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Perceptions of Women of Color Improving Patient Outcomes Through Hospital Leadership Advancement

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2022

Abstract

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MS, Harvard University School of Public Health, 1995

MHA, Chapman University, 1990

Dissertation Submitted in Partial Fulfillment

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Abstract

Women of color have been underrepresented in hospital leadership positions and face challenges in advancing their careers. The benefit to hospitals providing women of color with training and support to move into leadership positions may be improved patient outcomes. Grounded in the interactional model of cultural diversity framework, the purpose of this basic qualitative study was to explore the perceptions of women of color advancing in leadership roles in hospitals and their impact on patient outcomes. The study participants included 16 women of color in leadership positions from hospitals in a western U.S. state. Data were collected through semi structured interviews. Resulting themes included (a) lack of mentorship opportunities; (b) discrimination; (c) lack psychological safety; (d) importance of representation by women of color; (e) women of color need to lead and support diversity, equity, and inclusion; (f) focus on performance and quality improvement; and (g) leading with values. Implications for positive social change include understanding the impact of racism and sexism on women of color leaders and developing programs that encourage more women of color to aspire to and work towards leadership positions. This will increase the number of women in hospital leadership roles and ultimately can help to improve health care for everyone.

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Dedication

I would like to dedicate this work to my heavenly Father. I am so thankful and grateful for His Son Jesus and the Holy Spirit, who ensure life, health, and strength to continue to do His good work and His will even when times are tough. I appreciate my reminders that He has placed me here on earth with much work to do in a little time. It is very important, sometimes challenging but very fulfilling work, and I am eternally grateful for the many opportunities to serve Him and His people.

I would also like to dedicate this work to my dear mother, who has stood by my side through thick and thin. I will never forget the early years of her courage and determination, of her strength and encouragement, and mostly her caring heart and willingness to sacrifice it all for others. I also remember the latter years when she continued to share wisdom, companionship, and friendship. She has always been there to support and cheer on me and my sisters and brothers. I thank God for you, Mom. You're the best!

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I also want to acknowledge my Committee Chairs, Dr. Compreca Martin and Dr. Eboni Green. Dr. Martin has been a tremendous blessing. She is highly knowledgeable and never hesitates to share her knowledge, resources, and tools. Dr. Martin has always been extremely encouraging and supportive throughout this process and never gave up even when I wanted to. She always picked me up when I was down and got me back on track when I got off track. I also want to acknowledge Dr. Green for her willingness to step in and fill a critical role. I am extremely grateful to you both.

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Chapter 1: Introduction to the Study

An increasing demand for health care services in the United States is projected for the next decade because of a growing older population, an increase in chronic diseases, greater demand for behavioral health services, and advancements in medical technologies (American Hospital Association [AHA], 2021). This demand means there must be trained people available from all genders, raced, and ethnic backgrounds to fill various health care roles. To serve the needs of increasingly diverse populations, health care systems must take steps to improve staff cultural competency and ensure staff racial and ethnic diversity (Nair & Adetayo, 2019). But women of color have not been well represented in hospital leadership positions and confront many barriers in advancing their careers (Lobaton et al., 2020). Women of color in health care often struggle to navigate advancement opportunities and do not receive needed support to attain leadership positions (Brown-DeVeaux et al., 2021).

The lack of women of color in leadership roles in healthcare has a significant consequence (Lobaton et al., 2020). Without women of color working in leadership roles there will continue to be little understanding of and focus on the cultural needs and the distinctive health care issues of communities of color (Brown-DeVeaux et al., 2021). The need to increase diversity of the healthcare profession is fueled by forecasts of growth in communities of color in the United States, many predicting the country to reach “majority-minority” status by 2050 (Krosch et al., 2022). The lack of diversity among health care professionals including at the leadership level may cause disparities in access and outcomes especially for minority populations (Livingston, 2018). Yet little

work has been done to explore the perceptions of women of color advancing in leadership roles in hospitals and their impact on patient outcomes. This study was conducted to address this gap. In this chapter, the background of the problem leading to the development of the problem statement, including a description of the gap in the literature will be presented. The purpose, significance, and nature of the study, the research questions, and the conceptual framework of the study will follow. I will also offer operational definitions used throughout the research and state the assumptions, scope, delimitations, and study limitations.

Background

Helping professions are a popular career choice for women of color in the United States and are well known for employing women of color in significant numbers, with Black women making up 41%, and Asian and Hispanic women each making up 31% (U.S. Bureau of Labor Statistics, 2020). Further, women of color occupy up to 35% of health occupations in U.S. health care (U.S. Department of Health and Human Services, 2017). Data gathered between 2000 and 2019 indicated there has been an increase in minority women in health care profession roles such as nurses, therapists, and health care aides (Ly & Jena, 2020). During that period, there were also increases for Black and Hispanic women in the occupations of physicians, surgeons, pharmacists, and dentists, but the increases for White women were larger (Ly & Jena, 2020).

In recent years health care organizations have discovered the benefits of having diverse staffing, including improved overall performance and better patient outcomes (Gomez & Bernet, 2019). Patients who have providers with similar racial, ethnic, and

language backgrounds experience greater satisfaction, which leads to better health outcomes (Coe et al., 2020). Diverse workforces are better able to care for diverse populations (Ly & Jena, 2021). One reason for this is because of similar lived experiences or greater ability to empathize. Empathy positively affects the quality of care by reducing patient concerns, increasing confidence and follow through with treatments, and improving medical outcomes (Greeno et al., 2018). With the rapidly growing diversity of the U.S. population, many health care organizations are more proactive in recruiting staff from diverse backgrounds (Diversity Best Practices, 2017). The demand for more transparency in hospital quality and patient care outcomes will impact competition and encourage organizations to be more culturally competent (Nair & Adetayo, 2019).

Emphasis in recruiting a diverse workforce must extend to health care leadership positions. The importance of diversity extending beyond those providing direct care to those in leadership could result in policy, procedure, and service changes and changes in decisions about the distribution of resources (Gomez & Bernet, 2019). There is a direct association between leadership and performance in health care organizations (Curry et al., 2020). The association between leadership and performance is critical in that leaders have the opportunity and the responsibility to direct and support personnel to ensure their highest level of performance and thereby the organization's highest level of performance. The leadership process has several fundamentals, including shaping and inspiring others, reaching goals, and developing a shared vision (Villarruel, 2017). Therefore, having the right leaders in place is critically important to organizational success. Leaders are

selected based on many factors, including their values, demonstrated decision-making skills, and their ability to influence others (Boyle & Mervyn, 2019). There is a need to have individuals in positions of influence who understand and value various cultures in order to build trust, assess conditions, and improve communications (Livingston, 2018).

Although women of color are growing in representation in the health care profession, they occupy only a small percent of senior-level management positions (Lobaton et al., 2020). Ninety-eight percent of senior leaders in health care organizations in the United States are White (Nair & Adetayo, 2019). Although women of color are growing in representation in the healthcare profession, they occupy only a small percent of senior-level management positions (Lobaton et al., 2020). Women and people of color bring their unique experiences and viewpoints to leadership roles and support both the organizations and the community's need for translation of culture and language by demonstrating innovative and creative ideas, welcoming diverse perspectives and responding to cultural needs. (Thomas, 2019). Women may enter the health care field at various levels; however, most enter at the entry-level because many roles available at this level are considered traditionally reserved for women and therefore easier to obtain (Dill, 2017). As women attempt to advance their careers, they often face many challenges such as incidents of discrimination, sexual harassment, and hostility (Farrugia et al., 2020). In addition to those impediments for women, the challenges of women of color in health care are even more magnified by overlapping identities of their gender and their race and ethnic background (Coe et al., 2020). Women of color are often asked to choose between identification as a woman or identification as a person of color.

There are many complications that women of color face, both internally as well as externally, when confronting multiple identities. Many organizations are starting to recognize these struggles and are investing in diversity training, but they must consider efforts to promote inclusiveness (van der Heever & van der Merwe, 2019). Although the impact of the hospital leadership diversity on staff and the effect on patient outcomes has been studied (Livingston, 2018), what has not been studied are the perceptions of women of color advancing in leadership roles in hospitals and their impact on patient outcomes. This study attempts to fill this gap in the literature.

Problem Statement

Diversity in health care leadership has been acknowledged as a business imperative for hospitals (Gomez & Bernet, 2019), yet women in health care leadership roles remain under-represented (Lobaton et al., 2020). Although there is a growing interest in increasing the diversity of hospital staff to yield better patient outcomes, little work has been done by senior health care leaders to understand and mitigate the challenges of women of color advancing in hospital leadership roles. The specific research problem that was addressed are the challenges of women of color advancing in hospital leadership roles and their impact on patient outcomes.

Purpose of the Study

The purpose of this basic qualitative study was to explore the perceptions of women of color regarding their advancement in hospital leadership and their impact on patient outcomes. Research has supported that additional inquiry was needed to explore

how hospitals can increase leadership diversity to improve patient outcomes (Banister et al., 2020).

Research Questions

The research questions (RQs) that I sought to answer were as follows:

RQ 1: What are the perceptions of women of color advancing into leadership roles within hospitals?

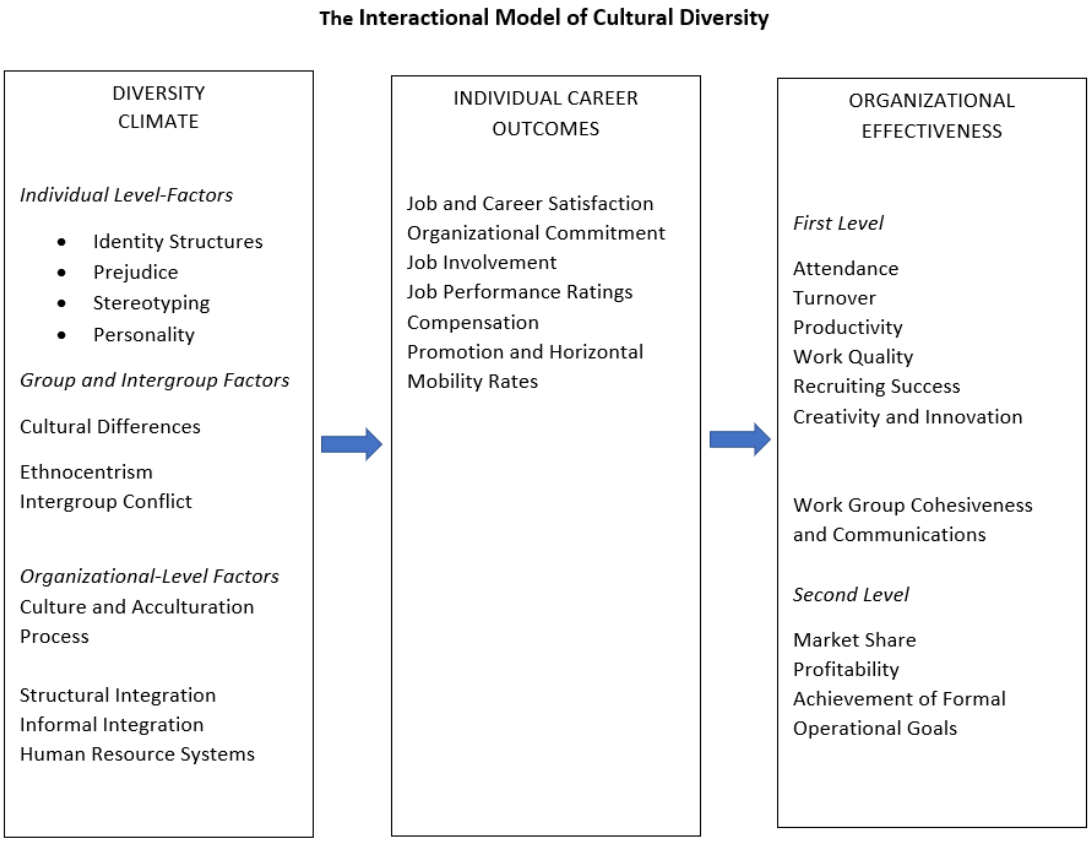
RQ 2: How do women of color perceive diversity at the hospital leadership level and its impact on patient outcomes?

Framework

The concept that grounded this study is the interactional model of cultural diversity (IMCD). The IMCD states that an organization's diversity environment impacts organizational effectiveness directly and indirectly (Cox, 1993). It is affected directly through organizational interactions and indirectly through individual career outcomes and organizational (patient) outcomes. Additionally, the IMCD states that the diversity environment consists of individual dynamics, group/intergroup dynamics, and organizational dynamics. Further, the effect of diversity on organizational outcomes is a multifaceted intersection of individuals and their environment. The IMCD provided a framework for exploring the perceptions of women of color and the impact of diversity at the hospital leadership level on patient outcomes because it explores three similar central issues: diversity climate (perceptions of women of color), individual career outcomes (advancing in leadership roles) and organizational effectiveness (impact on patient outcomes). The IMCD is shown in Figure 1.

Figure 1

Interactional Model of Cultural Diversity



Source: Cox, T. (1993). *Cultural diversity in organizations: theory, research, and practice.* Berrett-Koehler

The IMCD sets the foundation for organizations to use a three-step process to help women of color advance in health care organizations (Cox, 1993). Step 1 is the "diversity climate" step, where human resources leaders will assess the overall organizational climate, gain insights about cultural competency, and understand the current acceptance level of women of color in leadership roles. During this step, human resources leaders will also institute training and education to reduce bias, improve cultural understanding and cultural competency, and improve the acceptance of women of color in leadership roles. Step 2 is the "individual career outcomes" step. During this step, the organization will demonstrate its commitment to advancing women of color by investing in tools such as 360-degree evaluations and individual coaching to identify areas for leadership development. A 360-degree evaluation includes feedback from a full circle of sources including supervisors, peers, subordinates, customers, and the individual themselves through a self-assessment, which takes into consideration more viewpoints, observations, and sources of evidence to ensure a more comprehensive and integrated review that can be shared with the individual (González-Gil et al., 2020). The difference between a 360-degree evaluation and a more traditional assessment review is that the 360-degree evaluation takes into consideration more viewpoints, observations, and sources of evidence to ensure a more comprehensive and integrated review that can be shared with the individual (González-Gil et al., 2020). The 360-degree evaluation can be used by individuals, leaders, and human resources to determine training and support needs. The organization will also offer leadership development programs and training to women of color during this step. Step 3 is "organizational effectiveness," which involves

an organization evaluating and reporting the effectiveness of its advancement programs by studying recruitment and retention data and overall employee satisfaction and morale, evaluating workgroup cohesiveness, and exploring patient outcomes.

Nature of the Study

The research design was a basic qualitative design. The characteristics of qualitative research include a natural setting, the researcher as the key mechanism for data collection and analysis, numerous data sources, logical data assessment, learning from participants, organized design, role reflection, and complete report (Creswell & Creswell, 2018). These characteristics fit well with a study about women of color advancing in hospital leadership. This research also fits well with the basic qualitative inquiry because it asks a *what* question and uses words familiar to qualitative inquiry, such as "experience." The primary source of data for this research came from interviews, which was appropriate for a qualitative inquiry because it offers a rich and deep information source. The benefits of qualitative interviewing are that it delivers highly trustworthy findings and requires accuracy and transparency in reporting (Patton, 2015).

Definitions

Diversity: Acknowledging dissimilarities in demographics, such as race, ethnicity, sex, age, and education of workers, teams, leaders, or customers (Gomez & Bernet, 2019).

Health care facility/Hospital: Any institution providing inpatient medical and surgical treatment and nursing care for sick or injured people.

Helping professions: Occupations that provide health and education services to individuals and groups, including in the fields of psychology, counseling, medicine, nursing, social work, teaching, and education (American Psychological Association, 2022).

Human resources: That unit, department, or agency within an organization responsible for supporting activities such recruitment and onboarding, training and development, evaluation, compensation, and other employee services (Fried & Fottler, 2018).

Leadership: A practice of influence over a group of people or an organization to achieve shared goals (Packer et al., 2018).

Patient outcomes: The results of care that people receive from a hospital or health care facility (Gomez & Bernet, 2019).

Positive social change: A deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies (Walden University, 2022).

Women of color: Anyone of the female gender who does not consider themselves Caucasian or White.

Assumptions

The assumptions made in this study were as follows. The first was that individuals in senior hospital leadership positions see the value of diversity in leadership roles. Another assumption was that individuals in senior leadership positions in hospitals want

to understand how to increase diversity in leadership roles. It was also assumed that hospital human resources personnel are interested in improving diversity in leadership positions. Finally, it was assumed that women of color are viewed as bringing value to organizations in leadership roles.

Scope and Delimitations

The scope of this study encompassed the perspectives of women of color in hospital leadership. This study includes women of color currently or previously involved in hospital leadership who had advanced e in leadership. For this study, delimitations include women of color who work or have worked in hospitals and who have achieved at least one career advancement into a leadership position. The scope involves interviews of 16 women of color leaders from hospitals throughout California.

Limitations

Challenges in conducting this study were finding women of color in hospital leadership, finding women of color in hospital leadership who had the time available for the interview, and finding women of color in hospital leadership willing to participate in the interview.

Significance

This research project was meaningful because it establishes that organizational diversity is important. It is critical that hospital leaders understand the challenges women of color may face in career advancement. It is also crucial for hospitals to understand the impact of diversity at all levels on patient outcomes. By examining the perceptions of women of color advancing in leadership roles in hospitals, I was able to identify specific

strategies that hospital leaders can implement to ensure women of color have advancement opportunities. I was able to learn how women of color believe they impact patient outcomes.

The results of the study will help hospital and human resources leaders gain more insights to assist women of color in advancing in leadership roles in hospitals. Information learned from this study will also help hospital hiring managers recruit women of color for leadership roles. Knowledge gained from this report will also help women of color understand what is needed to advance in leadership roles in hospitals. If there is a better understanding of the perceptions of women of color who advance in hospital leadership roles, there might be more opportunity to improve advancement opportunities for others. Additionally, this study will demonstrate the impact of diversity at the hospital leadership level on patient outcomes.

Summary

Women of color often gravitate to the helping professions and the service industry, including health care jobs (U.S. Bureau of Labor Statistics, 2020). Culturally, women of color are often encouraged to be caregivers and often have early experiences and interest in helping others. This desire to help others often results in the pursuit of health care roles. Health care organizations are now embracing and promoting diversity because they have discovered the many benefits of diverse staffing, including better patient outcomes (Gomez & Bernet, 2019). However, health care leaders' interest in diversity has not translated to leadership roles. Although a significant number of women of color are in the health care professions, women of color possess only a small

percentage of hospital leadership positions. Women of color face many barriers to advancing to leadership roles. Health care leaders must integrate women of color into leadership development and training systems that help them feel included and supported. Health care leaders and human resources leaders should work together to learn from women of color and understand what additional support they need to help them advance and ensure that advancement leads to better patient outcomes.

Chapter 2: Literature Review

Due to increased life expectancies and more identified low-level sicknesses and diseases, communities face more challenges to sustaining health care, such as ensuring better care for individuals, improving health for populations, and reducing health care costs (Boyle & Mervyn, 2019). The U.S. population is moving to a 43% majority–minority demographic balance, and the health care system will need a more diverse workforce to serve the needs of a more culturally diverse population (Persaud, 2020). By 2024 the workforce is projected to be made up of almost 40% people of color and 47% women of all races and ethnic backgrounds; therefore, organizations will need to be able to recruit and retain diverse top talent including women of color (Gupta, 2019).

Additionally, around the world, women represent a large portion of the health workforce but continue in the minority in global health leadership (Barry et al., 2017). In 2017, only 31% of the world's ministers of health were women, and there was only one-woman CEO of the 27 health care companies in the global Fortune 500 that year (Barry et al., 2017). Although a significant number of women of color are in the health care professions in the United States, women of color possess only a small percentage of hospital leadership positions. Many health care organizations embrace and promote overall staff diversity because of the changing demographics of patients and improved organizational and patient outcomes that result from increased diversity. However, health care organizations' leadership often does not mirror the communities they serve (Poole & Brownlee, 2020).

Health care leaders' interest in diversity has not translated to more leadership roles for women of color. Women of color often find challenges and barriers such as lack of diversity acceptance, lack of role models, lack of access to training and lack of sponsorship while attempting to advance in health care leadership roles. Diversity focus has advanced slowly due in part to lack of cultural education and awareness programs as well as some organizations not valuing change (van der Heever & van der Merwe, 2019). Although interest in increasing the diversity of hospital staff to yield better patient outcomes is growing, senior health care leaders have done little to understand and mitigate the challenges of women of color advancing in hospital leadership roles. The specific research problem addressed in this study is the challenges of women of color advancing in hospital leadership roles and their impact on patient outcomes.

The literature review in this study provides information that senior hospital leaders and hospital human resources professionals can use when developing leadership development and support programs for women of color advancing in health care leadership roles. This chapter includes existing research and information about issues in workplace diversity including information on the interactional model of cultural diversity theoretical framework. This chapter also includes the literature review strategy, definition of leadership, research and data on the importance and benefits of a diverse health care workforce, information on the impact of leaders on health care organization success and need for women of color in helping professions leadership, and discussion of need for senior leaders to address challenges of women of color advancement in health care leadership. The last part of this chapter covers the challenges preventing women of color

from advancement, need for senior leaders to address challenges of women of color advancement in health care leadership, impact of leadership on patient outcomes and the impact of women of color in health care leadership on patient outcomes.

Literature Review Strategy

The literature review has several purposes, including showing other related studies, connecting the new study to the field, filling gaps, demonstrating the study's importance, and comparing it to other studies (Creswell & Creswell, 2018). The literature review also helps chronicle the topic's history, identifies impacts on the phenomenon, assists with acquiring new and original perspectives on the topic, helps discover the language of the field, and finds intersecting topics (Ravitch & Carl, 2021). The mainly electronic and online literature search for this study used various sources. However, the primary source was the Thoreau Multi-Database Search. Other sources for literature and information included MEDLINE, ProQuest Central, ProQuest Dissertations, SAGE, Marin County Free Library system, and LINK Encore. Search terms included *health*, *health care*, *hospital*, *women of color*, *women*, *minorities*, *African American*, *Latino*, *Asian*, *diversity*, *leadership*, *helping professions*, *career*, *advancement*, *patient outcomes*, and *health outcomes*.

Available literature for this specific topic of interest was limited. Although a rigorous search yielded several hundred documents for consideration, very few had direct relevance. Not much has been written about the experiences of women of color in health care leadership. However, issues of diversity in the workplace and issues on women's career advancement are well studied. There is also not a lot written about the impact of

leadership on patient outcomes. The following table shows a breakdown of the sources used for the literature review for this study.

Table 1

Sources of Literature

Sources	2018–2022	2015–2017	1993–2014	Total
Peer Reviewed Articles	63	8	1	72
Books	11	2	1	14
Fact Sheets/Reports	3	2	0	5
Total	77	12	2	91

Using the search terms indicated above, a total of 91 sources including 72 articles, 14 books and five fact sheet/reports were used for this study. Eighty-eight of the sources used were five years old or less with the majority (77) written between 2018 and 2022. The older sources were foundational references for the theoretical and social change frameworks. Only peer-reviewed scholarly journals/articles were reviewed.

Theoretical Framework

The theoretical framework for a study consists of the hypotheses and/or theories that builds a frame for the study's objectives and conclusions (Merriam & Grenier, 2019). Many frameworks were considered for this study, but the IMCD is the most suitable theoretical framework for the study of women of color advancing in hospital leadership and the impact on patient outcomes. The IMCD posits that an organization's diversity environment impacts organizational effectiveness directly and indirectly (Cox, 1993). The environment is affected directly through organizational interactions such as advancement supports and indirectly through individual career advancement and patient health outcomes.

The IMCD model affirms why it is essential to manage workplace diversity. Focusing on building organizational environments with an understanding of diversity and enhanced cultural intelligence leads to better team performance and creativity (Kadam et al., 2020). According to Cox (1993), the IMCD model states that the diversity climate consists of three parts: individual factors, group factors, and organizational factors. The individual level factors include personal identity structures, prejudice, stereotyping and personality type. The group level factors include cultural differences, ethnocentrism, and intergroup conflict. The organization level factors include organizational culture, acculturation processes, structural integration, informal integration, and institutional bias. Cox suggested that the diversity climate in an organization can influence the career experiences and career outcomes of individuals through how people feel about their work and actual career accomplishments. Consequently, those individual outcomes will impact organizational outcomes. This model provides an ideal frame for looking at individual women of color experiences as part of a group, advancing as part of the hospital organization and impacting patient (organizational) outcomes.

Literature Review Findings

Definition of Leadership

Leadership is a process that occurs in groups, requires influence, and involves shared purposes (Athanasopoulou et al., 2018). Leadership is a practice of influence over the group to achieve shared goals (Packer et al., 2018). Leaders are most successful when they focus on being change agents rather than being administrators of established methods or experts of management skills (Boyle & Mervyn, 2019). Hospital

administrators who focus on understanding what is happening and what is needed at the ground level have the best opportunity for success (Freed, 2017). Great health care leaders are expert negotiators, able to bring people together, and create a case for change (Boyle & Mervyn, 2019). Health care leaders have credibility, display honesty, build trust, and are patient focused. In brief, leadership is a process in which a group is able to achieve a common goal through influence from an individual (Nair, 2018).

Importance of Cultivating a Diverse Health Care Workforce for the Future

Hospitals and health care systems impact the U.S. economy, employing more than 6 million individuals and purchasing more than a trillion dollars in goods and services (American Hospital Association, 2021). The highest expense for most hospitals in the United States is paying staff wages and benefits, which account for 56% of all hospital expenses (Michas, 2019). But the World Health Organization (2021) estimates a projected shortfall of 18 million health workers worldwide, including the United States, by 2030. Many conditions will contribute to a shortage in the U.S. health care workforce in the coming years. That includes an aging population and an increase in chronic diseases and mental health issue (American Hospital Association, 2021). Advancements in the delivery of services will also put more pressure on the health care workforce from which they will need to be more supported.

To ensure support for the health care workforce, to attain improved health care outcomes, to meet the demands of greater access to insurance coverage, and to support the change in demographics, leaders must ensure diversity in the health care workforce (Persaud, 2020). Additionally, organizations must have diverse leadership including

senior leaders and board members who can provide different perspectives and ensure culturally competent care to support the increasingly diverse population (Silver, 2017). Organizations must make managing diversity, including designing, and implementing systems and procedures to maximize the advantages of diversity, a high priority (Cox, 1993).

Benefits of Diversity in the Workplace

Queensborough Community College in Bayside, New York, defined diversity as an idea that includes both acceptance of differences as well as respect for differences (Davis, 2018). Diversity can also be defined as acknowledging dissimilarities in demographics, such as race, ethnicity, sex, age, and education of workers, teams, leaders, or customers (Gomez & Bernet, 2019). With African Americans accounting for only 2% of the U.S. workforce (while accounting for 13.6% of the population), and Latinos occupying 5% of the workforce (while accounting for 17% of the population), most large organizations in the United States cannot boast of a diverse workforce (Fulp, 2018). Even with the acknowledgement of the importance of diversity by such influential groups as the American Hospital Association (2021), there is still a need for increased education for leaders about the benefits of a diverse workforce.

When organizations emphasize diversity and inclusion in the workforce, they allow for a vast pool of talent that brings unique experiences, differing viewpoints, and special qualifications to enhance innovation (Chyu et al., 2021). Similarly, workforce diversity leads to deeper consideration of data and facts and better acknowledgment of variations in the outside world (Gupta, 2019). A focus on diversity brings more

consciousness to employees of their biases and encourages them to pay closer attention and be more culturally competent (Gupta, 2019). Diversity also fuels innovation, improves employee morale and retention rates, and helps connections with worldwide markets (Fulp, 2018). Organizations that are more racially and culturally diverse are 30% more inclined to see monetary success above similar organizations that are less diverse (Fulp, 2018). Diversity in the workplace has 10 financial benefits (Kerby & Burns, 2012, as cited in Davis, 2018). These benefits include economic growth, increased market share, increased opportunities to compete on the global market, and achieving the full potential of the business. Diversity is seen as a "competitive differentiator" where every 10% increase in management or leadership diversity produces a 0.8% increase in returns (Fulp, 2018). When the workplace is diverse, it also has an improved opportunity for obtaining a qualified candidate pool when recruiting, decreased turnover, a more creative and innovative workforce, adaptability to changing customer demographics, increased connections with new business owners, and moving the economy forward when it comes to business ownership (women of color own 1.9 million companies, generate $165 billion in annual revenue and have 1.2 million employees). Diversity in health care leadership has been seen as contributing to increased productivity, improved pay equity, and better staff retention (Fulp, 2018; Poole & Brownlee, 2020).

Diverse health care teams also work together better, which leads to better quality of care and better health outcomes (Wooding et al., 2020). Researchers such as Gomez and Bernet (2019) and Livingston (2018) have shown that patients have better health outcomes when cared for by diverse teams. Patients from minority groups show better

compliance and higher satisfaction when their provider is also from a minority group (Wooding et al., 2020). When the workforce reflects the patient base, the results are stronger patient-doctor relations, better communication, and more effectively designed care plans (Livingston, 2018). Additionally, with a more diverse workforce the patient encounters an organization that understands their needs, removes barriers to care, and is more responsive (Livingston, 2018). Organizations that invest in diversity can look for improved communications, decision-making, creativity, and innovation, and better patient and population health outcomes (Etowa & Debs-Ivall, 2017). There are positive correlations between diversity, better quality care, and fiscal consequences for health care organizations (Gomez & Bernet, 2019).

The principles and ideals of an organization's employees form the organization's behaviors (Davis, 2018), but the organization must seek collaboration from all stakeholders if they want to promote diversity (Etowa & Debs-Ivall, 2017). Organizations that emphasize diverse, supportive cultures see fewer problems associated with any change initiative (Gomez & Bernet, 2019). The positive impacts of diversity efforts, however, are achievable only when individuals and teams are open to different viewpoints and outlooks from people who differ from them (Packer et al., 2018).

The positive value of diversity also applies at the leadership level. Ensuring diversity and inclusion in leadership has many merits (Chyu et al., 2021). More diversity in leadership positions allows for different viewpoints and opportunities for sharing new thoughts and concepts (Chisholm-Burns et al., 2017). A diverse health care workforce can ensure more accessible and equitable health care and accountability for hiring and

advancing people who are not part of the majority group into management (Etowa & Debs-Ivall, 2017). Diversity in leadership has been linked to more successful population health initiatives and the inclusion of diverse viewpoints in decision-making (Poole & Brownlee, 2020). Given this overwhelming amount of information, many hospitals and health care organizations have officially made their commitments to diversity and equity (Choi & Rustgi, 2021).

Impact of Leaders on Health Care Organization Success

Leadership is crucial to organizations because it impacts staff satisfaction, commitment, and productivity (Hussain & Khayat, 2021). Quality leaders believe in life-long learning and continual growth (Boamah et al., 2018). Great leaders communicate effectively at all levels of the organization, define what is most important, set the vision, and put the organization on the correct path to achieving the vision (Williams, 2019). Effective leadership is especially important in health care because it correlates with organizational success in areas such as patient safety and health outcomes (Curry et al., 2020). Trustworthiness is an essential virtue for all health care organizations, and leaders are vital in cultivating and promoting trust internally and externally (Jain et al., 2020).

Transformational leadership is a relational leadership style in which a leader positively influences followers by setting high standards of conduct, leading by example, and winning trust through intellectual inspiration, coaching and development, and vision sharing (Boamah et al., 2018). Men are usually known for being more dictatorial and transactional, as stated by Chyu et al. (2021). They wrote that women are typically seen more as transformational leaders who support leader development through mentorship

and encourage individuals to find innovative solutions to problems. Women are more likely to demonstrate transformational versus transactional leadership styles (Gillard & Okonjo-Iweala , 2021). Women more often use a transformational leadership style that is likely to connect well with a contemporary organization, which favors supporting employee morale and performance, as it promotes employee optimism, drive, and trust in leadership (Chisholm-Burns et al. ,2017).

As there is an increased interest in hiring more transformational leaders, hospitals and health care organizations must look to women and women of color. Women of color often possess the characteristics of transformational leaders. However currently, ninety-eight percent of senior leaders in health care organizations are White (Banister et al., 2020). People of color fill less than 1% of senior health care leadership positions (Silver, 2017). That leads, as stated by Silver (2017), to a situation in which individuals who may fail to notice or understand vital racial or ethnic cultural norms create and implement policies that determine access to health care services. Having more women of color in leadership roles can fill this gap.

Need for Women and Women of Color in Helping Professions Leadership

In the United States, as of 2015 women are more than 50% of the population, earn 60% of the bachelor's and master's degrees, and hold about 50% of the total jobs (Chisholm-Burns et al., 2017). Women make as much as 80% of household health care decisions and comprise 77% of all hospital employees, 92% of nursing school students, and 51% of U.S. medical school students, yet they continue to be under-represented in health care senior management positions (Belasen et al., 2021). Women working in

overall management positions increased from 17% to 51% between 1971 and 2012 (Seo et al., 2017). However, as of 2017, women still hold only about 25% of health care leadership roles from middle manager positions such as a pharmacy manager to vice president to hospital chief executive (Chisholm-Burns et al., 2017).

Women are 30% less likely to advance from entry-level to management than men, as stated by Chisholm-Burns et al. (2017). They noted that companies are thereby missing opportunities to develop and promote some of their best future leaders. Chisholm-Burns et al. reported that women hold only 18% of hospitals' top executive positions, and similarly, Farrugia et al. (2020) stated that promotions for women in academic medicine do not materialize at the same rate as for men.

Although the number of women holding senior management positions remains low (just nine percent of worldwide chief executives), women have proven their interest in taking on senior leadership positions through higher rates of graduation from undergraduate and graduate programs than men (Athanasopoulou et al., 2018). Women and men start their careers equally confident about promoting to the senior levels; however, women's self-assurance seems to decrease over time (Chan, 2017).

Many women look for work, career opportunities, and jobs where they find their life purpose and meaning (Marks et al, 2018). What some refer to as a *calling* is a central piece of career selection and can lead to opportunities for women to achieve life-work satisfaction. Many times, a family member starts and/or guides a woman's decision of a career path. A strong desire to help others, gain a sense of purpose, and make the world a better place might also determine the calling. People from disadvantaged groups

sometimes find a *calling* to service-oriented careers to address or correct societal inequities.

Although many women attain advanced education and find their *calling* in sectors of helping professions, such as education and health care, they do not hold many senior leadership roles such as chief executive, board member, and president (Chisholm-Burns et al., 2017). Historically in the United States, women and people of color have been overly represented as educators at most education levels, yet white men lead in higher education (Freeman et al., 2019). Even with their high representation in education fields, women and people of color are less likely to be considered for advanced positions due to lack of training, coaching, and mentorship (Freeman et al.).

The growth in the health care field over the past 100 years is primarily because of women; they hold 76% of full-time health care jobs in the United States (Cheeseman Day & Christnacht, 2019). In some professions, such as midwives and medical assistants, women make up more than 90% of the workforce (Cheeseman Day & Christnacht). Through their high percentages of women workers, the education and health care fields have long held gender diversity for staff, but this needs to extend to women of color in leadership roles.

Challenges Preventing Women and Women of Color from Advancement

Advancement for women and women of color in health care does not come easy. Many challenges prevent them from advancing in health care leadership. Chisholm-Burns et al. (2021) discussed several of them. Men are more likely to be assigned to general management positions versus specialized positions, which are considered better

preparation for advancement opportunities. Men are also more likely to achieve their first leadership position at a more senior level, such as vice president. Women have fewer opportunities to advance from lower-level positions. Also, gender stereotyping and conscious and unconscious bias prevent women from advancing to senior leadership positions.

Many barriers to women's health care leadership opportunities exist, including lack of family support, work/life balance, gender bias, culture, and lack of social support (Kalaitzi et al., 2019). Chisholm-Burns et al. (2021) mentioned the "glass ceiling," a commonly used term to describe the obstacles many women face in that they are allowed to advance only so far in the leadership ranks before being stopped. They pointed out the glass ceiling not only hurts individual women but also robs organizations of the many advantages of leadership gender diversity. Women experience the glass ceiling as well as the "leaky pipeline" influenced by lack of mentorship and recognition (Wooding et al., 2020).

Athanasopoulou et al. (2018) had come to similar conclusion earlier, stating that women face many negative challenges in career advancement, including inadequate network connections and deficient sponsorship. Additionally, when women do compete for higher positions, they may be judged as aggressive when they negotiate as well as men do, and both men and women may label them as less likable, which can have career consequences per Belasen et al. (2021). They also reported women competing for advancement face unconscious bias and must balance the expectation of being friendly,

caretaking, and “liked” as a stereotypical woman rather than being strong and respected as a stereotypical male leader.

Athanasopoulou et al. (2018) wrote that women often must be more experienced and competent than men to be considered for senior leadership roles, much like Chyu et al. (2020) stating women report feeling they must have specific skills or experiences or be invited or endorsed before seeking advancement. In some professions, women, and people of color face difference standards of competency (Skarupski et al. (2017) . In some helping professions underrepresentation by women in leadership may be due to lack of self-confidence or possessing lower self-esteem because of higher expectations (Herbst, 2020).

Within health care specifically, women have more difficulty than men finding role models at the senior levels of academic medicine, and fewer women are involved in hiring for senior positions (Farrugia et al., 2020). Women are much less prone to advance to senior positions than men (Belasen et al., 2021). Women face gender stereotyping and male domination of senior leadership roles (Coleman, 2020). When women are promoted, they are usually moved into less strategic and less visible roles, such as human resources, risk, nursing, and legal (Belasen et al., 2021). Administrators often offer women positions called “glass cliff” appointments that set them up for failure (Barnes, 2017). These “glass cliff” roles often include impossible, un-resourced or under-resourced expectations that women often encounter in the workplace. Another advancement challenge women face is sexual harassment. For many reasons, including fear of professional retaliation, sexual harassment is underreported in medicine (Coe et al., 2020).

Women of color face even more challenges. They are highly educated, yet still face barriers to career advancement and do not hold as many leadership positions as white women (Harts, 2019). African American women encounter a "concrete ceiling" representing the level of challenge women of color face in advancing to leadership roles (Barnes, 2017). However, they still believe they can lead just like their white counterparts (Harts, 2019). Marks et al. (2018) theorized that women of color who have higher amounts of critical consciousness have higher career aspirations and would be better able to cope with oppressive experiences and sociopolitical obstacles. Women of color show strong abilities to change, adapt quickly, innovate, and lead, all beneficial organizational skills (Sims & Carter, 2019). Women of color have natural leadership tendencies, transformational leadership styles, and a yearning to use those leadership skills in the helping professions.

Despite their contributions and skills, women of color face many barriers and they do not advance at the same rate as their peers (Domingo et al., 2020). In general, women of color make up almost 14% of the population but occupy less than 11% of management positions and less than 4% of executive positions in U.S. Fortune 500 companies (Harts, 2019). Women of color face the challenge of the intersectionality of gender and race, which often leads to discrimination and stereotyping that threaten opportunities for advancement (Belasen et al., 2021). Intersectionality theory posits that people are negatively affected by multiple sources of oppression based on race, gender, sexual orientation, class, religion, and other identifications (Corneille et al., 2019).

Women of color face prejudices, in-house organizational obstacles, and stereotypes that prevent them from advancing into leadership positions (Bouabdillah et al., 2021). They must face and overcome stereotypes that lead to discouragement (Barnes, 2017). African American women leaders struggle with being a "double minority" and people judging them on their race and their sex, and they encounter harsh punishments for mistakes (Barnes, 2017). Women of color in health care believe that they face more scrutiny in their work than other groups leading to a feeling of victimization (Bouabdillah et al., 2021).

Many internal and structural factors cause women of color to be underrepresented in health care leadership and suggest they are "othered" (Bouabdillah et al., 2021). Othering is a form of discrimination when individuals or groups are looked at and treated as inferior because of their visible differences (Reifman and Huynh, 2021). Bouabdillah et al. found that women of color experienced marginalization and exclusion leading to perceived discriminatory treatment regarding access to management opportunities. They faced many obstacles in gaining leadership positions, including a lack of leadership development and mentoring, resulting in invisibility.

Women of color are often subject to the "minority tax," which is the burden of extra responsibilities, such as mentoring, placed on minority faculty in academic medicine in the name of diversity, but which can hamper opportunities for advancement (Coe et al., 2020). Women of color in education carry a heavier load in teaching and service responsibilities, and those in science, technology, engineering, and math (STEM) contributed more time to mentoring and service than men did (Corneille et al., 2019).

Domingo et al. (2020) found three service-related barriers to advancement for women of color including (1) unfair distribution of service responsibilities, (2) undervaluing of service by the institution and (3) lack of understanding of the role of service in career advancement.

People of color who do advance in health care often get trapped in middle management and are unable to progress to senior positions (Silver, 2017). When they do attain senior leadership positions, those are often serving low-income communities (Banister et al., 2020). Women of color are often offered the most difficult positions and feel required to accept them to prove they can do the job even when there is no chance of fixing the bad situation (Barnes, 2017).

In health care, women of color struggle with issues of race, diversity, and inclusion, and risk being considered a troublemaker for calling attention to issues or concerns (Livingston, 2018). Women and people of color experience many negative consequences from tokenism, such as isolationism, invisibility, and amplified racial identification (Sims & Carter, 2019). Non-White leaders are less likely to be positively viewed and supported in organizations with few people of color. In organizations without mentoring, they experience increased isolation feelings (Freeman et al, 2019).

Health care organizations can make improvements in the areas of inclusion and isolationism. Diversity initiatives do not often address the work satisfaction of women of color in leadership (Barnes, 2017). This can be corrected by creating engagement programs specifically for women of color. Health care organizations invest in cultural competency training for those who provide face to face services to patients but forget to

support leaders who are supposed to be engaged in workplace relationships (Etowa & Debs-Ivall, 2017). This can be corrected by building and presenting cultural competency training for and training about women of color in leadership.

Need for Senior Leaders to Address Challenges of Women of Color Advancement in Health Care Leadership

Top organizational leaders must build a culture of diversity, inclusion, and collaboration to achieve organizational success (Belasen et al., 2021). To fix health care's diversity challenges, leaders need to talk more openly about race and racial issues (Livingston, 2018). Senior leaders in academia, business and industry have the responsibility to establish diversity, equity and inclusion efforts and ensure such are integrated into the organization culture (Alfred, Ray & Johnson, 2019). Packer et al. (2018) stated that climates of inclusion have three main attributes: efforts that reduce bias, such as employment and diversity practices; openness to and acceptance of differences; and inclusion in decision making. They stated that organizational leaders should develop a shared vision for "what we are striving for." Davis (2018) recommended making a detailed plan of action for organization-wide diversity and inclusion once they have a vision, with investments in team building and leadership skill development being paramount. She also mentioned engagement with other leaders from different organizations with different leadership styles can help skill development.

Demolishing inequities includes full transparency, learning and training, policy transformation, accountability, and close supervision (Corneille et al., 2019). Organizations have a responsibility to ensure that women of color have opportunities to

advance in business and industry and that senior leaders must ensure accountability for diversity and inclusion efforts, which can include establishing hiring practices to ensure a diverse candidate pool (Alfred, Ray & Johnson, 2019). Ongoing training for leaders on completing fair evaluations and avoiding microaggressions can help create a more inclusive work environment, as stated by Corneille et al. (2019). They also stated implicit bias training is effective in combating bias in hiring practices. Senior leaders can endorse revised mission statements and policies that promote women into leadership roles (Athanasopoulou et al., 2018). And to achieve complete organizational change for women of color, organizations must acknowledge intersectionality and employ transformational tactics (Corneille et al., 2019). Transformational tactics could include many leader-directed efforts such as developing a sponsorship program for women of color. Leaders can support people of color through development opportunities, mentoring, and increasing cultural competency, especially in White staff (Bouabdillah et al., 2021).

Human Resources teams should develop strategic goals to ensure more diversity in managerial roles (Seo et al., 2017). They can design recruitment materials that target leaders without regard to gender identity (Athanasopoulou et al., 2018). Senior leaders can strive for early identification of potential leaders with desired leadership values, traits, and abilities (Boyle & Mervyn, 2019). Leaders must promote leadership development that occurs through "the doing," moving from a taught curriculum to an experience-based format (Boyle & Mervyn, 2019). That can be in conjunction with creating an environment where everyone feels safe to communicate and share their

personal experiences and knowledge for the betterment of the organization (Gupta, 2019).

Human Resources can support women specifically by helping them build networks that aid professional advancement and by developing organizational, non-gendered stereotype leadership policies (Athanasopoulou et al., 2018). Executive coaching can be offered as part of a leadership development program to assist women in accepting their identities as leaders and embracing their leadership style (Athanasopoulou et al.). Senior leaders need to understand the importance of role models when hiring leaders (Bouabdillah et al., 2021). In the early part of their careers, support networks and mentors are critical to inspiring women to advance to leadership roles (McCullough, 2020). A mentorship team can assist potential leaders in identifying and applying for the most appropriate openings (Coe et al., 2020). Organizations can help women with high leadership potential find sponsors, not just mentors (Singh, 2020). Sponsorship occurs when specific advancement opportunities are shared and promoted with a group (Chyu et al., 2021). Another way to promote equity is through amplification, where women promote other women at work and ensure that they are heard and get credit for their ideas (Chyu et al., 2021). Finally, leaders must acknowledge the importance of social capital and encourage relationships and social ties between minority staff and management (Bouabdillah et al., 2021).

Organizations should find approaches to emphasize the value that underrepresented leaders bring to their organizations (Thomas, 2019). Health care organizations need to see underrepresented minority groups as valuable resources and

assist in their continued growth through leadership development and mentorship programs (Zambrano, 2019). Curry et al. (2020) stated that there is a worldwide acknowledgment of the importance of leadership development to achieve the goals of health care organizations. They explained leadership development includes focusing on the relationship aspect of work, including working collaboratively and with diverse groups. Athanasopoulou et al. (2018) wrote that leadership development programs do not sufficiently help women develop leader identity because of limited examples, established career paths for different genders, and biases. One solution they recommended is that women should early on think of themselves as leaders and ask for promotions as men do.

Impact of Leadership on Patient Outcomes

Workplace inequities are more concerning in health care because they can negatively impact patients and health outcomes (Farrugia et al., 2020). As previously stated, transformational leadership has many positive aspects. One way in which leadership can influence patient outcomes is through transformational leadership, as stated by Boamah et al. (2018). They explained transformational leadership has been proven to be crucial in forming supportive work environments where health workers are empowered through organizational structures to ensure the best patient care. the supportive environment allows workers to become more confident and connected to their work, leading to improved patient outcomes. Patients experience fewer adverse events, such as falls and infections, when cared for by nurses who work in supportive practice environments. Transformational leaders motivate and inspire followers to achieve high expectations and support a collective vision, and they look after the needs of followers by

creating a supportive environment for growth. Additionally, Boamah et al. stated that these leaders use evidence-based practices and encourage workers to seek new solutions to problems and better ways to provide care. They promote the benefits of collaboration, open communication, and innovative thinking. One part of transformational leadership is authenticity. Authentic leadership also results in greater trust by staff in leaders and is associated with less nurse-assessed adverse events.

Par et al. (2021) provided similar recommendations under relational leadership styles. These lead to better staff work experiences, improved patient safety, and increased patient satisfaction. Relational leadership styles emphasize relationships and include coaching and affiliation. They are associated with positive patient outcomes. The combination of high trust in the manager and high use of care pathways through relational leadership is associated with fewer medication errors. This style is also associated with expanded investment in the nurse-patient relationship, such as the nurse provides a different level of attentiveness to the patient, thereby preventing falls. The relational leadership style was associated with increased work fulfillment, dedication and loyalty, cooperation, and confidence-building (Cziraki et al, 2020)

Supporting relational leadership through increased diversity in health care leadership will improve patient outcomes and strengthen links between the health care organization and the community (Persaud, 2020). When minority leaders can affect resource decisions impacting underserved groups, they can sway organizational policies to reduce health disparities. Leaders who are people of color are more likely to have experience with diversity and inclusion issues and more likely to support diversity

initiatives. A diverse leadership team is an organizational asset that contributes to innovation, increases patient satisfaction, and drives improved health outcomes.

Poole & Brownlee (2020) stated health care leadership diversity leads to improved data analytics and the capability to impact social determinants of health. Through improved patient and community engagement, they wrote, diverse health care leadership can elevate the ability of patients to navigate the health system leading to enhanced utilization. Etowa and Debs-Ivall (2017) showed that combining physician leadership training with a diversity program for the entire organization allowed for collaborations that could positively impact the overall quality of health services.

Banister et al. (2020) believe that with the implementation of the Affordable Care Act and the expansion of health care access across racial, ethnic, and diverse social frames, came the need for the growth of diversity among health care professionals to deliver culturally appropriate care. They explained that health care organizations and policymakers should accept that culturally competent training programs can be linked to better patient experiences. As there is more transparency on hospital quality and patient outcomes, health care competition will increase and encourage organizations to strive for cultural competency. Banister et al. discussed that in 2014, the United States surgeon general formally introduced a strategy for reducing health inequities that involved recruiting and training persons from underrepresented racial and ethnic backgrounds for health care roles. There are five possible strategies to improve cultural competency: recruit and maintain staff members from diverse backgrounds; ensure cultural competency training for all health care providers; ensure prolific use of interpreter

services to ensure effective patient-provider communications; develop culturally appropriate health education materials; and provide culturally specific health care locations.

Impact of Women and Women of Color in Health Care Leadership on Patient Outcomes

In one study, over 80% of senior health care executives stated that racial diversity on executive leadership teams positively impacts access to care for people of color while at the same time acknowledging that people of color are underrepresented in health care senior leadership (Silver, 2017). Increasing women and people of color representation into white male dominated health care fields can expand access to health care in underrepresented populations (Banister et al., 2020). In their study of Texas schools, Gomez & Bernet (2019) found student performance was significantly improved when there was diversity in the top management team and a closer racial representation between management and students. Given the similar importance of communication between the fields of education and health care, they suggested a similar potential impact on patients when diverse hospital leadership design programs, distribute resources, and decide on services.

In health care, interpersonal skills translate to better health outcomes, per Belasen et al. (2021). Their study showed that women chief executive leaders improved the relational care experience faster than male senior executives. They also found diversity at the top leadership levels spreads to all levels of management, advances health care fiscal outcomes, and confirms stakeholder support. Glass & Cook (2018) state that when

women hold senior leadership positions, there are sounder business procedures and a stronger equity culture. The Institute of Medicine and the National Institutes of Health extols the value of diverse medical teams in improving health outcomes by connecting culture and language separations (Gomez & Bernet, 2019). Bouabdillah et al. (2021) found minority nurses add tremendous value to the hospitals where they work and committing to a diverse workforce in leadership roles can ultimately positively affect patient care. Minority nurse leadership oversees diverse populations' culturally competent care and provides effective role models for nurses. They also give trusted education and advice in providing health education to minority populations.

Health care organizations with leadership teams who all think and look the same and with physicians who do not have experiences similar to the populations they care for will be challenged to change health inequities caused by social determinants of health and positively impact health care outcomes (Livingston, 2018). Khuntia et al. (2022) state that a diverse health care workforce is needed to increase the reach of care and improve satisfaction with care for communities of color. A workforce that reflects the diversity of its patient population is better able to promote trust and ensure conformity with medical advice while lessening bias and resulting in better health outcomes (Livingston, 2018).

Summary

In Chapter 2, evidence was presented to support that diversity has a positive impact on health care organizations and facts that support when women of color are advanced to health care leadership roles there is a positive impact on patient outcomes. This chapter also provided information on the interactional model of cultural diversity

theoretical framework, data on the benefits of a diverse health care workforce, information on the impact of leaders on organizational success, need for senior leaders to address challenges of women of color advancement in health care leadership, and the impact of women of color in health care leadership on patient outcomes.

Data in this chapter confirm that diversity has many organizational benefits and yet women of color face many barriers to advancing to leadership roles in health care. Barriers include lack of cultural and gender understanding and group acceptance, lack of training opportunities and lack of role models and sponsorship. Information presented shows that women of color make great transformational leaders and transformational leaders are greatly needed in health care to ensure positive organizational (patient) outcomes. Senior health care leaders and human resources professionals must acknowledge the challenges of women of color, seek to gain greater understanding of needs and create innovative solutions.

The literature review presented in this chapter includes relevant information reviewed and synthesized from previous researchers who addressed issues and concerns regarding themes related to or similar to health care workplace diversity and impacts on patient outcomes. The interactional model of cultural diversity framework was also reviewed and provides an accurate model including individual, group and organizational factors from which health care leaders can build solutions to identified challenges. The results of this chapter demonstrate a gap in the literature and the importance of the current study regarding women of color advancing in hospital leadership and their impact on patient outcomes.

In Chapter 3, the study's investigative methodology for gathering the perceptions of women of color advancing in health care leadership and their impact on patient outcomes will be explored. This includes identifying the sections of the study: purpose of the study, research and design method, population, setting, sample, participant protection, data collection, research questions, interview protocol, data analysis, and ethical procedures.

Chapter 3: Research Method

In this study I examined the perceptions of women of color advancing in leadership roles in hospitals and their impact on patient outcomes in California hospitals. Research has shown that additional information is needed to understand how diversity in hospital leadership can result in improved patient outcomes (Banister et al., 2020). The participants' voices will illustrate the many challenges they encountered within their chosen career fields, physical settings, mental and social environments and more. Chapter 3 addresses the methodology of exploring the perceptions and experiences of women of color along their career paths and their impact on patient outcomes. This chapter is organized into the following sections: research and design method, research questions, population, setting, sample, participant protection and informed consent, data collection, interview protocol, recruitment and participant selection, limitations of the study, dependability, trustworthiness, credibility, transferability, confirmability, data analysis, ethical procedures, and summary.

Research Design and Method

This study's research method was a basic qualitative research approach. Basic qualitative inquiry has disciplinary roots in human science, constructionism, and phenomenology (Patton, 2015). The characteristics of qualitative research include a natural setting, the researcher as the key mechanism for data collection and analysis, numerous data sources, logical data assessment, learning from participants, role reflection, and complete story and report (Creswell & Creswell, 2018). The benefit of qualitative interviewing is the delivery of trustworthy findings, accuracy, and

transparency in reporting (Patton, 2015). I used thus approach to answer the following RQs:

- RQ1: What are the perceptions of women of color advancing into leadership roles within hospitals?
- RQ 2: How do women of color perceive diversity at the hospital leadership level and its impact on patient outcomes?

Methodology

Population, Setting and Sample

The population for this study was women of color who currently or previously have held leadership positions at or above the level of manager at hospitals in the state of California. The researcher must pay close attention to issues of representation including participant social identities, experiences, and roles as they connect to the study (Ravitch & Carl, 2021). Purposeful sampling was used for this study, which emphasizes selecting information-rich cases where research and analysis will amplify the questions under study (Merriam & Grenier, 2019). A purposeful, select number of women who self-identify as women of color and hold a leadership position in California hospitals for at least two years were invited to participate in this study. The sampling size was estimated to be at least 15 women of color who were suitable and met the study's criteria. The setting for the study was a quiet room using a virtual platform (Zoom) for the interviews.

Protection of Participants and Informed Consent

The most crucial aspect of protecting the participants, the selected women of color, was to ensure that participant information was highly safeguarded and participant

responses were de-identified. During participant selection, all participants of this study were assigned a participant number, which was used throughout the study in lieu of the participant's name. The participant names associated with the assigned numbers are kept on a password-protected flash drive, in a locked file, in a locked room. The protected files will be maintained for the required maintenance period as indicated by the Institutional Review Board (IRB) and will be destroyed in accordance with proper destruction procedures at the indicated date.

One of the critical steps of ensuring participant protection is gaining informed consent. In general, consent means that research participants make a voluntary agreement to be involved in research before it begins and informed consent adds a participant clear understanding of what is being asked of them as a participant (Ravitch & Carl, 2021). Research participants must receive an informed consent form, detailing the study, explaining and confirming that no personal or identifying information would be disclosed to anyone other than the IRB who may seek and inquiry and inspection of the research questions. A consent form should (a) explain that study participation is voluntary and that the participant may chose to leave the study at any time, (b) explain the expectations for participation in the study including time obligations, (c) explain potential risks of participating in the study, and (d) explain the level of data and report confidentiality (Ravitch & Carl, 2021).

There is also legislation that governs the protection of vulnerable populations, including special considerations which affect how research is conducted (Pope & Mays, 2020). Although this study population has been historically marginalized, due to their

level of education and economic status, the participants of this study were considered at a low level of vulnerability. I ensured that all participants receive the highest level of information about the study available and were individually informed of the protection plans.

Data Collection Procedures

Data collection in the qualitative research generally involves interviews, observations, document review, or a combination of these methods to assure a full understanding of the experiences of the participants (Creswell & Creswell, 2018). Data for this study were collected through individual in-depth structured interviews conducted virtually. I used audio/video recording and concurrent note taking, reflective journaling, listening to recording, and amending notes and thematic review (see Ravitch & Carl, 2021). A virtual platform (Zoom) and license was obtained specifically for these interviews and used to schedule, meet with and record (audio and visually) interviews. The developed interview guide was used for all interviews. Interviewees were informed that they would be protected in the interview with the use of the IRB Office of Research and Compliance standardized invitation, which will be emailed to them. They were again reminded of their rights to privacy and the researcher commitment to confidentiality in the introduction part of the interview. After all questions are asked and answered, I again reminded the interviewees once more of the commitment to interviewee confidentiality and each participant was provided verbal appreciation and de-briefed following the interview. The de-briefing consisted of explaining next steps. All interviews lasted no than 60 minutes each.

Interview Protocol

The interview guide approach with standardized questions was used for this study. With the interview guide approach, subjects are specified upfront, using an outline form (Patton, 2015). The interview guide is appropriate to ensure organized, thorough, and unbiased interviewing of large numbers of people (Patton, 2015). The interview guide for this study offers three main parts: introduction, questions, and conclusion. Most questions of this interview guide are open ended. The interview guide allows for easier analysis of interview results (Patton, 2015).

Questions on this interview guide were drafted purposely to lead the research participant to answer the research question. The interview guide keeps the researcher focused on collecting data on a specific topic (Patton, 2015). For this study, interview guide questions were developed by analyzing the interactional model of cultural diversity model and the qualitative inquiry approach. The interview guide for this study is in Appendix B.

Validity and credibility are extremely important in research. Researchers must work diligently to ensure that what they do is reliable and can be repeated but it also thoroughly researched and developed to ensure high credibility. A pilot study can assist with validation of a main study (Ravitch & Carl, 2021). Reliability and credibility have at their foundation and core trustworthiness and transparency (Ravitch & Carl. 2021).

Other sources of data for the study included collecting the nuances (i.e., long pauses) and voice inflection of the interviewees through repeated reviews of the audio

interview recordings, review of field notes taken during the interviews, review of journal entries and review of other literature.

Recruitment and Participant Selection

The potential participants were recruited through colleagues, cold calling, and social media. None of the potential participants had a past or current supervisory or instructor relationship with me. Potential interviewees were sent an email inviting them to participate in the study. Preference was given to women of color who worked in a hospital leadership position for at least two years.

Data Analysis

Given the many challenges of manual coding, selection of a robust and user-friendly qualitative data analysis software program is particularly important. There are many options and choices available however different data analysis products have many different features. NVivo has the highest number of pertinent features and was selected as the qualitative data analysis research tool to be used for this study. Some of the most pertinent features for the researcher in deciding the suitable research tool are ease of availability, desktop access, ready customer support, full-scope training, importation, and exportation ability and more. NVivo has a strong and positive reputation for high quality output. The data analysis of the verbatim interview transcripts used descriptive coding. Saldana (2021) stated that descriptive coding condenses the basic essence of a passage with content that results in an explanatory topic. In addition to the codes, categories and themes will also be identified.

Trustworthiness

Trustworthiness and validity are foundations of certifying credibility and rigor in qualitative research (Ravitch & Carl, 2021). Trustworthiness and validity are often used synonymously. However, trustworthiness refers to the use of ethical practices (Urban & van Eeden-Moorefield, 2018). Validity is where the researcher checks for the accuracy of the findings (Creswell & Creswell, 2018). I ensured trustworthiness and validity throughout the study through transparency, repetition, multiple reviews, verification of data and informed consent.

Dependability

Dependability refers to data that is reliable, consistent, and stable over time (Urban & van Eeden-Moorefield, 2018). Researchers focus on dependability ensures that the research question will be answered (Ravitch & Carl, 2021). A good research design, such as the one in this study that uses a reliable qualitative approach, a consistent theoretical framework, and a stable methodical data collection, will ensure dependability. Data saturation was used in this study to ensure dependability. Data saturation is the point where the researcher is no longer finding new themes from the data (Ravitch & Carl, 2021). Data saturation was achieved during this study.

Credibility

Ravitch & Carl (2021) believe that credibility is the researcher's ability to consider all the intricacies and complexities that arise in the study. It also includes the researcher's ability to manage and explain unusual patterns. I was very observant regarding emerging patterns and unusual occurrences throughout the data collection

phase of this study. Due to the multi-dimensionality of the study, I paid close attention to the details to ensure credibility.

Transferability

Transferability is the way that qualitative research can be relevant or transferable to other circumstances or populations and at the same time maintaining its uniqueness (Urban & van Eeden-Moorefield, 2018). Transferability is similar to generalizability. Because the research design of this study is well developed, this research study is transferable to other industries and worksites other than hospitals and health care.

Confirmability

Confirmability refers to the need for qualitative findings to be relatively neutral, authenticated, and unbiased (Urban & van Eeden-Moorefield, 2018). Researchers need to understand how their biases affect their explanation of data (Urban & van Eeden-Moorefield, 2018). During this study, I remained self -aware and sought opportunities to explore personal biases in order to maintain confirmability. Another way to gain confirmability is to seek feedback from others including reviewers.

Ethical Procedures

Transparent communication with research participants is what makes the research study ethical (Ravitch & Carl, 2021). Poor communication with research participants can make the research process unethical as well. It is a critical piece of research is to carry out promises to participants. One of the usual promises of researchers to participants is to keep their personal information and responses attributed directly to them private. One of the ethical challenges of protecting privacy is also providing transparency of the research

process which is foundational for trustworthy research. Researchers must carefully balance participant privacy and research transparency at every step of the research process.

As stated by Ravitch & Carl (2021), harm to research participants can come in many forms such as:

- Putting undue pressure on research participants to engage in the research process.
- Providing inaccurate or misleading information about the purposes or goals of the research or data collection.
- Asking questions or reacting to participant responses in ways that could make them feel ostracized, criticized, or troubled.
- Asking work subordinates to participate in studies where they feel pressured.
- Not being clear about time requirements for the research upfront or changing time requirements along the way.
- Providing data that discloses the personal information that was promised to be protected.
- Researcher judgement displayed to research participants about their responses.
- Being too casual about gaining informed consent.
- Focus group placement that leads to discomfort.
- Inaccurate representation of participants.
- Failing to manage research informed information with publicly available information.

I minimized harm during this study in several ways. For example, I minimized contact with potential participants who originally agreed to participate in the interviews but could not be contacted at the time of the interviews. I was formal and consistent with the informed consent process. I did not ask any work colleagues to participate in the study. I was always on time for the interviews, and I ensured that the time allocated for the interview was more than adequate. Most importantly, I followed through on promises, secured participant privacy and minimized participant chance of harm throughout the process.

Another way to minimize potential harm to participants is for researchers to respect and not judge the experiences of others. It is unethical for the researcher not to examine and regularly monitor their own biases and how those biases might be influential as part of the research process (Ravitch & Carl, 2021). Throughout this process I was careful to monitor and control my own biases. I was able to stay neutral despite the answers provided by the participants. Another ethical challenge is how to ensure the ongoing care of research participants. Since qualitative studies deal with many emotional topics it is important that I consider the emotional needs of each participant as an individual. Knowing the potential responses that this study could elicit, I remained highly observant and mindful of each participant's emotional state throughout the process. I reminded participants of helpful support resources identified in the consent form.

Summary

This chapter addressed the methodology used to investigate and report the perceptions and experiences of women of color advancing in hospital leadership and their

impact on patient outcomes. This chapter has detailed the following areas: purpose of the study, research, and design method, research questions, population, setting, sample, participant protection and informed consent, data collection, interview protocol, recruitment and participant selection, limitations of the study, dependability, trustworthiness, credibility, transferability, confirmability, data analysis, ethical procedures, and summary. These areas ensured study completeness.

Chapter 4: Results

I examined the perceptions of women of color advancing in leadership roles in hospitals and their impact on patient outcomes in California hospitals. The RQs that I sought to answer through this study were: What are the perceptions of women of color advancing into leadership roles within hospitals and how do women of color perceive diversity at the hospital leadership level and its impact on patient outcomes? Chapter 4 will present an overview of the pilot interview, data collection and interview process, organization of the collected data, and thematic data analysis. The analytical focus of thematic analysis allows for the identification of themes associated with the research questions. Finally, data validity and trustworthiness including credibility, transferability, dependability, and confirmability of the data will be explored and summarized.

Pilot Interview

Prior to conducting the first interview, I conducted a pilot interview with an individual from the health care field who would not be participating in the actual study. Permission was sought and granted to produce an audio recording of this interview. The same interview protocols for the actual study were used during this interview including informing the participant of their rights to privacy. The interview was conducted and recorded over a virtual platform (Zoom) to confirm the viability of this medium. The participant was asked 14 questions to be used during the actual interviews.

The goal of the pilot interview was to gain an understanding of how the actual interviews might proceed and also learn insights into the flow and length of an average interview process. Piloting assists with the assessment of data collection instruments and

allows for further refinement of these instruments (Ravitch & Carl, 2021). It also allows for the identification resources needed or potential problems in collecting data or conducting the study (Creswell & Creswell, 2018). Piloting involves conducting a small-scale study that serves as a precursor of the larger study and allows for enhancement and improvement of the research design and methods (Ravitch & Carl, 2021).

Results of the Pilot Interview

In addition to gaining insights on the flow and length of the interview process, the pilot participant provided important initial information from the interview questions. I gained the first insights to the emotional impact of the interview questions on the participants. The pilot interview demonstrated the importance of gathering demographic information (race ethnicity and highest education level achieved) as part of the interview. Finally, the pilot participant recommended that I add one additional question: "How do other professionals you encounter as part of your work but outside your hospital respond to you as a woman of color in leadership?" This question was added to the final interview questions. Information from the pilot interview was not included in the final study.

Data Collection

Purposeful or purposive sampling allows researchers to purposely select research participants who meet certain criteria (Pope & Mays, 2020). Participants for this study were found by contacting known colleagues, recommendations from participants, cold calling, and social media. A quiet private room was used to conduct all interviews over Zoom. All interviews were completed using the established interview guide in about four weeks yielding 17 interviews. During one interview, I discovered that one of the

participants did not meet the criteria, so she was excluded from the final data analysis. This interviewee had not worked in a hospital as a leader for two years. She had worked in a hospital as a staff nurse, but she had only worked in a clinic as a leader, so she was excluded although the interview was completed. Sixteen interviews were allowed to go forward for the analysis. All interviews were recorded using the Zoom platform recording tool. After completing all the interviews, the audio recordings were uploaded into NVivo Transcription for transcribing.

Data Analysis

I reviewed and compared all 16 written transcripts to the audio recordings, making corrections to the transcripts as needed. The transcripts were then exported from NVivo transcription to word documents. To conduct manual coding and for later importing to NVivo, all interview questions and answers were input into one Excel spreadsheet. During this process I listened to the interviews again, read the transcripts, and kept a manual journal of observations and thoughts.

Saldana (2021) refers to initial coding as open coding, open ended approach or first cycle. I conducted a first cycle of high-level manual coding using the Excel spreadsheet. Noteworthy sections of each response were colored coded in red on the spreadsheet. The completed spreadsheet was then loaded into NVivo to start a second cycle of in vivo coding. In vivo coding, also known as literal or verbatim coding, is an inductive approach to data analysis that uses participant words or short phrases to label data segments (Saldana, 2021). The NVivo auto-generate code feature was used with the spreadsheet to find major codes and to have a starting place. NVivo identified 737 codes

(483 positive sentiments and 254 negative sentiments). I completed a Word Frequency Query in NVIVO which revealed some top codes for consideration (see Figure 2).

Figure 2

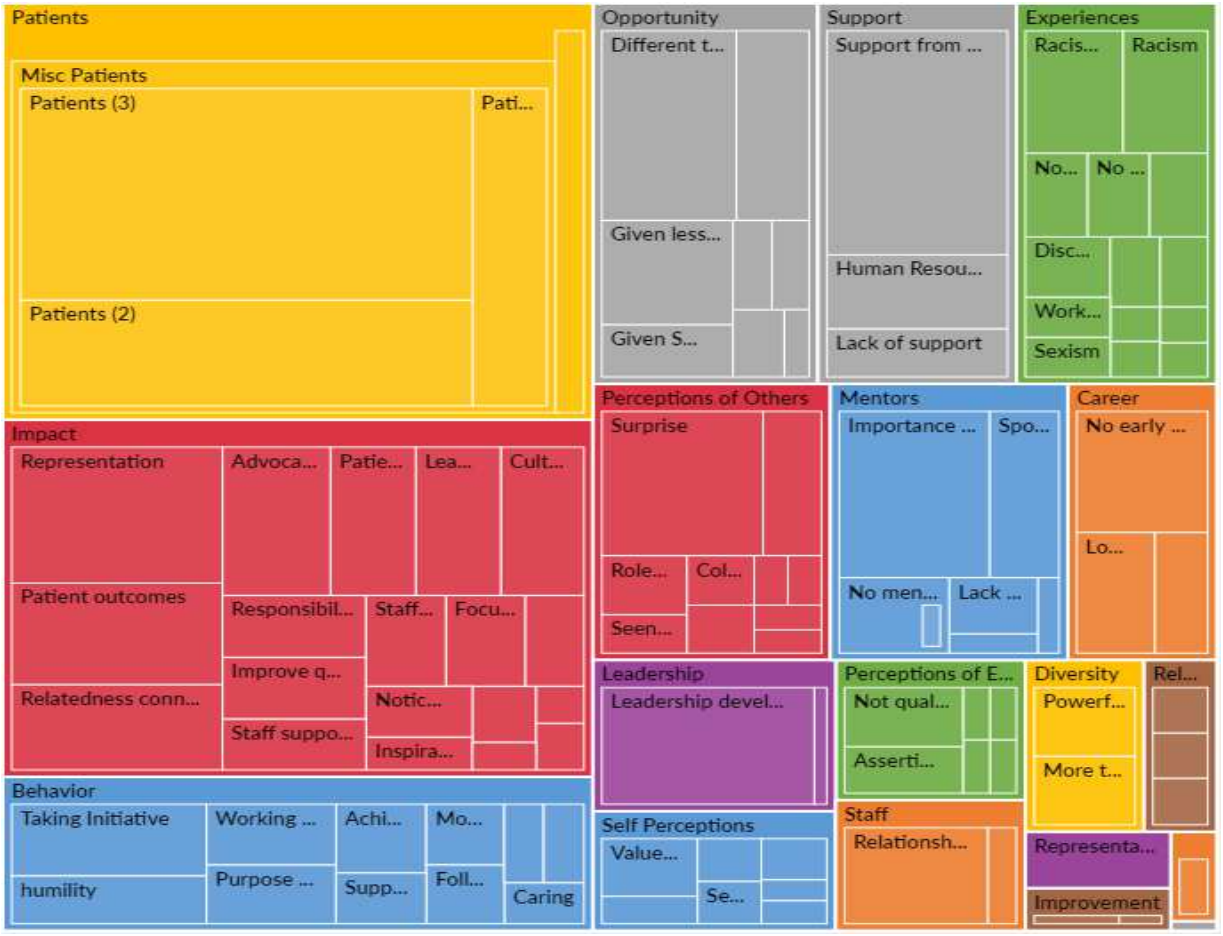
Word Frequency

I manually reviewed 460 words to identify possible key codes. I was initially able to manually identify 80 possible codes to go forward including 11 possible top or parent codes. Some of the key words from the word frequency query were career, opportunities, leadership, support, impact, and mentor. I entered those 11 codes into NVivo as a starting point and begin coding the interviews from the spreadsheet. I manually coded each participant response to a code and created new codes from the response. Through this coding process I identified and ended up with 89 codes including parent and child codes. These codes were matched to the originally identified 80 codes for verification. Next, I started over with a new project in NVivo. I loaded each participant transcript with interview answers as a separate file or case. These 16 transcripts were imported to NVivo individually.

I then manually entered some of the previously identified codes into the new project in NVivo. I started coding, highlighting appropriate comments from all 16 interview transcript answers excluding for the demographic questions. I coded the participant answers to many of the previously determined codes (where appropriate) but also identified additional codes. Once that was done, I ended up with 122 codes including 19 parent and 103 child codes. Below is a hierarchy chart that shows a comparison by coding references (see Figure 3). The different colors of this chart show the different parent codes and within the colored box are the identified child codes. The size of the box compares the number of references and the number of cases or participants associated with those codes.

Figure 3

Hierarchy Chart—Comparison by Coding References



I also created a table of participant attributes or demographics in NVivo that match four distinct demographic areas to each participant. These four captured demographics are (a) participant race ethnicity, (b) highest education, (c) first hospital status, and (d) highest position. These demographics are connected to each participant's file or case in NVivo. Table 2 displays the demographics of all survey participants.

Table 2

Participant Demographics

Participant	Race/Ethnicity	Highest education	First hospital status	Highest position
001	African American / Black	Masters	Private	Senior Level
002	African American / Black	Doctorate	Not for Profit	Senior Level
003	African American / Black	Masters	Not for Profit	Senior Level
004	African American / Black	Doctorate Masters	Not for Profit	Senior Level
005	Indian American	Working on Doctorate	Non-Profit	Middle Management
006	African American / Black	Masters	Not for Profit	Middle Management
007	African American / Black	Masters Working on Doctorate	Not for Profit	Senior Level
008	African American / Black	Masters Working on Doctorate	Not for Profit	Middle Management
010	Korean American	Masters	Government	Senior Level
011	Filipino American	Bachelors	Not for Profit	Middle Management
012	Biracial - Black and Caucasian	Bachelors	Non-Profit	Middle Management
013	Mexican American / Hispanic	Masters	Public	Senior Level
014	Mexican American / Hispanic	Masters	Non-Profit	Senior Level
016	Mexican American / Hispanic	Masters	Non-Profit	Senior Level
017	African American / Black	Masters	Non-Profit	Senior Level
019	African American / Black	Masters	Public	Senior Level

Protocol coding, also called a priori or top-down coding approach refers to specific procedural guidelines for conducting all facets of field research and data analysis according to a pre-established system (Saldana, 2021). A priori coding was used on the collected data where highlighted sections of responses were assigned to identified codes. This cycle of coding yielded more details in the codes and allowed for more refinement in the codes. After the codes were identified they were grouped and combined into emerging categories. From the categories I analyzed the categories for overlaps and patterns and was able to identify the top emerging themes that answered the two research questions.

A coding summation table was created that displays all 122 codes from all interview questions, the categories for the codes, the themes, the associated participants, and a sample excerpt from the participant responses. A more complete table is available in Appendix B. Table 3 is a sample of the a priori codes and identified themes for the two research questions. The excerpt quotation was provided by the participant with the asterisk. Additional thematic analysis involved identification of invariant constituents for each interview question. The following sections include the 16 interview questions along with their emerging invariant constituents with percentage of participants with those particular responses.

Table 3

Sample A Priori Coding for Research Questions 1 and 2

Codes	Categories	Themes	Participants	Excerpts
RQ 1: What are the perceptions of challenges of women of color advancing into leadership roles within hospitals?				
Sponsors versus mentors	Need for organizational support of leadership development	Not enough early exposure, development, and mentorship opportunities	001, 007, 013*, 016, 017	"I do have a mentor, and I consider her both a mentor and a sponsor. She's helped me in different ways. So, she is a current hospital CEO. I met her about, well, I believe six or seven years ago, at a networking event for process improvement professionals. At that time, she was already in her hospital's CEO position. Our relationship first started by me wanting to just do an informational interview with her. That informational interview turned into her learning that I was looking to move to my next organization and the next promotion."
Given less opportunities	Living with racism and sexism and fear of rejection	Discrimination impacts advancement	003, 004, 006, 010*, 012, 013, 016, 017	"Well, let me put it this way that I think it's tougher for me to advance or to get the job that I wanted as a woman of color. It's. It's tough. I won't lie, you know, no one handed me a silver plate, it's always been work and I've always had to work very hard to advance. I've had some help, but then I've had some setbacks too where I really thought I was the perfect person for this job and whatever. So, I think it's hard. I think it's tougher as women of color."
Self-doubt - imposter syndrome	Fear of non-acceptance or rejection	Lack psychological safety and face many fears	008, 011*	"I'm sometimes I feel that they don't think that anyone young and brown could cut it. Because there's and this is where the imposter syndrome comes in, where. I don't know if they think I'm good enough, you know, or because I'm this homegrown kind of girl, you know, I this is the only I this is the only nursing job that I've had. So, I'm wondering if they think there should be someone of better prestige, you know, but that's all. That's all my perception. I don't know if that's true"

(table continues)

Codes	Categories	Themes	Participants	Excerpts
RQ 2: How do women of color perceive diversity at the hospital leadership level and its impact on patient outcomes?				
Responsibility to community	Need for representation to build trust	Representation is critical	003, 006*, 011, 014	"I think I have a I have a really important role to play, especially in, you know, in a community where in a community that is diverse as the one that I'm serving right now, I just I think it's so important that the people that care for the community actually look like the community because it helps us build relationships and build trust so that we can help, you know, people in the community."
Focus on equitable treatment	Need leaders who are welcoming or accepting of diversity	Leads and supports diversity, equity, and inclusion	003, 010, 012*, 017	"If we had a black family that had a problem, I would get called to go in to talk to the family. And at first, I did it. And you know, I just want to help the family. And if they're more comfortable talking to someone of color, I want to be there for them, and it continued to happen, and we had a situation that escalated, and mom was very upset. And then the nurses and the doctors were upset saying that this person was abusive. I didn't see this parent being abusive. And we went into like a recap meeting after this incident and I looked around the room and everyone was white."
Patient outcomes	Improved quality of care	Focus on Quality and Performance Improvement	002*, 003, 005, 007, 008, 010, 014, 019	"I think as a woman first, I think, you know, their details related to the patient's experience, how they might perceive quality that go, that there is an innate part of a woman's leadership style that increases the value of the outcome, the patient outcomes, and their experience. And then as a woman of color, there's even more experience, right? There's the experience of being a female and those experience being a woman of color in America. And all of that comes into your leadership style and helps you to think about the best possible way to achieve the highest quality, possible outcomes with that with patients."
Value added	Willingness to put in the extra effort to succeed	Known for value added and contributions	002*, 014, 016, 017	"Invaluable. It is absolutely invaluable. I think as a woman first, I think, you know, their details related to the patient's experience, how they might perceive quality that go, that there is an innate part of a woman's leadership style that increases the value of the outcome, the patient outcomes, and their experience. And then as a woman of color, there's even more experience, right? There's the experience of being a female and those experience being a woman of color in America. And all of that comes into your leadership style and helps you to think about the best possible way to achieve the highest quality, possible outcomes with that with patients."

Interview Question 1

"Thinking about the beginning of your career as a leader in health care, can you tell me what kind of hospital you worked at the beginning? If more than one, please specify. Is this hospital considered Not for Profit, Non-Profit, Public, Private? How long did you work there prior to your first leadership position and afterwards? How long did you work there in total?" The full list of invariant constituents and frequencies are presented in Table 4.

Table 4

Invariant Constituents and Frequencies for First Hospital in a Leadership Position

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Not-for-profit	7	43.8
Non-profit	5	31.3
Public	2	12.5
Government	1	6.3
Private	1	6.3

The responses offered for interview question one resulted in 43.8% of participants reporting that their first employment as a hospital leader was with a not-for-profit hospital, 31.3% with a non-profit hospital, 12.5% with a public hospital, 6.3% with a government or military hospital and 6.3% with a private hospital. More women of color in the study obtained leadership roles at not-for-profit, non-profit, and public (usually local or county) hospitals than in government (state or federal) or private hospitals even though, consistent with information from the Kaiser Family Foundation (2022) that stated that of the 353 hospitals in the state of California in 2020, 19% were state/local

government,58.1% were nonprofit and 22.9% were for profit status. Table 5 displays the range of time it took for a woman of color to attain their first leadership roles at their hospital.

Table 5

Years Before First Leadership Role and Frequencies

Years Before Leadership Role	Number of participants with this experience	Percent of participants with this experience
0 to 4	11	68.8
5 to 8	3	18.8
10 to 15	2	12.5

Of the 16 women of color leader participants, 68.8% attained their first leadership role within the first four years of employment at their hospital, 18.8% gained their first leadership role between five and eight years of working at their hospital and only 12.5% took up to 15 years to attain their first leadership role. Most women of color from this study were able to start their leadership trajectory early in their overall career.

Interview Question 2

"What is your current position? Is this the highest career position you have achieved? If not, what is the highest leadership position you have achieved? What level of leadership position is this considered? Entry level, middle management, senior level? How long did it take you to achieve this position? The full list of invariant constituents and frequencies are presented in Table 6.

Table 6

Invariant Constituents and Frequencies Regarding Current or Last Position of Participants

Invariant constituents	Number of participants in these roles	Percentage of participants in these roles
Chief Executive Officer	4	25.0
Executive Director	2	12.5
Deputy Commander for Health Care Operations	1	6.3
Chief Nursing Officer	1	6.3
Chief Administrative Officer	1	6.3
Chief Quality Officer	1	6.3
Director	2	12.5
Manager	3	18.8
Assistant Manager	1	6.3

The largest percentage of participants in a single position was the title of CEO at 25% with the second largest in the title of Manager at 18.8%. Even though one Director considered themselves at senior level and one considered themselves at middle management, the majority of participants (68.8%) indicated that they had achieved a senior level of leadership and the remaining participants (31.3%) indicated middle management.

The range of time between first leadership position and current or highest leadership position is surprisingly long for most of the participants. Fifty percent (50%) of the participants had an experience of between 16 and 35 years to attain their highest position or role. Table 7 below displays the range of time it took for a woman of color to attain their highest level of leadership position.

Table 7

Years to Attain Highest Level of Leadership and Frequencies

Years to attain highest level of leadership	Number of participants with this experience	Percent of participants with this experience
0 to 5	4	25
6 to 15	4	25
16 to 25	6	37.5
26 to 35	2	12.5

Interview Question 3

"When (at what point in your career) and how did you develop an interest in being a leader in health care? How many years in?" The full list of invariant constituents and frequencies are presented below in Table 8.

Table 8

Invariant Constituents and Frequencies Regarding How and When Interest Developed in Health Care Leadership

Invariant constituents	Number of participants with this experience	Percent of participants with this experience
Didn't want it - encouraged and/or asked by others	5	31.3
Within first four years of first health care job	5	31.3
In college or prior	3	18.8
Was leader in previous career	3	18.8

A significant percentage (31.3%) of participants pursued a leadership career upon entry into their health care or hospital role. Conversely a similar percentage (31.3%) did not consider a leadership track but were encouraged by others to pursue it. One participant said "I didn't want to be a leader. I never wanted to be in a leadership role. I was perfectly happy as a clinical nurse. I was a cardiovascular ICU nurse and they promoted me to a charge nurse for night shift. I wanted to go back and get my nurse

practitioner, which I did, but my whole purpose and goal was to take care of patients. But I was asked by the CEO of the hospital to step into a leadership role, and I did not think that I could decline that request." Overall interest in health care leadership didn't occur for most participants until after being in health care at least four years but nonetheless did come early for most.

Interview Question 4

"How many promotions have you had since starting your career and what are those promotions?" The full list of invariant constituents and frequencies are presented below in Table 9.

Table 9

Invariant Constituents and Frequencies Regarding Number of Leadership Promotions

Invariant constituents	Number of participants with this experience	Percentage of participants with this experience
2	1	6.3
3	3	18.8
4	3	18.8
5	4	25
6	1	6.3
7	2	12.5
0	2	12.5

The invariant constituents that emerged from the responses provided for interview four indicated that 6.3% of participants had two career leadership promotions, 18.8% had three career leadership promotions, 18.8% had four career leadership promotions, 25% had five career leadership promotions, 6.3% had six career leadership promotions, and 12.5% had seven career leadership promotions. Two of the 16 (12.5%) participants had

non-traditional journeys and provided lots of information but did not answer the question directly or clearly.

Although the participants were at all levels of position from manager to CEO, the mean number of promotions for participants who answered this question is 4.5 and the median number of promotions for all participants is 4. The two participants who had seven promotions had achieved the level of CEO.

Interview Question 5

"Again, thinking back on the beginning of your career until now, tell me about your experiences as a woman of color advancing in hospital leadership? How, when, and why did you decide to pursue a leadership role? What comes to mind as the most challenging aspects of advancement as a woman of color? How have you been received by peers, subordinates, and superiors once you announce your intent to advance? How have you been supported by human resources and hospital leadership when sharing your interest in advancement?" Participants provided many responses to these questions relating to challenging aspects of advancement. A sample list of the top invariant constituents and associated participants relating to challenging aspects of advancement are listed in Table 10.

Table 10

Top Invariant Constituents and Frequencies—Challenges of Advancement

Invariant constituents	Participant responses	Percentage of responses
Lack of opportunities	9	23.1
Racism and sexism	5	12.8
Racism	4	10.3
Constantly have to prove self	4	10.3
Lack of mentorship and network	3	7.69
Told too aggressive	3	7.69

No one looks like me	3	7.69
Imposter syndrome/ self-doubt	2	5.13
Glass Ceiling	2	5.13
Discouraged in promoting	2	5.13
Language bias	2	5.13

Most participants provided multiple answers to this question. Of the 39 answers, the challenge that rose to the top was lack of opportunities at 23.1%. Equally common answers had to do with racism and sexism also at 23.1% combined. One participant said "about a year and a half, I really became interested in being a nurse leader. And so, I think I remember inquiring about it to my clinical manager at the time. And from that time, I think I spent another, I don't know, maybe seven years trying to figure out how I could become a nurse leader."

Interview Question 6

"Was your hospital leadership supportive of your advancement? How was that demonstrated? Were you invited or encouraged to attend any leadership development programs? Were you given the time and support to participate in these programs? What were your experiences in learning leadership skills? Did you have a mentor or sponsor? How did you initiate that relationship?" The list of invariant constituents and frequencies are presented below in Table 11.

Table 11

Invariant Constituents and Frequencies Regarding Mentorship

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Had a mentor	12	75
Didn't have a mentor	4	25

The invariant constituents that most frequently emerged from the responses to interview question six had to do with mentorship. Seventy-five percent (75%) of participants reported having a mentor during their career and 25% reported not having a mentor. One participant said "I've had several. I really believe in mentors. I've had several and I usually do that through a leverage relationship, whether it's either through professional organizations that I've sought out and paid for affiliations with and through those organizations."

Interview Question 7

"How do staff respond to you as a woman of color in leadership?" The full list of invariant constituents and frequencies are presented in Table 12.

Table 12

Invariant Constituents and Frequencies for Staff Response to Women of Color in Leadership

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Wonderfully, good, well, positively	5	31.3
Good relationships – mutual support	2	12.5
Respectful of me	2	12.5
Appreciate work ethic and appreciate support	1	6.3
Appreciate open, transparent, and receptive responses	1	6.3
Have to prove self every time; have to gain confidence	1	6.3
I don't know. No idea	1	6.3
Surprised to see me in the role	1	6.3
Challenged by ethnicity	1	6.3
Seen as too aggressive or intimidating	1	6.3

Reviewing the replies and phrases frequently used by the participants when responding to interview question seven, the invariant constituents displayed 31.3% of participants had a well, good, or positive responses to their leadership from staff. Another 12.5% felt that they had mutually supportive relationships and another 12.5 felt that they had the respect of staff. The majority or 68.9% of the respondent responses were positive. One participant said "So the staff that I've always had, and this is just me being very transparent, transparent. I've always felt that I have had a good working relationship with my team. "Another participant said "Generally speaking, I think they've responded to me positively. Generally, very cooperative."

Interview Question 8

"How do patients respond to you as a woman of color in leadership?" The list of invariant constituents and frequencies are presented below in Table 13.

Table 13

Invariant Constituents and Frequencies Regarding Patient Responses to Women of Color Leaders

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Welcoming, positively, and pretty good, patients of color like it	6	37.5
Neutral, mixed, nothing negative, don't care and no bitter experience	5	31.3
Representation Matters	2	12.5
Surprise or disbelief in seeing woman of color leader	2	12.5
Mistaken for housekeeping staff	1	6.3

Examining the responses most often given by the participants when responding to interview question eight, the invariant constituents showed 37.5% of participants reported that patients were welcoming or positive of them as leaders, 31.3% reported neutral or mixed responses from patients, 12.5% reported that representation was a key issue with patients, and 12.5% experienced surprise or disbelief from patients regarding their position. Of note is that several of the participants reported that they had an experience where a patient that said that they did not want a Black or Mexican person to help them. One participant said "I've been asked for my papers when administering medication. All kind of stupid, stupid questions. Just. It's been interesting. Maybe they don't, they, they don't ...it's challenging for them, or it's kind of a surprise for them, maybe I'll say that it's a surprise for them to see a woman of color in a position of authority. It's almost like there's a belief that we shouldn't be here. It's interesting."

Interview Question 9

"How do other professionals you encounter as part of your work but outside your hospital respond to you as a woman of color in leadership?" The full list of invariant constituents and frequencies are presented in Table 14.

Table 14

Invariant Constituents and Frequencies for Responses for Other Professionals Outside the Hospital

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Generally positive, welcoming, positive, courteous, and collaborative	5	31.3
Surprised	4	25
Don't know	3	18.8
Respected	2	12.5

Distant	1	6.3
Expectation of assertive or adversarial behavior	1	6.3

The invariant constituents that emerged from responses given to interview question nine suggested 31.3% of participants had generally positive and courteous responses from other professionals, 25% experienced surprise from other professionals, 18.8% were not aware of any response and 12.5% felt respect from other professionals. Noteworthy is the high percentage of colleagues that display surprise. One participant said "They seem to be shocked and surprised most that time. But I think because I've been around health care so long that people know me, but I get the feeling sometimes that they feel like I'm an exception."

Interview Question 10

"From your perspective, what is the impact of your specific presence in the hospital as a woman of color on patient outcomes? What about the impact of other women of color in leadership on patient outcomes?" The full list of invariant constituents and frequencies are presented in Table 15.

Table 15

Invariant Constituents and Frequencies for the Impact of Woman of Color Leader Presence on Patient Outcomes

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Supporting and promoting diversity, equity, and inclusion	4	25
Representation	4	25
Advocacy for patients of color	2	12.5

Improved patient experience	2	12.5
Focus on quality of care	1	6.3
Staff development	1	6.3
Policy change	1	6.3
No impact	1	6.3

Of the 16 participants, 25% said that their impact on patient outcomes came from their support and promotion of diversity, equity, and inclusion. Another 25% said their impact had to do with representation as a woman of color to leaders, staff, patients, and community. Another 12.5% reported the importance of advocacy for patients of color and another 12.5% reported their impact from their focus on quality of care. One participant said, "but my hope that that through my leadership and in the really kind of being clear with all of the team that every patient is equal regardless of payor class, racial or ethnic origin, sexual orientation, religion that they thought twice, maybe you know about, just open their mind up a little to any unconscious bias that they might have."

Interview Question 11

"Have you developed a new/ leadership philosophy or leadership practice since becoming a leader? What has influenced your philosophy the most?" The full list of invariant constituents and frequencies are presented in Table 16.

Table 16

Invariant Constituents and Frequencies for Leadership Philosophies

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Don't know everything, still learning; maintain humility	2	12.5

People are just people, need to show up for people	1	6.3
Treat people as individuals, treat people with dignity, respect, and fairness	1	6.3
Invert the organization chart and put staff on top, give staff input for decision making	1	6.3
Communicate effectively; maintain humility	1	6.3
Do the right thing	1	6.3
Support other leaders	1	6.3
Be honest, transparent, and fair; have grace	1	6.3
Be a servant leader	1	6.3
Be a transformational leader; help others to grow	1	6.3
Recognize and show appreciation for staff	1	6.3
Continuous improvement and respect for others	1	6.3
Patient safety	1	6.3
Performance improvement	1	6.3
Be authentic	1	6.3

Although many of the responses were similar, of the 16 participants only two participants gave the same answer to this question. 12.5% reported that they lead from a place of humility where they admit to their staff that they don't know everything. One participant said "So I learned a lot of things ... how humble yourself, no matter who you are, and you stand firm in certain circumstances. So, I was able to use all the things that I have learned in Christian life. I use that."

Interview Question 12

"Talk to me about your feelings regarding your opportunities to advance. Have you been given equal opportunities or more opportunities or less opportunities because of

your gender and race?" The full list of invariant constituents and frequencies are presented in Table 17.

Table 17

Invariant Constituents and Frequencies for Advancement Opportunities

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Less opportunities	9	56.3
Equal opportunities	3	18.8
More opportunities	3	18.8
Opportunity only from another Woman of Color	1	6.3

The responses offered to interview question 12 were limited with 56.3% of participants reported feeling that they had less opportunities, 18.8% reported feeling they had equal opportunities, and 18.8% felt they had more opportunities. Only one participant, 6.3%, said they had opportunities, but the opportunities only came from another woman of color. She stated: "Now I feel that this is a very interesting question because I do feel that if it wasn't presented to me by these sistas that maybe I wouldn't have had as much of an opportunity as I would have without that being presented by them, I'll say that."

Interview Question 13

"Do you believe your experience as a woman of color advancing in hospital leadership is different than white women or men of any color?" The full list of invariant constituents and frequencies are presented in Table 18.

Table 18

Invariant Constituents and Frequencies for Different Experiences

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Yes	15	93.8
No	0	0.0
Maybe	1	6.3

In response to interview question 13, remarkably 93.8% of participants said that they believed their experience of advancing in leadership was different than white women or men of any color. Only one person was unsure. One of the 15 affirmative respondents said "I do think. Yes, I think men in general are more looked at as leaders and ready and then women and women have had a harder road to hoe to get to that higher level. But I do think there's a difference between white women and black women."

Interview Question 14

"How close have you come/ did you come to achieving your original career goals at this point in your career? Are you satisfied with your progress?" The full list of invariant constituents and frequencies are presented in Table 19.

Table 19

Invariant Constituents and Frequencies for Achieving Career Goals and Satisfaction

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Close to achieving goals and satisfied with progress	10	62.5
Close to achieving goals but not satisfied with progress	6	37.5
Not close to achieving goals and not satisfied with progress	0	0.0

Reviewing the replies and phrases frequently used by the participants when responding to interview question 14, the invariant constituents displayed 62.5% of participants stated that they were close or had achieved their goals and were satisfied with their career progress, 37.5% stated that they were close or had achieved their goals but were not satisfied with their progress. One participant said "I felt that I achieved my goals. I was interested in making a difference in patient safety and patient outcomes. And being able to be in a leadership role and actually contribute to those outcomes was a significant achievement in my in my eyes"

Interview Question 15

"Is there anything else that you'd like to share regarding your experiences as a woman of color advancing in hospital leadership and the impact on patient outcomes?" The full list of invariant constituents and frequencies are presented in Table 20.

Table 20

Invariant Constituents and Frequencies for Additional Comments

Invariant Constituents	Number of participants with this experience	Percent of participants with this experience
Women of color need to choose community, markets and facilities that embrace diversity and support health equity	6	37.5
Women of color need to make opportunities for, advocate for and mentor other women of color	5	31.3
There is a great need for women of color representation in hospital leadership	2	12.5
Women of color help build trust in the community	2	12.5

Follow up to previous question	1	6.3

Invariant constituents that emerged from the responses given to the interview question 15 suggested participants (37.5%) believe that women of color need to choose a community, market, or facility to work for that embraces diversity and health equity. Another 31.3% of participants said that women of color need to make opportunities for and mentor other women of color. Another 12.5% of participants said that hospitals need women of color representation in hospital leadership and another 12.5% said women of color are needed to build community trust. One participant said, "I think it's important that we don't forget that we need to pave the way for our up-and-coming people of color in leadership." Another participant said "So I looked for organizations that it is not just profit oriented, oriented and one that employs people who are not just belong to, born in this country, or are the white people. I also look for where cultural diversity is embraced." Another participant said "What I've been noticing is a lot of VPs, nurse leaders don't often have education beyond a master master's degree. Yet I feel like as a woman of color, I have to have the highest level of education just to compete. I feel like the tables are kind of slanted. It just feels like I have to work twice as hard and be twice as educated and be way ahead of everyone just to get...just recognition, it feels like.

Interview Question 16

"A few demographic questions: What is the highest level of education you have achieved? Would you mind sharing your race/ethnicity? It is ok if you prefer not to." Of the 16 participants, nine (9) were African Americans or Black, three (3) were Mexican

Americans or Hispanic, one (1) was Indian American, one (1) was Korean American, one (1) was Filipino American and one (1) was Bi-racial – Black and Caucasian. Multiple coding techniques were used for this project. Both the in vivo coding and thematic analysis and the evaluation of the invariant constituents led to similar results for answering the research questions.

Data Validity and Trustworthiness

Ravitch & Carl (2021) believed validity and trustworthiness are foundations of certifying credibility and rigor in qualitative research. Urban & van Eeden-Moorefield (2018) define trustworthiness as the degree to which the findings can be trusted as accurate illustrations of the data and true experiences and perceptions of the participants. Many efforts have been made to ensure validity and trustworthiness of this study however there are four standards that help with assessing and ensuring this level of research integrity and they are credibility, transferability, dependability, and confirmability.

Credibility

Credibility is the degree to which the research to represents the realities of the participants experiences and perceptions and takes into account complex study outcomes (Urban & van Eeden-Moorefield, 2018). This study demonstrates high credibility through several ways. One way was that most research participants were unknown prior to the study and were selected through random cold calling or through other participant recommendations. Secondly, credibility came through the diversity of participants. Research participants came from six different race and ethnicity backgrounds, four

different educational levels, five different hospital status' and two different levels of management. Lastly, credibility for the study came from the real-life diversity of responses from those facing many challenges to those who did not face any challenges in advancement. Katz-Buonincontro (2022) believes that reflexivity, which is when the researcher is aware of their self-identity and assumptions, is core to good research. Given my background as a woman of color hospital leader, prior to and throughout this research process, I practiced reflexivity which adds credibility to this study.

Transferability

Transferability is the ability of the research to be applicable or transferable to other circumstances, populations, or situations (Urban & van Eeden-Moorefield, 2018). Although this research was conducted in a virtual environment and setting, it could as easily be conducted on site and in person. Another demonstration of transferability was the desire of some research participants to include colleagues from other states in the study. This research could be easily transferred to another state or region. A final demonstration of transferability comes through whether men of color could be substituted for women of color as research participants. There are no criteria for this study that would prevent men from being the research participants in another study.

Dependability

Consistency or stableness of the data and strong research design will ensure dependability (Urban & van Eeden-Moorefield, 2018). The basic qualitative research approach or basic qualitative inquiry is the best research method for this study. It was purposely chosen because it allows for direct data collection by I in a natural setting,

opportunity for learning from participants, logical data analysis and reflection and completed story and reporting (Creswell & Creswell, 2018). Dependability in this study is demonstrated through consistency in the data collected and clear emergence of answers to the research questions. Dependability is also demonstrated in this study in that the results are consistent and verified across all various analysis modes. The same patterns and themes emerged not only through three cycles of coding but also through manual analysis and review of each interview question and comparisons of participant answers.

Confirmability

Confirmability is when the research is free from researcher bias (Urban & van Eeden-Moorefield, 2018). Confirmability is achieved when someone else conducted the study, they would have the same results. Confirmability of this study has been gained through verification of the data and through numerous and varied reviews and in-depth analyses of the data using different techniques. In this study I provided a clear and unbiased presentation of the interview questions to the participants, and I did not influence any participant responses.

Results

The results of this study demonstrate that women of color advancing in hospital leadership have had a wide variety of experiences leading to a wide variety of perceptions of challenges in advancement as well as a variation of views of their impact on patient outcomes. Although a long list of fascinating topics emerged from the interviews, I was able to eventually identify a few primary themes. The two study research questions generated a total of seven primary themes.

Research Question 1

"What are the perceptions of challenges of women of color advancing into leadership roles within hospitals?" Participants of this study believed that women of color faced many challenges advancing in their hospital careers such as discrimination, direct discouragement, language or background bias, racism, sexism, lack of exposure and lack of mentorship and networks, self-doubt, fears, lack of psychologically safe environments and more. However, multiple analyses and reviews yielded three important top themes from collected data. Theme one: There are not enough early exposure, development, and mentorship opportunities for women of color advancing in hospital leadership. Theme two: Discrimination impacts advancement for women of color in hospital leadership Theme three: Women of color lack psychological safety and often face self-doubt, lack of confidence and many fears.

Theme 1: There are not Enough Early Exposure, Development, and Mentorship Opportunities for Women of Color Advancing in Hospital Leadership

Many of the participants perceived that they or their women of color colleagues faced advancement challenges because of the lack of exposure to different career options early in their career. They felt that others received more opportunities to learn about leadership career options earlier as well as were given preparation opportunities to take these roles more often. Most of the participants did not even consider a leadership role until several years into their career. It was especially interesting that only two of the participants stated that they had even considered a career in hospital leadership prior to or during college. Participant 003 said "That started well before I entered the field, and I

decided I wanted to be a hospital administrator when I was a junior in high school. And I just pursued that path through undergraduate, asking the graduate program at the university I went to for my bachelors what was the best preparation for getting into that program, and they advised me to go to the business school. So, I did my undergraduate work in business administration and then applied to the master's programs in hospital administration."

Several participants expressed dismay that they had to pursue development opportunities on their own and outside of or without organizational support. Many stated they were not encouraged to grow and felt unsupported when attempting to do so. Participant 017 said "No, I have not been invited to attend a leadership development course or training. I pursued it on my own." Participant 014 said "And in one of the last positions I had, I felt that I was not being encouraged to be a strong leader because it was a new organization and all I was given as far as orientation was a binder and told to make reference to that." Several stated that although their organizations provided leadership development training, they were not able to take advantage of these trainings due to staffing or scheduling constraints. Participant 011 said "Unfortunately, COVID kind of put a kibosh on that. Like, right before COVID hit, I was slated to start it's called an MCE program, which only four, four candidates per affiliate are invited per year." There were however a few participants who did express feeling valued and supported in their leadership development. Participant 013 said "I was given the training and I was also a coordinator for this training. We called it our leadership academy and it was a

multidisciplinary team that came together to work on things like Central Line infections or falls, things that were part of the core measures for the hospital."

Mentorship or better yet sponsorship can have an important place in the career of most professional women (Singh, 2020). Most of the study participants believed that having the support and encouragement of someone who has already experienced a similar career journey could help steer an advancing leader in the right direction and keep them on track. Participant 002 said "'I've had several. I really believe in mentors. I've had several and I usually do that through a leverage relationship, whether it's either through professional organizations that I've sought out and paid for affiliations with and through those organizations I try to identify, mentor folks can either be kind of ad hoc mentors or more formal mentors."

The lack of mentorship can slow down or stall career progression. Although most study participants believed that mentorship was important, only seventy five percent (75%) had a mentorship relationship of some kind in their career, even though most desired a formal mentorship relationship. And most of the seventy five percent found their mentors on their own or the mentors were former or current bosses. Participant 011 said "I would love to have some kind of like mentorship other than my direct supervisor, but I don't think there is an active plan to say, OK, we're going to make a concentrated effort to raise up, you know, raise me up."

Theme 2: Discrimination Impacts Advancement for Women of Color in Hospital Leadership

Many of the responses (23.1%) relating to challenges of advancement were related to direct or perceived experiences with racism or sexism or both. Several of the women stated that they had been a finalist for several advancement opportunities and were told they were highly qualified and had a great interview however they did not get selected, and they attributed those decisions to either racism and/or sexism. Racism showed up in many forms for the study participants. Several women of color reported that they were told they were too assertive or aggressive. Participant 012 said "And at the beginning, when I first started my career, it was met with you're being aggressive, you are being intimidating. And my, my white counterparts could say the same thing, but I was continually perceived as being aggressive." One participant said that she was subject to some classic code language. Participant 017 said "And one instance that stands out, I actually was interviewing, I had an interview with the COO of a children's hospital in Boston, and he said, you know, your resume is great, your experience is great. We're just really looking for the right fit."

In some cases, direct and derogatory comments by those in authority were made in relation to woman of color's accent and culture. Participant 005 said "I was not well received. They make a comment about my how I speak, you know, how I dress, all of those things, but I continue to focus on what I can improve and what I can focus on. And I always remember the purpose that I am here is to make a difference in patients and to feed my family."

In another case women of color faced staff members who refused to work for them and quit when it was announced the woman of color was taking over a particular unit, division, or department. Participant 007 said "They may have made comments well, I had few of them would quit just when I became the director. They took off. They felt a little bit overwhelmed, maybe because of the way I designed or restructured the department and the workflows."

In many cases there were no overt racist remarks made however it was unspoken words or a general feeling of the respondent. Participant 010 said "They led me (in) several organizations, led me to believe that I was the handpicked person and in fact, this happened three times and it was really, really disappointing and two of the three, I don't know, on the third one, but, you know, a non, you know, a white person got the job and then two of the occasions it was an internal candidate. So, I don't know. I mean, I can't prove that it was because of my race or ethnic background or gender or experience, because they don't tell you much. But it was it was extremely disappointing."

Some participants sometimes felt more challenges from sexism such as with Participant 010 who said "I feel more of a challenge looking back on my career and is more of a challenge as a as a woman in a male dominated field. You know, when you look at all the leadership and who is running this organization, who's making all the decisions, it's mostly all men. And then on top of that is, you know, when you're not a white woman." Sexism was sometimes overt such as in the case of the CEO who told a nurse executive that he did not like nurses. Participant 014 said "I don't know if it was because I'm a woman of color or if I'm just a woman, but one of the last CEOs that I

worked for, he verbally said to me that he hated nurses. Yes. And so, as a result, it made for a difficult situation overall. He was difficult to speak to. And he did not provide, I felt, the encouragement to continue on and be able to achieve anything further beyond my role. And on the contrary, he at one point recommended that I might want to consider taking on a lesser role."

Sometimes racism and sexism were on full display such as when a woman of color was told she was not selected because the community was not ready for a woman of color in leadership. Participant 004 said "You know that the organization was making money off of the cardiovascular service line again, but he did not feel that the community was ready for a person of color in a leadership role. He actually said those words to me. And there was nothing I could say or do because it wasn't performance based. The reason why I didn't get the job was because of my ethnicity and appearance." Or in the case where the Board member asked why he wasn't told a woman of color was coming for the job interview. Participant 016 said "And the chairman of the board was a banker, a white Anglo. And when he met me with the Comptroller who was supportive of my promotion, he said to him, you didn't tell me it was a woman, and you certainly didn't tell me she was Mexican. And I'm sitting right there, and he doesn't even look at me."

Theme 3: Women of Color Lack Psychological Safety, Experience Self-Doubt, Lack of Confidence, and Face Many Fears

Although only one participant called out directly the need for psychological safety for women of color, many of the women did express a similar thought or expressed many different doubts and fears. Participant 002 said "So there's that I mean, in even thinking

about leadership development, the psychosocial support you need for leadership development. So, you think about establishing a psychologically safe workplace for people to have conversations about opportunities for development and feel safe to even say to their manager, hey, like, I've been in my role for five years now, we've never had a conversation about my advancement. You know, what should I be working on? "Many women of color worry about how they will be perceived by others on a regular basis.

One of the prevailing sentiments that kept coming up during the interviews was around fear, self-doubt, lack of confidence and imposter syndrome. Participant said "One thing that I had to deal with, and I talked to a friend about this, is imposter syndrome. Thinking like, can I be in that space? And can I do this, you know, and having all those kinds of internal battles of who I belong here? Can I do this? You know, once again getting over that hump." Many of the women expressed fears of rejection, fear of isolation or fear of failure. Fear of rejection was the most common of the fears expressed. Some less experienced women of color leaders expressed fears about facing a glass ceiling as they progressed in their careers. Participant 011 said "I believe that they believe in me, you know, but I sometimes feel like there's a glass ceiling where I think, I'm not sure. I mean, that's the whole .... that's the curiosity piece of me is I want to see how far I can go, not only for my own personal professional curiosity, but I want to see how far they're willing to place."

Fear of isolation was also commonly expressed by women of color leaders. Participant 008 said: "So, you know, those challenges and I always say, you know, when I do talk to my mentors a lot of times, even going back to nursing school, I always look

around and I always have the situations where I say I'm the only one in the room that looks like me and I've run into those times." Participant 007 said "Because most people come as a group, as a team and then maybe when they shove all you in one of the tables and you kind of speak intelligently and then someone says oh, this person has a brain. But it's lonely to be out there being in a leadership position and not having a companion with you."

Given the constant range of responses to their positions of leadership such as surprise and shock by staff, colleagues and patients to direct racism and bias by patients - in several cases women of color in senior positions were misidentified by patients as janitorial workers -it is not surprising that women of color face imposter syndrome or other fears. Participant 006 said "I can share with you that I walked into a patient room because I round on every patient as a unit manager during the time and I was mistaken for EVS (Environmental Services)."

Research Question 2

"How do women of color perceive diversity at the hospital leadership level and its impact on patient outcomes?" Participants of this study indicated that they believed that women of color in general demonstrate many qualities that impact patient outcomes. Some of these qualities include acceptance of diversity, advocacy, cultural understanding, diversity of thought, focus on equitable treatment, improved quality of care, innovation, inspiration, leader of equity work, focus on policies, relatedness or connectedness, representation, responsibility to the community, staff development and support, trusted by the community and patient experience improvements. Participants also believed that,

based on their own lived experiences, women of color had a greater appreciation for, and deeper understanding of the multiple issues facing patients' lives and therefore worked harder to enrich those experiences.

Results from analysis of RQ 2 yielded four important top themes. Theme one: To impact patient outcomes, representation by women of color is critical. Theme two: To impact patient outcomes, women of color are needed to lead and support diversity, equity, and inclusion. Theme three: To impact patient outcomes, women of color leaders are needed for their focus on performance and quality improvement. Theme four: Women of color in leadership have a great impact on patients' outcomes because they lead with their values and thereby make significant contributions.

Theme 1: Women of Color Perceived Diversity at the Hospital Leadership Level as Essential For Having Impact On Patient Outcomes and is Accomplished Through Representation

Women of color expressed that representation by women of color positively impacts all patient outcomes but especially for patients of color. Participant 004 said "And that there's a lot of focus that needs to be done on that because there are a lot of unnecessary co-morbidities and mortality that are impacting people of color because of some of the existing biases that are present and demonstrated in health care. So, I'd like to see more representation in leadership of people of color so that there can be more recognition of the need to have equity in, you know, in the care that people of color get."

Representation occurs when individuals perceive their needs, concerns and desires are understood and heard by someone in power who may have a similar background,

culture, or experience. Participants expressed that representation needs were not limited to patients only but also extended to staff who need representation and themselves impact patient outcomes. Participant 002 said “think, you know, just like anything else, you know, representation matters and not seeing black, black female leaders on the boards of hospitals or in these leadership roles. Or I mean, I mean, just the lack of representation across the board is just sometimes discouraging. You know, in what you need to individually, if you’re a person that’s trying to establish a senior leader, establish yourself as a senior leader in the hospital system, I think there is a tremendous amount of fortitude that you have to develop.”

Theme 2: Women of Color in Leadership Roles Support Diversity and Advocacy

Similar to and intersecting with theme one, study participants also felt that women of color in leadership roles provided more support for and focus on diversity, equity and inclusion including health equity issues as well as ensured more advocacy for people of color at the decision-making levels. Leaders that focus on diversity, equity and inclusion in data collection and evaluation, strategic planning, setting organizational priorities, and decision making have proven to create organizational environments that are more inclusive, more sensitive, and more responsive to and understanding of cultural needs (Battle, 2022). As there are more women of color in leadership positions there will be more focus on diversity, equity, and inclusion. Participant 008 said “So, but you know, at the time, it was really, you know, inspiring to have her (woman of color in senior leadership) and to try to be impactful. She, too, was really passionate about diversity, equity, and inclusion. And really made an impact in trying to make sure that middle

management, where the position where I'm at, really try to understand and have a better focus on diversity within their specific nursing units. And I know that was a big part of when we would come together as leaders and we have like weekly meetings, there would be a focus on that."

Theme 3: Ensuring Quality for Performance Improvement

Participants perceived that women of color had a good track record for ensuring quality improvement and performance improvement initiatives in hospitals, positively impacting all patients. Many participants stated that women of color are known for creative and innovative ideas that lead to improved patient experiences and outcomes. Participant 002 said "I've seen more innovation in hospitals when there's been a black female leader in place. So, innovation in how they use technology innovation, innovation in partnering with physicians. And like I say, in innovation and in staff training and development that ultimately leads to higher, more positive health outcomes."

Several of the participants talked a great deal about performance or quality improvement work or stated that they had a leadership philosophy based in performance improvement. Participant 016 said: "That we must consistently look at what we do today and attempt to improve it the next day. And the principles that I live by is: one, to engage everyone; two, to ensure that there is a value proposition for the patient and the employees; three, that we have improved flow in order to eliminate waste; and four, that, we are practicing high reliability, standardization of work."

Theme 4: Ensured Positive Patient Outcomes

Women of color believed that women of color in hospital leadership ensured positive patient outcomes through their values and hard work contributions. Transformational leadership in health care is associated with quality patient outcomes (Fischer & Nichols, 2019). Most participants of this study reported that they led from a place of values and/or are values driven. Whether that drive is from a religious belief, cultural belief system, education, or experience, most were not hesitant to state they lead from their value position primarily. Almost all the responses also referred to or suggested some form of humility as leadership philosophy. Participant 019 said "I think that, recognizing that as a leader, you know, I am still learning. Right. We all, none of us have the answers and I think, you know, going into every situation with a sense of humility that there's probably somebody at the table who can teach you something, is important." Leader humility can lead to greater organizational improvements and staff learning and thereby improved patient outcomes.

Additionally, women of color often believe that they must work twice as hard as others to gain respect or achieve acceptance as equally as what others achieve. Although it is driven by negative connotations, women of color believe that they have a reputation for hard work that has a positive impact on patient outcomes. Participant 006 said "What I've been noticing is a lot of VPs, nurse leaders don't often have education beyond a master master's degree. Yet I feel like as a woman of color, I have a must, I have to have the highest level of education just to compete. I feel like the tables are kind of slanted. It

just feels like I have to work twice as hard and be twice as educated and be way ahead of everyone just to get...just recognition, it feels like."

Summary

The answers to the two research questions revealed the perceived challenges of women of color advancing in hospital leadership and their impact on patient outcomes. Even with all the attention to associated issues associated with diversity, equity and inclusion, women of color still perceive that they face many challenges advancing in health care leadership. Much of these challenges are rooted in racism and sexism. Some women believe that the issues are foundationally connected to their sex alone while others believe it is based on their race, but most believe it is both. This intersectionality causes multiple dilemmas and difficulties for women of color.

The feelings and experiences that women of color face that give question to their chances for equal opportunity are their reality. Fifteen of the sixteen participants said during the interviews that they thought their experiences in advancing in health care were different than that of white women or men of any color and 50% of participants said they had fewer overall opportunities than other groups.

Women of color perceive that they have less chances for advancement in the form of exposure to job prospects, access to certain positions, and options for mentorship. Several of the participants mentioned having to find their own leadership development opportunities. Several of the participants mentioned having to even find their own leadership development opportunities. Many of the participants of this study felt that they had experienced others getting those opportunities and progressing at a much faster rate

in their careers than they did. Opportunities for special assignments or certain jobs were not made available to them. The lack of mentorship seems to be one of those issues that not only involved lack of support and resources but also a circular problem where not having enough women of color in leadership would lead to a problem of not enough mentors for women of color, a vicious cycle. Several women of color leaders even reported not seeking out a mentor because they had long learned that they had to only depend on themselves to get ahead and that they could not depend on others.

Women of color face covert and overt discrimination. One thing that was striking were the number of participants who mentioned incidents where they were a top candidate for a job, were told they were the best candidate or had interviewed exceptionally well but still did not get the job. They reported feeling broken and discouraged and especially dismayed that they were not told why they did not get the job. They were only left to wonder if it was because of their race and/or sex. Several participants were told that they were not selected because the organizational was looking for the right fit and they were left wondering if this was code language.

Even with discrimination as one of the three top themes to answer the research question, the underlying concepts of racism and sexism seemed to present with the other themes including lack of psychological safety. Many women of color face many fears and lack of psychological safety in pursuit of career advancement. Fear of failure, fear of rejection, fear of isolation and imposter syndrome all have as their foundation racism and sexism for women of color. All these fears can have a negative impact on advancement

for women of color and can cause them to second guess their goals or delay implementation.

It is ironic that women of color face so many challenges advancing in health care when they have many positive impacts in the field. With RQ 2, four themes emerged describing positive impacts by women of color in health care. Representation or just being present has a huge impact not just for patients to see a woman of color in leadership, which may give them some sense of support or system trust but also for staff of color who see women of color in leadership as role models and someone to aspire to be like or even just a trusted colleague. Representation by itself however is not enough, women of color are also needed in health care to promote and support diversity, equity, and inclusion initiatives. Many times, they are responsible for these initiatives either by asking to lead them or by being assigned these responsibilities, either way they still bring an added emphasis, commitment, and determination to see these initiatives to successful interventions. They see the value of these initiatives from a personal perspective and that gives the more energy to their worth. Sometimes leading these initiatives is an extra burden but most feel it is an important responsibility. Finally, women of color in health care see leadership from a foundation of values. Women of color are value led and value driven leaders.

It is important that women of color in health care leadership keep striving to create welcoming environments and communities for all. Being open and transparent about these challenges will help us to overcome them and bring more diversity to hospitals. The entire patient community, not just communities of color, benefit from

women of color in health care leadership. Women of color bring with them a commitment to quality and performance improvement. They know that organizations will only succeed if they are moving forward and growing. They often have performance improvement as their core leadership philosophy.

The impacts of women of color in leadership and their effects on patient outcomes can also be seen in other industries like education. When people of color are in positions of leadership, more attention goes to the previously marginalized groups and more resources are directed to them and invested in them, they are better understood and cared for. Several women from this study stated that they never sought out a leadership role but were encouraged to take on such work by senior leaders. Longman et al. (2018) stated that this phenomenon is actually common because women are generally very relationally driven and often enter leadership roles this way.

Several other interesting observations were found in this study including the fact that many of the women of color participants were pursuing their doctorate degrees in order to advance their career. Another interesting observation were that many women of color stated that they had gotten their advancement opportunities through other women of color. Finally, another observation was that none of the participants used Human Resources as a resource for career advancement. In fact, most participants saw it as a negative involvement or hinderance to their career advancement.

The results of this study shows that women of color in health care leadership are very resilient and incredibly determined to succeed despite the odds and setbacks. They have a strong drive and desire for advancement and with that many have achieved

success. They are willing to work hard and go above and beyond the minimum requirement for recognition and advancement. They believe that they have a tremendous ability as well as responsibility to be leaders in health care, that they can be successful, and they have a lot to add. They do have fears of failure and rejection and they do face discouragement, but they do not let those fears stop them from moving forward. Because of their talent, their brilliance their hard work ethic, their lived experiences with racism and sexism and because of their compassion they actually are the most highly equipped to be leaders in the field about caring. They bring much more than any other group to the healing arts, and they are the most prepared for all the challenges in this field. They sincerely care about their communities, their patients, their work, their organizations and most importantly their teams and staff.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this basic qualitative study was to explore the perceptions of women of color advancing into hospital leadership and their impact on patient outcomes. A basic qualitative research approach was used to understand the experiences of participants. I interviewed 16 women of color who had worked in California hospitals in a leadership role for at least two years. This racially and ethnically diverse group of women included individuals from African American, Mexican American, and Hispanic, Korean American, Indian American, Filipino American, and bi-racial backgrounds. Participants differed greatly in education levels and years of experience.

Participants answered 16 semi structured interview questions. Collected data were analyzed using several techniques with the goal of ensuring the elimination of researcher bias. Many of the study participants reported similar experiences. From the thematic analysis, seven themes emerged from the study to provide answers to the research questions:

- RQ 1: What are the perceptions of women of color advancing into leadership roles within hospitals?
    - Theme 1: There are not enough early exposure, development, and mentorship opportunities for women of color advancing in hospital leadership.
    - Theme 2: Discrimination impacts advancement for women of color in hospital leadership

    - Theme 3: Women of color lack psychological safety and often face self-doubt and many fears.
- RQ 2: How do women of color perceive diversity at the hospital leadership level and its impact on patient outcomes?
    - Theme 1: Representation by women of color is critical to impact patient outcomes.
    - Theme 2: Women of color are needed to lead and support diversity, equity and inclusion.
    - Theme 3: Women of color leaders are needed for their focus on performance and quality improvement.
    - Theme 4: Women of color in leadership have a great impact on patients' outcomes because they lead with their values and thereby make significant contributions.

The following paragraphs will provide the interpretation of the findings, limitations of the study, recommendations, implications, and conclusions of the study.

Interpretation of Findings

The perceptions of women of color advancing in hospital leadership were that they faced many more challenges than their White women or men of any color counterparts. Many of these challenges were based in racism and/or sexism despite the fact that these same women made significant positive impact on patient outcomes. The results of this study support the findings of the literature review and supports the fact that more research like this study is needed to fill the gaps in understanding the impact of lack

of diversity, not supporting the advancement of, and not having enough women of color in health care leadership.

The pillars of the IMCD, the theoretical framework for this study, have a direct correlation to the findings of this study. The IMCD states that an organization's diversity environment impacts organizational effectiveness directly and indirectly (Cox, 1993). It is affected directly through organizational interactions and indirectly through individual career outcomes and patient outcomes. Additionally, the IMCD states that the diversity environment consists of individual dynamics, group/intergroup dynamics, and organizational dynamics. Further, the effect of diversity on organizational outcomes is a multifaceted intersection of individuals and their environment.

The first pillar of the model has to do with the diversity climate and includes the three level factors (individual, group and organizational) that influence the climate or environment. Two of the study themes from RQ 1 are correlated with this pillar, and both fall under the individual level factors: Theme 2: Discrimination impacts advancement for women of color in hospital leadership, and Theme 3: Women of color lack psychological safety, experience self-doubt, lack of confidence and face many fears. Although both themes are connected to the individual level factors of the diversity climate pillar, they could also be connected to group or intergroup factors and organizational factors. Much of the data behind these themes have to do with experiences or perceptions of isolationism and experiences with lack of support by women of color leaders. There were many examples of being overlooked multiple times for advancement opportunities and being left with feelings about whether it was a racial and/or gender-based decision.

Although at times they were encouraged or rewarded for their hard work and commitment, many faced many more career disappointments and organizational discouragements that could not be fully explained. Women of color face a minimal of two different kinds of discrimination on a regular basis. These regular aggressions or traumas can lead to loss of confidence, self-doubt and more.

The second pillar of the IMCD model has to do with individual career outcomes. The theme that emerged from the study that has to do with this pillar is Theme 1 from RQ 1: There are not enough early exposure, development, and mentorship opportunities for women of color advancing in hospital leadership. Women of color in hospital leadership perceive or have experiences that support that their career advancement is stalled by not having sufficient development opportunities and/or access to sponsors or mentors. Exposure to different leadership career pathways was also a big concern. Most of the participants did not even get started on their leadership career paths until they had been in the health care field for several years because of lack of knowledge or exposure. This lack of knowledge or exposure can lead to slow starts, stalled ambition, missed opportunities, and more. Women of color perceive that there is not enough being done to level and/or advance the opportunities for them and this sometimes leads to thoughts of giving up.

The third pillar of the ICMD model has to do with organizational effectiveness. The themes that emerged from the study that has to do with this pillar are Themes 1–3 from RQ 2. Theme 1 was that representation by women of color is critical to impact patient outcomes. Women of color strongly believe that having women of color in

leadership roles at hospitals can have a positive impact not only on staff productivity and satisfaction but also on patient outcomes. The trust and confidence that women of color present were a major factor for this. With the growing diversity of the United States, it is important to have someone in a position of authority is relatable. Theme 2 was the ability to stay focused on equity issues and concerns while continuing to push other organizational priorities is a key organizational effectiveness advantage by having women of color in hospital leadership. Theme 3 was that women of color leaders are needed for their focus on performance and quality improvement. Many study participants perceived that organizational focus on quality improvement increased when women of color were in leadership roles. For many reasons including feelings of having to continually have to prove themselves, women of color promote high standards in organizations.

Cox (1993) concluded that organizations must invest in improving at all pillars and within all levels if they hope to have successful outcomes and results. In order to support a diversity climate, organizations must openly welcome, embrace and support people of color at all levels of the organization. It is especially consequential that they support diversity at the leadership level to have a well-rounded and successful organization. All the findings of this study are directly associated with the premise of the IMCD model and supports why it is imperative not just to understand and support workplace diversity but also to actively engage in the nurturing, development, and growth of a strong, confident and (feels supported) diverse workforce. Viewing cultural diversity through the lens of IMCD in hospitals provides an appropriate structure for future

exploration of the perceptions of women of color advancing in hospital leadership level and their impact on patient outcomes.

Limitations of the Study

The originally identified limitations of the study proved to be only partially correct. There were some initial challenges with finding willing participants. Some individuals who initially agreed to participate, did not respond or were not available at the interview dates. However, because of the positive experience of the interview process, several participants recommended their colleagues who agreed to participate in the study.

Because the interviews were completed during the coronavirus disease (COVID) pandemic, permission was given to conduct the interviews over a virtual platform (Zoom) however to ensure participant privacy and anonymity, the camera was turned off and only the audio was recorded for transcription purposes which prevented me from observing participant facial expressions and reactions during the interviews.

The virtual platform however did allow for participants to complete the interview in a comfortable setting of their choice. I also provided lots of flexibility of dates and times for interviews to accommodate the busy schedules of the women of color leaders including weekends and evening appointments. Although all the participants had worked in California hospitals as leaders at some point in their career, not all the participants were living in California during the interviews and consideration had to be made for time zone differences.

Recommendations

The results of this study conclude that women of color leaders perceive that they face many challenges and difficulties as they navigate their career advancement pathways and yet they stay focused and resolute of the value and impact of their presence on patient outcomes. There are many recommendations that result from this study including better awareness of the challenges faced by women of color, more support for women of color advancing in hospital leadership, more acknowledge of the special skills and experiences of women of color, better sharing of diversity, equity and inclusion program leadership, more training for health care leaders about bias and more.

As stated by McGee et al. (2018), leaders should embrace the complexities of workplace diversity. Leaders in health care and hospitals should be honest and transparent about the challenges that women of color face. It should not be downplayed or hidden for the sake of protecting the industry or an organization. Health care and hospital associations and academia needs to make sure that they are alerting senior hospital leaders and boards of directors of these challenges and these leaders need to be held accountable for making changes in organizational culture. As recommended by Crews & Wesson (2018), leaders must not just focus on reducing bias in the workplace but also work on intervening when bias is identified and eliminating the demonstration of bias from the organization's culture. There must be more diversity, equity and inclusion training and programs that are not short term or temporary but are built into the fabric of the organization's culture.

Health care leaders must provide more support for women of color who are interested in leadership roles. It is also important that women of color who are pursuing leadership roles be alerted early about the challenges discussed so that they do not feel isolated or that they are solely responsible for the challenges they face. Woolnough et al. (2019) pointed out that women who were more aware of the "glass ceiling effect", as defined in chapter two, were better equipped to navigate the glass ceiling in their career journeys. However, there still needs to be more support for women of color to deal with prejudice and discrimination. There should also be a focus on building organizations that promote psychological safety for everyone.

More training opportunities for women of color including but not limited to leadership development training will lead to more women of color pursuing leadership roles. The development of a mentorship program modeled after the Culturally Aware Mentorship (CAM) program (Byars-Winston et al., 2018) could be used to guide and train mentors from all backgrounds to support women of color. CAM provides training to willing individuals from all backgrounds to be culturally competent mentors. I was fortunate to get several women of color leaders who were current or past CEOs to participate in this study. These women have phenomenal experiences, great knowledge and cherished wisdom. Another recommendation is to create a virtual mentorship program where these accomplished women can support other women of color who specifically aspire for these senior leadership roles.

Part of the hiring process should include a commitment to the values of diversity, equity, and inclusion for all new employees. There should be more consideration for

lived experiences in selection and promotion considerations. As we value language skills and expertise, we should also value cultural understanding skills and experiences of women of color especially as it relates to serving certain patient populations when making hiring decisions.

Women of color should not be solely responsible for diversity, equity, and inclusion programs as they should not be solely responsible for advocating for people of color or understanding cultural differences and cultural norms. In order to gain more understanding regarding these issues, more White personnel should be trained to lead or co-lead these programs and trainings. Erskine and Bilimoria (2018) suggests that especially White women can take on an ally role to support the advancement of women of color in leadership roles.

It is critically important that hospital senior leaders understand the challenges that these women face and embrace the opportunity to support, develop and promote them knowing that the ultimate results will lead to better staff engagement and improved patient outcomes. This paper or similar should be mandatory reading for new CEOs. Besides the senior executive, other influential hospital leaders such as Chief Human Resource Officers, should be aware of this information and held accountable for implementing programs and policies. One of the observations during the study that did not become a theme was the fact that none of the participants had a positive interaction with human resources regarding their leadership development, support, or advancement opportunities. This seems like a missed opportunity and hospitals and health care

organizations should reconsider the role of human resources in developing and promoting support for women of color advancing in hospital leadership.

Recommendations for future research opportunities include further exploration of the perceptions of women of color advancing in health care leadership and their impact on patient outcomes in states other than California; study of the impact of mentorship on the success of women of color in health care; and study of the role of human resources in women of color career success.

Implications

Women of color are a critical and growing part of the hospital leadership workforce. Senior leaders have a responsibility to not only support their growth and advancement but also to safeguard their psychological safety. This study and similar studies provide good foundational information, but not enough research has been done to understand the experiences and perceptions of women of color health care leaders as they navigation their career pathways. Further studies must occur to gather additional data but also to ensure this topic remains a top priority.

There are many implications as a result of this study. Women of color should be encouraged to share their stories and their journeys. Sharing their experiences and perceptions will hopefully lead to more trainings for senior level leaders and more compassion and empathy and more support for programs for women of color advancing in leadership roles in hospitals. There needs to be more acknowledgement of past harms and better understanding regarding the lack of trust often displayed by women of color, leading to better trust.

There should be mandatory training for leaders and hiring managers regarding bias and unconscious bias to heighten the awareness of this issue. There is a lot of covert bias and some overt bias in the health care industry that has a damaging effect on staff and patients. The implications for no changes and no action are that racism and sexism will continue to prevail and the environment will become more toxic and more difficult for women of color who want to advance their careers. Patient outcomes will also be negatively affected. Another implication if nothing is changed is that women of color will stop pursuing leadership roles because of lack of support. This will result in the loss of strong leaders, loss in creativity and negative impacts on patient outcomes.

The results of this study also have several implications for social change. Jean-Marie et al. (2009), state that social change involves generating a change in the social order whereby previously sidelined populations have the same opportunities in society of more advantaged groups. I believe that the results of this research will lead to positive social change for women of color by inspiring further research into the experiences of women of color in health care as well as in other career fields who are attempting to advance their careers.

This research demonstrates the impact of racism and sexism on women of color leaders, but the results will spur positive social change by encouraging more women of color to aspire to and work towards leadership positions and thereby increasing the number of women in hospital leadership roles. This research should also inspire positive social change when organizations not only to examine their cultures to be more supportive of women of color seeking to advance their careers but also to evaluate the

effectiveness of their current programs to meet the needs of women of color. This research may even demonstrate enough disparity to encourage positive social change when organizations seek to create special programs specifically to support women of color. Finally, this research will lead to positive social change by calling attention to the impact of women of color leaders on patient outcomes and the need for their presence and representation.

The social change model of leadership (SCM) is a values-based model for social change, which combines elements of collaborative, transformational, and courageous leadership (Kaslow, 2020). Given the close alignment of its elements with the values of health care, this model should be further explored for possible implementation within health care organizations.

Conclusion

As stated by Coetzee and Moosa (2020), women have a lot to add to workforce through their vast experiences, intelligence, and skills. Women and especially women of color continue to face many barriers in advancing their careers. The continuation of racism, sexism, and other forms of discrimination in American society seems destined to continue at most institutions and organizations for the unforeseeable future. This study clearly showed that most women of color perceived that they had faced many challenges in career advancement working in California hospitals and yet they also see and value their important impact on patient outcomes. Health care and hospital leaders must take responsibility for the perceptions and experiences for the women of color in the industry if there is to be any hope for an improved environment or positive effects on patient

outcomes. The glimmer of hope from this study is also that despite their perceived challenges and experiences most participants were not dissuaded from their advancement pursuits and goals for themselves or for other women of color. They remained committed to using their talents, skills, and experiences to support improved patient outcomes and to serve as role models furthers.

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Appendix A: Interview Guide

	Interview Questions
Introduction	Hello Interviewee Number _____. Thank you very much for helping me with my research. The purpose of this study is to explore the perceptions and experiences of women of color advancing in leadership roles in hospitals and their impact on patient outcomes. This interview should take no more than 60 minutes. After the interview, I will be analyzing your answers as part of my study. I also be interviewing many others. I will not identify you in my documents, and no one will be able to identify you with your answers. You can choose to stop this interview at any time. Also, I need to let you know that if you agree this interview will be recorded for transcription purposes. • Do you have any questions or concerns? • Are you ready to begin?
Question 1	We will start with a little background information. Thinking about the beginning of your career as a leader in health care, can you tell me what kind of hospital you worked at the beginning? If more than one, please specify. a. Is this hospital considered a not for profit, nonprofit, public, or private? b. How long did you work there prior to your first leadership position and afterwards? How long did you work there in total?
Question 2	What is your current position? Is this the highest career position you have achieved? If not, what is the highest leadership position you have achieved? a. What level of leader is this considered? Entry level, middle management, senior level? b. How long did it take you to achieve this position?
Question 3	When (at what point in your career) and how did you develop an interest in being a leader in health care? How many years in?
Question 4	How many promotions have you had since starting your career and what are those promotions?
Question 5	Again, thinking back at the beginning of your career until now, tell me about your experiences as a woman of color advancing in hospital leadership. a. How, when and why did you decide to pursue a leadership role? What comes to mind as the most challenging aspects advancement as a woman of color? b. How have you been received by peers, subordinates, and superiors once you announced your intent to advance? c. How have you been supported by human resources and hospital leadership when sharing your interest in advancement?
Question 6	Was your hospital leadership supportive of your advancement? How was that demonstrated? a. Were you invited or encouraged to attend any leadership development programs? Were you given the time and support to participate in these programs? What were your experiences in learning leadership skills? b. Did you have a mentor or sponsor? How did you initiate that relationship?
Question 7	How do staff respond to you as a woman of color in leadership?
Question 8	How do patients respond to you as a woman of color in leadership?
Question 9	How do other professionals you encounter as part of your work but outside your hospital respond to you as a woman of color in leadership?
Question 10	From your perspective, what is the impact of your specific presence in the hospital as a woman of color on patient outcomes? What about the impact of other women of color in leadership on patient outcomes?

Question 11	Have you developed a leadership philosophy or leadership practice since becoming a leader? What has influenced your philosophy the most?
Question 12	Talk to me about your feelings regarding your opportunities to advance. What opportunities (more or less) have you been given because of your gender and race? Have you been given equal opportunities or more opportunities or less opportunities because of your gender and race?
Question 13	Do you believe your experience as a woman of color advancing in hospital leadership is different than white women or men of any color? How?
Question 14	How close have you come to achieving your original career goals at this point in your career? Why? Are you satisfied with your progress?
Question 15	Is there anything else that you'd like to share regarding your experiences as a woman of color advancing in hospital leadership and the impact on patient outcomes?
Question 16	A few demographic questions" What is the highest level of education you have achieved? Would you mind sharing your race/ ethnicity? It is ok if you prefer not to.
Close	Thank you for your answers during today's interview. a. Do you have any questions for me? This concludes the interview for today. I'd like to remind you of our/my responsibility and commitment to ensure and protect your privacy. I greatly appreciate your participation in this interview. Thank you again for your time. And I will stop the recording now.

Appendix B: A Priori Coding for Research Questions 1 and 2

(The asterisk annotates the participant that provided the quote for the excerpt.)

Codes	Categories	Themes	Participants	Excerpts
Behavior				
Purpose Driven	Values driven and led	Ready for leadership success - leads with positivity and strength	5, 8*, 10, 12, 13	"I don't know if I've technically like really thought out like this is my actual leadership philosophy, but what I do utilize as a leader, is I really try to be honest, transparent and fair."
Diversity				
More Tolerance	Need leaders who are welcoming or accepting of diversity	Leads and supports diversity, equity and inclusion	2, 3*, 4, 8	"Well, I think that's ...in California that's actually been not as much of a challenge because I think there's just enough diversity in California and in the market in California, I've worked in that I feel like it's just a greater appreciation that someone, a minority is going to show up in this, you know, professional meeting or something like that."
Experiences				
Glass Ceiling	Living with racism and sexism and fear of rejection	Discrimination	11*, 17	"They've given me pretty high-profile responsibilities, pretty high-profile kind of quality and like safety metrics and all those things. I believe that they believe in me, you know, but I sometimes feel like there's a glass ceiling where I think, I'm not sure. I mean, that's the whole ....that's the curiosity piece of me is I want to see how far I can go, not only for my own personal professional curiosity, but I want to see how far they're willing to place."
Impact				
Cultural Understanding	Need leaders who are welcoming or accepting of diversity	Representation is critical	3, 5, 8, 10, 12*, 13,19	"I felt that being bi-racial, I was able to say, hey, I've seen both sides and my white side is telling my white people like, you aren't culturally sensitive. You know, I grew up with my black family and we were louder. We were more expressive. It wasn't anger, we were more communicative. We expressed ourselves in a way which, you know. After a lot of these incidents, I started reading a lot. It's perceived as being aggressive because it's done sometimes without emotion

				and very direct, and it comes across that way and just sometimes being black and being direct makes you aggressive."
Focus on Equitable Treatment	Need leaders who are welcoming or accepting of diversity	Leads and supports diversity, equity, and inclusion	3, 10, 12*, 17	"If we had a black family that had a problem, I would get called to go in to talk to the family. And at first, I did it. And you know, I just want to help the family. And if they're more comfortable talking to someone of color, I want to be there for them and it continued to happen and we had a situation that escalated, and mom was very upset. And then the nurses and the doctors were upset saying that this person was abusive. I didn't see this parent being abusive. And we went into like a recap meeting after this incident and I looked around the room and everyone was white."
Leads Equity Work	Promotes diversity, equity, and inclusion	Leads and supports diversity, equity, and inclusion	1*, 8, 11, 12, 17, 19	"I wear two hats in the organization, both for patient experience. The other one, I oversee our diversity, inclusion, and equity work. And from both of those in my perception, I feel that right now, the diversity, equity inclusion is a really strong piece."
Patient Outcomes	Improved quality of care	Focus on Quality and Performance Improvement	2*, 3, 5, 7, 8, 10, 14, 19	"I think as a woman first, I think, you know, their details related to the patient's experience, how they might perceive quality that go, that there is an innate part of a woman's leadership style that increases the value of the outcome, the patient outcomes, and their experience. And then as a woman of color, there's even more experience, right? There's the experience of being a female and those experience being a woman of color in America. And all of that comes into your leadership style and helps you to think about the best possible way to achieve the highest quality, possible outcomes with that with patients."

Relatedness/ Connection	Need for representation to build trust	Representation is critical	3, 8, 10*, 12, 13, 19	You know, I think it's important that leadership reflect the diversity of the patients and the clients that you're trying to serve. So, I think it was a good thing. Because we serve a diverse community in military medicine and at (XXX hospital), you know, or wherever the organization is. So, I think that is a good thing and I think it's good for the patients and their families to see that there's diversity on the executive level. So, you know, it's almost kind of like, you know, relatable-ness. You know. Whether it's experience or where you lived or what your heritage is or just the fact that, you know, you're something else besides a white male, you know. "
Representation	Need for representation to build trust	Representation is critical	1, 5, 6*, 8, 11, 12, 13, 14, 17	"Other women of color, I think I mean, I feel like. Like, for instance, we serve a multicultural community, and I feel like our leadership team is multicultural and the impact is important. Again, representation matters. It matters a lot to the community. That's kind of, I think that's kinda how I would answer that. They have the same impact."
Responsibility to Community	Need for representation to build trust	Representation is critical	3, 6*, 11, 14	"I think I have a I have a really important role to play, especially in, you know, in a community where in a community that is diverse as the one that I'm serving right now, I just I think it's so important that the people that care for the community actually look like the community because it helps us build relationships and build trust so that we can help, you know, people in the community."
Support				
Leadership Development	Need for organizational support of leadership development	Ready for leadership success - leads with positivity and strength	2, 3, 4, 5, 6, 7, 8*, 10, 11, 12, 13, 14, 16, 17, 19	"So, when I was an assistant patient care manager, I actually started. We have a leadership and management academy that we can apply for to be a part of. I started in that, I think it was called Cohort four, but at the time when I was an assistant manager, we were having a lot of staffing issues, so I had to kind of go back into the count. So, I started that leadership academy ended up stopping, but then they allowed me to join the next Cohort which was cohort five."

Sponsors versus Mentors	Need for organizational support of leadership development	Not enough early exposure, development, and mentorship opportunities	1, 7, 13*, 16, 17	"I do have a mentor, and I consider her both a mentor and a sponsor. She's helped me in different ways. So, she is a current hospital CEO. I met her about, well, I believe six or seven years ago, at a networking event for process improvement professionals. At that time, she was already in her hospital's CEO position. Our relationship first started by me wanting to just do an informational interview with her. That informational interview turned into her learning that I was looking to move to my next organization and the next promotion."
Given Less Opportunities	Living with racism and sexism and fear of rejection	Discrimination impacts advancement	3, 4, 6, 10*, 12, 13, 16, 17	"Well, let me put it this way that I think it's tougher for me to advance or to get the job that I wanted as a woman of color. It's. It's tough. I won't lie, you know, no one handed me a silver plate, it's always been work and I've always had to work very hard to advance. I've had some help, but then I've had some setbacks too where I really thought I was the perfect person for this job and whatever. So, I think it's hard. I think it's tougher as women of color."
Human Resources not Helpful	Willingness to put in the extra effort to succeed	Ready for leadership success - leads with positivity and strength	2, 4*, 7, 10, 14, 16, 17, 19	"Most of the time, I didn't really relate to human resources with respect to advancement. But when I was in the one position where the other person of color was not being equitable and fair to me, I did not get supported from human resources. I, you know, there was a request to have a conversation, not even a complaint, just a request to sit down with an objective party and have a conversation with that individual that I felt was treating me in an equitable way and human resources was not supportive at all."
Self-Perceptions				

Self-Doubt - Imposter Syndrome	Fear of non-acceptance or rejection	Need for psychological safety	8, 11*	"I'm sometimes I feel that they don't think that anyone young and brown could cut it. Because there's and this is where the imposter syndrome comes in, where. I don't know if they think I'm good enough, you know, or because I'm this homegrown kind of girl, you know, I this is the only I this is the only nursing job that I've had. So, I'm wondering if they think there should be someone of better prestige, you know, but that's all. That's all my perception. I don't know if that's true"
Staff				
Relationships with Staff	Willingness to put in the extra effort to succeed	Known for value added and contributions	1, 3, 4, 10, 12, 13, 14*, 16, 19	"Generally speaking, I think they've responded to me positively. Generally, very cooperative, I can only think of a couple of times where there were some conflicts and in having to do some discipline. But I don't think it was reflective of me being a nurse of color was rather just me taking on a disciplinary role."