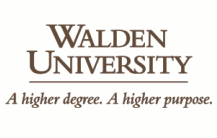

2015

Factors Relating to Underrepresentation of Black American Women in Health Care Administration

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This is to certify that the doctoral dissertation by

Alquietta Brown

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
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Abstract

Factors Relating to Underrepresentation of Black American Women in Health Care Administration

by

Alquietta L. Brown

MHSA, Strayer University, 2008

BSN, Howard University, 1987

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

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Abstract

There is a low representation of Black American women (BAW) in health care senior leadership. With the high level of health problems found among the Black community, diversifying the executive leadership with BAW may be instrumental in increasing provider trust and reducing discriminatory action. Using critical race theory as the conceptual framework, this study examined the experiences, perceptions, and influential or deterrent factors inhibiting advancement of BAW in the health care field. Inquiry centered on factors related to lack of advancement, experiences at different stages of career progression, and strategies impacting career advancement. A qualitative research design using a transcendental phenomenological approach was the chosen method. Seven BAW who met the criteria for inclusion were selected by purposive sampling. Data were collected from semi-structured, audio-recorded, interviews using a newly created protocol. Data analysis included open coding; line-by-line data review; and the use of NVivo to search for frequencies of themes, coding, and text queries. Emergent themes were identified that provided comprehensive descriptions of the participants' experiences. According to study findings, perceived and experienced racial issues were apparent in hiring and work relations. Disparate practices were evident through a lack of inclusion in succession planning, being overlooked despite qualifications, and stereotyping. These findings may stimulate social change by helping those BAW aspiring for senior healthcare leadership to be more successful and by improving health outcomes for BAW through enhanced trust.

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Dedication

I would like to dedicate my research effort to my spouse and family that have supported me throughout this opportunity. My spouse has been understanding, loving, and my greatest cheerleader throughout this process. He inspired me to embark on this journey.

Acknowledgments

I would like to thank God for making all of this possible. In addition, I would like to thank my Chair, Dr. Jeanne Connors, Cochair, Dr. Jeff Snodgrass, University Reviewer, Dr. James Goes, and the entire Walden Faculty for accepting my request for their expertise and guidance. The expert advice of each faculty member has been instrumental in getting me to this point. I would like to thank my family, friends, and employer for their patience and support throughout this process.

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Chapter 1: Introduction to the Study

A disparity exists in the underrepresentation of Black American women (BAW) reaching senior health care leadership (Johns, 2013, para 2). BAW in this predicament do not have a wealth of literature to assist them with the discovery of best practices or knowledge of barriers from the BAW's perspective. Knowledge of the barriers to advancement in health care senior leadership from the standpoint of BAW may be instrumental in helping them to successfully achieve desired leadership roles.

The purpose of this study was to examine the career progression of BAW who aspire to advance to executive roles in health care, but have failed to do so. The intent of this qualitative, transcendental, phenomenological study was to understand the experiences, perceptions, and influential or deterrent factors attributing to BAW's lack of advancement in health care senior leadership. This chapter includes information on the background, purpose, research questions, theoretical framework, and nature of the study. Other sections include a glossary of definitions, assumptions, scope and delimitations, limitations, significance, and the summary.

Background

The health care industry continues to grow and evolve to meet market, societal, and population demands. According to the Centers for Disease Control and Prevention (CDC, 2013), there are health disparities for Black Americans. Black Americans have a lower life expectancy, higher death rates, and higher infant mortality than people of other ethnicities. This problem challenges health care administrators to find knowledgeable and culturally competent leaders to represent the interest of diverse patient populations and

manage myriad cultural perspectives. Despite these health disparities and changing demographics, little change has been realized with respect to demographic and cultural diversity of hospital board's representatives and senior leadership with respect to the presence of Black Americans (Selvam, 2012, p. 6).

Demographics are an area of consideration for health care leaders. According to McDaniel (2013), the country's makeup is evolving (p. 21). Washington, DC has a high number of minority residents (McDaniel, 2013, p. 21). According to the US Census Bureau (2013), the population of Washington DC includes 50.7% who are Black and 13.93% of people who are of other minority descent. There is a growing need for leaders with cultural and gender competence to help reduce health care disparities and better serve different ethnic minority patient populations.

Providing better service to the various patient populations requires both trust and understanding of their unique needs, practices, and beliefs. The Institute of Medicine (IOM, 2003) found that "stereotyping, biases, and uncertainty on the part of health care providers can contribute to unequal treatment" (p. 1). Addressing disparate health care practices, maintaining financial and strategic viability, and the changing providers' mindsets may inevitably require the diversification of leadership. Diversification of executive health care leadership in areas with a high percentage of Black Americans, as seen in the Washington, DC metropolitan area, may be significant. Having a diverse leadership core may meet the community's culturally based health needs and help advance a deeper understanding of the primary stakeholders in health care institutions, ushering in innovation and creativity, and the reducing of health disparities.

Diversification of care may have some impact on the provision of care for minorities. The IOM suggested that quality of care may be enhanced by diversification of the workforce (p. 2).

Women are an under recognized and underused potential leadership group (Lantz, 2008, p. 298). According to Lantz, it was only 15 of the top 100 acute care hospitals in the US that were led by a female chief executive officer (CEO). Lantz noted from the American College of Healthcare Executives according to the Spell Out in Full (ACHE) and the National Association of Health Services Executives (NAHSE) "African American women only make up 26% of top female executives" (pp. 293-294). Women and minorities make up more than half of the people in Washington, DC (United States Census Bureau, 2013). Many are not present in executive roles, where the health care strategic plans are created. Without diversity at the executive level, it may be difficult to pinpoint unique needs of varied ethnic groups in the communities (Cohen, Gabriel, & Terrell, 2002, p. 91).

Health care leaders have a role in planning and refining organizational operations to improve clinical outcomes. The inherent role of health leaders desiring to reduce health disparities is to establish and institute culturally considerate strategic plans, based on community demographics, which are designed to advance health equity. Minorities often do not benefit from health services "as a result of a poor cultural match between minority patients and their providers, mistrust, misunderstanding of provider instructions, poor prior interactions with healthcare systems, or simply from a lack of knowledge of how to best use healthcare services" (IOM, 2003, p. 7). There are differing rates of disease

presentation in Black women. Blacks have unique health care needs and "differences in the distribution of polymorphic traits" (IOM, 2002, p. 8) yielding varied clinical outcomes.

Not only are there differences in clinical outcomes and presentation of disease by population group, further differentiation is noted by gender. Certain diseases are more prevalent among Black women, such as diabetes mellitus and cardiovascular disease (Kirby, 2010). Many variables affect clinical outcomes. It is important that clinicians have understanding and explore dietary habits, exercise, environmental factors, and other culturally specific aspects, concurrently.

Literature Gap

Healthcare is evolving with new imperatives (Zuckerman, 2009, para 4). It is a period when new ideas are sought and rewarded (Zuckerman, 2009, para 4). Healthcare organizations must comply with the mandates of regulatory bodies. The guidelines of regulatory bodies may change to meet the changing needs of society in the provision of safe and quality healthcare. Many regulatory agencies like the Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS) created guidelines requiring participating health care organizations' compliance as terms and conditions of reimbursement or accreditation (McDaniel, 2013, p. 22).

The amount of published literature illustrating BAW's perspectives of challenges to career advancement, in health care administration, is limited. I only found two literary sources that illustrated or included perspectives of BAW's career advancement experiences within the health care industry. Spates (2012) emphasized that not many

scholars illustrated the challenges BAW face that may be of value in directing care. Researchers have focused on cultural diversity, racism, or health disparities. Articles addressing minorities or women as a classification were available. Maintaining the competitive advantage, quality of care, safety, and organizational viability in highly diverse regions may be inversely proportionate to the racial and ethnically diverse population connecting with the health care team.

There is a tendency for Black persons seeking health care to seek out Black care providers. Mitchell and Lassiter (2006) stated, "The Sullivan Commission's report show Black patients are significantly more likely to receive their care from Black dentists (who treat almost 62% of Black patients) than from White dentists (who treat 10.5% of these patients)" (p. 2093). With the high demand for expert leaders, adding more diversity to the executive leadership body potentiates value added differences of thoughts and knowledge (Selvam, 2012). As the demographics in the Washington Metropolitan region continue to evolve with increasing numbers of minorities, the demand for more diversified health care approaches also increases, necessitating a higher degree of cultural competence and connection. Mitchell and Lassiter found that "the number of underrepresented minorities would comprise 40% of the U.S. population by 2050. This will intensify the need for heightened awareness of health disparities and increased diversification of the workforce" (pp. 2-3).

Caring for and interacting with people from various cultural backgrounds poses challenges for health care governing bodies. Interpersonal dynamics of the health providers may impact quality of care (Kocolowski, 2010). Healthcare organizations

should consider keeping options open to acquire influential leaders, including women of color. “Women of color comprise 33 % of the female workforce and are twice as likely to hold low paying service roles” (Kerby, 2012, p. 2). This finding indicated that there are not a large number of BAW in decision making roles, but more of service occupations. Establishment of connection with the community may require that health care organizations tailor hiring practices to include women and minorities for roles previously only offered to White males. The process of tailoring hiring practices to attain more diverse leadership groups and workforces comprised of more Black Americans is not an easy task. Many women, not only BAW and health care applicants, could benefit from the knowledge of barriers, so that alternative strategies can be employed.

Varying degrees of access to quality care have attributed to health disparities of minorities (Russell, 2012). The health disparities are effects of racial division that dominated U.S. history for centuries. Race relations between Whites and minorities over the past century have led to a gap in trust and confidence in health care providers. The Institute for Diversity in Management (2012) claimed trust in healthcare providers increases when semblance of color exists. Discovering what barriers, if any, continue to inhibit the progression of BAW is the cause for further exploration.

The Problem

A disparity exists in the lack of representation of BAW in positions of health care senior leadership (Johns, 2013, para 2). It is a multifaceted problem that encompasses the quest for women’s equality, the fight for equal representation for persons of color, the issue of ethnic and cultural competence, and on the quality of care in U.S. health care

institutions. According to the IOM (2003), race and gender are influencing factors in hiring decisions. Witt and Keiffer (1998) revealed that

> 80% of racial/ethnic minorities studied disagreed that they were well represented in health care management. Seventy-eight percent of the racial/ethnic minorities and 57% of the majorities disagreed that the diversity of the management teams at their organizations reflected the patient's demographics. (p.4)

Witt and Keiffer found that "63% of the majority polled concurred that diversity recruiting of leadership enabled the organization to reach it goals, and 70% of the majority believed that cultural differences support successful decision making" (p.5). The growth of minority populations increases the demand for cultural competence for healthcare providers (Cohen, Gabriel, & Terrell, 2002 p. 91). This element affords healthcare workers greater understanding and enhanced ability to make appropriate recommendations on prevention and treatment.

Senior leaders in health care lack the exploration of new dimensions, which includes serving a broader range of patient demographics with a new order of social power, leader effectiveness, and the ability to affect the workforce while connecting with the persons served. Race affects society's actions (Delgado & Stefancic, 2001). Few measures are evident in counteracting racially-based actions (Ospina & Su, 2009, p. 132). Societal actions may further be described as norms that have a tendency to have an impact on decision making. It is unclear, with the demands on health care institutions to increase organizational performance, retain clientele, and market goods and services, why recruitment of some qualified candidates is ignored (Mallon, Hefner, & Corrice, 2011).

Gender- and minority-based diversified leadership might enhance knowledge of community needs, improve communication, and improve understanding of different cultural perspectives (Sullivan Commission on Diversity, 2003). Finding out why there is a lack of BAW in health care leadership is an opportunity to build upon this premise.

The Washington, DC metropolitan region is a diverse urban area where change is evident in all facets of health care, except the face of the leaders occupying senior leadership roles. According to the United States Census Bureau (2013), in Washington, DC, the Black and other minority population is 64.63% of the total; Whites make up 35.37% of the population. Mirroring the workforce and clients may aid performance across many fronts as "health disparities continue to grow" (Blouin & Bututusis, 2012, p. 22). Having more of a connection with healthcare providers may be critical element in building trust.

The presence of women in health care organizations highlights the need for organizations to advance with a diversified executive body, inclusive of not only minority men, but also women of color. A disproportionate number of males hold top-level executive roles in the work industry, as opposed to females. According to the ACHE (2006), the percentage of men advancing to the executive level was greater than that of women aspiring to the CEO position. There are fewer minority women than White women in pursuit of these top-level jobs. It is unclear why this disparity exists when BAW vying for these roles are typically overachievers, over credentialed, over prepared, and ready to serve (Hannah-Jones, 2011, p. 5).

Trust is a recurrent factor in discussions about health disparities. Williams and Rucker (2000) touched on the significance of leadership diversification in addressing trust. Enhancing provider trust is important. It is recommended that leaders sharing racial, ethnic, and cultural traits must be available.

Betancourt, Green, and Carrillo (2005) sought to discover whether "(a) diversification of the workforce yields better identification, understanding, and connection between the workers and the patients; (b) improved communication; and (c) increased quality of care" (p. 500). Results favored cultural competence as the caveat to improve quality and equal treatment in the provision and outcomes of clinical care. Although, this research was informative, an opportunity to discover why a lack of BAW exists and how BAW could affect cultural competence remains unclear.

The make-up of organizational cultures includes many demographic considerations. Age, religion, ethnicity, and styles of leadership are among the key components (Kiamba, 2008, para. 6). The viability of organizations in the current health care market may require goals designed for diversity inclusion (Gardenswartz & Rowe, 2003, p. 41). Health care organizations must have fewer preconceived ideations in hiring practices and a greater willingness to take risks to eliminate the associated pitfalls, limitations, and judgment errors common to exclusionary practices. Encouragement of diversified hiring in areas where high concentrations of minorities exist may be beneficial (Monster, 2012).

Hiring practices are more inclusive of diverse candidate pools. According to the United States Equal Employment Opportunity Commission (EEOC, 2012), minority

women in the private industry only make up 4.07% of senior executive level officials. The benefits of further research on what barriers, if any, attribute to the unequal representation of BAW may prove to be multifaceted and touch many people and organizations, both inside and outside of the health field.

Based on a review of more than 100 articles around this general problem, no researcher focused on the barriers to career advancement from the perspective of BAW. Some listed barriers to advancement; but, those identified were from the experiences of minorities overall or were gender-based. Bridging this gap in the literature may require additional research to discover the descriptive data detailed in the lives and experiences of BAW, told from their own perspectives. The purpose of this study was to concentrate on BAW working in health care middle management roles who have been subjected to unequal tendencies based on race, gender, and social class.

Purpose of the Study

The purpose of this transcendental, phenomenological study was to examine the experiences, perceptions, and deterrents, if any, to the advancement of BAW aspiring to achieve senior health care leadership roles. Types and sources of information or data, along with the details of the methodology, are outlined fully in Chapter 3. Collection of data for this research effort included interviews. The interviews were in-depth with detailed accounts provided. Each interview generated unique perspectives that may lead to the refinement of the research questions over the course of the data collection and analysis process.

Guiding/Research Questions

The overarching research question was as follows: What are the lived experiences of BAW, in the Washington DC metropolitan region, encountered during career advancement toward their ultimate goal of senior leadership?

Subquestions included the following:

1. What factors, if any, have contributed to the lack of advancement up the ranks to senior health care leadership posts?
2. What are the lived experiences, if any, described, in terms of race/ethnicity encountered in career progression?
3. What experiences, if any, are perceived as instrumental, unequal, or deterrents to leadership advancement in health care?

Theoretical Framework

The role of theory in qualitative research is multifaceted. For this research initiative, critical race theory (CRT) served as the conceptual framework. According to Hiraldo (2010) and Parker and Villapando (2007), a purpose of CRT is to unearth what someone might take for granted when analyzing race, privilege, and the patterns of exclusion that exist in the U.S. society (p. 54). Previous researchers have used CRT in various ways-education, gender, and health research.

CRT has been used in health related topics. Ford and Airhihenbuwa (2010) studied the different approaches to human immunodeficiency virus (HIV) treatment. Ford and Airhihenbuwa used CRT to discover if "racism-related factors were potential barriers to African Americans obtaining readily available, routine HIV testing as recommended

by the Centers for Disease Control and Prevention (CDC)" (p. 4). Not all aspects of CRT were employed in this research. Ford and Airhihenbuwa focused on the prevalence of racial awareness and understanding of cultural dynamics in treatment. A paradigm designed to reduce disparate practice for this disease was created (p. 6). The paradigm is necessary in assuring that treatment plans are consistent across the racial divide.

CRT is used in a variety of different ways. Chapman (2007) used CRT in combination with portraiture. Race, class, and gender were central themes investigated to understand and the discover dynamics associated with urban classrooms (Chapman, 2007, p. 156). Solorzano, Ceja, and Yosso (2000) used CRT to discover the impact clandestine racial practices had on the environment. The perceptions and experiences of Black students were illustrated. (p. 60). Solorzano, Villapando, and Oseguera (2005) used the CRT platform to analyze the challenges and variations in education afforded to the Latino students in college. Ladson-Billings and Tate (1995) used CRT as the conceptual framework for their study on educational inequality (p. 55). In examining how students of Chinese and Filipino descent were classified and considered based on their race/ethnicity, Teranishi (2002) used CRT as the framework to discern if variations existed in the way Chinese versus Filipinos were treated in terms of education.

The chosen framework of CRT was used analytically for this study. A constructionist lens guided this research effort, thus placing the researcher at the heart of the setting to gain an intimate understanding of the phenomena understudy. A deeper understanding of the barriers was acquired from this vantage point. Learned experiences of those exposed to these barriers served as the foundation of this research. The barriers

may yield information on inequality in health care organizations and disproportionate executive body demographics. Only key concepts of CRT were used in this study. The role of theory will be discussed further in Chapter 3.

Lessons learned from BAWs' experiences, relative to this study, were analyzed against the three major tenets of CRT. The three tenets are as follows: (a) a collection of recent stories of unequal practices from the perspective of people of color, (b) an argument for the eradication of racial subjugation through storytelling, and (c) other areas of difference (Creswell, 2007, p. 28). The three tenets identified help shape the research questions. It is critical to understand some originating concepts aligned with CRT outlined in the following text.

CRT focuses on inequalities in society. In CRT, Marx dealt with the problem of dominance by the wealthy. The theory has been used to explore the issue of race and ethnicity. Because people of color, and BAW in particular, continue to face exclusionary challenges, it is important to address the intersecting complexities imposed by race, gender, and class.

Nature of the Study

The nature of this research study was to complete an in-depth exploration of the lived experiences of BAW; attributing factors; and deep-rooted ideologies on race/ethnicity gender, social class, or any other perceived or actual barriers inhibiting advancement to the senior leadership roles in health care. Barriers exist from a broad range. It was unclear exactly how BAW described these experiences.

The range of barriers may be social, institutional, personal, or perceived. Researchers have offered a myriad of perspectives on barriers. Catalyst (2004) revealed that BAWs' "perceived barriers were the limited networking opportunities, exposure, and like- mentors (p. 12). However, Kiamba (2008) suggested that barriers included a male dominated culture, submissive roles of women, and unfair practices. Witt and Kieffer (1998) found that "minorities (persons of color) considered barriers to be the lack of commitment by top management, the board of directors, and human resources" (p. 6). The majority (White persons) considered the lack of diversity candidates, lack of access to diversity candidates, lack of diversity candidates in executive search processes, and lack of commitment by top management as barriers (Witt & Keiffer, p. 6). These findings show to some degree, whether actual or perceived, there are some challenges faced by women aspiring to advance.

Through this study, I explored the lived experiences and perceptions of BAW striving for executive health administration roles to discover what the participants felt thwarted their progression. The choice of a qualitative phenomenological research design was best suited to answer the research questions. Qualitative methods afford an in-depth exploration of a particular phenomenon that provides more understanding from the vantage point of the participants. Maxwell (2005) offered this unique perspective on the advantages of qualitative inquiry.

> Qualitative research substantially contributes to understanding the meaning of situations, events, experiences, and actions. Understanding particular content reflective to participant's actions and influences identifies unanticipated

> phenomena and influences, and understanding of processes of events and develops causal explanations. (pp. 22-23)

The objective of this study was to gain understanding on what BAW perceive or experienced as barriers to advancement, if any. Accomplishing the objective of this research effort required more meaning. The method best suited to answer the proposed research questions was a qualitative method.

Use of a quantitative method, for this type of study, would not provide the descriptive details sought. A quantitative study would have been instrumental in measuring variables as the means to gain better insight of the phenomena understudy. The quantitative method would not provide the viewpoints, in detail, of the participants.

Mixed methods tend to provide a more comprehensive approach to understanding complex context. However, the mixed methods approach was not chosen because of the need for a higher degree of researcher skill, time, and resources. Mixed methods would provide additional information, but the focus was on getting a better understanding as described from the lived experiences of the BAW studied.

Phenomenological designs are commonly associated with the works of Husserl (Moerer-Udrahl & Creswell, 2004). According to Patton (2002), phenomenological analysis is used to grasp and elucidate the meaning, structure, and essence of the lived experience of a phenomenon for a person or group of people. Use of this research approach includes a concentration on lived experiences embodying the essence of a person’s perception of a particular situation. Research questions are shaped and refined

throughout with this methodology, which entails exploring the phenomenon in natural settings, by describing individuals' feelings.

My first inclination was to do a case study. However, a case study approach was not selected because I focused on comprehensively garnering the participants' experiences regarding a shared phenomenon- failing to advance to senior leadership. My objective was to narrate experiences from the participants' subjective viewpoint. Finding solutions to the barriers was not the goal of this study; therein, a grounded approach was ruled out. Ethnographies are studies of a culture or a group's way of life and were not aligned with this study. Narrative studies are reflective of stories. Although storytelling is being used in part with the CRT, this method did not give the most comprehensive approach to answer the research inquiry.

Of the different approaches offered in phenomenology (i.e., hermeneutic and transcendental), the transcendental method was selected. A transcendental, phenomenological study was used as the platform for obtaining answers to the research questions. This method offered a more systematic and structured approach to data analysis. With this approach, I was able to limit bias through bracketing and epoché. According to Moustakas (1994), epoché is the process of setting aside prejudgments and opening the research interview with unbiased, receptive presence (p. 180). Through this study, BAW's perceptions, experiences, opinions, and drives were explored with investigatory techniques of in-depth interviewing.

Definition of Terms

Black American women (BAW): Women born and raised within the continental United States.

Disparity: A disparity is a "population-specific difference that is evident across racial and ethnic groups" (NCSL, 2013, para 1). Disparities represent a lack of efficiency within the health care system and account for unnecessary costs. According to the CDC (2004), "disparities are disproportionate burdens of disease, injury, premature death, and disability translating to decreased productivity, fewer economic opportunities, and social inequality" (p. 755).

Leadership: According to Northouse (2004), Leadership is a process whereby an individual influences a group of individuals to achieve a common goal (p. 3)

Racism:

> Race is defined as a social category or social construction that we treat as distinct on the basis of certain characteristics, some biological, that have been assigned social importance in the society. It is not the biological characteristics that define racial groups, but how groups have been treated historically and socially. It is that society assigns people to racial categories such as black, white, and so on, not because of science, logic, or fact, but because of social experience. (Crossman, 2011, para. 1)

Regulatory bodies: State, federal, and local agencies that have an impact on the operational practices within hospital, including the Center for Medicare and Medicaid Services (CMS), the Joint Commission (TJC), and the local health departments.

Senior leadership: According to the Joint Commission (2009), the chief executive and other senior managers, and in this case, the leaders of the medical staff, make up the governing body (standard LD.01.01.01)

Assumptions

Participants for this study were chosen to provide information regarding the presence of barriers, if any, in advancement to health care senior leadership roles. It was assumed that participants would provide a wealth of meaningful information learned or perceived from their career advancement experiences. A phenomenological design was selected to get at the core of these issues. In the use of this design choice, I assumed that the participants will provide truthful answers. Lastly, I aspired to gain a deeper understanding of challenges faced by BAW and of the ways gender, race, and social class shaped women's' journeys to executive health leadership. The assumption was that the participants chosen encountered inhibiting factors to advancement with respect to gender, race, and social class.

Data reporting included the subjective words of the participants. Epoché and reduction were used to ensure that the experiences of the participants were not masked by my thoughts or impressions. At the beginning of my study, I took the time to write out my thoughts on the phenomenon to separate them from those of the participants. I tried to

capture the essence of my participant's perceptions and experiences through verbatim commentary.

Scope, Limitations, and Delimitations

A delimitation of this study was that the scope was limited to BAW from Washington, DC. A second delimitation was not interviewing BAW from other hospitals, long-term care facilities, and outpatient clinics. A third delimitation was limiting the study to minority women holding health care leadership roles.

Additional limitations associated with this study stemmed from design or methodological weaknesses. The sample was primarily homogeneous, which may not provide multiple perspectives. Results may be important to the persons under study and to those with similar circumstances. The second limitation was potential skewing of data due to the participants' abilities to accurately recall experiences and events that occurred earlier in their careers. A final limitation was that the scope was limited to seven BAW in Washington, DC.

Addressing boundaries of the study included paying close attention during the planning phase to account for quality, integrity, and credibility. Careful attention was paid to reduce bias on the part of the researcher. I used epoché and reduction to limit my own ideas. Moustakas (1994) suggested "that no position whatsoever is taken... nothing is determined in advance; the researcher remains present and focuses on one's own consciousness by returning to whatever is there in… memory, perception, judgment, feeling, whatever is actually there" (p. 84). An interview protocol and a semistructured

interview process were employed to promote order and consistency. I stopped reviewing here.

Methodological weaknesses of the study required assurance of trustworthiness, credibility, quality, and careful planning. An interview protocol provided information about the project, encompassed a few preliminary questions, and served as a data collection tool. Having the introductory questions on hand provided a means of ensuring that each interviewee was given the same starting point to open the interview dialogue. The interview protocol served as a roadmap, keeping the inquiries on course. The protocol was open to amendment as needed. Making amendments included adding additional questions to ensure the true meaning of the participants' statements were being captured.

A formalized set of standards for interpreting and analyzing the data were all part of the initial protocol. The systematic procedure outlined by Moustakas (1994) guided the analysis. CRT was used to help outline units of information for the thematic analysis. In trying to capture the essence of what is being said and take notes during an interview, relevant information may inadvertently be missed. To capture each detail from the interviews and to avoid missing relevant information by note taking, I taped each session using a Samsung voice recorder. Open-ended questions were presented to limit researcher influence.

The data were coded by creating nodes in NVivo. Initially, I used the software to conduct a word query. I used the software to search for key words and phrases that could translate into themes. I read the transcripts line by line to highlight words and passages

that fit under the respective key words and phrases. Use of the combination of hand coding and computer assisted coding helped eliminate ambiguity, when aggregating the high volume of information. Common themes and discrepancies were discerned.

To ensure standards of validation and evaluation, I considered sampling requirements, major themes identified, key findings, the research protocol, and delimitations of the research. I took time to get to know my participants, to aid in building trust. Throughout, the interview process, to control bias, clarification was sought to make sure that I was capturing the participants' views accurately. Patton (2002) suggested that finding such inconsistencies ought not to be viewed as weakening the credibility of results, but rather as offering opportunities for deeper insight into the relationship between inquiry approach and the phenomenon under study (p. 248).

Significance of the Study

This study was conducted to achieve a deep understanding of the perceived/actual barriers faced by BAW in their experiences while trying to advance up the healthcare corporate ladder. However, the findings may be pertinent to both women and minorities interested in attaining executive health care senior leadership roles. Minorities have made significant accomplishments over the past few years; the IOM (2003) concluded that "the healthcare workforce and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" (p. 2).

It is difficult to embrace the intricate cultural and ethnic perspectives of African Americans from outside the race. Issues of access to quality care place Blacks at a

disadvantage (IOM, 2003, pp. 476-477). Knowledge of barriers is necessary to heighten awareness and give insight to the current and future generation of prospective senior leaders. Results from study can be used to inform healthcare organizations of benefits associated with diverse business practices, attractive to communities represented and the workforce. Monster (2012) concluded "diversity inclusion in the workforce is beneficial in many ways. They found that 84% of the time it brought about new attitudes/ideas, learning opportunities (76%), and increased creativity (69%)" (p. 4).

I found leaders with cultural and ethnic knowledge can aid in making critical decisions in resource allocation to better serve increasingly diverse communities, like the urban Washington, DC metropolitan area. Cultural knowledge is necessary to help organizations appreciate the social dynamics influencing minority health. Selvam (2012) noted minority executives use learned experiences in guiding their actions (p. 6). The IOM (2003) suggested that "health professionals and policy makers must also be cognizant of the importance of healthcare as a resource that is tied to social justice, opportunity, and the quality of life of individuals and groups" (p. 36).

Innovativeness and creativity in treating growing diverse populations in modern health care may require more minority leadership as opposed to the typical ethnic makeup with "90% of hospital governing boards being Caucasian" (Selvam, 2012, p. 7). The rationale behind this statement is that including minority perspectives may add better understanding and different ways of approaching care for minorities that fosters enhance trust in providers. The importance of mirroring the face and scope of health care

leadership practice to contend with the demographics in urban areas should not be understated.

This study lends itself to future researchers to determine evidenced-based practices on how to surpass the barriers inhibiting BAW's progression to the executive sphere. Racial and gender concordance can improve quality and patient satisfaction only by employing less exclusionary practices that contribute to disparities not only in leadership, but also among the primary stakeholders, patients.

Summary

The health care market today is fast paced. Organizations hope to maintain competitive advantage. In doing so, organizations will need to be equipped with committed and high performing leaders. Refinement with a more diversified candidate pool is encouraged as part of organizational strategic initiatives aligning with new ideas and sustained growth amongst the ever-changing demographics in the United States. No qualified candidate, despite gender or ethnic origin, should be overlooked in the search for the best health care leaders.

For over 2 centuries, racism has been evident in the United States. What was an outward norm has now become a clandestine practice, which adversely affects business capabilities to exercise fair treatment (Yosso, 2005, p. 70). Discoveries of the lived experiences of BAW venturing to attain executive leadership may benefit this group, as well as all women of color and minorities in the health care administration field. Through this study, I aimed to discover whether any actual or perceived barriers exist which were inhibiting factors contributing to BAW not reaching executive level healthcare roles, in

the Washington, DC area. Chapter 2 is a review and synthesis of the literature related to this topic.

Chapter 2: Literature Review

Introduction

A disparity exists in the underrepresentation of BAW reaching senior health care leadership. Diversification of the nation's workforce may be beneficial. Cohen, Gabriel, and Terrell (2002) noted that "diversifying the healthcare workforce my help improve access and quality of care, advance medical research efforts, as well as, optimize management of the healthcare system" (p. 91). Although Black Americans have made strides in in career advancement, a lag is apparent in terms of representation (Kerby, 2012). BAW continue to have gender and race issues (Sdonline, 2011, para. 9). The purpose of this transcendental phenomenological study was to understand the lived experiences, perceptions, influential factors, or deterrents to the advancement, to BAW's progression toward senior health care leadership. This literature review includes a summary of barriers to advancement including race, gender, and class issues, and factors facilitating advancement into senior level administration.

Prior to undertaking the literature review, I reviewed a number of articles to establish the gap in the literature. Very little literature was available that discussed the BAW's perspective on the reasons for lack of representation in senior healthcare leadership positions. For this literature review, I reviewed over 115 literary sources. Scant literary resources were found that give theoretical acknowledgment to the subject matter. Most theories found in the literature related to career development were written with a focus on White males. The findings are noted in the table on the following page.

Table 1

Literature Search

Accessed Library Databases and Search Engines	Key Search Terms and Combinations of Search Terms	Relevant Themes Identified
Pub Med	• Gender • American Women in Healthcare • Poor Health • Black Culture • Black Women and Healthcare • Disparate Healthcare Matters • Academic Medicine • Unequal Treatment • Culture • Promotion of African Americans	• Diversity • Racial Health Disparities • Cultural Diversity • Reducing Disparities • Mentoring • Cultural Competence • Barriers to Recruitment • Meshing with the Community • Recruitment and Retention • Conceptual Barriers
ProQuest	• Black Women • Black Women Leaders • Disproportionalities • Inequalities in work	• Cultural Competence • Race and Gender Matters • Lack of Diversity • Skin Complexion
SAGE	• Race • Inequality in Work Promotions • Gender • Ethnicity	• Intersectionality of Race, Gender, and Class
Google Scholar: Used when limited literary sources were apparent from other databases. Almost all articles could be accessed through Google Scholar, but were not all provided through the Walden Portal	• Black Women Leaders • Lack of Black Women in Leadership • Discrimination in the Workplace • Discrimination in Hiring • Race and Gender • Promotion of Blacks in healthcare • Covert racism • Barriers to Black Women's Advancement • Successful Strategies for Black Women Health Providers • Perceptions of Black American women	• Unfair Hiring • Limited Advancement • Dual Disadvantage • Race Related Matters • The Historical Perspective regarding BAW

Because of the limited publications on this subject matter, multiple databases and search engines were used to obtain relevant information. Literary sources were inclusive of over 100 articles, and a few books. Limited resources were found in the review of literature that provided information from the perspective of BAW and the absence or presence of barriers to advancement. After reviewing the numerous articles, I focused my review on the intersectionality of race gender and class with respect to BAW in quest of advancement. I looked closely at historical matters aligned with this approach. Issues consistent with struggles for persons of color were the foundation for this study. The theoretical framework was critical race theory, which is further discussed in this chapter. Grasping a full understanding of the phenomenon under study requires some insight into the historical perspective.

Historical Perspective

Historical analysis of the events that wedged tension between Blacks and Whites from the times of slavery lends insight and may be instrumental to the future integration of care. Since the formation of this country, Blacks in America experienced myriad challenges. Smedley, Stith, and Nelson (2003) articulated that "racial tension and conflict was constant between Anglo-Protestant Americans and African Americans under 246 years of brutal and explosive chattel slavery, followed by 100 years of social segregation, physical oppression, political subjugation, and economic exploitation" (p. 459). The lengthy epoch brought on strong feelings that Blacks or Whites cannot be easily erased. Unequal practices continue affecting Blacks as a race in entirety.

Even after the abolishment of slavery and the launch of civil rights movements, Blacks in America experienced unequal practices. The enactment of different legislation, such as the Civil Rights Act of 1964, helped Blacks become an integral part of society's workforce. Advancement of women of color, in particular, has not occurred at the same pace.

Black American women have experienced barriers to equal employment opportunities. According the IOM (2003), women struggled continuously for their rights. "The Civil Rights Act of 1964 specifically addressed exclusionary practices against women and ethnic minorities from positions within organizations through recruitment and selection practices" (Smith & Joseph, 2010, p. 744). Changing imbedded prejudices holding Blacks in a lower social status and Black women virtually invisible has been a century long battle that has yet to be won.

Black women lagged further behind the movement of Black men and White women in the workforce. "Women of color currently make up about 33 percent of the female workforce and are twice as likely as their white female counterparts to be employed in lower-wage sectors such as the service industry" (Kerby 2010, p. 2). According to CNN Money (2010), there were "only 15 women holding the position of Chief Executive Officers of Fortune 500 companies in the United State" (Kerby, 2010, p. 2). With all of the advancements, inequality exists in hiring practices, unequal pay, slower promotion rates, and disparities in health care (Kerby, 2010). BAW have a double disadvantage due to being a minority and female.

Changes in healthcare leadership hiring practices virtually remained at a stalemate with respect to the White male status quo. Women in leadership have made great strides to equally advance; but, there is a lag in the number of BAW making it to key senior leadership posts in health care administrations. The number of women reaching executive posts in business, in general, has been low. According to Heller (2011), "only 15% of all Fortune 500 Company directors are women. In those same companies, women account for only 6% of executives, and 3% of Chief Executive Officers (CEOs), and women account for only 2.8% of Fortune 1000 company CEOs" (p. 2).

Catalyst (2004) concluded that "African American women occupied 1.1 % of the 10,092 corporate office positions within Fortune 500 companies" (p. 2). History boasts of equal rights legislation; but, the reason behind the underrepresentation of BAW remains unknown within the health care administration and Fortune 500 Companies. Currently, only one Black female CEO of a Fortune 500 company is in office; that is Ursula Burns at Xerox (Black Profiles, 2015, para. 3).

There is a lack of BAW in health care executive leadership roles exists. The issues of race, social class, and gender are elements of inquiry. According to the American College of Health Executives (ACHE, 2008), disparities in the proportion of top-level management positions held by White women and minority women remain (p. 2). ACHE also reported disparities were noted in pay, minority representation, and thoughts on diversity with respect to executive positions (pp. 2-5). The remainder of the literature review delves deeper into the problem, the theoretical foundation, as well as a review of current literature on the topic.

Theoretical Foundation

Explicating the role of theory in qualitative research is multifaceted and differs from the use in quantitative research. Creswell (2009) stated, "in phenomenology, theory may be used in an attempt to build the essence of experiences from participants through rich detailed descriptions" (p. 64). Theoretical frameworks are used to support the findings from research or the need for additional research on the topic. The focus of this study was an exploration of perceptions, perspectives, and experiences of BAW vying for executive leadership roles in health care.

CRT was used as the framework, methodological, and epistemological tool for this study. Although CRT does not address the proposed study population in terms of education, it is being applied to address the promotional inequalities faced by BAW. CRT is a framework that has semblance with the issues with race as a core concept. This theory ties into the problem and purpose of this research. Barriers to advancement were explored for BAW including race, issues of inequality, conflict between racial groups, and racial implications on promotion and health. CRT was used to aid in thematic analysis to discover how race and racism played a role in advancement to the executive sphere for BAW.

The reason CRT was chosen for the framework is twofold: (a) the theory addresses the interconnection with the sociohistorical context of racial barriers in the United States; and (b) it highlights race, class and gender, which can silently impede career growth for Black people (Carbado & Gulatati, 2003, pp. 1766-1767). Racism has

been an integral, endemic, and a consistent part of mostly every aspect of American history, law making, and institutional norms.

CRT uses storytelling to illustrate current racial issues "that make up common culture about race" (Delgado & Stefanic, 2013, p. 3). Of interest was the story noted by Ladson-Billings (1998) about "Arizona refusing to acknowledge Martin Luther King Day as a major holiday" (p. 12). Black people started protesting. The governor decided to acknowledge the holiday, not because of Blacks protesting, but because the loss of revenue due to services from the NFL and NBA being cut. Both Blacks and Whites benefitted from this yielding "converging intersects" (Ladson-Billings, 1998, p. 12).

According to Ladson-Billings (1998), "CRT emerged as a counter legal scholarship to the positivist and liberal legal discourse of civil rights. The origin of this theory can be traced back to 1970 as a primary masterpiece of Derrick Bell" (p. 10). Initial work on this theory began as the Critical Legal Studies, (CLS). Later, the CLS took on a different perspective as scholars discerned that not much advancement was made from their work unless there was some associated benefit for Whites. That thought catapulted the race principle. CLS advanced to another dimension with race at the core changing the name and course to the CRT. The original scholars postulated that laws are not designed without error. Per CRT, humans are fallible, and the work of humans is also fallible.

CRT disagrees with the persistence of adverse effects of race (Delgado & Stefancic, 2012, p. 7). Three themes emphasized in CRT are consistent with this research effort. The theory considers that racism is essentially the way of life for persons of color.

According to Carbado and Gulati (2003), "CRT considers blindness to race as means of eliminating racism" (p. 1766). The theory posits race has become so embedded in society that it is virtually invisible, and difficult to detect or eradicate.

CRT surmises that society has a best interest principle. Under this principle, laws are passed when they benefit the white population, more so than they benefit blacks. Under CRT society groups and assigns a character stigma based on color, not individual values; the latter is referred to as "social construction" (Delgado & Stefancic, 2012, pp. 7-8).

CRT focuses on racial inequities in education, but was used in this study to illustrate inequalities in promotion and the struggle for gender-dominance. This study aligns with the following major tenets associated with this theory: (a) the importance of storytelling; (b) the push to move past the racial divide; and (c) the inclusiveness of the impact of sexism, racism, and classism (Creswell, 2007, p. 28). The research design will be discussed more in Chapter 3. Even though the racial divide has lessened, subliminal tension between the cultures remains a struggle (Pierre, 2005).

CRT, as the framework, is intended to provide information from the BAW's perspective, which is void from many earlier studies. For many years, scholars appeared unaware of the Black women's role in the modernization healthcare process. It is desired that this study bring about health care administrators' growth in recognition of the importance of the role Black women play in reducing health disparities simply by their presence as well as their ability to connect with people of color and understand the culture.

Background Literature

The number of women in executive roles is less than for men (Warner, 2014, p. 1). For some reason males, whether Black or White, seem to be more widely accepted. Black males made strides in advancement up the health care corporate ladder. Nevertheless, their progress continues to lag behind that of White males. According to Lantz (2008), males are ideal candidates.

Women are not widely considered as ideal candidates for what have been male-dominated roles. Lantz (2008) found race, lack of mentorship, and lack of networking as barriers to advancement (p. 13). For women, variances in wages, a decrease in opportunities for advancement, and little or no support, respect, or involvement in succession planning is evident across the health care industry.

Overall, women hold "31.2% of senior level positions" (Lunney, 2011, para. 2). Lantz (2008) showed "women compose 78 percent of the healthcare industry's workforce and are the largest consumers of healthcare" (para 4). Despite this large representation in the workforce, women remain underrepresented in top management and executive leadership positions. Women continue to face serious structure barriers inhibiting equal representation and limiting diversity in leadership demographics (Lantz, 2008, para. 4; Weil & Mattis, 2001).

Despite of the progress made by women in terms of gender and racially based diversity in the advancement to the executive level, BAW remain severely underrepresented. According to ACHE (2008), "only 13% of BAW held chief executive roles; while the percent of Whites stands at 24%; Hispanics 22%; and Asians 7%" (p.

27). Not only are there disparities in representation of BAW, pay is disproportionate. "Among the women CEOs, whites earned a mean of $213,000 which is 14% higher than the $187,000 average earnings of black women in the study" (ACHE, 2008, p. 15).

There were very few current researchers who addressed the issue of BAW in health care. Keywords used in the search were *women, race leadership, culture*, and *Black women leaders*. Various study results reviewed exposed hindrances to the progression of women. BAW face two major deterrents, "historic race and gender barriers to reaching full potential" (Rosser-Mims, 2010, p. 2). The presence of the race factor widens the gap in representation in top-level positions beyond consistent gender disparities. Parker (2005) revealed "contemporary African American women's organizational leadership is grounded in a tradition of survival, resistance, and change that historically has been ignored or devalued" (p. xiv). Black women desiring to advance to higher roles in leadership must be driven and internally motivated to continue trying to overcome the perceived or actual barriers encountered either on the premise of race or gender.

The issue of class designation also informs the problem. Class distinction for Blacks emanates from earning lower wages, placement in lower positions, or not being recognized for the progressive track. Maume (2012) concluded that Blacks in labor and leadership roles make less than Whites in small or large companies (p. 207). The salary gap was sizable for both roles.

Racial, gender, and class were frequent themes resonating throughout the literature as key barriers inhibiting BAW's careers. Race has roots deeply entwined that have grown into a complex set of interconnected challenges still faced by Blacks. Gender issues have been common for women of all races and ethnicities as long as racial issues have been apparent for Blacks. Women's roles have slowly evolved from the mindset that the woman's place is in the home. Another area of consideration is one of class, which tends to have even more of a stigma for people of color. Minority class distinction has been a secondary underlying consequence from the "larger context of the increasing polarization of income and wealth in the United States" (Williams, Yu, Jackson, & Anderson, 1997, p. 336).

Currently, Black Americans struggle to overcome stereotypical socioeconomic factors limiting benefits of earlier and better educational opportunities, networking and professional exposure, along with mentoring. Williams and Rucker (2000) reported stereotyping was the reason for employment denials of Blacks by White employers (p. 78). Kay and Gorman (2012) found empirical evidence indicating that "at least a portion of the racial gaps in promotion and managerial representation is explained by differences in education and technical skill across racial groups" (p. 93). These findings discuss collateral issues that may inhibit the progression of BAW, but fall short of discussing how the experiences evolved.

Pervasive and systematic inequalities within organizations, society, educational institutions, and health care, which favor the reduced advancement of minorities, force BAW to make a number of sacrifices. Kiamba (2008) examined the challenges

encountered by African women aspiring for leadership roles and the difficulties they faced. Stereotyping and family matters were among the barriers described (Kiamba, 2008). There remain opportunities for exploring how this same phenomenon affects BAW. Women are still seeking leadership advancement "in all spheres of governance in both the public and private sector" (Kiamba, 2008, para 1). Non-Black women are advancing in leadership, while BAWs' advancement is seemingly stagnated (Acker, 2006, p. 444).

Documented accounts of BAW leadership history are limited (Parker, 2005). An initial step in the change process may be learning from others' analytical insights on alternate routes to overcome obstacles stunting advancement. "Within the ethnicity paradigm, leadership studies have not seriously examined African American women as leaders" (Parker, 2005, p. xiv). Parker's study was conducted to gain a better understanding of culture, beliefs, and values associated with BAW, demystifying the unknown.

Collectively, the literary findings were compiled to provide factual representation of major workplace challenges and documented perceptions and experiences of BAW. I explored relevant issues cited, which accentuated documentation of lived experiences of BAW and recommended strategies for BAW to consider while striving for senior health care leadership roles.

The comprehensive review of the literature did not reveal a host of current literary works relating to BAW's perception of milestones encountered as they navigated the career ladder. There were limited meta-analyses, randomized control trials, and

systematic literature reviews that explain or solidify issues as perceived by BAW on the health care career progression. The lag in career progression of BAW may adversely affect the Black community, who may have benefitted from their presence in executive healthcare leadership. Issues related to race inequality remain a primary issue for BAW. The problem is the lack of empirical evidence addressing discriminatory hiring practices and discriminatory care that continue today.

BAW remain severely underrepresented in healthcare leadership, and in the corporate world. Caldwell and Watkins (2007) noted "despite inadequate resources, low socioeconomic status, and insufficient opportunities, African American women have managed to survive" (para. 3). Irrespective of BAW's advancements in the workforce, a great deal of published literature failed to address challenges faced by Black women striving for corporate roles. In general, the findings were principally based on the journeys and opinions of White American women (WAW). Theories were not based on the Black American perspective, nor did they capture the quality of life most Blacks endured. Some material outside of the 5-year span recommended for this research effort was used as the framework divulging this problem. Vast amounts of historical references are present to illustrate the origin and context of the problem. In this section, findings from the literature are discussed framing the problem and demonstrating opportunities for further research from the perspective of BAW on why their career advancement to executive leadership has been inhibited.

A qualitative research approach, transcendental phenomenological design, was chosen for a richer account of the real or perceived barriers, from the perspective of

BAW. The purpose of this study was to gain a better understanding of the disproportionate number of Black women versus White women/men holding senior health care leadership positions. Phenomenological studies provide information on experiences from the participants' point of view, which will be discussed further in Chapter 3.

The following section of the literature review is an in-depth analysis of three themes synthesized from the research, closely aligned with the research problem. The identified themes encompass implications of race, class, and gender on BAW's advancement. As each theme is discussed, inhibiting factors to BAW's advancement are also explored.

Societal and Health Implications of Race, Class, and Gender

Three overarching themes were identified through the review of literature. The most recurring and challenging factors that I noted from the literature hindering the advancement of BAW were: race, class, and gender barriers. These interrelated themes were found to have some inference on advancement of BAW. Although not all factors are told through the voices of BAW, it is important to discuss the context of the issue. The IOM (2003) surmised that "the United States is still highly stratified based on race, ethnicity, and class, and growing income inequality over the past decades may be accentuating these trends" (p. 474). In the subsequent text, information from the literature regarding race, class, and gender, which are "analytically separable, but closely interrelated" (IOM, 2003, p. 474), are reviewed in depth.

The Race Factor

The Race Concept

Race is an integral part of American culture and social history. Both race and racism are prevalent in some form today in America. The historical aspect of race regarding Black Americans is introduced in the following section to better understand the potential implications of racial oppression on the career advancement of BAW.

Race by Definition

Historical origin of the word race stems far back in American history. According to the IOM (2003) and Feagin (1999), the term "race historically was used as a means of singling out people within the human species in terms of a biologized 'race' hierarchy, a distinctively European and Euro-American idea, that highlights the Western origins of today's pervasive racial worldview" (p. 490). The definition of race evolved through history and is connoted various ways by anthropologists, biologists, and historians.

The topic of race is difficult. Coming up with a definition that fits most criteria is challenging. According to Foster (2009), "geneticists recognize the scientific complexity surrounding the relationship between genetic data and analyses and racial and other social identities, the debate itself for the most part does not reflect that scientific complexity" (p. 356). The topic of race is so intricate that it evolved into an entire field of study (i.e., biological anthropology). Strkalj (2007) posited two conclusions regarding "the concept of race in biological anthropology: there is still no consensus on the race concept and there are significant natural/regional differences in anthropological attitudes toward race" (p. 75). Crossman (2011) articulated the definition of race adopted for this study.

> Race is defined as a social category or social construction that we treat as distinct on the basis of certain characteristics, some biological, that have been assigned social importance in the society. It is not the biological characteristics, per se, that define racial groups, but how groups have been treated historically and socially. That is, society assigns people to racial categories such as Black, White, and so on, not because of science, logic, or fact, but by social experience. (para. 1)

Racism is a term used to "note difference, but evaluates that difference ranking it into superior or inferior, higher or lower types" (Fluehr-Lobban, 2006, p. 4). Asians are credited with the top-level of intellect, while Blacks are the least (Fluehr-Lobban, 2006, p. 4). With these variables, there is a potential for the racial divide to widen. The issue of race has resounding implications that are apparent today.

Racial Implications

Given the significance of how race shapes relationships in America, it is understandable why it is difficult to define. Racial issues between Blacks and Whites in America span over 200 years. "Race and ethnic prejudices, biases, oppression, and conflict were embedded in the colonial antecedents, the founding period, and central documents of the new republic" (IOM, 2003, p. 458). Despite advancements in the quest for equal rights and acceptance of racial and ethnic groups, race remains a sensitive topic within organizations and society. Years of oppression from slavery, segregation, and clandestine discriminatory practices contribute to the racial divide between Blacks and Whites in the United States.

There are issues and examples in society that illustrate the reality of race. Twentieth century racism was overt and often undeniable (Brown, 2004, para. 3). According to Fluehr-Lobban (2006), "racism can be easily identified with ideas of white or Aryan supremacy associated with Nazism or the Ku Klux Klan" (p. 4). Racist actions of this era are difficult to detect (Brown, 2004, para. 3). Deep-seated racism may be difficult to erase from the minds of those subjected to it as well as from the minds of the oppressors, whose beliefs may have been inherited.

Deeply embedded thoughts of Black inferiority may transcend too many areas of society, including the job market. Institutionalized racism is a "differential access to the goods, services, and opportunities of society by race. Institutional racism is normative, sometimes legalized, and often manifests as inherited disadvantage" (IOM, 2003, p. 523). Institutionalized racism may be evident at an individual or organizational level. This form of racism may have an impact on hiring practices regarding BAW in a health organization.

The Impact of Race in Health Organizations

Numerous aspects of society witness institutionalized racism in education, the judicial system, and in health care. Since institutionalized racism takes on various forms and roles, it is important to clarify that this research effort focuses exclusively on the racial implications regarding BAW. The problem with this form of discrimination in health care is that it may adversely affect patients and often results in health disparities. Wagner et al. (2011) concluded racism is detrimental to wellbeing. This finding was substantiated in the study (Wagner et al. (2011) conducted on African American

women's beliefs on racism. "The women reported that exposure to racism was a common phenomenon and their beliefs did in fact link racism to poor health" (Wagner et al., 2011, p. 224).

Institutionalized racism is disadvantageous in that it poses barriers to the advancement of minorities, and "is perhaps the most invidious form of racism, because it operates with the imprimatur of the state. It is, though, a form of racism that is often officially denied" (Jackson, 1987, p. 9). This finding aligns with one of the tenets of CRT. Delgado and Stefancic (2000) remarked that CRT considers racism normal in American society. The presence of racism becomes acceptable and part of the scenario.

Race alone is a contextual electromagnetic energy that has delivered undesirable currents. Gender and class stratification may add challenges. Lower income status, living in underprivileged communities, as well as issues with access and quality of health care are challenges associated with mounting racial disparities for Blacks and other minorities.

Betancourt, Green, Carrillo, and Anaeh-Firempong (2003) created a "framework of organizational, structural, and clinical cultural competence interventions" (p. 293) to address health disparities imposed by race. Among the best practices found as counter measures for reduction of organizational barriers was the establishment of "leadership and workforce reflective of the racial/ethnic composition of the general population" (Betancourt et al., 2003, p. 295). Cohen, Gabriel, and Terrell (2002) found the importance of matching the workforce to some degree with the leader, recommending early career planning.

Not all researchers argued that matching the leadership, workforce, and patient population is sustainable as a standalone measure for reducing a portion of health disparities. Cooper, Hill, and Powe, (2002) offered the following perspective, "surface structures include matching of intervention materials and messages to observable characteristics of the target population, identifying the channels, and setting most appropriate for delivery of the intervention, and incorporating interpersonal sensitivity and cultural competence" (p. 483). Cooper et al. suggested that it would be even more sustainable if experimental studies were done to highlight the different values, beliefs, and unique facets affecting behavior of the population to find common qualities with other races.

Changing leadership to match the image of the community served may not be the definitive solution to eliminate disparities. It may be instrumental in the reduction of health disparities. Having BAW in health care leadership and the workforce may potentially benefit the majority of the Black population in a city like Washington, DC. Increased trust in health care providers may increase compliance with preventative medicine and could inversely aid in the reduction of healthcare disparities. Betancourt (2006) surmised elimination of disparities involves addressing barriers. The barriers Betancourt described were the identification of the causes and education on the effects-clinical outcomes (p. 791).

In 2009, Ospina and Su conducted a qualitative study to examine the inner workings of race in fostering social change within organizations. Ospina and Su contended that omitting focus on race factors cannot continue. Enhanced comprehension

of race may influence social change in leadership, lessening the promotion of racial justice and equality. Better understanding of the dynamics of race could catapult to a new approach to hiring. As long as institutionalized racism exists, BAW may remain challenged in health administration career promotion. Without there being major shifts in the provision of care, improvement in patient provider relationships, and changed hiring practices in healthcare, racism may continue to tear away at all of the progress made following the civil rights amendments an add to adverse clinical outcomes. In this last section on race, I discuss clinical implications.

Adverse Clinical Outcomes

Failing to address the issue of race may yield adverse outcomes and circumstances linked to poor clinical outcomes for a number of Black Americans. For example, nutritional patterns are significant in proper treatment regimens (DHHS, 1998, pp. 5-6). Such research has provided evidence that race may have adverse influence on clinical outcomes for Black Americans. The IOM (2003) stated "evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare service" (p. 5). Carlson and Chamberlain (2004) posited that "racism experienced in organizations may adversely impact health, advancing disparities" (p. 372). Incidence for disease is higher for Blacks than Whites (SAGE, 2010, p. 473). Williams, Yu, Jackson, and Anderson (1997), Krieger (1987), and National Center for Health Statistics (1994) articulated that this is a persistent problem. "African American women who are diagnosed with breast cancer are less likely than White women to survive five years after diagnosis" (National Cancer Institute, 2013, para. 1).

Mortality rates for Blacks from cancer were the highest overall (National Cancer Institute, 2013).

There are differences in the clinical outcomes of Blacks as opposed to Whites. Randall (2002) asserted that "infant mortality rates are 2.5 times higher, the death rate from heart diseases is higher; 50% of AIDS, cases are among minorities; diabetes is 70% higher among African Americans" (para. 1). Likewise, Jha et al. (2013) concluded that "Black women less often received appropriate preventative therapy and adequate risk factor control despite a greater congestive heart disease (CHD) event risks" (p. 1089). Inequalities in treatment, approach, and response to health care have been evident for some time in America among Blacks. Disproportionate clinical outcomes result from a conglomerate of factors (Betancourt, Green, Carrillo, & Anaeh-Firempong, 2003, p. 294).

With significant health challenges prevalent in Black American's lives, the need for BAW in senior decision-making roles is more apparent. Collectively, race and class were common variables, found throughout the literature, linked to health care disparities, unequal hiring practices in healthcare administration, and societal implications.

Class/Social Determinants and Health

Class is not part of the U.S. equation in computing healthcare statistics (Kawachi, Daniels, & Robinson, 2005, p. 343). Race has been used to differentiate issues that should have been categorized as class or independently. The role of race is evident in matters of employment and compensation (Kay & Gorman, 2012, p. 93). According to Acker (2006), class designation is determined by income. Class designation may impair career advancement, maintenance, and promotion of health. How class is determined is a

sum of different intersecting factors such as relationships, health, and socioeconomic factors.

Hardaway and McLoyd (2008) stated class distinction is propelled by education and financial stability (p. 242). Class, a euphemism for race, can affect health (Kawachi et al., 2005, p. 344). The IOM (2003) found that historically, "some groups were confined to lower-class positions because of lack of access to both power and economic means that are built into the status system by formal and informal, structural, and to some extent legal norms" (p. 474). This finding makes health disparities seem inevitable.

Healthy lifestyles are a well-known indicator of higher social class (Marmot, 2005, p. 2). The ill effects of social and economic factors are consistent with the hierarchy in life and work. Higher socioeconomic status is associated with a decreased incidence of disease (Shavers, 2007, p. 1013). "Social determinants are relevant to communicable and noncommunicable disease alike" (Marmot, 2005, p. 1). Those privy to better jobs have a better quality of life.

Prolonged subjection to poverty can breed a type of "social exclusion with a major impact on health and premature death, and the chances of living in poverty are loaded heavily against some social groups" (Wilkinson & Marmot, 2003, p. 16). The case for Black Americans is that for years society regarded this group as indigent. Poor beginnings have adversely affected career advancement and health.

Educational disadvantages, lesser employment opportunities, poor housing, and lack of access/quality of health care within the Black community are primary deterrents to advancement on many fronts. Acker (2006) articulated that "race, even when paired

with ethnicity encapsulate multiple social realities always inflicted through gender and class differences" (p. 442). This vantage point illustrates that race, gender, and class have common facets that converge as indicators of inequalities that translate into gender disparities.

Using Black and White as the variables does not separate or capture income level, scholastic propensity, or other socioeconomic status. Not all Blacks are categorized as low income. "Using class as a control variable is recommended" (Kawachi et al., 2005, p. 346). Race has a bearing on how society characterizes individuals; but, this burden is equally differentiated by class.

Fuller-Rowell (2012) conducted a study with the support of the Robert Wood Johnson Foundation and did not use race as a dominant variable. Most of the participants were White. Fuller-Rowell focused on class distinction. "Fuller-Rowell's (2012) model suggests that about 13% of the negative health effects if poverty on health can be attributed to perceived discrimination" (para. 7). The type of discrimination being referred to in this study is class-based. Living with the class distinction of being poor can negatively affect health (Fuller-Rowell, 2012, para. 8).

Inequalities are notable between classes differentiated as poor, middle, and upper class. Being disadvantaged whether race, gender, or class issues, has an emphasis on health outcomes, job placement, and community acceptance. The significance of class is as heavily weighted in the workforce as it is in the community. Acker (2006) stated that organizations have played a role in constructing class inequalities (p. 441).

Even in the armed forces, class distinction is present. The officers cannot fraternize with the enlisted personnel. Armed forces officers have better accommodations and privileges not afforded on the same scale as for the enlisted. With the government setting that standard, other privately owned agencies may have even more distinctions by class. What is noted here is consistent with how Acker (2006) described class as an "enduring and systemic difference in access to and control over resources for provisioning and survival" (p. 444).

Within organizations, class distinctions are evident through the hierarchy of positions and variations of pay scales. This relevant fact has attributed to the continued presence of disparities in health status. Kawachi and Kennedy (1999) reported that the "United States led the industrialized world in the extent of income inequality, and the gap, was growing" (p. 216). With health status being proportionate to class, among other factors, it is not difficult to understand the degree of health disparities plaguing the indigent and Black Americans.

Health disparities in the United States have been apparent from the time of the early settlers. "National data reveal that over the past 50 years, the health of both black and white persons has improved in the United States as evidenced by increases in life expectancy and declines in infant and adult mortality" (Williams & Rucker, 2000, p. 75). Race intersects and complicates issues imposed by class distinction. As addressed by Williams and Rucker, "throughout the history of the United States, non-dominant racial groups have, either by law or custom, received inferior treatment in major societal institutions" (p. 76).

Gorin, Badr, Krebs, and Das (2012) synthesized a body of research redefining the underlying health disparities in "cancer as falling under three categories: distal, intermediate, and proximal determinants" (p. 100). These common themes are of significance as they can be used to articulate how race, class, and gender influence lifestyle, career path, and health. The distal facets are those related to access and quality of care and social determinants. Socioeconomic inferences, including environmental settings, are intermediate determinants. Proximal determinants are those that are aligned closely with the human health factors.

Race, class, and gender fit well into these categories. Class distinction is closely configured with the distal determinants. Class distinction/social status emphasizes shared social norms. Betancourt (2006) described "social determinants as lower level of education, overall lower socioeconomic status, inadequate and unsafe housing and living in proximity to environmental hazards" (p. 788). The well-to-do are not in need of definition by class attributes. Most wealthy people are privy to higher quality lifestyles. Social determinants are characteristics assigned mostly to Blacks (Betancourt, 2006, p. 788).

People categorized as low income have shared social behaviors that may not mimic those of the upper echelons of society. Those in the lower income level may not have the same health care benefits, which tend to yield lesser access to quality service. Unlike the middle class, the rich have options for health care that are seemingly limitless. Working class individuals may not have the flexibility to go to the doctor's office during

work hours. Some lower income jobs are paid by the hour and people in that category cannot afford to leave work to make it to the doctor during their office hours.

The concept of race fits with intermediate determinants. Race encompasses the lifestyles of people and their relationships in society. What is significant under this category is that race has inference from a biological standpoint to one of cultural socialization. The IOM (2003) optimized the view on racism by proclaiming that "race and racism embody virtually all of the moral, egalitarian, medical ethical, and American Creed issues that burden our society and health system" (p. 492). Race could also be intertwined with the proximal determinants due to its biologic affiliation.

Gender can be grouped as a proximal determinant. When gender is classified as a proximal determinant, culture defines the gender role assignment, irrespective of the dominant gender. Dependent upon the respective theorist, proximal determinants may be categorically defined differently. The suggested and implied meaning generally remains consistent. There are many ways of classifying determinants that may be interchanged to emphasize variables used in exploration of the impacts of race, gender, and class. For this study, the sub groupings are race, gender, and class.

Gender Challenges

Race, gender, and class are attributing factors to health disparities when influencing hiring practices for minorities (Pager & Shepherd, 2008, p. 181). Race is an unwelcomed discussion (Bulmer, 1986), that is a central theme noted in studies on inequality. Class and race themes noted from literature reviewed for this study were evident as single topics or combined elements that have overarching themes linked to

disproportionality in health care outcomes for Black Americans. Gender is a topic that was well represented throughout either combined with race and class, or used in a category of its own.

Gender related issues are common throughout the world. This study is concentrated on a gender-related issue found exclusively in the United States. Sen (2001) revealed "gender is not a homogenous phenomenon, but a collection of disparate and interlinked problems" (p. 466). When coupled with race and class, gender becomes a tertiary barrier making the progression for some BAW leaders impenetrable.

Race and gender are recurrent themes generally found in literary works on unequal practices. From this literature review, these themes resonated in studies on the unequal representation of women and treatment thereof, not only women in healthcare leadership, but in the general workforce (Johns, 2013, p. 2). "As evidenced, these theories based on the White male experience attempt to generalize leadership characteristics and as a result do not reflect and devalue black women and other disadvantaged groups' leadership experiences" (Rosser-Mims, 2010, p. 5). Gender is one of the most common barriers found impeding advancement of women in the workforce (Johns, 2013, p. 2). Whether organizations favor male dominated leadership, or imposed implications related to women's role in families, gender is a common issue.

The Civil Rights Act of 1964 was passed and organizations formed, like the Equal Employment Opportunity Commission (EEOC) and the Department of Fair Employment and Housing (DFEH), to increase gender and racial equality. There is a lack of empirical data documenting the lived experiences of BAW and their perception of unequal

practices, if any, in the workplace. BAW experience variances in pay, slow promotion rates, and health disparities, compared to other ethnic groups (Acker, 2006, p. 445). Allowing equality in hiring decisions of BAW leaders is an introductory step in reducing health disparities (Sullivan Commission, 2004). Health disparities incurred among BAW alone are concerning. All of these inequalities demonstrate that the quest for equal rights has not ended.

Problems remain for BAW aspiring for promotions overall (Williams & Rucker, 2000, p. 78). Having an introspective viewpoint directly from the BAW's perspective may help in devising a counter measure to overcome both perceived and actual barriers to advancement that may exist. Available literature documenting the experiences of BAW is scant and dated. To gain an understanding of the difficulty imposed on BAW by gender and race, it is discussed below.

BAW's Historical Challenges

Black Americans have encountered many struggles in America. According to Williams and Rucker (2000), "throughout the history of the United States, non-dominant racial groups have, either by law or custom, received inferior treatment in major societal institutions" (p. 76). The abolishment of slavery was not the end-all in the quest for equal rights. As cited by Rosser-Mims (2010), "black women of to-day occupy … a unique position in this country…. She is confronted by both a woman question and a race problem, and is yet an unknown or an unacknowledged factor in both" (p. 2).

BAW struggle with two unchanging factors: being female and Black (Lantz, 2008, p. 291). The Civil Rights Act of 1964 prohibited discriminatory practices. To date,

the fight for equal health care career appointments, to executive roles, for blacks remains challenging. Laws limit overt discriminatory practices, not the clandestine practices. Studies have been conducted with the intention of analyzing the degree of diverse representation in organizations and the ability to manage diversity (Sullivan Commission on Diversity, 2003).

In health care leadership, "blacks still do not feel equally represented" (Witt & Kieffer, 2006, p. 4). Blacks' mindsets and approach to work may have been influenced by years of oppression and "educational, cultural, and social disadvantages" (Kay & Gorman, 2012, p. 93). Stories of Blacks, expressive of their work ethics, are not readily evident in the literature.

Unique Perspectives of Blacks and Women

Women today may actually be discouraged from vying for top leadership roles. Vanderbroek (2010) studied the impact of gender and its association with diversity in organizations. Vanderbroek revealed two roadblocks encountered by women with stagnating career growth in leadership: (a) women fail to demonstrate their individual perspectives and unique leadership abilities, and (b) corporations make decisions based on assumptions of character and performance primarily aligned with male-dominated practices.

Men and women have different styles of leadership with varying performance-based measures. Smith and Joseph (2010) did a qualitative case study to find themes "on gender differences in leadership, career progression of women, gender diversity in organizations and leadership development methods such as 360º evaluations" (p. 743).

The findings illustrated a clear distinction in the perspectives of Blacks versus Whites in terms of productiveness and success in transitioning up the corporate ladder. White participants seemed oblivious to the issues pertaining to race while blacks felt this was a primary issue, stagnating progression. Ventilation of feelings and concerns is important when diversity matters are apparent. The lack of discussion on pertinent issues led to attrition (Smith & Joseph, 2010).

Gender plays an essential role in the conduct of leaders. Leadership approaches may differ. For instance, approach and practice often differ. In a study of managers in the Netherlands, Schuijer (2006) found women willing to change their approach to include masculinity. Another researcher contradicted these findings. The masculine stance did not assist with advancement (Vanderbroek, 2010, p. 766). Having a degree of masculinity in character may prove androgynous (Begley, 2000, p. 177).

Gender can be a factor determining consideration for being hired into key executive roles. Changing of character and becoming more masculine in practice to meet the assumed demands of the employer may not be the winning strategy. Vanderbroek (2010) surmised being true to one's self is often best. Each individual possesses different qualities, values, and practices that make each unique. Relevant literature anecdotally suggests discovering introspectively one's self may aid in projection of influence and leadership abilities. Finding the niche that makes women successful in penetrating the glass ceiling is not easy. Becoming gender bilingual is perhaps the greatest take away from the Vanderbroek perspective (p. 768).

Failure of organizations to consider all candidates for leadership advancement opportunities, irrespective of race or gender, may potentially contribute to declining organizational viability. Without different perspectives in decision-making, the full benefits of innovation may be inhibited. According to the IOM (2003), "the healthcare workforce, and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented ethnic minorities among health professionals" (p. 2). Additional training, education, and work are needed to dispel stereotypical impressions of women and minorities.

Education of the workforce on gender specific traits is important for organizations desiring to embrace and capitalize on racial and gender-based diversity. From a qualitative study using semistructured interviews, Smith and Joseph (2010) found detailed descriptions of factors affecting relations in diverse organizations. A portion of this study focused on socially directed experiences within organizations in terms of gender and race. "The findings demonstrate that diversity management practices need to consider race, gender, as well as multiple group memberships (e.g. African-American women) which reveals unique issues to be addressed within organizational contexts" (Smith & Joseph, 2010, para. 5). The authors discovered a gap in knowledge and perception of racial and gender-based issues. According to the authors' results, Whites with less education who were promoted over a more qualified Black person did not see race as a factor in the decision making process. The divided perceptions may be what segregates organizations culturally. Results were noteworthy of discriminatory practices

were apt to mark differences in opinions of Blacks and Whites in terms of promotion. Blacks equated their lack of advancement in terms of systemic racial practices.

The Push for Equal Representation

Investing in leadership for the good of the organization has the propensity for enhancement when the top candidates are chosen, developed, and equipped for duty, irrespective of gender. “Jobs and occupations may be internally segregated by both gender and race: what appears to be a reduction in segregation may only be its reconfiguration” (Acker, 2006, p. 446). Organizations may consider establishing mentorship programs, relinquishing stereotypical inhibitions associated with gender based familial roles, and creating sound succession planning that lends exposure to key officials. Smart succession planning does not limit possibilities of ushering in new dimensions in leadership capable of sustaining viability of organizations in the changing market.

Women have made strides in management positions in the workplace. This acceleration up the ranks indicates obstacles hindering women’s progression to executive leadership posts can be overcome. With the development and phenomenal growth made over the years, women leaders continue to encounter major deterrents when attempting to advance to the top positions. BAW continue to lag behind due to limited inclusion in succession plans, limited professional development, and lack of mentorships (Kay & Gorman, 2012, p. 93).

The quest for women’s equal representation is far from being over. According to Acker (2006), “the managerial ranks now contain women in many organizations, but

secretaries, clerks, servers, and care providers are still primarily women" (p. 444). Pai and Vaidya (2009), revealed hindrances to women's advancement in Texas. They discussed how individuals might be oppressed by societal perceptions and norms. Results showed a true disparity in Texas; out of "257 corporations in the sample, there were only two that had women chief executive officers (0.78 percent)" (Pai & Vaidya, 2009, p. 106).

The equal rights movement addressed many issues related to getting women into the workforce, but fell short of getting women into key executive roles. Nearly half a century later, some of the same disparate practices prevail. Pai and Vaidya (2009) found that stereotyping has a negative impact on hiring of women. Pai and Vaidya showed that milestones are evident. Although the study was limited to Texas, it would be interesting to discover the prevalence in other geographic areas. Acker (2006) found from a "study of high-level professional women in a computer development firm, the culture of their work to be highly masculine, aggressive, competitive, and self-promoting" (p. 446). Women have adapted to fit in organizations.

Stereotypically, the character of women is often generalized as more nurturing than emotionally intelligent. To many, the traits of being nurturing and emotionally intelligent are not seen as strengths, but more as drawbacks, inferring that these characteristic make women less decisive or assertive. BAW may even be perceived by "organizational leaders as less competent than Whites" (Kay & Gorman, 2012, p. 93). Acker (2006) noted that" hierarchies are usually gendered and radicalized, especially at the top, with White men at the top" (p. 445).

Advancing the Workforce

Health care is an extensive field offering a wealth of employment opportunities for those with the proper educational preparation. According to Betancourt (2006), "the health care work force composes 30% of the overall U.S. population, minority students accounted for approximately 11.4% of medical school graduates in 2005" (p. 790). Often women of color experience disparate practices in admissions to Ivy League schools. Educational opportunities are often limited because barriers imposed by strong familial ties and increased responsibilities for this population continue.

Diversification of health care leadership may prove beneficial in the long-run. Cohen, Gabriel, and Terrell (2002) offered the following rationale regarding the need for diversity of the health profession, "(a) advancing cultural competency, (b) increasing access to high quality health care services, (c) strengthening the medical research agenda, and (d) ensuring optimal management of the health care system" (p. 91).

Catastrophic experiences may hamper Black Americans' ability to be receptive to the caregivers. Caregivers who are not culturally compassionate may not identify with the unique needs of their minority patrons. In a qualitative study involving content analysis, Betancourt et al. (2003) found evidence supporting having leadership and a workforce that reflect the racial/ethnic composition of the general population to a gain acceptability of health care for racial/ethnic groups (p. 295).

Not having minority representation in leadership poses challenges for decision makers attempting to develop care regimens that meet the needs of the population (Sullivan Commission, 2004, p. 13). Lack of cultural competencies may result in

stereotyping. According to the IOM (2003), "subjective understanding of patients' needs play a role; thus psychological sensitivity, cultural language competency, and conscious and unconscious stereotypes and biases may influence therapeutic decision-making" (p. 130). Clinicians need more than book knowledge. Betancourt et al. (2003) discovered when "sociocultural differences between patient and provider are not fully accepted, appreciated, explored, or understood, it causes barriers between the provider and patient/family" (p. 297). A gap in the literature exists in understanding the social lived experiences of Black Americans.

Lack of knowledge may result in stereotyping and attribute to BAW being overlooked for advancement to executive leadership. In the absence of senior leader's comprehension of Black American's lifestyles and tendencies, it is difficult to make informed decisions in hiring and the establishment of varied care regimes. There is not one category specific to BAW. "Understanding the unique and indispensable role that minority health providers play in health care delivery requires a fundamental appreciation of the powerful impact of culture on beliefs, behaviors, practices, and language related to health" (Sullivan Commission, 2005, p. 16). Failure to undo misguided perceptions with sound knowledge may only add layers to the wall separating BAW from the top health care roles.

Executive roles in health care often belong to White males. There is a lack of research that delves at the core of what barriers exist or are perceived by BAW as hindering their career advancement to executive leadership. I aimed to discover those

real, as well as perceived barriers. The gaps identified in the literature are discussed below.

Gaps and Deficiencies in Prior Research

Prior researchers have failed to capture the voices of BAW by articulating their lived experiences regarding preconceived/actual barriers. The voices of BAW may assist in gaining a deeper understanding of the role race, class, and gender serve for those striving for senior healthcare leadership positions. Through the review of literature for this study, I deduced barriers to advancement still exist for BAW. In terms of explaining how BAW perceive or experience challenges to healthcare executive leadership advancement, if any, is an opportunity for continued study.

The most profound knowledge on the subject matter was provided in Catalyst's (2004) study. Catalyst used a mixed methods approach to illustrate challenges with recruitment and retention of African American women. Barriers such as racially based stereotyping and the double minority issue of being black and female were consistent. According to Catalyst, "women of color often characterized the barriers they encountered as comprising a concrete ceiling-one that is dense and less easily shattered" (p. 12). Although Catalyst discovered some barriers, a gap of this literary work was that it was not specific to health care or specifically BAW. A host of the literature referenced the implications of race, gender, and social class on advancement prospects for African American women.

Other studies reviewed focused on why women and minorities, in general, are holding far less leadership roles. Caldwell and Watkins (2007) conducted a study to

discover factors contributing to the underrepresentation of women and minorities. They discovered that gender and race were variables that had a great emphasis on advancement. Although this review of the literature provided information on challenges faced by women and minorities, it did not discuss the lived experiences of BAW.

There were also limited studies on leadership advancement for BAW. This lack of research may stem from race, class, or gender being issues that many choose not to address. Race, class, and gender were themes found through the review of literature. Lantz (2008) conducted a content analysis to discover the number of women holding healthcare leadership roles. From 1990 through 2006, Lantz found that "women made up 11% of the CEOs" (p. 8). By "2006, the percentage of women CEOs only increased by 1% to 12%" (Lantz, 2008, p. 8). Common themes identified as barriers through this study included "mentoring issues, lack of preparation for leadership succession, limited board and board committee exposure, trade-offs and sacrifices made within two career families, and stereotyping" (Lantz, 2008, p. 33). Knowledge of the barriers is important, but does not describe how the presence of these actual or perceived barriers, influence BAW, in their own words.

Of the literature reviewed, references were found that discussed cultural competence in health care. Mitchell and Lassiter (2006) did a content analysis study focused on the changing demographics in oral health care and the need for a better understanding of cultural dynamics (p. 2093). Mitchell and Lassiter found that having a racially diverse workforce could be instrumental in improving care. "Workforce diversity has been associated with both greater satisfaction with care received, and improved

patient provider communication" (Mitchell & Lassiter, 2006, p. 2093). This and similar studies that had interrelated cultural competence themes failed to capture the clear picture of how BAW's career tracks were affected by varied cultural perspectives.

The journey BAW face toward executive health care leadership roles may seem daunting at times, but every success story decreases the gap between. What is known from the literature is that there is a host of socioeconomic and historic factors influencing career accomplishments. These factors often guide decision-making in organizations and drive career decisions of many minorities. Most of the reviewed literature centered on women's issues with advancement or issues of race, gender, and social class. The issues illustrated in the literature specific to women's advancement stem from the experiences and empirical evidence associated with White women in mainstream America. Articles and studies written regarding BAW have historic perspectives and many centered on race. Recent studies done by ACHE (2008) and the Sullivan Commission (2004) have been the largest body of research that I found in my search.

A vast segment of the literature reviewed focused on the interrelatedness of race, gender, and social class to minority advancement. The principles of CRT were evident regarding race. Racism is interwoven in the daily lives of persons of color making the effects seem normal (Delgado & Stefancic, 2001). These factors may be instrumental in understanding the phenomenon under study. The inclusion of race and gender variables may make BAW's advancement opportunities challenging whether combined issues or isolated concepts. According to Carbado and Gulati (2003), "CRT states one can fight racism without paying attention to sexism" (p. 1766). Rich descriptive data of BAW's

experiences in higher-level leadership roles will be the foundation for analyzing obstacles inhibiting women from achieving top-level executive positions. This will be noted in the results section through story telling. This layout is consistent with the second principle of CRT related to "storytelling" (Delgado & Stefancic, 2001).

Importance of the Present Study for Positive Social Change

Health care today has many obstacles to overcome. According to the Sullivan Commission (2004), "this current generation of leaders faces a host of challenges including diversifying executive leadership and the management of the workforce" (pp. 3-4). The Sullivan Commission found the health system has not transitioned as rapidly as the changing society. Newer population compositions present different challenges for healthcare leaders. To date, the "number of women in executive healthcare leadership positions lags below the level of men" (ACHE, 2008, p. 22).

By knowing the relationship between race and leadership, it may stimulate social change to address the problem. "Today's physicians, nurses, and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring" (Sullivan Commission, 2004, p. 1). This study will help in establishing equal opportunities and removal of barriers, if any, through knowledge and in-depth analysis of BAW's experiences, as well as the identification of the role of women in healthcare executive leadership.

BAW are and have been at a disadvantage in this country. However, other minorities and women with similar experiences may also benefit from this research effort for social change. Undertaking this study may provide health care leadership with the

information necessary to remain vigilant and viable through understanding of the needs for a diversified workforce.

This study is important simply because other studies have indicated that despite the fact that women may be equally qualified to men, women are still not the first choices for top-level leadership roles (Vanderbroek, 2009, p. 764). Learning about perceptions aids in finding working solutions for women aspiring for executive healthcare leadership posts. The result of this research may open the door to continued research on the diversity issues and the adverse implications for organizations that have not managed diversity with ongoing education.

The literature review suggests forward progression may include being socially connected, having a vision and clear plan, knowing oneself, and having confidence and the wherewithal to make dreams a reality. It is important that leaders seeking advancement know who they are. Unique and distinctive leadership qualities may be what brings BAW to the front of the line. Transitioning up the corporate ladder might include taking risks and applying for jobs that seem unreachable. Chapter 3 is an explanation of the methodology that was used to discover if there are barriers to and influential factors for BAW's advancement to senior leadership.

Chapter 3: Research Method

Introduction

The purpose of this transcendental phenomenological study was to understand the experiences, perceptions, influential factors, or deterrents to BAW's advancement through the ranks toward senior healthcare leadership roles of president or vice president. BAW were generally defined as those born and educated within the United States of America.

This chapter includes insight on the method that was used to conduct this research study and the rationale behind the selection of a qualitative research method. The objective of this qualitative study was to explore the following overarching question: What are the perceived, actual barriers, and experiences articulated by BAW desiring to advance to executive health care senior leadership roles? To ensure that I captured the essence of the phenomenon and was able to get the most comprehensive answer to the research question, a qualitative inquiry was selected.

Research Design and Approach

A qualitative transcendental phenomenological research design was chosen to determine whether any perceptions or experiences with being overlooked or not being advanced to the next level existed, despite having the specified qualifications for the role sought. This study was undertaken to answer the following overarching research question and the following subquestions.

1. What factors, if any, have contributed to the lack of advancement up the ranks to senior health care leadership posts?

2. What are lived experiences, if any, described, in terms of race/ethnicity encountered in career progression?
3. What experiences, if any, are perceived as instrumental, unequal, or deterrents to leadership advancement in health care?

Phenomenological designs are commonly associated with concentration on experiences. The phenomenon under study was explored in the natural setting by describing the feelings of individuals. The rationale for choosing this tradition is further discussed in the subsequent text.

Research Tradition

Qualitative studies provide insightful information collected from a wide range of investigatory techniques that are not expressed, numerically. Qualitative studies allow researchers to assess perceptions, experiences, opinions, and drives. Researchers desiring to explore a phenomenon through descriptive data may employ inductive qualitative methods.

Creswell (2009) described qualitative research as a "means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (p. 4). To get the most comprehensive picture of the phenomenon under investigation, in qualitative studies, data is examined from many angles. Patton (2002) stated "qualitative designs are naturalistic to the extent that the research takes place in real world settings, and the researcher does not attempt to manipulate the phenomenon of interest (e.g., a group, event, program, community, relationship, or interaction" (p. 39).

Researchers choose from a plethora of different strategies to evaluate the context of a particular situation, individual, or group. Extracting the meaning of certain circumstances in their natural setting may require researchers to assume the role of the instrument. Although I had preliminary open-ended research questions, each question was refined as the study advanced as needed.

Phenomenological designs offer an introspective vantage point of individuals studied. Vandenberg (1997) offered this unique perspective on phenomenology, "We are all born phenomenologists; poets and painters among us, however, understand very well their task of sharing, by means of word and image, their insights with others-an artfulness that is also laboriously practiced by professional phenomenologist" (p. 41). Creswell (2009) defined phenomenological research as "a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants" (p. 13). Discovering the meaning, structure, and essence of the lived experience of BAW who encounter barriers as they endeavor to attain senior leadership roles in health care will require a unique sample. The sample was inclusive of BAW from the Washington Metropolitan region working in health care leadership roles that could potentially advance to the CEO position.

In reducing the likelihood of prejudicial influence from skewing the results of the study, the suggested systematic procedure outlined by Moustakas (1994) which includes epoché and reduction, may be used. This method offered a predetermined roadmap for data analysis. To explore the participant's experiences, in-depth interviews were conducted. Delving to the inner or outer core of this disparity will frame the essence of

the experience. The interview data were evaluated to discover the common denominators shared by the participants to produce a manuscript, which captured the perceptions, perspectives, and a deeper understanding.

Data collection for this research was used to identify the experiences of BAW working in healthcare leadership positions that inspire to excel to executive leadership heights. Multiple perspectives from selected samples were examined to understand their viewpoint. Most of the data were collected from interviews.

Methodology

I followed a transcendental phenomenological format. Use of this approach allowed me to view the phenomenon's true meaning as expressed by the participants. Face-to-face and telephone interviews were used to collect data from the representative participant sample. The potential for bias was reduced through the use of the outlined principles as ascribed by Moustakas (1994). Epoché and reduction were two processes included. Using the Moustakas approach, reduction was used to capture the essence of the participants' lived experiences during the data collection for thematic analysis. In the following section, the sampling strategy is outlined. This strategy included the criteria for inclusion in the study, the anticipated number of participants, and a description of the relationship between saturation and the sample size.

Setting and Sample

To discover what impeded aspiring BAW from seeking or achieving high-level executive positions in health care, the venue chosen for this study was in the Washington, DCs metropolitan region. Washington, DC has a high number of Black Americans in

corporate and healthcare leadership. I visited each of the acute-care hospitals in the Washington, DC metropolitan region to audit the number of Black female CEOs. I did not find any. The contents of the subsequent section include a discussion on the rationale for sample size, the factors contributing to sample size; the proposed sample size, and the strategy for this qualitative research plan.

Qualitative research is viewed in terms of the number of subjects needed to explore different perspectives. This research effort was comprised of a relatively small sample of participants studied in depth to the point of saturation, to capture true meaning, deeper insight, and perceived values and beliefs. I chose a limited sample in effort to explore the research objectives.

Experience plays a major role in the determination of sample size, sampling strategy selection, and expected outcomes. Mason (2010) suggested "there is a point of diminishing returns in a qualitative sample—as the study goes on more data does not necessarily lead to more information" (para. 1). This is because one occurrence of a piece of data, or a code, is all that is necessary to ensure that it becomes part of the analysis framework (Mason, 2010, para. 1). A smaller sample size for qualitative research may produce data that are more meaningful.

Factors attributing to the sample size suggested for this qualitative research study included the following: (a) the parameters of the phenomenon understudy, (b) what it took to answer the research questions, (c) time and resources, and (d) the point of saturation. Brenner (1994) suggested "projected sample sizes are often adjusted depending on the quality of the text and the participant's responses that may reshape the

lines of inquiry" (p. 107). Purposive sampling encompassed selection through a screening process, yielding a final sample size of seven participants.

After obtaining the required Institutional Review Board (IRB) approval, participants were asked to complete an online questionnaire with all the necessary disclosures and consent information attached (see Appendix A). All persons consenting to participate, with qualifications for higher positions, were eligible for the study. This study included participants who met the identified criterion characteristics associated with in-depth, qualitative analysis (Patton, 2002, p. 238). The framework of inclusion criteria is further discussed below.

Procedures for Recruitment

In answering the research questions, sampling criteria included: (a) myself, the researcher, as the primary research instrument with use of interviews, taping, and field notes; (b) purposeful sampling; (c) Washington, DC area setting; and (d) CRT introduced at the beginning of the research effort. Participants were selected through screening. The inclusion criteria were the following: (a) the participants must be either aspiring to move up the ladder or attempted to do so in the past, but failed to make it to executive leadership; (b) be a BAW born in United States; and (c) serve in a leadership role. All candidates had to possess supervisory experience.

Each potential participant was asked to complete a brief survey. The participants were asked to answer a few brief questions on what it was like to experience the phenomenon. The purpose of this additional effort was to select volunteers that have specific experiences aligned with this research effort. Those that answered the questions

completely were among those selected. The contingency plan if recruitment results in too few participants included seeking participants from career alliance and professional memberships, such as the District of Columbia Hospital Association (DCHA), and The American Organization of Nurse Executives (AONE), local chapter in the District of Columbia.

Instrumentation

The sole method of data collection was through interviews. As the researcher, I was the instrument used for the data collection. Data collected from the interviews were essential in identifying experiences of BAW working in health care leadership positions that aspired to excel to executive leadership. Establishing a rapport with the participants was an important step. Since the participants felt comfortable, an openness to share sensitive experiences became evident. I had an advantage. The sample was selected from within my own career field (health care), gender, and race.

Face-to-face and telephonic interviews were the data collection mechanisms used in this study. In-depth interviews, up to 1 to 2 hours, were the foundation of the data collection. I maintained an audit trail by specifically labeling the contents from each interview. Societal trends, perceptions on stereotyping, and experiences with racism were among topics explored. The units of analysis for this phenomenological study included individuals and their personal experiences with common interests in advancing up the corporate ladder. I developed a template that was used as a roadmap for the semistructured interviews (Appendix B). Consent was acquired prior to data collection. The participants were interviewed in a semistructured manner using a data collection tool

and protocol, listed in Appendix B. A semistructured approach was used to ensure each participant provided responses to the majority of the questions. It was anticipated that each interview would elicit some unique perspectives.

Telephone interviews were used when the participants were not available for in-person interviews. The interviews were an open exchange between the participant and me. With the informed consent of the participant and privacy considerations, conversations were recorded with a Samsung voice recorder. Note taking was also a method of data collection.

At the culmination of each interview, there was a review of the information collected. Each participant was informed that they may be contacted later if clarification was needed, following transcription of the interview contents. The best contact times were discussed during the interview, should the need for further inquiry arise.

Data Collection and Recording Plan

After typing up the transcripts, the data from the field notes were reviewed and placed with the transcripts in a binder labeled with the respective pseudonym. I compared the transcripts to my notes. As needed, I added notes in the margins of the transcripts. Key words and phrases were highlighted to make sure I captured the full details of the participant's experiences. Before each interview, I reviewed the contents of the informed consent, found in Appendix A. The interviews were consistent with the interview protocol found in Appendix B.

At the onset of each interview, I reiterated the reason for the study and the intended use of the information. Responses were recorded verbatim with hand written

notes and taped/transcribed sessions. Clarification was obtained as needed throughout the sessions. No interviewer editorials or distracting body language was introduced. The agenda was followed closely to respect the participants' time. At the culmination of each interview, the summary of interview notes was reviewed with the interviewee. Should something have been unclear, a follow-up interview would have been conducted.

There are specific recording procedures outlined for this research. A special document was prepared to facilitate note taking. The length of the interview was conveyed in advance and agreed upon, by myself and the participant. Audiotaping and note taking were both instruments used to capture and document the data.

I had an established rapport with the participants, which facilitated the interview process. This rapport was evident from the flow of information provided from the participants on sensitive subject matters. No person was recorded by audio without expressed and written permission. Audio was used, as the richness of the environment could not be captured solely through field notes. What the notes could not capture was the inflection of the voices, sighs, and laughter of the participants in response to any discussion of varied topics. Comprehensive and concise overviews of each interview session were provided to the participants at the culmination of the interview to maintain objectivity.

During the research process, data management was paramount. The protocols were the primary tool facilitating collection and the management of the data. The protocol tool organized the data so that after each preliminary question there was a space for the answer to be written. Each interview question was open-ended to allow

commentary by the participant. The interview questions and protocols are located in Appendices A, B, and C. Appendix C was included if I saw environmental factors relevant to the research. For this study, the data analyses were facilitated with NVivo, using the information from the notes and the tape-recorded transcriptions.

Data Analysis Plan

A formalized set of standards for interpreting and analyzing data followed a systematic plan outlined similar to that of Moustakas's (1994) archetype. "After discerning a topic that is chalked with experiences, the researcher describes the experiences encountered with the phenomenon understudy" (Moerer-Urdahl & Creswell, 2004, p. 6). Collection of data from field notes and tape recordings of interviews generated a great deal of information. Triangulation was accomplished through cross verification of responses from the variety of data sources in the sample. The diversity of the sample was in terms of their differing roles within healthcare leadership; some were at higher levels of leadership, and others were midlevel or baseline. Their different perspectives were used to cross verify answers to each research question. I further discuss the application of triangulation in Chapter 4.

To assist with data analysis, NVivo was used. The data analysis process began with importing my transcripts into NVivo. Next, I read the transcripts and the field notes in entirety. On the first view of the transcripts, I wrote notes in the margins to highlight pertinent content. I reread the transcripts line-by-line to look for emerging dimensions. The search for frequencies of themes, coding, and text queries were facilitated by NVivo, which is further outlined in Chapter 4.

Issues of Trustworthiness

In establishing trustworthiness of this study, I used participant validation of the data to affirm accuracy. The "identified themes and categories were reviewed with the participants for accuracy" (Lincoln, 1985, p. 314). To make certain standards of validation and evaluation were apparent, this research effort included clear processes in terms of the sampling requirements, identification of major themes, clear descriptions of key findings, a defined research protocol, and noted delimitations of the research effort. The approach to conformability is further discussed in the next paragraph.

Patton (2003) defined "reflexivity as a way of emphasizing the importance of self-awareness, political/cultural consciousness, and ownership of one's perspective" (p. 64). During this research effort, to maintain objectivity, the researcher was cognizant of her individual voice, not to be misconstrued with the voice of the persons interviewed. Attention was paid to hear the perceptions of those interviewed.

To prevent data loss, computer software was used. The software assisted with the retrieval of data. Data collected were entered directly into the computer during observations or interviews. Prevention of data loss included saving the information on the computer, and emailing it to a known database. Memoing, tape recordings, and field notes were utilized. Tape recordings were transcribed, and the original tape served as the backup.

Limitations and Quality Control

The study has a great deal to offer to in terms of knowledge, but there are limitations that stem from design or methodological weaknesses. First, the sample pool

was limited due to the few number of minority women holding key healthcare leadership roles. The sample was also primarily homogeneous, which may have a bearing on the ability to generalize. The results are important to the population understudy, and to those with similar circumstances. The second delimitation was the potential skewing of data due to the participants' ability to accurately recall experiences and perceptions of events that may have occurred earlier in their careers.

Close attention during the planning phase was taken into account for quality, trustworthiness, and credibility. The use of a semistructured interview protocol helped facilitate quality. The interview protocol provides information about the project, encompasses a few preliminary questions, and serves as a data collection tool. Having the introductory questions on hand provided a means of ensuring that each interviewee is given the same starting point to open the dialogue. The preset agenda and interview protocol served as a roadmap, keeping the study on course. These tools offer guidelines, but may be amended as needed.

Protection of the Participants

Use of human participants posed potential opportunities for legal, ethical, and bias issues prevalent in any research study. Approval from the IRB was obtained before conducting the research. The institutional permissions and disclosure regarding the treatment of the participants is outlined in the IRB application, found in Appendix A.

Obtaining informed consent, assurance of privacy, and maintenance of integrity were completed as a precursor to all activities associated with this research study. The

protocols and consent form have a disclosure statement to protect the participants. Confidentiality was maintained by protecting the participants' identity.

Addressing my bias up front was implemented to prevent the data from being tainted. The process of epoché and reduction was utilized as an opportunity for the researcher to articulate and isolate the reader's bias. With the high degree of subjectivity anticipated in qualitative research, close attention during interviews was paid to maintain the participant's voice, keep objective facial expressions, and avoid self-directing the interview.

Reliability, Validity, and Generalizability

Reliability was established in this effort by planning to maintain consistency, in approach, across the continuum of the research effort. "Yin (2003) suggests that qualitative researchers need to document the procedures of their case studies and to document as many of the steps of the procedures as possible… and setting up a detailed case study protocol and database" (Creswell, 2009, p. 190). Validity can be strengthened with checks and balances. For the accuracy of this study, the focus was to get the true representation of the participants' experiences. Threats to validity were managed by closely following the prescribed detailed protocol.

Ethical Scholarship

Ethical consideration was instituted throughout the research effort. As required, ethical considerations related to recruitment for this research ensured that the researcher will "protect the research participants, develop a trust with them, promote the integrity of

the research, guard against misconduct and impropriety that might protect their organizations or institutions; and cope with new problems" (Creswell, 2009, p. 87).

All data collected during this research effort were used exclusively for research, and will not be used inappropriately. Each participant was provided an identification number to protect the confidentiality. The data were kept secure by me in a confined area. I am the only one that has access to the data. The data will be destroyed at the culmination of the study. If participants refuse to participate or withdraw from the study, the data collected would be destroyed. All effort for this research study included honesty and integrity.

Summary

BAW remain widely overlooked for senior leadership roles in health care (ACHE, 2008). I aimed to discover what barriers in the words of BAW, if any, inhibited promotion to higher positions in health care. According to AHRQ (2014), unequal treatment in the provision and access of health care remains a problem for Blacks (para 2). "In the United States racial and ethnic minorities and low income populations experience serious disparities in rates of insurance and access to healthcare" (AHRQ, 2008, p. 3). This problem exacerbated preexisting disparities in the treatment for minorities and the low-income population. For a community that is already at risk for a myriad of clinical complexities and long-term illness, this is not good news. Having a greater level of representation at the executive level may help in gaining better understanding of the Black culture and intrinsic health needs.

The intent of this study was to bring about social change through heightened awareness of the existence barriers to advancement for BAW. Future research opportunities may be centered on development of countermeasures. The collection of data for this study was through use of interviews. The data were analyzed with the aid of NVivo software. Evidence from the findings suggest barriers whether actual or perceived were apparent. The next chapter provides the results of this study, followed by the discussion, conclusions, and recommendations.

Chapter 4: Results

Introduction

The purpose of this study was to explore the experiences, perceptions, and deterrents, if any, to the advancement of BAW aspiring to achieve senior health care leadership roles. Discovering lived experiences of BAW encountered during career ascension to senior healthcare administration is hoped to ignite social change regarding this phenomenon by providing information necessary for successful advancement. Below are the subquestions posed to discover information essential for advising, encouraging, and enhancement of knowledge on best practices useful for BAW.

1. What factors, if any, have contributed to the lack advancement up the ranks to senior health care leadership posts?
2. How are lived experiences, if any, described, in terms of race/ethnicity encountered in career progression?
3. What experiences, if any, are perceived as instrumental, unequal, or deterrents to leadership advancement in health care?

The remainder of this chapter is focused on the setting, demographics, data collection and analysis, evidence of trustworthiness, and the results of this research.

Research Setting

The qualitative methodology selected for this research was a transcendental phenomenological design. This method aligns with the concept of intentionality. Patton (2002) defined "intentionality as consciousness of an internal experience when the act of consciousness and the object of consciousness are intentionally related" (p. 483). The

strength of this design is that it allows the depiction of a phenomenon to be viewed from as many perspectives as possible. It is of importance to note that personal or organizational conditions, if any, that may have influenced participant's experiences at the time of the study, are also discussed.

This study was conducted in the Washington, DC metropolitan region. This region has a high minority composition. There are a number of large hospitals serving the various communities in this region. The Sullivan Commission (2004) reported that "historically racial and ethnic minorities have always been underrepresented in the health profession in America" (p. 4). For this study, I explored if barriers exist that inhibit BAW from progressing to senior healthcare leadership roles. To capture the full essence of the experiences and perceptions of BAW, as well as gain answers to the research questions, in depth interviews were conducted.

The interviews were conducted using a semistructured approach. Semistructured interviews were chosen to capture the voice of the participants. The significance of using semistructured interviews was to eliminate any query that would be supportive of any preconceptions on the part of the researcher. Bias was limited by using bracketing.

Each of the interviews was conducted in relaxing and quiet environments. This type of setting was ideal for optimizing meaningful dialogue. The areas chosen for the interviews had limited opportunity for personal or organizational influences that may have made the participants uncomfortable.

Demographics

The participants for this study were BAW health professionals aspiring to move up the corporate ladder or those that have attempted to do so in the past, and failed to be hired as CEO or other senior leadership roles. Each participant had to have been born in United States. It was required the participant's career advancement consist of service in the capacity of middle to upper level healthcare management through the vice president or chief operations officer level.

For consideration of participation in this research effort, the participants filled out a questionnaire. A sample of the questionnaire is in Appendix C. Upon meeting the requirements, the participants were offered the opportunity to take part in the study. The participants were notified and sent the informed consent document (Appendix A). Once this document was signed and returned to me, the participants were scheduled for interviews. Pseudonyms were assigned to prevent the data from being identifiable (see Table 2).

Profiles for each participant were created from information obtained in the demographic questionnaires and the interview responses. The data collection process is reviewed in the next section.

Data Collection

In total, there were seven participants from which data were collected through in-depth interviews. As a Black American with 27 years of experience in healthcare, I believe this factor contributed to the rapport I developed with the participants. Each participant's identity was kept confidential. The data were filed using the assigned

pseudonyms to identify and organize the content. Face-to-face and telephonic interviews were conducted, in quiet and private areas that afforded minimal disruption, to capture the richness of the data. The interviews ranged from 60 to 90 minutes.

Packed schedules of the participants slowed the data collection process, elongating the time span anticipated necessary for completing the participant interviews. This was a circumstance beyond my control. The timing of the data collection for this study happened at the ending of a fiscal year, placing the interviews at the far end of many of the participant's schedules. There were no other extenuating circumstances to report.

Table 2

Demographic Profiles

Names (Pseudonyms)	Years of Experience in Healthcare Leadership	Education Level
Molly	30	Doctorate
Sally	7	Masters
Karen	20	Masters
Penny	12	Masters
Jane	8	Bachelors
Ann	6	Masters
Renee	26	Bachelors

Using a Samsung Voice Recorder and note-taking, interview data were recorded. The data from the recordings were uploaded onto the computer. Later, the data from the recordings were transcribed into manuscript format. Notes collected were attached to printed copies of transcripts. Each participant's data set, consent form, and questionnaire were organized in a binder and kept secured.

Data Analysis

The first step following the data collection was transcription of the audio-recorded interviews into transcripts. Once the data were transcribed, grouped with each corresponding set of field notes, and labeled with the appropriate pseudonym, I began the data analysis phase. Through thematic analysis, I endeavored to unearth themes which described the essence of the participants' experiences. In a qualitative study, a researcher can improve the rigor of data analysis through the use of triangulation.

Triangulation refers to the use of a variety of data sources or data collection methods to examine a phenomenon from different perspectives and arrive at better-validated conclusions (Hanson, Balmer, & Giardino, 2011). For this investigation, I used data source triangulation in the analysis of the data. Data source triangulation denotes the use of several different informants during the process of data collection (Yin, 2013). In this phenomenological inquiry, I conducted interviews with a diverse sample of participants. By collecting and comparing data from these different sources, I was able to identify commonalities that emerged across the data sources to increase the validity of the research findings (Barratt, Choi, & Li, 2011). This helped to ensure that the results of this analysis represented an accurate depiction of the phenomenon of interest, and further enhanced the credibility of the study.

The analysis of data in this study mirrored the method of analysis illustrated by Leech and Onweugbuzie (2011) in their examination of computer-assisted qualitative data analysis. Leech and Onwuegbuzie displayed the application of NVivo software to

facilitate thematic analysis of qualitative data. I chose to forego hand coding of the data due to the program's ability to facilitate the organization of data in this study.

In the initial stage of data analysis, I imported the interview transcripts into the NVivo program (Leech & Onwuegbuzie, 2011). Next, I read over the data to obtain a general understanding of the overall content of the material (Smith & Firth, 2011). Additional rereadings of the data enabled me to begin to identify significant statements and phrases among the participants' responses (Smith & Firth, 2011).

In the second phase of the analysis, I used open coding to select portions of the textual data and assign them succinct evocative codes that reflected the meaning of the text (Leech & Onwuegbuzie, 2011). Through the use of text queries in NVivo, it enabled me to search the collective body of interviews to locate all text which was relevant to each of the identified codes. Once this level of coding was completed, I similarly coded text gathered together and assigned to an organizational classification, or node, within the NVivo program.

I continued with this level of analysis until all data had been apportioned to at least one Node. Through this process, 18 keywords and phrases were saved as Nodes within NVivo. During the progression of the analysis, some of these Nodes eventually developed into themes, and others were collapsed and subsumed into other thematic groupings.

In the third phase of the analysis, I began to find connections between nodes to ascertain the broader relationships that were suggested by these connections (Leech & Onwuegbuzie, 2011). Following that step, I combined nodes which were comparable in

meaning or which pertained to a shared concept and assigned them to a single tree node within NVivo. The tree node denoted the overall idea(s) that the nodes mutually evoked. This third phase of the analysis continued until all nodes had been assigned to a tree node, and all data had been coded.

The last stage of data analysis was the organization of tree nodes to form a detailed explication of the research questions (Leech & Onwuegbuzie, 2011). Upon the conclusion of this organization, I named each of the identified tree nodes as a theme. Table D1 is a summary of the frequencies for all of the identified themes and subthemes.

These findings were triangulated by verifying sufficient support for each theme across the participants to enhance the validity of the identified themes. The abundance of participant endorsement for each of the identified themes is illustrated in Table D2. These themes ultimately served the purpose of signifying the essence of the experiences, perceptions, influential factors, or deterrents to BAW's advancement through the ranks toward senior leadership roles of president or vice president within the field of healthcare.

Evidence of Trustworthiness

In accordance Cohen and Crabtree (2006) and (Guba & Lincoln 1985), evaluation of worth and establishment of trustworthiness are accomplished using four steps: credibility, transferability, dependability, and confirmability (para 1). These four steps were taken into consideration in conducting this study. In this section, I discuss how these steps were carried out for this research effort.

Credibility

Credibility for qualitative research differs from quantitative. In quantitative research, credibility is evaluated based on whether studies measure what was intended to be measured. Researchers in qualitative studies assess if the findings are consistent with the real world. To ensure credibility of this research work, I followed the outlined procedures.

The research methodology outlined was followed closely to gain detailed and rich descriptions of the participant's experiences, perceptions, influential factors, or deterrents to BAW's advancement through the ranks toward senior healthcare leadership. I established a rapport with the participants through engagement to ensure that the participants felt comfortable with me. Interviews followed the outlined protocol. The interview period did not exceed the allocated 2 hour period. This included the time for review of the data collected from each interview with the participants. The data were recorded and transcribed into a manuscript. For this study, there was only one source of data, interviews. Different questions were used to examine multiple perspectives from varied vantage points.

Part of determining credibility is discovering if the findings are consistent with the real world. Through this study, it was noted that barriers exist inhibiting the advancement of BAW, whether perceived or actual. Stereotyping, race, gender, and the "old boy networks" were found to inhibit the career advancement of BAW. These findings coincide with the real world. "Research has confirmed theoretical perspectives as to why women and women of color in particular are underrepresented in leadership

positions" (Comas-Diaz & Greene, 2013, p. 367). Sanchez-Hucles and Davis (2010) offered this perspective, "The reasons for slow progress of women of color in leadership include lack of line experience, inadequate career opportunities, racial differences in speech and socialization, ethnosexual stereotypes, 'old boy networks' , and tokenism" (p. 173). Comas-Diaz and Greene noted the deterrents to advancement of Black women are a result of "discrimination, including bias and negative stereotyping on the part of those in power as well as structural systemic discrimination is the root cause of differential treatment as reflected in policies and practices in the social system" (p. 367).

Transferability

A second significant means of ensuring trustworthiness for this study was transferability. This study was inclusive of both purposive sampling in identification of the participants and rich descriptions of the data. The steps in selection of the participants included providing a questionnaire, found in Appendix C. Once the participants provided the appropriate information outlined in the selection guidelines, the participants were made aware that they were selected to participate in the study. Each participant was required to read and sign the consent, found in Appendix A, before being allowed to participate in the research effort. Upon return of both the questionnaire and the consent form, the participants were notified that they were eligible to participate in the study.

Rich detailed descriptions of the data were apparent through the extensive inclusion of verbatim commentary from the participants. The context of this research was clearly articulated throughout the manuscript. In-depth interview data were collected that contributed to the vivid descriptions and verbatim commentary used in support of the

research context. The purpose of outlining the steps is so the format can be repeated using a different setting or research participants.

Boundaries of this study were that it was limited to the Washington, DC metropolitan region. The data collection method was only through interviews. The use of interviews afforded thick descriptions from multiple perspectives of the participant's experiences with the phenomenon under study. At the culmination of each interview, I reviewed information from my notes to gain clarification, if any, from the participants. The ability to ask questions to clarify findings was a means of better understanding of the participant's views. The next step in assurance of trustworthiness was to ensure dependability.

Dependability

For accuracy and consistency in this research process, the approach to data collection was followed as outlined in Chapter 3. The data collection methodology was clear, detailed, and easy to replicate. It is not known whether the participant pool, in other areas outside of the Washington metropolitan region, would yield the appropriate sample.

I used a transcendental phenomenological research design. At the beginning of the study, I addressed my views, by writing them out, to limit researcher bias. This was a means of isolating my thoughts. The data collection followed the identified protocol. Interview data were collected that were in-depth enough to provide a rich description of the phenomenon under study. I used interview protocols to start each interview in the same manner. However, the interviews were semistructured to afford the flow of the data unscripted and to reduce bias. The process was outlined in an incremental manner. The

coding was implemented in phases to afford recoding. Findings and results were documented in accordance with the outlined plan. The last step in affirming trustworthiness was confirmability.

Confirmability

It is important that each research effort address confirmability to determine if the findings are representative of the participants. Having the supporting documentation on hand, interview transcripts and field notes were a reference point to ensure my findings were from the data collected, and not my thoughts. Raw data from in-depth interviews and field notes were secured in a binder with a copy of the audio tapes and the consent forms.

Overarching themes with supporting quotes from the interview transcripts were addressed in keeping with each research question. To validate the voice of the participants, numerous verbatim quotations were added to project sentiments of the participants and illustrate the significance of the issues. The study results are discussed in the following section.

Study Results

In this section, the themes derived from the data are discussed in response to each research question. Supporting data are presented through verbatim stories told by the participants. The overarching research question was posed to discover lived experiences of BAW, in the Washington, DC Metropolitan region, encountered during their career advancement toward senior leadership. Answers to the three subquestions were captured from the context of the interviews. The next section contains thematic findings that

answer the respective research questions. The section was organized by themes, with a reference to the respective research question. There were no discrepant cases to address.

Lack of Advancement

The first research question posed: What factors, if any, have contributed to the lack of advancement up the ranks to senior health care leadership posts? In answering this question, participants were asked about career developmental factors that either facilitated or inhibited their progression. Themes that emerged indicated that there were factors attributing to the lack of advancement. Among those factors were issues related to color classification, age, stereotyping, education, lack of succession planning. The next section contains detailed discussions of overarching themes identified, which attributed to the lack of presence and progression of BAW, in healthcare leadership, as described by the participants.

Color Classification

Of the findings in the analysis, one of the most prevalent themes that emerged among all participants had reference to color. The term color classification has been assigned to highlight data that were specifically related to perceived or actual experiences verbalized by participants regarding color. Not all participants answered every question the same. The interviews were semistructured with varied questioning. Questions were gauged according to the conversation with the aim of answering the research question. The contexts of the conversations, in some instances, have been added to assure the proper meanings of the participant's responses were conveyed.

Participants were asked to describe their feelings and experiences concerning advancement in healthcare leadership as a BAW. Major themes that emerged were that of or pertaining to color and appearance. According to Sally, "It does not feel good to be judged based on your color. You are just not a part of the group. Nobody wants to feel left out, or be judged on anything other than his or her merit."

At the point when this statement was made, Sally was discussing frustration with futile efforts in trying to advance her self-worth. Sally felt the lack of acknowledgement from others was based on her color. She stated that it does not feel good to invest a lot of time and energy developing herself whether it is through education or some other skill set and not be acknowledged.

Color was overtly a factor in decision making at Sally's place of employment. Sally recounted her experience with color classification, beyond herself, in her recollection of an incident when a local university's nursing program was denied the opportunity to come in for clinical rotation due to the majority of the student population being of color. This decision stemmed from an experience one of the leaders had with a Black student. Sally stated,

> You know, indirectly, you are not allowing an entire program, that is predominantly Black, come to your facility, because of personal experiences with a particular nurse. It's a judgment, because one thing went wrong, and none of the students could come. There's only a couple of Black nursing programs in Baltimore, so when they are not able to train at our hospital, that affected a lot of Black people.

Jane stated,

> By no means am I ashamed of my skin color or anything. I am proud of my African American heritage. At the same time, it plays a part when you go into different business worlds and health care is a hard one to get in.

Penny answered the question with a different perspective.

> The competition: I believe, as a Black American, you have to go three or four steps above the average individual. Some of my fears are, just, am I good enough? Are you going to be looking at my education or are you going to be looking at me?

Penny said because of her color, she needed to advance her skills beyond the skill-set of others. She considers others outside her race as her competition. According to Penny, "Black women must work harder and have better accolades, and still may be overlooked". Renee said, "It seems like as a Black woman, I work double hard to get what I need, versus white people. It seems like they have been handed things." Karen shared the following:

> As I progressed through the years, it just kind of depended on who was running the show, or who had access to the ceiling. I felt as if when I was associated with a minority owner, he saw beyond color, sex, gender, and all that. But when I'm exposed to nonminorities, it seems to be that race and color are factors.

Karen has peers that have aspired and became presidents of their own companies. They are quit trying in other companies, because of color-related issues. The construct of color, in terms of race or ethnic identity, is often described with biological or sociopolitical

identifiers. Generally, color classification is not a widely acceptable means of quantifying an organization's ethnic makeup. However, Karen experienced this phenomenon as viewed through one of her colleagues of a different ethnic persuasion.

> Well, let me just be clear, this is a white colleague of mine, who has her own company. She comes to visit, and she has only been in once or twice. She comes down and looks at the executive board members' pictures. She points out the lack of minorities. Then, she says you should position yourself where you are more visible so that you can be part of this. The fact that she noticed brought my awareness up.

Ann shared her opinion.

> I have to prove that I deserve to be here. I didn't just get here because they needed someone who looks a little different to even out the number. I think people are always going to question us. Let me see if you know what you are talking about. We could be talking about the same thing, and someone else can just breeze over the facts and make a general statement.

Participants discussed issues they experienced regarding color. There were specific references made regarding appearance. The following section contains some of the unique experiences that centered on appearance, and how appearance could be a deterrent or used in their favor.

Appearance

Among the descriptions, in response to the question of what events or experiences affected career advancement, concerning advancement in healthcare leadership as a BAW, references were made to appearance. Although all participants referenced color as a barrier, only four mentioned the significance of appearance. They described grappling with wanting to be themselves, versus having to appear the way society dictates they should be. Appearances can be viewed from different angles. The following text is an illustration of different facets of appearance as experienced by participants in this research. Ann said,

> Part of the build is that they have some personal thoughts about just what a black person should look like in corporate America. They believe in not being too ethnic, although, you really can't. I have an ethnic name. I'm brown skin. There's no passing over here.

Molly shared the following.

> There is nothing you can do about changing your look. You cannot change the color of your skin. That is obvious walking in, and …. I know there have been discussions about black women having vast hair-dos, and all that kind of stuff. I personally believe that you know the institutions have to accept that not everyone has a straight haircut. There are certain things you have to accept. It does not matter what your hairdo is like or what the color of your skin is, but are you able to articulate your confidence, your compassion, and do you know what they want?

Karen put it another way.

> Once I made it to college, there were counselors that tried to keep us on the right path. They set up mock interviews to let you know what is happening in the real world: how to dress, how to speak, and how to hold yourself in a way that people are not just impressed by looking at you, but also what you speak.

Karen recalled that preparation for socially acceptable business appearance started for her in high school, and was reinforced upon reaching college.

> They're going to underestimate me. So, when they underestimate me, I have to prove them wrong. I already go in, and I don't want to say with a chip on my shoulder, but I go in knowing, because of the way that I look, my height, my size all that, the physical pieces of it, what I must do.

Socially acceptable appearance and demeanor is taught across cultures, and in various places such as etiquette schools and formal curriculums. Each individual may have personal thoughts of what is required to be a success. Penny responded,

> I'm feeling that as a Black American, you can only rise to a certain level, and if you do not fit their model, you will not rise. What I mean by that is as I've experienced over the years, myself and another individual of a different race could be going for the same job, and I feel that we have to be well-educated, you have to dress a certain way, you have to have a certain look to go for the same job. That if that individual did not, they could, and they would still get it based on their race.

Differences in appearance are often judged within races and outside races. Ann described an experience she had at her place of employment.

> A young woman that is on the same level as me happens to be a minority as well. In a conversation about hair in general, I informed her that I decided I wanted to go natural. She said she did not think that it was professional. I asked her what she thought was not professional. She discussed, it would be a short cut. She said, I just do not think it is professional. I thought wow; you know… what would have been acceptable, permanently treated hair, longer hair? I have always worn shorter hair, but permanently treated. My normal hair color has a couple of grays. My hair is short and curly. In her mind, it was too ethnic. People will perceive it as being too ethnic, and will be intimidated by it. I have spoken to executives… talking on a personal level, and they said, one thing, you already stand out. People are already going to notice you, because you are a minority and a female. You do not want to stand out.

Jane's said:

> There's nothing you can do about changing your look. You can't change the color of your skin. That's obvious walking in and …. So, you know, and I know there have been discussions about black women having vast hair-dos and all that kind of stuff and I personally believe that you know the institutions have to accept that everyone doesn't have straight hair, haircut in a certain way, and that there are certain things you have to accept. But, how do I tell folks where I work that you have to conform?

The majority of the participants experienced appearance issues in some respect, including targeted recruitment. Karen said, "They look at me and say, well she's short,

she's African American, and she's of this physique…. They type cast. You know how you have someone in the same movie role over and over again." What Karen was saying is that she was not selected for the different roles, because she did not have the desired look.

Age

In conjunction with appearance, age was a significant factor for three of the participants. Age is often a measurement people use to signify maturity or experience. In some instances, age is a consideration for women in terms of highlighting childbearing years. One participant considered the issue of the childbearing years a deterrent to advancement. The following statement from Karen illustrates her experience with this phenomenon. Karen stated,

> I think my goals have changed to the point where family has taken over the career path. I'm also concentrated on being mom, so I think I've shifted not necessarily change, but shifted. I'm in this mode, and then I can pick back up. You get, oh well, we don't want anyone between child bearing age. They could get pregnant. We don't want someone with kids in a certain age group. They have to take time off to deal with the kids.

Age may pose a barrier to advancement when it is used as a means of judging experience, as noted by Ann. Per Ann:

> I would even take it down to age. You know some people think I've been doing this for a few a years, so what could you know? How old are you really? I'm all for, you know, experience, trial and errors, learning things over time. I'm very

> respectful of that. But some people are just cut and dry, I've been here 30 years and you haven't. Age is a deterrent to progression, as it equates to lack of knowledge.

According to Jane,

> I think they do look at age, because they link at age with maturity level. For my age, I feel that I am pretty mature. People think that because of my age, I lack experience. Then, when they actually give me the chance, they see I am capable. But with this one thing holding me back… and also even with educating my children, I say, it's a strike against you. I went to corporate, and looked around the table and found I'm the youngest here, and I'm the only African American at this table.

Addressing perceptions associated with child bearing were not the only challenges experienced. Education, fear, and quotas were among other issues felt to have an impact on career progression. Issues of color classification and age are not the only challenges or concerns mentioned by the participants in this study. They also mentioned that they had issues concerning stereotyping.

Stereotyping

Among the factors facilitating or hindering career development, another theme of stereotyping was evident from the experience of two participants' responses. Stereotyping is a principal theme that emerged from the categories, related to appearance. This theme embodies the research participant's conceptualization of elements with meanings synonymous to that of Cardwell's (1996) definition for the term stereotyping-

"fixed or over generalized beliefs about a particular group or class of people" (McLeod, 2008, para. 1). Stereotyping may yield such believable cognitive distortion that it could have ill effects on shaping attitudes of others. In addition, Sanchez-Hucles and David (2010) suggested "stereotypes may adversely impact the self-perceptions of BAW and others" (p. 173). Below are some of the participant's responses related to stereotyping to show how these preconceived ideations may have a bearing on advancement of BAW. Karen said:

> In my perception when they see a strong black woman, she is not assertive; she is aggressive. So with that being said, if you make a statement, and you try to do it for the good of the order, you are the loud mouth that is being aggressive not necessarily the concerned person that's trying to meet the needs of the good of the order. I think that factor has a lot to do with it. They are already going to have some stereotyping. I am not necessarily saying that all of the leaders are the same. I am saying that some already have a preconceived notion. If you look a certain way or speak a certain way, they, whoever they are, already have a stereotype in their mind of how they think this person is going to react and behave. It is whatever they come up with. I just say, I have to come out and try to be 110% better.

Ann offered this perspective:

> People will perceive something as being too ethnic, and will be intimidated by it. You really cannot help it. One of the persons talking to me was my colleague. She and her family are from Africa. If you look at her, her origin is obvious.

The comments from both Ann and Karen offer different perspectives with regard to stereotyping. Karen talks of the preconceived ideations imposed commonly by society that paint BAW as angry. BAW are often characterized as *Mammy, Sapphire*, and *Jezebel* (Sanchez-Hucles & Davis, 2010; West, 1995). Tainted perception can impede advancement for BAW (Sanchez-Hucles & Davis, 2010, p. 173).

Education

Aside from color classification, education was the second most widely mentioned factor impacting advancement. In response to series of inquiries regarding issues felt to facilitate or hinder career advancement, education was a dichotomous factor. It was believed to be useful for advancement in the minds of some participants. Others considered education irrelevant if employers failed to impose fair hiring practices. Different views expressed by various participants are noted in the subsequent text. All but one participant discussed the relevance of education to advancement up the career ladder. Renee responded, "I do believe that getting higher education will move me to the next level. In getting higher education, I am not limited to the job that I am doing now."

Some participants cited education as a factor impeding career progression when it was not accessible. Cost was mentioned as a problem affecting some participants' desires to return to school. Molly said,

> One barrier, in the physical therapy profession, is the doctorate requirement. Being in school 6-7 years, accumulating debt, and not making a high enough salary, may yield on average $100,000 plus dollars in debt. Right now, I would be a little skeptical about trying to get a loan.

When asked what caused a lack of initiation to move your career forward, Penny responded it was "education." She felt like she lacked the education needed to move forward to the next level.

> If I'm applying to those particular positions, and not getting them, then it could be my educational background. I have been in the organization for over 20 years. They might be looking for a more diverse work experience. Or am I good enough? Are you going to be looking at my education or are you going to be looking at me as an individual? Whether I am good enough…. It is just that for so many years, I just didn't feel I was adequate or questioned if I could be in a leadership role. I did not have the encouragement at a younger age. I didn't get it until, you know, once I was in undergraduate school. I got a job, and had those who were pushing me. Oh, the catalyst was that in my upbringing, I saw my parents struggle. They did not have an advanced degree. I wanted to not be in the same situation that my parents were. My catalyst was to be better, not to be better than them, but to have a better life than they did, because I looked at how they struggled, because of their lack of formal education.

Jane said,

> Even though the position I currently work in did not warrant a degree, they wanted somebody with a degree to come in to that position. That's why I say as I reflect back, I knew at that point that the only way that I am going to progress to where I want to be, and get to my career goals was to go back to school. I know I must be educated. Do you think someone wants to go out and spend thousands of

> dollars on education in which the person next to me may have less education, but because they have the right skin color, they'll get the position? However, I think may experience, that.

Sally responded:

> I did a lot of precepting on the unit, and staff education. I really enjoyed that. I decided that I was going to pursue my master's degree, so that I could work full time in those of areas, or doing that type of work. I have a master's of science in Nursing, and I have been in this leadership position for 7 years.

With education, the discussion of quotas was apparent from participant responses. Although this theme was not apparent in each interview, it was significant to mention how it is viewed.

Quotas

From the series of questions on what impacted career development, remarks were made about quotas. Although there were only two views raised regarding quotas, they are still of consideration regarding hiring practices. Quotas were considered a means of getting into healthcare leadership roles. Quotas are often not spoken of in hiring, but are in existence. The following section is an excerpt of one participant's experience with quotas. She worked in a mid-level management role in health administration.

Quotas in this instance were perceived to justify the presence of only one black person executive when the majority of executive bodies were white. Karen and Jane describe this phenomenon. Karen said, "If I see one, it's like the killing two birds with

one stone- a black woman, so you've got your two minorities, a black, and a woman. They were just brought on board to fill a quota."

Jane said:

> If you look at the organizational picture chart, it speaks to you. It may sound direct, but I think the African American that got there is just so that they could be quota, so they can say they are diverse as an organization.

Not all participants' experiences were consistent with all barriers described. Two participants had experiences related to five of six most common barriers to advancement. Some participants had fewer experiences with the wide array of factors. Other information regarding lack of advancement by the participants were described as complacency-in a particular job too long, being female and African American, and family matters serving as roadblocks. In addition, most participants spoke of experiences with disparate practices in hiring. Some candidates were hired over participants that did not have the required degrees or certifications. The majority of the participants acknowledged that they felt they had to have a higher educational level and better performance outliers than others. In the next section, I examine participants'' experiences on the progression of their careers.

Stages of Career Progression

Many received mentoring at early stages before college; others received none. Some early mentoring and training recounts were instrumental in the advancement of educational and job pursuits. Participant's experiences at various stages in their career progression are elaborated on in the subsequent section. The second research question

was posed to discover how BAW described lived experiences at various stages of their career progression. Information provided by the participants in answering this question ranged from entry level into the job market to current day scenarios. Not all participant responses included specific inference regarding the stages of their career development. Answers to the questions were varied.

Karen is currently working as a director, and hopes to advance to a regional level. At this time, she is not sure whether she will remain at her current organization. She has excelled up the career path, but her priorities at the present are centered on the needs of her family. It is apparent from the context of her next statement that she has become frustrated the business practices of her current employer. The tactics described have enticed her to see outside opportunities to advance her career.

> My perception is that the president is the jock, and some of the members of his senior team are the cheerleaders. I think there are certain people in middle management, lower management, and other positions that they bring into their club. Maybe, I'm just jaded at this point, but I'm not trying to build a brand at the current organization that I'm in.

Penny at the midpoint of her career said, "While working as a staff nurse, I looked around, and saw there was not a lot of Black Americans in the leadership role, and felt I could make a difference in that role." Penny said that she feared competition and favoritism. "As far as I believe, as a black American, you have to go three or four steps above the average individual."

Ann got her motivation in nursing school. Ann at the beginning of her journey remarked,

> When I went to college, my instructors were very much for nursing. They emphasized moving forward and doing more in nursing. They helped me with giving me more to do than working at the bedside. They always talked about ways I could get there. It was something that was embedded in my nursing program.

Ann talked of being invisible to the other directors that did not bond with her in this new role. She discussed her challenges with unequal treatment at the midpoint in her career progression.

> At first, I was in a director-like position, but I wasn't a director. It wasn't a year before I got the title of the director. It was very obvious that other directors, nursing directors, didn't see me as a director. I felt that they didn't always give me the same courtesy. And umm, well before I actually got the director title. I had always gone to the director meetings. There were comments "Oh well, you aren't a director"…. I could be sitting right next to them, and we reported to the same person. They even called a meeting, and were just kind of testing me on what I did, who I was, all of the things that I do. What I did do was let my boss know that this woman, who is supposed to be a director, was behaving in this manner in front of her subordinates, and it wasn't professional. I was disappointed and disgusted. She came to apologize to me because my boss let her have it.

Jane, midpoint of her career, felt she was being used as her boss's scape goat. She said she intended to leave her organization because of concern that she would not be acknowledged for the next leadership advancement opportunity.

> Right now, I feel that my growth is stagnant, no where I can go here. Other people may see things in me, but unless the person, in charge, can actually see it in me, I am not going to grow.

This commentary was based on her frustration of being passed over for a promotion. The job was given to someone with fewer qualifications. Molly at the latent stage of her career, nearing retirement, made the following assertion.

> I think there's this plan underfoot that stemmed from our government's effort to have cultural diversity. I know in APTA, that cultural diversity is something that they are trying to have a mirror image of the populations that we treat, and the people treating them. I had this experience where I was a assisting a patient, and the patient didn't want me as a therapist because I was black. He said to our secretary, "I don't want a black therapist". So I was like, 'Hey, he's missing out, because I'm a better therapist for the issue that he had, but he has the right to decide. So, it was his loss, not mine. I really didn't take any offense. I didn't take really offense to it because, you know, this person, obviously to me was pretty trite, not well educated, not well rounded, and whatever. They have the right to decide.

As the participants discussed their experiences at various stages of their career track, many made mention of myriad unfair practices experienced during the prime time

in their careers. These perceptions and experiences were grouped as themes relating to deterrents and success factors. This next section is comprised of data that were in response to the third and final research question regarding experiences, if any, that were perceived as instrumental, unequal, or deterrents to leadership advancement in health care administration.

Deterrents and Success Factors

Some participants conveyed that they were subjected to disparate practices in the work place. Those hurdles, as described by the participants, were classified under the overarching theme of deterrents/disparate practices. There were myriad disparate practices noted from the participants, which included, but were not limited to cronyism, unequal treatment, and lack of exposure to the executive body. Age and gender issues were also noted as challenges to career progression as related to experience level and family rearing. In conjunction with the deterrents expressed, success factors were evident.

Deterrents to Progression

There were unequal practices that each participant experienced, in one way or another. Subtle racial discriminatory practices, disparate treatment, and diversity issues were themes that emerged as deterrents to career progression as expressed by the participants. The following section contains findings regarding deterrents as expressed by the participants.

Subtle Racism

The issue of subtle racism was experienced by the majority of the participants. This theme is comprised of all of categories that had a relevance to race and race

relations. Racism was a term used by one of the participants, as she described her experiences. Discriminatory practices were evident from the candidate's recollections. Most discriminatory practices appeared in many guises like stereotyping and color casting. Racism, in any form, may have a negative influence on individuals, organizations, and groups. People use euphemisms to describe conduct, which is defined as racist. In the following text, different elements of unequal practice are discussed. The experiences are articulated from the participant's viewpoints to illustrate issues believed to be hindrances to the advancement. Many of the participants spoke candidly about their perceptions of racism, as one of the unfair practices witnessed in organizations. They considered their experiences as clandestine, since most of what they lived with regarding racism was not overt. Renee explained her experience with racism.

> I have been on my job for 20 years, and as time went on, I saw politics and racism. Different things… discourage you from wanting to be a part of the organization, in terms of leadership and moving forward. One thing I feel about racism in organizations is that Caucasians, in leadership, can say anything, and be very offensive to the Black race, but if we as the Blacks say anything, we could be fired. They do not think of us as human beings sometimes. They say anything and think it is okay with us. As a black person, I have to watch what I say back to them… and that is very offensive to me. I know there will be a level of racism wherever I go. I am hoping that individuals see the quality of my work, and not look at race. It is very obvious, but leadership knows how to cover up racism.

> They put it out, and then use other/different words to try to change what they are doing.

Renee felt that racism was prevalent in her organization, as evidenced by limiting job descriptions, hiring practices, and comments made.

The election of the first Black president was revered as a milestone in American politics. Molly added a different reflection on the issue.

> I think the racism still prevails, and I think because we have a black president, it is coming out here like crazy. Fighting prejudices and biases is challenging. If you are born black and female, you are challenged. Affirmative action and all of these other things have been created to make an equal playing field, but the playing field is not equal.

Jane said:

> A company can say that cultural diversity is what they are seeking. They seek different faces, and are open to it. But, when you sit around the table of your peers, and remember these are hospitals all over this network, I am the only African American sitting at the table, and the only female. I'm sorry to say this; it goes right down to color. They don't want you, even when, I'm sure… this is not right.

Penny replied, "This is my personal opinion, there is racism within the corporate world, and within the private sector."

Affirmative action and other legislations to bring about equal rights are in place to control racism, but have not seemingly controlled the perceptions of its presence in the

minds of some participants. Ann said, “I do not know if it is knowledge. You know, sometimes I have to prove that I deserve to be here.”

Double Jeopardy

Double jeopardy was the most prominent theme for this research question. Being advantaged or disadvantaged because of the dual minority status was a theme that could not be overlooked. Overall, participants felt that they had a double dilemma that they faced, being female and black American. Ann stated,

> You’re an African America female. That is what it is, I’m comfortable with that. Most time if I’m around a counterpart that may not look like me, they can talk about something in a very confident way, and may not need to know all of the inner workings or elaborate details that they need to know. They can kind of fudge their way through it. Wherein, my experience is that I cannot just do the same. I will be questioned. I will be asked to give additional details. I consider myself to always be ready.

Jane’s response to the question was, “If one is African American and she’s a woman, they met two criteria’s of diversity in one role.”

Being Overlooked

Sixty percent of the participants experienced being overlooked. Participants believed career progression was hindered despite working diligently to exceed expectations. Many felt they were often overlooked. Penny stated:

> Even though there was still racism, I could go above it. I was good enough to do the job, when I was in that acting role. It still was racism there, unspoken. I am

> seeing that there are more White Americans in the lead roles in administration, and you would see maybe one or two black Americans in that role. So right then, I don't feel that there is a diversity in the top of administration so to get there you are going to have to work even harder and struggle. And will all that you put in, will it be valued? Will they took note of that? I do not think I would be given a fair chance. I think I would have to try a lot harder, so my résumé, my education would have to be top notch, my grades would have to be top notch…. That is what I have experienced, and what I believe.

Renee said,

> It seems as a black woman, I work double hard to get what I need, need, versus white people. It seems like they have been handed things, even in our organization. Our president, he knew the president before. It was almost like he was handed the job without even working hard. So again, it's all in who you know, too. There was an episode where there was a black person that was qualified, and the person they hired had less credentials. They still hired the white verses the black. It makes you know that even though it's not being said, sometimes vision is more of a… how can I say it? Seeing it, speaks louder than words.

It is of interest to discover that BAW were actually being promoted without power and privileges, as well as being disregarded for the role undertaken. This takes on a different perspective. BAW make it to the next level but are not revered by their peers as equal in status.

Sally said,

> Someone else was given the position, and I had applied for it. That person did not have the educational backing for the position. I was disappointed in that. I did an interview, but I am not sure if she went into the interview process. I just heard that she had the job. Later, I heard she stayed in it a very short time, and was given another leadership-type of position. I felt bad, because I actually wanted that position. She did not even stay in it. I think it was less than a year.

In addition to not being treated equal, participants discussed their limited opportunities for exposure.

Limited Exposure to the Board

Lack of exposure to the executive board was a major theme that surfaced. This factor was experienced by six of the seven participants. Some participants considered lack of exposure a drawback in career progression and acknowledgement. Hospital boards consist of key decision makers with high stakes in organizations. Participants described their organization's failure to include them in respective career development opportunities. Penny stated:

> I feel I could get more exposure. I think my exposure is limited. I believe my VP, if you will, could have us more involved in a lot more executive type of organizations to get more exposure beyond the current organization. I have not been exposed. I have not been in front of the board of the facility where I work.

Jane's said:

> I feel I could get more exposure. My exposure is limited. I believe my vice president could have us more involved in a lot more executive type of organizations to get more exposure beyond the current organization. I feel like sometimes you are used. It is just like you are used in so many different ways, in essence, behind the scenes. A manager that I used to work with, I know, many accolades that she has gotten is off the work that I have completed. It seems to be that she did it. I have not had any exposure with the board of directors.

Ann said:

> I feel like I'm acknowledged here at the facility by my immediate supervisor. I think it is a new role, informatics that scares a lot of people. I can honestly say I feel that other nursing roles aren't supporting of an informatics role.

Molly was asked about her experiences in being exposed to the board of directors and said, "being acknowledged at the board level, maybe indirectly". Ann stated that she is not getting exposed to the board.

Sally's said:

> I haven't had any exposure with the board of directors. I guess the closest to exposure would be working on the council that we have at our facilities, and having access to the CNO that leads that. This is on the corporate level. It's really grey or blurred sometimes. I think many organizations, including this one, function on what they call the good boy or good girl club. You really have to know people, and be in the mix. I don't think that it's always based on skill set. I think sometimes it's just where you are in the organization, and who you know.

Along with lack of exposure to the board, it is important to mention that participants expressed that although they moved up the ladder to key leadership roles, they were often not respected or given the authority known to the position. Other hindrances were perceived as deterrents to advancement.

Challenges

Barriers, deterrents, hurdles are all terms that define challenge in career progression. The occurrences of challenges in some form or another were experienced unanimously by the participants. This finding indicates that there are some definite circumstances that have by some means hindered progression of BAW's career advancement. Not everyone considered the barriers as adverse circumstances. The drawbacks were considered as setups for fresh starts. According to Penny, "There will be barriers. I think that there will be barriers in any role or your next stepping-stone in your life, but if you are determined, you can overcome those barriers."

Molly was specific in her identification of what she believed to be a major deterrent, spoken language.

> I think one of the barriers is sometimes or maybe quite often even that African American folks have their own lingo and they are not using the King's English or the white man's talk and that's your first impression.

Sally discussed her sentiments on challenge in career advancement and unfair hiring practices.

> I think a lot of times the decision is already made on the candidate, and then something happens. I don't really see or hear about a fair interview process. I've

had plenty of experiences before I got into this role. Same thing with the educational development positions while I was at another facility. Someone else was given the position, and I had applied for. That person didn't have the educational backing for that position. I was disappointed in that, and I took this position here. I was later called in about the other one. I already had a nasty taste.

Participants also mentioned fear, lack of succession planning, lack of networking opportunities, and discriminatory practices as deterrents. All participants had some experience with deterrents and disparate practices. The subthemes that emerged from disparate practice are listed in Appendix D, Table D2.

Disparate Practices

All participants in this study were found to have experience with disparate practices. The experiences may have been actual or perceived, but were considered hindrances to career advancement. In the context of this study, disparate practices are defined, in accordance with Burton (2013) as "inferences of discriminatory actions that are related in some way to race, gender or any other characteristic subjecting them to adverse employment actions, and allege that they have been intentionally treated differently on account of their race" (para. 2). It is noteworthy that BAW are still facing roadblocks along career paths. When asked what experiences were considered unequal or disparate practices, some participants described occasions where they felt they were treated differently, and not equal to that of their colleagues.

Molly noted that ethnic names were often associated with people of color. The concern is how others would be regarded if they had ethnic names in terms of career

advancement and hiring. “African Americans have given their children names like, Alquietta, Lashanda, or whatever. People look at the name, and that is it. Those kinds of things are a big concern.” Feeling devalued was expressed due to perceptions of disparate practices. This theme was one the majority of the participants expressed being subjected to.

Feeling Devalued

Karen’s perception was that she did not feel valued enough to be acknowledged beyond her immediate supervisor.

> I do not think they feel my worth. Although, I feel very supported by the manager I report to. We have an open and honest communication. I think it stops at his level. I do not think it goes past a forum of them getting together-them being the executive team getting together collecting their thoughts. I do not think it goes beyond him.

To be recognized Sally ensured that her work was showcased in a variety of settings. Sally replied:

> I would never put myself in a situation where there’s only one group of people that can speak for my work. Sometimes, those very same people will drop you. If one door shuts, you go to the next one and that how I’ve always functioned in my career.

One of the major road blocks regarding being devalued is related to not getting in for interviews. It had already been stated previously that ethnic names were a deterrent.

Being qualified and not afforded the opportunity get equal consideration for a job attributed to participant's feelings of devaluation. Renee's perception was:

> They do not give you the opportunities that they will give their own race. Sometimes they limit you. Whites are always in charge. We have one black on our board, so they are always in charge. You feel like they always give their race the opportunities first, not the black race. They do not really even give you an opportunity to apply for the position. They will tell you something, as they are looking outside the organization verses looking internal. You don't really get the opportunity to apply to a position.

Sally said,

> I think many organizations, including this one, function on what they call "the good boy or good girl club" where you really have to know people and be in the mix. I do not think that it is always based on skill set. I think that sometimes it is just where you are in the organization, and whom you know.

The term *good old boys network* "has long been viewed as an exclusive club that affords inside information, facilitates advancement, and provides a social and support networks to its members" (Rand, 2009, para. 2). Generally, it is not something that is overt and acknowledged. This network's membership "is automatic if you are white, male, and white collar. Women and people of color do not have ready access for membership to this exclusive group" (Rand, 2009, para. 2). According to Karen,

> I've seen them use the term 'good old boy network' to help for some other people. I just have not experienced it helping me. If you are a part of the jocks and the

> cheerleaders, I think you get more exposure and recognized as being part of the jocks and the cheerleaders, but if you are in nerd land, not so much**.** My perception is that the president is the jock. Some members of his senior team are the cheerleaders, but not all. Moreover, I think there are certain people in middle management, lower management, and other positions that they bring into their club. Even in our organization, our president knew the prior president, so it was almost as if he was handed the job.

Karen provided another example of this situation that happened to her straight out of college.

> This young lady finished one semester ahead of me, with no experience. She was straight out of college. Both of us were waiting to take our certification exam, but her dad was a president. The president called another president to say my child needs a job. She and I were at the same interview. They told me, you will do fine, you will do great, but we are looking for something else. They could not explain to me what the something else was.

Similarly, Ann provided another example from an experience she had in applying to a consulting firm.

> They needed to get a copy of my nursing license before they even had a phone interview with me. I talked with two people on the phone. When I got there, I had to go through a series of interviews. There was a man who interviewed along with me. Later, at one of the out of town dinners, I was sitting with the recruiter. She had a little alcohol, and was a little loose with her lips. She told me about the guy

> interviewing with me. She said they could not find him. I asked what she meant. They could not find him. She said he just dropped off the face of the earth. We never verified his anything. They did not verify his education, so this man had a job. They did not verify anything. I had to go through several things in order to get a phone interview. Now, it might have been other things. I cannot just make an assumption, but I am thinking this man, you actually offered him a job, and then later on, after you offered him the job, you are going through the background check you cannot find out anything on him? I had to literally send you a copy of my nursing degree in order to get a phone interview.

The perceptions of unfair practices are obvious in the following commentary from Sally:

> Some people were given jobs, with an associate's degree (AD). I was told I would at least have to have a bachelor's degree in nursing (BSN) to be considered for a supervisory position, within nursing. I bypassed the AD, and went straight to the BSN. Later, I began working in an area with diploma-trained nurses and AD nurses that are in leadership roles. I have heard about things in a roundabout way instead of a more direct way, which I would have preferred. When there are opportunities that come up, certain people are approached, and others are not. I imagine the positions are posted, because they have to be posted. I think maybe it should be more open to everyone, and then, whoever wants to apply can apply.

Fear

With respect to the same question regarding what experiences were perceived as roadblocks, fear of not being considered for healthcare leadership roles was shared by four participants. The issue of fear has resulted in various thoughts and actions taken by participants to remain viable in the quest for executive leadership appointments. Penny said,

> I foresee that it is just going to take motivation to continue the goals that I'm going after, using the experiences that I have at this current facility, and use it as a driving factor to move forward. It was probably some fear in moving outside of my comfort zone. Now, to advance in any career, you have to move out of your comfort zone. You have to move forward.

Ann stated:

> One thing when you start thinking about the job market, in general, it's just a little tricky, right now, the way things are moving to an ambulatory setting. So, you know, going back to school right now is not in the cards for me. I'm just trying to focus more on just working.

Jane said:

> I knew which organization I wanted to work for. Coming into an organization, I set up goals, which I write down. Then, I progress from there to moving in, especially, ambition, endurance, an eagerness to learn, and then critical thinking. I think critical thinking in a lot of different aspects of health care is a critical aspect

> that nurses and health care administrators, no matter which part you serve in, they have to have that aspect in order to progress.

Finally, according to Molly:

> I think part of when you look at positions that get eliminated and more in this environment, in this training yesterday, they were talking about hospitals that across the country they are going to look at getting rid of some of these upper level positions, eventually. For job security, do I want to risk that? Because, I'm looking towards retirement now, I don't want somebody to force me into something that I don't want to do or am not ready for. I think you can be more vulnerable at some of these positions.

The presence of fear was expressed as a concern, as well as the lack of succession planning.

Lack of Succession Planning

Discussions of lack of succession planning were part of conversations in response to what participants considered as issues, if any, inhibiting advancement. Of those conversations the accounts by Sally and Jane provided an example of those experiences. Sally said,

> I am not sure how that happens as far as who is chosen to cover or manage something in a director's absence. I think that if there were proper succession planning, the entire group would be trained to manage, because you should want to build up your entire staff. They had an unwritten type of succession plan if we knew that individual was going to be retiring or moving to a different job, then at

> that time they would start to prepare us. It was not as if I was a staff nurse, and you were prepping me to be the assistant or the head nurse through my nursing profession. It was by default.

Jane responded:

> I would not say that it was succession planning. I would say that, then again, I was used as seat filler. I took on many of my previous director's roles. As far as a change in my immediate position, they left me in the same position. I just assumed her role to complete her daily duties in so many things. When, my manager left, no one talked to me about moving up, or asked where I wanted to go in the company. I have pulled and proved myself here. That is why I am going to stay even with my boss leaving. I thought the new person coming in would do the right thing. Here recently, we had a change in administration. When you are going through a change in administration, literally, you do not make any position changes to the rest of the organization until they get those new people in place. They let those people pick their administration. I have worked with nursing. You cannot blame that on a vice president or anybody else, because it is up to her to come up with a succession plan for me. So, if that did not happen, there is no real succession planning.

In conjunction with lack of succession planning, issues related to diversity were discussed as a significant deterrent by the participants. The impact of diversity was expressed in different contexts, and is discussed below.

The Diversity Principle

Diversity is another major theme that emerged regarding deterrents to advancement. Participants viewed diversity many different ways including principles of gender, age, and race. The degree of diversity may be controlled with quotas to establish equality in numbers. How diversity is perceived is not easily regulated with such a quick fix. People can be moved about to balance out the presence of particular cultures, but there needs to be a connection for understanding and effective communication.

Some participants perceived that in predominantly Black-staffed organizations opened up opportunities and afforded more advancement options. Penny said,

> I'm feeling that as a Black American, you can only rise to a certain level, and if you do not fit their model, you will not rise. I'm seeing that there are more White Americans in the lead roles in administration. You may see one or two Black Americans in that role. So right then, I do not feel that there is a diversity at the top of administration. To get there, you are going to have to work even harder and struggle.

Other participants wondered why there was such a mystery about BAW. This mystery often stimulated stereotyping and odd commentary. Ann responded,

> It was a little odd. I do not think that a white person would tell another white person you are the first white person I have seen in this department, or you are different from the other White people. It is odd in that context, but I do openly allow the conversation. Maybe, they can learn a little something about me. The fact that I am diverse or a minority makes me stay on my toes at all times. It is

> just that people are learning how to accept you, and understand you while working next to you.

A different perspective was that companies boast that they are culturally diverse. Although the organization claimed to be open to cultural and racial diversity, Jane recalls sitting around the table of her peers-from hospitals through her workplace network, and being the only African American at the table, and the only female. Jane said,

> It was like people just draw to you in the room. It is like, how do you put it? It is like you are a centerpiece. When people come, they talk to you because they want you to feel comfortable. I think even with them, their ethics might be the same as the organization for which they work for. It makes them feel uncomfortable.

Many organizations speak of cultural diversity training to help in understanding the true qualities and characteristics specific to a race or ethnic group. Whether or not this training was successful is not yet determined. However, in spite of the challenges faced by BAW, the participants also noted success factors.

Success Factors

In answering the second part of the third research question, participants were asked what strategies were recommended that might help with advancement to executive leadership. In response to this subquestion, most participants considered mentorship necessary for their advancement.

Mentorship

Mentorship and family support were key attributes voiced by participants as success factors essential for continued motivation and advancement. (See Appendix D,

Table 2). Not everyone had a mentor, but each had determination, a critical factor for success. Participants who had mentors felt their mentors were instrumental in guiding their career track and providing emotional support. Molly said,

> I always had good family support, from my parents. Whatever I wanted to do, they always supported it, and were either actively involved or accepted whatever I had an interest in. They let me go try it or do it.

Molly also considered finding mentors imperative. Karen said:

> No, I can't take credit for doing it on my own. I've been exposed to mentors. There was a woman that is in a leadership position at a different hospital that has been encouraging me. She is a white woman that said I should go back to school, because we need Black doctorate prepared nurses.

Sally said:

> I had a mentor that encouraged me to pursue administrative type positions, which sat me down and talked about the benefits of leadership roles. Along the way I've met really good people. Those are the people, I will lean on.

According to Molly,

> Mentors. I think, we as Black women, have to be open and willing if somebody calls you or if somebody may have interviewed and they want to get to physical therapy school, nursing, or whatever health care profession, hook them up with somebody.

Penny said:

> I have had a mentor and those who have encouraged me to pursue administrative type of positions, sat down, and talked about the benefits it would be to be in that leadership role. They were very instrumental in encouraging me to go back to school. They were instrumental in giving me opportunities to work in various positions. They were very instrumental and their roles were in leadership roles. Seeing what they could do and how they helped me was instrumental. Family support, colleague support, peer support, and just seeing other black females in leadership roles that have propelled, It was a matter of seeing if they could do it, I could do it.

However, Penny grapples with her understanding and knowing her own self-worth and wonders, "Am I good enough?" She is currently working on professional development, and is now serving on committees and planning to advance her education.

> There will be barriers in any role or your next stepping stone in your life. If you are determined, you can overcome those barriers. I have found that it's a harder struggle for black Americans. As a Black American, you have to go 3-4 steps above the average individual. My ambitions are in seeing others, seeing other Black Americans in leadership roles. That is inspiring. If we have other individuals in that place, we can set the road for them to be able to achieve just what I'd like to be able to achieve.

Determination

Determination, translating negative inferences into positive thoughts and actions, and resetting priorities were subsets of success factors described by participants for their

continued success. Ann said, “In true honesty, I use the fact that I’m diverse or a minority. I try to look at it is a positive, because it makes me stay on my toes at all times.”

Higher educational achievement and determination were considered imperative factors for advancement. Sally felt that undertaking other duties was essential.

> Toast Masters for the speaking part and volunteers for other organizations in Baltimore, where she does grant reviews. I get myself involved in all types of things so that I can at least have the experience of working in other groups.

Sally is currently working on her doctoral degree. She credits her renewed drive and professional growth to her mentors. Although Sally has experienced unequal practices along her career path, she keeps moving forward with her goals.

> I am a social person regardless of race, age, gender, or whatever…. I make myself available to all, speak to all, volunteer, and get myself involved. I am involved with different organizations so I keep my network circle big.

Karen thinks big. She said her aspiration is to “confront the world goals”. She chose to take time from forging her career to raise her two children. Karen says her goal is to become president of her own company. She feels that there are a number of issues in the traditional health administration market. “I have seen nepotism, stereotyping, type casting, and tokenism”. She does not let her experiences with unfair practices stop her. “I just have to come out and be 110% better.”

Jane started down the road that led to dead end middle management. She realized that she was misled. “They tell you a lot of fluff. It does not work. They tell you so many

aspects, and so many places you can go, but that's not reality." When she found out the path to a brighter future, she took it. Jane feels her greatest barriers have been her age and her skin color. After taking personal inventory of her credentials, she began putting her career into the proper perspective. "That is why I reflect back, I know the only way I am going to progress to where I want to be, and get my career goals were to go back to school."

Despite feelings and experiences of being used, passed over, and unappreciated, Jane is still moving forward. She believed by advancing her "education, perseverance, and a lot of praying", she will reach her goals.

Ann said,

> My father made everybody look at the Department of Labor book. It was a rite of passage in 10th grade. This process equipped me with knowledge of what the chosen career path required. I use the fact that I'm … a minority as a positive. You are an African American female. I'm comfortable with that.

Ann grew up in a predominantly successful household. She recalls, along her career journey, lacking exposure to the board, limited inclusion with succession planning, and experiencing disparate practices. Appearance was a major concern. Ann said she faced concerns from both her black and white peers of being too ethnic, which was intimidating to some. She also experienced lack of respect. "Directors did not see me as a director." Ann continues on her career quest, and she is not afraid to stand for what she believes in.

Renee said, “One thing I wanted to do was to move up and get paid for my work. My supervisors were making the money, and it was my ideas they used to spearhead projects.” Renee was very candid about her career goals, experiences, and obstacles. She comes from a large family with a host of support. Renee has mentors as well, who have been instrumental in propelling her career choices. “I have a supervisor that really pushed me to get back into school. I am very grateful, in previous years I just had a high school diploma.”

Renee felt that racism and politics are barriers. Despite her feelings that she has not been given equal opportunities to move forward she noted,

> Racism has really become a great challenge for me. It makes me want to move forward, so I can be on the level where I can address some things associated with racism. I am able to progress, because I know who I am. Challenges make me strong. Even when I see the racism and the lack of blacks in leadership in my organization, it makes me fight harder to get to where I need to go.

Summary

It was clear that barriers exist that have a bearing on the pace and success of career advancement in healthcare leadership. There were a host of factors discovered which were considered deterrents. Collectively, the participants experienced disparate practices thwarted career progression.

In answering what factors contributed to BAWs’ lack of advancement and were considered inhibitory, the overarching two consistent themes were double jeopardy and subtle racism. The inescapable double jeopardy factors were innate qualities of their race

and gender. The theme of racism had intersecting elements, which formed perceived and actual barriers thwarting advancement. Stereotyping, being overlooked despite being qualified, and color classification were factors found associated with racism. Unequal practices and feeling devalued were deterrents to leadership advancement. Gender related issues, lack of inclusion in succession planning, and limited exposure to the board were also deterrents experienced.

Success factors were noteworthy from the vantage points of participants, which were instrumental in promoting progress up the ranks. The two most prominent themes were determination and having mentors. Factors influential for career progression were the presence of mentors, strong familial support, and self-driven determination.

The following chapter provides a review of the purpose, summary of the findings including conclusions, and the impact on social change. The methodological, theoretical, and empirical implications, as appropriate are discussed. Recommendations for practice are also discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this transcendental phenomenological study was to understand the experiences, perceptions, and deterrents, if any, to the advancement of BAW aspiring to achieve senior health care leadership roles. The nature of this research study was to explore in-depth lived experiences of BAW, attributing factors, deep-rooted ideologies on race/ethnicity, gender, social class, or any other perceived or actual barriers inhibiting advancement to the senior leadership roles, in health care. The choice of a qualitative phenomenological research design was best suited to answer the proposed research questions. The following section contains information regarding the key findings from this study.

Summary of Key Findings

The findings from this study were based on interviews with seven BAW serving in healthcare leadership supervisory roles. All of the participants were born in the continental United States. The participants were employed in the Washington, DC metropolitan region at various local hospitals. The analysis of these BAW aspiring for executive healthcare leadership roles found that barriers exist, perceived and actual, that may predispose deterrents to advancement. The number of BAW in healthcare administration's higher level executive roles remains very low. Issues pertaining to perceptions of racism, appearance, and color-based disparate practices were central themes.

It was discovered that the participants experienced issues with color classification, appearance, racism, educational variances, lack of exposure to the executive boards, stereotyping, and limited inclusion in succession planning. The factors contributed to lack of ascension up the ranks to senior leadership. Each predicament significantly posed challenges to advancement with their intersectionality to race and gender, the two constant factors.

The findings are discussed in this section with descriptions of how knowledge has been confirmed, disconfirmed or extended from what has been found in the literature from Chapter 2. Since the themes were grouped in response to the actual research questions, the next section contains an expansion of the interpretations in the same format.

Interpretation of Findings

According to Warner (2014), "the last decades of the 20th century brought considerable progress in women's professional advancement in the United States. The number of women, in general, in top management roles is 9%" (para. 4). Women of color have made advancements, but still have low percentages of accomplishment. "Women of color holding managerial and professional positions are only 5.3%, with only 3.2% occupying board positions" (Warner, 2014, para. 5). These numbers are for the entire United States, which makes the percentages of women of color holding executive leadership roles in healthcare anecdotally less. The purpose of this study was to discover if barriers exist that hindered progression of BAW to senior healthcare leadership roles. From the review of literature, it was discovered that most of the information regarding

black women's career advancement was not indicative of their own unique perspectives or experiences. I found few, if any, recent studies that explored the career journeys of BAW's advancement in health administration from their own perspective. Most of the literature was focused on the lack of women's presence in executive roles and failed to differentiate between the different minorities. "With growing emphasis on inclusiveness, there is a tendency to subscribe to the view that there is little differentiation in the experiences of racial/ethnic minority group members (e.g. Hispanic, Americans, Asian Americans, African Americans, and Native Americans)" (Combs, 2003, p. 386). Studies were found that were related to gender-based disparities and ethnic disparities.

There is a limited number of BAW in executive healthcare roles. This finding was compounded by there being few literary resources available that facilitate understanding of the complexities faced by many BAW in their quest for executive healthcare roles. A gap in the literature exists on how BAW feel regarding the reason so few have excelled to senior leadership roles. Exploring this phenomenon related to BAW's perceptions and experiences became the foundation for this research in conjunction with CRT.

After studying the lived experiences of seven BAW healthcare leaders aspiring for senior leadership, data analysis revealed there are deterrents to progression. Deterrents causing lags in career advancement noted by the participants studied were either experienced or perceived. There were some success factors experienced by the participants instrumental for career progression. This section is organized in terms of the findings in response to each research question.

Factors Contributing to Lack of Advancement Findings

Factors were found that had an impact on career progression. Many factors were perceived, since no tangible events explicate the phenomenon experienced. The participants agreed that there were issues related to their color. This theme was framed as color classification.

Color Classification Revealed

Since earlier times in American history, color has been a central theme, whether clandestine or overt that seemingly has left its mark on society. Color and gender are two factors found in this study to have a significant impact on BAW. As surmised from Hochschild and Weaver (2007), the issue of color is complex and depends often the degree of darkness. Color is a single aspect of one's appearance. Davis, Dollard, and the American Youth Commission (1946) stated, "what is really crucial behind the color point is class; the implication that light color goes with higher status and the Negroid appearances with lower status is what makes these characteristics so important" (p. 137). This statement was from the 1940s era and is still being referenced by the participants today. Findings from this study are consistent today. Color is used as a means to either consciously or unconsciously judge others.

Results of the data analysis noted color was one means the workforce and society used to subliminally judge an individual aside from merit or professional prowess. There was a constant need, in existence, to prove they were worthy. Very few opportunities for advancement were apparent. Participants noted decisions were often made in their organizations that seemed to favor white candidates.

The demand for advancement in education, productivity and performance was greater for individuals aspiring to advance. Even with the advanced performance indicators on hand. Being overlooked became the norm, unless something did not work out with the other candidate.

Color classification is one way of narrowing advancement and could have a bearing on income potentials for BAW. Inversely, the lack of advancement was found to have an impact on the participant's finances. This was a deterrent to having some amenities of life such as: higher education, better job appointments, and improved health outcomes. The findings mesh with the literature in that class distinctions are evident through the hierarchy of positions and variations of pay scales (Marmot, 2005, p. 2).

The discussion of color from this premise provides an extension of knowledge. It was not framed in the same way found in the literature. In the literature there were more discussions of class distinction, with limited mention of color implications. Color distinction may create as much of an impact on limiting advancement as financial classification could. Overall, issues regarding appearance were encountered by the participants. In conjunction with color, other aspects of appearance such as demeanor, socially acceptable appearance, and spoken language were mentioned by the participants in this study as deterrents. This study's finding have semblance to those found by CRT, as well as Zebrowitz and Montepare (2009) in a study conducted to determine why appearance matters. Zebrowitz and Montepare noted "appearance matters because some facial qualities are so useful in guiding adaptive behavior that even a trace of those qualities can create and impression" (p.1).

Appearance

Society tends to dictate acceptable appearance. What the participants described as appropriate and acceptable appearance was framed from the perspective of society that preferred less Afro-Americanness. Early on in their careers, participants stated they were guided on how to dress, speak, and conduct themselves to get proper acknowledgement in the workforce.

Seemingly, there is an ongoing undertone of being underestimated based on their appearance. Participants in this study commented on being overlooked based on their appearance, and not valued for their qualifications. The issue of appearance intersects with issues involving stereotyping in a number of ways for BAW. The stereotypical images of Black women have impacted how many BAW respond in shaping their appearance. Results from this study were bifurcating on the issue of whether to comply with societal norms concerning appearance, or be themselves. Some women willfully conceded with aligning appearance with what was socially accepted, while others stood their ground and bore the ethnic look.

Those women that dared to defy the socially acceptable look were consistent with West's (2008) views, "Black women are generally happy with their complexion and appearance, particularly if they have strong racial identities and family support, other sometimes feel ashamed and unattractive" (p. 291). The feelings of those who conceded may have been due to historical beliefs that lighter complexion and straighter hair was more appropriate. Hesse-Biber, Howling, Leavy, and Lovejoy (2004) concluded this premise evolved from "Black girls growing up in the shadow of the dominant White

culture; their experience concerning their bodies is filtered through the prism of race as well as gender" (p. 72).

Hesse-Biber et al. (2008) conducted a qualitative grounded study on "78 Black American adolescents and found: race is linked with self-esteem, non-internalization, and maternal support that in turn these factors serve to prevent the African American sample from body image dissatisfaction" (p. 49). Their findings were confirmation to the experience noted by one participant in her refusal to wear her hair the way others felt she should conform and wear it.

The knowledge of how appearance shaped mindsets and decisions of BAW may be beneficial for others facing similar circumstances in health administration. It was evident from this study that some participants were not swayed by the opinions of others, or the potential consequences of expressing their individuality. Expressions of their own cultural identities through appearance may facilitate acceptance of the health care providers by patients. According to Betancourt, Green, Carillo, and Anaeh-Firmpong, (2003), "racial/ethnic diversity in the health care workforce has been well-correlated with delivery of quality care to diverse patient populations" (p. 296).

Appearance, under the umbrella of color classification, is a broad subject within itself. Appearance has a number of intersectional elements that may influence career advancement in the workforce. Society is plagued with advertisements used to project the ideal images of what is imagined and defined as acceptable beauty and image. These perceptions for socially acceptable norms, subconsciously made, are what people are predominantly judged on.

The appearance standards embedded in the minds of society become the guiding forces for decision-making in many instances. More attractive individuals, as gauged by society, "statistically receive more job offers, better advancement opportunities, and higher salaries than their less attractive peers-despite numerous findings that they are not more intelligent or capable" (Toledano, 2012, para. 1). Similarly, participants in this study, with regard to their career advancement, experienced the same types of subtle treatments regarding appearance.

Data from this study indicated that society tries to frame how BAW should look. Their desire to be natural was not widely accepted by the participant's employers. Being natural refers to BAW who refrain from chemically processing their hair, nails, or even using make up. The BAW in this study faced not only their employers, but their peers in terms of strong opinions of what is considered socially acceptable. They were told being too ethnic made them stand out too much. Some of the participants felt that irrespective of what society dictated they were going keep their appearances in a manner that is comfortable to them.

There were two factors that they could not change, color and gender. Most certainly, there is a difference in the type of hair, and the management of it, among most Black women versus White women. Many, for a myriad of reasons, have gone to extreme measures to appear more like White women by wearing wigs, weaves, hair extensions, and even bleaching their skin. Hesse-Biber et al. (2004) surmised:

> Perhaps hair, more than any other physical attributes serves to exemplify the beauty struggles faced by African American women. On one hand, hair represents

> one's assimilation into the popular culture; while on the other hand, it can serve to reject all cultural norms surrounding beauty. (p. 67)

How women carry and conduct themselves is another aspect found to have some relevance to their appearance. A participant in this study decided to cut her hair into a small Afro, similar to that of Black men with close haircuts. Her stance taken by cutting her hair was for convenience.

Some participants were taught early how to conduct themselves in a professional stance. Manner of speaking and accent were considered important. Not using Ebonics was emphasized. Within the race, those with mentors were taught to be careful about their tone of voice. In addition, teaching included being conscious of body language that may be misconstrued as offensive. They were informed to avoid being considered aggressive as opposed to assertive.

From the review of literature, it was discovered that to reduce the presence of organizational barriers, it was important to have "leadership and workforce reflective of the racial and ethnic composition of the general population" (Betancourt et al., 2003, p. 295). Having BAW as healthcare leaders in a city with the demographic composition of Washington, DC, may help bridge the gap in critical decision making to improve health disparities. If BAW continue to be overlooked due to color and appearance for advancement in healthcare leadership, it will not help in addressing the greater dual disadvantage of being minority and female. Nor will there be a significant contribution to impact vital changes economically, socially, or politically that directly impact BAW. This may impact the degree of BAW's representation in leadership roles. This confirms that if

this practice remains unchanged there will continue to be a lack of BAW in senior leadership roles.

Age

Age was another contributory factor that adversely influenced advancement. In general, age is a consideration of significance in terms of hiring for most entities. The issue of age in this study was found to intersect with child bearing imagery, and impressions of thoughts of immaturity.

This study revealed challenges in balancing family life and work. The family connections were instrumental in providing a strong support. Family life took precedence for the women raising children, but many did not stop working during this period. Instead, women in this study maintained the status quo on their jobs, and refrained from pursuing career growth activities until they were comfortable with their accomplishments.

BAW must contend with race-based images of black women and age specific challenges. The issue of age as related to childrearing is not a problem limited to women of color. It is gender-based as well. Statistics show age discrimination laws have been effective, but are still apparent as evidenced from this study and the number of discrimination claims filed. Although the number of claims has declined, the monetary benefits have increased. As cited by the Equal Employment Opportunity Commission (EEOC, 2014), in fiscal year 2013, there were 3,541 charges filed under the Age Discrimination Employment Act (ADEA). Of the charges filed, 3,580 were resolved,

which yielded $17 million in benefits. In 2010, there were 4,029 charges filed, 4,130 resolutions, and $ 14.7 million paid in monetary benefits.

The women in this study were professionals who were able to hold their roles and care for their families. This finding is contradictory to the low class images commonly associated with BAW as welfare recipients, the Sapphire image or domestic workers- the mammy image. These images have become a part of American history, and are projected today through roles often played by women of color- Tyler Perry's Madea character, or even labeling such as that seen on the "Aunt Jemima syrup" (West, 2008, p. 289). According to West, Collins (2000), and Stephens and Phillips (2003), these images were influenced by structural inequalities such as race, gender, and class oppression. The images were "further reinforced by the scientific, popular, and social science literature as well as the media, policies, and the law" (p. 288) and CRT. Over time these issues may impinge on BAW's health due to stress in coping. Stress alone is a catalyst to many other health related ailments.

OWL (2012) found age was a factor impeding employment, as found with this research. The study by OWL is inconsistent with the findings from this study, because age issues were related to midlife and older women. Women "under age 45 are 40% more likely to receive an interview request than older workers with similar skills and work history" (p. 18). This study noted women of younger years were denied advancement, because they were considered too young and immature.

Age was also found to be a deterrent with regard to level of confidence and ability to perform jobs with the degree of experience warranted. Although age discrimination is

prohibited in the United States, it is hard to pinpoint whether age is the determining factor inhibiting hiring. Black women are not only constrained by age-related issues, but live under the umbrella of stereotyping.

Stereotyping

Moskowiz, Stone, and Childs (2012) suggested stereotypes develop because they help make us more efficient processors of information, able to focus on greater amounts of information and do so more quickly. The danger is that sacrificing accuracy for speed by making assumptions may be costly and even lethal. Stereotypical views of African Americans have been apparent from the early days of slavery in this country (West, 2008). "Stereotypes broadly categorize members of the same race are all alike" (Green, 1999, para. 1). From the findings, I concluded that stereotyping is a barrier to advancement of BAW in health administration.

Demystifying the true character of Black women is clouded by age-old perceptions that have translated into reality in the minds of many. The findings add to knowledge that this factor is considered an inhibitor to advancement for BAW in health care. Participants considered stereotyping pernicious and dangerous with negative impacts besmirching the image their BAW.

BAW in this study revealed they were often considered as aggressive as opposed to assertive or passionate about their profession. The image of the *angry black women* syndrome has become an extension of stereotypical viewpoints of BAW (West, 2004). Media often portrays BAW as uneducated, designed for domestic work, or angry. The preconceived image ideations of the BAW, in this study, are contributing factors

inhibiting their career advancement. Consistent with this finding was that of Williams and Rucker (2000) that found "racial stereotyping was a vehicle to limit and deny employment of black applicants" (p.78). Concerns about BAW's character that remain unexplored are often assumed, yielding stereotypes.

Stereotyping is not something easily proven. It is something that is perceived. There is not a large quantity of data on stereotyping from the review of literature that tells the extent white people hold stereotypical views about black women working in health administration roles. Moskowiz et al. (2012) conducted a study that used imagery of Blacks and Whites to assess action of physicians. They were asked to input diagnoses based on the images. Findings from that study concluded when physicians saw the black images, they responded based on "stereotypical diseases commonly associated with African Americans, such as: obesity and drug use" (Moskowitz et al., 2012, p. 996). This study illustrated how use of stereotypes could lead to potential dangers adversely affecting clinical outcomes. BAW in this study spoke of being typecast as domineering angry women. This finding is consistent with the findings from the literature.

The pictures painted by the media, history, and beliefs about Blacks should not be ignored, but addressed as they may have some impact on how BAW are perceived. The findings from this study suggest advancing knowledge through education on what stereotypical thinking entails. In addressing this first, there must be an acknowledgement or understanding that issues related to stereotyping in health administration exist. Not addressing the stereotypical viewpoints may cause a chain reaction of events and eventually add to health disparities. Adding knowledge and erasing assumptions may be

the second step in addressing this. The issues related to education as a deterrent are discussed in the next section.

Education

Education was considered by the participants in this study as an opportunistic factor necessary to enhance acknowledgement. They all were either advancing or had advanced their education through doctoral status. A deterrent to advancing education found in this study was having sufficient financial resources. Concerns were raised regarding whether opportunities for career growth would be attainable that would remediate the financial obligation.

According to the Psychological Association (2015), low socioeconomic status and its correlates such as lower education, poverty, and poor health, ultimately affects our society as a whole (para 2) Educational barriers for the participants in my research were linked with the lack of promotion, which inversely is often tied to lower income and lessened potential for higher career achievement. This reduces the number of minority decision makers. The participants found that most of their organizations lacked minorities in key healthcare senior leadership roles. Cohen, Gabriel, and Terrell (2002) remarked,

> Increasing the cadre of minority health professionals interested in assuming management and policy-making roles in the future health system would help ensure that tactical and strategic decisions about matters such as resource allocation and program design are tailored to the needs of a diverse society. (p.101)

Hardaway and McLoyd (2008) concluded that racism and discrimination were key factors limiting social mobility, in conjunction with its consequences for academic achievement. This finding supports the finding in this study regarding education. Cohen et al. (2002) found the "paucity of such individuals in the current health professions workforce and influential policy-making posts constitutes yet another barrier to achieving high-quality healthcare for all Americans" (p. 95). This view substantiates the views of the participants in this study.

In 2003, Betancourt, Green, Carrillo and Ananeh-Firempong conducted a content analysis to discover measures to address racial/ethnic disparities in health and health care. This study differs from the educational enrichment suggested by the participants in this study. The participants felt advancing their formalized education to obtain advance degrees would assist in bringing more minorities to the senior roles. The authors of this study felt that advancing cultural competence through a "framework of organizational, structural, and clinical cultural competence could facilitate the elimination of disparities and improve care for all Americans" (Betancourt et al., 2003, p.293).

Lack of mentorship was noted to have an impact on career progression with regard to education. The participants felt having mentors helped them orchestrate their career tracks, guiding them with the appropriate educational curriculum. This finding supports part of what was identified by through the study by Dios et al. (2013) regarding education. Dio et al. found that mentors were instrumental in reducing diversity related barriers to educational advancement. Witt and Kiefer (2002) is a "large executive firm that specializes in education and healthcare" (p. 3). They conducted a quantitative study

to find out about leadership preparation. Their findings suggested that limited financial resources are at the helm of why there is ineffective mentoring of future leaders. This finding is not consistent with the findings from this research effort. The limited mentors were attributed to the few people readily available to be a mentor. Participants from this study encourage BAW in healthcare leadership roles to seek opportunities to share what has been learned on their journeys. At different phases of career progression the participants in this study discussed varying experiences. The findings related to this section are noted in the subsequent section.

Stages of Career Development Findings

The second research question asked how participants described different phases in their careers. The findings suggest that the participant's experiences and perceptions of different situations encountered on their career track changed as they achieved career maturity. Notably, participants did not succumb to the issues stereotypically associated with child rearing. This finding supports results noted in the preceding section. They changed their focus for a period of time to afford family life development, and then later returned to pursuing career development aspirations.

Many found at midpoint of their career course a disinterest in the organizations they worked for due to the myriad of challenges encountered. Disparate practices were among the reasons the participant's aspirations turned to operating their own businesses. Being typecast, overlooked, witnessing nepotism, and cronyism were dissatisfying. One participant said she was not among the "jocks and the cheerleaders," and she could never fit in. These perceptions guided decisions to move outside the walls of their

organizations. The disparate practices witnessed brought in a snow ball "negative effect on employee's psychological, physical, professional, and spiritual well-being, making them more likely to leave the organization" (Myers & Dreachslin, 2007, pp. 3-4). Other participants chose not to surrender aspirations and wanted to make a difference wherever they were. They saw the need for their special contributions in healthcare leadership, and decided to persevere despite challenges faced or experienced.

The decision to move outside the traditional organization is not only relevant in health care, but in other business operations. Ahmad (2014) found women of color have the most self-owned businesses. As noted from this study, the driving force behind this was the discovery "women, and women of color in particular, face a wide array of work-related obstacles, but their participation as employees, business owners, and consumers is fundamental to the success not only of their own families but also to the success of the U.S. economy" (Ahmad, 2014, p. 6).

Midpoint in their careers most participants discovered that there were some unsettling disparate practices. Unfair practices were deemed as roadblocks to progression. Some experienced progression, but were not given the authority or respect associated with the title or position. This finding is consistent with the study by Dancy, Wilbur Talashek, Bonner, and Barnes-Boyd (2004) in which power is differentiated and levied by both class and race.

There was a lack of cultural diversity training, which was disconcerting. The finding suggests deterrents and success factors were apparent to advancement. Most of the findings in this segment extended the knowledge in the discipline. Knowledge of the

different experiences at different phases of career development was not found in the literature search from the perspective of the BAW. Rites of passage are notable regarding the advancement of human beings. Little information is provided about how BAW feel at the beginning of their career through to retirement. What was evident at the varied stages discussed was evidence of deterrents and success factors for career advancement.

Deterrents and Success Factor Findings

The last question examined what was perceived as unequal practices, deterrents, and success factors to advancement up the ranks. The findings indicated there were deterrents experienced and perceived by the participants that slowed their advancement. A major deterrent experienced was subtle racism.

Racism

Racism was one of the words used by participants to express what was considered unequal practice central to persons of color. The sting of racism and its down range adverse effects is a feeling that cannot be denied, as evidenced by the depth of discussion from the participants in this study. From the participant's viewpoint racism's presentation was multifaceted. It was experienced and perceived through: subtle means, unintentional racial bias, and overt ways. Limited literature was evident to substantiate or refute these findings.

Volumes of literature reviewed for this study centered on women's gender, Black men, or White women's perspectives, as opposed to race and its implications on BAW in health care. The BAW's perspectives were essentially invisible. According to a study by Lantz (2008), "data currently available regarding executive leadership in healthcare

administration tends to focus more on gender than racial/ethnic diversity, ignoring the intersection of these two elements" (p. 5). It is unfortunate that since the late 1990s limited research has been conducted on BAW, and views remain relatively consistent with the post slavery era. King (1988) noted,

> The experience of black women is apparently assumed, though never explicitly stated to be synonymous with that of either black males or white females; and since the experiences of both are equivalent, a discussion of black women in particular is superfluous. (p. 45)

Participants felt that they had a dual disadvantage in terms of their gender and race. The implications of race were more pronounced than that of gender. Race and gender were intersecting elements, and constants that must be addressed for life. This finding did confirm those cited by ACHE (2006) and Lantz (2008), with respect to the sentiments noted related to gender and fairness. Participants from that study did not experience issues related to gender or unequal treatment. In the context of race and gender, Myers and Dreachslin (2007) found different perspectives on levels of equity and opportunity apparent from varied racial groups in the workplace. This finding is more consistent with the findings in this study, as all participants were from a single race and gender.

Despite much legislation passed regarding equal rights, participants experienced unfair hiring practices of being overlooked, prejudices, being limited in terms of exposure, and treatment showing they were not equal contenders. One participant described her observation of a promotion to senior leadership based solely on the prior

senior leader's friendship with that person's father. The majority of participants witnessed candidates being selected based their racial kinship and not merit. These experiences were not proven as the causative factors, although all factors pointed to race as the culprit from the perspective of the participants.

Other disparate practices were evident from this research, with discrimination related to ethnic names. It was a concern of the participants that having ethnic names added to BAW being overlooked for job opportunities. Ethnic names are often stereotypically associated with under educated and underprivileged persons in the eyes of society, irrespective of their credentials. This finding is consistent with current literature noted through a University of Chicago study conducted in 2002. "Race has an impact on hiring practices, despite African American applicant's qualifications" (Bertrand, 2003, para. 6). Statistically, the authors found that discrimination levels were consistent across all the occupations and industries covered in the experiment.

The experience of racism was hard to define in terms of what the problem actually was. Many of the research participants felt devalued for work contributions with the credit going to their superiors. Their limited exposure to the executive board of directors was consistently expressed by the majority of the participants. Participants described watching others get promotions simply based on who they knew and their color. Disparate practices prevailed as a major deterrent to their advancement.

Fear was among the disparate practices found to hinder participant's progression. Some participants feared being set up, and not supported. Others discussed the job market being unsteady. It was apparent that there were some issues with lack of mentorship and

guidance. Lastly, there was commentary on fear of moving out of their comfort zone. Feeling invisible, fear, disparate practices, and racism each serve as intersectional elements to lack of inclusion in succession planning.

Lack of Succession Planning and Diversity

The majority of the participants were alienated from succession planning in their organization. Findings suggest that they were added into the mix by default when issues with primary candidates surfaced. Most participants were only exposed to their immediate supervisor or their boss's supervisor. Many were simply waiting in the queue for an opportunity. Often promotions were in titles with little respect and lack of authority associated with their role. Diversity issues were deterrents to progression. This finding differs from those of Witt and Kieffer (2002) that from their study found leaders are not regularly making succession plans. The participants from my study worked for organizations that had succession planning, but excluded them.

In addition, my findings indicated that participants did not see a vast percentage of diversity in senior leadership profiles in their organizations. Some organizations used quotas to ensure that the minority representation was apparent. It is clear from the results of this study that a disparity exists in the representation of BAW in positions of senior leadership among the participants studied. This was despite the participants all being employed in the Washington, DC's metropolitan region, which is an area with a high minority-based population, and holding varying college degrees.

Although it seems like the course for BAW aspiring for senior leadership in healthcare is tough, nothing is impossible. It was apparent that determination was a

characteristic shared by each participant. Some findings were not deterrents or disparate practices, but success factors.

Success Factors

Success factors were found that helped propel many to the leadership roles currently held. The most consistent factors noted were determination, mentorship, advanced education, and faith. Although many faced challenges along their journeys, none gave up. The degree of perseverance was remarkable.

Women in this study realized that it was not up to their employers to enrich their professional development. Most learned that advancing education was paramount to success. Not much literature was found on the extent of determination as a success factor for BAW. This finding added to the existing body of knowledge regarding this phenomenon.

Having mentors was one of the most influential success factors. This finding confirms and boosts knowledge of what was found in the literature. In a related study, "The women agreed that it was not easy for them in corporate America, and overall, they believed that mentoring was useful" (Farrow, 2008, p. 36). There is not a great deal of research specifically on the impact of mentorship on BAW. However, there is mention that mentoring is of significance. The persons serving as mentors for the BAW in this study are from many backgrounds, but not limited to the following: parents, professors, friends, spouses, and coworkers. Having mentors was a way that others that have been successful can give back and help someone else. Mentors in place early in careers provided substantial guidance for the participants.

Overall, it is evident that BAW face myriad challenges to progression in the healthcare workforce. As articulated by King (1998), "the dual and systematic discrimination of racism and sexism remain pervasive, and for many class inequality compounds those oppression" (p. 43). The experiences found were concurrent with some of the principles outlined in the conceptual framework. CRT is the conceptual framework chosen for this research study.

Conceptual Framework Analysis

The conceptual framework for this research effort was the CRT. In this study, CRT was used as a lens to help explore potential barriers experienced by BAW aspiring for healthcare senior leadership. There was a correlation between CRT and the findings of this study with respect to the social constructs of race and gender. CRT posits race and gender as central elements viewed "at their intersection with other forms of subordination such as gender, class, and color" (Solorzano, 1998, p. 122). Gender, class, and color were factors found to be deterrents and yielding challenges for BAW.

CRT was instrumental in gaining understanding of the complex roles of race, racism, and interrelated concepts, in the lived experiences of BAW's career development paths in healthcare administration. The presence, if any, of barriers to advancement were explored. Findings indicated that there were the race implications, inequality issues, conflict between racial groups and racial implications on promotion.

The intersectionality of gender and race-based factors were central themes identified in this study. Even today, there is a racial divide in the United States. At the present, rioting and protesting found across the states signifies that racial tension is at a

critical point. How this turmoil translates into hiring and promotion practices is yet to be discerned.

In this study, three major tenets of CRT were employed: "(a) a collection of recent stories of unequal practices from the perspective of people of color, (b) an argument for the eradication of racial subjugation through storytelling, and (c) other areas of difference addressed" (Creswell, 2007, p. 28). First, the transcendental phenomenological approach, allowed the participants to voice their experiences of unequal practices respective to color through the semistructured one-on-one interviews. Color classification which is an element of race was a recurring experience in all participants. To fully capture the lived experiences of this phenomenon, I used copious verbatim commentary, as illustrated in Chapter 4.

Secondly, racial subjugation was apparent from the participants' recounts of subtle racial practices. All participants experienced some form of disparate practices along their career track that intersected with racism. This aligns with CRT with respect to the "centrality and intersectionality of race and racism" (Solorzano, 1998, p. 122). The difference is that this is related to healthcare administration as opposed to education.

Lastly, other areas of difference were discussed related to color, gender and age and their impact on career progression for BAW. Each principle was instrumental in deriving answers to the proposed overarching research question. As aligned with CRT, race, in this study, intersected with other "forms of subordination such as gender, color" (Solorzano, 1998, p. 122), and class. The double jeopardy of gender and race was

inescapable for the participants. Other aspects regarding their appearance, diction, and ethnic names were deterrents also.

Among participants' experiences under the race umbrella were feelings of being devalued, lack of inclusion in succession planning, issues with diversity of the workforce, and fear. It was apparent from participants' stories that even when fully qualified, they experienced being overlooked or they felt invisible. According to Hiraldo (2010), the "majority of African Americans do not become part of the driving force in higher education, such as faculty" (p. 55). Without minority representation in schools, the subject matter is taught as seen by those in position (Hiraldo, 2010, p. 55; Patton, McEwen, Rendón, & Howard-Hamilton, 2007). This problem is similar to the findings from this study. The BAW in this study were underrepresented in senior leadership roles, and not afforded input in critical decision-making in healthcare administration due to the presence of barriers. This may place them at a disadvantage in addressing issues based on ethnicity.

"CRT considers racism embedded in society" (Hiraldo, 2010, p. 55). From the findings related to this study, racism does have an impact on advancement. All of the foundational elements of CRT as related to stigmas based on color, inequalities in promotion regarding education, and color classification, had some semblance to the findings. Barriers regarding education were findings found from the majority of the participants in this study.

The use of CRT was helpful in guiding this research effort. I recommend organizations use CRT as noted by Hiraldo (2010), when "references are needed and

when striving to become more inclusive through changes in diversity initiatives, infrastructure of institutions, and analysis of hostile environments" (p. 58). Although CRT was initially used in education (Hiraldo, 2010, p. 55), the tenets of CRT may be used to determine the presence of racial inequality in different contexts for future studies.

Limitations of the Study

I explored the lived experiences of BAW seeking healthcare executive leadership roles. Limitations of this study were introduced in Chapter 1. There were limitations that arose from this study regarding ethnicity, design, and issues regarding methodological weakness. Contained in this section are also the reasonable measures to address bias and limitations.

The first issue was related to ethnicity. The study was limited to only Black American women in health care administration roles. The findings may not apply to other ethnicities, jobs, or sexes. Secondly, the setting was in the Washington, DC area that has a high concentration of minorities. The findings may not be generalizable to other areas with different demographics. Third, there was the issue related to data collection. I had to rely on the participant's abilities to recall information accurately.

There were issues regarding the design and methodology. Time was a factor. I was subject to the availability of the participants schedules. The data collection period was during the time when the fiscal year was ending. The heath administrators are generally busy at this time. Another limitation was that this was a qualitative inquiry which may have provided more in depth knowledge without the constraints of money and

time. Lastly, the scope was limited to a homogenous sample of a few BAW in health administration.

Recommendations

Existing literature regarding BAW's experiences and perceptions regarding their journeys to executive leadership are limited. Most of the literature centers on statistics of women in leadership, or regarding minorities grouped as African Americans which could translate to include all ethnicities that are of color. There is an abundance of literature regarding women's movements in America. To date, there are a lack of studies regarding BAW, and their unique nature and effects on life. This study adds to the body of literature a rich description of what BAW experience and perceive in their quest for senior leadership in healthcare.

Recommended topics for further research relate to the influence of gender-based prejudices and failure to appropriately assess and consider credentials, worthiness, and prospective candidates solely based on merit. More research is needed to identify proven strategies that may help guide BAW's career paths in successfully reaching executive healthcare leadership positions. There are many minority subgroups. Further research may be intricately designed to study what barriers, if any, other races face while trying to advance in health care administration.

It is recommended that health care organizations expand their knowledge on the benefits of having minorities and women in executive leadership roles. BAW should advance their knowledge regarding hiring practices that may adversely impact their advancement. It is recommended that this body of literature be further explored to discern

if barriers exist for this population over wider regions and among various other racial and ethnic compositions. This study could serve as a foundation to develop a quantitative study with a much larger population of BAWs in the field of health care administration.

Organizations should not ignore the patient demographics and ensure that leadership composition has some semblance to the community served. Practice should inform organizations that BAW should be part of succession planning if there are qualified applicants. Devising formalized mentorship training in collaboration with other successful women, despite race, may be essential. It is recommended that the findings from this research effort serve as a catalyst for social change, not only in the way health administration is viewed, but in how society at large views BAW. Lastly, I recommend health administration curricula, primarily at the graduate levels, consider incorporating content related to barriers and facilitators for health administrators in the context of BAW in this field.

Implications for Social Change

The findings contribute to knowledge on barriers faced by BAW desiring to advance up the ranks of health administration to senior leadership. There are implications for positive social change on different levels. These implications are relevant to not only individuals, organizations, government, educators, but also social policy.

Individuals could benefit from knowledge of what the participants' experiences were. Factors of being black and female were identified as two challenges that are constants. Having information of what others experienced may provide the insight necessary for the next person so the phenomenon is not as taxing. In addition to the

enhanced knowledge, individuals may be encouraged through the success factors and testimonials of others. Determination and mentorship were key factors for consideration. Individuals are encouraged to get connected with informal networks as a starter.

It is recommended that organizations explore the tenets of CRT to bring about social change in reducing racism in decision making that may be "color blinded" (Hiraldo, 2010, p. 56), and not realized in terms of the potential for downstream adverse impact on BAW or other minorities. "Colorblindness is a mechanism that allows people to ignore racist policies that perpetuate social inequity" (Hiraldo, 2010, p. 56). I recommend that organizations develop support groups for working families, and consider flexible work schedules, whenever appropriate.

Regulatory bodies, federal, state, and local, may be beneficial in bringing about social change. There have been laws developed to protect from discrimination based on age, race, gender, and more. It is imperative that these legislations be upheld and monitored. It is recommended that there are some requirements imposed by the Centers for Medicare and Medicaid (CMS), that as a condition of participation in high minority demographic regions, organizations must have minority representation on hospital and corporate boards. As CMS conducts regulatory audits, it is recommended that they mandate healthcare organizations actively have functioning diversity programs and outreach activities that align with the demographic and ethnic origins represented in their communities. To bring about social change systematically, it is recommended that regulatory bodies assess community needs and design programs that eradicate disparate hiring practices at the executive level, and continue to promote minority presence.

This study may bring light to the need for more diversity and cultural competency training for leaders and human resource departments. For example, knowledge that a name cannot determine one's character may seem simple, but eye opening. It may be a simple process of scanning over difficult names and ruling those applicants out because of preconceived ideations. Knowledge of concealed prejudicial behaviors may assist the Human Resource departments reevaluate screening of applicants. In addition, it is recommended that colleges and universities educate students on the historical context of the racial divide that has been prevalent in America since the dawn of slavery. The presence of more minority faculty at colleges and universities may be bolstered by mentoring high school students on the need for more minority professors and mentors.

Family support was deemed one of the strong points for the women in this study. Outcomes of this study could have positive emphasis on social change in motivation for both the families, and the persons on the journey by providing hope through other's successes. The results of this study may help families become aware of their role as a key supporter.

Having information from the BAWs' perspective may be instrumental in bringing about positive social change inside and outside of organizations. More understanding of how BAW think may reduce concerns envisioned about this population planted through historical views and stereotyping. This study has in-depth accounts of BAWs' perceptions and experiences that may be instrumental in demystifying the character and perceptions commonly associated with women of color and reducing stereotypes. Recruiters may become less inhibited in hiring practices and widen candidate pools to

include BAW. From the views of the respondents, it was apparent that issues related to participants being passed over for promotions often stemmed from factors other than merit.

This study may have implications for positive social change on society at large. Health disparities are evident today regarding people of color. Some disparities are related to trust issues in America between Blacks and Whites. Having more BAW in decision making roles may assist organizations in bringing about social change. Combining learned information from CRT with the findings of this research may have critical implications in guiding the career paths of black women across the United States.

Conclusion

The purpose of this study was to explore the lived experiences of BAW aspiring for healthcare senior leadership roles. Findings from the rich descriptions provided through the seven participants' experiences/perceptions provide insight useful for others embarking on similar career advancement tracks. In many respects this research confirmed and added to existing knowledge.

This study illustrates the importance of understanding the plight faced by BAW that is coined a double jeopardy (Rosette & Livingston, 2012), being Black and Female. The dual minority status adds extra inescapable challenges that must be faced by this population on continuum. The concept of the dual disadvantage mirrored findings from the literature in terms of the intersectionality of race and gender. Rosette and Livingston (2012) confirmed that "Black women leaders suffered from a double jeopardy, and were evaluated more negatively than Black men and White women, but only under conditions

of organizational failure" (p. 1162). Respondents' accounts from this study of either feeling like a centerpiece or looking around and not seeing others of like descent reaffirms there is a disparity of BAW in executive healthcare leadership. One participant mentioned that her friend visited her on the job and saw no other persons of color within the posed pictures of the executive team.

The participants shared candid descriptions of their experiences and perceptions regarding lack of advancement. The most salient causes cited for their lag in advancement was attributed to color and education. Beliefs regarding the implications of their color, which is an element intricately aligned under race, were shared by the by all participants. It was noted through this study that barriers to advancement included: appearance, age, educational status, use of quotas, and stereotyping.

Education was a concern raised by participants who feared the additional associated costs and of not being educated enough. Additional deterrents experienced or perceived were subtle racism, being overlooked, a lack of inclusion in succession planning, limited board exposure, being dually disadvantaged by race and gender, and other challenges-limited diversity. The disparate practices produced untoward reactions such as fear and feeling devalued.

Barriers to advancement as cited by Diversity Primer (2011) included "lack of mentorship, limited networking, lack of role models, being invisible, and balancing work and family life" (para. 2). Catalyst (2004) found that race-based stereotypes, credibility issues, limited executive support, and exclusion from informal networks to be primary reasons for lack of advancement in the workplace. In an independent study, Johns (2013)

classified the "barriers from a broader perspective as being imposed from society, government, and organizational standpoints" (para. 2). Those barriers were further broken down to note that the key factors facilitating underrepresentation of minorities in leadership included "prejudice, bias, color-based differences, gender, and cultural perspectives" (Johns, 2013, para. 2). What is unique regarding my findings, despite a myriad of overlapping themes, are that the setting for my study is not the workplace in general, it is reflective of health administration. My study had a narrower scope than broadly classifying minorities, as with the studies cited above. My study was specifically regarding BAW.

There are similarities in the findings on barriers to advancement. For example, Catalyst (2004) noted the lack of inclusion in social networks as a barrier. Similarly, in this study, one of the participants commented that she felt excluded, because she was not one of the "jocks and cheerleaders" in the old boy network. Johns (2013) noted that "color-based barriers as deterrents to progression" (para. 2). That was the most widely experienced theme, under the umbrella of racism experienced. Primer (2011) found lack of mentorship to be a barrier. This finding was consistent with my results. I inversely reported mentorship as a key success strategy of career advancement.

Schwanke (2013) provided a prolific synthesis of challenges faced by BAW in pursuit of executive roles in health care leadership. Complex, pervasive and ongoing barriers limit the progress of millions of women who wish to move into positions of power. The structural, prejudicial, and discriminatory hurdles these women face are often subtle and misunderstood, creating a complex, pervasive, and multi-faceted labyrinth that

thwarts any progress they may make (p. 2). The increasing significance of the findings from this study point to evidence that equality remains an issue for women and minorities, today. Although much legislation has been passed, it is disheartening to accept that there are barriers to equal representation of BAW in healthcare senior leadership. The participants in this study each held two common success strategies necessary to overcome barriers to career advancement, determination and mentorship.

If I have done nothing more than heighten awareness from this research, I have been successful in fueling social change. The battle is not over. There is room for additional research on this topic from a broader geographical standpoint and across the races.

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Appendix A: Informed Consent

CONSENT FORM

You are invited to take part in a research study to discover what factors, if any, from the lived experiences of black American women have inhibited their progression to senior leadership roles. The researcher is inviting black American women health professionals either aspiring to move up the ladder or attempted to do so in the past, but failed to make it to roles of CEO; (b) that were born in United States; and (c) serve in the capacity of middle to upper level healthcare management through VP level. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Alquietta Brown, who is a Doctorial Student at Walden University.

Background Information:

The purpose of this study is to gain a deeper understanding of why there is a disparity in the underrepresentation of black American women in health care senior leadership roles.

Procedures:

If you agree to be in this study, you will be asked to:

- Sit for an in-depth interview with the researcher. It is anticipated that the interview may take up to two hours. The interview will be audio recorded.
- You may be recalled once the data is has been sorted to affirm the accuracy of the researcher's work. This will take up to 30 minutes.

Here are some sample questions:

- What were your initial career goals before college? How have they changed over the years?
- What were the factors attributing either to your ambition or to lack of initiation, if any, in seeking healthcare executive leadership positions? If you lack ambition or initiation, what are the reasons resulting in this?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. The researcher will not treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue or becoming upset. Being in this study would not pose risk to your safety or wellbeing.

The potential benefits of being a part of this study include contribution to the body of knowledge on the subject matter. Your participation may increase knowledge for those embarking on similar career paths, which may be instrumental to their success.

Payment:

For voluntarily participating in this research study, you will receive two movie passes that will be provided to you at the culmination of the interview process.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by use of code names. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone or email. My phone number is (703)362- 6168. E-mail address: alquietta.brown@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is
05-08-14-0159557 and it expires on **May 7, 2015.**

The Underrepresentation of black American Women:

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below or replying to this email with the words, "I consent", I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix B**:** Interview Data Collection Tool

Date	
Time of Interview	
Place	
Name of interviewer: Name of Interviewee:	
Location of Interview	
Position of interviewee	
Project Description	

Preliminary or Opening Questions:

What is your level of education and number of years serving in a healthcare leadership capacity?

1. What were your initial career goals before college? How have they changed over the years?
2. What were the factors attributing either to your ambition or to lack of initiation, if any, in seeking healthcare executive leadership positions? If you lack ambition or initiation, what are the reasons resulting in this?

3. What factors propelled and contributed to success, professional development, and achievement in reaching your current position?

4. In what way has succession planning influenced, or detracted from your advancement? In addition, what do you think will help you achieve your goals?

Thank you for taking time from your busy day to participate with this interview. As a reminder, any information received in this interview or future interviews will be kept confidential.

Appendix C: Research Participation Questionnaire

Research Participation Opportunity Questionnaire

Alquietta Brown, Walden University PhD student, is conducting a research study. You are receiving this questionnaire because you may be eligible to participate in this research study. If you are interested in participating, please provide answers to the brief questionnaire below, and return the survey via email to alquietta.brown@waldenu.edu. I will be in contact with you within 2-3 days following receipt your entry. Please note that this questionnaire will be kept **confidential** and will only be used in conjunction with this research effort.

Please answer each question, save your answers, and return to the researcher's email address.

1. Are you a black American female?

____ Yes ____ No

2. Do you work in health administration?

____ Yes ____ No

3. Are you in supervisory role?

____ Yes ____ No

4. What is your dream position in health administration?

_____

Thank you for your time!

Alquietta

IRB Approval Number: 05-08-14-0159557 **IRB Expiration Date:** May 7, 2015

Appendix D: Data Tables

Table D1

Appearance Frequencies of Identified Themes

Theme	Frequency
Research Question 1	
Lack of Advancement	**56**
1. **Color Classification**	**12**
2. **Appearance**	**13**
3. **Age**	**5**
4. **Stereotyping**	**7**
5. **Education**	**16**
6. **Quotas**	**3**
Research Question 2	
Stages of Career Progression	**13**
Research Question 3	
Deterrents and Success Factors	**210**
1. Deterrents to Progression	**115**
a. Subtle Racism	**18**
b. Double Jeopardy	**28**
c. Being Overlooked	**11**
d. Limited Exposure to the Board	**14**
e. Challenges	**44**
2. Disparate Practices	**43**
a. Feeling Devalued	**18**
b. Fear	**8**
c. Lack of Succession Planning	**7**
d. The Diversity Principle	**9**
3. Success Factors	**52**
a. Mentorship	**19**
b. Determination	**33**

Table D2

Participant Endorsement of Identified Themes

Theme	Ann	Jane	Karen	Molly	Penny	Renee	Sally
Research Question 1							
Lack of Advancement	✓	✓	✓	✓	✓	✓	✓
1. Color Classification	✓	✓	✓	✓	✓	✓	✓
2. Appearance	✓		✓	✓	✓		
3. Age	✓	✓	✓				
4. Stereotyping	✓		✓				
5. Education	✓	✓		✓	✓	✓	✓
6. Quotas		✓	✓				
Research Question 2							
Stages of Career Progression	✓	✓	✓	✓	✓		
Research Question 3							
Deterrents and Success Factors	✓	✓	✓	✓	✓	✓	✓
1. Deterrents to Progression	✓	✓	✓	✓	✓	✓	✓
a. Subtle Racism	✓	✓		✓	✓	✓	
b. Double Jeopardy	✓	✓	✓	✓	✓	✓	✓
c. Being Overlooked	✓				✓	✓	✓
d. Limited Exposure to the Board	✓	✓	✓	✓	✓		✓
e. Challenges	✓	✓	✓	✓	✓	✓	✓
2. Disparate Practices	✓	✓	✓	✓	✓	✓	✓
a. Feeling Devalued	✓	✓	✓		✓	✓	✓
b. Fear	✓	✓		✓	✓		
c. Lack of Succession Planning		✓		✓	✓		✓
d. The Diversity Principle	✓	✓			✓	✓	✓
3. Success Factors	✓	✓	✓	✓	✓	✓	✓
a. Mentorship	✓	✓	✓	✓	✓		✓
b. Determination	✓	✓	✓	✓	✓	✓	✓

Note. ✓ Signifies that the participant made a remark or observation pertinent to the identified theme.