inclusivity. Managers are then apt to imitate and spread their organization’s values and behaviors since they are organizational agents (Mawritz et al., 2012; Mayer et al., 2009). Through role modeling, supervisors illustrate what values and behaviors are critical within the setting (Grojean et al., 2004; Shore et al., 2010). It follows that managers who work for inclusive organizations demonstrate and create a trickle effect of inclusiveness related to their subordinates (Rice et al., 2021).

McKinsey (2020) concluded based on their analysis that workers’ experiences of inclusion are affected by the nature of their experiences within the organization as well as by their interactions with leaders, peers, and team members. Rice et al. (2021) conceptualized inclusion as a psychological process that involves integrating and exhibiting what one has learned or observed from reliable sources, according to a learning and integration paradigm that has been offered. They thus suggested that supervisors adopt the inclusive characteristics seen in higher level leaders. According to the social cognitive theoretical perspective, supervisors are viewed as credible representatives of the organization and may similarly pass corporate inclusion down to lower-level employees via a trickle-down effect.

Social cognition theory's central tenet is that lower-level employees mimic management behavior and prominent organizational cues (Bandura, 1986). Accordingly, the trickle-down effect happens as a result of role-modeling and the system of organizational rewards and disciplinary measures. Furthermore, the general attitudes, perceptions, and behaviors observable in organizations tend to be positively correlated with supervisors' perceptions, attitudes, and behaviors (Ambrose et al., 2013; Mawritz et al., 2012; Mayer et al., 2009; Ruiz et al., 2011). Such trickle-down effects have been presented in ethics literature. Based on social cognitive theory, Ambrose et al. (2013) concluded that supervisors' perceptions of interactional fairness trickled down to influence their workgroup perceptions of interactional fairness. Mayer et al. (2009) similarly found that ethical leadership demonstrated by senior leaders affected followers' behaviors and attitudes as demonstrated in ethical leadership at the supervisory level. Mawritz et al. (2012) additionally showed that abusive behaviors exhibited by senior level managers affected similarly deviant expressions two levels lower in the organization. These studies converge on the idea that supervisors learn through modeling the organization's values, philosophies and attitudes, behaviors and actions, as demonstrated by their managers. Furthermore, lower-level employees adopt the attitudes and behaviors of their own supervisors. Rice et al. (2021) hypothesized and found in their examination that organizational inclusiveness and supervisory inclusiveness are positively correlated.

Ely and Thomas (2020) emphasized that leaders play a fundamental role in creating inclusion and belonging. Namely, leaders must exhibit the value they attribute to diversity and inclusion by endorsing such things as creativity, being flexible, justice, and dignity.

Perceptions of threats to DEI projects and emotions of exclusion or inclusion come about as a result of intricate interactions between perceived organizational support for DEI, individual views on workplace diversity, and membership in a minority or majority group. Inclusion involves paying attention to workers' opinions of DEI activities, beyond an objective assessment of diversity representation in the workforce and the availability of diversity-supportive policies

(Dover et al., 2020; Wilton et al., 2020). However, it has been difficult to identify the border circumstances that affect how DEI efforts relate to the sense of fitting in at work.

For instance, researchers contend that the best way to comprehend the relationship that exists between employees' perceptions of the importance their organization accords to diversity (i.e., psychological diversity climate) and diversity outcomes is a multilevel approach that captures both individual and group perceptions of diversity climate (Ward et al., 2021). The same investigators recognize that workers from different teams, divisions, or demographic categories have distinctive views on the company that affect diversity results, but they also draw attention to the fact that general perceptions of the climate surrounding diversity are rarely examined in light of these group distinctions.

Others have examined how job results are affected by worker perceptions regarding the company's commitment to diversity or the individual worth that they attribute to diversity by contrasting the experiences different group members while relying on social identity theory, psychological contract theory, and other frameworks that describe psychological mechanisms (e.g., Lee et al., 2020; Yeung & Shen, 2020). Although these study streams have made significant contributions, there is a clear disconnect between them that, if resolved, might increase our understanding of the mechanisms behind employee perceptions of DEI programs and their influence on diversity results.

While acknowledging that these connections might be most effectively comprehended by also taking into account employees' opinions regarding DEI, recent literature has offered substantial insights into the many associations between diversity climate diversity outcomes (Ward et al., 2021). On the other hand, research that compares DEI results to individual worker perspectives of DEI frequently ignores assessments of the DEI climate. This gap needs to be closed in response to demands for research that examines whether and how alignment between the degree to which workers value DEI activities and the implied value of DEI initiatives to the company influences diversity results (Wilton et al., 2020).

Inclusive Practices and Initiatives

Inclusive organizations uphold practices such as making an attempt to incorporate all employees in the organization's mission and operation in light of their unique talents (Avery et al., 2008), remove obstacles that prevent employees from contributing fully to the organization (Roberson, 2006), and often seek out and acknowledge the contributions of every employee (Lirio et al., 2008). Thomas and Ely (2001) argued that a learning and integration approach, which is characterized by the conviction that people's varied backgrounds are a source of insight that should be used to adapt and improve the organizations' strategic tasks, is what it means for an organization to be inclusive.

Rice et al. (2021) built upon Thomas and Ely's (2001) assertions to propose that the successful implementation of the organizations' strategic tasks depends on supervisors adopting a learning and integrating viewpoint that sees people's varied experiences as an asset. Rice et al. (2021) found in their studies of inclusiveness that even in the absence of organizational inclusiveness, supervisory inclusiveness toward employees yields employee-level sense of belonging and associated behaviors.

Within organizations, the DEI initiatives are used to enhance employees' inclusion and sense of belonging. In order to support the strategy of the company, these efforts cover a range of systems that ensure fair treatment for all groups, reduce stereotyping, enhance impact for underrepresented populations, and take advantage of DEI representation (Cachat-Rosset et al., 2019). In particular, we examine how much a sense of belonging depends on the weight that a worker and a company place on things like all employee groups should have the same opportunities and representation, and there should be official diversity activism on behalf of pro-diversity purpose and values, equal chances for recruiting, and selection.

The input of different groups is regularly sought out and encouraged in workplaces that value fair treatment and employee voice, and social norms are in place to make sure employees are held responsible for their discriminatory views and actions (McKay et al., 2009; Sliter et al.,

2014). In reality, top leaders show their commitment to diversity by ensuring that every employee is treated fairly, and workers are frequently encouraged to express their views and concerns in a safe and courteous manner, particularly those that relate to diversity through addition to fair treatment and speech, an organization may express its support for diversity through its mission statement, fundamental values, and even through symbols (Sedgwick et al., 2014). When the efforts of DEI are unambiguously in line with the company's overall strategy and brand, when pro-diversity messages appear regularly in internal communications and external marketing materials, and when artifacts and other esthetic elements that emphasize the value of diversity in the workplace are visible across the company, there is evidence of the company's dedication to diversity.

As employees feel accepted and valued for their distinctive contributions, organizations that uphold fairness and non-discriminatory policies toward laborers have been associated with experiences of belonging among minority groups (Enwereuzor, 2021; Otten & Jansen, 2014; Sedgwick et al., 2014; Sherman et al., 2020). Little is understood, however, regarding how relationships between minority and majority ethnic groups and employee views of the business and personal diversity values surrounding these DEI activities effect sense of belonging.

In order to lure talent and guarantee a diverse candidate pool, equal opportunity recruitment and selection policies provide fair and equitable hiring processes and communicate a pro-diversity attitude to potential candidates at all phases of the selection process (Hennein et al., 2021). According to the available data, people of color with a strong sense of ethnic identification are more likely to apply for a job at a company that promotes diversity in its hiring practices (Kim and Gelfand, 2003). In order to ensure that their workforce reflects the diverse community they serve, organizations typically develop equal opportunity recruitment and selection practices. However, these procedures may be seen as tokenistic or as giving marginalized groups preferential treatment, which may worsen intergroup conflicts and encourage discriminatory beliefs (King et al., 2010; Richard and Wright, 2010; Watkins et al.,

2019). Investigators have outlined these unforeseen implications of DEI initiatives within and between groups, as well as their detrimental effect on sense of belonging, and called for further study to look at both company opinions regarding DEI initiatives as well as people's views on efforts related to DEI.

According to Dover et al. (2020; Luu et al., 2019), the goals of diversity training are to show that the company values diversity, to explain the benefits of having a diverse workforce for organizational growth and performance, and to inform employees about biases, historical context, and other elements that can lead to stereotypical attributions and discriminatory behaviors. Prosocial behaviors (Ashikali & Groeneveld, 2015; Luu et al., 2019), cohesiveness, perspective-taking, reduced group conflict, and better cultural competency (Young & Guo, 2020) are just a few of the advantages that diversity training has been associated to. In particular, experts claim that providing diversity training alongside strong accountability mechanisms and when workers find the training valuable and relevant increases the probability that it will be successful in fostering an inclusive atmosphere (Bezrukova et al., 2016; Luu et al., 2019). This shows that fitting assessments of the personal value of diversity training to opinions of how highly the company values thorough diversity education may help us understand the impact of diversity instruction on a person's sense of belonging.

Diversity champions promote conversations about advantage, prejudice, and discrimination in job settings and make ensuring that policies and support systems are in place that are culturally sensitive and responsive (Buengeler et al., 2018). Leaders can be particularly effective diversity ambassadors due to their official position and great exposure (Rice et al., 2021). In summary, pro-diversity leaders serve as role models by engaging in predictable actions that encourage staff to embrace the principles, put them into practice, and help to create an inclusive workplace (Luu et al., 2019). Little is understood about how employees' perspectives of diversity advocacy connect with their experiences of advocacy in the company,

despite mounting evidence that diversity advocacy influences inclusivity at the team level (Mor Barak et al., 2021).

Importance of Inclusion

Modern workplaces are characterized by a workforce that is more varied as a result of globalization and changes in society and the labor market. Workforce diversity has been associated with higher levels of engagement and caring in human service companies, as well as ensuring that clients and the larger community feel represented in the service providers (Baumann et al., 2021).

The persistent challenge struggle for employees—particularly, those who are underrepresented—is attaining a measure of success and feeling they belong in their organizations. This challenge has earned the attention of scholars and practitioners as they have sought to investigate and demonstrate the criticality of organizational inclusiveness (Shore et al., 2010; Wu et al., 2015).

According to organizational studies, diversity can boost innovation, force organizations to reexamine long-held beliefs, and boost financial success (Hunt et al., 2015; Hunt et al., 2018). Only when executives and employees feel included will organizations be able to fully benefit from the insights of a diverse workforce (Sancier-Sultan & Sperling-Magro, 2019).

When the significance of creating an inclusive work environment is downplayed, organizations run the danger of employee churn and alienation (Rice, 2018). Poor levels of inclusion can be detrimental for organizations, as it results in polarization within teams (Nishii & Mayer, 2009), reduced retention (Nishii, 2013; Nishii & Mayer, 2009; Wiersema & Bird, 1993), increased conflict among employees (Jehn et al., 1999), as well as diminished group cohesiveness and communication (O'Reilly et al., 1989). Contrarily, research has shown that views of inclusivity among organizational members have a favorable impact on engagement, performance, and job satisfaction (Avery et al., 2008; Cho & Mor Barak, 2008; Nishii, 2013).

Hence, many organizations' top priority now is to foster an atmosphere where people of all backgrounds feel included and at home (Bilimoria et al., 2008; Roberson, 2006).

Effectively promoting organizational inclusivity throughout the company is likely to increase how much employees invest in the company emotionally through affective commitment and behaviorally by going above and beyond the scope of their formal job responsibilities. Increased employee commitment and citizenship behavior also has been found to enhance the work environment (Lambert, 2000; Zhao et al., 2013). According to Rice et al. (2021), citizenship behavior and commitment result when subordinates feel a sense of inclusion because these behaviors convey a sense of organizational unity and inclusion (Eisenberger et al., 1990; Katz 1964; Shore et al., 2010).

To the extent that they feel engaged and have full membership inside an organization, subordinates typically respond with citizenship behavior and dedication, which results in an emotional attachment to the organization (Colquitt et al., 2001; Cropanzano & Mitchell, 2005; Mayer et al., 2009; Shanock & Eisenberger 2006). Rice et al. (2021) showed that organizational inclusiveness cascades downward to the level of subordinates. Accordingly, citizenship behavior and affective commitment also tend to be representative of an inclusion-related behavior and inclusion-related attitude, respectively. In turn, the trickle-down effect of organizational inclusiveness throughout the levels of the organization is additionally evidenced.

When departments are purposefully constructed to enhance both diversity and inclusion, various benefits for patients and departments follow, such as expanded health equity, improved quality of patient care, an increase in diverse research, enhanced financial performance, better engagement of the workforce, increased levels of innovation, and expanded individual opportunities for career advancement and success (Bersin, 2015; Lightfoote et al., 2016; Morris et al., 2020).

According to studies, diverse workplaces foster greater innovation and better workplace engagement, which includes more positive work attitudes, better recruitment, and better

employee retention (Lightfoote et al., 2016; Morris et al., 2020) Promoting diversity and inclusion can additionally help departments avoid legal action, which can be expensive in terms of both capital and reputation (Dobbin & Kalev, 2016).

A more inventive, forward-thinking, and productive faculty and staff can result from the diversity of ideas and opinions communicated in an accepting, non-judgmental environment of free conversation and sharing ideas without fear of jeers and/or retaliation (Corritore et al., 2020). People who work in diverse and welcoming workplaces report higher levels of job satisfaction, engagement, and retention—all of which can help them advance their careers. Representation matters; to maximize their chances of having a successful career, people should have access to a wide range of prospective role models, mentors, and sponsors (Weaver et al., 2021). Departmental success can result from individual accomplishment. If a department is successful, it will subsequently be able to recruit additional excellent and diverse employees, continuing the cycle of departmental success and effective hiring. A self-sustaining circle, diversity and inclusion breed diversity and inclusion.

Citizenship behaviors are a special kind of behavioral investment within the organization that involve going above and beyond the call of duty to foster a sense of cohesion and inclusion among others (Shore et al., 2010). Helping at the interpersonal and organizational levels is one of these activities. A sense of belonging and emotional attachment to one's employer are conveyed through affective commitment, a particular sort of emotional investment within the business, which is also a crucial component of feeling included (Shore et al., 2010). Shore et al. (2010) recognized that commitment ought to follow inclusion because of shared attachments and the conceptual connection between the two. Furthermore, Cho and Mor Barak (2008) found inclusivity and commitment were positively associated. According to our earlier theory, organizational inclusivity ought to have a beneficial trickle-down effect on subordinate citizenship and commitment. In other words, we think inclusive supervision is a key factor in the transmission of these effects.

Impact of Person-Centered Leadership and Person-Centered Listening on Inclusion

Organizational leaders' behavior effectively communicates inclusion—or lack of it (Nembhard & Edmondson, 2006). Employee's immediate managers, in particular, are the leaders responsible for allocating rewards and opportunities to direct reports (Douglas et al., 2003). In turn, direct supervisors play a key role as agents of the organization. That is, employees formulate judgments about the organization based on the inclusiveness of the manager (Liden et al., 2004). Rice et al. (2021) used social cognitive theory to explain the process through which organizational inclusiveness trickles down from higher to lower levels of organizations. They further emphasize that central to the transmission of organizational inclusiveness is the supervisor, adding that inclusiveness at the supervisory level is a form of modeling resulting from inclusiveness at the broader organizational level.

Subrahmanyam (2018) elaborated that leaders who practice person-centered listening encourage employees to give and receive open and honest feedback on an interpersonal level. In turn, an atmosphere of working with people rather than directing them results, thus, enhancing the sense of collaboration and inclusion (Amin et al., 2018). McCormack and McCance (2017) further observed that worker-oriented managers find room for commonality with direct reports, especially regarding vision, which has the potential to boost feelings of inclusion.

Carmichael et al. 's (2021) study of the training experiences of racial and ethnic minority genetic counseling graduate students underscores the importance of supervisors' listening and understanding in helping students feel a sense of inclusion a belonging in the profession. Data from the National Society of Genetic Counselors (2020) indicates that genetic counselors in the U.S. and Canada are predominantly White (90%), with the remaining counselors identifying as Asian (5%), Asian Indian (3%), Latinx (2%), Black (2%), or other races or ethnicities (1%). Carmichael et al. (2021) administered 13 focus group interviews via web conference with 32 attendees heralding from genetic counseling education. Participants needed to identify a

racial/ethnic minority. In their training program, during supervised clinical rotations, and at professional gatherings, participants described unpleasant experiences. Negative encounters included remarks implying they were foreigners in the country, being mistaken for a non-white student, and intrusive inquiries or presumptions about their family, culture, or religion that were not similarly directed towards white peers. Muslim and Black/African American trainees expressed feeling particularly alone as a result of these incidences. Following unpleasant encounters, participants claimed they sought help from a variety of sources. The perception of non-minority program professors was that they could provide action or listening but not understanding or advice, which were thought to be more likely to come from those who identify as racial or ethnic minorities.

Occupationally Minoritized Healthcare Professionals

An occupational minority is a worker who is rare in their occupation, such as male nurses or female engineers (Taylor, 2010). Occupational minorities are assessed at the national (occupational) level, rather than at the level of their organizations. Taylor (2010) proposed that employees' jobs are filled with meaning about who the worker is and how fitting that worker is to the role. These meanings can be flattering or discouraging and, accordingly, influence worker interactions. The concept of occupational minority is in contrast to the concept of *token,* defined as people of a common demographic being in numerical minority in the workplace (Kanter, 1977). The idea of an occupational minority departs from ideas about tokens, which means those who are rare in their organizational setting (Kanter, 1977).

Demographics of Healthcare Profession

Based on data from U.S. Census Bureau (2018, 2020), White individuals comprise 57. 8% of the general population but make up 67. 4% of healthcare practitioners and health-related technical occupations (see Table 1). While Black individuals are well-represented in healthcare (12. 1% in the general population v. 11. 3% of healthcare workers), Asian individuals are overrepresented (5. 9% general population, 9. 6% healthcare workforce), and Latinx individuals

are significantly underrepresented (18. 7% general population, 9. 0% healthcare workforce). Examination of the data by occupation revealed that underrepresentation of non-White individuals is most pronounced for physician and higher level or lead practitioner roles such as chiropractors (86. 4% White), podiatrists (86. 4% White), veterinarians (86. 1% White), nurse anesthetists (86. 1% White), and surgeons (76. 7% White). In contrast, technical roles are disproportionately staffed by non-White individuals. For example, of all clinical laboratory technologists and technicians, 15. 9% are Black, 11. 8% are Asian, and 12. 2% are Latinx. These data indicate that Latinx individuals qualify as occupational minorities across all healthcare professions, and non-White individuals in general are occupational minorities in higher level physician, surgeon, and practitioner roles, while Black and Asian individuals generally are not occupational minorities in technical roles.

Differences in occupational representation are even more marked when examining occupation demographics by gender (See Table 2). The U.S. Census Bureau reports that the nation’s workforce aged 25–64 years is equally split between males and females. However, nearly three of every four healthcare workers are female. Males disproportionately occupy higher level and specialist physician roles such as surgeons (79. 8% male), radiologists (75. 5%), podiatrists (68. 7%), and emergency medicine physicians (66. 4%). In contrast, women disproportionately fulfill supportive roles such as dental hygienist (92. 9%), nursing roles such as licensed practical and licensed vocational nurse (88. 2%), therapist roles such as occupational therapist (86. 7%), and technician roles such as dietetic technician and ophthalmic medical technician (81. 7%). These statistics indicate that women are occupational minorities in physician roles. Having identified non-Whites and women as occupational minorities in physician and other leadership roles in healthcare, it is important to understand their experiences to determine the reason for their underrepresentation in certain occupations and identify potential interventions for addressing their underrepresentation.

Table 1

Healthcare Occupations by Race

	White	Black	Asian	American Indians and Alaska Natives	Native Hawaiian or Other Pacific Islanders	Other	Two or More Races	Latinx
General population	57. 8	12. 1	5. 9	0. 7	0. 2	0. 5	4. 1	18. 7
Healthcare Workers	67. 4	11. 3	9. 6	0. 4	0. 1	0. 2	1. 9	9. 0
Chiropractors	86. 4	-	-	-	-	-	-	-
Podiatrists	86. 4	-	-	-	-	-	-	-
Veterinarians	86. 1	-	-	-	-	-	-	-
Nurse anesthetists	86. 1	-	-	-	-	-	-	-
Radiation therapists	83. 8	-	-	-	-	-	-	-
Speech-language pathologists	82. 6	-	-	-	-	-	-	8. 1
Audiologists	82. 1	-	-	-	-	-	-	-
Occupational therapists	80. 9	-	7. 4	-	-	-	-	-
Veterinary technologists and technicians	79. 6	-	-	-	-	-	-	10. 6
Paramedics	78. 7	-	-	-	-	-	-	9. 7
Dental hygienists	78. 1	-	6	-	-	-	-	9. 9
Nurse practitioners	77. 2	7. 1	7. 3	-	-	-	-	6. 3
Radiologists	77. 0	-	-	-	-	-	-	-
Surgeons	76. 7	-	-	-	-	-	-	-
Physical therapists	76. 6	3. 9	12. 5	-	-	-	-	5. 2
Physician assistants	75. 4	-	8	-	-	-	-	8. 9
Healthcare diagnosing or treating practitioners, all other	75. 1	-	-	-	-	-	-	-
Diagnostic medical sonographers	74. 8	-	-	-	-	-	-	10. 2
Radiologic technologists and technicians	74. 1	6. 7	5. 2	-	-	-	-	11. 4
Magnetic resonance imaging technologists	72. 1	-	-	-	-	-	-	-
Optometrists	72. 0	-	-	-	-	-	-	-

	White	Black	Asian	American Indians and Alaska Natives	Native Hawaiian or Other Pacific Islanders	Other	Two or More Races	Latinx
Emergency medical technicians	72. 0	-	-	-	-	-	-	14. 5
Opticians, dispensing	70. 9	-	-	-	-	-	-	15. 2
Dietitians and nutritionists	70. 2	13. 5	-	-	-	-	-	9. 4
Dentists	69. 5	-	18. 3	-	-	-	-	5. 7
Registered nurses	69. 3	11. 9	9	0. 3	-	-	1. 8	7. 4
Recreational therapists	69. 0	-	-	-	-	-	-	-
Therapists, all other	67. 1	12. 3	5. 1	-	-	-	-	12. 4
Other healthcare practitioners and technical occupations	66. 7	12. 1	-	-	-	-	-	12. 4
Pharmacists	66. 0	5. 8	21. 6	-	-	-	-	4
Respiratory therapists	65. 8	12. 9	6. 6	-	-	-	-	12
Medical records specialists	63. 9	14. 2	6	-	-	-	-	13
Nuclear medicine technologists and medical dosimetrists	63. 8	-	-	-	-	-	-	-
Acupuncturists	63. 5	-	-	-	-	-	-	-
Other physicians	63. 0	5. 4	21. 6	-	-	-	2. 5	6. 9
Surgical technologists	62. 0	15. 6	-	-	-	-	-	15. 3
Cardiovascular technologists and technicians	58. 6	-	-	-	-	-	-	-
Dietetic technicians and ophthalmic medical technicians	58. 3	21. 7	-	-	-	-	-	-
Pharmacy technicians	58. 1	14. 5	8. 9	-	-	-	2. 5	15. 1
Miscellaneous health technologists and technicians	57. 4	18. 6	7. 2	-	-	-	-	13. 3
Clinical laboratory technologists and technicians	57. 1	15. 9	11. 8	-	-	-	-	12. 2
Licensed practical and licensed vocational nurses	53. 4	25. 8	5	0. 7	-	-	1. 7	13. 2
Psychiatric technicians	47. 6	27. 2	-	-	-	-	-	15. 9

Note. An "-" entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate. Data sources: U. S Census Bureau. (2020). Hispanic or Latino, and not Hispanic or Latino by race 2020: DEC Redistricting Data (PL 94–171). Universe: Total population. https://data.census.gov/table?t=Hispanic+or+Latino&g=0100000US&y=2020; U.S. Census Bureau. (2018). Detailed Occupations by Race and Hispanic Origin: 2018 ACS. https://www.census. gov/data/tables/2018/demo/industry-occupation/acs-2018. html

Table 2

Healthcare Occupations by Gender

	Male	Female
General workforce aged 25–64	50. 0	50. 0
Healthcare workforce aged 25–64	27. 1	72. 9
Surgeons	79. 8	20. 3
Radiologists	75. 5	24. 5
Chiropractors	74. 6	25. 4
Paramedics	70. 7	29. 3
Podiatrists	68. 7	31. 3
Emergency medicine physicians	66. 4	33. 6
Dentists	65. 6	34. 4
Other physicians	60. 2	39. 9
Emergency medical technicians	59. 8	40. 2
Optometrists	51. 6	48. 4
Nuclear medicine technologists and medical dosimetrists	51. 4	48. 6
Magnetic resonance imaging technologists	47. 8	52. 2
Acupuncturists	45. 3	54. 7
Cardiovascular technologists and technicians	44. 6	55. 4
Pharmacists	44. 5	55. 5
Exercise physiologists	43. 4	56. 6
Nurse anesthetists	42. 1	57. 9
Physical therapists	39. 9	60. 1
Miscellaneous health technologists and technicians	37. 8	62. 2
Respiratory therapists	37. 0	63. 0
Other healthcare practitioners and technical occupations	35. 7	64. 3
Radiologic technologists and technicians	35. 2	64. 8
Radiation therapists	35. 0	65. 0
Physician assistants	34. 3	65. 7
Psychiatric technicians	34. 2	65. 8
Veterinarians	32. 5	67. 5
Healthcare diagnosing or treating practitioners, all other	32. 3	67. 7

	Male	Female
Clinical laboratory technologists and technicians	29. 7	70. 3
Surgical technologists	29. 1	70. 9
Opticians, dispensing	28. 8	71. 3
Recreational therapists	26. 6	73. 3
Diagnostic medical sonographers	24. 3	75. 7
Pharmacy technicians	23. 8	76. 2
Therapists, all other	22. 3	77. 7
Dietetic technicians and ophthalmic medical technicians	18. 3	81. 7
Audiologists	17. 2	82. 8
Veterinary technologists and technicians	14. 9	85. 1
Registered nurses	13. 5	86. 5
Occupational therapists	13. 3	86. 7
Nurse practitioners	12. 4	87. 6
Licensed practical and licensed vocational nurses	11. 9	88. 1
Dietitians and nutritionists	9. 9	90. 1
Medical records specialists	8. 3	91. 7
Dental hygienists	7. 1	92. 9
Speech-language pathologists	5. 5	94. 5
Nurse midwives	-	100. 0

Note. A "-" indicates that either no sample observations or too few sample observations were available to compute an estimate. Data sources: U. S Census Bureau. (2020). 2020: ACS 5-Year Estimates Subject Tables: S0101 age and sex https://data. census. gov/table?t=Age+and+Sex&g=0100000US&y=2020; U.S. Census Bureau. (2018, May 18). Table 1. Full-Time, Year-Round Workers by Sex, Educational Attainment and Detailed Occupation: ACS 2019, Universe: Full-time, year-round civilian employed population, ages 25 to 64, with earnings, excluding Puerto Rico. American Community Survey. https://www.census. gov/data/tables/2022/demo/acs-2019. html

Impact of Occupational Minoritization

Occupationally minoritized employees reportedly experience various forms of microaggression, discrimination, and prejudice based on the results of several studies. Numerous phrases are frequently used to refer to the unfavorable encounters that people may have as a result of their ethnic or racial background. According to Murray-Garca et al. (2014), implicit prejudice refers to unintentional views toward a person or group that might lead to discriminatory conduct. According to Dovidio et al. (2008), stereotyping is the practice of

ascribing particular traits to every member of a group. Microaggressions are defined as short remarks or interactions that send the wrong message to people because of their membership in a minority group. For instance, remarks that insinuate Asians do not belong in the United States or imply African Americans are criminals might fall under this category. Microaggressions are recognized by their detrimental effect on the victim, even though the offender may have done so unintentionally (Sue et al., 2007).

Discrimination has an extensively reported negative effect on minority employees' experiences and achievement, which includes social marginalization, lost career possibilities, an inadequate level of team identification, distress, loneliness, and a decline in satisfaction with work, commitment to the organization, and general wellbeing (Hennein et al., 2021; Miller, 2021; Mor Barak et al., 2003). Other common results of discrimination include escalated negative emotions such as isolation and diminished sense of belonging in the discipline (Brunsma et al., 2017; Clark et al., 2012; Gay, 2004; Haskins et al., 2013; Smith et al., 2007; Torres et al., 2010). For example, a 2019 American College of Radiology nationwide survey of advanced healthcare professions in radiology revealed that occupational minoritized individuals are at greater risk for unfair or disrespectful workplace interactions and these experiences, in turn, erect obstacles to recruiting retaining, and advancing diverse professionals (Pandharipande et al., 2019).

At every stage of their journey through the medical school continuum, students who are underrepresented in medicine have encountered differences and frequently prejudice (Fnais et al., 2014). When compared to the relative age adjusted population in the US, Lett et al. (2019) analysis revealed that Hispanic applications and matriculants are underrepresented by 70% and American Indian and Alaskan Native applicants and new students by more than 60%. There is no doubt that the physician profession lacks diversity, but this just serves to emphasize the discriminatory hiring practices and poor retention efforts. UIM students have long suffered from traditional measures that are frequently dependent on scores, accolades, and recommendations that are used to give interviews. Compared to their counterparts, black medical students are

less likely to be inducted into the Alpha Omega Alpha organization (Boatright et al., 2017). The mean scores on the United States Medical Licensing Examination (USMLE) Step 1 vary significantly depending on ethnic background and race (Williams et al., 2020), with UIM students doing worse than their White colleagues. Despite research indicating minimal association between these scores and clinical performance, the USMLE has been utilized to select postgraduate residents. One study indicated that white residency applicants in orthopedics had increased acceptance rates, even in situations where Hispanic applicants had published more and Black applicants had volunteered more hours. A glaring omission in this study was not studying conscious and unconscious bias, which is an established factor affecting occupational minorities in the medical field.

Nwora et al. (2021) noted that simply receiving an interview despite the structural barriers facing non-White candidates is an impressive feat. Conversion to virtual technology did not correct the systemic discrimination built into the oppressive systems endemic to the medical field. Moreover, Nwora et al. predicted that virtual application systems actually would heighten the obstacles for UIM students, impacting diversity initiatives in unprecedented manifestations. Furthermore, Nwora et al., predicted that the elimination of recruitment activities that extend beyond interviews (e.g., rotations, dinners) would additionally disadvantage diverse candidates in their attempts to demonstrate their suitability for certain programs.

Carmichael et al. ’s (2021) study of minoritized genetic counseling graduate students found that most minority students receive their education from mostly white instructors and fellow students due to the very small number of non-white genetic counselors. Minoritized students' feeling of belonging in the medical field is adversely affected, leading them to feel othered, according to Carmichael et al. ’s identification of a wide range of covert and overt exchanges that take place among participants and other students, instructors, and medical professionals. Some of the respondents described experiencing culture shock when they first entered a place that was so ethnically and culturally homogenous. A variety of

microaggressions from peers or teachers heightened their sense of alienation. Two minority respondents reported being mistaken for other minority students in their cohort. To describe the sense of being seen as a member of one's ethnic or cultural group first and as a human being second, Hassouneh and Thomas (2017) introduced the word invalidation. Participants who took engaged in the discussion part of the study mentioned remarks that were more overt, such as a Muslim student being informed by her classmates that they were "intimidated" to meet her or a student who was born in the United States being called "foreign. " Even while the students saw these words as microaggressions, they may not have been meant to be cruel or insulting.

Participants' perceptions of their differences were strengthened even by comments made by peers that seemed well-meaning. Students from minority cultures were made to feel more alienated by excessively positive remarks about their potluck offerings and invasive questioning about private matters, which violated their right to the same level of discretion as their White classmates. Students studying genetic counseling are not the only ones who have had these encounters; they have been reported in a number of academic fields, such as radiology. As they highlight the importance of ethnic and racial identity as an important distinction between minority students and their peers, they cause a sense of diminished belonging and increased separation (Brunsma et al., 2017; Clark et al., 2012; Gay, 2004).

Minoritization, discrimination, and exclusion has dramatic and concerning effects on healthcare, especially given that patient care relies on the effective communication and collaboration of cross-disciplinary teams (Nembhard & Edmonson, 2006). Along with the tremendous increase of medical data, healthcare teams have to cope with growing specialization that splits vital expertise across personnel. This knowledge must be combined to provide high-quality treatment and to improve care. According to research (Lee & Doran, 2017; Nembhard & Edmonson, 2006), medical mistakes and adverse events connected to misunderstandings across healthcare personnel threaten the safety of patients. It has been found that between 70% and 80% of errors in medicine are due to exchanges inside the team

providing healthcare. Human variables, such as interpersonal relationships, have an impact on healthcare practitioners' interactions. However, there is a dearth of literature on healthcare teams that addresses interpersonal connections and communication. In order to explain how interpersonal relationships among healthcare team members impact communication and team performance, such as patient safety, Lee and Doran (2017) suggested a theoretical framework. To achieve this, they used research from the social and health sciences to build a theoretical framework that explains the connections between these categories. They concluded that perception, evaluation, and feedback, which emphasize relational communicative behavior and provider relations strongly influence the nature of interpersonal processes on healthcare teams and, in turn, patient outcomes.

When processes go wrong, human lives are at danger. This sensible risk aversion might prevent people from being ready to participate in the disorder and unpredictability of team brainstorming and experimenting. Furthermore, successful multidisciplinary cooperation that integrates information and experience from several sources is essential to providing superior care for patients. In actuality, it is challenging to accomplish this goal (Edmondson et al., 2003). It is inevitable that diverse perspectives, each based on extensive understanding of a distinct part of the process, are needed in order to improve the standard of medical procedures. While nursing and other allied health professionals (such as respiratory therapists and nutritionists) have a stronger understanding of routine patient interactions, doctors have specific expertise in medicine. They provide a more complete knowledge base when combined. But information is frequently kept to oneself. According to a recent research, nurses often fail to share their innovative problem-solving approaches with others in the hierarchy, despite the fact that they see and encounter a wide range of difficulties every day (Tucker & Edmondson, 2003). Consequently, collaborative learning does not happen organically in the health care industry, despite its relevance for enhancing the delivery of treatment.

Thus, the established professional hierarchy in the medical field complicates efforts to communicate across role demarcations (e.g., doctor vs. technician vs. therapists) and further intensifies the effects of occupational minoritization (Edmondson, 2003). The tendency of practitioners to look for chances to learn to interact, delegate responsibility, and participate in problem-solving and quality improvements can be reduced by medical education that fosters a climate of autonomous action (Nembhard & Edmonson, 2006). This apprehension may have a negative impact on patient treatment. The level of hierarchy in exchanges amongst healthcare team members is strongly associated with health outcomes for patients. Research from the Institute of Medicine concluded that many mistakes in medicine are partly caused by dysfunctional interaction practices due to hierarchy and disparities in professional status (as cited in Nembhard & Edmonson, 2006). A nationwide study of malpractice cases in medicine found that the highest status members of the medical teams (i.e., doctors) disregarded critical data shared by lower status team members (e.g., nursing staff). Furthermore, nursing staff additionally were found to refrain from sharing data crucial to effective care (Schmitt, 1990). Opportunities for learning and development can be lost in this status-conscious setting because people are reluctant to communicate in a way that improves quality out of concern for high-status individuals' retaliation.

Importance of Inclusion for Occupationally Minoritized Healthcare Professionals

Healthcare professionals serve a diverse patient group; therefore, healthcare organizations should strive to ensure that their workforce reflect the communities they serve (Weaver et al., 2021). The state of healthcare and clinical research are improved by departmental diversity by offering equal representation by factors such as race, ethnicity, and sex, which allows for improved insights of the day-to-day patient experience (Emery et al., 2018; Morris et al., 2020).

From the perspective of the workforce, however, diverse representation is insufficient to foster an atmosphere of inclusivity (Ashikali et al., 2021). Inclusion is based on the extent to

which company processes support the felt sense of fitting in within the professional setting, whereas diversity representation indicates that the company does hire (or at least is open to hiring) individuals with varying backgrounds and attributes (Miller, 2021; Rice et al., 2021). Literature and research to date suggests that the absence of a documented strategy as is pertains to DEI, combined with misperceptions that diverse representation alone enhances inclusivity results in execution of strategies that fall short of the goal to reduce tension between employee groups (Leslie, 2019; Mor Barak et al., 2021). The result is a pernicious reiteration of poor management of diversity negatively impacts corporate atmosphere, performance, retention, and innovation (e.g., Cho et al., 2017). These undesirable results support the idea that diversity presents a barrier to firm performance, which in turn supports unfavorable perceptions about minority groups and hinders the creation of an inclusive atmosphere (Galinsky et al., 2015; King et al., 2010).

According to academic works that emphasize the unanticipated negative effects of DEI programs (such as Leslie, 2019), both minority and majority groups are negatively impacted by well-intentioned DEI methods. On the one hand, even when companies assure their representation, employees from minority or marginalized groups may still encounter prejudice and a diminished sense of belonging (Amarat et al., 2019). On the other hand, workers from either group may perceive the initiatives as dishonest or as efforts to offset ability deficits among minority employees instead of as strategies to correct persistent disparities (Dover et al., 2016, 2020; Leslie, 2019). Majority groups can perceive the measures taken by DEI as an imminent danger to their livelihoods and standing and feel disadvantaged.

Nembhard and Edmondson (2006) made the study hypothesis that inclusive leadership enables multidisciplinary groups to overcome the barriers provided by status inequalities, enabling teammates to work together on process improvement. The necessity for quality improvement and the fact that there is a hierarchy in medicine, as well as the distinct statuses assigned to persons in other fields, are extensively documented in the literature on health care. Nembhard and Edmondson

came to the conclusion that status associated with professional role is associated with psychological safety, a crucial precondition for speaking out and engaging in learning behavior, in healthcare teams based on their survey research of 23 neonatal intensive care units engaged in quality improvement initiatives. They also discovered that inclusivity of the leader predicts psychological safety and mediates the association between rank and psychological safety. Finally, they suggested that psychological safety mediates the link between leader inclusiveness and engagement and predicts involvement in quality improvement efforts. According to Nembhard and Edmondson's study, inclusive leadership practices may help mitigate the impacts of occupational minoritization by fostering psychological safety and, in turn, engagement.

Impact of Person-Centered Listening on Inclusion Among Occupationally Minoritized Healthcare Professionals

Masimula et al. (2020) argued that healthcare is in need of person-centered leadership, due to the complexity of the responsibilities facing healthcare professionals. In health organizations, managers' approaches affect nurses feelings of being satisfied with their jobs and, in turn, their desires to leave or stay, bubbling up to organization-level turnover rates (American Nurses Association, 2013; Eide & Cardiff, 2017; McCormack & McCance, 2017). In addition to turnover and dissatisfaction, inadequate focus on workers exacerbates work stress (Pishgooie et al., 2019). Nursing leaders should consider forgoing traditional and top-down leadership styles in favor of transformational leadership approaches for the purpose of improving retention within the nursing staff, in addition to enhancing nurses' job satisfaction (American Nurses Association, 2013). Heyns and McCormack (2014) also indicated that in order to address shortfalls in nursing personnel, healthcare systems may consider shifting from crisis intervention to person-centered care. Heyns and McCormack (2014) urged healthcare organizations to create nurturing work environments through person-centered leadership, which in turn would enhance the patient experience. Masimula et al. (2020) concluded based on their

research that person-centered leadership is crucial for changing the culture of healthcare workplaces so that all healthcare professionals may thrive.

Studies by Armstrong and Rispel (2015) as well as by Blaaw, Ditlopo and Rispel (2014) similarly concluded that nursing education institutions should also employ adaptable and effective leadership styles to enhance the experiences of nurse educators. Additional study findings indicated that examination of nursing professionals' academic experiences could be used to identify opportunities to enhance student centeredness in nursing programs (O'Donnell et al., 2017). Moreover, O'Donnell et al. (2017) argued that nurses should learn about worker-centered leadership styles when they are students—and, further, learn this from educators who have real-world management experience. However, more research is needed to explore this topic to a further extent (O'Donnell et al., 2017). Masimula et al. (2020) subjectively investigated the impression of medical caretaker teachers and medical attendant directors in a nursing schooling establishment with respect to the authority characteristics expected to work with an individual focused work environment culture.

In Carmichael et al. 's (2021) study, when occupationally minoritized genetic counseling students sought understanding, they did not think that having White professors or managers would be beneficial. They discovered that White managers either failed to notice the racism or did not react as anticipated when contacts with racism in the clinical environment occurred. Participants believed that their White professors or supervisors would not know what would be beneficial, even when they thought they had the best of intentions. Instead, participants sought out other people who identified as members of minority groups to overcome feelings of loneliness (González, 2002; Museus, 2008), receive cultural nourishment (González, 2002), and deep understanding of their experience without having to explain it (Carmichael et al., 2021). Based on these findings, it appears that person-centered listening, which focuses on deep listening from the perspective of the speaker, also might help combat the sense of isolation and, instead, may promote a sense of inclusion among occupationally minoritized employees. Given

the dramatic underrepresentation of ethnic and gender minorities across many healthcare professions, it seems imperative to cultivate this type of listening in leaders.

Synthesis of the Literature

While person-centeredness and/or people-centered leadership have been examined (at least in part), person-centered listening has not. Person-centeredness is linked to personal meaning, feeling of belonging, engagement, performance, and job security. A body of knowledge also documents the experiences of occupational minorities in healthcare; however, few studies have been produced on person-centered listening or how leaders can implement techniques and behaviors to inspire occupational minorities to feel they belong.

Based on the discussion of research and theory presented within this chapter, it may be tentatively concluded that person-centered listening creates a container for both the leader and the other wherein both parties experience greater self-awareness, enhanced understanding of the other, and improved ability to pursue ideal outcomes for oneself and the organization. In turn, it is anticipated that the leader who practices person-centered may experience a greater ability to influence others.

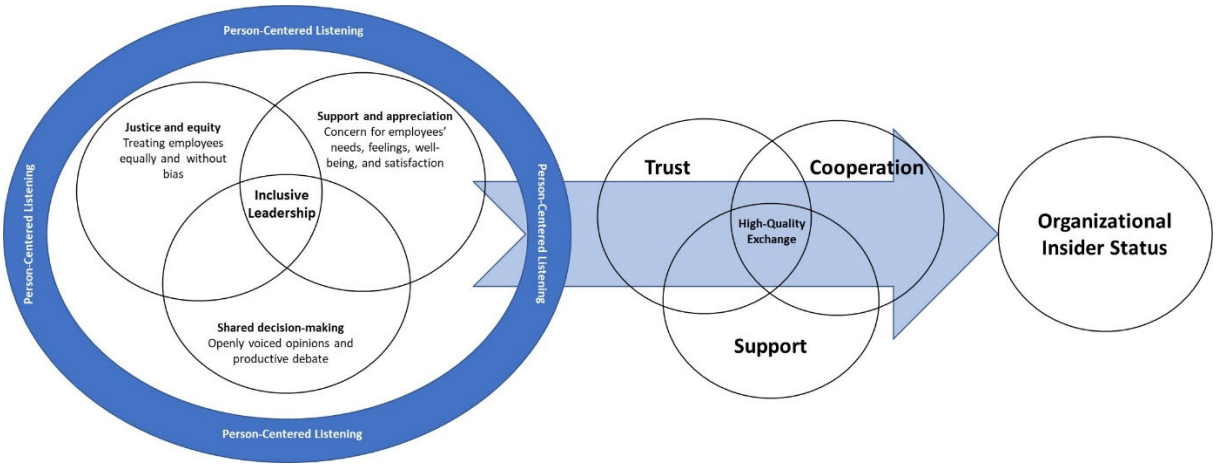
Conceptual Framework

A conceptual framework was developed to guide the present study based on the study's theoretical framework and review of extant literature. The conceptual framework (see Figure 1) reflects the principles of inclusive leadership, person-centered listening, and leader-member exchange. According to research on inclusive leadership, inclusive leaders assure justice and equity across all employees, demonstrate support and appreciation for their employees, and allow their employee to engage in shared decision-making (Al-Atwi & Al-Hassani, 2021). The present study proposes that these activities are best achieved through person-centered listening, described as an accepting and nonjudgmental approach of perceiving and responding to an individual (Rogers, 1959, 1975) and enacted through the leaders' acceptance of their own knowledge gaps, engagement of collaborative and structured problem exploration with

employees, deep listening, and collaborative discussion (Jentz & Murphy, 2005). Synthesis of the literature suggests that when person-centered listening is applied to the aims of inclusive leadership, high-quality leader-member exchanges become possible, characterized by high levels of trust, cooperation, and support (Graen & Uhl-Bien, 1995). For the organization, this dynamic results in improved employee performance and citizenship behavior (Settoon et al., 1996; Sparrowe, 1994; Wayne et al., 1997, 2002). Relevant and most important to the present study, an employee's high-quality relationship with their leader is associated with the sense of being an organizational insider for the individual employee (Wang et al., 2019). Achieving this aim of having a sense of insider status and inclusion is of central importance for occupational minorities in healthcare, due to the vital need for these individuals to remain in the healthcare workforce and the current problems evident for these populations (Cho et al., 2017; Emery et al., 2018; Galinsky et al., 2015; King et al., 2010; Morris et al., 2020; Weaver et al., 2021).

Figure 1

Conceptual Framework



Summary of the Literature Review Chapter

Literature was examined in this chapter concerning person-centered leadership, inclusion, and occupationally minoritized healthcare professionals. The applications and examinations of person-centered leadership in the workplace have provided a reasonable

foundation for continued exploration and practice related to this style of leadership. The next section expands upon this discussion by exploring the topic of person-centered listening.

Chapter 3: Research Methodology

Chapter Overview

In the present chapter, the methodology for this study is described. The chapter opens with an introduction to the study and an overview of the research design. The research design was qualitative and relied on interviews. This approach allows researchers to collect data that are less observable (Brinkmann & Kvale, 2014). The study population and the procedures for recruiting participants are then described. Topics related to participant selection include sample size, sampling strategy, selection criteria, and selection procedures. Considerations for the protection of human subjects are then reviewed. The instrumentation for gathering data then is presented, which describes the semi-structured interview script that used to guide the participant interviews. Data collection procedures then were outlined, followed by a discussion of the approaches for data management and analysis.

Introduction

The purpose of this study was to examine the impact of supervisors' person-centered listening on occupationally minoritized healthcare professionals' sense of belonging. The main question for exploration was: What is the impact of supervisors' person-centered listening on sense of belonging among occupationally minoritized healthcare professionals? Two subquestions were examined:

1. What supervisor behaviors do occupationally minoritized healthcare professionals associate with feeling a sense of belonging?
2. What do participants report as the impact of supervisors' person-centered listening behaviors on their sense of belonging?

Research Design

This study used a qualitative interviewing design. This type of research allows for a deep inquiry into a small number of cases, which is why it is often used in situations where there is little existing research on the topic (Creswell & Creswell, 2022). Qualitative research is designed

to examine a variety of phenomena when conducting research, compared to quantitative research, which is designed to investigate and measure a small set of clearly defined variables. The qualitative design of the present study was anticipated to enable the researcher to examine the depth and breadth of participants' perceptions and experiences. The main challenge of qualitative research is that it can be difficult to analyze all of the information collected (Brinkmann & Kvale, 2014).

Research interviews also have their strengths and drawbacks. The advantage is that abstract information such as nonverbal gestures and other communication can be captured, perspectives and emotions can be explored deeply, culminating in an intimate understanding of participants and their experiences (Brinkmann & Kvale, 2014). In summary, research interviews allow researchers to probe deeper than most other methods. The main challenge of the interview approach is that it often yields an enormous amount of data that are cumbersome for assimilation, examination, and interpretation (Patton, 2014).

Interview methods were deemed suitable for this study because of the relative lack of research on listening in general, person-centered listening specifically, and the impact of supervisors' personal-centered listening on occupational minorities' sense of inclusion in healthcare fields. Qualitative research is the preferred approach in such situations (Brinkmann & Kvale, 2014). In addition, the interview approach allowed the researcher to gain in-depth knowledge of participants' perceptions, reactions, expectations, and experiences related to supervisors' listening behaviors and to inclusion experiences in healthcare professions (Brinkmann & Kvale, 2014). It would have been quite difficult to obtain these insights through survey, observation, or archival methods.

Population and Sample

The population for this study consisted of licensed healthcare professionals living and working in the United States. A purposive sample of 14 physicians, advanced practitioners, or leadership-level individuals who are occupational minorities in their profession were recruited to

participate in this study. According to Brinkmann and Kvale (2014), a sample size of 14 is appropriate for a qualitative research interviewing study, as the nature of this type of study generates a substantial amount of rich data. Participants were recruited using convenience, criterion, and snowball sampling strategies (Creswell & Creswell, 2022). Convenience sampling involves drawing from the researcher's personal and professional network, whereas criterion sampling involves defining the characteristics participants needed to have to qualify to take part in the study (Miles et al., 2019). Snowball sampling involves asking qualifying participants to recommend other participants who may qualify and be interested in participating.

Criteria for Inclusion

Participants needed to meet four criteria to be in this research. The following criteria assured that the participants were part of the population intended to be studied and that they had accrued sufficient experience in the workplace to have had experiences as occupational minorities:

1. The participant is a licensed healthcare professional in the United States.
2. The participant is employed full-time as a physician, advanced practitioner, or management-level professional.
3. The participant is an occupational minority within their profession, meaning their gender or ethnicity is underrepresented in their profession based on data from the U.S. Census Bureau (2018, 2020; see Tables 1 and 2 on pages 43-46) or self-identifies as an occupational minority.
4. The participant has at least 3 years of full-time experience in their profession.

Criteria for exclusion were that participants are unable or unwilling to complete an interview during the data collection period.

The first step of participant recruitment was the researcher listing all personal and professional contacts who may fit the selection criteria or may be connected to those who do.

The researcher created a list of 48 individuals, given the aim of recruiting a sample of 14. These individuals were emailed the study invitation (Appendix A). The researcher also posted a study recruitment notice on his social media (Appendix B) to raise awareness about and interest in participating. The invitation and social media ad communicated the study purpose, characteristics of desired candidates, voluntary and confidential nature of participation, and the researcher's university affiliation and purpose for conducting the study. The invitation and ad also asked recipients to forward the notice to individuals they believed might qualify for the study and be interested in participating. Prospective study candidates were asked to contact the researcher for pre-screening and scheduling the interview.

When candidates contacted the researcher, a pre-screening interview was held to confirm the participant satisfied the selection criteria. The questions presented in Table 3 were asked.

Candidates who qualified for the study based on the pre-screening interview were presented with the consent information (Appendix C) and asked if they would be willing to schedule an interview. Those who consented were scheduled for an interview and emailed the consent form to review, sign, and return in advance of the interview. Candidates who did not qualify or consent to proceed were thanked for their time. A final sample of 14 individuals were interviewed.

Table 3

Pre-Screening Interview

Eligibility Question	Qualifying Response	Qualifying Response Follow-Up Questions	Non-Qualifying Response	Non-Qualifying Response Follow-Up Questions
1. Are you a licensed healthcare professional currently working full-time in the United States?	Yes	What is your license? When did you obtain it?	No	Thank you for your interest. However, I am seeking to interview healthcare professional currently licensed and working full-time in the United States. Do you know of anyone like this I could contact who might interested in participating in this study?
2. What is your role?	Physician, advanced practitioner, or management-level professional	None	Not a physician, advanced practitioner, or management-level professional	Thank you for your interest. However, I am seeking to interview physicians, advanced practitioners, or management-level professionals here. Do you know of anyone like this I could contact who might interested in participating in this study?
3. What is gender identity? 4. What is your ethnic identity?	Occupational minority based on gender and/or ethnic demographics of their profession (U. S. Census Bureau, 2018, 2020)	None	Not an occupational minority based on gender and/or ethnic demographics of their profession (U. S. Census Bureau, 2018, 2020)	I am interested in interviewing people who are occupational minorities in their profession. An occupational minority is someone who, by virtue of their personal characteristics, is underrepresented in their profession. In other words, there are few [role] like you. Based on your gender and ethnic identity, you do not seem to be an occupational minority, but you may have other characteristics (e.g., national origin, sexual orientation, ability status) that designate you as one. Do you self-identify as an occupational minority? *If yes:* Answer this if only you feel comfortable doing so: In what way are you an occupational minority? *If no:* I am interested in interviewing people who are occupational minorities in their profession. Do you know of anyone like this I could contact who might interested in participating in this study?
5. How many years of full-time experience do you have in your profession?	3 years or more	None	Less than 3 years	I am interested in interviewing people who have at least 3 years of full-time experience in their profession. Do you know of anyone like this I could contact who might interested in participating in this study?

Protection of Human Subjects

This study was reviewed, approved, and overseen by Pepperdine's Institutional Review Board and the researcher completed training in human subjects protection (see Appendix D). The full set of human protection guidelines were implemented in this study to assure that participants did not face any undue risks as a result of taking part in the study. To make sure participants did not face potential harm or risk, they were provided with an informed consent (see Appendix C) to complete. This form outlined all the details of taking part in the study. Participants were informed that taking part is confidential, purely of a volunteer nature, and protected under California law. The consent form described the researcher's background and qualifications, the study purpose, and the researcher's relationship with Pepperdine's PhD program in Global Leadership and Change at the Graduate School of Education and Psychology.

Participants were invited to contact the principal investigator, the dissertation chair, or the head of the institutional review board if they had concerns about the direct results of their participation in this study. Various measures were put in place to protect the privacy and security of the participants. Study data and electronically signed consent forms will be stored separately and for a period of 3 years after the study ends. After this time, these files will be permanently deleted. Only the researcher and the Institutional Review Board will have access to the data. Permission to access the data will be only for the purposes of data collection, reproduction, or analysis purposes. All results will be reported in combination, and all participant identities will be kept confidential.

Instrumentation

Data collection occurred through one-on-one semi-structured interviews conducted with 14 participants. Each interview followed a 10-question interview script (see Appendix E) created by the researcher for this study based on the literature review. Interview questions were created with the aim of promoting a dynamic and flowing conversation rather than a mechanical

question-and-response session (Brinkmann & Kvale, 2014). Robson and McCartan (2016) advised creating an interview script with (a) an introduction that explains the reason and purpose for the interview, (b) warm-up questions that build trust, (c) core questions that address the main purpose of the interview, (d) cool-down questions that diffuse tension, and (e) a closure that thanks the participant and ends the interview. Robson and McCartan further suggested placing potentially risky questions later in the interview when trust is likely to be highest. Alignment between the interview questions and the study's research questions is presented in Table 4. The questions were designed to yield ample data to explore both research questions.

The interview script for the present study is organized into four categories:

1. Opening: Participants were asked to describe their general experiences as an occupational minority to gain an initial impression of the participants' opinions and perspectives.
2. Experiences of inclusion: The next set of questions examine participants' experiences of inclusion. First, participants were informed that inclusion refers to the extent to which you feel that your authentic self is welcomed at work, enabling you to contribute in a meaningful and deliberate manner. Next, they were asked to think of a time at work, whether in their current role or in any role in the healthcare field, where they felt this kind of inclusion. Once they thought of an experience, they were asked to describe it, the effects it had on them, and what helped them feel this level of inclusion. Prompts were used as needed to uncover the role the organizational setting, their supervisor, and their peers played in their sense of inclusion. Participants also were asked what would have helped them to feel even more included.

Table 4

Alignment of Interview Questions and Research Questions

Interview Question	RQ1	RQ2
1. In our previous conversation, you identified yourself as an occupational minority, meaning there are relatively few [your demographic characteristics] who are [your role]. In general, how would you characterize your experiences as [your demographic characteristics] [your role]?	X	X
2. Inclusion refers to the extent to which you feel that your authentic self is welcomed at work, enabling you to contribute in a meaningful and deliberate manner. I would like you to think of a time at work, whether in your current role or in any role in the healthcare field, where you felt this kind of inclusion. Please tell me about this experience.	X	X
3. What effect did this have on you?		X
4. What do you think helped you feel this level of inclusion? • Was there anything particular to the organizational setting? • What, if anything, did your supervisor do to help you feel this sense of inclusion? • What, if anything, did your peers do to help you feel this sense of inclusion?	X	
5. What do you think would have helped you feel even more included?	X	
6. Now I want to zero in more on the role of supervisors. I am investigating a specific kind of listening called person-centered listening. In this way of listening, the supervisor demonstrates attentiveness; presence with you; emotional involvement; and a non-judgmental, genuine, open, and attuned attitude. Please reflect on your work experiences, whether in your current role or in another role during your healthcare profession. Think of a time when a supervisor listened to you in this way. Please tell me about the situation.		X
7. What gave you the feeling that your supervisor was listening to you in this attentive, engaged way?		X
8. How did that affect your perceptions, if at all? • Impact on feelings about your supervisor? • Impact on feelings about your work or profession? • Impact on feelings about your organization?		X
9. How did that affect your sense of inclusion, if at all?		X
10. That concludes my formal questions. Is there anything else you would like to share about your experiences as an occupational minority in the healthcare field or about what could increase your feeling of inclusion?	X	X

Note. RQ1: What supervisor behaviors do occupationally minoritized healthcare professionals associate with feeling a sense of belonging? RQ2: What do participants report as the impact of supervisors' person-centered listening behaviors on their sense of belonging?

3. Role of supervisors' person-centered listening in inclusion. The next set of questions explore the role of supervisors' listening in promoting a sense of inclusion. First, participants were informed about person-centered listening, meaning that the supervisor demonstrates attentiveness; presence with you; emotional involvement; and a non-judgmental, genuine, open, and attuned attitude. Participants were asked to think of an experience, whether in their current role or another healthcare role, when a supervisor listened to them in this way. If they could not think of a situation, they were asked to think of any work situation. If they still could not think of a situation, they were asked to think of any personal or professional situation when they felt listened to in this way. Once they had thought of a situation, they were asked to describe the situation. Next, they were asked, "What gave you the feeling that your supervisor was listening to you in this attentive, engaged way" and how that affected their perceptions, if at all? Prompts were used as needed to identify how the experience of being listened to in a person-centered way affected their feelings about their supervisor, their work or profession, and their organization. Participants also were asked to consider how the experience of being listened to in that manner affected their sense of inclusion, if at all.
4. Closing: Participants were informed that the formal set of questions had been asked. Participants then were asked whether they would like to share anything else about their experiences as an occupational minority in the healthcare field or about what could increase their feelings of inclusion. Upon completion of the participants' answering of this final question, the participant was thanked and the interview was brought to a close.

Data Collection

A one-on-one semi-structured interview was held with each participant. The interview script (see Appendix E and description in the Instrumentation section of this chapter) was used

to guide the conversation. Morse and Field (1995) noted that the interview setting should be selected carefully to promote the sense of confidentiality and psychological safety, as these conditions help enhance data quality. Each interview was conducted using Zoom web conferencing software. The data were audiorecorded using the researcher's personal digital audiorecorder. Transcriptions were created using otter. ai. Participants selected their interview time. Each interview lasted 45 minutes to 1 hour in duration. This interview duration was based on guidance from Robson and McCartan (2016), who advised that 30-minute interviews generally fail to produce sufficiently rich data and that interviews lasting more than 1 hour place an excessive burden on participants, thus, reducing the number of willing participants.

Before each interview, the researcher prepared by reviewing the study purpose, research questions, and interview questions. Robson and McCartan (2016) further emphasized the need to end on time. Interview data were audio-recorded and supplemental notes were taken by hand during the course of the interview to support the researcher in following and attending to the conversation. After the interview, the researcher took a few minutes to note any additional reflections and observations related to the interview (Brinkmann & Kvale, 2014; Robson & McCartan, 2016).

Data Management

Data consist of pieces of information captured during research. Data may be examined in small units, entire sets of data to create a gestalt, or psychological meaning units (Miles et al., 2019). Data may be captured in a variety of forms. Examples include physical elements, handwritten recorded pieces of data, audio-recordings, electronically captured survey responses, software or code, measurements and observations captured through experiments or interventions, images, and more.

Research data are fragile and can be easily lost. Therefore, managing data during the research process involves deciding how to create, enter, structure, organize, reify, store, back up, and distribute information (Bell & Foster, 2019). Managing information effectively is central

to effective research. Effective data management affects the efficacy, outcomes, and validity of research as well as participant safety and confidentiality. Data management also is critical to contributing to the body of literature so that the present study can be replicated and follow-up research can be performed (Whyte & Tedds, 2011). “The scientific process is enhanced by managing and sharing research data. Good research data management practice allows reliable verification of results and permits new and innovative research built on existing information” (Whyte & Tedds, 2011, p. 3). According to Whyte and Tedds, the full benefits of a study cannot be realized without appropriate methods of data management.

Managing data in the present study was done by storing answers in a password-protected document. Any identifying information, such as personal names, names of employers, or other data that could reveal the participant’s identity was replaced with fake names. To protect informants’ confidentiality, electronic copies of the research data will be stored for 3 years. The only purpose for individuals having data access will be for the intention of collection, transcription, or analysis. To further protect participants’ identities, study results are reported in aggregate.

Data Analysis

Interview methods often yield copious volumes of data (Creswell & Creswell, 2022). Researchers need to utilize a methodical, repeatable, and valid approach to examining the data. Raw transcripts of the data were created using otter. ai. Data in this study were examined using six content analysis steps (Miles et al., 2019):

1. The researcher read and reread all interview transcripts. This reflected the researcher’s efforts to immerse in the data in an effort to understand what is being conveyed.
2. The researcher then identified words, phrases, sentences, or entire paragraphs that related to the same central meaning (Braun & Clarke, 2006; Miles et al., 2019).

3. The meaning units were reviewed, and a list of thematic codes were recorded. In addition to any emergent codes indicated in the data, the following codes related to the present study's conceptual framework were utilized: Inclusive leadership behaviors, listening behaviors, justice and equity behaviors, support and appreciation behaviors, shared decision-making behaviors, evidence of trust, evidence of cooperation, evidence of support, perceived organizational status.
4. Each meaning unit was assigned a code. Simultaneous codes were applied, if needed.
5. Upon completion of the coding, the results were carefully reviewed and adjusted to confirm the accuracy of the analysis.
6. Upon completion of the coding, the final set of codes were reviewed to examine how the codes link together, if at all. Where possible, similar codes were grouped under supraordinate codes. Meaning units then were reorganized and saturation for each code was identified.
7. A peer reviewer trained in doctoral-level research reviewed the analysis for all interviews and gauged its accuracy. The principal investigator and peer reviewer discussed how to change the analysis where discrepancies appeared in the analyses. Interrater reliability was calculated throughout this process. The final analysis reflected 93% interrater agreement.

Summary of the Methods

The present qualitative research examined the impact of supervisors' person-centered listening on occupationally minoritized healthcare professionals' sense of belonging. The aim was to uncover (a) the supervisor behaviors occupationally minoritized healthcare professionals associated with feeling a sense of belonging and (b) how supervisors' person-centered listening behaviors affect their sense of belonging. The chapter opened with an introduction to the study and an overview of the research design. The study population and the procedures for recruiting

participants were then described. Topics related to participant selection included sample size, sampling strategy, selection criteria, and selection procedures. The ethical considerations guiding this study were then reviewed. These considerations include study oversight, procedures for protecting participants, and approaches for safeguarding the data. The instrumentation for gathering data was then presented. Data collection procedures then were outlined, followed by a discussion of the approaches for data management and analysis.

Chapter 4: Results

In the present chapter, the study results are outlined. The chapter begins with an introduction that reiterates the study purpose and questions that were examined. The next section reorients the reader to the steps of data analysis used to examine the data. Subsequently, an overview of the participants' demographics is presented, followed by delineation of nine themes that were deduced from examination of the study data. The final section of this chapter is a summary.

Introduction

The purpose of this study was to examine the impact of supervisors' person-centered listening on occupationally minoritized healthcare professionals' sense of belonging. The main question for exploration was: What is the impact of supervisors' person-centered listening on sense of belonging among occupationally minoritized healthcare professionals? Two subquestions were examined:

1. What supervisor behaviors do occupationally minoritized healthcare professionals associate with feeling a sense of belonging?
2. What do participants report as the impact of supervisors' person-centered listening behaviors on their sense of belonging?

Process of Data Analysis

Data analysis for this study involved six content analysis steps as outlined in Miles et al. (2019). First, the researcher read and reread all interview transcripts. This reflected the researcher's efforts to immerse in the data to understand what was being conveyed. The researcher then identified words, phrases, sentences, or entire paragraphs that related to the same central meaning (Braun & Clarke, 2006; Miles et al., 2019), yielding 153 meaning units.

The 153 meaning units were reviewed and a list of thematic codes were identified. The following codes related to the present study's conceptual framework were utilized: inclusive leadership behaviors, listening behaviors, justice and equity behaviors, support and appreciation

behaviors, shared decision-making behaviors, evidence of trust, evidence of cooperation, evidence of support, perceived organizational status. Additionally, nine emergent codes were indicated in the data. Each meaning unit was assigned at least one code. Simultaneous codes were applied as needed. Upon completion of the coding, the results were carefully reviewed and adjusted to confirm the accuracy of the analysis. Meaning units then were reorganized, and saturation for each code was identified.

The final step of analysis was subjecting the findings to peer review by a colleague trained in doctoral-level research. The peer reviewer was given the data analysis procedures documented in Chapter 3 and findings along with the supporting data. Upon initial review, 87% interrater agreement was achieved, indicating the findings exhibited sufficient reliability.

Participants

Fourteen physicians, advanced practitioners, and leadership-level individuals who are occupational minorities in their professions were interviewed for this study (see Table 5). Participants were located throughout the U.S. and worked for different healthcare organizations. Six were male and eight were female. Four racial/ethnic backgrounds were represented: Asian American (*n* = 5), Hispanic (*n* = 4), African American (*n* = 2), White (*n* = 2), and multiracial (*n* = 1). Participants noted additional sources of diversity stemming from their immigrant or first generation status, educational attainment, age, disability status, and other factors. P14 shared her experience as an occupational minority in this way:

> I am Japanese, German, and English. I also am a single mom of four and not a college graduate. There aren't too many people from my racial background doing what I'm doing. I started off in healthcare as an ER secretary and a tech. I moved to a surgery scheduler and pre-certification coordinator. Typically, you don't see anybody of Asian descent as anything less than a provider. So there's always the stereotype when I go into meetings with reps and they say, "Dr. So-And-So, what do you specialize in?"

The next section describes the nine emergent themes that resulted from the analysis.

Table 5

Profile of the Participants

Participant	Gender	Race/ethnicity	Role
P1	Male	Hispanic	Physician
P2	Male	African American	Vice President for Mission and Community Integration
P3	Female	Asian American	Director of Intensive Care Unit/ Critical Care Unit
P4	Male	Hispanic	Director of Healthcare
P5	Male	Hispanic	Director of Operations Healthcare
P6	Female	Asian American	Executive Director Hepatic Services
P7	Male	Asian American	Medical director
P8	Female	Asian American	Assistant Vice President of Clinical Operations
P9	Female	Hispanic	Administrative Fellow
P10	Female	White	Nurse manager
P11	Female	White	Healthcare Management
P12	Male	African American	Healthcare Leader
P13	Female	Asian American	Assistant Vice President of Clinical Operations
P14	Female	Multiracial	Practice Manager

Emergent Themes

A total of nine emergent themes were identified based on examination of the meaning units extracted from the data. These emergent themes are described in this section. Themes are organized by research question, with five themes for RQ1 and four themes for RQ2.

Supervisor Behaviors Associated with Sense of Belonging

RQ1 sought to uncover the supervisor behaviors that occupationally minoritized healthcare professionals associate with feeling a sense of belonging. Examination of the interview data revealed five themes: giving subordinates growth opportunities, practicing active listening and seeking deep understanding, being intentional about inclusion and seeking diverse

voices, seeking subordinates' input, and providing mentoring and sponsorship. These themes are described in the following sections.

Giving Subordinates Growth Opportunities

All participants expressed that supervisors who promoted their sense of belonging provided them with growth opportunities including challenging assignments, stretch experiences, cross-training, and constructive feedback and support. Participants explained that this action by their supervisors let them know as employees that they are valued not only for their present-day abilities but also for their potential. P2 provided the example of being on the President's Council as a significant growth opportunity that contributed to his sense of inclusion:

> The President's Council is a group of seven that really are the ones that make the difference in the leadership part of the hospital. This Council purposely goes out of its way before finalizing anything to get the pulse of the community. I was brought in to have a voice so that the plans represent what the community looks like. They have realized that it's helpful for the system. It's helpful for the budget for them to know in the very competitive market we're in how to get people to come into our hospital when they have five different options within the city limits. As a professional, it made me feel valued because I was given a fair chance in this position.

P8 shared that she has been given several growth experiences that have helped her feel included as a valuable member of the organization. She explained:

> There have been times where I felt I have been chosen to speak on behalf of administration or to do a presentation with the hopes that my youthful appearance is also going to relate to a younger generation of frontline staff. It's been such a blessing to be able to represent the organization and to feel trusted enough that while I am young, that I can speak on behalf of people multiple years my senior and be able to connect with frontline staff in a way that is effective. … I learned early on that the way that my organization and my bosses expressed their approval of my work, was to give me more opportunities to do work.

P10 shared that her supervisor pushed her and other subordinates to achieve their best through growth opportunities and accountability. She explained:

> She holds them accountable to their actions if they're inappropriate or they're wrong, and that to me is one of the best things you can have in a boss—to challenge you and make you better. But also to know that, no matter what, they're there for you.

P12 recalled the powerful effect of supervisors' confidence in his potential on his inclusion. He explained:

> I felt that he was genuinely interested in my growth, my development, and my capacity. And while there was nothing available at the time, he was very affirming, very attentive. And he promised to make space as they become available for me to grow. … It happened in incremental steps of being given small tasks to do and, over time, being given more responsibilities. It was a progressive approach over my entire time in the industry.

In summary, participants believed that when their supervisors encouraged and supported their growth, they felt included. Participants enjoyed many ways that their supervisors supported their growth. When supervisors offered such opportunities, participants felt they were a valuable member of the organization.

Practicing Active Listening and Seeking Deep Understanding

All 14 participants stated that supervisors' use of active listening and efforts to deeply understand them increased their sense of belonging. As described by participants, believed their supervisors were active listening when they fully focused on them, demonstrated their understanding through paraphrasing, and responding appropriately—both during the interaction and afterwards as appropriate. More than simply hearing them, participants believed their supervisors were giving them their full attention, offering comments and suggestions, and allowing them full expression. P1 described the way his supervisor listened to him when he had concerns in the workplace, noting her way of listening was similar to the person-centered listening being examined in the present study. He recalled this situation:

> There was a time where I felt like I wasn't being treated the same as certain of my peers. I felt like I was always getting kind of the short end on the stick and having more work to do than the rest. I brought this to my supervisor. How she approached the situation is kind of [the person-centered listening] you described. … The biggest thing I took away from that was I knew she was actually listening to my concerns because she was able to echo what I was saying. She basically said, "What I hear you saying is this, this, and that. I see that your concern is this, this, and that. " Never throughout the time I shared my concerns did she cut me off to say, "No, it's not like that. This is not what it seems like. " She really allowed me to kind of express everything that was concerning me before she went on and kind of gave her rebuttal or her opinion on the matter. And was able to restate what I was saying and never took a side between me and the other provider, but instead stayed neutral and provided suggestions and opinion on the matter. She did not say I was right or wrong or that the other person was right or wrong.

P3 recalled and described experiences of her supervisor demonstrating active listening and seeking to deeply understand her:

> We had a lot of stressors and had a lot of things we had to deal with. There were one-on-ones where she asked and delved … into really understanding me as a person and my culture. She would ask how my family would deal with this, or what I thought about it, or what I would do in my experience. In doing so, it allowed me to step away from the work thing and get more personal and bring that into the situation or project. It made me feel like I belonged.

P6 had the experience of a supervisor who would not listen effectively, but once that feedback was offered, the supervisor changed to reflect active listening, resulting in an enhanced sense of inclusion:

> I had a face-to-face conversation with her where I shared my feeling that when she talked to me or when I talked to her, it seemed that she had an answer instead of listening and trying to understand. After we had that conversation, things changed. In the last two years since that conversation, our relationship is much, much better because she now she listens and give me her full attention. She then pauses and says, “May I make a clarification? Just want to make sure, …. ” Those are the technique that I suggested to her that if she’s not sure, ask for clarification and make sure at the end of any of our conversations. … Since then, it's been great.

P7 shared his experience of being actively listened to by one of his supervisors. He further associated this type of listening with person-centered listening:

> In one instance, I was having a conversation with one of the VPs I report to. This person actually sought me out when she was new in her role and said, “Hey, I have not had an opportunity to roundtable with you yet. ” She made it a point to come and sit next to me after a big meeting. She got out her notepad and she just asked me general questions about how things were going. She was genuinely, sincerely curious about me. And she took time to get to know me professionally and personally and to see what was going on. I felt like she was exercising what you term as a person-centered listening, She leaned in and made eye contact. She was actively taking notes based on what I was saying. She was nodding and she was very pleasant, and she asked more questions and listened more than she talked. It was very refreshing at that moment to have someone actually be curious about me and listen to me.

In summary, participants appreciated their supervisors’ encouraging presence, empathy, open-mindedness, trust, and active communication. They explained that their supervisors’ active listening created the sense that they were deeply understood, and these together helped increase their sense of inclusion.

Being Intentional About Inclusion and Seeking Diverse Voices

Thirteen of the 14 participants shared that their sense of inclusion was enhanced when their supervisors were intentional about inclusion and seeking diverse voices. Participants described that their supervisors did this through actions such as deliberately architecting opportunities for people of diverse backgrounds, perspectives, and experiences to contribute and be heard. Such activities include encouraging open communication, supporting diverse hiring and promotion practices, creating inclusive spaces, sharing leadership, acknowledging contributions, regularly checking in, and supporting diversity and sensitivity training. P4 described a situation where the hospital recognized it needed to better understand its Hispanic patients. Thus, they initiated a program to achieve that aim:

> This was a recent situation where the system felt they needed to address cultural competencies, especially for Hispanic population, which we tend to serve in our system. Our healthcare professionals were unaware of the needs, not just from identity, but also perspectives on healthcare within this particular population. The planning committee set up sessions for us to talk about who we are as Hispanics, including our history, identities, and challenges. … Because of my role within leadership, my expertise, my own experience, and my education, I could be one of the ones contributing, and the team looked forward to having me address some of these things that we needed and to listen so they could not only take note, but also improve the experience of our Hispanic patient population.

P11 recalled her experiences in a previous organization where inclusion of occupational minorities was commonplace and second nature. She elaborated:

> My previous institution was very welcoming towards women. All three of my leaders at that organization were women and half of my team were women. There was never even a hesitation there that I would be in the role that I was in. It was just commonplace. It was not even looked at as different or exceptional. It was fully embraced and supported. It made me feel safe and secure that people actually saw me fully for who I was instead of, “Oh, we're checking off this box by having a girl in this role. ” I felt totally like I wasn't given the role because I was a woman, but that I was completely accepted for who I was and for the talents and gifts I brought. That made me feel included. That was a wonderful experience.

P13 described her experience of being included:

> I was the first foreign graduate in a leadership position. Noticing that there was not many of us at the table, I started paying attention to how I was perceived. I really felt that even if I was the only one, or there were very few of us, or I was the first one, I don’t feel my voice was ignored. I felt listened to and that my ideas were brought up.

P14 described the powerful impact that employee groups had on her sense of inclusion:

> I've been able to really connect with people and that has opened doors to be included in things, such as BIPOC, a program that started this year and stands for black or indigenous people of color. It's a mentor group that I was actually a mentee and not only was it a mentoring group, but we got together on a monthly basis via Zoom or Teams calls. It was really a chance to be inclusive and connect with other leaders. And you were able to see other leaders that looked like you, that maybe had the same background as you, maybe not a hundred percent, but you were able to connect with them in ways that you would've never been able to connect with. I've had great conversations about how it is to be mixed race and how there's a very small community of us that we really don't belong in, in either bucket.

In summary, when supervisors demonstrated their commitment to inclusion through intention and action, participants felt supported and included. By practicing and implementing the strategies identified in the data, supervisors intentionally or unintentionally create workplaces that support and celebrate inclusion. The activities identified by participants helped them feel included by their supervisors.

Seeking Subordinates Input

Eleven of the 14 participants stated that when supervisors seek their input, their sense of inclusion was created. Mechanisms included creating open channels of communication, having one-on-one meetings, holding team meetings and brainstorming sessions, sharing leadership with subordinates and involving them in decisions, asking specific questions, recognizing and appreciating subordinates' contributions, and following up on past input shared. P1 described his experience during his residency, when he observed that his input was sought, heard, and acted upon:

> I felt like I was actually being heard and that the things that I was sharing were going to lead to a positive change, rather than just sharing things, knowing that you're going to either be turned down or they're going to "hear" what you're saying, but no action is going to be taken. … Whenever she stated my concerns, she said what she planned on doing to fix those. … It made me feel like my opinion actually mattered … even though I was a small fish in a very big pond.

P3 recalled her experience of working with a supervisor who deliberately sought the input of all members of the team by emphasizing that their performance as a team was a collaboration, not a competition; therefore, every member's input was important. P3 elaborated:

> We would say, “This is not a game. This is not a competition. We as a hospital have to figure this out together. We're a team to get to excellent. ” My supervisor helped create that culture. It’s a trickle-down effect because she's leading and mentoring. We had directors and managers at different ages and experiences, some of whom hadn’t experienced that before. … We pulled back the competition and emphasized that this is not a competition. This is a team event. She made sure it was a safe space for all of her different-aged managers to then excel on their own.

P5 expressed that seeking subordinates’ input is an essential component to feeling a sense of inclusion:

> It’s about being really supportive of my ideas and understanding where I'm coming from. Understanding who I am as a person and as an individual, you then have a sense of what I’m going to bring to the table and that I'm here to contribute innovative ideas and good work, and that I have the same goal as him. That's where the inclusivity starts.

Participants explained that actively seeking subordinates’ input helped create an open environment where they felt empowered to offer their ideas and felt included. These actions helped participants feel welcome.

Providing Mentoring and Sponsorship

Four of the 14 participants expressed that mentorship and sponsorship have a key impact on their sense of inclusion. Participants explained that mentoring and sponsorship occurred through sharing guidance and experiences, advocating for them related to their career advancement, aiding in their skill development, and helping to develop essential skills. P9 described the experience of receiving supervisory mentoring and sponsorship in this way:

> What made me feel that she was really listening to me was because she gave me advice that was very tailored to what I was going through. It was not general advice, it was something specific about what we were talking about how hard it was for me to transition from my leadership position in Peru to a leadership position in the United States. What were the cultural differences? She was very honest, not telling me what I wanted to hear or that I would figure it out, which is what a lot of people tell you. No, she took the time to tell me what worked for her, and I actually apply it to this day. I apply her advice to this day. So I feel like her response to what I was talking about made me feel listened to with all those characteristics of person-centered listening.

P13 expressed that her favorite supervisor paired person-centered listening with mentoring, yielding a strong boost to her sense of inclusion. She elaborated:

> One of my favorite bosses of all time was the best listener. She challenged my thinking, such as telling me in grad school, “What do you need an A for? Tell me, explain to me

> why you need an A. ” She would say, “Okay, tell me about that,” and if there's something that I feel wrong about or strongly about, she's very good at that. She would actually ask if this was a good day to give feedback.,,, She had mentored me to grow without feeling belittled. It's more like, “grow your best self. ” You don't change who you are, but be the best of who you are.

To sum up, these four participants identified mentorship and sponsorship as effective means of advocating for supporting inclusivity in the workplace. These connections support a professional atmosphere that is more varied and egalitarian. These participants greatly valued their supervisors’ efforts to this end.

Impact of Supervisors’ Person-Centered Listening Behaviors on Sense of Belonging

RQ2 sought to discover the impact that supervisor person-centered listening had on occupationally minoritized healthcare professionals’ sense of belonging. Examination of the interview data revealed four themes: Sense of being seen, heard, and included as a valuable member of the organization; enhanced trust in and commitment to supervisor and organization; improved self-confidence; and improved performance outcomes. These themes are described in the following sections.

Sense of Being Seen, Heard, and Included as a Valuable Member of the Organization

Thirteen of the 14 participants stated that their supervisors’ person-centered listening helped them feel seen, heard, and included as a valuable member of an organization. in this way, participants felt acknowledged, understood, and actively integrated into the workplace community. P9 reported that being listened to in a person-centered way enabled her to feel “part of the decision-making process. I felt part of the team. It really helped me contribute as a team player as well. ” P10 reflected on the depth of acceptance and support she felt from her supervisor’s person-centered listening and leadership style. She shared:

> Sometimes during COVID, it was very, very bad. I was having a lot of issues with staff on the unit. Always, somebody was hurt, somebody was sick, my family was sick, somebody was in the hospital. She would come in and didn't have to say anything. And I didn't have to say a word. She just came in. She didn't turn the light on. She just shut my door and stood there. I think I cried for like 20 minutes and she didn't say a word. She just stood there. I won't ever forget that. I felt like it was okay to cry and she wasn't going

> judge me. She understood that I had all my walls crashing down on me, and that I had been trying to keep it together for a long time, and she just loved me for me.

P11 similarly described the feeling of being understood when her supervisor engaged in person-centered listening, recalling:

> The person who I call my favorite boss definitely did person-centered listening. I knew that that was the case because when I would speak, they didn't respond just to respond. They would actually ask very specific, targeted questions to dig deeper or to help me bring forth the fullness of what I was saying. So instead of being like I talk and they respond, they would actually ask thoughtful questions that would probe deeper into what I was saying. Also, they would bring things back up later when we'd have another meeting to follow up, to check in on what I had said previously to see how things were going. They also cared about me as a holistic person. It wasn't just about work.

P14 shared a similar story of her supervisor's person-centered attentiveness and care during a time of family crisis:

> I have been very blessed in the past two and a half years with the director that I've had. One example that stands out was last year, I sent my director him a quick Teams message saying, "Hey, I need to fly out to California. I need some time off, but I'm gonna take my laptop with me. " He knew that doing something sudden like that was totally out of character for me. I immediately got a call. First thing he said was, "What's going on?" At that time, I had just gotten news that my dad had just been diagnosed with Stage 4 melanoma in the brain. My leader has an outrageously busy schedule. I know what his schedule looks like. He did not have the time to chat with me at all. So I was shocked that he called me and I was already at home, so we couldn't do a face-to-face, but he sat on the phone, he let me talk. You can tell when someone is multitasking on the phone, and I could tell that he wasn't doing anything else. He was actively listening to what was being said. He shared his own stories of his late father as well. And what I noticed with the conversation is not only did he listen and hear everything, but he also followed it up the next morning with an email and pointed out certain things that I even forgot were going on in the conversation. And then during every weekly one-on-one, he would take five minutes out of it to drop everything. His cell phone would be put away, and he would sit and be engaged in the conversation and ask how my dad was doing.

In summary, it was important for participants to feel seen, heard, and included as a valuable member of an organization. In being seen, they felt their contributions were recognized and they were able to showcase their talents. In being heard, they felt they had voice, could give their input, and received helpful feedback. In being included, participants expressed having a sense of belonging and gaining access to opportunities.

Enhanced Trust in and Commitment to Supervisor and Organization

Thirteen of the 14 participants expressed that their supervisors' person-centered listening enhanced their own trust in and commitment to their supervisors and organizations. Participants explained that, in response to being heard in this way, they had confidence that their supervisors and organizations were competent, honest, and supportive. In turn, they felt increased engagement, loyalty, willingness to go above and above, goal alignment, and emotional connection to their supervisors and organizations. P2 reflected that his experiences of his supervisor listening to him enhanced his trust in his leadership and, further, helped him realize that allies who were supportive of him were present within the community. He elaborated:

> It built a trust in me of my leader that I felt heard and listened to. I really felt that's that's what made a difference. … I also realized that there are other people out there I would call allies, such as white males, who will use their influence to help with change that's needed. Prior to that, I wouldn't have even thought to ask that person to be in our DEI because they're a white male. I was surprised that they had become some of our biggest allies on some of these committees.

P4 similarly explained that he feels that his supervisor has listened to him,

> …it builds a sense of trust that this leader cares not only for me, but for what's best for the team, and the institution that they're part of. That if I have to share something of concern or an idea, it's going to be taken seriously. So I feel it builds trust and maybe motivates me to be more loyal, to work harder to be a better teammate or employee for somebody like this.

P7 shared that his experiences of being listened to in a person-centered way enhanced his views of the organization. He elaborated:

> It left a positive taste in my mouth about the organization. This person, as an executive-level officer in the organization, was making a very good faith effort to positively represent the organization to me. It added towards a positive perception.

P9 shared that when her loyalty was won when her supervisors listened to her in a person-centered way. She explained it in this way:

> She got my buy-in to whatever project, whatever adventure at work she was heading towards. I was loyal to her. I knew that I could come to her with any problem I had. Any roadblock I found on my path to complete a project, I could come to her and she was able to solve them on time.

In summary, when supervisors demonstrated person-centered listening, all but one participant trusted their supervisors and organizations more. These participants also expressed having more commitment and willingness to dedicate their best to their work. Participants recalled their enhanced commitment and trust with positive accounts.

Improved Performance Outcomes

Twelve of the 14 participants shared that their supervisors' person-centered listening resulted in improved performance outcomes. These outcomes ranged from individual performance to team performance to overall organizational performance. P3 explained that being listened to in this way by her supervisor inspired her to pursue top performance:

> It was very validating. I just felt even more validated. I felt … the glory of God. I really felt embraced. I felt beloved. … Then you want to commit and give your all and go, "I'm in. I'm all in. Let's do this!" And you give love, you get love, and as a team, you're on the right path.

P5 shared his own experience that when supervisors took care to listen to and validate their staff, higher organizational performance follows:

> When we make sure that everybody, from the managers to the frontline workers, has a voice at the table and they're being heard, they're feeling validated, … in the very end, our patient experience goes higher, the turnover goes down, and the outcomes are much better.

P10 shared that, because of the person-centered listening, acceptance, and unconditional positive regard she received from her supervisor, she was motivated to elevate her own leadership. She explained that her supervisor "makes me want to be the best boss I can be because of how great she was and because of how she made me feel. I want to do the same for my team. " P12 similarly shared that his supervisors' person-centered attention inspired him to contribute. He explained:

> His responses and his attention to me helped kind of stir my passion even more than what already existed. It instilled me to want to do better, to want to grow further. So what he saw, I began to believe and responded to his encouragement and affirmation.

All but two of the participants reported that their supervisors' person-centered listening resulted in improved performance outcomes. These participants agreed that that effect of in-

depth listening enabled them to identify and resolve possible obstacles to performance as well as identify solutions to issues. These participants expressed gratitude for the performance enhancements they gained through supervisory listening.

Improved Self-Confidence

Eight participants reported that their supervisors' person-centered listening created a communication atmosphere that was encouraging and affirming, which in turn boosted their self-confidence. Participants explained that their supervisors' attentive listening conveyed to them that their ideas and feelings were respected and understood. P8 reflected that her experiences being listened to and her talents being validated increased her confidence. She affirmed, "It gave me more confidence. It allowed me to one practice the skill of public speaking, which did not start off as a strong suit and is arguably a strong suit today. " P9 similarly reflected that her supervisor's person-centered listening

> …really made me feel more confident about who I was and the background I had. It helped me actually be more productive and active, and helped me trust in myself and just start bringing to the United States the leadership that I had in Spanish in Peru.

P11 reported that the acceptance she received as part of her supervisor's person-centered listening gave her a "marrow-deep" sense of security and self-confidence that eliminated any concerns about being a minority or being included. She described the experience in this way:

> It made me feel very secure where I didn't ever worry about, "Am I doing enough? Am I going to get fired? What's going on?" I always felt very secure in my job. It produced confidence in me to be able to keep going out and doing what I was doing because I had the approval of my direct supervisor and, therefore, everything was good. Not having that judgment and instead knowing I was acceptable as I was helped because the more someone can do that, the less you think about being in the minority. … This transcended even my minority status. It focused on me as an individual. … Therefore, none of my minority statuses were even brought to light. We never thought about it, ever. I didn't ever even have to stop and wonder if I was included. I knew it to the deep of my marrow.

P12 recalled the powerful effect of supervisors' person-centered attention on his own self-confidence. He explained:

> The affirmation that I was capable deepened my sense of inclusion. It meant a lot. Truthfully, I think they saw more in me than I saw in myself. I think I expected to fail. When a director said, “No, you, can do this,” it was encouraging. I didn't believe it. But the affirmation of those white leaders, both male and female, was very helpful. I felt like I actually could do it. So I pursued and ultimately did become a leader in a department.

In summary, eight participants emphasized that their supervisors’ active listening helped create a workplace environment that they experienced as having supportiveness and positive communication, which led to participants’ sense of being validated, understood, and valued. These feelings, in turn, helped them feel more confident about themselves and their place in the organization.

Chapter Summary

This chapter outlined and discussed the results of the present research. The chapter began with an overview of its contents and reiteration of the process used to examine the data. The next section of this chapter presented an overview of the 14 participants interviewed in this study. Next, the emergent themes were presented, and these were organized by the two research questions examined in the study. A total of nine themes across the two research questions were identified. Five of these themes related to the behaviors participants’ associated with enhancing their sense of inclusion and belonging. Four of these themes concerned the effects they experienced when their supervisors utilized person-centered listening. Overall, the study data indicated that all participants had experiences related to inclusion and exclusion, that specific supervisor behaviors enhance the sense of inclusion and belonging, and that supervisors’ person-centered listening produces effects within the occupational minority that in turn yield performance impacts. These findings lead to conclusions, implications, and recommendations that will be discussed in the next chapter.

Chapter 5: Discussion

Chapter Overview

The present chapter offers an interpretation and consideration of the study results. The first section is an overview and introduction to the chapter, in which the study purpose is reiterated and the main questions examined in this study are outlined. Thereafter, the conclusions drawn from the findings presented in the previous chapter are provided. Examination of the conclusions in light of extant literature is then conducted and documented, followed by consideration of the study's practical implications. An original model for inclusion within healthcare, which was created based on the results and conclusions of the present study is outlined. The chapter closes with acknowledgment of the study's limitations and suggestions for continued research. A final summary of the dissertation is then provided.

Introduction

The purpose of this study was to examine the impact of supervisors' person-centered listening on occupationally minoritized healthcare professionals' sense of belonging. The main question for exploration was: What is the impact of supervisors' person-centered listening on sense of belonging among occupationally minoritized healthcare professionals? Two subquestions were examined:

1. What supervisor behaviors do occupationally minoritized healthcare professionals associate with feeling a sense of belonging?
2. What do participants report as the impact of supervisors' person-centered listening behaviors on their sense of belonging?

Conclusions

The study findings presented in the previous chapter led to two primary conclusions related to enhancing the sense of inclusion and belonging among occupational minorities in healthcare. The first conclusion indicated by the findings concerns the behaviors that are critical for supervisors to demonstrate toward occupational minorities. These behaviors include seeking

to understand and engage subordinates as well as actively supporting their development. The second conclusion indicated in the study findings concerns the multilayered impacts of person-centered listening. Examination of the data revealed that person-centered listening affects the personally oriented attitudes and experiences of occupational minorities, as well as their attitudes and behaviors toward their teams and supervisors, resulting in a net impact on organizational performance. These conclusions are discussed in the following sections

Critical Behaviors for Supervisors

Seeking to Understand and Engage Subordinate. All 14 participants emphasized that it was critically important for supervisors to actively seek to understand and engage subordinates. Examination of participants' accounts revealed that supervisors' efforts to do this helped produce healthy, high-performing workplaces characterized by effective communication, improved motivation and satisfaction, enhanced trust, team cohesion, and an overall positive organizational culture where they feel respected, heard, and valued. In other words, understanding and engaging subordinates leads to positive environments that are better equipped to deliver excellent patient care. Specific behaviors and strategies mentioned by participants included actively listening to subordinates' concerns, ideas, and feedback; confirming the accuracy of their understanding through feedback; offering empathy; demonstrating focused listening by making eye contact, eliminating distractions, and bringing up details of previous conversations in subsequent conversations; taking an individualized approach to each subordinate; and actively seeking subordinates' perspectives and input. Demonstrating active interest and engagement with subordinates can lead to the creation of positive and inclusive work environments, fostering job satisfaction, high performance, and cohesive healthcare teams. For example, P1 recalled a supervisor who took time to deeply listen to his concerns, paraphrased these back to make sure she understood, and took action to address the situation. This supervisor demonstrated her commitment to understand and accommodate P1, leading to deeper trust and commitment to the supervisor. Meanwhile, P3

described her experiences with a supervisor who actively recognized the different cultural values present within the workplace, gave a platform for all voices to be heard, leading to greater understanding, respect, and cohesion across the entire team.

Actively Supporting Subordinates' Development. All 14 healthcare professionals interviewed in this study emphasized the importance of supervisors supporting their professional growth and development. Such activities involve training and skill development, discussing career goals, providing guidance on their progression, offering challenging assignments, offer constructive feedback, advocating for and supporting their advancement, and providing performance coaching. Additionally critical to these efforts was acknowledging their achievements, rewarding their efforts, and doing so in a way that left subordinates feeling heard, seen, valuable, and competent. According to participants, the supervisors who demonstrated these behaviors tended to produce motivated, skilled workforces that were noteworthy for their job satisfaction and team performance. For example, P2 described his experience being part of the President's Counsel, which focused on making sure that diverse voices were represented. This experience and those like them inspired him to create a community program to create awareness and self-efficacy among diverse youth to pursue careers in healthcare.

Multilayered Impacts of Person-Centered Listening

Examination of the study data revealed that supervisors' use of person-centered listening produced a variety of impacts across the organization, occurring at multiple levels. These findings reveal that what occurs in the dyadic exchange between supervisor and subordinate yields immediate impacts on the individual subordinate which then has ripple effects cascading out toward that individual's interpersonal relationships, the team, and ultimately the organization.

Intrapersonal Impacts. Eight of the 14 participants expressed that supervisory person-centered listening served to increase their self-confidence. These findings reveal that subordinates' confidence is greatly influenced by the actions of their supervisors. Activities that

are uplifting, encouraging, and empowering can help create a work environment where people feel appreciated, competent, and self-assured. Conversely, unfavorable or unsupportive actions might negatively affect one's sense of self-worth and level of job satisfaction in general. For example, giving subordinates constructive criticism and acknowledging their accomplishments can help them feel capable and appreciated. By giving a path for development, constructive criticism that concentrates on opportunities for progress rather than personal inadequacies also can boost confidence. Encouraging and facilitating professional development opportunities, such as training, challenging projects, and mentorship, can empower subordinates to acquire new skills and knowledge, enhancing their self-confidence. As people see the results of their work, their sense of competence and self-efficacy can grow accordingly.

Interpersonal and Team-Level Impacts. All 14 participants pointed out that their supervisors' use of person-centered listening produced impacts within their relationships and teams—particularly with regard to feeling seen, heard, and included as valuable member of the organization and developing greater trust and commitment to their supervisors and teams. Supervisor's person-centered listening profoundly and positively affects subordinates in various ways due to the improved communication, enhanced understanding, sense of safety and reciprocity, enhanced respect and morale, and reduced misunderstandings. Within such environments, subordinates are more inclined to voice their opinions, ideas, and concerns. Supervisors then can better comprehend the viewpoints, difficulties, and requirements of their subordinates, leading to improved support and more informed decision-making. The listening modeled by supervisors also can trickle down to all their subordinates, further fortifying the sense of unity and willingness to collaborate within the team. For example, P3 contrasted her experiences of feeling valued as a person when her supervisors practiced person-centered listening to her first 28 years of work in healthcare. She shared, “You are always aware that you are a minority. You’re aware when your ideas are not accepted. How small you are is glaring in a large group. I had no voice. ” In summary, the participants in this study emphasized that their

supervisors' inclusion-oriented behaviors and, specifically, person-centered listening had real and powerful impacts on their views and experiences of their colleagues and teams.

Organizational Impacts. All 14 participants interviewed in this study expressed that their supervisors' use of person-centered listening enhanced their trust in and commitment to their organizations and additionally enhanced their performance. Findings suggested that supervisors' use of this kind of listening improved many elements at the level of organization, including interpersonal relationships, problem-solving abilities, staff participation, resolution of disputes, and employee development. Moreover, such listening helps create an environment that encourages flexibility and creativity, all of which have a substantial positive impact on organizational performance. For example, P2 noted that his experiences with his supervisor opened his view to recognize that other allies and supporters were available to him within the organization. P8 shared that her leaders' use of person-centered listening "made me want to work harder and do more for the organization. I put my personal life on hold because I felt the organization was supporting me 100%. " These findings help to demonstrate that the way supervisors listen to subordinates can create an environment of high performance. When workers believe their opinions are appreciated, they are more inclined to offer original and creative suggestions. The organization's performance can be positively impacted by this flexibility and openness to innovation in a healthcare environment that is changing quickly.

Connection to Literature

The findings from the present study exhibited strong alignment with extant literature. Past literature has emphasized the critical role supervisors play in supporting and advancing DEIB. For example, research has demonstrated that supervisors illustrate what values and behaviors are critical within the setting through their role modeling (Grojean et al., 2004; Shore et al., 2010), creating a trickle-down effect of inclusiveness (McKinsey, 2020; Rice et al., 2021) where lower-level employees mimic management behavior and prominent organizational cues (Bandura, 1986). Additionally, the general DEIB climate observable positively correlates with

supervisors' perceptions, attitudes, and behaviors (Ambrose et al., 2013; Mawritz et al., 2012; Mayer et al., 2009; Ruiz et al., 2011). For example, Mawritz et al. (2012) found in their study that senior leaders' abusive behaviors tended to be mimicked two levels lower in the organization. This body of research emphasizes that supervisory DEIB behaviors must be examined and addressed. The present research contributes to extant literature by outlining the critical supervisory behaviors that create a sense of inclusion.

Moreover, the present research aligns with past findings regarding the importance of supervisors regularly seeking out and encouraging the input of different groups (McKay et al., 2009; Sliter et al., 2014). For example, Bodie (2012) and Steil and Bommelje (2004) similarly found that listening to employees has the positive potential to develop and maintain strong leader-follower relationships. By making sure that each employee receives fair treatment and that they are regularly encouraged to voice their opinions and concerns in a polite and safe manner, especially when they pertain to diversity, leaders can show their commitment to inclusion.

The present study findings also align with Hollander's (2013) concepts of inclusive leadership—specifically that perception and response of followers to a leader is crucial in the dynamics of leadership, as it involves a mutually reliant relationship. The field has shifted its focus to acknowledge the significant influence that followers have in perceiving a leader's traits, actions, and motives, which has diverted attention from the prevailing emphasis on how a leader impacts their followers. This dynamic process commences with the leader's perceived legitimacy, such as by election or appointment. Leadership is a process that involves mutual influence and interpersonal assessment, where followers respond to the leader based on their needs and expectations, including matters of fairness. Inclusive leadership highlights the importance of actively including followers by demonstrating concern in collaborating with rather than controlling people (Hollander, 2009), emphasizing respect, acknowledgment, responsiveness, and accountability in both leadership and follower positions. Within the

dynamic of the leader-follower relationship, it is beneficial to consider the recognition given to leaders by their followers, which can be referred to as upward influence and leader emergence. The so-called idiosyncrasy credits (Hollander, 1958; Willis & Hollander, 1964) are primarily obtained by perceived competence in the major group work and adherence to group norms by meeting expectations for proper behavior. After being acquired, a leader's credits can be utilized to implement necessary actions for making changes, or they can be forfeited for failing to do so. The research on idiosyncrasy credits is given, along with comments and adjustments. The results obtained from analyzing important instances of both so-called good and bad forms of leadership, as reported by individuals within the company, highlight the significance of relational factors such as communication and support in establishing and sustaining strong leader-follower relationships, which are essential for fostering trust and loyalty.

Study conclusions that supervisors need to actively support subordinates' development through growth opportunities and participation also align with past literature. Several past studies have stressed the importance of accepting and valuing employees for their unique impacts and that these efforts enhance the sense of belonging among minority groups (Enwereuzor, 2021; Otten & Jansen, 2014; Sedgwick et al., 2014; Sherman et al., 2020). Furthermore, it was shown by Lobdell et al. (1993) that there is a positive correlation between supervisor listening abilities and employee views of leader responsiveness and support. Similar studies have found a link between managers' listening skills and employees' perceptions of the quality of their relationships with managers (Stine et al., 1995).

The present study additionally uncovered a range of positive outcomes resulting from supervisor listening, affecting the individual employee, their relationships with and perceptions of their supervisor and teams, as well as their organizational commitment and performance. Past literature similarly associated a range of beneficial outcomes with leader listening, such as employee engagement (Lobdell et al., 1993), organizational trust, and performance (Stine et al., 1995), as well as perceived leadership effectiveness (Johnson & Bechler, 1998). Lloyd et al.

(2014) found that perceptions of supervisor listening additionally affected employees' emotional tiredness, organizational citizenship behavior, and intentions to leave.

Other studies illuminated some specific leader interpersonal actions that enhance the sense of inclusion. For example, consistent with the present study findings, Subrahmanyam (2018) added that leaders who practice person-centered listening encourage employees to give and receive open and honest feedback on an interpersonal level. In turn, an atmosphere of working with people rather than directing them results, thus, enhancing the sense of collaboration and inclusion (Amin et al., 2018). McCormack and McCance (2017) further observed that worker-oriented managers find room for commonality with direct reports, especially regarding vision, which has the potential to boost feelings of inclusion. Similarly, in the present study, P9 emphasized that she experienced inclusion most when she had a leader who, like her, had an immigrant background. This shared experience created a sense of having common ground and shared understanding of the world and the workplace.

In summary, the present study exhibited strong alignment with past research on inclusion and the impacts of supervisor listening. Additionally, the present study offered more in-depth and current findings specific to healthcare settings regarding the supervisors' use of person-centered listening specifically and the impacts on occupational minorities occupying advanced practitioner and leadership roles in healthcare. The next section discusses the implications of the study findings.

Implications

The extant literature and the findings of the present study collectively emphasize that hiring people who look diverse is not sufficient to create inclusion. In other words, the fact that the organization looks diverse does not automatically translate into really including people in meaningful ways, such as in decisions that operations, the employee experience, and the delivery of care. Furthermore, superficial approaches to inclusion, such as inviting diverse individuals to attend meetings does not mean that they are truly included or that they belong, as

in the case of P5, who shared that he “was brought to the table, but not allowed to speak at the table as the Director of imaging. ” Instead, he shared that he was expected to simply do as he was told and, when he shared his opinions, he was put on a performance improvement plan. The end result was that rather than feeling included, he shared that this experience “traumatized me, creating self-doubt and having to rethink my career and rebuild my confidence. It damaged my relationship with my boss. ”

Overall, the findings presented in this study reveal that supervisor behaviors have far-reaching, whole person impacts on occupational minorities within healthcare. The substantial and potentially adverse impacts of supervisor behaviors are particularly noteworthy given that all the participants held advanced practitioner or leadership roles, were highly experienced and remarkably talented, and all but one had extensive academic and professional training (P14 shared that her highest level of education was high school). Specifically, non-inclusive supervisor behaviors reportedly served to reduce or eliminate participants’ opportunities to contribute and, worse, neutralize the positive impacts of their experience and expertise as it concerned participants’ self-evaluations. In turn, the effects of supervisor behaviors can create multiplying and long-lasting impacts on the healthcare professional’s mental and emotional wellbeing, their career, and the impact they can have on patients and their organization.

In contrast, inclusive supervisor behaviors—and, specifically, person-centered listening—have equally powerful and far-reaching positive impacts, beginning with helping occupational minorities feel seen, heard, and included as valuable members of the team and culminating in self-confidence, improved personal and organizational performance, and improved loyalty and trust in the supervisor and the organization. Considering that these dynamics are occurring around the clock and across the nation within the vast healthcare workforce suggests that the problem of poor inclusion is having extensive and debilitating effects on our healthcare workforce, patient care, and in turn health outcomes at a national level. Similarly, when supervisors practice person-centered listening and the other inclusive

behaviors identified by participants, the positive implications can be equally powerful and pervasive, culminating in cohesive healthcare teams, high performing professionals, optimized delivery of care, and enhanced national wellbeing.

It follows that the study findings create a compelling case for strengthening supervisors' competencies related to demonstrating inclusive behaviors and for practicing person-centered listening, specifically. These findings confirm and extend the extant literature. The next section presents an original model for inclusion in healthcare based on the findings of the present study. The subsequent section outlines practical recommendations for supervisors, healthcare organizations, and the healthcare industry at large to respond to the pressing need for inclusion revealed in participants' accounts.

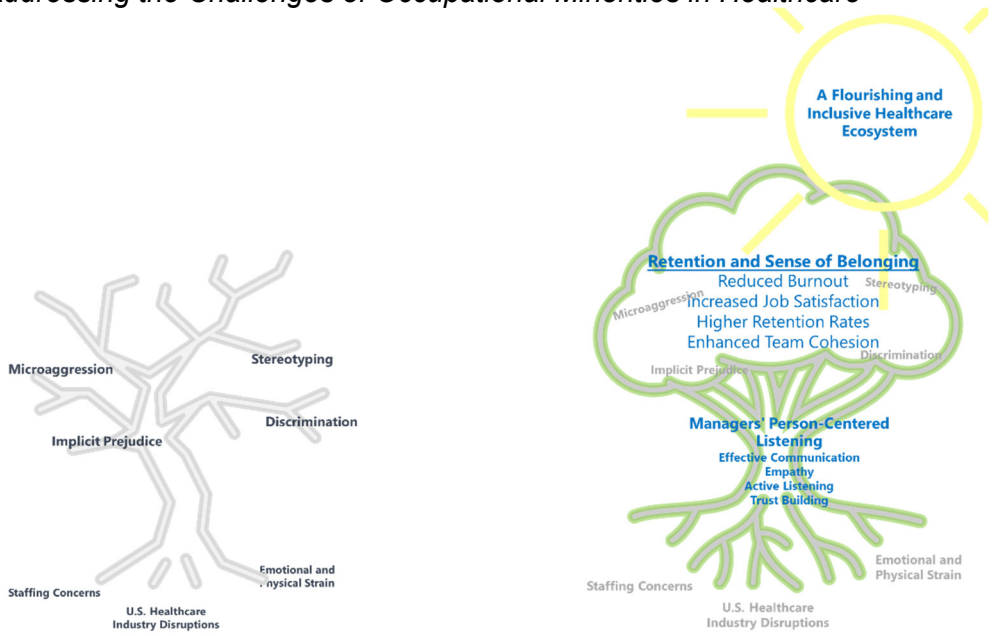
Model for Inclusion in Healthcare

The findings of this study have been incorporated into a model depicting an idealized future for inclusion in healthcare (see Figure 2). The tree represents the healthcare industry and its ecosystem. The roots signify the foundational challenges that exist in the sector. Given the challenges of U.S. healthcare industry disruptions, staffing concerns, and emotional and physical strains, the tree is unable to bear leaves, and staff are left to work within the barren conditions of microaggressions, stereotyping, implicit prejudice, and discrimination.

However, when the trunk is strengthened through managers' person-centered listening, characterized by effective communication, empathy, active listening, and trust building within a flourishing and inclusive healthcare ecosystem, the tree is able to bear leaves, resulting in retention and sense of belonging, including reduced burnout, increased job satisfaction, higher retention rates, enhanced team cohesion, and trust building. This model is intended to provide a vision for a possible future and set of desired outcomes for the healthcare industry, thus, symbolizing hope, growth, and positive change.

Figure 2

Addressing the Challenges of Occupational Minorities in Healthcare



Recommendations

The study findings identified the importance of supervisors understanding and engaging subordinates as well as actively supporting subordinates' development. Moreover, supervisors' person-centered listening behaviors were associated with positive intrapersonal, interpersonal, team, and organizational impacts. While healthcare organizations have made the attempt to increase inclusion by achieving greater diversity in hiring, and supervisors have made further attempts by inviting diverse professionals to attend meetings or other events, the present study findings are clear that these efforts do not constitute inclusion and do not produce the intended effects of inclusion. Moreover, superficial attempts at inclusion appear to have a deleterious effect, resulting in greater frustration, lowered confidence, an exacerbated sense of otherness, and reduced cohesion. These results reveal the need for practical recommendations that outline what needs to occur beyond hiring and invitations to participate so that authentic inclusion occurs. This section outlines the practical recommendations indicated by the present research for creating this kind of authentic inclusion.

Person-Centered Listening Based Cultural Sensitivity and Inclusiveness Training

The first recommendation for healthcare organizations is to institute cultural sensitivity and DEIB training for all leaders, ideally, offered as part of onboarding and on a regular basis thereafter. Given the extensive and positive impacts associated with person-centered listening, this training should have at its center training in person-centered listening. Cultural sensitivity training aims to raise awareness and comprehension of cultural differences and to encourage polite and productive interactions, collaboration, and communication between people of other racial backgrounds, ethnicities, genders, sexual orientations, and other identity groupings. DEIB training similarly aims to educate people about respecting, appreciating, and accommodating differences, but also encompassing differences owing to age, disability, and more. In addition to topics related to cultural competency, P11 noted the power that these programs have on inclusiveness in organizations:

> the organization I work in now really teaches people about dignity and honoring and respecting people no matter where they're at. And so now in my current organization, I don't feel that bigotry or prejudice because I'm female, because everyone is taught before they walk in the door that we're going to honor and respect and provide dignity to all those around us.

Grounding the training in person-centered listening will ensure that the principles of supporting subordinates' growth, active listening, seeking deep understanding, being intentional about inclusion, and seeking input—factors participants identified as being key to inclusion—are at the heart of organizational DEIB initiatives. Other key features of these programs include building awareness about one's own biases; gaining knowledge about other cultures and backgrounds; cultivating skills for cross-cultural communicating—including person-centered listening, collaborating, and resolving conflict; and expanding one's mindset to embrace diversity. DEIB training programs also address unconscious bias and principles and practices of inclusive leadership and communication within diverse environments. Cultural sensitivity and DEIB training can help reduce and eliminate misunderstanding while improving collaboration and inclusion. To be effective, this training must be aligned with the organization's goals and

values. This may involve incorporating diversity and inclusion principles into policies, procedures, and workplace culture.

Additionally, it is important to evaluate the training to ensure that it is effective (Duke & Reese, 1995). Assessment is crucial to verify that investments in training are effectively producing business outcomes. Kirkpatrick (1996) delineated four tiers of curricular evaluation:

1. Reaction. Reaction generally pertains to the learners' preference or satisfaction with the training. If learners have a positive attitude towards the training, they are more inclined to put into practice the knowledge and skills they acquired (Duke & Reese, 1995). The assessment of reaction is commonly conducted in an informal manner by the trainer during the training session, and then formally evaluated immediately after the training concludes. Although reactions are usually assessed retrospectively, focusing on whether learners enjoyed the training, it is important to also prompt learners to consider the future and anticipate how they will apply the acquired skills and knowledge in their profession. This is because it reveals their objectives regarding the practical application of the taught ideas.
2. Learning. Learning encompasses the fundamental concepts, factual information, acquired knowledge, and specific techniques that the learner has acquired via the training process (Kirkpatrick, 1996).
3. Behavior. Behavior encompasses the modifications in behavior that are acquired during training and subsequently used in the workplace (Kirkpatrick, 1996). Behavior changes are usually assessed immediately after the completion of training and at one or more subsequent intervals. Evaluating behavior change in the workplace is a crucial aspect of curriculum evaluation, as learners may struggle to effectively apply behavioral changes in their work environment. The capacity of learners to modify their behavior in the work environment is a crucial indicator of the efficacy of the curriculum.

4. Results. Results pertain to the tangible outcomes of the learning process, specifically the benefits and achievements that an organization experiences as a direct result of the learners' acquired knowledge and changed behaviors (Kirkpatrick, 1996). This level presupposes that the outcomes of training go beyond only providing individuals with the necessary abilities and knowledge to do their tasks. According to McNamara and Kirkpatrick, measuring results is the most crucial aspect of evaluation since it provides the ultimate proof of the effectiveness of the training. This step entails the identification of anticipated business outcomes and the assessment of actual accomplishments in comparison to the predicted ones. The approach and emphasis for assessing outcomes vary based on the objective of the training. For instance, evaluating the efficacy of a change-promoting training session may entail assessing the level of organizational support obtained, whereas a customer service skills training session may gauge the improvement in customer satisfaction.

Furthermore, assessments can be categorized as either formative or summative. Formative assessments are carried out with the purpose of gathering data that can be examined and utilized to enhance the program (Fitzpatrick, 2010). In this scenario, formative evaluations would be employed to assess the effective application of implementation processes, the extent to which desired audiences are being reached, and the achievement of desired results. The outcomes of these evaluations would subsequently be provided to the change team in order for them to modify their endeavors for enhanced impact. The process of formative evaluations is initiated at the early stages of the project and carried out frequently throughout the change attempt to continuously enhance the efforts.

On the other hand, summative assessments are carried out to assess whether the main project goals, such as establishing a common language for leadership, building a consistent growth path for leaders, and reducing the budget for leadership development, have been accomplished (Fitzpatrick, 2010). There are various forms of summative evaluations. Efficiency

studies, such as cost-benefit analyses, analyze the cost and cost-effectiveness of programs by using metrics (Rossi et al., 2004). An efficiency review aims to ascertain whether the program's benefits justify its expenditures and whether there are other treatments or delivery systems that can accomplish the same benefits at a lower cost. Efficiency studies are typically carried out exclusively for well-established programs. Rossi et al. (2004) highlighted that assessment outcomes are cumulative, meaning that each subsequent evaluation builds upon the previous findings.

Impact evaluations analyze the overall impact of a program, including whether the intended program outcomes have been accomplished and any unintended side effects that have occurred (Rossi et al., 2004). Conducting impact assessments can be challenging and expensive since the observed outcomes in a target group may be influenced by factors unrelated to the program. Although it presents difficulties, the impact evaluation serves as a crucial instrument for evaluating the worth of well-established initiatives.

Process assessments analyze the functioning, execution, and provision of services in a program (Scheirer, 1994). The objective of this form of assessment is to pinpoint concerns related to personnel, facility, and target population, such as issues with staff motivation, expertise, or training. Process evaluations can serve as a beneficial approach to assist programs in achieving high performance (Rossi et al., 2004). Process assessments are performed to assess the implementation of programs. The guiding questions for this evaluation focus on determining if the program objectives are being achieved, if the planned services are reaching the intended audience, if there is an underserved population in need, if the target population is satisfied with the program, and if the administration, organization, and personnel are effectively managing the program.

Irrespective of the category, summative assessments are conducted at the conclusion of the project. Summative evaluations can also be conducted at the conclusion of each significant project cycle, if the project is structured in this way. Validating the project's desired impact is a

crucial aspect of showcasing the return on investment of the endeavor. The results of a summative review can also assist decision makers in determining whether to replicate a similar project.

It will be important to conduct both formative and summative evaluations to measure the effectiveness of the proposed change project. These evaluations will investigate whether any changes have happened at all four levels as defined by Kirkpatrick (1996) and whether learning is taking place at three levels of learning, as outlind by Bloom's (1956) taxonomy:

1. Cognitive: The process of acquiring knowledge and enhancing intellectual abilities, such as retaining specific information and understanding concepts (Bloom, 1956). Cognitive learning occurs rapidly and can be readily assessed through exams.
2. Affective refers to the emotional aspect of coping with situations. It involves the process of paying attention to, responding to, valuing, organizing, and internalizing one's feelings, values, motivations, and attitudes towards a particular phenomenon. These tend to progress gradually, frequently taking several years to mature (Krathwohl et al., 1973).
3. Psychomotor refers to activities that require physical movement, coordination, and the use of motor abilities. Acquiring these talents typically necessitates extensive and consistent practice. Success is often evaluated based on factors like velocity, accuracy, or methodology (Simpson, 1972).

Accountability and Enforcement Measures

A second recommendation is to institute measures for DEIB accountability and enforcement. P14 emphasized:

> You could preach diversity all day long. You could put it on billboards. You could spend the money on advertising. But if you aren't going to educate your leaders and hold your leaders accountable to make sure that that trickles down and that they are teaching their coworkers how important this is, nothing's going to change.

Effective DEIB initiatives need to include supportive elements such as leadership commitment, training, establishment of key performance indicators, and employee resource groups as well as enforcement and accountability measures such as clear policies, ongoing measurement, transparent reporting, and consequences for non-compliance. Related to supportive structures, the fundamental one is that upper management's vocal and visible support is needed to send the organization as a whole a strong message when executives support DEIB activities. An important element of this is aligning organizational strategy with DEIB. DEIB training, as described in the previous recommendation, also needs to be required for all employees and leaders. This training can help ensure that a common language, vision, and set of practices are instituted within the organization. Training should be continually improved to ensure it stays relevant. With this common framework established, measurable goals must be set for every function and area related to DEIB. Finally, employee resources groups can aid in providing leaders and employees with tips and feedback for how DEIB may be enhanced within their units.

DEIB cannot flourish within organizations without enforcement and accountability measures, however. Several approaches can be utilized for that purpose. The first step is creating and disseminating explicit DEIB standards and policies. All staff must have easy access to these policies. Next, standards for decision-making, behavior, and communication should be set so they are consistent with DEIB. Once these standards are set, each employee and function should be routinely evaluated according to these metrics and the results reported. Integrate DEIB objectives with professional advancement via performance reviews. Employee opinions regarding DEIB efforts can be gathered through surveys, focus groups, exit interviews, whistleblower programs, and other methods.

Critical to accountability is designating specific individuals or teams ownership over DEIB initiatives and enforcement. Organizations must also be transparent about their DEIB initiatives, accomplishments, and difficulties. Provide staff members with regular updates on

initiatives and progress via internal communications channels. Lastly, it is necessary to specify and implement uniformly the penalties for breaking DEIB policy. Consequences should be aligned with the severity of the infraction and could include verbal or written warnings, education, probation, loss of funding or privileges, termination, and more. In summary, for DEIB to flourish, these initiatives need to be clearly outlined, deeply ingrained into every aspect of the organization, and enforced through measurement and consequences.

Limitations

An important part of discussing the findings of a study is acknowledging the limitations and delimitations that affect those findings and any conclusions and implications based upon them. Limitations are those issues that unexpectedly arise as well as other events that occur while the study is conducted and affect the study data. Bias is a primary limitation affecting qualitative research interviewing. Bias can originate in the researcher and in participants (Creswell & Creswell, 2022). Personal prejudices, convictions, and viewpoints of the researcher may affect how data is gathered, interpreted, and analyzed (Bryman, 2008). Participants might give answers they believe (a) the researcher wants to hear, (b) are socially acceptable, (c) place themselves or their organizations in a favorable light. All of these biases can skew the findings and result in incomplete or inaccurate understanding about the phenomenon investigated. Researcher bias was controlled in this study by subjecting the analysis to review by a peer examiner. Participant biases were controlled for in this study by making participants' identities confidential, safeguarding the data, and assuring participants that there were no right or wrong answers. Despite these measures the potential bias remained.

Problems with generalizing findings is an issue endemic to qualitative research due to its reliance on small, purposive samples which by their nature fall short of being representative of the perspectives of all participants in the population of focus. Further complicating this issue can be sampling biases. The time and resource constraints associated with unfunded doctoral research further exacerbate sampling and generalizability issues. In lieu of generalizability, the

findings may transfer to other settings (which is the typical aim of qualitative studies). However, care needs to be exercised to ensure that conclusions and recommendations are applied correctly. Moreover, the aim in qualitative research is in-depth examination instead of generating findings with sufficient statistical power and significance. In this study, the findings may be tentatively applied to leaders in other healthcare settings, although additional research is advised to further strengthen the findings.

Qualitative researchers approach issues of validity and reliability differently than do quantitative researchers. Qualitative researchers aim for trustworthiness, meaning the findings are credible, dependable, confirmable, and transferable. In contrast, quantitative researchers aim for statistical validity, meaning the study measures what the researcher meant for it to measure, and reliability, meaning achieving consistency and repeatability. While the aims of validity and reliability are difficult if not improbable to achieve in qualitative research, the researcher sought to achieve trustworthiness by carefully documenting the research process, continuing the interview process until saturation was achieved, triangulating participants' responses, and subjecting the findings to peer review.

Delimitations refer to the researcher's design decisions that may affect the study data and findings. A leading delimitation of the present study centers on its use of research interviewing and reliance on self-reported data. These methodological choices increase the risks of participant biases, particularly because informants are limited to what they recall, can describe, and are willing to share. Future studies may utilize experimental approaches to avoid the limits of interview research.

Another delimitation pertains to the utilization of convenience sampling, in which informants are selected from the researcher's network. Convenience sampling has attracted criticism due to its detrimental effects on external validity. Nonetheless, given doctoral students' limited budgets and schedules, convenience sampling is a frequent sampling approach. A related delimitation that often happens with convenience sampling are geographical or other

boundaries. In the case of the present research, the broad aim was to understand inclusion experiences of occupational minorities in healthcare. To make this study researchable, the boundaries of sampling were further set to focus on leaders and advanced practitioners. The experiences of these individuals cannot be assumed to be the same as those of occupational minorities in other roles. Moreover, the study was limited to those participants who were fluent in English. It is likely that individuals whose English skills are more limited would have different experiences of inclusion and may experience greater degrees of exclusion stemming from cultural and language barriers. Future studies could expand the sample beyond the researcher's social and professional network and beyond English speakers to expand the findings.

Suggestions for Further Research

A primary suggestion for continued research is to address the limitations and delimitations in the present study and conduct the study again—particularly those concerning sample size. Such a study may expand the interview sample to include as least 25 participants (Brinkmann & Kvale, 2014) and to ensure coverage of various types of healthcare settings. Alternately, case studies may be performed to conduct more in-depth investigations of particular healthcare settings, healthcare roles, or healthcare organizations in a specific geographic region. For example, it could be helpful to conduct more research within southern California, as participants from this region expressed that they experience more inclusion than participants in other regions of the U.S. report experiencing. To more deeply understand these dynamics and potentially identify best practices that could be implemented in other regions, it would be helpful to examine the regional and organizational demographics and culture. From this continued study, it might be possible to isolate whether the higher levels of inclusion originate within the organizations themselves, the state and its policies and regulations, society and its culture, political influences, or religious orientations, or other sources.

Another suggestion for research is to examine the differences by role and area within the healthcare organization. For example, it would be helpful to more deeply examine clinicians'

experiences of inclusion versus nonclinicians' and executives' experiences. Similarly, it would be helpful to examine whether the potentials and uses of personal-centered listening would vary across roles and functions. The insights from the subsequent study would be valuable for identifying best practices and designing training to increase leaders' use of person-centered listening.

A third suggestion for research is to examine the reciprocal impacts and influences between singular departments and the entire organization. As an open system, each department affects other departments as well as the organization, as vice versa. Therefore, inclusiveness (or lack of inclusion) in a department does not occur within a vacuum. According to the study findings, the impacts of that inclusion or lack of it affects subordinates and, in turn, their relationships and work performance, with a ripple effect ultimately influencing patient care and overall organizational performance. It would be valuable to measure the organizational effects of dyadic supervisor-subordinate inclusion in a more systematic way.

A fourth suggestion is to administer a person-centered leadership listening training intervention within two equivalent healthcare settings. This study could be designed as a randomized controlled trial where leaders in one setting are trained in the concepts and practice of person-centered leadership listening through workshops and mentoring delivered over 12 months, while leaders in the other setting convene for leadership lunches that cover leadership principles, excluding the concept of person-centered leadership listening. Pre/post measures of retention, job satisfaction, patient outcomes, diversity hires, diversity promotions, complaints, and financial performance would be administered. The degree and significance of the pre- and post-intervention differences will be compared across settings. The findings from this study would demonstrate whether person-centered leadership listening produces measurable differences for healthcare organizations.

Summary

The present study, combined with extant literature, demonstrated that some progress has been made related to hiring occupational minorities within the healthcare field. However, the present study findings conveyed an even more powerful and urgent message: Authentic inclusion remains to be lacking, and that lack is undermining diverse healthcare professionals' confidence as well as their motivation and ability to perform on the job. It follows that lack of inclusion has practical implications for patient health and wellbeing on a national level. Therefore, the need to increase inclusion could not be clearer.

Hiring diverse professionals is a start, but it is not enough. In addition, it is critical to listen to those people to learn what is working and what is not working. Educational programs deployed during onboarding of new leaders are needed to train them how to work with people of all backgrounds. Only when the diversity of population is reflected in the healthcare workforce and when occupational minorities are seen, heard, and valued as integral members of the team will our organizational and national healthcare outcomes begin to change. Based on the findings of this study, person-centered listening and the other inclusive supervisor behaviors are possible, are being practiced by some supervisors, and do have dramatic, positive effects. As documented in extant research and confirmed by the present study findings, supervisor behaviors supersede the statements organizations make about DEIB. It follows that diverse hiring and diversity statements are necessary but insufficient conditions to create the diverse and equitable climates organizations need.

Conducting this study and hearing the stories of the highly talented and passionate healthcare professionals I interviewed triggered a range of emotions, including sadness, anger, hope, and gratitude. I am grateful for their tenacity, their leadership, and their achievements. For example, one participant shared that his nephew was astonished to learn his uncle worked in healthcare, as he had thought African Americans only go to hospitals when they are shot. Hearing that minoritized individuals do not feel they have a place in healthcare is disheartening.

I believe this is a misconception that we all, as a society, are guilty of propagating. The result is that we miss out on the genius and potential achievements of our full population. This breaks my heart and makes me angry. The present research has been an attempt to help reduce and eliminate the barriers for occupational minorities, whether those barriers are real or perceived. I believe such a future is possible, and the findings of the present study suggest that managers' person-centered listening plays a fundamental role in creating that future.

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APPENDIX A

Participant Recruiting Email

Hi _____:

As part of my doctorate in Global Leadership and Change at Pepperdine University, I am conducting one-on-one in-person interviews with physicians, advanced practitioners, or leadership-level individuals who are occupational minorities in their profession for the purpose of understanding your experiences of inclusion and lack of inclusion in your workplace. I am contacting you because I believe you would have very valuable insights to share.

The interview would last 45–60 minutes and would be conducted via Zoom at a time convenient for you. The only condition is that our conversation would need to be held in a quiet, private setting free from interruption or distraction.

To participate, you need to meet certain criteria. Specifically, you need to:

1. Be a licensed healthcare professional in the United States.

2. Be employed full-time as a physician, advanced practitioner, or management-level professional.

3. Be an occupational minority within their profession, meaning you are underrepresented in your profession based on your gender, ethnicity, or other personal characteristic.

4. You have at least 3 years of full-time experience in your profession.

Participation is voluntary and confidential. You would not be identified in the study and any answers you provide would be pooled with others' responses and reported in aggregate.

Although you aren't anticipated to get any direct benefits from being in this study, your insights may help guide future research and practices related to improving underrepresented healthcare professionals' sense of inclusion in their workplaces. You also would be entitled to a copy of a summary of the findings when my work is finished.

Please contact me by email (nelu. nedelea@gmail.com) or phone (909-999-1133) if you would like to talk more or enroll in the study.

I sincerely thank you for your help!

Nelu Nedelea
PhD Candidate
Pepperdine University

APPENDIX B

Participant Recruitment Social Media Ad

APPENDIX C

Informed Consent Form

Participant Study Title: Experiences of Belonging Among Occupational Minorities in Healthcare

Formal Study Title: Impact of Supervisors' Person-Centered Listening on Sense of Belonging Among Occupationally Minoritized Healthcare Professionals

Authorized Study Personnel

Principal Investigator: Nelu Nedelea, PhD Candidate Office:
Faculty Advisor: June Schmieder-Ramirez, Ph. D. Office:

Key Information:

If you agree to volunteer and participate in this study, you will be asked to take part in one, one-on-one, 1-hour interview regarding your experiences of inclusion as a healthcare professional. You will be provided a copy of this consent form.

Invitation

You are invited to participate in a research study conducted by Nelu Nedelea, Ph. D. candidate, and **June Schmieder-Ramirez**, Ph. D., at Pepperdine University, because you are an occupational minority and healthcare professional. Your participation is voluntary. You should read the information below and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends.

Why are you being asked to be in this research study?

You are being asked to be in this study because you are an occupational minority and healthcare professional.

What is the reason for doing this research study?

Significant gender and racial disparities are evident when comparing the composition of the U.S. healthcare workforce to the general U.S. population. Lack of diversity poses problems for underrepresented healthcare professionals, their organizations, and their patients. The purpose of this study was to investigate the impact supervisors have on diverse professionals' workplace experiences.

What will be done during this research study?

If you volunteer to participate in this study, you will be asked to take part in a 1-hour individual interview, for a total of 1 hour of participation. During the interview, you will be asked to reflect on and share ideas about your workplace experiences.

How will my data be used?

The researcher will record your answers in a password-protected document and a unique identifier (such as "Participant 1") will be assigned to your information. Any information you

share that could uniquely identify you (such names, places, or events unique to you) will be given a fake name and anonymized during the interview process.

What are the possible risks of being in this research study?

This research presents risk of loss of confidentiality and possible emotional and/or psychological distress as you think about your workplace experiences.

What are the possible benefits to you?

You are not expected to get any benefit from being in this study.

What are the possible benefits to other people?

Benefits to society include guiding future research or creating services to help improve underrepresented healthcare professionals' sense of inclusion within their organizations.

What are the alternatives to being in this research study?

The alternative to participation in the study is not participating or only answering the questions with which you feel comfortable. You may withdraw from the study at any time and for any reason.

What will being in this research study cost you?

There is no cost to you to be in this research study.

Will you be compensated for being in this research study?

You will receive no compensation for your participation in this study.

What should you do if you have a problem during this research study?

Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the beginning of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. The data will be stored electronically through a secure server and will only be seen by the principal researcher during the study and for 3 years after the study is complete.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person, agency, or sponsor as required by law. The information from this study may be published in scientific journals or presented at scientific meetings but the data will be reported as group or summarized data and your identity will be kept strictly confidential.

What are your rights as a research subject?

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study.

For study related questions, please contact the investigator(s) listed at the beginning of this form.

For questions concerning your rights or complaints about the research contact the Institutional Review Board (IRB):

- Phone: 1(402)472-6965
- Email: gpsirb@pepperdine. edu

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study ("withdraw') at any time before, during, or after the research begins for any reason. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator or with Pepperdine University (list others as applicable).

You will not lose any benefits to which you are entitled.

Documentation of informed consent

You are voluntarily making a decision whether or not to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study. You will be given a copy of this consent form to keep.

Participant Name:

_____

(Name of Participant: Please print)

Participant Signature:

_____ _____

Signature of Research Participant Date

APPENDIX D

IRB Approval and Proof of Training

eProtocol
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: August 07, 2023

Protocol Investigator Name: Nelu Nedelea

Protocol #: 23-06-2186

Project Title: Impact of Supervisors ' Person-Centered Listening on Sense of Belonging Among Occupationally Minoritized Healthcare Professionals

School: Graduate School of Education and Psychology

Dear Nelu Nedelea:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your 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 46.101 that govern the protections of human subjects.

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 an amendment to the IRB. Since 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 IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the 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 IRB as soon as possible. We will ask for a complete written explanation of the event and your written 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 IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

CITI PROGRAM

Completion Date 28-Jan-2023
Expiration Date 28-Jan-2026
Record ID 53865861

This is to certify that:

Nelu Nedelea

Not valid for renewal of certification through CME.

Has completed the following CITI Program course:

Graduate & Professional Schools HSR
(Curriculum Group)
Graduate & Professional Schools - Psychology Division Human Subjects Training
(Course Learner Group)
1 - Basic Course
(Stage)

CITI
Collaborative Institutional Training Initiative

Under requirements set by:

Pepperdine University

Verify at www.citiprogram.org/verify/?w57a5982d-40de-44e4-92f2-5935b46f06f6-53865861

APPENDIX E

Interview Script

Opening Question

1. In our previous conversation, you identified yourself as an occupational minority, meaning there are relatively few [your demographic characteristics] who are [your role]. In general, how would you characterize your experiences as [your demographic characteristics] [your role]?

Experiences of Inclusion

Inclusion refers to the extent to which you feel that your authentic self is welcomed at work, enabling you to contribute in a meaningful and deliberate manner. I would like you to think of a time at work, whether in your current role or in any role in the healthcare field, where you felt this kind of inclusion.

2. Please tell me about this experience.
3. What effect did this have on you?
4. What do you think helped you feel this level of inclusion?

Possible prompts:

- Was there anything particular to the organizational setting?
- What, if anything, did your supervisor do to help you feel this sense of inclusion?
- What, if anything, did your peers do to help you feel this sense of inclusion?

5. What do you think would have helped you feel even more included?

Role of Supervisors' Person-Centered Listening in Inclusion

Now I want to zero in more on the role of supervisors. I am investigating a specific kind of listening called person-centered listening. In this way of listening, the supervisor demonstrates attentiveness; presence with you; emotional involvement; and a non-judgmental, genuine, open, and attuned attitude.

Please reflect on your work experiences, whether in your current role or in another role during your healthcare profession. Think of a time when a supervisor listened to you in this way.

6. Please tell me about the situation.
7. What gave you the feeling that your supervisor was listening to you in this attentive, engaged way?
8. How did that affect your perceptions, if at all?

Prompts:
Impact on feelings about your supervisor?
Impact on feelings about your work or profession?
Impact on feelings about your organization?

9. How did that affect your sense of inclusion, if at all?
10. That concludes my formal questions. Is there anything else you would like to share about your experiences as an occupational minority in the healthcare field or about what could increase your feeling of inclusion?

Thank you!