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Sex Based Differences in Trust and Dissent: An Exploration of Leaders and Followers in Healthcare Management

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by

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Dedication

This study and resulting dissertation are dedicated to the women who have told me stories about their female work relationships and sent me on the journey to identify what was happening.

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I would like to thank, my husband, Mark Carmean, for being so supportive through this whole journey. Thank you to my mother, Dr. Cheryl de Zayas, for all the cheerleading and encouragement. Thank you, Dr. Dustin Berna, for helping me cut through the Gordian knot. You have been a lighthouse for me, and I cannot express my gratitude in simple words. Thanks to Dr. Neil Katz for mentoring me and opening vistas of covert behavior. Thank you to Dr. Alexia Georgakopolous for sticking with me as my faculty adviser from the start. Finally, I know there are many family members and friends who I have not listed, but they know who they are. I cherish the help, cheer, and kindness you have all given me through this process.

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Abstract

This dissertation is a quantitative study which looks at the ways in which healthcare followers perceive their leaders regarding gender, over the concepts of trust and organizational dissent. The study was open to members of non-clinical healthcare associations, but clinicians were not specifically excluded. Inferential statistics were inconclusive, as they directly contradict literature that directly correlates trust and dissent in the general business world. Reading subtextual, the outcome indicates possible sublimated conflict between and among both genders, for both followers and leaders. Objectively, women showed more trust in their female leaders, but subjectively this was not true. Indicators in the subjective material suggest potential negative social capital use in the social network and potential gender solidarity bias. Further study and ramifications for covert behavior, relational aggression and healthcare conflict research are discussed.

Chapter 1: Introduction to the Study

The goal of this study is to identify if followers in the healthcare industry trust female leaders more than they do their male leaders and whether that distrust correlates with the method followers choose to dissent. Male and females interact differently in social situations and in their places of employment. Part of this interaction, specifically how followers feel about their leaders, shows up in how trustworthy the followers feel the leaders are and how the followers choose to express disagreement with leadership. A follower might not trust a leader and might be able and willing to openly dissent to leadership and expect change; but the converse is also true, and followers may not feel comfortable expressing concerns or objections to leaders whom they feel are untrustworthy. The healthcare industry in the United States is vast. In recent years, studies and position statements have identified that conflict among employees creates an environment of discomfort, which may have impacts on patient wellness.

Background of the Study

Media, anecdotes, social stories, and books of nonfiction are replete with women who react differently to one another than they react to men. This has been shown in a variety of ways throughout popular books, social platforms, and fictional stories. From the young schoolchild age through the teens and young adult women, there are many books and studies that discuss the social ranking in female groups. Various leadership styles of women have been an integral part of a variety of studies, but these studies focus on the leader rather than the make-up of the followership or the acceptance of that leader. To this point there have been few studies focusing on how the female leaders manage the female groups versus how the male leaders handle the female groups.

Research Concern

Since female leaders are said to have more "feminine" leadership qualities, and relational aggression is mostly carried out by females to other females in social situations, the relationships in business settings are different between female leaders and followers. As an axillary to this idea, it is possible that women feel more uncomfortable with female leaders. Since healthcare has literal life and death outcomes when business relationships do not work, covert conflicts and unspoken challenges between females can threaten the welfare of patients and should be studied.

Main Research Question

Do female followers in the healthcare industry perceive a difference between male and female leaders? Using the overlap in trust and dissent outcomes, can a statistically relevant outcome be made for further research in gender conflict in healthcare settings, specifically between women?

Examples in Literature

There has been a great upswing in the number of women who have begun taking leadership roles after WWII. In tandem with these changes, there has been a tremendous amount of discussion about how women lead and whether men should take on "feminine" traits of empathy and understanding with their followers (Jamieson, 1995). This type of thinking has put women in a double bind. This is a paradox of tremendous proportions. If they manage their employees as they would their household, they are viewed by their male counterparts to be overly caring and weak. If they manage their employees in the manner of their male colleagues, they were too tough, bossy, crass and ineffective as role models. Over time, these roles have modified with the interactions of the male and female

leaders. Today's leaders are exploring different techniques that enhance both models to be able to employ leadership as well as management skills and to be able to incorporate both the traditional masculine roles and the traditional feminine roles. Until recently, there was no concept of women been treated differently. More than 25 years ago the social psychologist Faye Crosby stumbled on a surprising phenomenon: Most women are unaware of having personally been victims of gender discrimination and deny it even when it is objectively true, and they see that women in general experience it (Ibarra, Ely, & Kolb, 2013).

More recently there have been many statements that reveal that women are promoted almost accidentally, because the reasons they are not promoted are profuse and varied (Barsh & Lee, 2011). Further, women in the work world are expected to prove their value many times over and are expected to remain helpful and to be maternal in varying degrees throughout their working lifetime. Literature, both professional and social, asserts that their male counterparts tacitly agree to this and, perhaps knowingly or unknowingly, perpetuate the expectations of the other male colleagues (Williams & Dempsey, 2014). In the meantime, research and popular books have been created to address female bullying at young ages and to prevent this behavior in children and adolescent girls. Books like *Tripping the Prom Queen* (Barash, 2007) show how much female conflict as teens and pre-teens have affected girls into their adulthood. Little has been written about female working relationships and even less about how covert behaviors typical of relational aggression affect these relationships.

Theories

Theories abound regarding female relationships causing friction at home and at work. Unfortunately, theories are not found relating to the differences in how the female relationships function differently than male relationships. The identification of a real difference between these types of dyadic interactions would allow new management techniques and provide a true understanding of one the real sources of conflict in the healthcare workplace as well as other areas dominated by women. Most of the literature that is available focuses on specific areas such as barriers to leadership positions and the proverbial “glass ceiling” effect of being a woman in a man’s world (Williams & Dempsey, 2014).

Covert Behaviors

Covert behaviors are those which are felt and noticed, and even acted upon, but not visually or mechanically quantified. They are felt, not seen, but the results of these behaviors can be observed. When an individual acts in a passive-aggressive way, this is considered covert aggression (Lancer, 2018).

Theories about covert behavior are found in works of the famous founder of organizational sociology, Peter Blau (1986), in his organizational theory and the subtle social exchange in microstructures theories. While Omar Lizardo (2007) addresses social movement in the groups by the smaller groups or the inequities in the small groups relative to the larger ones. His theoretical work deals with social theory that has an emphasis on the link between practices, culture cognition and instructions. They do not address; however, the differences found between the male and the female followership.

Feminist Theory

Feminist theory has evolved since the 1840s and is generally considered to have existed in at least three waves. The first wave was for simple recognition of women as valuable to society. The second wave of feminism involved more divisive language between the sexes and the ideas that women were and are valuable for work, and not just as objects of status or imagery, and sisterhood was a popularly used expression. The third wave of feminist thought (after the 1990s) hedges away from the necessity of involving conversation about the patriarchy or social requirements of beauty and heads more towards women feeling empowered in their own bodies and having agency over their own lives. This third wave evolution of feminist theory has grown to include other minorities, including gender minorities. The idea that feminist theory means that women are united as sisters in a monolithic framework is being challenged by the next wave which is aiming for individualism and gender equity simultaneously. There is a distinct clash between the radical feminists of the second wave and the "girl" culture of the third wave. It is this evolution of feminism that informs the gendered component of this study and discussion.

According to an article in the *Atlantic*, there was a schism in the first wave of feminists in the US (Coates, 2016). In the 19th century Suffragists and Abolitionists struggled to deliver their messages. The Suffragists suffered from severe social opposition both in the USA and in Europe. Eventually the magnitude of the Abolitionist cause took center stage in the social change arena. Some Suffragists, including Susan B. Anthony, reached out to racists such as George Train for support, and used slogans such as: "Women now and Negro last". This left the black suffragists on their own and

separated from the feminist movement entirely. In fact, the black suffragists coined the term "womanist" to mean equality for all, not just women, and not just one race. The "womanist" ideals parallel third and fourth wave feminism. It took until the 20th Century with new national social views before the Suffragist movement could gain momentum and success (Coates, 2016). This schism supports the idea that feminism, and feminist theory, is not unified nor monolithic, and covert behaviors, negative social capital use and relational aggression were showing up early. As these ideas are divisive, they have largely been struck from the general conversation on feminist theory. Coates (2016) explores Evolutionary Psychology as it relates to the origins of sexual differences and similarities between men and women. Sexual behavior in mate selection, sexual risk taking, female sexual attractiveness and sexual relationships are explored pointing out the reproductive implications to men and women. The article favors the idea of psychological differences between men and women based on the differences in their roles in reproduction and care of offspring (Buss & Schmitt, 2011).

Hannagan explores woman's role in human social and anthropological development. The human historical need of survival and reproductive success is examined from the male and female point of view, with review of the often-neglected role of women in these activities. The women's social and political needs reflect the complicated roles that they fill in reproduction, childcare, food providers and family laborers. These needs and activities have been different from that of men since the time of foraging societies (Hannagan, 2008).

Negative Social Capital Theory

The use of power in any situation requires the possession of power. In social interactions, even at work, social capital theory can be seen when status symbols and personal influence sway others' opinions. It is the use of social capital that allows for reallocation of emotional or political resources. When this capital is used to berate, belittle, hurt, or harm another, it is called "negative social capital" (Muir & Byrne,2019; Smart,2008; Addis, & Joxhe,2017). Relational aggression among and between women, and in groups of young girls, is a potential example of negative social capital. Since relational aggression is generally about power and intangibles, employment of negative social capital may only be seen by the outcomes of its use.

This study is informed by the existence of relational aggression as a demonstration of use of negative social capital, and the idea that women use this without realizing it. The covert nature of negative social capital behavior ties into Bion's theories of covert behavior. One of the newer theories is transformational leadership. In an Australian article published in 2008, “Transformational Leadership and Innovative Work Behaviour: Exploring the Relevance of Gender Differences”, the authors Reuvers, Van Engen, Vinkenburg, & Wilson-Evered indicate that leadership has direct impact on the well-being of functioning work group, particularly in a transformational model, in which followers are encouraged to bring creative, novel, or new methods of problem-solving. They authors noted that followers indicated much more comfort bring creative ideas to male transformational leaders than to female transformational leaders.

Muir and Byrne explore positive and negative aspects of social capital in work-related learning networks. They indicate that education and healthcare organizations use

internal networking and social capital, both collective and individual, to improve collaboration and a sense of agency. Where strong bonding social capital within a group exists and this appears to be influential on the learning of its members. Through proactive development of social capital within partnerships and networks, activity could be sustained and become influential with the potential for positive outcomes. The findings also illustrate the risks of social capital that perpetuates the dual effect of feeling embedded in the community and requiring self-governance of the individual, which contributes toward exclusivity and inertia in the overall network (Muir & Byrne, 2019). It is this duality that implies that other behaviors or concepts are extant.

Madeline Allbright stated, "There is a special place in Hell for women that don't help each other". However, men are not held to that standard in their careers. To do so to women neglects the positions of each woman in her workplace and trivializes their challenges, needs and achievements. Woman to woman support is often expected in a man run work environment which is hostile or indifferent to both women. Support and understanding for fellow women cannot be at the cost of another woman's personal life or career (Edwards, 2017).

Statement of the Problem

The first part of this problem is the understanding that male and female leaders work differently and focus on different skills. Unfortunately, the effect of those differences in leadership types has not been measured by the followers. Women have been categorized as either “feminine” in nature using collectivism and collaboration to get work done, or “masculine” in creating competition and promoting individualism in their followers. The second part of this problem is the existence but relative dearth of

research about covert group behavior, and specifically covert behavior in the workplace. While there is anecdotal evidence that support these ideas and there are countless human resource and business management books to discuss the cultural impact of the personal space, territory and status symbols, there is little discussion on how those cultural and societal differences in norms impact individual workers in the way they feel they must do or should feel within a given situation, especially if it is at odds with their cultural upbringing. Consequently, the way in which looks, glances, vocal intonation, and non-verbal gesturing impact both female and male followers, especially of disparate cultures, needs to be addressed. The third part of the problem is the relative newness of healthcare to the arena of management and of conflict research. Since the Joint Commission, which monitors and oversees accreditation of healthcare providers and facilities, has only recently decided that conflict among medical providers (nurses, doctors, and staff) was significant enough to make a general position statement, it is timely to look at how conflict, and particularly gendered conflict, affects staff. The final part of the problem is how followers express either trust or dissent in their leaders. Separately taken, trust and dissent show individual actions for specific data points at specific time intervals. Together, trust and dissent show a pattern of comfort with a leader, which may not show up in overt ways. The concept of mutual faithfulness is restated in the article “Trust as a Social Reality” (Lewis & Weigert, 1985). This bears repeating for the importance it plays in the foundations of any group. This concept of *trust* allows people to feel secure in their mutual expected futures. It is trust that allows people to live rationally, while subliminally knowing that there are multiple complexities and multiple futures possible but trusting

that certain possible of these futures will not occur. This trust is a function both psychologic and sociologic and pervades all aspects of civilization.

Mainstream media platforms such as the well-known Forbes (2015), have indicated that trust is central to good functioning, and in fact the element of trust increases productivity and subsequently the bottom line by 30% or more. The converse, then, says that lack of trust means lower functioning and less empowering of the parent organizations. Proof of lack can only be disproven, so there is not much saying that followers distrust their leaders, and therefore the company is not doing well. There have been many versions of measurements for trust, from the organizational level to individual level. Discussions of dissent, in which the worker expresses disagreement with something the leadership wants/requires/expresses, vary in their attitudes and perceptions that, “dissent is necessary” to the opposite view of, “dissent needs to be carefully managed”. Kassing (2000) created a dissent measurement and in the process developed three types of dissent, one of which indicates covert behavior by not expressing concerns to anyone who can do anything about them.

Significance and Need of the Study

If this study proves correct in its assumptions and its hypotheses, there will be a quantitatively significant reason to explore covert behaviors, specifically as they relate to gendered relationships. Management scholars and conflict scholars will have a new arena in which to develop theories and to research conflict: hopefully, where it has a direct and measurable impact by virtue of patient outcomes. Using trust and dissent in the same study, as Payne did in 2014, but with an additional inclusion of gender as a variable means there is more depth to the data. This inclusion of gender as a variable will open

vistas into the interpersonal behaviors both covert and overt that are so reported in the healthcare industry. There have been studies relating to the leadership styles that are different between female leaders and the leadership styles of their male counterparts. It is known that healthcare "life" is rife with conflict in every department, and trust once broken across levels is severely detrimental to the cohesiveness and trust of the groups. It is further established that trust is needed for good organizations to work. It is well known that dissent manifests in various modalities and is present in organizations in both covert and overt forms. What has not been studied at this time is where these overlaps. The healthcare industry is formed primarily of female (mid-level) leaders and female followers. All are professional women with varying degrees. This is a relatively new field for research. This research in management writ large, and the actions of the female employees/followers, directly impacts the medical outcomes of the patients, and thus, this is a timely discussion. If there is a sublimated, or a covert action, which can be felt but not always expressed, as Bion (2004) and others indicate, then there is a need for investigation.

Research Question and Hypotheses

*RQ1: Is there a difference in type/level of dissent between male and female followers in the healthcare industry based on gender of supervisor or leader?

- H0: There is no statistical relevance between male and female followers in the healthcare industry.
- H1: Women with female bosses are more likely to engage in latent dissent than women with male leaders in the healthcare industry.

- H2: Women with female leaders are more likely to engage in latent dissent more than men with female leaders in the healthcare industry.
- H3: Women with male leaders will be more likely to engage in articulated or displaced dissent than women with female leaders in the healthcare industry.

RQ2: Is there a difference between male and female followers in the healthcare industry in terms of their level of trust in male versus female leaders?

- H4: Women with female leaders show lower levels of trust for their female leader than those women who work for male leaders in the healthcare industry.
- H5: Women with female leaders will have lower levels of trust for their female leader then men who work for female leaders in the healthcare industry.
- H6: There is no statistical relevance between male and female leaders in the healthcare industry.

Need for the Study

There have been studies relating to the leadership styles that are different between female leaders and the leadership styles of their male counterparts. It is known that healthcare “life” is rife with conflict in every department, and trust once broken across levels is severely detrimental to the cohesiveness and trust of the groups. It is further established that trust is needed for good organizations to work. It is well known that dissent manifests in various modalities and is present in organizations in both covert and overt forms. What has not been studied at this time is where these overlaps. The

healthcare industry is formed primarily of female (mid-level) leaders and female followers. All are professional women with varying degrees.

Limitations

This study is enacted on a website dedicated to the membership of a particular association, the extrapolation to the public will not apply. Therefore, it will be limited to the scope of healthcare leaders and followers. Because there is already a noted tendency for women to respond differently depending on their experience in the field, (Warning & Buchanan, 2009), while those who have less than 4 years of experience may report their trust levels differently to indicate solidarity with their female leaders; those with over 5 years of experience tend to have less of this bias, according to the same study (Warning & Buchanan, 2009).

Conclusion

There is overlap in three domains, which is ripe for research in conflict resolution: covert behaviors, relational aggression, and healthcare provider conflicts. Because covert behaviors can only be measured after they occur, models, theories and even studies have largely ignored the possibility of these behaviors on leader-follower trust and dissent outcomes. Literature abounds with studies on the differences between male and female leaders, but the followers, who make up the bulk of any organization, have not been researched quite as much, and when they have, gender has not been a variable. This study attempts to bridge these three areas and show that there exists a set of unspoken behavior which is gender based.

Chapter 2: Literature Review

There are several ideas in this literature review. The first is the existence of covert behaviors between and among individuals, most especially women. The next is that there is a difference between how men and women perceive the trustworthiness and comfort with dissent of their male and female leaders. The last idea is that this may be more visible and emergent in healthcare settings as the population of leadership is highly female and patient outcomes are related directly to organizational strength. Altogether, the overlap of these ideas indicates a potential area for enlightenment of sublimated conflict. This chapter explores the literature that helps inform the research questions:

RQ1: Is there a difference in type/level of dissent between male and female based on gender of supervisor or leader in the healthcare industry?

RQ2: Is there a difference between male and female followers in terms of their level of trust in male versus female leaders in the healthcare industry?

RQ3: Is there a correlation between trust and dissent in the healthcare industry?

Theoretical Framework of Covert Behavior

Bion's (2004) theories of covert behavior stem from extensive experience in watching small groups. Bion was a psychoanalyst who was studying, among other things, the way that therapy groups interacted with one another and the therapist. Bion identified several types of behavior, but more specifically that any behaviors which are perceived as assaults on basic assumptions will cause backlash. The effects of this backlash can be seen, even if the perpetuating events themselves are less obvious. This theory indicates the potential for a great deal of covert behavior to occur in groups of many sizes. Other

authors have used different terms for these events and have alluded to discomfort in trusting a leader or group member, even with a dissenting opinion.

Bion was a psychoanalyst who was studying, among other things, the way that therapy groups interacted with one another and the therapist. He determined that there were four groupings of behaviors, with the first being the overt Work Group. Every group meets to “do" something which he refers to as the “Work Group” (Bion, 2004, p. 144). Bion further determined three types of emotional or covert behaviors, which he term “Basic Assumptions”. He said “The interpretations in terms of work-group activity leave much unsaid: … The furtive glances...cannot profitably be interpreted as related to work-group function” (Bion, 2004, p.147). The smaller in-groups developed, called "aristocracy" by Bion, essentially translate the outside inputs and helps the others to deal with challenges to current basic assumptions, that is, current emotional state. If the challenge is made and the leadership does not follow, then the “aristocracy” falls, and the group function dissolves (Bion, 2004).

Differences in Gendered Relationships

Females are often not preferred as leaders, especially by other women in part because their gender appropriate behaviors are modified, leading to conflict in the workplace. Whereas, male leaders’ behaviors fit them, facilitating less conflict than their female counterparts, leading to a more casual relationship with their employees. These differences are reinforced in society through various norms, keeping the status quo. Over 25 years ago, the social psychologist Faye Crosby stumbled on a surprising phenomenon; most women are unaware of having personally been victims of gender discrimination and deny it even when it is objectively true and they see that women, in general, experience it

(Ibarra et al., 2013). The differences in treatment by leaders began to be addressed in mainstream articles and books. The differences in trust by followers of different genders have shown relatively little research.

A CBS News article called, “New Study: Do Men Make Better Bosses?” looked at citing a study of 142 legal secretaries; the majority indicated they would prefer to have male leaders. Some, by the words of the comments these are men, indicate that women take on emotional responses where male counterparts do not. Female, or no gender affiliation according to the article, indicate that female leaders are harder on female employees, and particularly female secretaries. There is an implication that women who are in subordinate positions receive the brunt of female boss’s ire (Lucas, 2011).

An article in *Men’s Health Magazine* looked at how men interact with one another, specifically around the use of the term “boss”. Although men will occasionally call each other “boss” it is generally not meant in a positive light. It is either a hyperbolic diminutive like “shorty” for a very tall man, or it is a general term like “man”. The author reflects that almost never is he called boss by an employee, and in fact it is mostly by service staff (O’Neal, 2019). There is indication of acceptable covert behavior in both male and female interactions as supervisors and leaders. Books, including *Tripping the Prom Queen* by Susan Barash (2007) and *Woman’s Inhumanity to Woman* by Phyllis Chesler (2001) aimed at identifying relational aggression in adult women. Honor killings, which are part of a system to maintain the purity of a culture, and specifically the purity of the females of the culture, are as much the action of the older women as they are the men.

Relational Aggression Among Women

Female inferiority is perpetuated by male systems of belief all over the world. Throughout their lives, women will face this inferiority being perpetuated between them and other women. This conflict is called relational aggression. The state of female interaction is potentially sublimated in work environment. There is evidence that relational aggression happens at the familial and interpersonal level. These effects are both national, with the mommy wars, and international in honor killings.

There has been much discussion about disparity between men and women in the workplace, and relational aggression between and among women of all ages, and this study is not designed to further disparage women, although some feminists would likely prefer that this topic did not arise. In fact, in *Women's' Inhumanity against Women* the author states that she was afraid and discouraged from writing these types of articles on the basis that this might endanger the tenuous hold women have on authority in the western world (Chesler, 2001).

> "Are you still doing that book?" For nearly twenty years she has asked me this same question... "Of course I am... I wish you'd give it up... this will delight every womanhater around. You'll be hurt, but you'll hurt other women too." (Chesler, 2001, p. 5)

The authors discuss many areas of relational aggression and use examples in mainstream media, specifically movies, to clarify the examples of relational aggression between and amongst women. At one point the authors discuss the theory of the female "original sin" which is essentially the sin of being born female equates to innately inferior to male, validated by male perspectives, and therefore mistrustful and disliking of other

females (Holiday & Rosenberg, 2009). This is not a uniquely Western issue. In fact, of the so-called "honor killings" that took place between 1989 and 2013, eighty-seven percent were Muslim on Muslim crimes; the remaining 13% were committed by Hindus, Sikhs, and Yazidis. Women were hands-on killers in 39% of these cases and served as conspirator accomplices 61% of the time. In India, women were hands-on killers 100% of the time (Chesler, 2015, p. 3). Finally, the Asian perspective on groups: "competition within a group which is in theory harmoniously united tend to become fiercer and more emotionally involved than in one where competition is accepted as normal" (Tannen, 1999).

In the meantime, research and popular books have been created to address female bullying at young ages and to prevent this behavior in children and adolescent girls. Books like *Tripping the Prom Queen* (Barash, 2007) show how much female conflict as teens and pre-teens have affected girls into their adulthood. Little has been written about female working groups and even less about female managers of female groups. Other literature by the likes of Chesler, Barash and Weiss refers to this concept as the Mommy Wars, Queen Bees and Wannabees, and "cattiness". For example, Weiss indicates: "Ninety-five percent of the legal secretaries who responded to the online survey were women. Most were middle aged and had considerable experience. They came from firms of more than 100 lawyers" (Weiss, 2011).

Sandra Bem describes gender polarization as having two parts: "First… the mutually exclusive scripts for being male and female. Second, it defines any person or behavior that deviates from these scripts as problematic" (Bem 1993, p. 81). She goes on to talk about the idea that women were sexual creatures when stimulated by men, but

never on their own. Further she pursues the idea that a "woman's special virtue is her ability to easily transcend the many isolated units and artificial polarities that men are said to almost compulsively invent" (p. 128). From this, the reader can further extrapolate that, even within the feminist movements and researchers of feminism, discrepancies exist in what women do or do not do and how women should or should not behave. If a woman would have been expected to behave in a certain way, required to be able to deal with circumstances beyond her delicate control, she is conversely not able to create the same pitfalls for others. She is destined to be reactive, while a man would be destined to be proactive. This correlates with modern media and another area of feminist research - the female rivalry.

Buss and Schmidt (2011) discuss the crossover of evolutionary psychology and feminism. They tacitly indicate that there is an underlying power structure to mate preference, sexism, rape (and rape prevention policy), female subjugation, and "honor" killings. They concede that either gender can inflict psychological damage on the other and interestingly identify women as being used as "sex objects" and men being used as "success objects" in mate selection (Buss & Schmidt, 2011). There is an implicit competition between and among women in the idea of "success objects" which is not apparent in "sex objects" terminology. Success implies a competitive win against others of similarity and a limited resource allocation, while "sex" is non-personal and non-competitive.

Gender in the Workplace

Workplace gender issues: Historical

This section discusses the historical context of feminism and puts it into application where if a woman is placed in a historically man's role, she is either viewed as too motherly or too masculine, therefore ruining the historically feminine stereotype of a women. Several authors, two of note Barash (2007) and Chesler (2001) have indicated that they saw areas in which women were creating and managing conflict between women hidden from view of men, and not talked about by other women. In effect, they are saying that any flaw in how women interact would be a flaw that would expand to all women and then would allow greater threats of exposure and risk of perpetuated sexism.

If they managed employees the way they managed a household, they were seen to be overly caring and weak. Leaders are now trying to employ leadership as well as management skills and are trying to incorporate both traditional masculine roles and traditional female roles. The literature in recent years has been focused mostly on the way that women lead, without regard to the followers' genders, which may have an impact, albeit covert.

According to Ritzer (2008, p. 460) there have been many waves of feminist thought. The first was simply about the question "what about the women?" or understanding how women understand and experience the world and whether that experience is different from or like that of men. This is termed "gender difference" (p. 460). "Difference feminists" view those who minimize gender differences as interfering with efforts at attaining gender equality. This is just one dimension, among many, along

which scholars who fall with the broad rubric of "feminism" differ (Buss & Schmidt, 2011; Campbell et al., 1998, p. 414).

Also, according to Ritzer (2008) these terms are still debated among feminist theorists (2008, p. 455). While this expanded the range of discussion available for research, this distinction makes the original tenets of "liberation … and articulation of the world in terms of the woman's experience in it" (2008, p. 459). This paper study will use the term "female" to indicate those who have chosen to refer to themselves as "female" whether this is a biological or social designation. Most theories cover things like barriers to leadership positions and the "glass ceiling" (Williams & Dempsey, 2014).

Several authors, two of note (Barash, 2007; Tannen, 1999), have indicated that they saw areas in which women were creating and managing conflict between women hidden from view of men, and not talked about by other women. Phyllis Chesler (2001) said that she had wanted to publish her book many years ago but was told by other respected feminists and colleagues that she would be undermining the entirety of the feminism. In effect, she would be saying that any flaw in how women interact would be a flaw that would expand to all women and then would allow greater threats of exposure and risk of perpetuated sexism.

In the 1970s, female researchers established a difference between the biological component of sex and the socially understood concepts of "gender". Concepts like "masculine" and "feminine" were deeply explored and are still evolving in the discussion, particularly in the workplace. Hofstede's theories on masculinity and femininity in the workplace indicate that ideas associated with femininity are "caring for other and preservation; people want warm relationships are important; everybody should

be modest; [the] weak deserve sympathy" (Editorial Board [EB], 2015, p. 99). Meanwhile, ideas associated with masculinity are, "material success and progress; money and material items are important; men should be assertive, ambitious, and tough; [the] strong deserve sympathy" (2015, p.99).

Since women began taking leadership roles after WWII, there have been discussions about how women lead and whether men should take on "feminine" traits of empathy and understanding with their followers (Jamieson, 1995). This put women in a double bind. If they managed employees the way they managed a household, they were seen to be overly caring and weak. If they managed employees like their male colleagues, they were too tough and ineffective as role models. Over time, these roles have modified. Leaders are now trying to employ leadership as well as management skills and are trying to incorporate both traditional masculine roles and traditional female roles. The literature in recent years has been focused mostly on the way that women lead, without regard to the followers' genders. The focus on the "glass ceiling" and salary inequality has the effect of homogenizing female leader behaviors (Williams & Dempsey, 2014). Joyce (2006) indicates a tendency not to move forward as essentially self-sabotage, or "sticky floor."

Gender Issues Today

Male managers are favored over female managers. Female bullying is commonplace in a workplace setting, but it is often not discussed because it opposes the historical feminist view of female relationships. A 2011 study published in *Human Relations* surveyed 60,000 full-time workers on their attitudes toward male versus female managers. Its conclusions seem to bolster Sandberg's claim that people are more

accepting of successful men than successful women: Of the 46% of respondents who expressed a preference for their boss's gender, 72% said they wanted a male manager (Barkhorn, 2013).

An article written by a man in *The New York Times,* talked about another study in workplace bullying. That study indicated that 40% of bullies are female. When the author of the article, Mickey Meese went on to interview other people he found a female respondent who said, “Women don’t like to talk about it because it is “so antithetical to the way that we are supposed to behave to other women, we are supposed to be the nurturers and the supporters” (Meece, 2009). Meece indicated further that other women have said that they are unhappy but afraid to speak up for fear of backlash, some just preferring to leave, or start their own companies than to stay in bullying situations with other women (Meece, 2009).

According to the American College of Healthcare Executives, there has been an increase in the proportion of women relative to men who achieve CEO status, particularly in healthcare. Using sampling methods to allow women and men a similar amount of time to obtain experience in healthcare management, about 12% of women, compared to 19% of men had achieved CEO positions. In contrast to the three previous studies where women achieved CEO positions at about 40% of the male rate, in 2006 they achieved CEO positions at 63% of the male rate (ACHE, 2006, p. 1).

Another article is a meta quantitative analysis of existing research compared perception about male and female mediators to see if gender affects disputing individuals’ perception of the mediation, and particularly the mediator. The mediator is a neutral party and therefore must be accorded trust for the mediation to be successful and

is a good analog for manager/leader positions. This article reinforces the “gender effect”, or the impact of gender on the perception of competency, in mediation. The authors indicated that the differences between the perceptions of the male and female genders of the specific mediators were more extreme when the perception measure was specific to the gender of the mediator and not related to the outcome or its process. Some of the points found are that males are perceived more positively and as more dominant than females. The authors suggested that males may be perceived to be more dominant, which is perceived as a male trait, in speech or style during mediation. Mediators should be aware of this effect and should be trained to deal with them (Stuhlmacher & Morrissett, 2008).

Vartia and Hyyti (2002) examined how male and female prison officers responded to their work conditions. They found that unsatisfactory working conditions and poor social climate are strong predictors of bullying. Female employees may treat inmates in a way that differs from that of their male colleagues. Women sometimes try harder to understand inmates and their behavior than do their male co-workers. This may, in turn, result in conflicts and perceived bullying between the female and their male colleagues. Female employees were willing to accept orders from their supervisors, whereas the males felt that the orders were dismissive or demeaning and constituted bullying.

Some studies have shown that people respond more to men who are authoritative. The same study shows that women who are authoritative are perceived as more competent, however the competency is offset by a higher risk of being rejected. Men do not feel the need to justify positive or negative outcomes, whereas women will adopt a

soft response and explanation for a negative outcome. This is set in Spain and the authors indicate that culture may play a larger role than in the United States of America (Medina et al., 2009).

Gender Issues in Leadership

There has not been much discussion about these relational aggressions between women within in academic literature. There is a fear among some that it would undermine feminist work or show weaknesses in what is already perceived to be a weak structure. The existence of relational aggression examples in mainstream media, nationally and internationally, provides evidence of research opportunity. It is timely to talk about, even as other feminist authors were concerned that talking about this issue earlier, would break the fragile shell of respect that women have begun to garner in the larger world. Tannen (1999) talked about how closed groups need to be strong and not disclose the weaknesses to a potential aggressor from outside. Therefore, women are hesitant to acknowledge or discuss this potential issue however when it is mentioned, or the question of female-bullying comes up, most women will have an anecdotal response as the bully or the bullied. “In the feminist research approach, the goals are to establish collaborative and non-exploitative relationships” (Creswell, 2007, p. 26). While critical theory perspectives “are concerned with empowering human beings to transcend the constraints placed on them by race, class, and gender” (2007, p. 26).

Kanter (2015) sampled dozens of workers to determine if women have better or worse job satisfaction under female leaders. There was a marked and significant negative impact on worker satisfaction when the leader was female. There is indication of covert behavior, referred to as "hidden bias" (Kanter, 2015). A study was done to determine if

female leaders were preferred over male leaders. The results indicated that newer female employees preferred female leaders, but this changed as the number of years of the followers' work increased; particularly after four years. Another study by Warning and Buchanan (2009) suggested that newer employees might want to identify with successful female supervisors in their early career, but their actual affinity for female leaders declines after experience. In general, men were better leaders for male employees than women, while the outcomes for female employees were less certain. Warning and Buchanan (2009) indicate that this might be due to the tendency of survey respondents to want to present themselves in a better light.

More recently, there have been many statements that women are promoted almost accidentally because the reasons they are not promoted are profuse and varied (Barsh & Lee, 2011). Further, women in the work world are expected to prove their value over and over and to remain helpful and maternal to varying degrees throughout their working lifetime. Literature, both professional and social, asserts that their male counterparts tacitly agree and, perhaps knowingly or unknowingly, perpetuate the expectations (Williams & Dempsey, 2014; Eagly & Johnson, 1990).

Healthcare Leadership Conflicts

Healthcare leadership has been largely unstudied until recently. Women make up most of the workforce and leadership. This provides research space for relational aggression and covert conflict behavior. Most administrative managers in healthcare are female. There are potentially other research options for conflict within those hierarchies that has not yet been explored for fear of creating a sense of vulnerability. This would indicate that healthcare is a new and appropriate environment for healthcare interventions

both for physicians and nurses and subsequent staff. Taylor (2017) indicates that good leadership requires that people be able to voice their disagreement or alternative ideas. This is called “obligated to dissent”. Good leadership requires humility, which invites respectful dissent, such that even the most junior member of a group can disagree with senior members.

Healthcare leaders and followers

Healthcare is filled with conflict and this conflict is managed poorly. The hierarchy of healthcare, though managerial positions are held by women, women are scarce in top tier positions. The conflicts females face in healthcare are often looked over, in fear of compromising the positions and mobility of the female healthcare leaders. Conflict in healthcare settings has potential for direct effects to patient care outcomes. A recent study at Dartmouth involving training residents in medical programs and others decided that conflict resolution skills were likely to assist in patient outcomes and interpersonal professional relations (Cochran, Charlton, Reed, Thurber, & Fisher, 2018).

Groups that have been traditionally very hierarchical have been seeing changes. Hierarchy still exists as a concern and a source of conflict:

> Relationship-based conflicts involve interpersonal dynamics such as personality frictions or differences in norms and values; examples are assigning blame to others or using disrespectful language. These conflicts are particularly challenging in health care due to complex and rigid power hierarchies that may discourage providers from speaking up. (Kim et al., 2016, p. 256)

This article also specifically mentions the extensive downsides of this conflict, “While some of the consequences were tangible, such as a cancelled surgery, some were less

tangible, such as persistent tension in a working relationship" (Kim et al., 2016, p. 267). A particularly poignant quote from one to the study participants is very telling of the organizational tension in medical hierarchies:

> I had a disagreement with a physician over a test order that I believed was the hospital standard. I felt the physician was dismissing the patient because of her socioeconomic status. I escalated the issue to my manager, who told me to directly communicate with the physician. The physician said to me, 'I am the doctor. I make the medical decision. You are just the nurse.' (Kim et al., 2016, p. 267)

In fact, The Joint Commission, an organization which accredits, and monitors healthcare facilities sent out a directive about conflict in the hospital as a potential risk factor in surgery and patient outcomes. Here is an excerpt of The Joint Commission's Issue 40:

> There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care… Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior… They can lack interpersonal, coping or conflict management skills…Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team. (The Joint Commission, 2008, p. 1)

The evolution of management and group theories could indicate that small groups of women are not as monolithic as they seem. There may some backlash however, as women are among the vulnerable groups in research, and some may feel that this type of revelation may perpetuate a backlash or regression in promotion of female leaders.

If there is shown to be a difference in the perceptions about female leaders, this will open many areas of discussion. Since most group analysis avoids the gender divide, this will create a new view on female group processing, trust in female leaders, and expose a new area of conflict to be addressed by managers that was previously undisclosed. Extrapolation to management methods can be made. Focus can be applied on building trust, exploring dissent and gender expression of same.

The fact that conflict in medical staffs is sufficient to prompt The Joint Commission to issue a mandate indicates that the medical industry is rife with conflicts and is not dealing with them very well. There is relatively little on how female employees are managed or choose to manage outside of nursing, but the groups are clearly showing conflict behaviors. According to an article in Forbes Magazine, “Consider that while women compose 73% of medical and health services managers, only 4% of healthcare CEOs were women” (Chase, 2015). Consequently, this is a sample population that will show how women feel working with and being led other women.

Judith Briles studied this conflict in general terms in interpersonal conflict in healthcare. It is specifically directed at healthcare and addresses the needs of female employees, and female behavior with other females, in healthcare (Briles, 1994). She has written several books on this topic: first to expose the issue from a study in 1980s and then to run the report again in the early 1990s. One of her later books, *Zapping Conflict*

in the Healthcare specifically talks about areas of conflict resolution that would be useful in healthcare settings. Her work was published in mainstream media as primarily demonstrative statistical review of narrative, qualitative surveys and her suggestions countering the conflict observed.

The American College of Healthcare Executives (ACHE) studies male and female leaders in healthcare. They report on and advocate for other issues in healthcare leadership at a variety of levels and encourage their members to do research to earn the accolade "Fellow", according to their website. One of their studies found the following: About three quarters of women and men are satisfied with their compensation compared to others in their organization at the same level, while more than 80% of both groups are satisfied with their overall advancement in the organization. Somewhat fewer, about two thirds, were satisfied with the availability of mentors and coaches. Both men and women express similar levels of commitment to their organizations. (*ACHE*, 2006, p. 2)

According to the 2007 Catalyst Census of Women Corporate Officers and Top Earners of the Fortune 500 in the United States, only 15.2% of corporate board seats were held by women in the Fortune 500 companies, at a time when more than 50% of managerial positions were held by women; only 15.7% of these companies have women in corporate office leadership positions (Catalyst, 2008). Specifically:

> The findings of the study indicate that young female leaders of today experience a number of factors they feel inhibit their ability to lead effectively. The factors they identified are all subparts of discrimination and range from domination and disrespect to overall biasness and negative stereotyping (Catalyst, 2008).

Gender Conflict in Healthcare

Troy Brown, RN, wanted to see if male and female medical school faculty perceived microaggressions differently. He used 34 real experiences to create 68 videos; half of the videos were intended to display microaggressions and the other half were intended as controls. Brown noted that the female participants found 33 of the 34 test videos displayed microaggressions; male participants tended not to find microaggressions in the videos. The control videos produced no difference between the participant genders' reaction. The female participants noted, in descending order of frequency: sexism, pregnancy/childcare bias, underestimation of abilities; sexually inappropriate comments, relegation to mundane tasks, and exclusion/ marginalization. Brown noted that relative power positions and bystander position are important. Germane to the covert behavior ideas, failure of bystanders to respond, immediately or later, may create a tacit approval of the negative behavior (Brown, 2019).

According to an article in the job website health careers, the gender pay disparity is the same as the regular population, as is the low number of female leaders. Interesting, this article says that even male nurses make more than their female nurse counterparts. That same is true for female physicians relative to tehri male counterparts. (Does Healthcare Have a Gender Problem? 2018)

Berlin et al (2020) indicate that although the healthcare industry has relatively higher levels of CEOs compared to the general business world, by a few percentages in each area of management, with 80% of nurses being women. Intriguingly promotion, as compared to the business world, are higher in healthcare. The representation of women at c-suite and senior levels match the general business world.

An article by the World Health Organization (WHO) indicates that what we are seeing in the US is like what we see in the rest of the world. For example, in large studies, the WHO found that "The report highlights occupational segregation by gender in the health sector that is both deep and universal. The clearest example is that 24 million of the 28.5 million nurses and midwives globally are women. Men, on the other hand, are more likely to be physicians and specialists than women.". (Ghebreyesus, 2019)

"When people behave passive-aggressively, what appears passive, or defensive is covert aggression... Being overly empathetic puts you in jeopardy of being mistreated again and again." (Lancer, 2019) This causally relates to jobs with feminine attributes, or those considered to use feminine attributes being afraid of being mistreated and being more hesitant to object, regardless of how they feel. Ulrich (2010) wrote in the AMA Journal of ethics that the "warm and fuzzy" recruiting campaigns for male nurses did not work, instead having to use taglines like "are you man enough to be a nurse?". This indicates that nurses are expected to be female and use female-oriented skills. Looked at more deeply, there is an implied bias that a man is disloyal to his gender if he takes on a role which is "feminine". Male nurses also have a stigma when it comes to specializing in certain areas, like gynecology or obstetrics, which are primarily the domain of women. The author indicated that this was not just a gender issue. Sexual harassment has increased over the last decade, with respect for nurses on the part of physicians falling over a similar period. The subtle and blatant conflict, "degrading comments" and "yelling and cursing" respectively, between nurses and physicians has direct impact on patient care. The author concludes that respect for the two sides' professional expertise and scope

of practice is more important for conflict reduction and good patient outcomes than simple gender parity (Ulrich, 2010).

Healthcare Power Bias

A Harvard Business review article said, "Female physicians continue to face myriad challenges in medicine ranging from implicit bias to gaps in payment and promotion to sexual harassment" (Rotenstein, 2018). Dorit Lotan, (2019) conducted a semi-structured study with 20 nurses in an Israeli hospital setting. The outcomes point to subtle power negotiations between nurses and female physicians. "Over the years, the balance of power between the two has shifted: nursing has undergone great development in the professional aspects, while the number of female physicians has increased. Nurses tended to define their professional identity in relation to physicians, presenting a united front against the so-called “other,” a distinct “us versus them” divide. They appeared to perceive themselves as superior to physicians, competing with them over their professional importance and prestige. They utilized aggressive and manipulative strategies as means of resolving conflicts with physicians. This was more pronounced with female physicians, who received little to no respect from nurses, and were judged by gender stereotypes, and only gained recognition if they proved themselves worthy of it" (Lotan, 2019). Apparently, physicians, and female ones shape the professional identity of the nurse through a struggle over influence, authority, and public prestige. By so doing, nurses simultaneously undermine and preserve the existing nurse-physician hierarchy". All of this indicates the existence of covert, implicit behaviors. Since women make up most of the industry, and the female physicians are the ones who have to prove themselves not only to male physicians but also female nurses, this indicates power

imbalances, and implies the existence of negative social capital expenditure and relational aggression among the female employees in healthcare, be they nurses or physicians. This rigid hierarchy also implies that fear of loss of power is a real motivator for female staff. The "us versus them" mentality, and both sides perceiving themselves to be superior to the other also lays the groundwork for fear-based responses.

The University of Missouri School of Medicine has this to say about physician-nurse relationships: "Reports of physician-nurse conflict appear more widespread than could easily be attributed to just the typical personality clashes one finds in the workplace and society in general. Several possible sources of conflict between physicians and nurses that have been repeatedly suggested are (1) the power imbalance between physicians and nurses, (2) differing goals of medicine and nursing, and (3) gender conflict between physicians, who have traditionally been men, and nurses, who have been overwhelmingly women." Explaining the theory of gender conflict from a sociological perspective, "The physician in the hospital, so the theory goes, sees the nurse as subservient because traditionally the nurse has been female, and females have been subservient in society." As to why this has not been addressed, the author says, "Nurses who feel intimidated or have low self-esteem might be less inclined to point out errors they perceive a physician to be making"(Physician and Nurse Relationships 2020). This fear and self-esteem issue are manifestations of covert behaviors like bullying, relational aggression and ostracism seen in other articles and studies.

Hoff (2019) indicated some reasons why female physician burnout, depression and divorce is higher than their male counterparts: "The perception of doctors as a privileged profession may lessen the urgency by which those in and outside of it

acknowledge the gender divide...Second, this insensitivity to poorer treatment of its own members continues to be a normal part of the medical profession's adverse alpha culture... Third, medicine is a profession built on power and control...Finally, and more subtle is that female physicians often report high levels of job and career satisfaction despite the presence of these negative realities...This implies a degree of compartmentalization that may allow some female doctors to navigate through hostile workplaces and yet still find rewards in the joy of clinical practice and other aspects of their work". All these factors imply subtle, unspoken conflicts within the hierarchical system of healthcare which is unique to this industry.

Trust and Dissent

Trust must be understood as part of the relationship between individuals. Since followers are inherently the reason for the existence of leaders, there must be trust between them in some fashion. Understanding how the trust or distrust plays a part in that relationship makes a difference in understanding why a follower would choose to follow a specific leader. Trust is a major part of transformational leadership styles as the follower must believe that engagement above and beyond the norm will benefit him/her and therefore trust that the leader has the followers' best interest at heart (Asgari, Silong, Ahmad, & Samah 2008). In some cases, this has shown to be more disruptive than not. Kotlyar and Karakowsky (2006) indicate that because of this connection to the followers' emotions, sometimes transformational leadership can create more destructive conflict because of the emotional entanglement. Therefore trust, specifically of the leader, may be one central indicator of conflict in a small group.

Brown (2018) said. "… believing we're trustworthy and being perceived as trustworthy by others are two different things" (p. 3040). She quoted an article from the annual list of 100 companies to work for in Fortune magazine: "'trust between managers and employees is the primary defining characteristic of the very best workplaces,'" and that companies with high levels of trust 'beat the average annualized returns of the S&P 500 by a factor of three'" (Brown, 2018, location 3055 of 4075). Feltman et al. (2009) indicates that trust and distrust are choices made to be vulnerable to another person. Poignantly, he said:

> When we distrust another person, we look for ways to protect what we value. The disaster of distrust in the workplace is that the strategies that people use inevitably get in the way of their ability to effectively work with others. (Feltman et al., 2009, location 99 of 1144)

Trust has implications not just for social interactions, but also that the conflicts are real and have real and tangible impact on work outcomes.

In an article entitled, "Gender Differences in the Relational and Collective Bases for Trust," Maddux and Brewer (2005) purport that, in terms of the way in which people feel a sense of interdependence with others, women may be more relationally oriented, while men may be more collectively oriented. Given that men work better in collectives, women rely on the interpersonal relationships. Hence, women in groups may work more dyadically than men with different expectations for the outcome of work. Shepard and Sherman (1998) indicate a four-category typology based on depth of dependence (shallow dependence, shallow interdependence, deep dependence, and deep interdependence) in which the risk taken in trusting another emerges as a factor of

dependence in the other. This is only one typology of the phenomenon of interpersonal trust. The authors indicate that trust is a central tenet of interpersonal interaction.

Gordon and Gilley (2012) discussed a leadership model based on trust. They found that empowerment seems to further reinforce trust, as the leader is first showing trust in the employee by delegating authority. Trust is promoted by leaders who are confident in themselves and at "peace" with who they are and are willing to be authentic. This allows for compassionate listening and furthers the ability of the leader to not only talk the talk, but to also place themselves in the employee's shoes and "walk the walk".

Rousseau, Sitkin, Burt, and Camerer (1998) wrote an article trying to unify the definitions of trust. The *Academy of Management Review* published this article in a special section printing dedicated to discussions of trust. This section of articles covers topics of trust like establishing a common use of the word "trust," determining whether trust can be statistically measured, and the understanding of trust as a cause, and effect or an interaction across disciplines. The authors found that, despite disciplinary biases and differences in thought processes, there is overlap in the understanding of trust across social sciences. They admit to "stacking the deck" since this article is one among several to specifically look at trust across disciplines, and that this might have influenced the nature of the discussion, as there was a dearth of interdisciplinary discourse on this topic. This article explores the interaction between management and employees in the setting of continuous work pattern improvements in a health care establishment.

Trust in management's purpose in instituting continuous improvement initiatives has a direct effect on worker's acceptance of such, and the success of said programs. Managerial acts such as tolerating job autonomy, broader scope of tasks and positive

guidance give a sense of achievement and responsibility to the worker with increased satisfaction and acceptance of changing work tasks and environments in today's ever changing work market. (Anand, Chhajed, Delfin.2012).

Dissent

When a follower disagrees with a leader it is often referred to as dissent. Various studies have uncovered types of dissent, some of which indicate sublimated or latent disapproval. The different types of dissent can help facilitate changes in the workplace. Antagonistic/Latent dissent, later renamed as lateral/latent dissent, is defined as complaining to coworkers and voicing criticism in a manner that is not always observable but may become directly observable when certain circumstances arise, like mounting frustration. Articulated dissent, later termed upward/articulated dissent, is the sharing of concerns openly and was found to be correlated positively with freedom of speech in the workplace (Kassing, 1998, p. 25). Displaced dissent is defined as verbal expression of dissent to other than those in the workplace, like non-work friends, spouses, and partners.

The authors, Analoui and Kakabadse (1989) present convincing arguments for their beliefs that “acts of defiance tend to reflect, amongst other things, the extent of man's understanding of his environment, both in immediate terms and beyond”. They could also be seen to be a mixture of his reaction to the organizational, socio-economic, and even political reality, as he views it. This can be seen both in individuals carrying a grudge as well as unions with an agenda. The situation is determined by the cultural bias and the result is the individual’s interpretation of the situation which then in turns becomes their reality.

Payne (2014) conducted a study about trust and workplace dissent. Surveys were given to workers to determine relationship with supervisors, and the dissent strategy leveraged most by asking how they express concerns at work. Findings suggest that when supervisors are trusted by their employees, employees are more likely to use articulated dissent, and less likely to use latent or displaced dissent. Conversely, employees who have low trust with their supervisors are more likely to leverage latent or displaced dissent, compared to articulated dissent.

Chapter 3: Methodology

Problem Statement

The level of trust in a boss is critical for there to be strong organizational outcomes. The literature has demonstrated the there are differences in trust among male and female leaders by their followers, but there a paucity of research in the health care field on this topic. This is critical to understand as the percent of women in leadership is higher in the medical field compared to other fields, making genderized trust of leaders a critical area of understanding to improve health care outcomes. The same can be said about the methods of dissent expression among followers in terms of their leaders' gender.

Trust and dissent are major areas of expression of covert behavior and indicate if there are underlying issues which are not regularly addressed. Conflicts which are not well understood or not well addressed can create long-term costs for any organization. For healthcare environments, the cost is not just monetary or production, but also in-patient outcomes, including death. Finding covert behaviors among female leaders and followers may indicate sources of potential impact.

Application to Leadership and Conflict Resolution

If the outcomes determine there are no significant difference between how female followers perceive female versus male leaders, or how female followers perceive leaders differently than male followers do, then the implication is that conflict resolution methods which are gender-neutral should apply to both groups.

Should the outcome indicate that female followers and or female leaders perceive a greater level of conflict in groups containing female leaders then, there will be

significant evidence to indicate that there are underlying conflicts which have yet to be addressed. Because this is a healthcare group, a relatively newly explored conflict area, and a field which historically has been female and its staff, the implications indicate much deeper research is required. Consequently, further conflict resolution and management options can be explored within the context of healthcare. Conflict resolutionists can find a new environment to plan and to participate in conflict resolution systems. This can indicate that standard conflict resolution design can be incorporated into existing hierarchical structures within the healthcare environment.

Research Questions

RQ1: Is there a difference in type/level of dissent between male and female based on gender of supervisor or leader in the healthcare industry?

- H1: Women with female leaders in the healthcare industry are more likely to engage in latent dissent than women with male leaders in the healthcare industry.
- H2: Women with female leaders in the healthcare industry are more likely to engage in latent dissent more than men in the healthcare industry.
- H3: Women with male leaders in the healthcare industry will be more likely to engage in articulated or displaced dissent than women with female leaders in the healthcare industry.

RQ2: Is there a difference between male and female followers in terms of their level of trust in male versus female leaders in the healthcare industry?

- H4: Women with female leaders in the healthcare industry show lower levels of trust of their leader than those women who work for male leaders in the healthcare industry.
- H5: Women with female leaders in the healthcare industry will have lower levels of trust of their leader then men who work for female leaders in the healthcare industry?

RQ3: Is there a relationship between trust and dissent in the healthcare industry?

Methods

This survey uses a quantitative, non-experimental method to examine the research questions and hypotheses. After IRB approval, the surveys were submitted to the Medical Group Management Association (MGMA), American Health Information Management Association (AHIMA) and American Academy of Professional Coders (AAPC) community groups. The data was collected in the online survey, since the link was posted in a community message board, one response by a potential respondent was made. The comment was kept, but not the person's identifying information. Survey Monkey has an option to collect data anonymously. No identifying data was collected or requested. This process allowed sufficient redaction of individual responses to be able to give data in the aggregate without revealing individual names unless they are willing to participate in a in an interview process later which may be relevant for future research.

Population

The survey was submitted to three groups of healthcare business professionals. MGMA is a group of medical group managers and is a nationwide association. The groups added were the American Health Information Association (AHIMA) and the

American Association of professional coders (AAPC). These are similar groups to MGMA in that they have been exposed to both male and female leaders. AHIMA has about 100000 members, and AAPC has just passed 200,000 members. Most of the members are national to the USA, with minority overseas membership.

Since the research questions are about female leadership in healthcare, the datasets are comprised of male and female followers, of various experience levels, who have or were working in healthcare at the time. The nature of the association in the study provided a consistency in job experience because the focus of the association is on medical practice management, from the small practice to the large hospital (MGMA, 2018). The MGMA membership director agreed to allow the survey with the caveat that the data must also be posted to that same discussion board. Participants are most likely administration staff, or likely had experience with both male and female managers. This was simply by virtue of training in medical healthcare administration. The reason for choosing MGMA was because it is a national organization specifically composed of medical group managers, and there are several thousand people participating in any given community discussion board. The reason to add AAPC and AHIMA were to add variety to the respondent pool and further randomization. No indication of which group the respondent belongs to was collected.

Statistically there is no difference between male and female trust of male and female leaders. However, the specific answers of women about women leaders are telling in the ranges of responses. This began as a statistical analysis but took on some qualitative components. The RQs included correlation between trust and dissent types, done line by line. In other articles (Hannagan, 2008; Payne, 2014) larger samples of

general business employees (around 200) indicated strong correlation. Since healthcare is a more hierarchical environment, this may have changed the non-response bias due to identity bias, based on gender. As women make up 75% (Lance & Maryland, 2008) of the employees in healthcare, this may skew the identity bias for non-responses. One respondent indicated the inability to complete the survey as she had three female leaders: two who were distrust worthy and one who was. This was an unexpected and unsolicited response. Inclusion criteria: male or female adults that had been a leader or follower under a male and a female leader.

Data Collection

Surveys were administered through a weblink in discussion threads at the MGMA, AAPC and AHIMA member community sites and were linked to SurveyMonkey, to maintain anonymity.

Instruments

Organizational Dissent Scale. Kassing developed the Organizational Dissent Scale (ODS) to help organizations, measure the extent of and methods of individuals' disagreement with leadership (Kassing 2000). Previous studies had been used to operationalize "voice" as the likelihood of an individual to communicate with supervisors over work concerns. The ODS was developed over the course of three studies, the first to establish the measurements and the next two to determine reliability and validity. Kassing proposed that dissent would be expressed as one of three types: articulated or upward (expressing consent within the organization to those who can do something about it); displaced dissent (disagreeing without challenging, or discussing with those who can do nothing about it, like family members); and latent or lateral (discussing concerns with

those of the same rank or those who can do nothing about it as it is too risky to directly confront management, originally referred to as antagonistic) (Kassing, 1998; 2000).

The final version of the ODS is 24-item self-report questionnaire reflecting the three types of dissent and inclusion of reverse coded questions. Factor analysis was performed by the ODS author and test-retest correlations were significant at .001 level. (Kassing, 1998). This scale did not prove to be useful as there was no difference between male and female responses. However, the difference among female respondents regarding female leaders was interesting as there are wider ranges of responses, indicating that there are potentially much greater ranges of emotions involved in the responses. There is also the possibility of identity bias, with an emphasis on female solidarity. Finally, the outcomes of this scale, previously shown to be reliable and valid, did not prove to be so in this case, which may imply that this population does not react normally, or as other populations might, considering the industry. When Holly Payne (2014) ran this test, her results were reliable, relevant, and valid. Her article indicates that she used the same two scales together, but with general business employees. The population demographics and cultural expectations are likely to be different than in healthcare.

Individualized Trust Scale. In addition to the above, it may be probative to see whether the followers are inclined to latent or displaced dissent methods if they find the leader untrustworthy. Because the RQs were based on aggregating the responses of individual followers regarding individual leaders, the Individualized Trust Scale developed by Wheeless and Grotz was useful. This is a Likert scale-based questionnaire that was run with the ODS, per gender of the leader.

As to reliability, there is not much evidence for this specific instrument, but there have been several variations of this instrument over the years:

> Wheeless and Grotz (1997) reported a split-half reliability of .92 for the ITS and Wheeless (1978) reported a reliability of .97 for a 14-item version. Van Lear and Trujillo (1986) chose four items from the ITS and reported an alpha of .82. Sanvely (1981) reported an alpha of .95 and Buller, Strzyzewski, and Comstock (1991) an alpha of .72 for the ITS. Rubin, R. B. (2011)

When validity was addressed, the authors found what they expected overall. The outcomes can clearly relate to how comfortable a person may feel with a leader and should correlate closely with the ODS above. Specifically, "Wheeless & Grotz (1997) performed the first validity studies… (b) individualized trust was related to control and conscious intent to self-disclose," Rubin, R. B. (2011) which is related to the three dissent types in the ODS. Related to the amount of risk avoidance in the ODS for displaced and latent dissent, Wheeless and Grotz found the ITS, "(c) in persons high and low in individualized trust differed in amount of self-disclosure to the target person, individualized trust, and interpersonal solidarity. And Wheeless and Andersen (1978) found that trust, as predicted, was related to self-disclosure, acquaintance time, relationship type, and solidarity" Rubin, R. B. (2011). The respondent was asked to think of a female leader first and answer questions about the female leader first, which is both the ODS and the ITS, and then the same questions regarding the male leader.

Data Analysis

The final data analysis strategy was discussed with the statistics lab director. At this time, the chi-square analysis appears most closely aligned with intended

measurements. The independent variables were gender (male, female or other) and the dependent variables were the level of trust identified for female leaders, the level of trust identified for male leaders, the type of dissent most common when dealing with female leaders, and the type of dissent expressed when dealing with male leaders.

The strength of trust was compared against dissent for female versus male participants. Initial thoughts on this were to identify scatterplots of data and correlation coefficients for each gender of response to each set of question, for example the response of female followers of female leaders in the trust scale. A t-test was probative here since the data will have 2 (or 3) gender categories and a continuous scale. Subscale t-tests were run to see if there were statistically relevant data in the types of dissent or gendered trust. Qualitative review of the responses, question by question, elucidate some covert perceptions, including possible fear responses.

Limitations and Assumptions

The greatest risk of bias was the potential for only female participants to take the survey, or confirmation/identity bias of female participants wanting to answer in ways to show solidarity with female leaders rather than answering honestly. Working with the Statistics Lab at the university helped with identifying any statistical opportunities for data clarification. If the difference is statistically significant, then this is an area of additional managerial conflict resolution training. These last two are central identifiers in this study. If this issue aligns with low levels of trust in female followers regarding female leaders, or differences in dissent types, then there exists an opportunity for further study in a previously only qualitative subject area. To identify if any difference exists between trust and dissent types by gender of leader and gender of follower(s) in a

healthcare setting. The hypothesis is necessary to identify statistical outcomes and will help to answer or provide further reflection on the research questions.

However, since this will be measured in tandem with another survey, this¬ measure may prove useful in winnowing down female-to-female interactions. The correlations between gender of the participant and the leader did not show a difference in relative trust and dissent of the gender of the follower, in an objective way, but there is evidence of covert behavior in the specific response which had no answers or variance between strong and very neutral responses. This were reviewed on a question level.

Research Instrument

This section presents the survey questions utilized and describes the rationale for including them in the research instrument.

Introduction: This study is looking at ways male and female healthcare employees deal with trust and express dissent. You will be asked the same set of questions twice, once for female leaders and once for male leaders. There are no right or wrong answers, and everything is confidential. The following table shows the questions and rational for asking them:

Table 1

Questions and Rationale

Question	Operationalization	Rational
Age	Number	Some research shows younger women may bias answers in solidarity for female leaders- may show identity bias
Gender	Male Female Other/Non-binary	Dependent Variable

Managerial Experience	Years of Experience	Some research shows identity bias in newer entrants (<4years) to the field vs. 5+ years showing less identity/solidarity bias with more experience
Residency	State where participant lives	Show dispersion of participants and validate randomness
Race/Ethnicity		Might be probative but can easily be removed if considered unnecessary.
Current Position Level	Entry level Midlevel Worker Middle Manager Upper Manager Other	May show bias away from speaking ill of other managers (professional courtesy bias), and combined with age might indicate whether this person tends often to move around professionally (displaced dissent)
Exposure to a female manager in Healthcare	Dummy Variable Yes/No	If no exposure, not useful to the study
Exposure to a male manager in Healthcare	Dummy Variable Yes/No	If no exposure, may skew data

The following are additional survey questions asked with the following Instructions*:* On the scales that follow, please indicate your reaction and experience regarding a **female** manager or leader, or **female** leaders in general. Place an "X" in the space between the colons that represents your immediate "feelings" about this person. Check in the direction of the end of the scale that seems to be most characteristic of this person. Mark only one "X" for each scale and please complete all scales.

Table 2

Additional Survey Questions Regarding Female Leadership

Variable Scale	Rational
Trustworthy:___:___:___:___:___:___: Untrustworthy	Overall perspective on leader professionally and trust
Distrustful:___:___:___:___:___:___:___: Trustful	Personal perception for interpersonal interaction, trust; counters the first question.
Confidential :___:___:___:___:___:___:___: Divulging	Openness to receiving important information with this person
Exploitative :___:___:___:___:___:___:___: Benevolent	Perception of power usage and leadership
Safe :___:___:___:___:___:___:___: Dangerous	Level of comfort in vulnerability with said leader
Deceptive :___:___:___:___:___:___:___: Candid	Character of the leader. Goes to trust in revelation of secrets/ personal information. Marking deceptive of a female by a female indicates discomfort confiding in that leader.
Not deceitful :___:___:___:___:___:___:___: Deceitful	Counter to above- character
Tricky :___:___:___:___:___:___:___: Straightforward	Trust of consistency in behavior and forthrightness of leader
Inconsiderate :___:___:___:___:___:___:___: Considerate	Basic social interactions, and possible covert behavior
Honest :___:___:___:___:___:___:___: Dishonest	How likely is the leader to speak untruths, typically for perceived personal gain, as perceived from the outside
Unreliable :___:___:___:___:___:___:___: Reliable	Since leaders need follow through, how much can a follower believe what is said. This relates to trust in follow through
Faithful :___:___:___:___:___:___:___: Unfaithful	Rationale: how comfortable the follower feels about loyalty. This opens doors to lack of loyalty and job insecurity.
Insincere :___:___:___:___:___:___:___: Sincere	How often praise is generic, versus hyperbolic
Careful :___:___:___:___:___:___:___: Careless	Can details be trusted by the leader, with the potential to harm the followers.

The following are additional survey questions asked with the following Instructions*:* On the scales that follow, please indicate your reaction and experience regarding a **male** manager or leader, or **male** leaders in general. Place an "X" in the space between the colons that represents your immediate "feelings" about this person. Check in the direction of the end of the scale that seems to be most characteristic of this person. Mark only one "X" for each scale and please complete all scales.

Table 3

Additional Survey Questions Regarding Male Leadership

Variable Scale	Rational
Trustworthy:___:___:___:___:___:___: Untrustworthy	Overall perspective on leader professionally and trust
Distrustful:___:___:___:___:___:___:___: Trustful	Personal perception for interpersonal interaction, trust; counters the first question.
Confidential :___:___:___:___:___:___:___: Divulging	Openness to receiving important information with this person
Exploitative :___:___:___:___:___:___:___: Benevolent	Perception of power usage and leadership
Safe :___:___:___:___:___:___:___: Dangerous	level of comfort in vulnerability with said leader
Deceptive :___:___:___:___:___:___:___: Candid	Character of the leader. Goes to trust in revelation of secrets/ personal information. Marking deceptive of a female by a female indicates discomfort confiding in that leader.
Not deceitful :___:___:___:___:___:___:___: Deceitful	Counter to above- character
Tricky :___:___:___:___:___:___:___: Straightforward	trust of consistency in behavior and forthrightness of leader
Inconsiderate :___:___:___:___:___:___:___: Considerate	Basic social interactions, and possible covert behavior
Honest :___:___:___:___:___:___:___: Dishonest	How likely is the leader to speak untruths, typically for

	perceived personal gain, as perceived from the outside
Unreliable :___:___:___:___:___:___:___:___: Reliable	Since leaders need follow through, how much can a follower believe what is said. This relates to trust in follow through
Faithful :___:___:___:___:___:___:___:___: Unfaithful	Rationale: how comfortable the follower feels about loyalty. This opens doors to lack of loyalty and job insecurity.
Insincere :___:___:___:___:___:___:___:___: Sincere	How often praise is generic, versus hyperbolic
Careful :___:___:___:___:___:___:___:___: Careless	Can details be trusted by the leader, with the potential to harm the followers.

The following are additional survey questions asked with the following Instructions for female leaders/managers*:* This is a series of statements about how people express their concerns about work leaders. There are no right or wrong answers. Some of the items may sound similar, but they pertain to slightly different issues. Please respond to all items. Considering how you express your concerns about **female** leaders/managers, indicate your degree of agreement with each statement by placing the appropriate number in the blank to the left of each item.

Table 4

Additional Survey Questions Regarding Concern About Female Leadership

Question	Operationalization	Rational
I am hesitant to raise questions or contradictory opinions in my organization	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).
I complain about things in my organization with other employees.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent.

I refuse to discuss work concerns at home.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent. Reverse coded to minimize bias(es).
I criticize inefficiency in this organization in front of everyone.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. This question should be correlated with the level of comfort the follower has with this specific leader. Specifically identify with ITS question # 2,4,7
I do not question management.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded. This question should be correlated with the level of comfort the follower has with this specific leader. Specifically identify with question # 3,5,11. Reverse coded to minimize bias(es).
I am hesitant to question workplace policies.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).
I join in when other employees complain about organizational changes.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Latent Dissent
I make it a habit not to complain about work in front of my family.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent. This may be a driver to blatant dissent and will check against time in business. Reverse coded to minimize bias(es).
I share my criticism of this organization openly.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. May track with Deceit and reliable questions in ITS.
I rarely voice my frustrations about workplace issues in front of my spouse/partner or nonwork friends.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree	Indicates Displaced Dissent. Reverse coded to minimize bias(es).

	1= strongly disagree	
I make certain everyone knows when I'm unhappy with work policies.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Lateral/Latent Dissent
I don't tell my supervisor when I disagree with workplace decisions. I let other employees know how I feel about the way things are done around here.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).
I bring my criticism about organizational changes that aren't working to my supervisor or someone in management.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Should match questions about comfort.
I do not express my disagreement to management.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).
I let other employees know how I feel about the way things are done around here.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent.
I talk about my job concerns to people outside of work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent
I talk about my job concerns to people outside of work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent
I do not criticize my organization in front of other employees.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. Reverse coded to minimize bias(es).

I make suggestions to management or my supervisor about correcting inefficiency in my organization.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Indicates comfort with leader.
I discuss my concerns about workplace decisions with family and friends outside of work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Latent Dissent
I hardly ever complain to my coworkers about workplace problems.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. Reverse coded to minimize bias(es).
I tell management when I believe employees are being treated unfairly.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent
I speak freely with my coworkers about troubling workplace issues.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent.
I talk with family and friends about workplace decisions that I am uncomfortable discussing at work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent.

The following are additional survey questions asked with the following Instructions*:* This is a series of statements about how people express their concerns about work leaders concerning male leaders/managers. There are no right or wrong answers. Some of the items may sound similar, but they pertain to slightly different issues. Please respond to all items. Considering how you express your concerns about **male**

leaders/managers, indicate your degree of agreement with each statement by placing the appropriate number in the blank to the left of each item.

Table 5

Additional Survey Questions Regarding Concern About Male Leadership

Question	Operationalization	Rational
I am hesitant to raise questions or contradictory opinions in my organization	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).
I complain about things in my organization with other employees.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent.
I refuse to discuss work concerns at home.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent. Reverse coded to minimize bias(es).
I criticize inefficiency in this organization in front of everyone.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. This question should be correlated with the level of comfort the follower has with this specific leader. Specifically identify with ITS question # 2,4,7
I do not question management.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded. This question should be correlated with the level of comfort the follower has with this specific leader. Specifically identify with question # 3,5,11. Reverse coded to minimize bias(es).
I am hesitant to question workplace policies.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).

I join in when other employees complain about organizational changes.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Latent Dissent
I make it a habit not to complain about work in front of my family.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent. This may be a driver to blatant dissent and will check against time in business. Reverse coded to minimize bias(es).
I share my criticism of this organization openly.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. May track with Deceit and reliable questions in ITS.
I rarely voice my frustrations about workplace issues in front of my spouse/partner or nonwork friends.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent. Reverse coded to minimize bias(es).
I make certain everyone knows when I'm unhappy with work policies.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Lateral/Latent Dissent
I don't tell my supervisor when I disagree with workplace decisions. I let other employees know how I feel about the way things are done around here.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).
I bring my criticism about organizational changes that aren't working to my supervisor or someone in management.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Should match questions about comfort.
I do not express my disagreement to management.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Reverse coded to minimize bias(es).

I let other employees know how I feel about the way things are done around here.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent.
I talk about my job concerns to people outside of work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent
I talk about my job concerns to people outside of work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent
I do not criticize my organization in front of other employees.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. Reverse coded to minimize bias(es).
I make suggestions to management or my supervisor about correcting inefficiency in my organization.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent. Indicates comfort with leader.
I discuss my concerns about workplace decisions with family and friends outside of work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Latent Dissent
I hardly ever complain to my coworkers about workplace problems.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent. Reverse coded to minimize bias(es).
I tell management when I believe employees are being treated unfairly.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Upward/Articulated Dissent

I speak freely with my coworkers about troubling workplace issues.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Lateral/Latent Dissent.
I talk with family and friends about workplace decisions that I am uncomfortable discussing at work.	5= strongly agree 4= agree 3= agree some and disagree some 2= disagree 1= strongly disagree	Indicates Displaced Dissent.

Chapter 4: Data Analysis

Analysis of Subjective Content Question-by Question

The following are question by question findings in purely demonstrative statistics. Ortu (2012) indicated that many studies of stimulus and response are limited by their ability to see the stimulus for which the response is identified. Further, if the instruments are more precise, using more modern methods, then quantification of the stimuli can be made later. The questions were studied at a qualitative, question-by-question level.

Q1: Do you understand, and do you want to be in the study? If you have read the introductory information and voluntarily wish to participate in this research study, please select the "Yes, I consent" button to continue.

Figure 1

Question 1

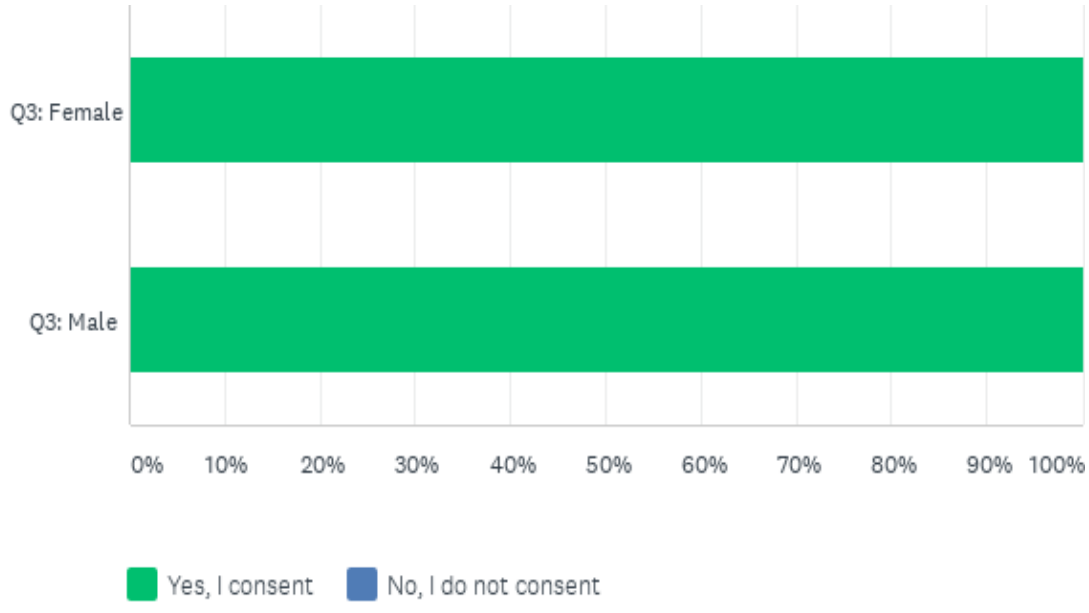


Table 6

Question 1

	YES, I CONSENT (1)	NO, I DO NOT CONSENT (2)	TOTAL
Q3: Female (A)	100.00% 48	0.00% 0	82.76% 48
Q3: Male (B)	100.00% 10	0.00% 0	17.24% 10
Total Respondents	58	0	58

BASIC STATISTICS

	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female (A)	1.00	1.00	1.00	1.00	0.00
Q3: Male (B)	1.00	1.00	1.00	1.00	0.00

Q2: What is your ethnicity? (Please select all that apply.)

Figure 2

Question 2

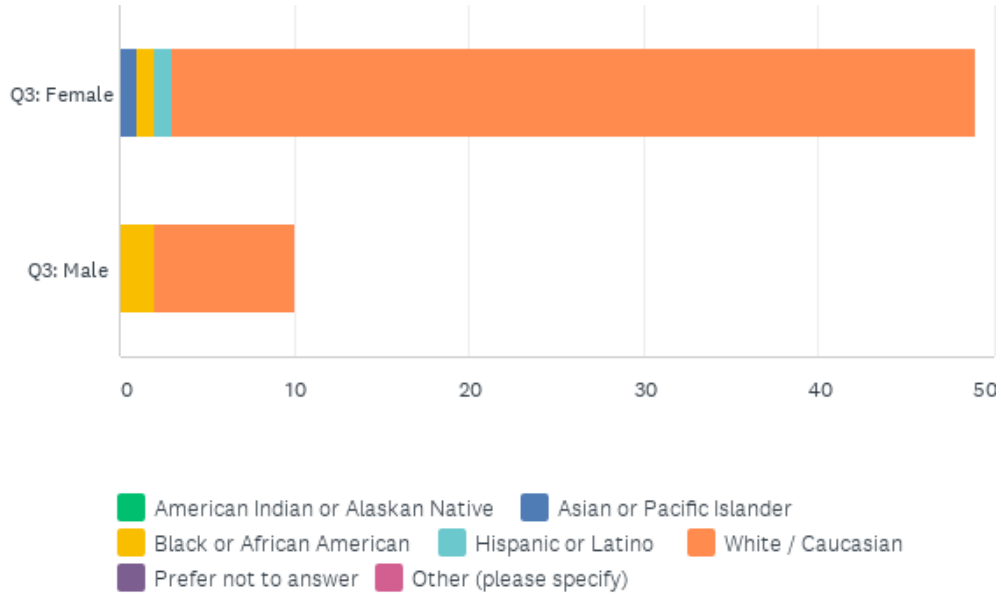


Table 7

Question 2

	AMERICAN INDIAN OR ALASKAN NATIVE (1)	ASIAN OR PACIFIC ISLANDER (2)	BLACK OR AFRICAN AMERICAN (3)	HISPANIC OR LATINO (4)	WHITE / CAUCASIAN (5)	PREFER NOT TO ANSWER (6)	OTHER (PLEASE SPECIFY) (7)	TOTAL
Q3: Female (A)	0.00% 0	2.08% 1	2.08% 1	2.08% 1	95.83% 46	0.00% 0	0.00% 0	84.48% 49
Q3: Male (B)	0.00% 0	0.00% 0	20.00% 2	0.00% 0	80.00% 8	0.00% 0	0.00% 0	17.24% 10
Total Respondents	0	1	3	1	54	0	0	58

Most of the respondents indicated white/Caucasian as their ethnicity. There is a larger representation of white female employees, but approximately parallel representation of Black/African American males, relative to the general population, as od 2019 Census Bureau information. ((*U.S. Census Bureau QuickFacts: United States - Vintage Year 2019*). Bureau of Labor Statistics data from 2020 indicates between 70 and 80% of any given healthcare (mental or physical) manager is female (Bureau of Labor Statistics, 2021).

Q3: Please select the gender with which you identify.

Figure 3

Question 3

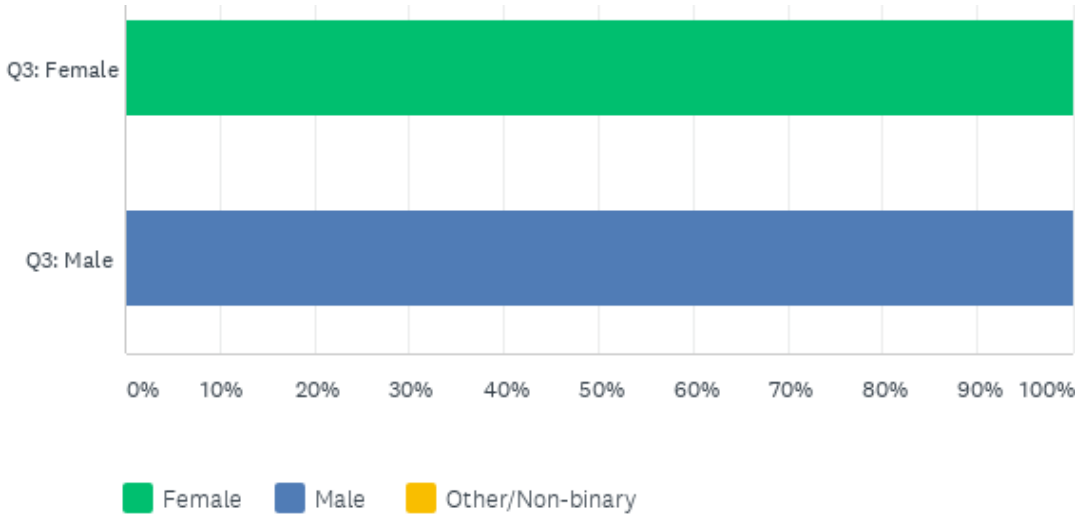


Table 8

Question 3

	FEMALE (1)	MALE (2)	OTHER/NON-BINARY (3)	TOTAL
Q3: Female (A)	100.00% 48	0.00% 0	0.00% 0	82.76% 48
Q3: Male (B)	0.00% 0	100.00% 10	0.00% 0	17.24% 10
Total Respondents	48	10	0	58

Since the population of healthcare employees is approximately 70-80% female (Lance & Maryland 2008), this collection is approximately equal to the overall population.

Q4: How many total years of working experience do you have (in any setting)?

Figure 4

Question 4

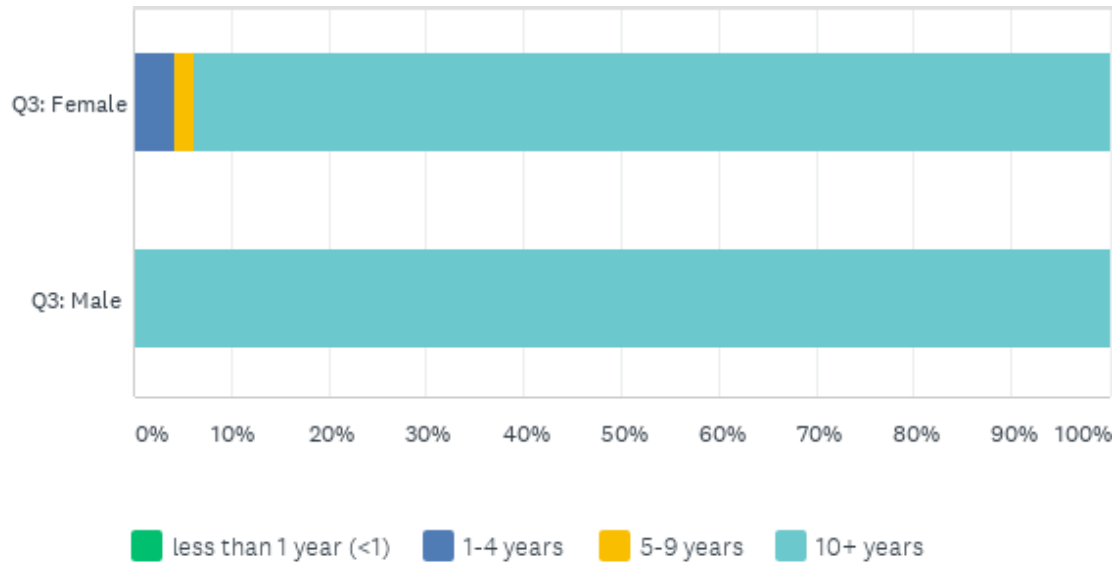


Table 9

Question 4

	LESS THAN 1 YEAR (<1) (1)	1-4 YEARS (2)	5-9 YEARS (3)	10+ YEARS (4)	TOTAL	WEIGHTED AVERAGE
Q3: Female (A)	0.00% 0	4.17% 2	2.08% 1	93.75% 45	82.76% 48	0.00
Q3: Male (B)	0.00% 0	0.00% 0	0.00% 0	100.00% 10	17.24% 10	0.00

Considering how many females answered that the have been in the field for more than 10 years (93.75%) and how many are with the information below, the relative level of male to female upper-level managers is about the same as the healthcare population overall.

Q6: Which of the following best describes your current job level?

Figure 5

Question 6

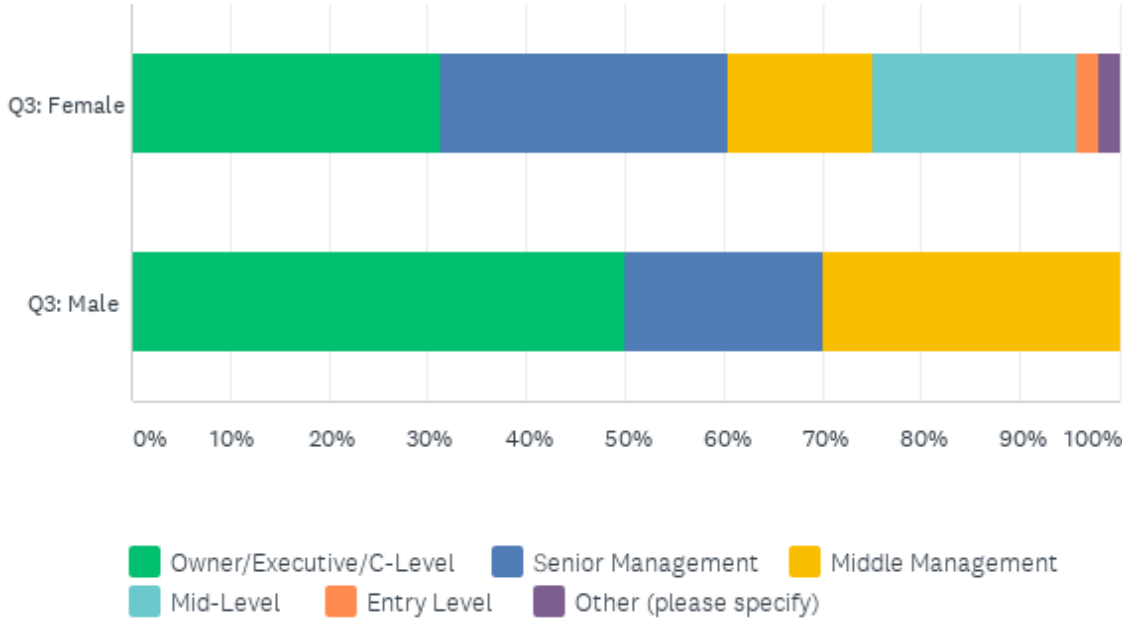


Table 10

Question 6

	OWNER/EXECUTIVE/C-LEVEL (1)	SENIOR MANAGEMENT (2)	MIDDLE MANAGEMENT (3)	MID-LEVEL (4)	ENTRY LEVEL (5)	OTHER (PLEASE SPECIFY) (6)	TOTAL
Q3: Female (A)	31.25% 15	29.17% 14	14.58% 7	20.83% 10	2.08% 1	2.08% 1	82.76% 48
Q3: Male (B)	50.00% 5	20.00% 2	30.00% 3	0.00% 0	0.00% 0	0.00% 0	17.24% 10
Total Respondents	20	16	10	10	1	1	58

These percentages track with the expected percentages of levels of management. In this context, Owner/Executive/C-Level could be the practice manager of a large practice or the owner of a small medical practice.

Q7: Have you ever had exposure to a female manager in healthcare?

Figure 6

Question 7

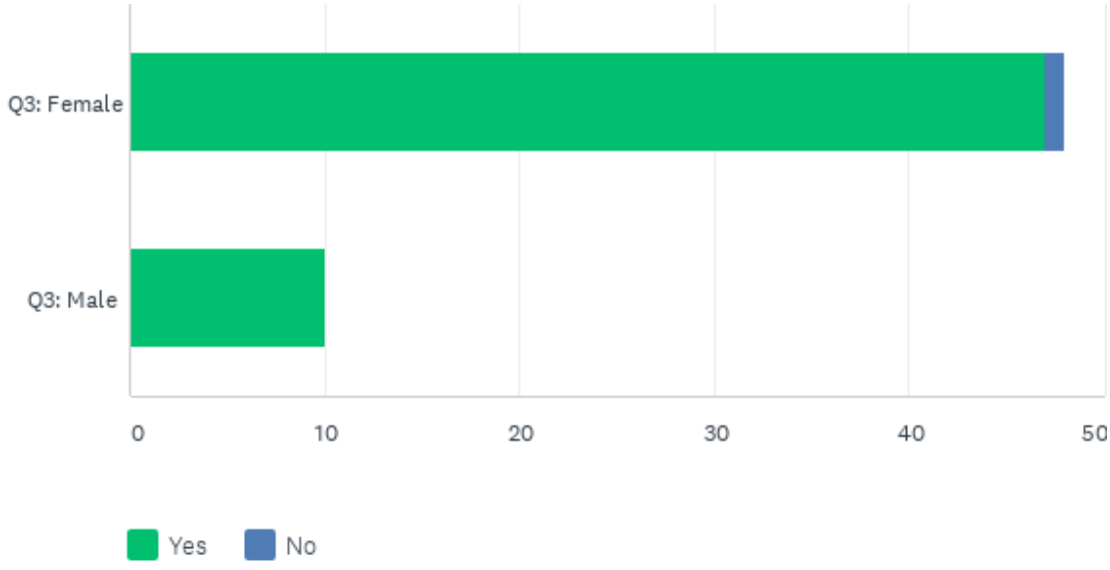


Table 11

Question 7

	YES (1)	NO (2)	TOTAL
Q3: Female (A)	97.92% 47	2.08% 1	82.76% 48
Q3: Male (B)	100.00% 10	0.00% 0	17.24% 10
Total Respondents	57	1	58

Only one of the female respondents indicated she had never had exposure to a female manager. Considering the above numbers, this appears to be an outlier and would benefit from a qualitative interview in future.

Q8: Have you ever had exposure to a male manager in healthcare?

Figure 7

Question 8

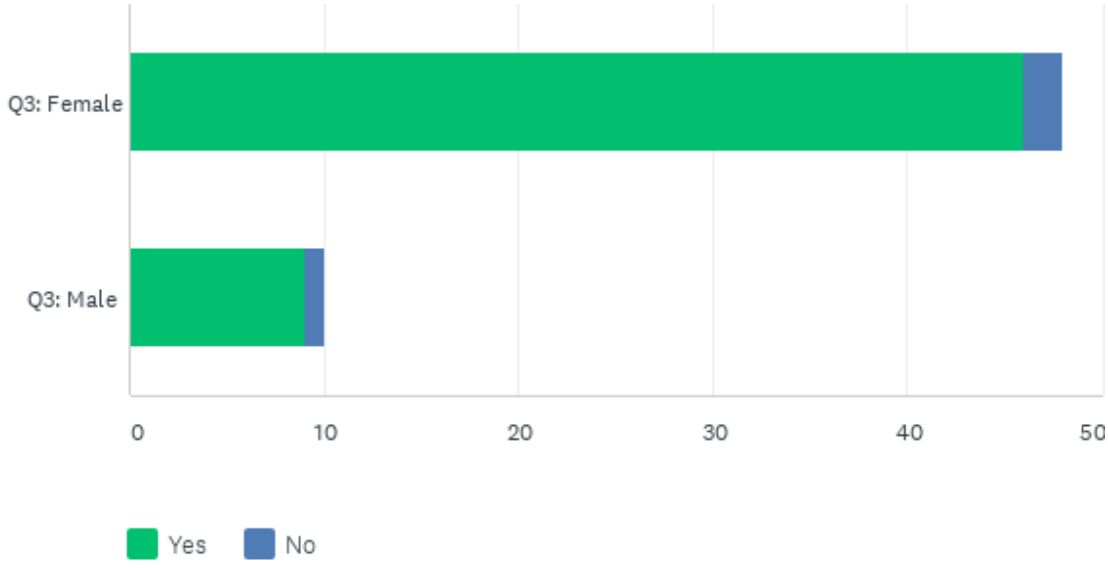


Table 12

Question 8

	YES (1)	NO (2)	TOTAL
Q3: Female (A)	95.83% 46	4.17% 2	82.76% 48
Q3: Male (B)	90.00% 9	10.00% 1	17.24% 10
Total Respondents	55	3	58

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female (A)	1.00	2.00	1.00	1.04	0.20
Q3: Male (B)	1.00	2.00	1.00	1.10	0.30

Considering the above numbers, this appears to be an outlier and would benefit from a qualitative interview in future.

Table 13

Question 9, Female Leader Trust Scale

		TOTAL
Q3: Female	100.00% 44	81.48% 44
Q3: Male	100.00% 10	18.52% 10
Total Respondents	54	54

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	6.00	2.00	2.50	1.66
Q3: Male	1.00	7.00	2.50	3.30	2.19

Note: Q9: On the next set of questions, please indicate your reaction to a female leader in healthcare with whom you are familiar. Click on the side of the scale that seems to represent your immediate “feelings” about this person. Check in the direction of the end

of the scale that seems to be most characteristic of this person. Mark only one answer for each scale and please complete all scales.
Table 9.a
Trustworthy - Untrustworthy
Answered: 54 Skipped: 4

Considering that that almost 19% (18.52%) skipped this question, it may indicate Gender Solidarity Bias which argues that women show solidarity with other women whether they realize they are doing it or not. In a way, this shows unintentional bias.

Table 14

Question 10

		TOTAL
Q3: Female	100.00% 48	82.76% 48
Q3: Male	100.00% 10	17.24% 10
Total Respondents	58	58

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	2.00	7.00	6.00	5.25	1.76
Q3: Male	1.00	7.00	6.00	5.00	2.14

Note: Q10: Please indicate your reaction to a female leader in healthcare with whom you are familiar.
Table 9.b
Distrustful of this person – Trustful of this person

Comparing the responses with the females in Q9, this indicates a semantic shift since the Original instrument was created.

Table 15

Question 11

		TOTAL
Q3: Female	100.00% 48	82.76% 48
Q3: Male	100.00% 10	17.24% 10
Total Respondents	58	58

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	3.00	3.06	1.82
Q3: Male	1.00	7.00	2.50	2.80	1.78

Note: Q11: Please indicate your reaction to a female leader in healthcare with whom you are familiar.
Table 9.c
Confidential - Divulging

This seems to point to females having slightly less (14.28%) confidence in female leaders keeping a confidence.

Table 16

Question 12

		TOTAL
Q3: Female	100.00% 43	81.13% 43
Q3: Male	100.00% 10	18.87% 10
Total Respondents	53	53

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	2.00	7.00	5.00	5.07	1.62
Q3: Male	1.00	7.00	5.50	4.70	2.00

Note: Q12: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.d
Exploitative – Benevolent
Answered: 53 Skipped: 5

This again, may be an example of semantic shift. This may indicate Gender Solidarity Bias which argues that women show solidarity with other women whether they realize they are doing it or not. In a way, this shows unintentional bias.

Table 17

Question 13

		TOTAL
Q3: Female	100.00% 46	82.14% 46
Q3: Male	100.00% 10	17.86% 10
Total Respondents	56	56

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	6.00	3.00	2.91	1.75
Q3: Male	1.00	7.00	2.50	3.40	2.06

Note: Q13: Please indicate your reaction to a female leader in healthcare with whom you are familiar.
Table 9.e
Safe - Dangerous
Answered: 56 Skipped: 2

Males thought their female leaders were more dangerous than female respondents. Comparing this question to the male leader version. The median for both genders indicates a greater sense of safety with female leaders than male leaders.

Q14: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.f, Deceptive - Candid

Table 18

Question 14

		TOTAL
Q3: Female	100.00% 48	82.76% 48
Q3: Male	100.00% 10	17.24% 10
Total Respondents	58	58

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	2.00	7.00	5.50	5.02	1.80
Q3: Male	1.00	7.00	5.50	4.50	2.06

No chart is available, but the range and mean are interesting. Males perceived that female leaders are/were entirely deceptive, but no female was willing to say that. The means are essentially the same, but considering the slight variation, and the small number of men, the males felt the female leaders were more deceptive than the female respondents did. Their opinions appear to be much more adamant as they ran the entire range. Again, this shows inherent male bias against female leadership.

Q15: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.g, Not Deceitful – Deceitful

Answered: 55 Skipped: 3

Table 19

Question 15

		TOTAL
Q3: Female	100.00% 45	81.82% 45
Q3: Male	100.00% 10	18.18% 10
Total Respondents	55	55

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.78	1.97
Q3: Male	1.00	7.00	2.00	3.10	2.34

When compared with Q14, this may indicate semantic shift, but essentially men and women both felt their female leaders could be anything from deceitful to not deceitful. Therefore, the findings show a range but when compared to the previous results men and women do perceive female leaders differently.

Q16: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.h, Tricky - Straightforward

Answered: 56 Skipped: 2

Table 20

Question 16

		TOTAL
Q3: Female	100.00% 46	82.14% 46
Q3: Male	100.00% 10	17.86% 10
Total Respondents	56	56

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	5.50	4.98	1.85
Q3: Male	1.00	7.00	5.50	4.40	2.11

If females were more trusting and otherwise happy with female leaders, there would be a shift in the range to either a smaller range or a min of 2 or higher. In this case, females felt their female leaders were as tricky as they are straightforward. This might also indicate semantic shift as “tricky” and “straightforward” may have different connotations in 2020, as compared with 1977.

Q17: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.j, Inconsiderate – Considerate

Answered: 57 Skipped: 1

Table 21

Question 17

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	5.00	5.13	1.72
Q3: Male	1.00	7.00	5.50	4.90	2.30

While the ranges on these responses are equal, it is interesting to note that males thought their female leaders slightly (0.50%) more considerate. This is fascinating, female leaders were slightly more considerate and yet, more deceptive.

Q18: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.k, Honest - Dishonest

Answered: 56 Skipped: 2

Table 22

Question 18

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.72	1.85
Q3: Male	1.00	7.00	2.50	3.10	1.81

This, combined with Q16, show a likelihood of semantic shift.

Q19: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.l, Unreliable – Reliable

Answered: 54 Skipped: 4

Table 23

Question 19

		TOTAL
Q3: Female	100.00% 45	83.33% 45
Q3: Male	100.00% 9	16.67% 9
Total Respondents	54	54

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	6.00	5.69	1.62
Q3: Male	1.00	7.00	6.00	5.44	1.95

Three females and one male did not answer this question. The wide range again gives indicate of strong feelings, both ways, about female leaders' reliability. This means, that both male and female respondents thought female leaders were reliable. Follow up qualitative questions would be useful in future.

Q20: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.m, Faithful - Unfaithful

Answered: 56 Skipped: 2

Table 24

Question 20

		TOTAL
Q3: Female	100.00% 46	82.14% 46
Q3: Male	100.00% 10	17.86% 10
Total Respondents	56	56

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.78	1.83
Q3: Male	1.00	7.00	2.50	3.30	2.15

The fact that two females skipped this question may be indicative of the number of respondents that had less than 5 years of experience. Both genders felt very strongly about their female leaders. Comparing this to the male version of this question. There is an underlying tension about female leaders compared to male leaders.

Q21: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.n

Insincere – Sincere

Answered: 53 Skipped: 5

Table 25

Question 21

		TOTAL
Q3: Female	100.00% 43	81.13% 43
Q3: Male	100.00% 10	18.87% 10
Total Respondents	53	53

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	6.00	5.33	1.90
Q3: Male	1.00	7.00	5.50	4.50	2.20

Interestingly, both male and female respondents felt that their female leaders could be anything between sincere and insincere.

Q22: Please indicate your reaction to a female leader in healthcare with whom you are familiar.

Table 9.o

Careful – Careless

Answered: 53 Skipped: 5

Table 26

Question 22

		TOTAL
Q3: Female	100.00% 43	81.13% 43
Q3: Male	100.00% 10	18.87% 10
Total Respondents	53	53

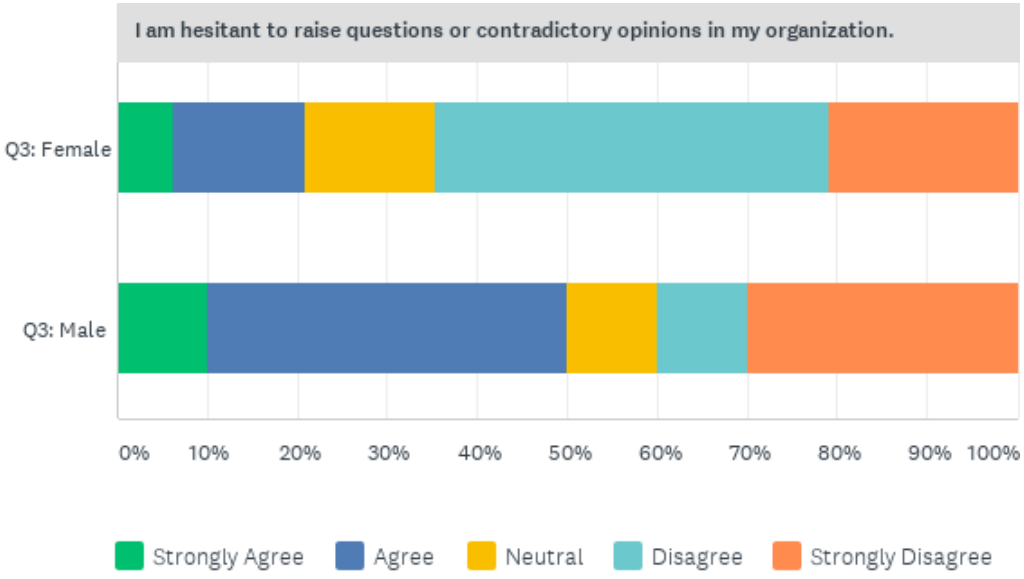
BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.33	1.57
Q3: Male	1.00	7.00	1.50	2.30	1.85

The female respondents find their female leaders slightly less (0.50%) careful than the males. This is a fascinating finding in that the respondents find female leaders less careful (or more careless) than male leaders.

Q23: Instructions: This is a series of statements about how people express their concerns about work leaders. There are no right or wrong answers. Some of the items may sound similar, but they pertain to slightly different issues. Please respond to all items. Considering how you express your concerns about a female leader/manager with whom you are familiar in a healthcare setting, indicate your degree of agreement with each statement by selecting the level of agreement or disagreement you have with each statement.

Figure 8

Question 23

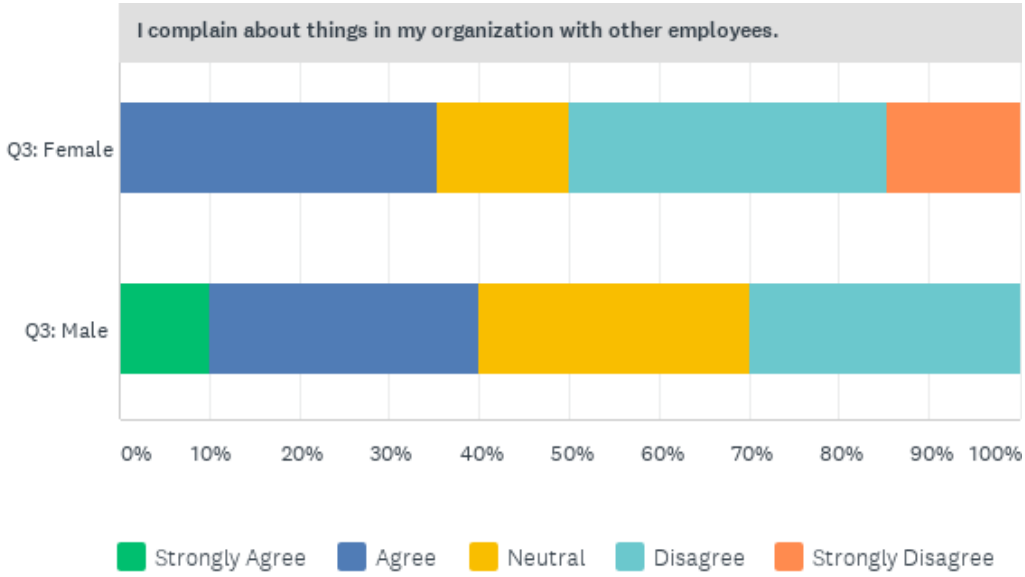


Male respondents feel more strongly about this both negatively and positively as it relates to female leadership. In other words, males are more hesitant to raise questions or contradictory opinions in their organizations. And females are more likely to raise questions or contradictory opinions within their organizations. On the other hand, more males strongly disagree with this and are more likely to raise questions and contradict the

opinions of their organization. Interestingly, this shows male respondents are polarized while female respondents are not polarized.

Figure 9

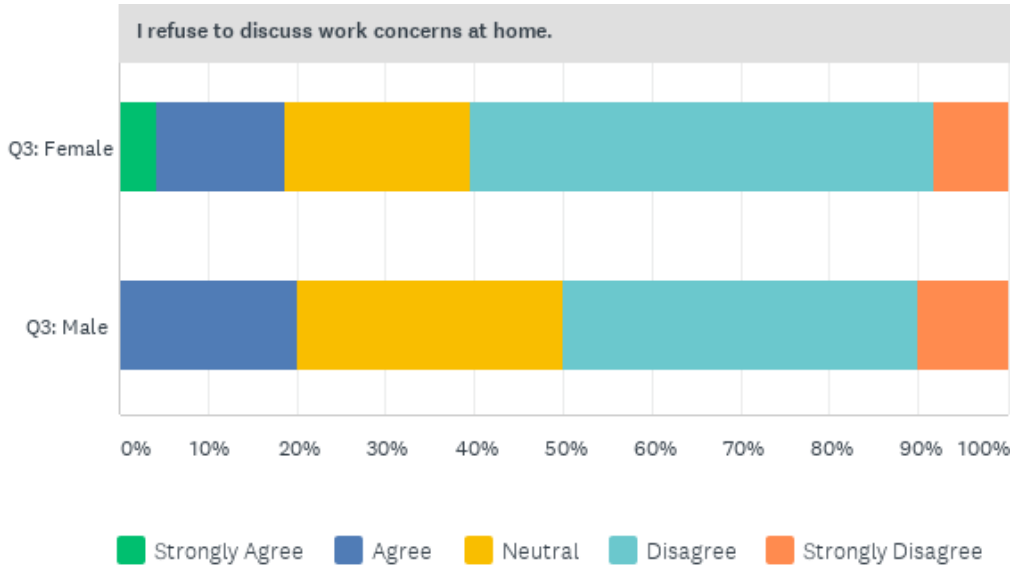
Female Leader- ODS



Male respondents strongly agreed more, while female respondents strongly disagreed more. Specifically, there are males who strongly agree that they would complain about things at their organization with other employees and zero females would. On the other hand, some female respondents strongly disagreed with the statement that they complained about things in their organization with other employees no male respondents strongly disagreed with this statement. An interesting follow up would be if the males who complained with other employees were complaining to other male or female employees about their female leaders.

Figure 10

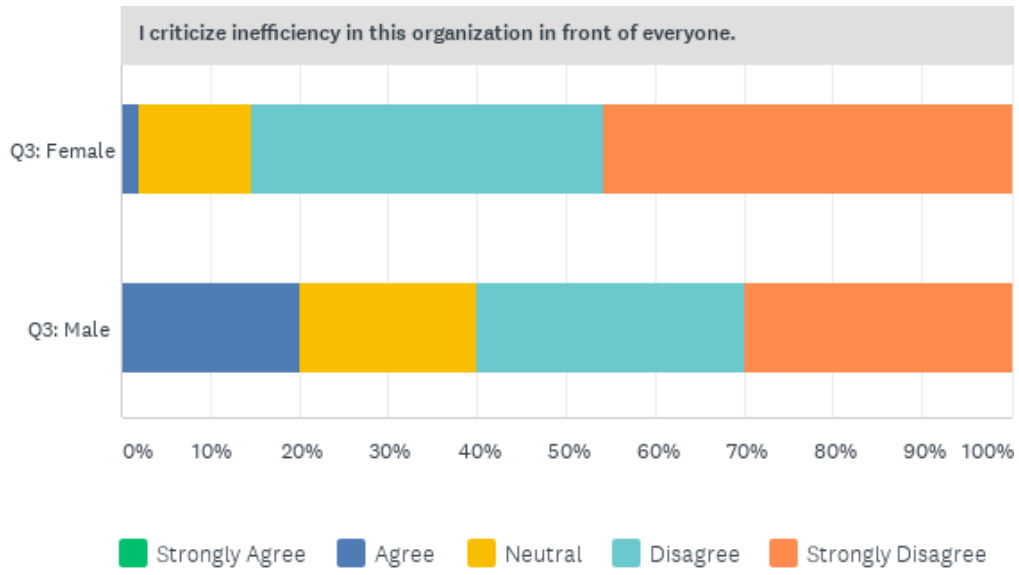
Female Leader- ODS



Both male and female respondents disagreed more than any other response. In other words, males and females bring their jobs home. Interestingly, only females strongly disagreed with the statement and did not bring their jobs home.

Figure 11

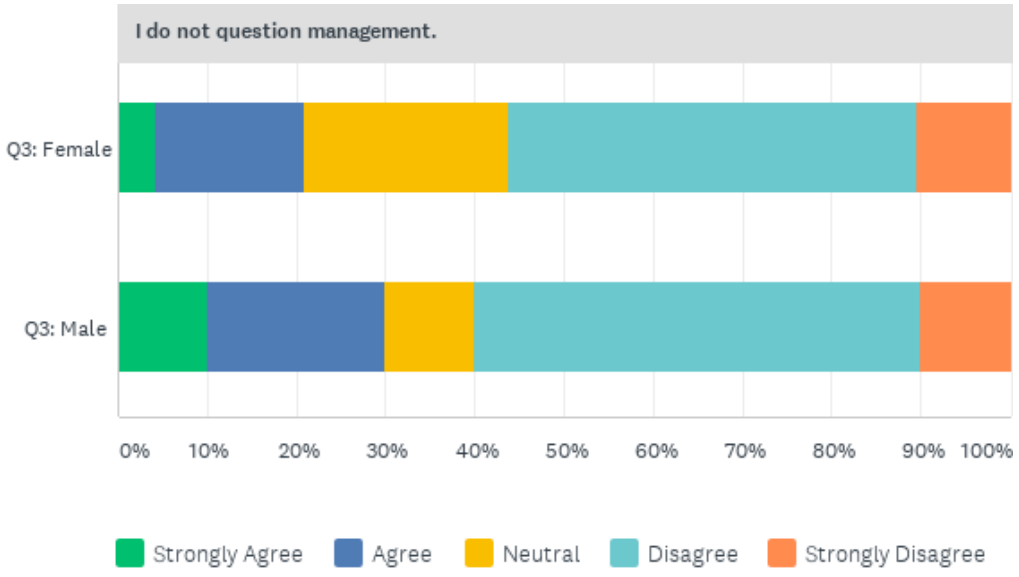
Female Leader- ODS



More Female respondents strongly disagreed than male respondents. In other words, neither males nor females criticized with inefficiency in their organizations in front of everyone.

Figure 12

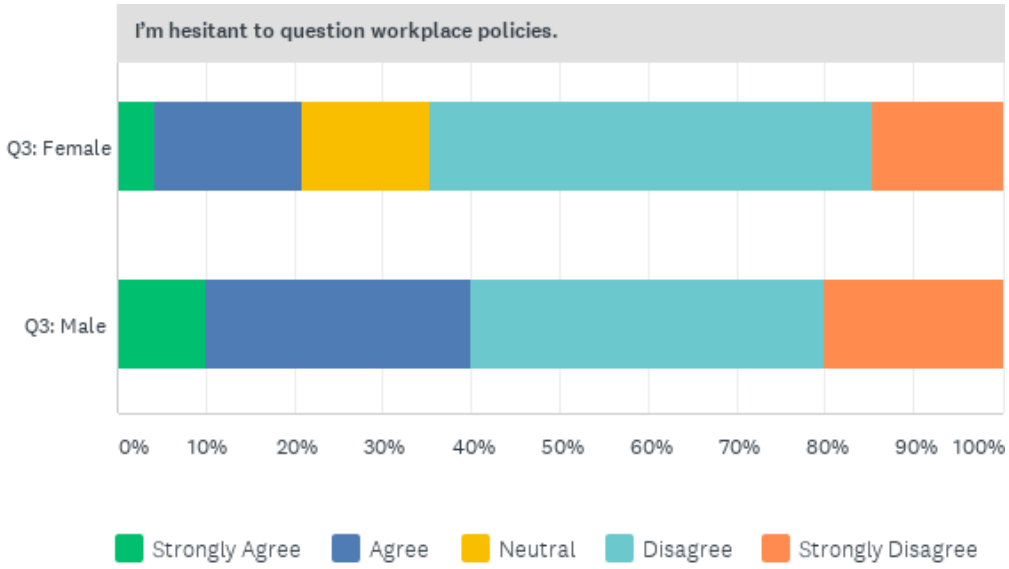
Female Leader- ODS



Most of both male and female respondents disagree with the question. In other words, both males and females do not question female management. It would be interesting to see if female managers agree with this perspective.

Figure 13

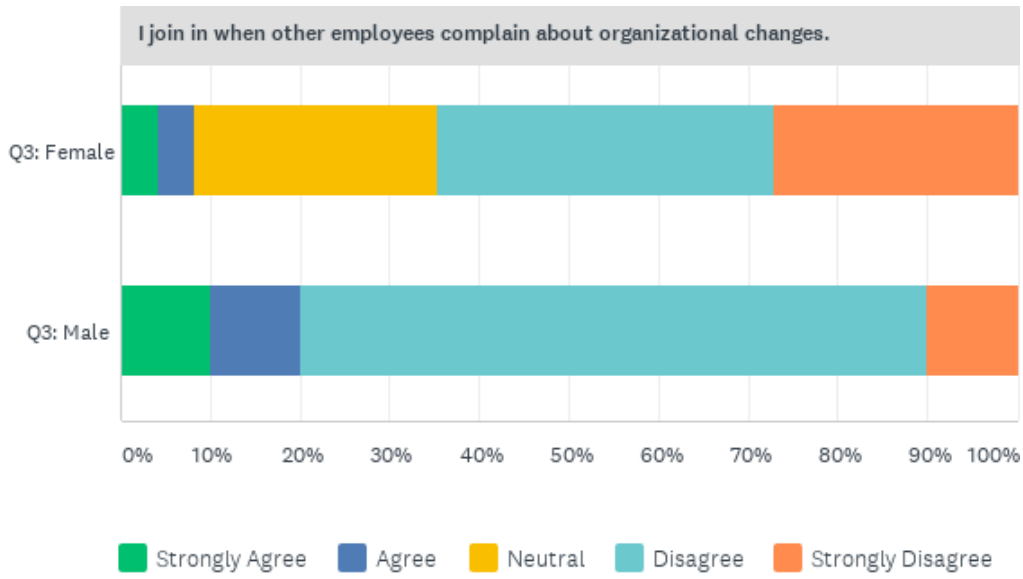
Female Leader- ODS



Male respondents feel more strongly about this question. In other words, males are more likely to question workplace policies than females. However, the differences seem to be minimal when females feeling neutral are included the analysis.

Figure 14

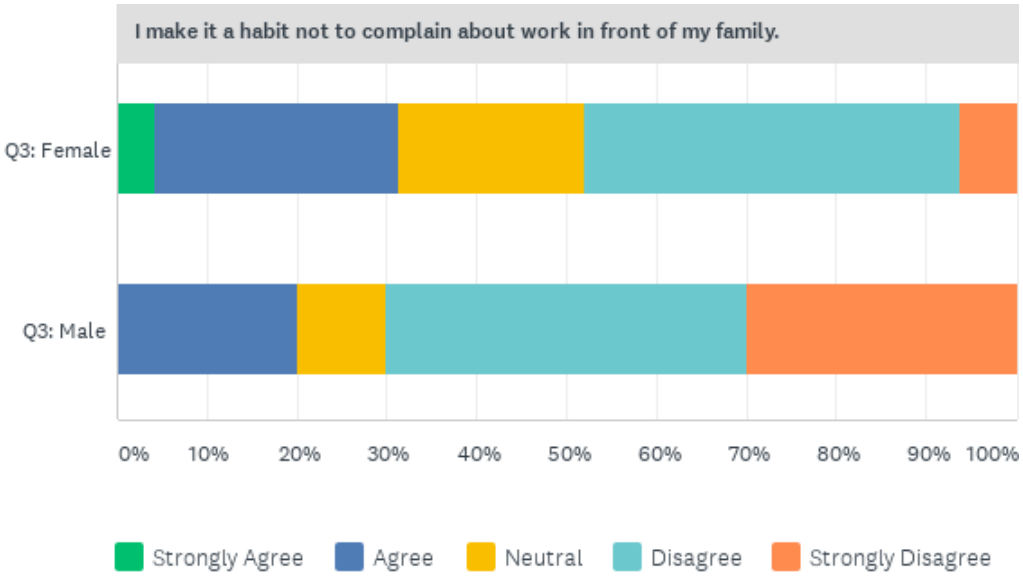
Female Leader- ODS



Male respondents are not neutral when it comes to joining other employees in complaining about their organization. Interestingly, this means males (based on previous data) are more likely to complain independently but remail neutral when others complain. Further, more females do not get involved with other employees complain.

Figure 15

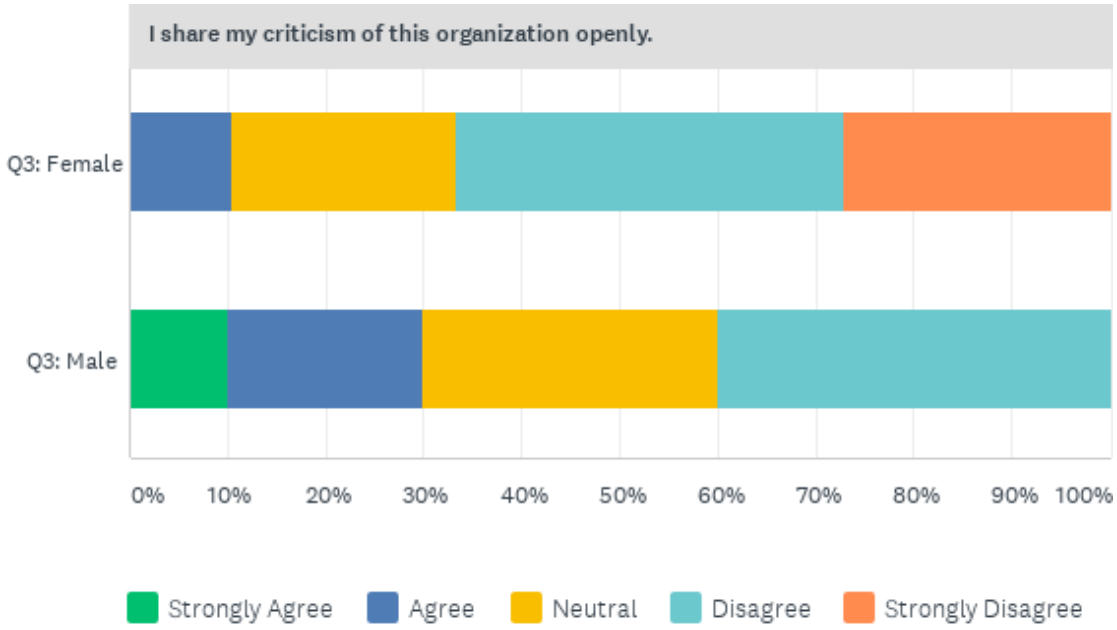
Female Leader- ODS



More male than female respondents disagree or strongly disagree. Interestingly, the data shows that there is a significant more males who strongly disagree and make it a habit not to complain about work in front of their family. On the other hand, more females strongly agree that they make it a habit not to complain about work in front of their families. This further shows, males are more likely than females to bring their work home.

Figure 16

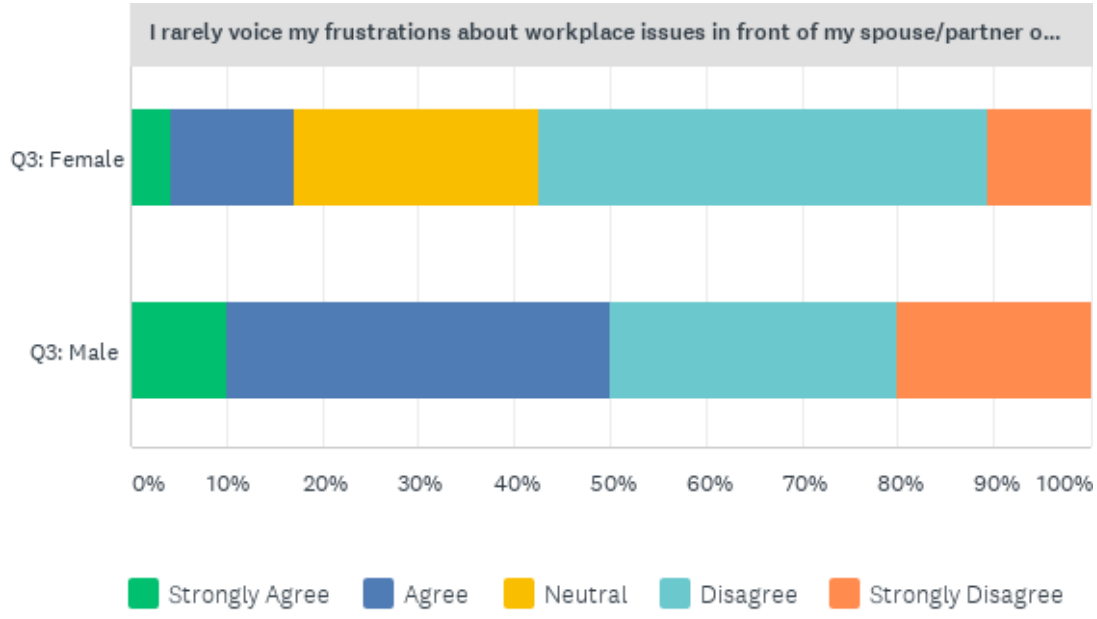
Female Leader- ODS



More females than males do not share criticism of the organization.

Figure 17

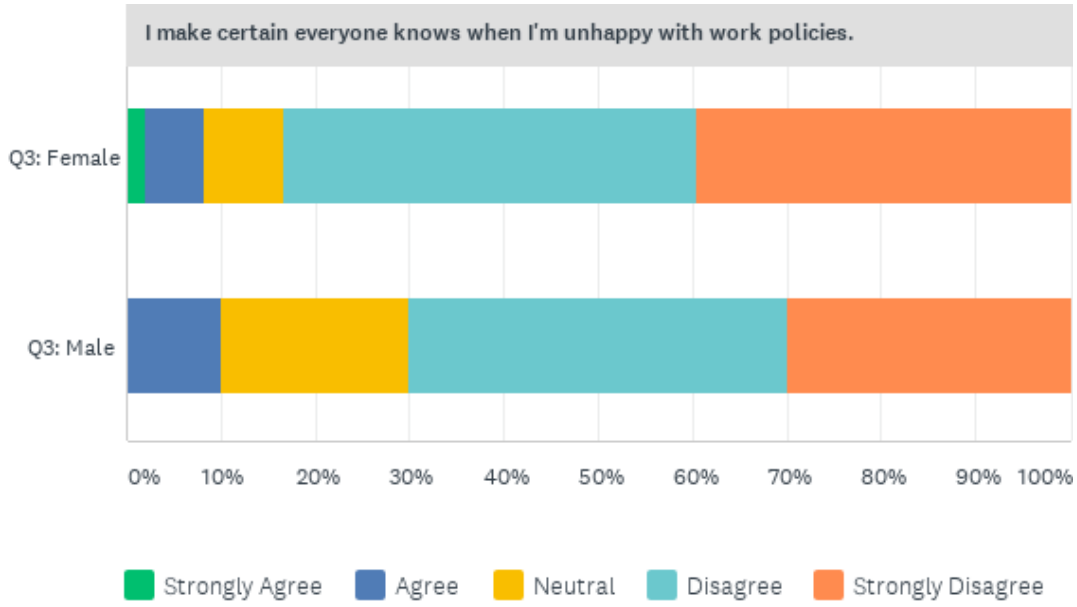
Female Leader- ODS



More male respondents agreed than females when it concerns voicing their frustrations in front of their spouse or partner. This seems to contradict the previous results that show men are more likely than women to bring their work concerns home.

Figure 18

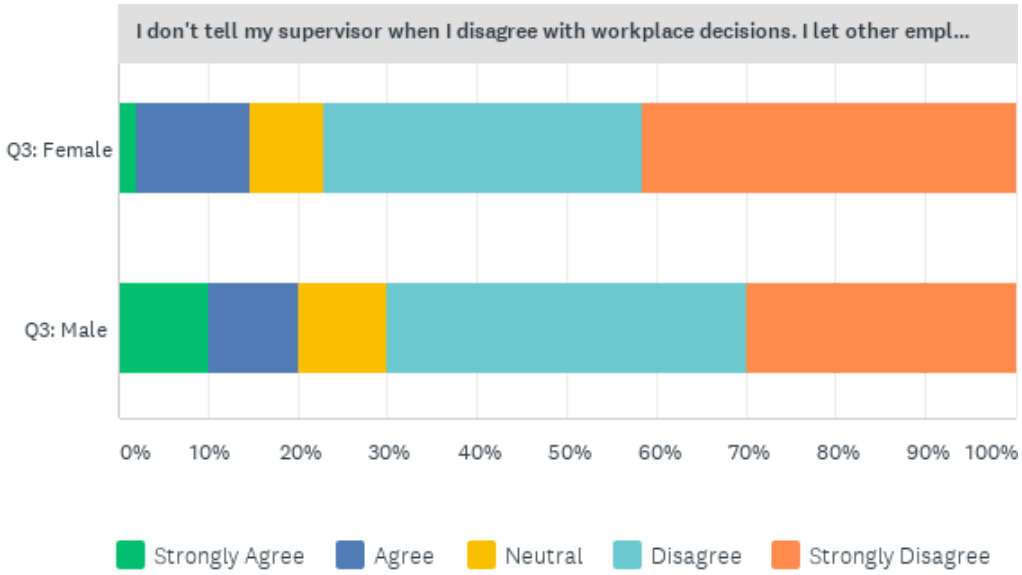
Female Leader- ODS



More females than males make certain everyone know if they are unhappy about work policies. However, the differences are slim and both sexes do not share their unhappiness concerning work policies. Interestingly, both are less likely to share their concerns with “everyone” but are inclined to share their work unhappiness with family (based on previous data).

Figure 19

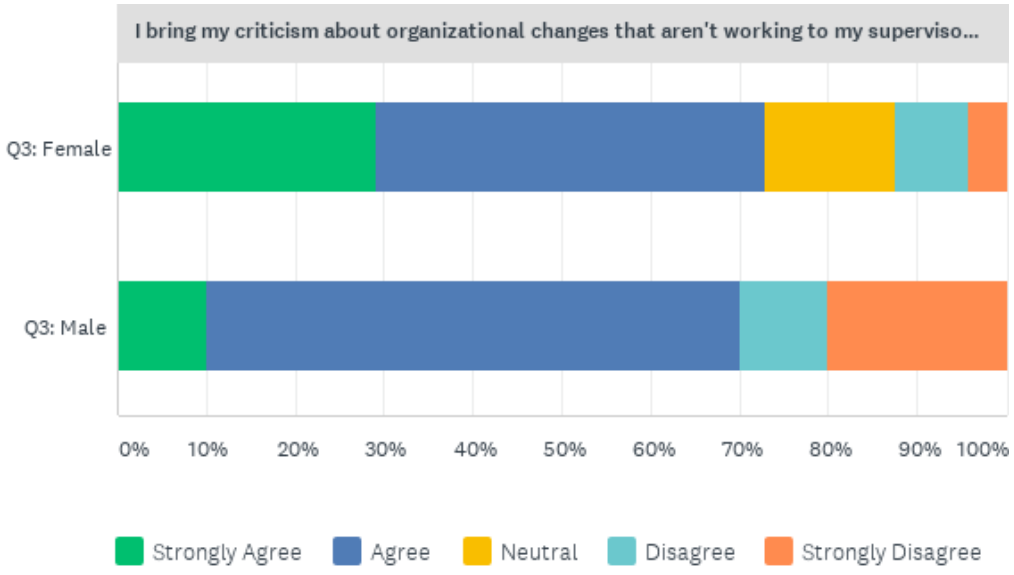
Female Leader- ODS



More female respondents strongly disagree; in other words, they do not tell their female supervisors when they disagree with workplace decisions and allow their coworkers to do it. Other than that, the results seem similar between the sexes.

Figure 20

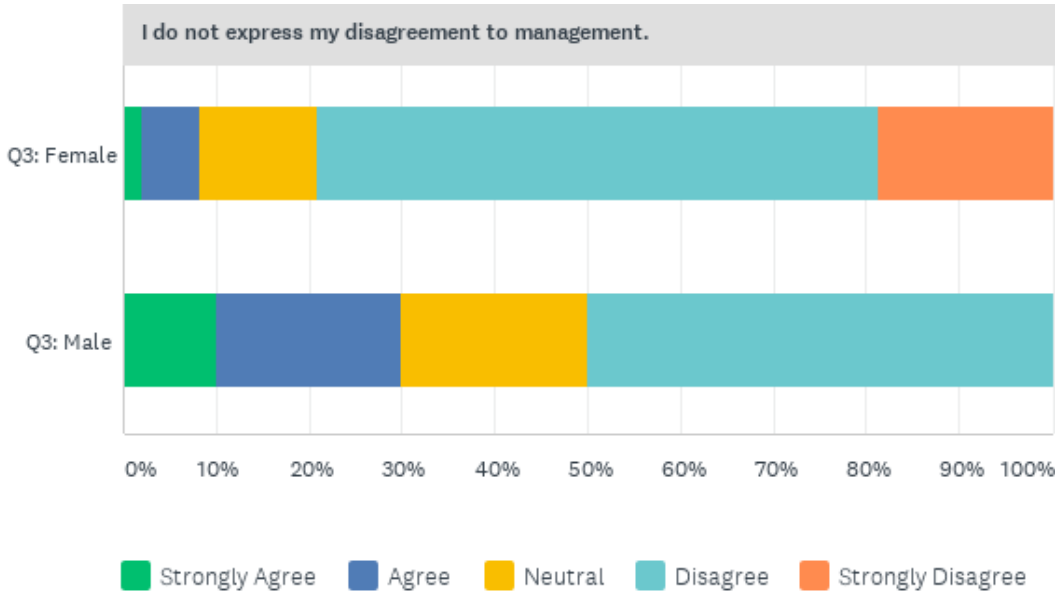
Female Leader- ODS



Many more females than males strongly agree, and more males strongly disagree than females. There is an opposite reaction between males and females. This means that females are more likely to bring their criticisms concerning their organization to their female supervisors.

Figure 21

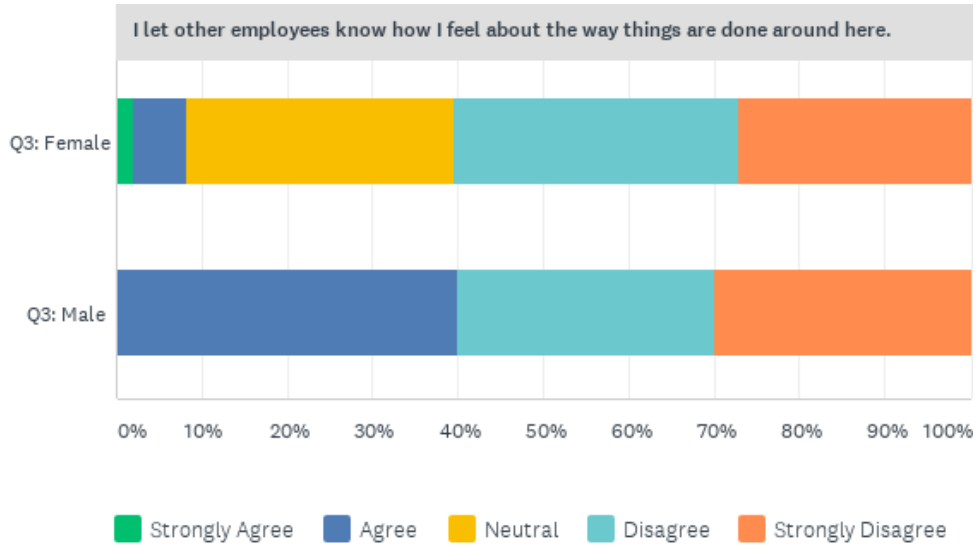
Female Leader- ODS



The disagreed categories are higher in female respondents. In other words, men are less likely to express their disagreement to female management.

Figure 22

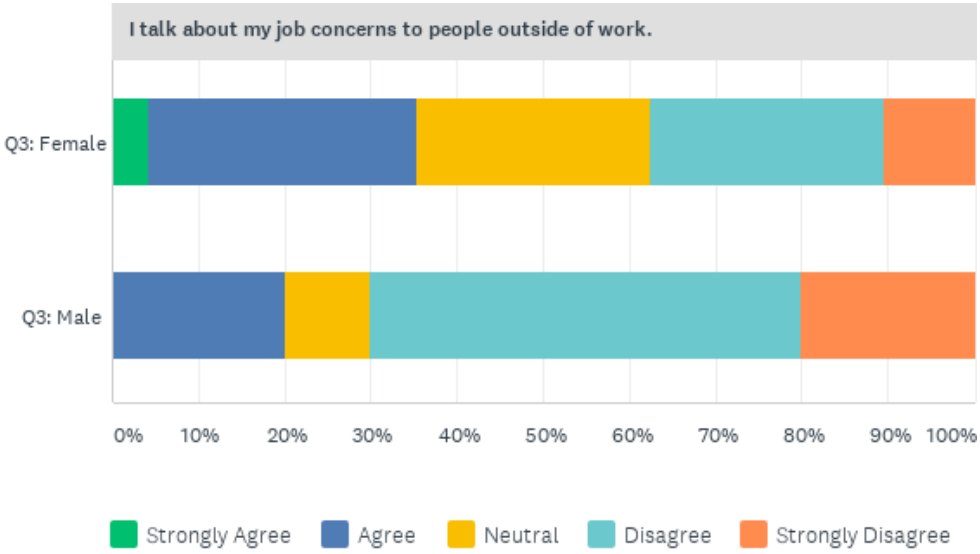
Female Leader- ODS



Males Agree more than females. In other words, men are more likely to let other employees know how they feel about the way things are done. It would be interesting to know if the reaction is the same to positive or negative views and if they are shared equally.

Figure 23

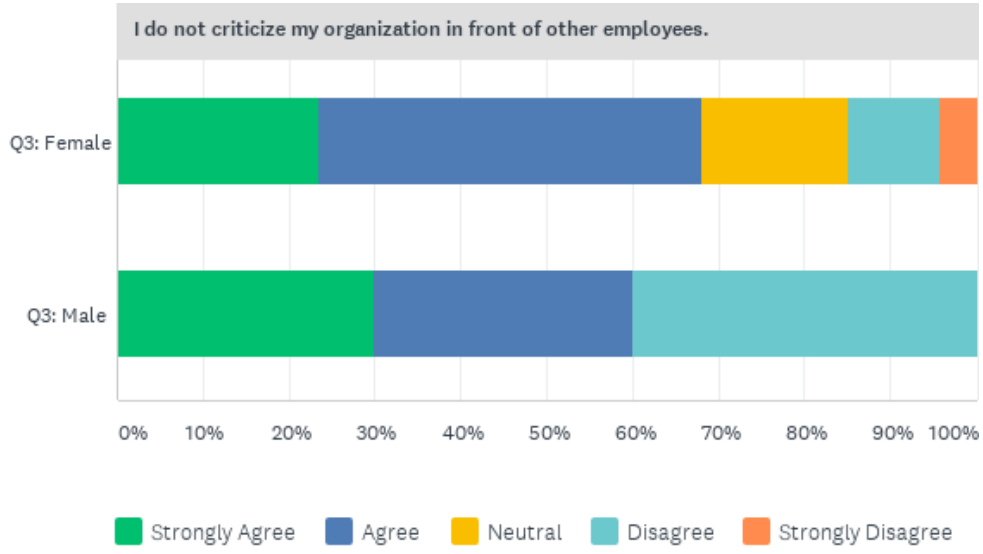
Female Leader- ODS



None of the males strongly agree and most males disagree. In other words, males are more likely to talk about their job concerns to people outside of their work.

Figure 24

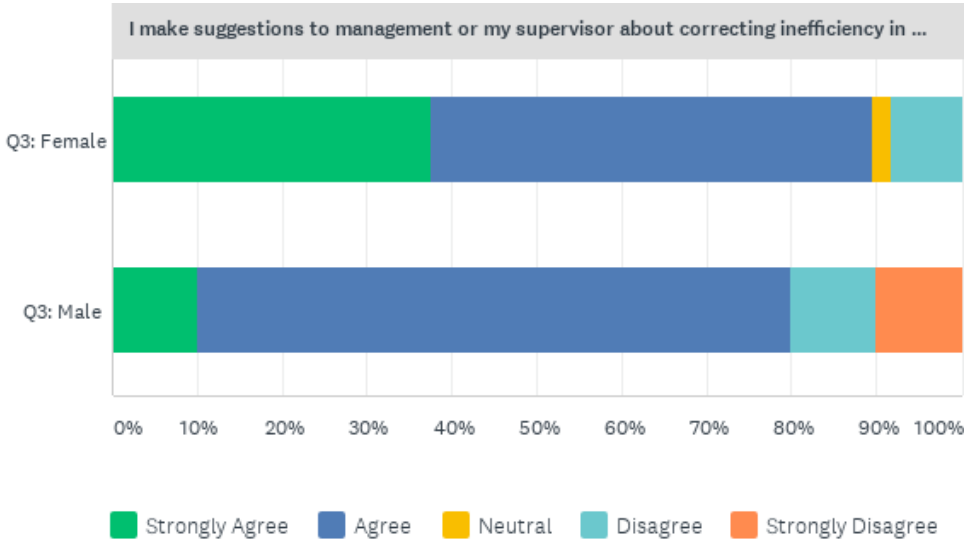
Female Leader- ODS



Males disagree much more than females. In other words, men are more likely to criticize their organization in front of other employees.

Figure 25

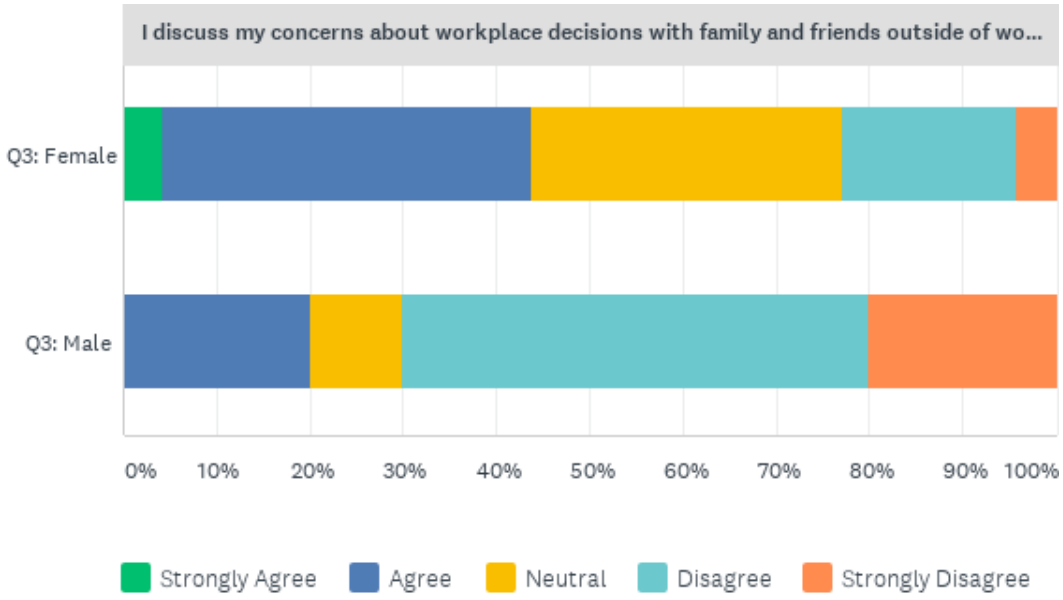
Female Leader- ODS



Females strongly agree much more than males. Based on the results, both males and females feel comfortable to make suggestions to female supervisors about correcting inefficiencies. The difference is females are inclined to strongly agree as compares to males who agree.

Figure 26

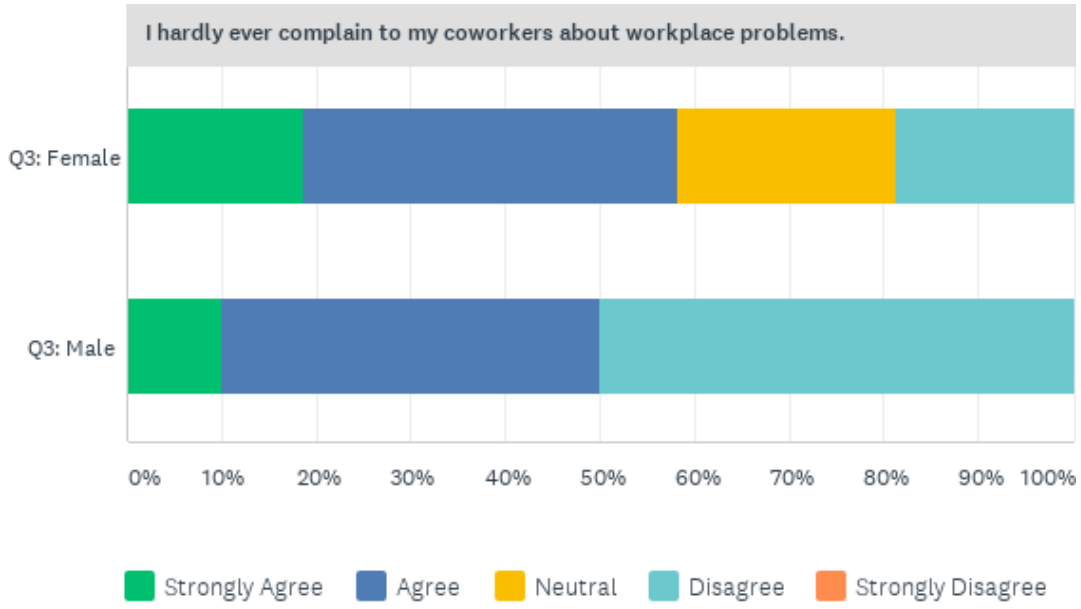
Female Leader- ODS



Males disagree more than females. In other words, females are more likely to discuss their concerns about workplace decisions with family and friends outside of the workplace.

Figure 27

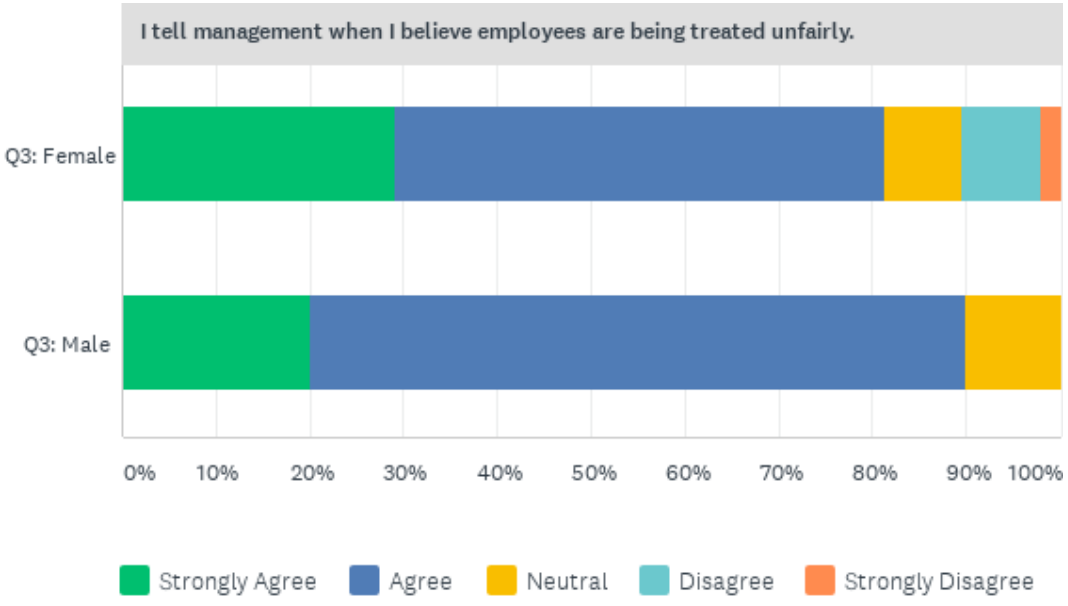
Female Leader- ODS



Female respondents disagree less than males. In other words, males are more inclined to complain about to their coworkers about workplace problems.

Figure 28

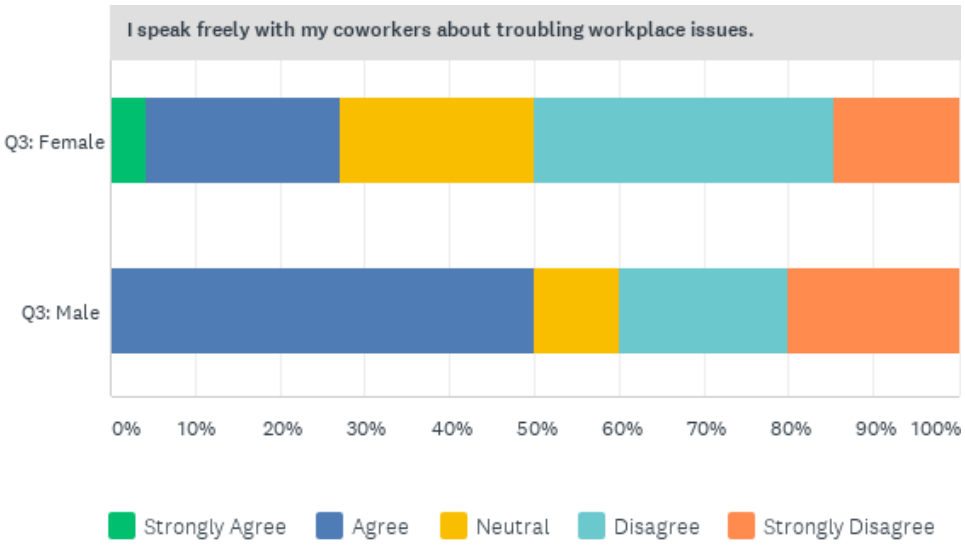
Female Leader- ODS



Most respondents will talk with management about fair treatment. In other words, both males and females are inclined to tell management when they believe an employee is being treated unfairly.

Figure 29

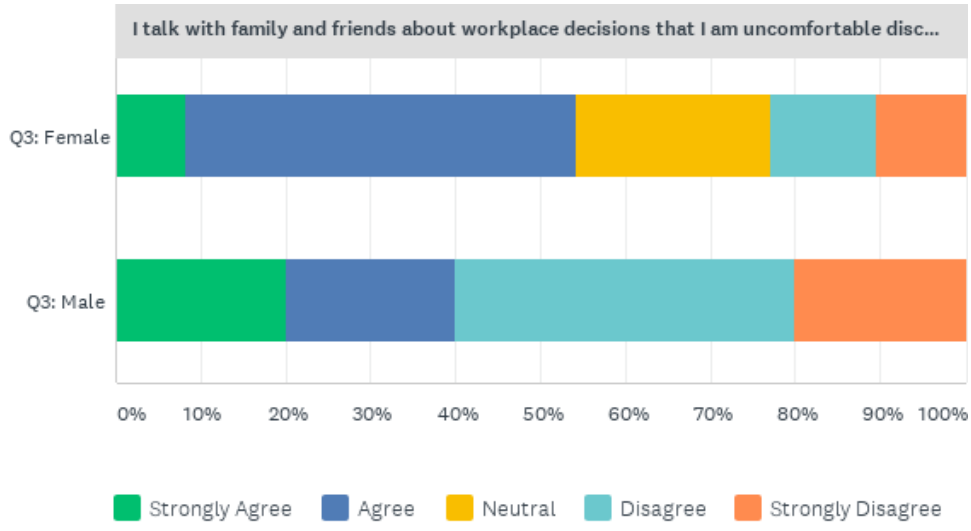
Female Leader- ODS



Male respondents speak more freely about workplace issues with coworkers.

Figure 30

Female Leader- ODS



More female than male respondents talk with friends/family about uncomfortable situations. In other words, males are more likely to express their workplace concerns at work and females are more likely to express their workplace concerns outside of work.

ITS- Male Leader

Q25: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 11.a

Trustworthy – Untrustworthy

Answered: 54 Skipped: 4

Table 27

Question 25

		TOTAL
Q3: Female	100.00% 45	83.33% 45
Q3: Male	100.00% 9	16.67% 9
Total Respondents	54	54

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	5.00	4.96	1.93
Q3: Male	1.00	6.00	5.00	4.22	1.69

Female respondents run the entire range of perceiving their male leaders to be trustworthy. Male respondents were less likely to answer that their male leaders are strongly untrustworthy.

Q26: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 28

Question 26

		TOTAL
Q3: Female	100.00% 45	83.33% 45
Q3: Male	100.00% 9	16.67% 9
Total Respondents	54	54

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	3.00	2.89	1.77
Q3: Male	2.00	6.00	3.00	3.67	1.33

Note: Table 11.b
Distrustful of this person – Trustful of this person
Answered: 54 Skipped: 4

Male respondents did not answer very strongly agree nor strongly disagree about being trustful of the male leader. This may indicate a semantic shift, as trusting another person is not necessarily indicated this way in 2021. It may also indicate an unwillingness to indicate distrust of someone with the minority gender in the field.

Q27: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 29

Question 27

		TOTAL
Q3: Female	100.00% 41	83.67% 41
Q3: Male	100.00% 8	16.33% 8
Total Respondents	49	49

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	5.00	4.76	1.75
Q3: Male	1.00	7.00	5.00	4.50	1.87

Note: Table 11.c
Confidential – Divulging
Answered: 49 Skipped: 9

There is substantively no difference between male and female consideration of their leaders. In comparison to the female leader version of this question. Both males and females felt both leaders range the entire range.

Q28: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 30

Question 28

		TOTAL
Q3: Female	100.00% 43	86.00% 43
Q3: Male	100.00% 7	14.00% 7
Total Respondents	50	50

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.67	1.76
Q3: Male	2.00	7.00	5.00	4.14	1.73

Note: Table 11.d
Exploitative – Benevolent
Answered: 50 Skipped: 8

Female respondents indicated that their male leaders are more exploitative, while male respondents mostly indicated that they believe their male leaders to be neutral or slightly more benevolent. This range outcome is directly opposite of the female version of this question in which females did not answer strongly agree to exploitative of their female leaders. This may be a gender solidarity bias and may also be an indicator of the same gender solidarity bias happening in the male population, as they are the minority gender in healthcare.

Q29: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 31

Question 29

		TOTAL
Q3: Female	100.00% 43	84.31% 43
Q3: Male	100.00% 8	15.69% 8
Total Respondents	51	51

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	5.00	4.88	1.82
Q3: Male	1.00	7.00	5.00	4.63	1.93

Note: Table 11.e
Safe – Dangerous
Answered: 51 Skipped: 7

The answers run the range for both genders, but the median score for both indicates that more respondents felt their male leaders to be dangerous than they felt them to be safe. It is interesting to note that 7 people opted to skip this question, but only 2 people did not have experience with a male leader. In such a small sample, this might be indicative of semantic shift, or perceived threat.

Q30: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 32

Question 30

		TOTAL
Q3: Female	100.00% 45	84.91% 45
Q3: Male	100.00% 8	15.09% 8
Total Respondents	53	53

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.93	1.88
Q3: Male	1.00	7.00	3.00	3.38	1.93

Note: Table 11.f
Deceptive – Candid
Answered: 53 Skipped: 5

Although both genders ran the full range of answers, the females felt their male leaders were slightly more deceptive than did the male respondents. The median is interesting as the female leaders received a median of 5 rather than 2 and 3, indicating that both genders felt their female managers were more candid. Once again, the change in the use of the term candid must be questioned.

Q31: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 33

Question 31

		TOTAL
Q3: Female	100.00% 46	85.19% 46
Q3: Male	100.00% 8	14.81% 8
Total Respondents	54	54

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	6.00	4.89	1.97
Q3: Male	1.00	7.00	5.00	4.63	1.80

Note: Table 11.g
Not Deceitful – Deceitful
Answered: 54 Skipped: 4

Males found their male leaders to be slightly more deceitful than did females. Compared to the female leader version of this question the medians are telling, because the medians of 5 and 6 indicate more deceitful. The female version of this question had a median response of 2 for both genders.

Q32: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 34

Question 32

		TOTAL
Q3: Female	100.00% 44	83.02% 44
Q3: Male	100.00% 9	16.98% 9
Total Respondents	53	53

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	5.50	4.91	1.81
Q3: Male	2.00	7.00	5.00	4.78	1.62

Note: Table 11.h
Inconsiderate – Considerate
Answered: 53 Skipped: 5

Both genders indicated similar response to the male leaders as being mostly considerate. It is interesting that no male wanted to indicate his male leader as completely inconsiderate. Also, there are many more who skipped this question than those who indicated no experience with a male manager. This can again be context for semantic shift, and unclarity of terms.

Q33: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 35

Question 33

		TOTAL
Q3: Female	100.00% 47	85.45% 47
Q3: Male	100.00% 8	14.55% 8
Total Respondents	55	55

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.91	1.89
Q3: Male	1.00	6.00	2.00	2.75	1.64

Note: Table 11.i
Honest – Dishonest
Answered: 55 Skipped: 3

Both male and female respondents indicated that their male leaders were mostly honest. Interestingly, no male respondents wanted to indicate that their male leaders were entirely dishonest. Dishonesty may have a connotation of “fraudulent” which can mean very dire personal and professional outcomes in the healthcare industry. Again, another case of semantic shift, but this time it may be industry specific.

Q34: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 36

Question 34

		TOTAL
Q3: Female	100.00% 46	83.64% 46
Q3: Male	100.00% 9	16.36% 9
Total Respondents	55	55

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	6.00	5.28	1.77
Q3: Male	2.00	6.00	5.00	4.44	1.42

Note: Table 11.j
Unreliable – Reliable
Answered: 55 Skipped: 3

Male respondents were more neutral about their male leaders being reliable. While females had a larger range of answers, they mostly agreed with the males that the male leader is reliable. Substantively these numbers are the same for both genders of leaders.

Q35: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 37

Question 35

		TOTAL
Q3: Female	100.00% 45	83.33% 45
Q3: Male	100.00% 9	16.67% 9
Total Respondents	54	54

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.82	1.74
Q3: Male	1.00	6.00	2.00	2.89	1.52

Note: Table 11.k
Faithful – Unfaithful
Answered: 54 Skipped: 4

Both male and female respondents indicated that their leaders were mostly faithful. This is another question of semantics as faithful had a different meaning decades ago. It is also hard to identify to what principle or person the leader is faithful with the terms used here.

Q36: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 38

Question 36

		TOTAL
Q3: Female	100.00% 43	84.31% 43
Q3: Male	100.00% 8	15.69% 8
Total Respondents	51	51

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	6.00	5.19	1.73
Q3: Male	1.00	6.00	5.50	4.50	1.80

Note: Table 11.l
Insincere – Sincere
Answered: 51 Skipped: 7

Seven individuals skipped this question, and only 2 did not have experience with male leaders. This can indicate semantic shift or bias. Interestingly no male wanted to say his male leader was completely sincere.

Q37: Please indicate your reaction to a male leader in healthcare with whom you are familiar.

Table 39

Question 37

		TOTAL
Q3: Female	100.00% 43	84.31% 43
Q3: Male	100.00% 8	15.69% 8
Total Respondents	51	51

BASIC STATISTICS	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Q3: Female	1.00	7.00	2.00	2.58	1.53
Q3: Male	1.00	5.00	2.50	2.88	1.36

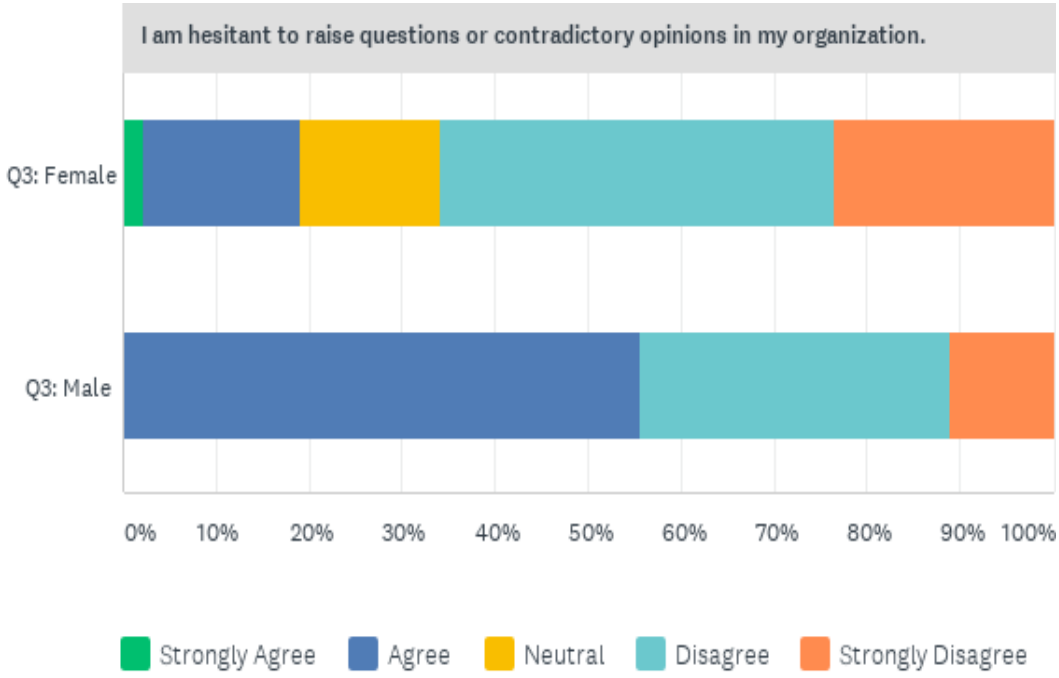
Note: Table 11 .m
Careful – Careless
Answered: 51 Skipped: 7

In a literal life and death environment, with tremendous scrutiny, it makes sense that both males and females would indicate their leaders are careful. It is interesting that the maximum for males was 5 when the maximum for females was 7. Females did have strong opinions about their male leaders being careless, but no male was willing to go that far. This may indicate gender identity bias for male respondents as the minority in the industry.

Q38: Instructions: This is a series of statements about how people express their concerns about work leaders. There are no right or wrong answers. Some of the items may sound similar, but they pertain to slightly different issues. Please respond to all items. Considering how you express your concerns about a male leader/manager with whom you are familiar in a healthcare setting, indicate your degree of agreement with each statement by selecting the level of agreement or disagreement you have with each statement.

Figure 31

ODS- Male Leader

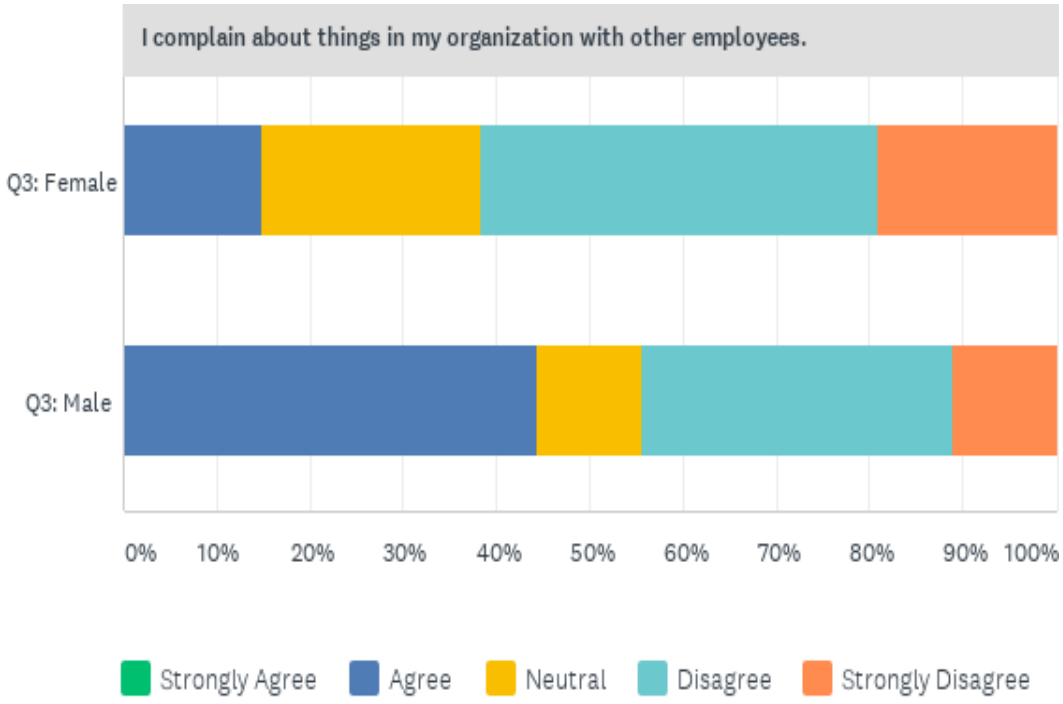


Note: Answered: 56 Skipped: 2
Table 12.a

Males are more hesitant to raise questions or contradictory opinions to male leaders. On the other hand, females are significantly less hesitant to raise questions or contradictory opinions about to their organization to male leaders.

Figure 32

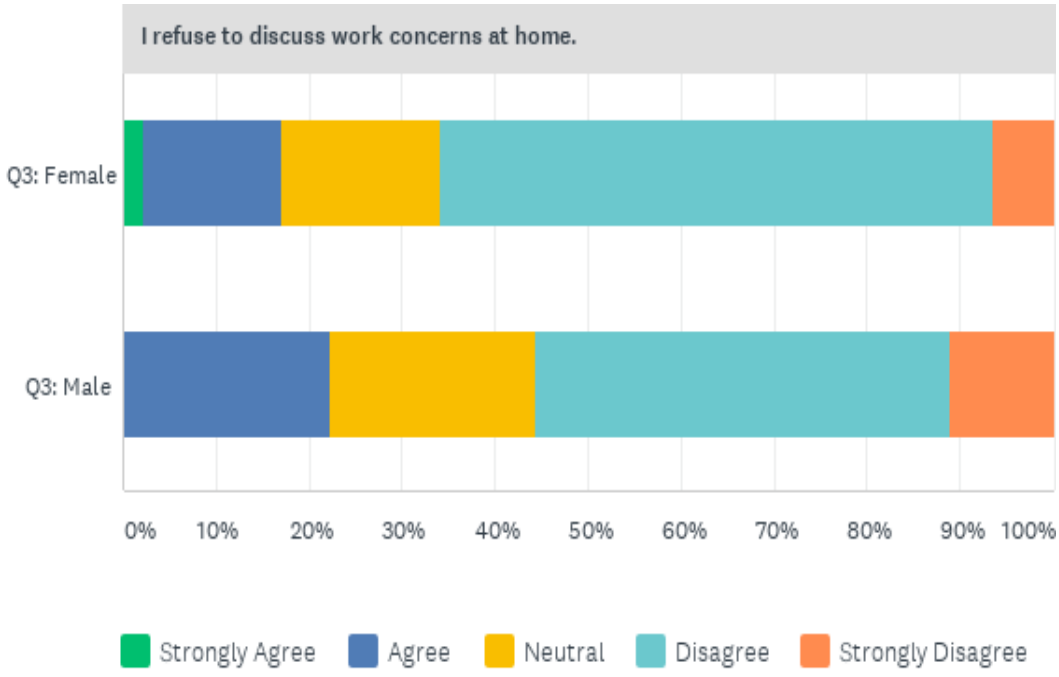
ODS- Male Leader



There is little difference between male and female responses as it relates to their complaining about their organization when their leader is with male or female. In other words, the sex of their leader has no influence on their behavior.

Figure 33

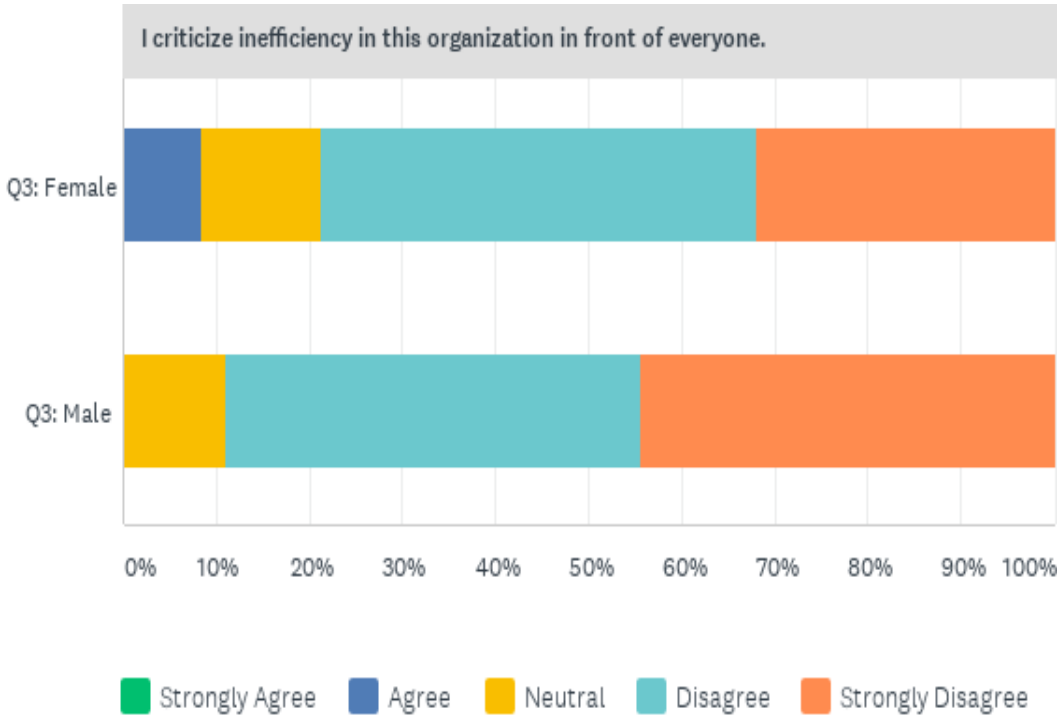
ODS- Male Leader



There is little difference between male and female responses as it relates to their bringing their work concerns home. In other words, the sex of their leader has no influence on their behavior.

Figure 34

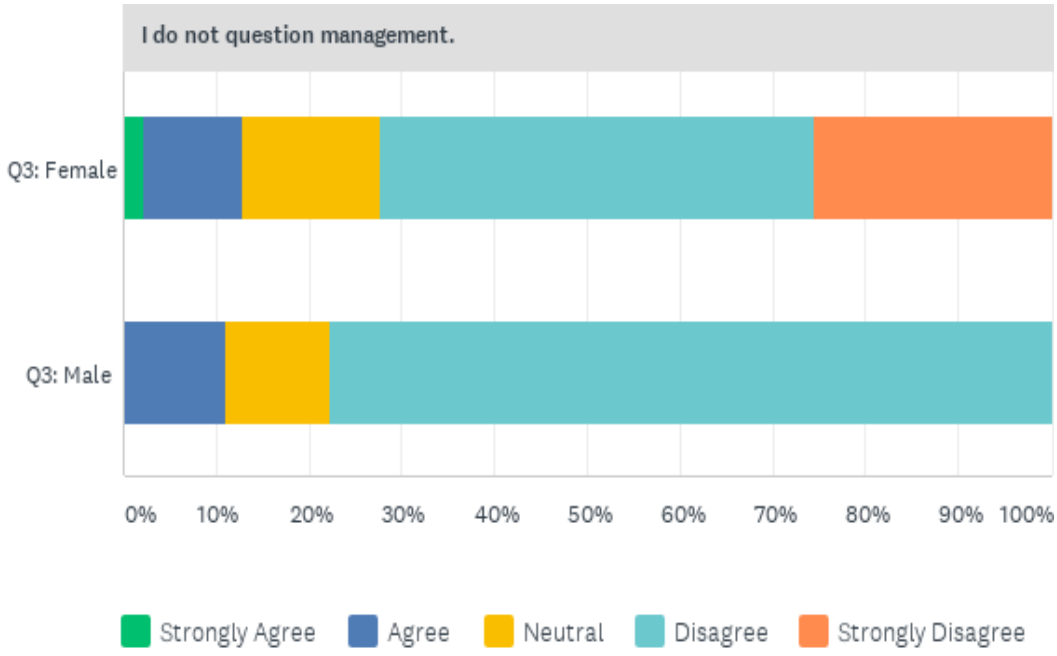
ODS- Male Leader



There is significantly less criticizing from both males and females when the leader is a male. This is a remarkably interesting finding.

Figure 35

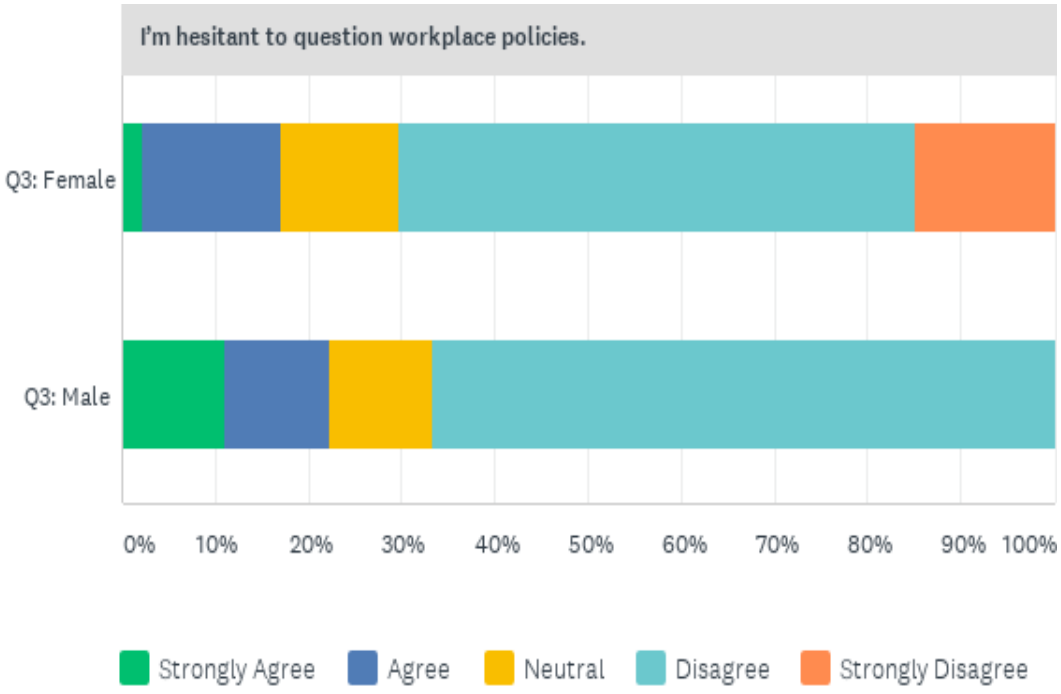
ODS- Male Leader



Under a male leader, men primarily are willing to question management, but the range of answers indicate no strong feeling either way. Women did indicate much stronger emotions of strongly agree and strongly disagree. This may be a strictly a healthcare concern, considering the statistical relevance of the female-to-female trust scale. This may be evidence of covert behavior or social identity bias.

Figure 36

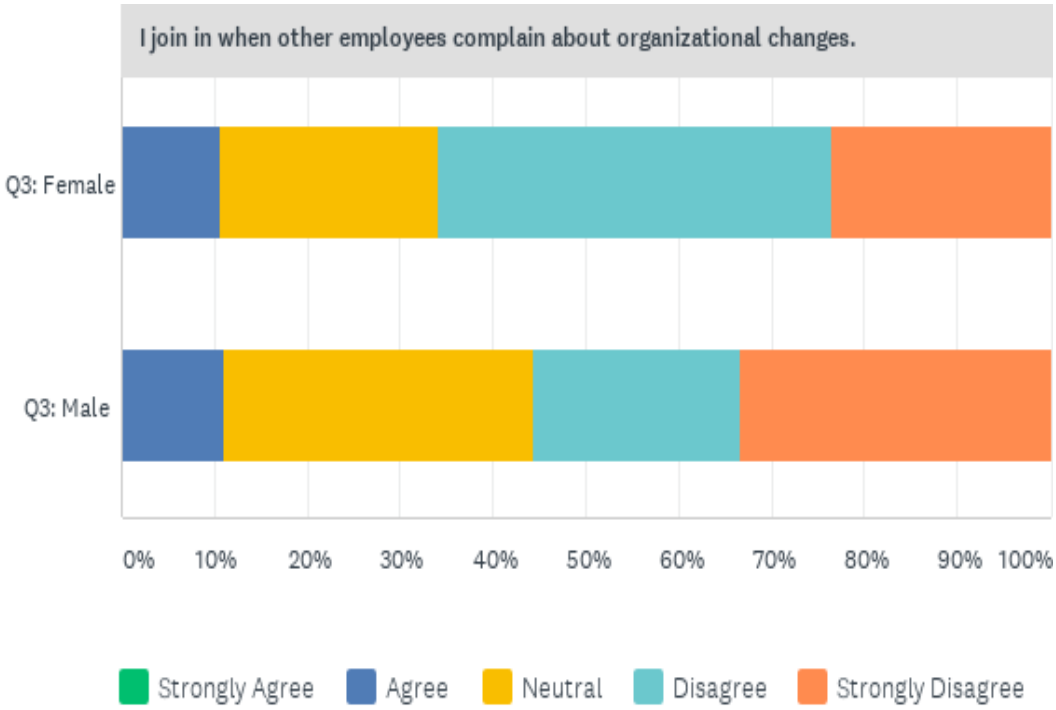
ODS- Male Leader



Under a male leader, more men were more strongly hesitant to question workplace policies. Overall, both genders indicated they were comfortable questioning workplace policies. This may be a good indicator of articulated dissent, or negative social capitol use in the network.

Figure 37

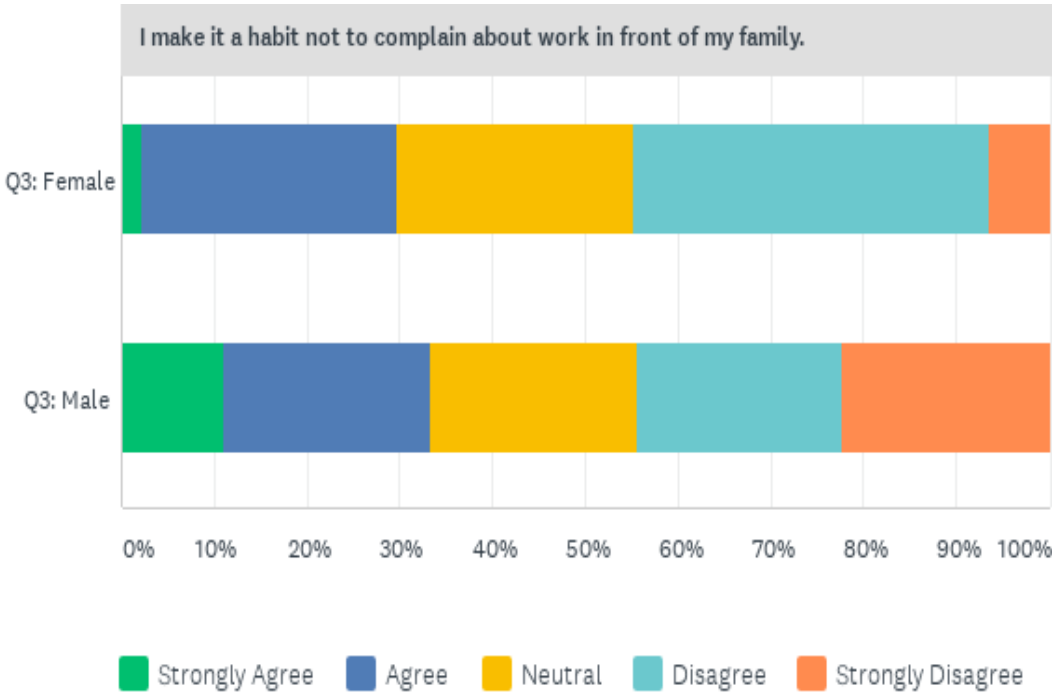
ODS- Male Leader



Under a male leader, male and female responses were 90% neutral or disagree or strongly disagree about joining in when others complain. This may also be indicative of dissent suppression.

Figure 38

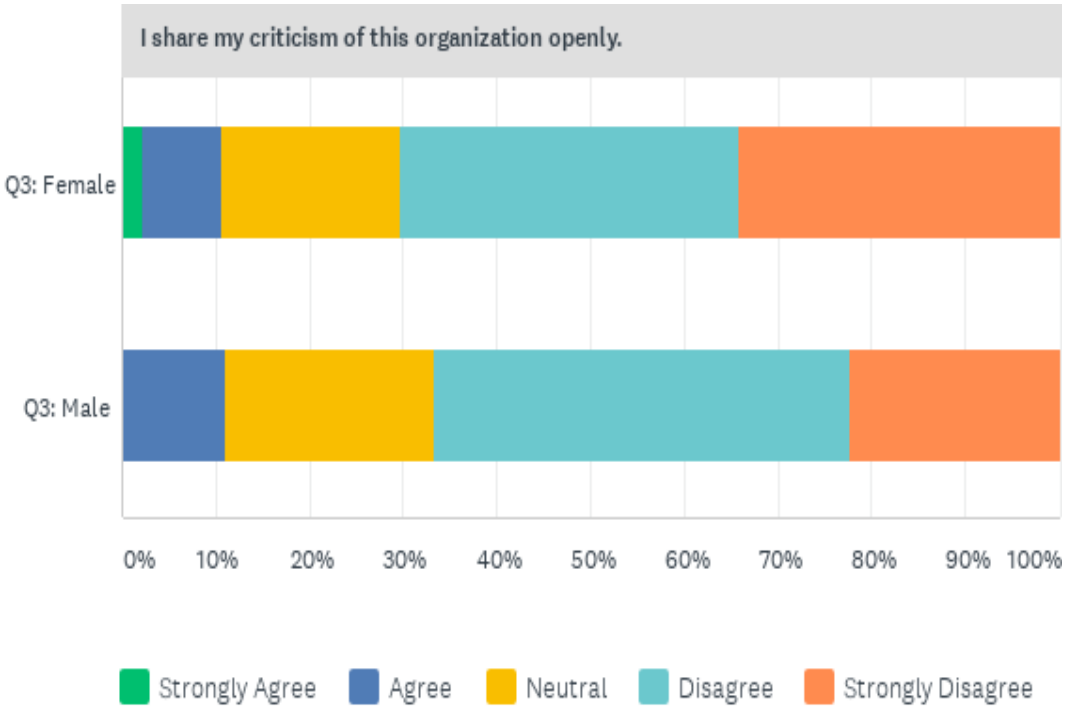
ODS- Male Leader



Under a male leader, men feel much more strongly either way about complain about work in front of family. This should be compared with table 12.j. The bands a very even.

Figure 39

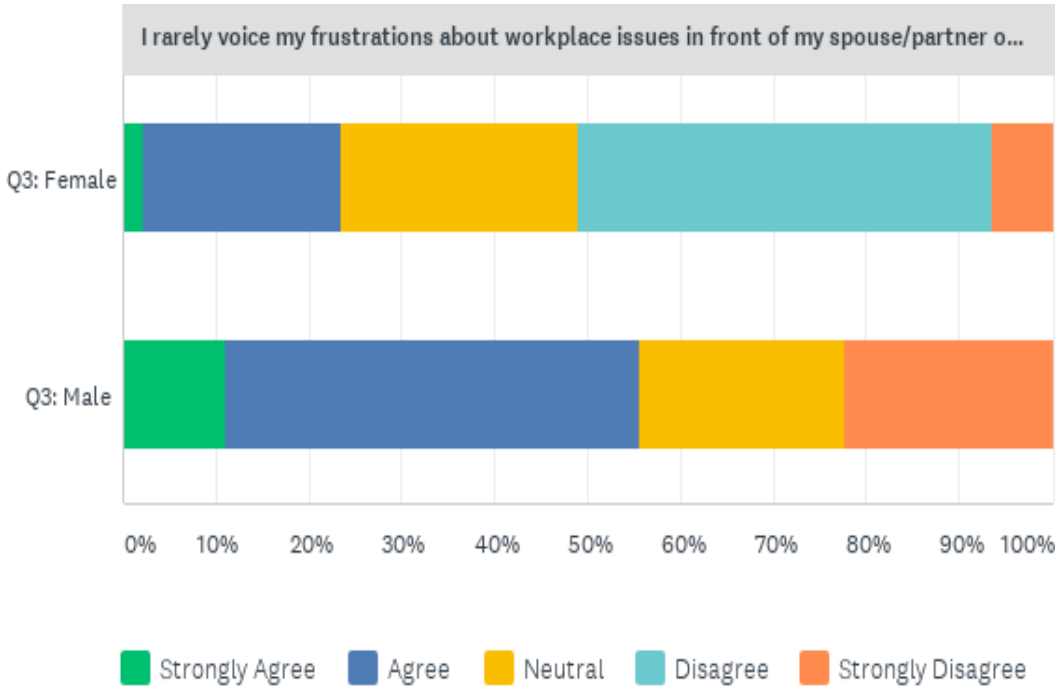
ODS- Male Leader



Under a male leader both men and women were either neutral or disagreed with sharing criticism of their organizations. This may indicate culture of decent repression in Healthcare and should be compared to the female leader version of this question.

Figure 40

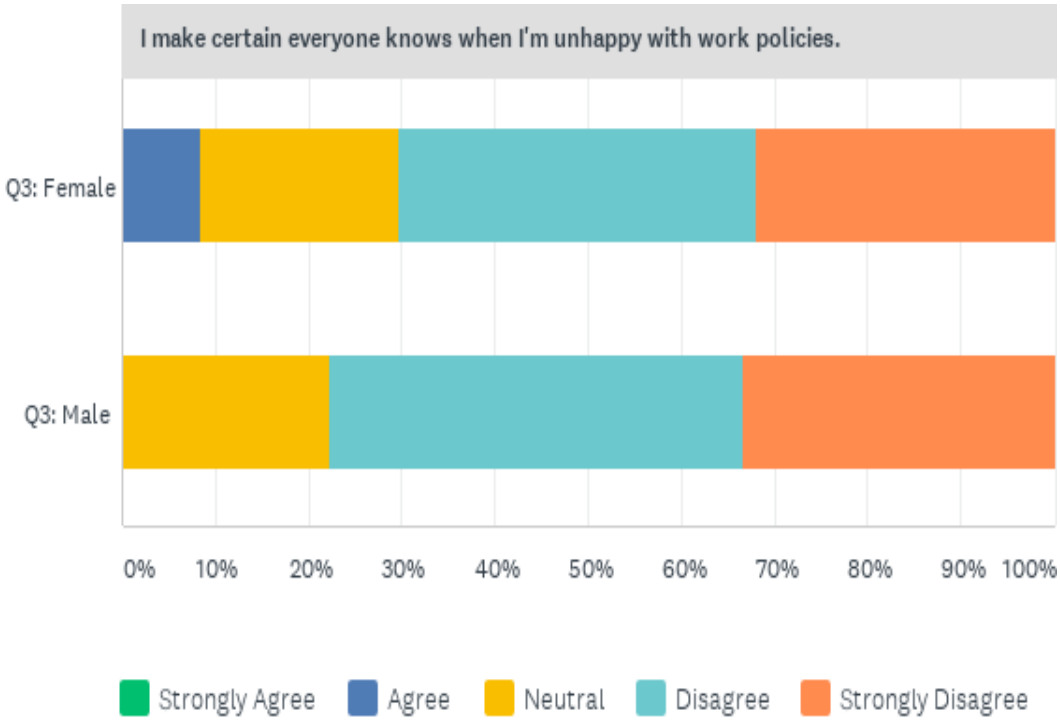
ODS- Male Leader



Under a male manager, men either strongly disagreed or agreed, but no "disagree" answers were given about "rarely voicing my frustration to my spouse/partner". Women answered ran the full range, with most disagreeing, or strongly disagreeing (approximately 45% and 8%, respectively). This indicates that women are much more likely to express frustration in a displaced way, with a male manager.

Figure 41

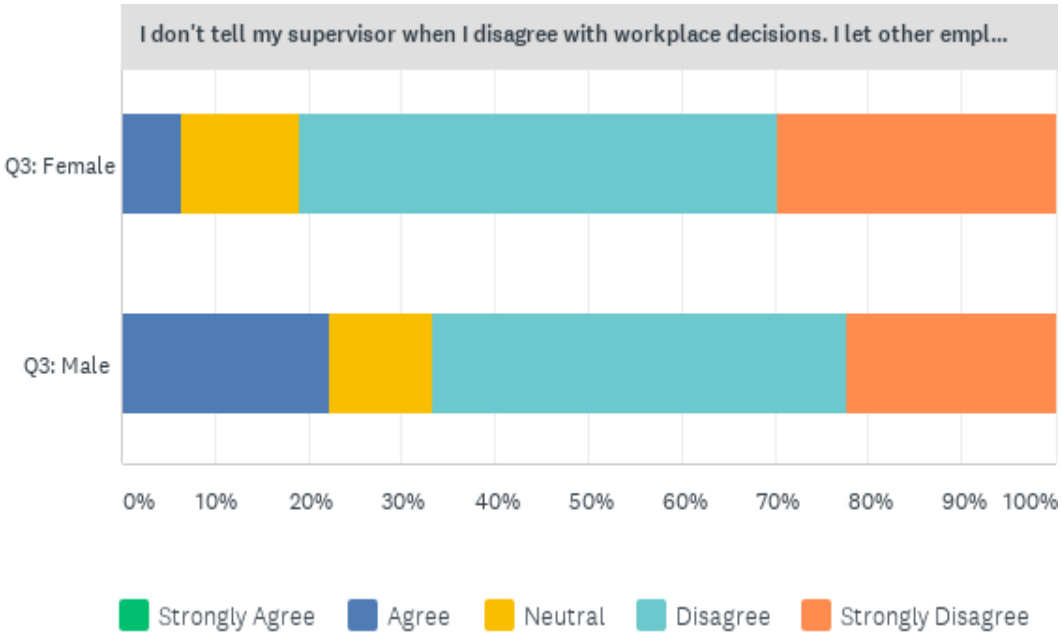
ODS- Male Leader



Under a male manager, neither male nor female respondents answered with strongly agree to making sure everyone knows about their displeasure. No male respondents agreed with this at all and less than 10% of women responded with agree. This might indicate a small tendency to displaced dissent among women.

Figure 42

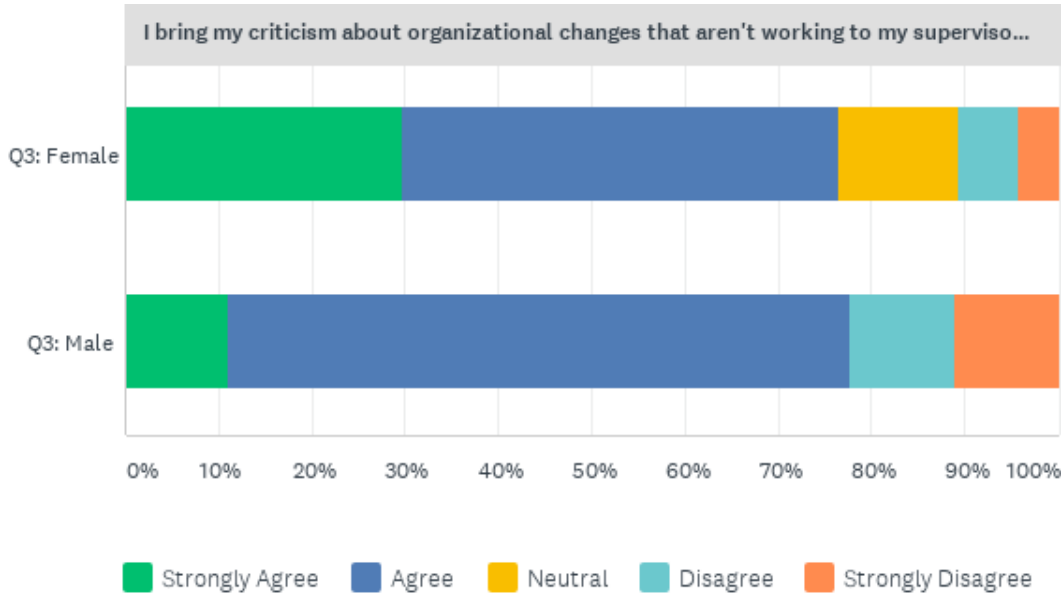
ODS- Male Leader



Under a male manager, women tended to answer more negatively when asked whether they "don't tell supervisors when I disagree". Neither male nor female respondents answered strongly agree, but more than 20% of men responded that they agreed, and therefore do not tell their supervisors when they disagree with workplace decisions.

Figure 43

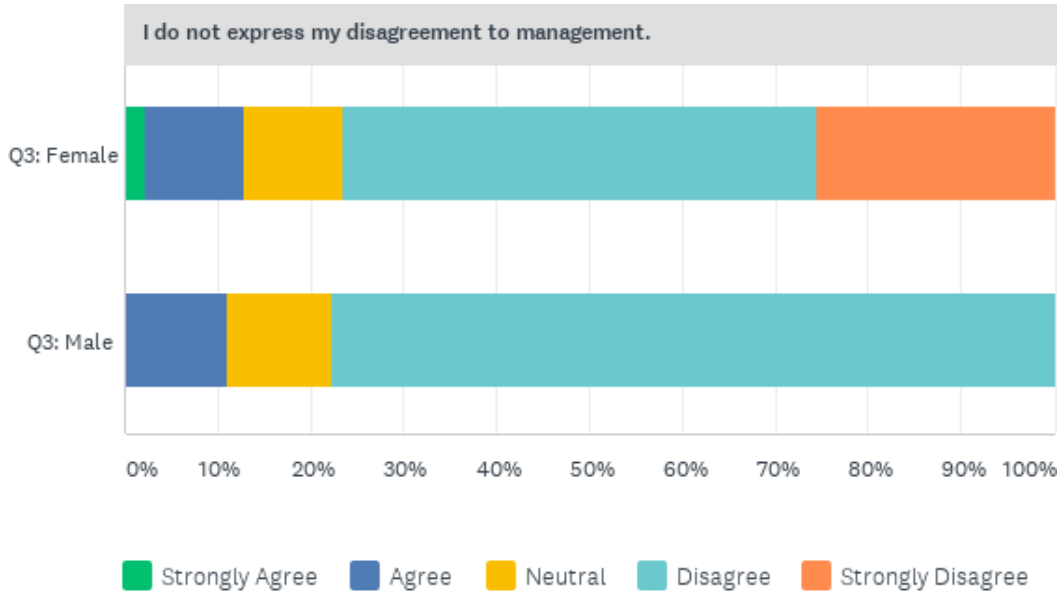
ODS- Male Leader



Male respondents were much more likely to bring their concerns to a manager than their female counterparts, with a male leader. Tying this with the trust scales of the male leaders, there is a disconnect between showing that there is trust in the male leaders, that they are careful and generally not deceitful, but not being comfortable approaching them.

Figure 44

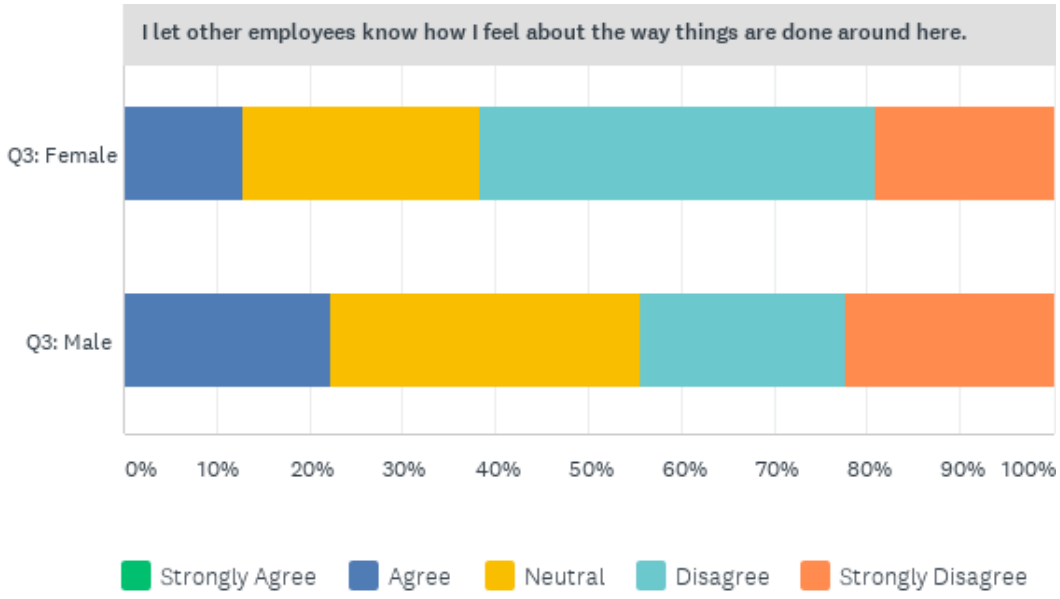
ODS- Male Leader



Under a male manager almost 90% of men indicated a negative or neutral answer to not "expressing disagreement to management". This indicates that men are likely to report disagreement to, at least, male leaders. This can be contrasted with the table representing this question with a female manager.

Figure 45

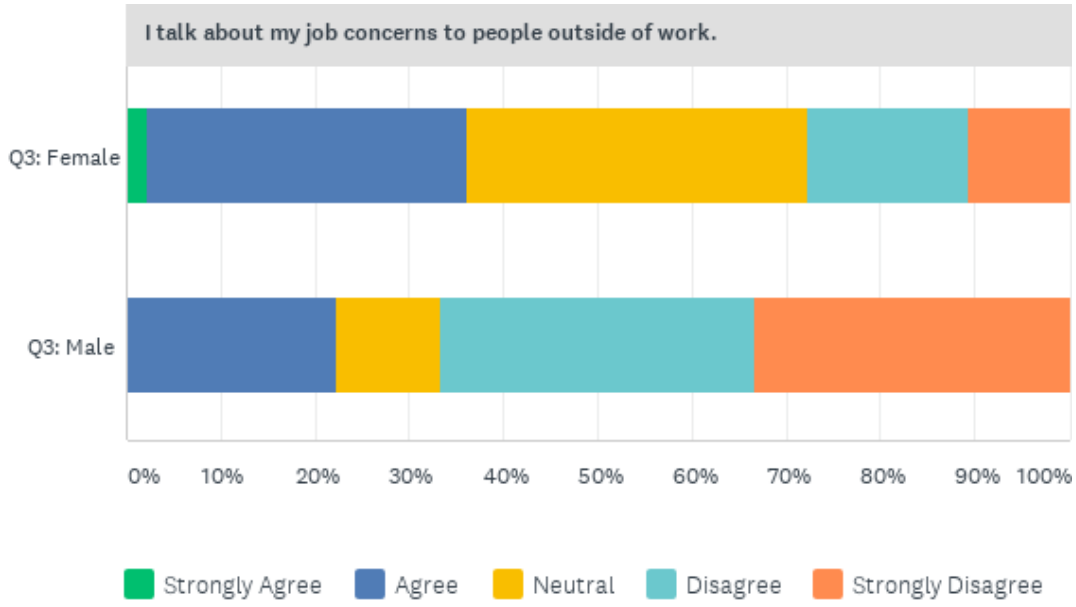
ODS- Male Leader



Under a male manager, neither gender felt very strongly positive about letting other employees know how they felt about the way work proceeds. Men tended to be more positive (agree) or neutral than women.

Figure 46

ODS- Male Leader

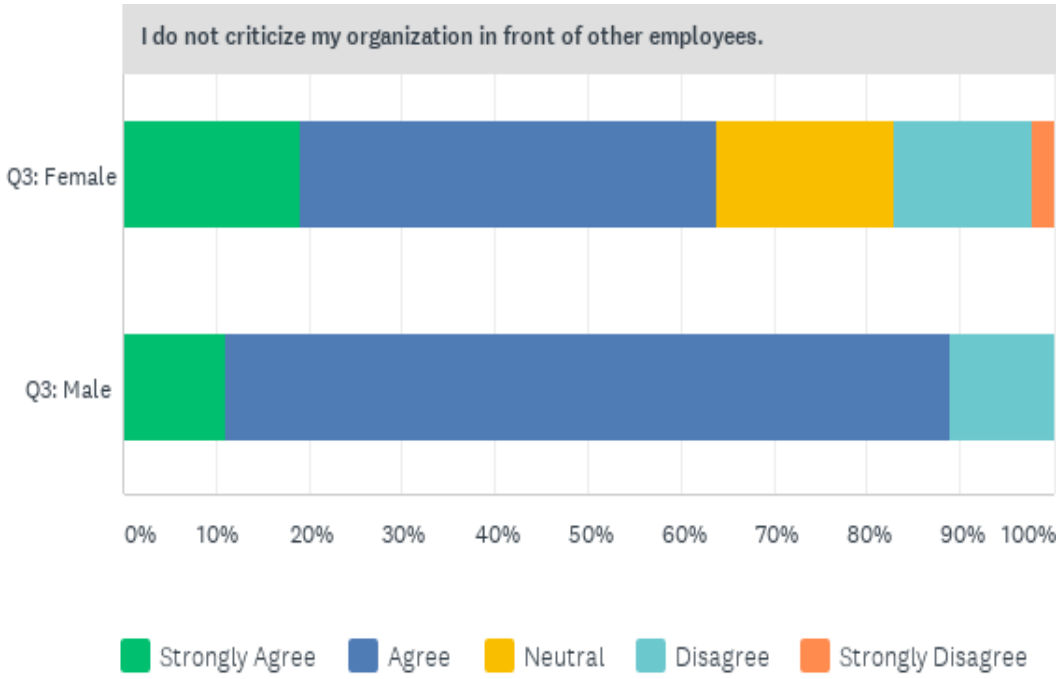


Under a male leader, men primarily do not speak to people outside of work, this can be contrast to table 12.t and table 12.q. However, there is little difference between male and female responses as it relates to talking about their job concerns to people outside of work. In other words, the sex of their leader has no influence on their behavior.

This suggests that men are more likely to discuss work problems with friends and not family outside of work. See table 12.t. Women were roughly spread across the spectrum. However, there is little difference between male and female responses as it relates to talking about their job concerns to people outside of work. In other words, the sex of their leader has no influence on their behavior.

Figure 47

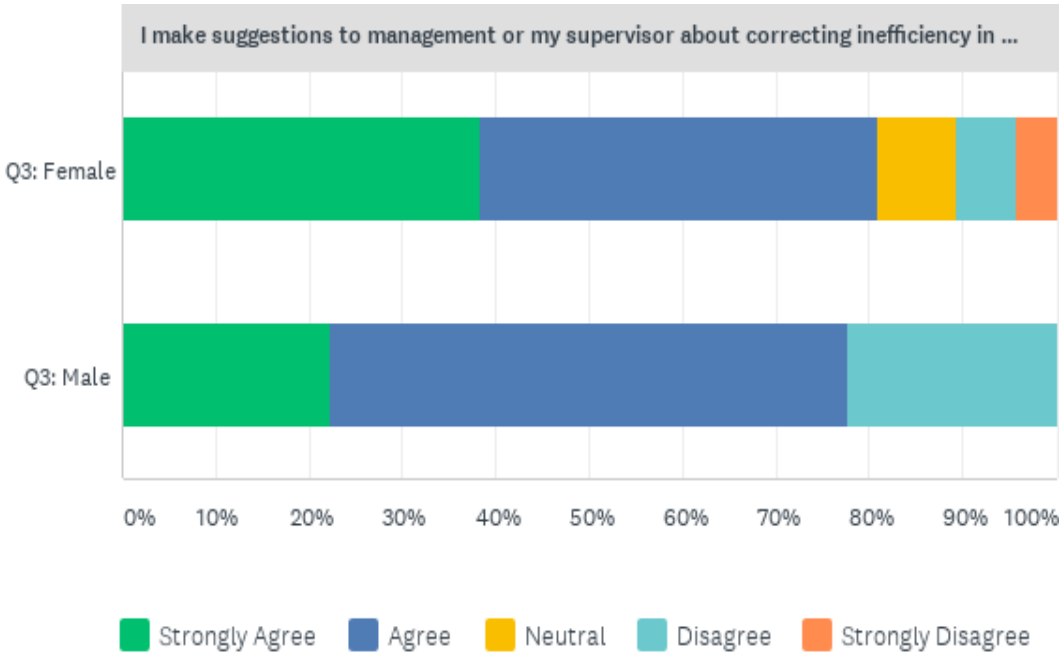
ODS- Male Leader



Under a male manager, responding to criticizing the organization, men answered almost 80% agree or strongly agree with no neutrals and the remainder disagree. Women mostly agreed but ran the entire range.

Figure 48

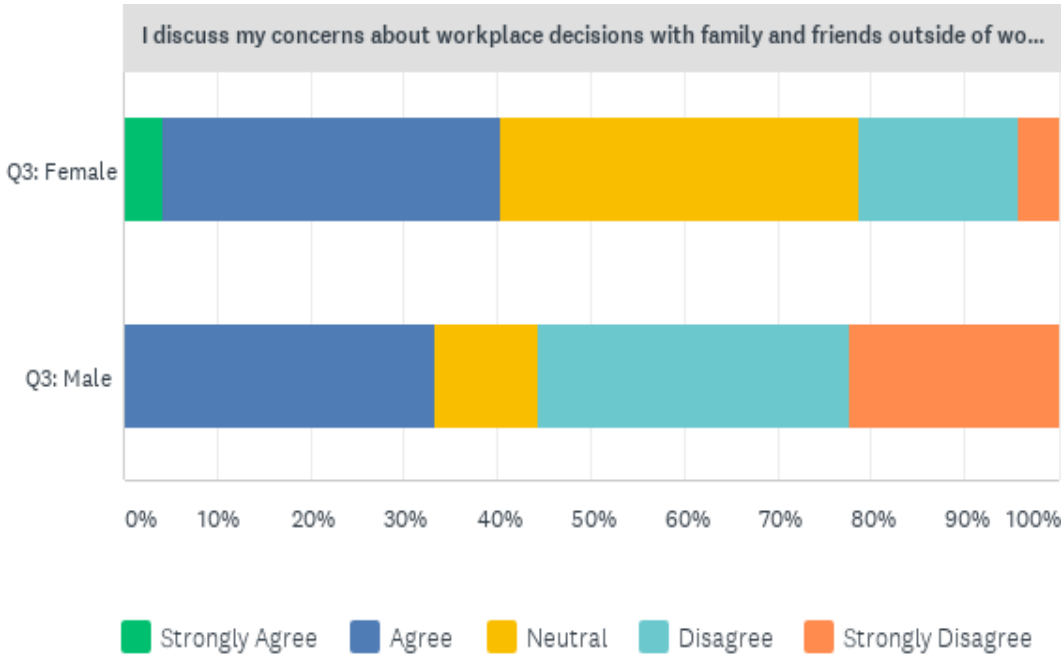
ODS- Male Leader



Under a male manager, responding to making suggestions about workplace efficiency, men answered almost 80% agree or strongly agree with no neutrals and the remainder disagree. Women mostly agreed but ran the entire range.

Figure 49

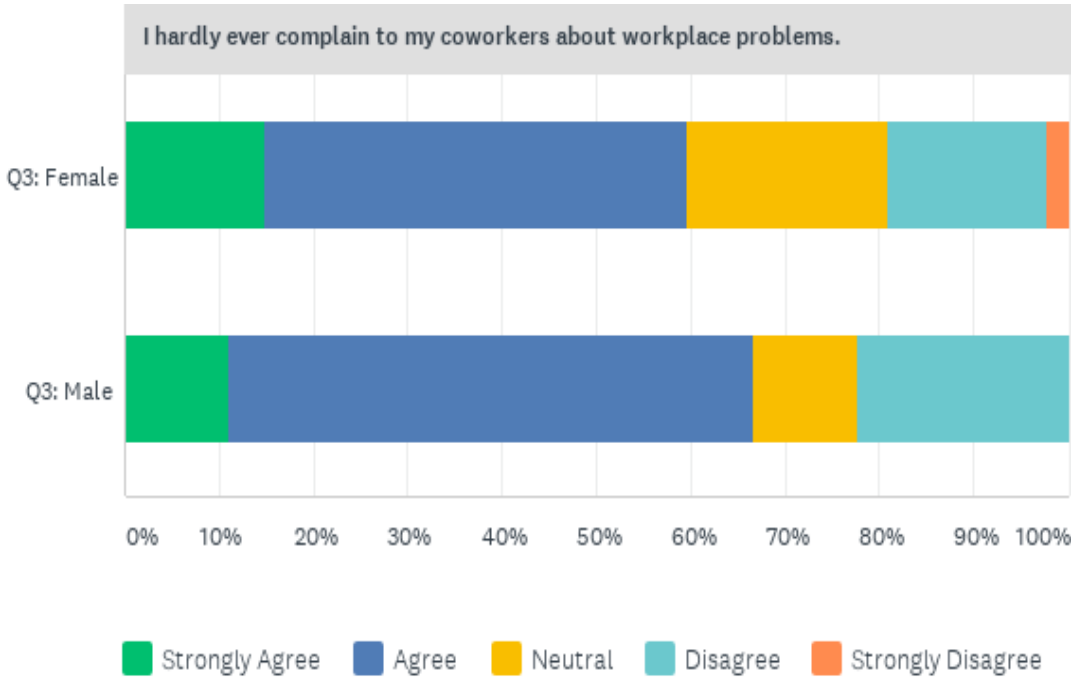
ODS- Male Leader



Under a male leader, discussing workplace decisions with family and friends outside of work, more men disagreed or strongly disagreed while women mostly remained positive or neutral.

Figure 50

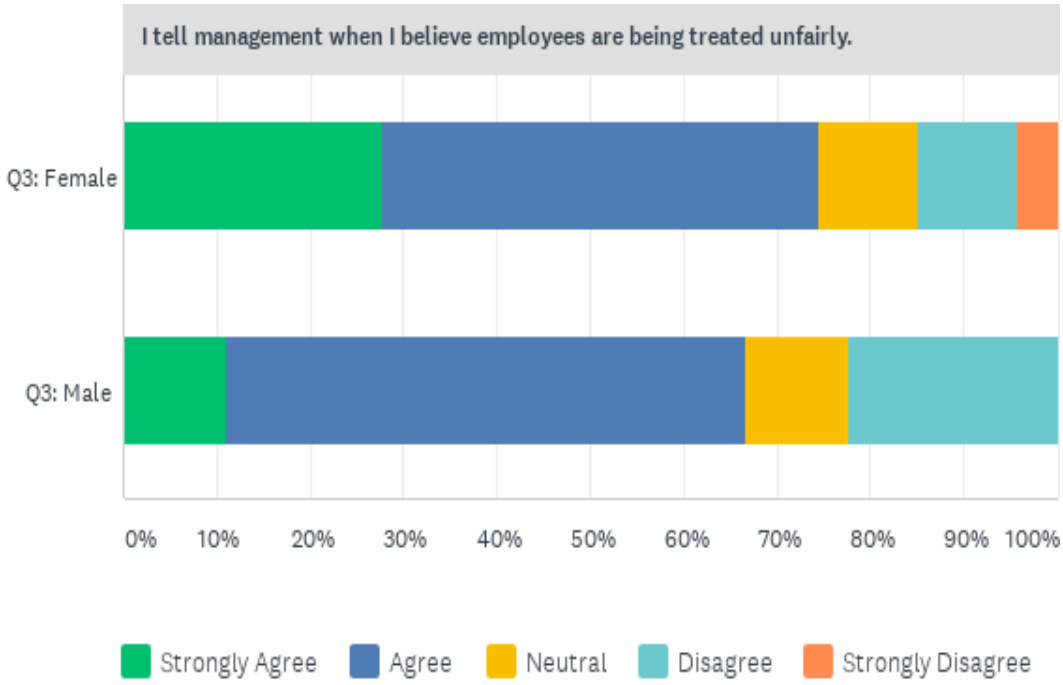
ODS- Male Leader



Under a male leader men and women had approximately the same response in venting to other employees. No men indicated strong disagreement with the statement.

Figure 51

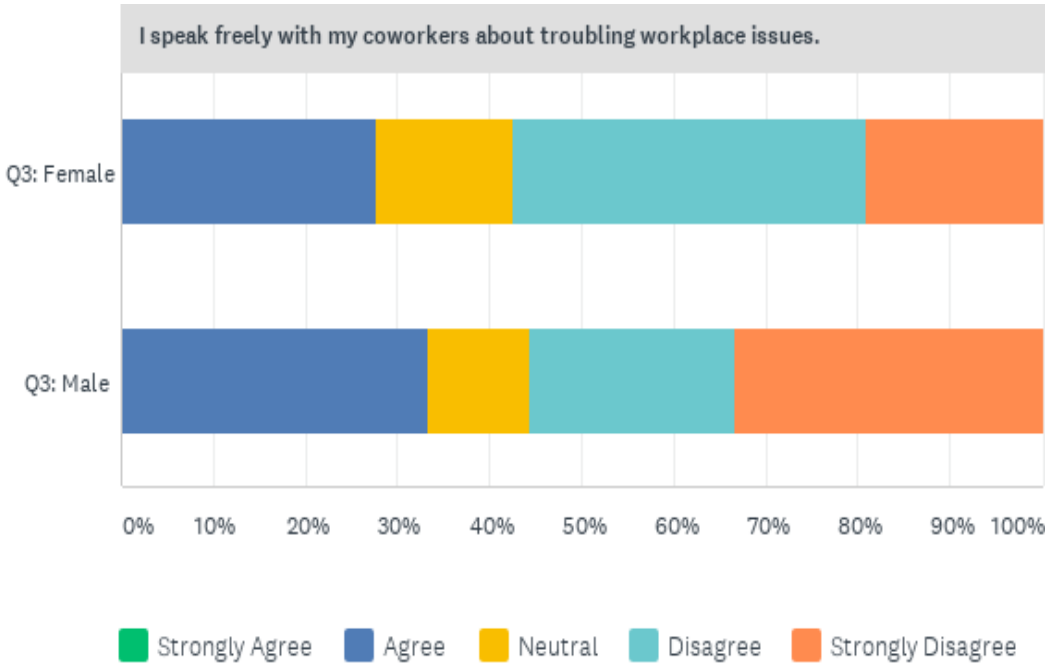
ODS- Male Leader



Males tended not to have strong opinions about telling management when employees are being treated unfairly under a male leader. Which is interesting because under female leadership they were more willing to tell female management when they believed employees were being treated unfairly.

Figure 52

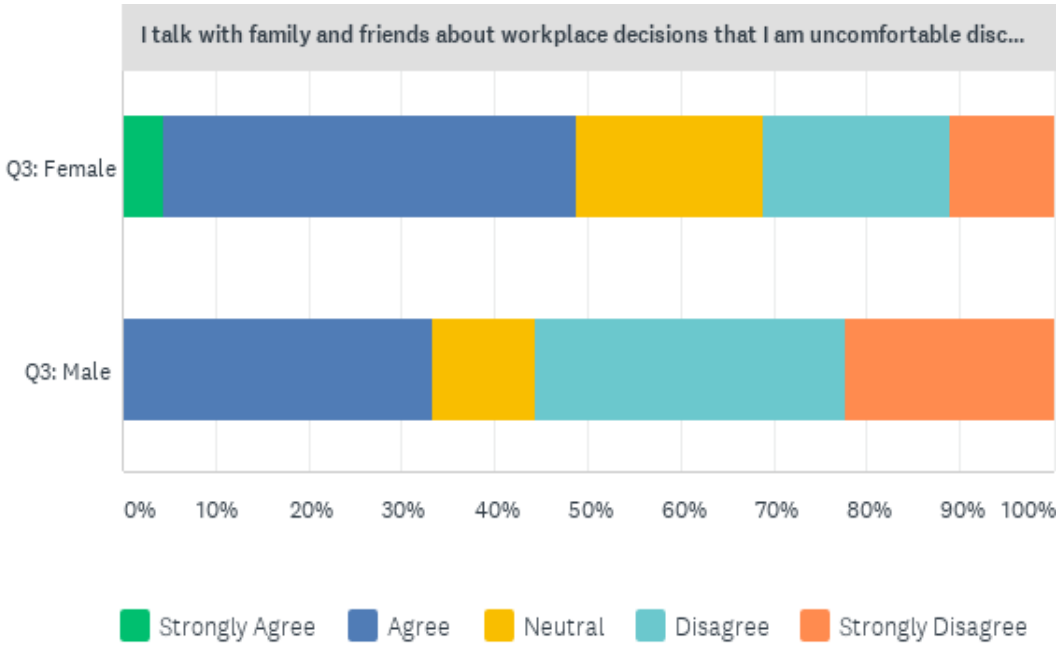
ODS- Male Leader



Men showed a stronger tendency to strongly disagree with talking to coworkers under a male leader. However, there behavior seems to be the same under either male or female leadership as do female employees.

Figure 53

ODS- Male Leader



More women agree or strongly agree that they are uncomfortable discussing work problems with their male leaders than men did. However, there is no differences between males and females as it relates to taking their work home the sex of their leader.

Statistical Analysis with Scales and Subscales

In keeping with standard statistical analysis, several t-tests, correlation, and Cronbach Alphas were run and are presented at the end of the individual questions. Data Cleaning- two people were removed because they did not have male leader information and thus were able to be included in the analysis. While there was missing data in several of the scales – a mean score of the questions that were answered was created to preserve subjects.

Scale Creation

Cronbach alphas were used to test the reliability of the scales.

Organizational Dissent Survey (ODS)

- Items 1, 3, 5, 6,8,10,12,14,18,21 are reverse coded for data analysis.
- A mean scale was created.

1. I am hesitant to raise questions or contradictory opinions in my organization.
2. I complain about things in my organization with other employees
3. I refuse to discuss work concerns at home
4. I criticize inefficiency in this organization in front of everyone.
5. I do not question management.
6. I'm hesitant to question workplace policies.
7. I join in when other employees complain about organizational changes.
8. I make it a habit not to complain about work in front of my family.
9. I share my criticism of this organization openly.
10. I rarely voice my frustrations about workplace issues in front of my spouse/partner or nonwork friends.

11. I make certain everyone knows when I'm unhappy with work policies.
12. I don't tell my supervisor when I disagree with workplace decisions. I let other employees know how I feel about the way things are done around here.
13. I bring my criticism about organizational changes that aren't working to my supervisor or someone in management.
14. I do not express my disagreement to management.
15. I let other employees know how I feel about the way things are done around here.
16. I talk about my job concerns to people outside of work.
17. I do not criticize my organization in front of other employees.
18. I make suggestions to management or my supervisor about correcting inefficiency in my organization.
19. I discuss my concerns about workplace decisions with family and friends outside of work.
20. I hardly ever complain to my coworkers about workplace problems.
21. I tell management when I believe employees are being treated unfairly.
22. I speak freely with my coworkers about troubling workplace issues.
23. I talk with family and friends about workplace decisions that I am uncomfortable discussing at work.

Trust Scales

- In order to have a trust scale, several of the questions needed to also be reverse coded to that 7 was associated with trust (1, 3,4,7,10, 12, 14)
- Then a mean scale was created

1. Trustworthy :___:___:___:___:___:___:___: Untrustworthy
2. Distrustful of this person :___:___:___:___:___:___:___: Trustful of this person
3. Confidential :___:___:___:___:___:___:___: Divulging
4. Exploitative :___:___:___:___:___:___:___: Benevolent
5. Safe :___:___:___:___:___:___:___: Dangerous
6. Deceptive :___:___:___:___:___:___:___: Candid
7. Not deceitful :___:___:___:___:___:___:___: Deceitful
8. Tricky :___:___:___:___:___:___:___: Straightforward
9. Inconsiderate :___:___:___:___:___:___:___: Considerate
10. Honest :___:___:___:___:___:___:___: Dishonest
11. Unreliable :___:___:___:___:___:___:___: Reliable
12. Faithful :___:___:___:___:___:___:___: Unfaithful
13. Insincere :___:___:___:___:___:___:___: Sincere
14. Careful :___:___:___:___:___:___:___: Careless

Statistical Results

Scales Results:

- The mean of the female leader scale was 2.96 as compared to the male leader ODS scale of 2.98
    - Neither scale reached the ideal reliability level of alpha = .7
- The mean female leader trust score was 4.79 as compared to the male one of 3.15.
    - Both reached the alpha level of .7

Table 40

Descriptive Statistics for Trust and Dissent Scales

	Mean	SD	Cronbach Alpha	#item
Female Leader ODS	2.96	0.32	0.572	23
Male Leader ODS	2.98	0.36	0.676	23
Female Leader Trust Scale	4.79	1.26	0.905	14
Male Leader Trust Scale	3.15	0.56	0.873	14

N= 56

Gender:

- 83.9% of the sample was female.
- The majority of the sample was White (92.9%, *n*=52)
- Most had over 10 years of experience (94.6%, *n*=53)
- The most common job levels were Owners (33.9%, *n*=19) and Sr. Management (28.6%, *n*=16)
- The vast majority have exposure to a female leader (98.2%, n=55)

Table 41

Descriptive Statistics of the Sample

		Frequency	Percent
Gender	Female	47	83.9
	Male	9	16.1
Race	Asian	1	1.8
	Black	3	5.4
	Hispanic	1	1.8
	White	52	92.9
Years Working	1-4 years	2	3.6
	5-9 years	1	1.8
	10+ years	53	94.6
Job Level	Educator	1	1.8
	Entry Level	1	1.8
	Mid-Level	10	17.9
	Middle Management	9	16.1
	Owner/Executive/C-Level	19	33.9
	Senior Management	16	28.6
Female Manger in Healthcare	No	1	1.8
	Yes	55	98.2

N=56

Female Leader and Dissent

RQ1: Is there a difference in type/level of dissent between male and female followers based on gender of supervisor or leader?

H1a. Women will have greater dissent with a female leader as compared to men with a female leader.

H1ø There will be no difference in dissent across genders with a female leader

- Independent samples t-test was used

- Leven's test showed equal variances could be assumed (F=.353, p = .555). There was not a significant difference between men and women in terms of their trust of a female leader $t(54) = -.377$, $p = .707$

Table 42

t-test of Gender on Dissent of Female Leader

	N	Mean	SD	t	Df	Sig.
Male	9	2.923	0.340	-0.377	54	0.707
Female	47	2.968	0.324			

N=56

Male Leader - Dissent

H2a. Women will have lower dissent with a male leader as compared to men with a male leader.

H2ø There will be no difference in dissent across genders with a male leader.

- Independent samples t-test was used
- Leven's test showed equal variances could be assumed (F=.052, p = .821)
- There was not a significant difference between men and women in terms of their trust of a male leader $t(54) = -1.173$, $p = .268$

Table 43

t-test of Gender on Dissent of Male Leader

	N	Mean	SD	t	df	Sig.
Male	9	2.923	0.340	-0.377	54	0.707
Female	47	2.968	0.324			

N=56

Female Leader Trust

RQ2: Is there a difference between male and female followers in terms of their level of trust in male versus female leaders?

H3a. Women will have lower trust with a female leader as compared to men with a female leader.

H3ø There will be no difference in trust across genders with a female leader.

- Independent samples t-test was used
- Leven's test showed equal variances could be assumed (F=.569, p = .454)
- There was not a significant difference between men and women in terms of their trust of a female leader t (54) = -.749, p = .457

Table 44

t-test of Gender on Trust of Female Leader

	N	Mean	SD	t	df	Sig.
Male	9	4.51	1.45	-0.749	54	0.457
Female	47	4.85	1.23			

N=56

Results – Male Leader Trust

H4a. Women will have higher trust with a male leader as compared to men with a male leader.

H4ø There will be no difference in trust across genders with a male leader.

- Independent samples t-test was used
- Leven's test showed equal variances could be assumed (F=.2.055, p = .157)
- There was not a significant difference between men and women in terms of their trust of a male leader t (54) = -.483, p = .631

Table 45

t-test of Gender on Trust of Male Leader

	N	Mean	SD	t	df	Sig.
Male	9	3.06	0.42	-0.483	54	0.631
Female	47	3.16	0.58			

N= 56

Correlation between Trust and Dissent

RQ: Is there a correlation between trust and dissent?

- A Persons correlation was run to test whether there were significant relationships between dissent and trust.
- There were no significant correlations between trust and dissent. This is perplexing as it has been shown in other studies, with business professionals, rather than healthcare managers. This may have indications for an approach to the healthcare industry as different from the business world.

Table 46

Correlation Between Trust and Dissent

		Female Leader Trust Scale	Male Leader Trust Scale
Female Leader Dissent	*R*	0.227	-0.141
	sig	0.092	0.300
Male Leader Dissent	*R*	-0.008	-0.127
	sig	0.956	0.351

N=56

Subscale Statistics

Paired sample t-test within Female for Leader Trust:

- A paired samples t-test for trust among just the female sample was run to see if there were difference
- The t-test showed there was a difference among women in their trust from male and female leaders t (46) = 9.83, $p < .001$
- Women were much more likely to have trust in female leaders (M=4.85, SD=1.23) as compared to male leaders (M=3.16, SD=.58)

Table 47

Paired Samples t-Test Among Women on Trust

	Mean	SD	t	df	sig
Female	4.85	1.23	9.83	46	<.001
Male	3.16	0.58			

N=47

Paired sample t-test within female for leader ODS

- A paired samples t-test for ODS among just the female sample was run to see if there were differences.
- The t-test showed there was not a difference among women in their dissent from male and female leaders, t (46) = -.520, p = .606

Table 48

Paired Samples T-Test Among Women on Dissent

	Mean	SD	t	df	sig
Female ODS	3.05	0.454	-0.520	46	0.606
Male ODS	3.07	0.518			

N=47

Paired samples t-test for subscales:

Items 1, 5, 6, 12, 13, 14, 16, 19, and 22= Upward/Articulated Dissent

Items 2, 4, 7, 9, 11, 15, 18, 21, and 23 = Lateral/Latent Dissent

Items 3, 8, 10,17, 20, and 24= Displaced Dissent

Items 1, 3, 5, 6, 8, 10, 12, 14, 18, and 21are reverse coded items

Question 16: I speak with my supervisor or someone in management when I question workplace decisions was not asked in the survey – instead, question 17 was asked twice.

Displaced Subscale

- These are the questions that were included in the subscale

Table 49

Questions for Displaced Subscale

Question	Reverse
3 I refuse to discuss work concerns at home.	R
8 I make it a habit not to complain about work in front of my family.	R
10 I rarely voice my frustrations about workplace issues in front of my spouse/partner or nonwork friends.	R
17 I talk about my job concerns to people outside of work.	
20 I discuss my concerns about workplace decisions with family and friends outside of work.	
24 I talk with family and friends about workplace decisions that I am uncomfortable discussing	

- The mean score for Female Leader displaced subscale was 3.26 (*SD*=.766) and the male leader score was 3.22 (*SD* =.798)
- Both had strong alphas
- A paired samples t-test was run for the displaced subscales among women. There was not a difference between their displaced scores, $t(46) = .608$, p=.546

Table 50

Descriptive Statistics for Displaced Subscales

	Mean	SD	Cronbach alpha	# Items
Female Displaced	3.26	0.766	0.845	6
Male Displaced	3.22	0.798	0.868	6

N=47

Latent Subscale

This is the questions in the latent scale:

Table 51

Questions for Latent Subscale

Question	Reverse
2 I complain about things in my organization with other employees.	
4 I criticize inefficiency in this organization in front of everyone.	
7 I join in when other employees complain about organizational changes.	
9 I share my criticism of this organization openly.	
11 I make certain everyone knows when I'm unhappy with work policies.	
15 I let other employees know how I feel about the way things are done around here.	
18 I do not criticize my organization in front of other employees.	R
21 I hardly ever complain to my coworkers about workplace problems.	R
23 I speak freely with my coworkers about troubling workplace issues.	

- Both had a strong alpha (female = .864 and male = .921)
- The mean score for Female Leader latent subscale was 2.24 (*SD*=.649) and the male leader score was 2.26 (*SD* =.782)
- A paired samples t-test was run and there were no difference between Latent scores among male and female leaders, *t* (46) = -.316, *p*=.745

Table 52

Descriptive Statistics for Latent Subscales

	Mean	SD	Cronbach alpha	# Items
Female Latent	2.24	0.649	.864	9
Male Latent	2.26	0.782	.921	9

N=47

Articulated Subscale

This is the questions in the Articulated scale:

Table 53

Questions for Articulated Subscale

Question	Reverse
1 I am hesitant to raise questions or contradictory opinions in my organization.	R
5 I do not question management.	R
6 I'm hesitant to question workplace policies.	R
9 I make suggestions to management or my supervisor about correcting inefficiency in my organization.	
12. I don't tell my supervisor when I disagree with workplace decisions. I let other employees know how I feel about the way things are done around here.	R
13 I bring my criticism about organizational changes that aren't working to my supervisor or someone in management.	
14 I do not express my disagreement to management.	R
16 MISSING	
22 I tell management when I believe employees are being treated unfairly.	

- The mean score for Female Leader Articulated subscale was 3.41 (*SD*=.483) and the male leader score was 3.40 (*SD* =.493)
- Female had a strong alpha (.937) and male was moderate (.651)
- A paired samples t-test was run and there were no differences between Articulated scores among male and female leaders, t (46) = .479, p=.634

Table 54

Descriptive Statistics for Articulated Subscales

	Mean	SD	Cronbach alpha	# Items
Female Articulated	3.41	0.483	.937	8
Male Articulated	3.40	0.493	.651	10

N=47

Chapter 5: Discussion of Finding

Although this study does not show inferentially relevant statistics about trust or dissent between the genders, it does allow for reading between the lines in a more subjective way. This study was made available to thousands of participants. Relatively few people responded, and for their own unknown reasons. Those who chose to participate either had extraordinarily strong opinions or thoughts about gender roles in healthcare, based on the name of the study, or were interested in furthering the study of same. It is not outside the possibility; therefore, those participating already had some awareness of gender role, or gender bias in healthcare leadership. This could color their perceptions in many ways and cause them to respond in subconscious reaction to social identity bias, gender bias, female solidarity bias and their perception of breaking a fragile understood code of behavior. In some cases, there may be indication of dissent suppression by means of negative social capital expenditure by gender, within the social network.

The areas of non-answer are probably more important to the discovery of covert behaviors since the actual behaviors are, theoretically, not measured, but their impacts are felt. This is rather like explaining the existence of a black hole by the dearth of light in that specific area; it is known to exist but cannot be specifically seen. It seems about the same number of females skipped questions as those who have not had much experience in the field. This may be probative of lack of confidence in social identity within the organization.

When males and females responded to a trust or dissent questions regarding a female leader, there was generally a very strongly held opinion about the answer one way

or another. The content of the questions demonstrated either articulated dissent or lateral dissent, or else generally positive statements about the female leader. When the questions were more negative sounding, or displaced dissent, the answer ranges were more generally neutral. Males showed less range in their responses about male leaders. This potentially means that males were more indifferent to their male managers. Females generally had nicer things to say about their male leaders, with ranges leaning more towards agreement with positive ideas and avoiding strong negative opinions.

Trust and Dissent Were Previously Correlated

Trust and dissent, specifically using these scales, were shown to have statistical correlation in a previous study. The scales themselves are stable, and the instruments are reliable. What this might indicate is that healthcare as an industry has unusual dynamics. As the idea of conflict resolution is still relatively new, and the ratio in the population of female to male employees is high, relative to the general population, there may be a reason to look deeper into these relationships.

Since the characteristics of a good nurse (i.e., compassionate, sympathetic, and patient) are at odds with the more male-oriented characteristics of physicians (i.e., rapid, dissipation, rational decision-making, professional detachment), this puts a different emphasis on female leaders because they must maintain likeability but also have the characteristics of doctors. Doctors have traditionally been higher in the command structure than nurses, and in fact nurses cannot by law act without doctors' orders. This can create a major disconnect in the role-expectations which is different form the general business world. To wit, a female doctor must act like a man, not a woman, to be a doctor, and a male nurse must act like a woman, not a man.

There is one question in the Organizational Dissent Scale (ODS) which was inappropriately duplicated, and consequently, one question which was left out. The data is the same in both the original and the duplicated question and was therefore left out of the analysis. This missing/duplicate question may account for the decrease in Cronbach's alpha in the ODS scale.

Semantic Shift and Vocabulary Differences

Connotations and denotations of words change over time with usage and social context. Many words changed over long periods of time. Indeed, most of the medical terminology used in the industry is based on Roman and old Greek terms which has vastly different meaning to what they do today. Terms are indeed created for new technologies and new usages of old expressions once the knowledge about that area becomes more refined. Because the two scales used in this study were written by previous generations, there very well may be a semantic shift that changes how these words are used and understood. For example, the term “trustworthy” may still mean “worthy of one’s trust” but the expression “trustful of the person” may have the connation of “vulnerability to the other”. This changes the intent of the question and may account for the shift in the range of answers for this question as none were confident enough to strongly agree to being trustful of the female leader. That lack of vulnerability may also imply a deeper experience of fear, which would need to be evaluated with a different instrument. Further, the expression of dissent, especially in the current political climate, and the “cancel culture’ of modern media, may be suppressed, explicitly regarding social media policies, and implicitly regarding professional codes of conduct. The simple declarative, direct, phraseology of the trust scale questions may have

triggered responses to current political climate, rather than the intend meaning of the words originally.

Social Identity Bias and Group Solidarity

Social identity theory talks about in-group and out-groups, where individuals may seek to find reasons to outwardly express negative comments or gestures to the out-group. This is reinforced by social capital theory which requires that the social network be both influenced by and the influencer of individuals. There are several variations of this idea by several theorists. The only statistically relevant attributes in the study showed, first the scales are reliable, and that females indicated a higher level of trust in their female leaders. This means that the female respondents do not trust male leaders. However, combined with the changes in the ranges, very strongly held opinions and the lack of correlation between the two scales may indicate that there is a gap in the expectations of respondents. This could be the fear of reprisal, even subconsciously, by the rest of the "in-group", namely females. The retaliation, subtle or blatant would have to come using social capital, and in a negative way. Nurses have been able to form unions since the 1890s, but independent practice physicians have been considered managers and cannot form unions. Physician employees have only recently been able to join unions, and then they are not managers, only employees. The length of time this has been truly makes the roles difficult to extract and makes the concept of loyalty difficult to quantify. It is specifically because of this solidarity that the decision to maintain group solidarity, specifically in gender, is so strong and yet unspoken. This is a unique proposition for an industry in which the provider of services has traditionally also been the leader. When

these roles change, there is ambiguity and therefore a stronger desire to maintain some semblance of identity and belonging.

The general business world has an even split of male to female workers, and everywhere, including healthcare, women are paid less than men. This is a constant source of conflict. The uncertainty that lies in the delineation of profession makes healthcare unique. There are more women than men in healthcare, but there are still more male CEOs than female CEOs. However, the concept of having administrative levels like CEOs and other c-suite executives, is relatively new to an old industry. The power balancing is still being worked out throughout the industry and among the types of professions: clinical, non-clinical/allied health and administrative. Given literal life and death dimension of healthcare, it makes sense that opinions and reactions would be very strongly held. It is the areas of ambiguity that mark the change and conflict areas.

Group Theory of Behavior

If the colloquial male idiot theory**,** or mob/herd theory, exists such that males in groups will act differently together and a single woman in the mix changes the dynamic, then there is no reason to think that groups of women would act differently with one another. The difference could be that women have been oppressed in many countries for centuries and are therefore very insular. Any outside weakening is selling out the group. Group dynamics go through stages, and anecdotally, people know that groups are difficult to navigate in the beginning. The stage called “storming” is problematic if the power conflicts are not resolved and the group can move on. In identifying covert behavior in children, bullying behaviors are seen everywhere, and are gender specific, in most cases. Bullying as an adult, as it is beginning to be explored, is much more

insidious and requires the mobilization of the social network, therefore negative social capital.

What can be measured is the result of the interactions, rather than the actual interactions themselves. The storming stage may be demonstrated only by seeing the group as non-functional, distrusting, or tenuous. Attempts at conflict resolution depend on the style of the communicators and show up in this stage. If someone were to indicate that the group was not functioning at its highest level, there is a chance that the out-group might see the in-group as weak, or fragile. Through subtle power manipulations, gestures and non-verbal interactions, the "traitor" of the group can be ostracized and left to suffer the consequences of known in that the group needs to function and get actual work done but knowing that it is his/her/their fault. In the general business world this state of casting out would lead to meetings and possible trips to Human Resources. In the healthcare world it means patients on a hospital ward or in a medical practice get substandard care or leave the practice. Plenty of the literature indicate that staff tension leads to poor patient outcomes in inpatient hospitals, and plenty of literature indicates that tension among staff can be one reason that patients leave their medical providers' practices.

Bullying Among Nurses and Female Physician Burnout

There have been studies about bullying of nurses in the workplace. Oftentimes this is female-to-female bullying, but most studies indicate it is based on the hierarchical structure, and less focused on the dyadic interactions. As healthcare evolves, the ideas of interpersonal communication and gender roles starts to come into the foreground. The dichotomy of "female trait" oriented jobs with "male trait" oriented jobs makes this dissent structure much more complex. There may be evidence in this study of dissent

suppression through the social network. This suppression can cause emotional backlash and mental health issues. Some studies back this up and one refers to it as “moral distrust” of the establishment among nurses. Female physicians noticed microaggressions more and felt the clash of gender roles more, and therefore burned out more than male doctors did. This, combined with the responses to questions about how dissent is expressed with both male and female leaders, leads to the idea that while individuals might express their concerns about their own work, specifically process, problems to their leaders, they are much more reluctant to do so when the issues concern how other employees are treated, regardless of the leader’s gender. This is suppression of articulated dissent by use of social capital.

Limitations

Non-Clinical Staff

Since the reason for using the specific groups in the study (MGMA, AAPC, AHIMA) was to get medical managers involved, there is room to discuss the idea that non-clinical managers may have a different perspective than clinical staff (physicians, nurses, etc.). The individuals who answered the study were not asked if they were also clinicians, so this may have conflated the answers, and further clarity might be useful. The specific ethnicities and level of experience may be useful for further studies, as they were not part of the control for this study as they were not anticipated to be pertinent.

Currently, the literature looks at how clinicians interact, and that is also the focus on interventions and The Joint Commission, but the interplay between clinical and non-clinical staff had been largely left unanswered. This may account for some of the gaps and unrelated answers in the reverse coded questions. Since clinicians can become non-

clinical managers, but the reverse is not true, the study population is potentially heavily skewed to the clinical hierarchy and archaic gender roles of the clinical world. This is without regard to the influence of the general business world's impact on healthcare. Non-clinical staff are generally more "healthcare business" oriented and come from many different areas of background. Clinicians are generally very well trained in just being clinicians, especially at the upper levels. Medical students do not learn business or finance, for example, but a healthcare administrator might learn anatomy, just to be able to converse with the doctors. A doctor might eventually become an administrator but is likely to expect the same culture as the clinical side.

This clash of culture is not uncommon in the general business world, either. Individuals who come from very hierarchical, vertically integrated organizational environments generally have a hard time adjusting to environments which are more horizontal in nature. This is a fact of business culture, and in truth of human cultural shock. Expectations of behavior bleed over from the formative experiences in the industry into expectations of behavior elsewhere.

Covert Behaviors are the Gaps, not the Answers

Covert behaviors are not seen directly. This is in line with communication principles that say most of the communication between individuals is non-verbal, sometimes uncanny, and not always quantifiable outside the relationship. Proxemics (the study of interpersonal space and territory), haptics (the study of cultural touching), and chronometric (the study of how individuals and cultures view and experience time) are all cultural. Cultural impacts are not universal and therefore cannot always be interpreted beyond the physiological. This study did not have the scope to include how the heartrate

might have changed, or pupils dilated, for example, when the respondent answered a specific question. Physiological expressions are usually not repressible within most human bodies and are mostly universal. These changes will tell more accurately how a person is reacting to a stimulus on a subconscious level and may therefore be a good observative measure of covert behavior.

The literature shows personal and group clashes between and among women, even at an early age to be subtle and insidious. This study attempted to get at those subtleties but was limited to direct answers. This was not sufficient to cover the tensions and pressures sublimated into expectations of behavior. This colored the outcome. The value of these scales is not in the direct outcomes, which is what they were designed to measure, but rather in what they do not measure: the gaps. The addition of open-ended questions, or follow-up interviews might have gotten more of the hidden information extracted from the respondents. As it is, the dissent measures do not line up, despite reverse coding. If an individual feels comfortable within an organization, so the theory goes, then she/he/they should be dissenting the same way regardless of the leader, and regardless of the way the question is asked. Questions that pointed to displaced dissent, or complaining to those outside the organization, were unclear as to whom the respondent did complain. Standing up for another person was not clearly a comfortable position among women, even though there should have been no concern of repercussions if the respondents were as comfortable as they indicated.

Implications for Research

Because the industry itself operates under such different implicit power structures than most other industries, further research will need to evaluate many different aspects

that were outside the scope of this study. Conflict research in this filed is very new, as are managerial theory applications. With the current trend of transformative leadership involving the emotions and self-esteem of the employees for the theoretical empowerment of staff, inclusion of the negative side of this type of engagement is necessary. The vulnerability involved in this style of leadership is potentially quite different in literal life and death industries like healthcare and the military. Further research should find a way to mitigate the fear of that vulnerability and reassure the participants of no reprisal for truthful and reflective response. Additional survey work would involve social network theory and identifying the formal and informal influencers of the network. Because there may be gaps in which covert behaviors are occurring, but are not being recognized, or specifically avoided to comply with corporate standards, future instruments will need to be more subtle and specific.

New Area of Conflict Research

This study concluded that the existing methods of research are not sufficient to get to the heart of leader-follower relationship conflict in healthcare. The gaps in the literature on relational aggression and social capital utilization needs to be further explored, but from the perspective of impacts of negative use and sublimated damage. The current literature on covert behavior focuses on group dynamics rather than dyadic relationships. Since dyadic relationships are essential in a humanist environment like healthcare, this is an area that is ready to be explored by mixed methods and phenomenological studies.

Conclusions

The nature of covert group behavior, and its resultant manifestations like relational aggression, fear or reprisal and gender solidarity bias, are shown here in the way that answers were made. Hesitancy to answer strongly is an indicator of deeper concerns and should be addressed. Covert group behaviors and power imbalances were identified in a subjective analysis outside the scope of the available instruments. The future of conflict resolution research in healthcare should include identification of new instruments to identify and quantify the actual behaviors which prompt the manifestations. Since behaviors remain covert until they are measured, this is new area of opportunity.

References

American College of Healthcare Executives (ACHE) (2006). *A comparison of the career attainments of men and women healthcare executives* [survey report]. (December 2006). https://www.ache.org/pubs/research/gender_study_full_report.pdf.

Analoui, F., & Kakabadse, A. (1989). Defiance at work. *Employee Relations, 11*(3), 2-62. Retrieved from https://doi.org/10.1108/01425458910133969

Anand, G., Chhajed, D., & Delfin, L. (2012). Job autonomy, trust in leadership, and continuous improvement: An empirical study in health care. Operations Management Research, 5(2012), 70–80. https://doi.org/10.1007/s12063-012-0068-8

Anand, G., Chhajed, D., & Delfin, L. (2012). Job autonomy, trust in leadership, and continuous improvement: An empirical study in health care. Operations Management Research, 5(2012), 70–80. https://doi.org/10.1007/s12063-012-0068-8

Asgari, A., Silong, A. D., Ahmad, A., & Samah, B. A. (2008). The relationship between transformational leadership behaviors, organizational justice, leader-member exchange, perceived organizational support, trust in management and organizational citizenship behaviors. *European Journal of Scientific Research, 23*(2), 227-242

Barash, S. S. (2007). *Tripping the prom queen: The truth about women and rivalry*. New York, NY: St. Martin's Press.

Barkhorn, E. (2013, March 14). Are successful women really less likable than successful men? [Electronic mail newsletter]. http://www.theatlantic.com/sexes/archive /2013/03/are-successful-women-really-less-likable-than-successful-men/273926/

Barsh, J., & Lee, L. (2011). *Changing companies' minds about women*. Retrieved from http://www.mckinsey.com/insights/organization/changing_companies_minds_about_women

Bem, S. L. (1993). *The lenses of gender - Transforming the debate on sexual inequality*. New Haven and London: Yale University Press.

Berlin, G., Darino, L., Greenfield, M., & Starikova, I. (2020, March 1). Women in the healthcare industry. McKinsey & Company. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/women-in-the-healthcare-industry#.

Bion, W. R. (2004). *Experiences in groups and other papers*. Taylor & Francis Group. Pp. 144-172.

Briles, J. (1994). *The Briles report on women in healthcare: Changing conflict to collaboration in a toxic workplace*. San Francisco: Jossey-Bass.

Brown, Brené. (2018). *Dare to lead: brave work, tough conversations, whole hearts*. Random House.

Brown, T. (2019). *Male clinicians miss microaggressions their female peers notice*. Medscape (2019, November 19). https://www.medscape.com/viewarticle/921527

Buss, D. M., & Schmitt, D. P. (2011). Evolutionary psychology and feminism. *Sex Roles, 64*, 768. doi: 10.1007/s11199-011-9987-3

Buss, D. M., & Schmitt, D. P. (2011). Evolutionary Psychology and Feminism. Sex Roles, 64(768). https://doi.org/10.1007/s11199-011-9987-3

Buss, D. M., & Schmitt, D. P. (2011). Evolutionary Psychology and Feminism. Sex Roles, 64(768). https://doi.org/10.1007/s11199-011-9987-3

Campbell, A., Muncer, S., & Bibel, D. (1998). Female-Female criminal assault: An evolutionary perspective. *Journal of Research in Crime and Delinquency*, *35*(4), 413-428. Available at http://journals.sagepub.com/doi/abs/10.1177/0022427898035004003.

Catalyst. (2007). *Report: 2007 Catalyst census of women corporate officers and top earners of the Fortune 500.* Available at https://www.catalyst.org/research/2007-catalyst-census-of-women-corporate-officers-and-top-earners-of-the-fortune-500/

Chase, D. (2015). Women in healthcare report: 4% of CEOs, 73% of managers. *Forbes Magazine* (2015, May 26). www.forbes.com/sites/davechase/2012/07/26/women-in-healthcare-report-4-of-ceos-73-of-managers/#5decfe277f38

Chesler, P. (2001). *Woman's inhumanity to woman*. NY: Thunder's Mouth Press/ Nation Books.

Chesler, P. (2015). When women commit honor killings. *Middle East Quarterly*, *22*(4). Retrieved from http://www.meforum.org/5477/whenwomencommithonorkillings

Coates, T.-N. (2016, November 11). The Great Schism. The Atlantic. https://www.theatlantic.com/national/archive/2011/10/the-great-schism/246640/.

Cochran, N., Charlton, P., Reed, V., Thurber, P., & Fisher, E. (2018). Beyond fight or flight: The need for conflict management training in medical education. *Conflict Resolution Quarterly*, *35*(4), 393–402. doi: 10.1002/crq.21218

Creswell, J. W. (2007) *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Does Healthcare Have a Gender Problem? Health eCareers. (2018, April 24). https://www.healthecareers.com/article/healthcare-news/does-healthcare-have-a-gender-problem.

Eagly, A. H., & Johnson, B. T. (1990). Gender and leadership style: A meta-analysis. *CHIP Documents*. 11. http://digitalcommons.uconn.edu/chip_docs/11

Editorial Board (Ed.). (2015). *Introduction to management* (12th ed.). Words of Wisdom, LLC.

Edwards, K. (2017, October 30). Why we need to be realistic about 'the sisterhood'. The Sydney Morning Herald. https://www.smh.com.au/lifestyle/why-we-need-to-be-realistic-about-the-sisterhood-20171029-gzakhi.html.

Edwards, K. (2017, October 30). Why we need to be realistic about 'the sisterhood'. The Sydney Morning Herald. https://www.smh.com.au/lifestyle/why-we-need-to-be-realistic-about-the-sisterhood-20171029-gzakhi.html.

Feltman, C., Marshall, A., Bendis, K., Hammond, S. A., & Hammond, R. (2009). *The thin book of trust: an essential primer for building trust at work*. Thin Book Publishing. [Kindle Version ASIN B001PBEXFQ].

Ghebreyesus, T. (2019, March 20). Female health workers drive global health. World Health Organization. https://www.who.int/news-room/commentaries/detail/female-health-workers-drive-global-health.

Gordon, G., & Gilley, J. W. (2012). A trust-leadership model. *Performance Improvement, 57*(7), 28-35. doi: 10.1002/pfi.21284

Hannagan, R. Gendered Political Behavior: A Darwinian Feminist Approach. Sex Roles, 59. https://doi.org/10.1007/s11199-008-9417-3.

Hannagan, R. Gendered Political Behavior: A Darwinian Feminist Approach. Sex Roles, 59. https://doi.org/10.1007/s11199-008-9417-3.

Hoff, T. (2019, June 9). The challenges of being a female doctor. Medical Economics. https://www.medicaleconomics.com/view/challenges-being-female-doctor.

Holiday, E., & Rosenberg, J. I. (2009). *Mean girls, meaner women: Understanding why women backstab, betray and trash-talk each other and how to heal*. Orchid Press.

Ibarra, H., Ely, R. J., & Kolb, D. M. (2013). Women rising: The unseen barriers. *Harvard Business Review* (September, 2013 Issue). https://hbr.org/2013/09/women-rising-the-unseen-barriers/ar/1

Jamieson, K. H. (1995). *Beyond the double bind: Women and leadership*. Oxford University Press.

Joyce, A. (2006, August 20). *You'd never guess! There's a glass ceiling and a sticky floor for aspiring women*. https://journalstar.com/business/you-d-never-guess-there-s-a-glass-ceiling-and/article_cf79e2a7-3a19-5834-a69c-5d34575c79e4.html

Kanter, R. M. (2015, October 1). The real reason men and women prefer male bosses [Web log post]. https://blogs.wsj.com/experts/2015/10/01/the-real-reason-men-and-women-prefer-male-bosses/.

Kassing, J. W. (1998). Development and validation of the organizational dissent scale. *Management Communication Quarterly, 12*(2), 183-229. doi: 10.1177/0893318998122002

Kassing, J. W. (2000). *Organizational dissent scale*. http://www.dissentworks.com/organizational-dissent-scale.html.

Kim, S., Buttrick, E., Bohannan, I., Fehr, R., Frans, E., & Shannon, S. E. (2016). Conflict narrative from the health care frontline: A conceptual model. *Conflict Resolution Quarterly, 33*(3), 255-277. doi: 10.1002/crq.21155.

Kotlyar, I., & Karakowsky, L. (2006). Leading conflict? Linkages between leader behaviors and group conflict. *Small Group Research, 37*(4), 377-403. doi: 10.1177/1046496406291388.

Lancer, D. (2019, July 2). Covert Tactics Manipulators Use to Control and Confuse You. Psychology Today. https://www.psychologytoday.com/us/blog/toxic-relationships/201907/covert-tactics-manipulators-use-control-and-confuse-you.

Lantz, P. M., PhD., & Maryland, P. A., DrP.H. (2008). Gender and leadership in healthcare administration: 21st century progress and challenges. Journal of Healthcare Management, 53(5), 291-301; 302-3. http://search.proquest.com.ezproxylocal.library.nova.edu/docview/206729816?accountid=6579

Lewis, J. D., & Weigert, A. (1985). Trust as a social reality. *Social Forces, 63*(4), 967-985. doi: 10.2307/2578601.

Lizardo, O. (2007). Peter Blau (1918-2002). In G. Ritzer (2007), *The Blackwell encyclopedia of sociology* (pp. 313-316). Malden, MA: Wiley-Blackwell. Retrieved from http://www3.nd.edu/~olizardo/papers/es-blau.pdf.

Lotan, D. (2019). Female nurses: Professional identity in question how female nurses perceive their professional identity through their relationships with physicians. Cogent Medicine, 6(1). https://doi.org/https://doi.org/10.1080/2331205X.2019.1666626.

Lucas, S. (2011). *New study: Do men make better bosses?* CBS News, CBS Interactive (25 Oct. 2011). https://www.cbsnews.com/news/new-study-do-men-make-better-bosses/.

Maddux, W. W., & Brewer, M. B. (2005). Gender differences in the relational and collective bases for trust. *Group Processes & Intergroup Relations, 8*(2), 159-171. Available at https://doi.org/10.1177/1368430205051065

McEldowney, R. P., Bobrowski, P., & Gramberg, A. (2009). Factors affecting the next generation of women leaders: Mapping the challenges, antecedents, and consequences of effective leadership. *Journal of Leadership Studies, 3*(2), 24-30. doi: 10.1002/jls.20105

Medical Group Management Association (MGMA), (2018). *About*. Retrieved from www.mgma.com/about/organization.

Medina, F. J., Povedano, A., Martinez, I., & Munduate, L. (2009). How do we approach accountability with our constituency?: Gender differences in the use of influence tactics. *International Journal of Conflict Management, 20*(1), 46-59. doi: 10.1108/10444060910931602

Meece, M. (2009). Backlash: Women bullying women at work. *New York Times* (2009, May 9). https://www.nytimes.com/2009/05/10/business/10women.html.

Meyers, S. (2013, September 24). Women who hate other women: The psychological root of snarky [Web log post]. https://www.psychologytoday.com/blog/insight-is-2020/201309/women-who-hate-other-women-the-psychological-root-snarky

Muir, N., & Byrne, J. (2019). Constructive and negative aspects of social capital in work-related learning networks. Higher Education, Skills and Work - Based Learning, 9(2), 420-433. doi:http://dx.doi.org.ezproxylocal.library.nova.edu/10.1108/HESWBL-08-2019-0104

O'Neal, S. (2019). *Why I hate it when other men call me 'Boss'*. Men's Health (2019, March 20). https://www.menshealth.com/entertainment/a26873430/why-men-call-each-other-boss/.

Ortu D. (2012). Neuroscientific measures of covert behavior. The Behavior analyst, 35(1), 75–87. https://doi.org/10.1007/BF03392267.

Payne, H. J. (2014). Examining the relationship between trust in supervisor-employee relationships and workplace dissent expression. *Communication Research Reports, 31*(2), 131-140. doi: 10.1080/08824096.2014.907141.

Payne, H. (2014) Examining the Relationship Between Trust in Supervisor–Employee Relationships and Workplace Dissent Expression, Communication Research Reports, 31:2, 131-140, DOI: 10.1080/08824096.2014.907141

Ramazzinna, G. (2016, November 17). Women drastically underrepresented among Fortune 500 CEOs [Web log post]. from https://blog.hrps.org/blogpost/Women-Drastically-Underrepresented-Among-Fortune-500-CEOs

Reuvers, M., Van Engen, M. L., Vinkenburg, C. J., & Wilson-Evered, E. (2008). Transformational leadership and innovative work behaviour: Exploring the relevance of gender differences. *Creativity and Innovation Management, 17*(3), 227-244. https://onlinelibrary.wiley.com/doi/10.1111/j.1467-8691.2008.00487.x

Ritzer, G. (2008). *Sociological theory* (8th ed.). New York: McGraw-Hill.

Rotenstein, L. (2018, October 1). Fixing the Gender Imbalance in Health Care Leadership. Harvard Business Review. https://hbr.org/2018/10/fixing-the-gender-imbalance-in-health-care-leadership.

Rousseau, D. M., Sitkin, S. B., Burt, R. S., & Camerer, C. (1998). Not so different after all: A cross-discipline view of trust. *Academy of Management Review, 23*(3), 393-404. doi: 10.5465/amr.1998.926617

Rubin, R. B. (2011). *Communication research measures II: A sourcebook*. Abingdon: Routledge.

Sheppard, B. H., & Sherman, D. M. (1998). The grammars of trust: A model and general implications. *The Academy of Management Review, 23*(3), 422-437. Retrieved from www.jstor.org/stable/259287.

Stuhlmacher, A. F., & Morrissett, M. G. (2008). Men and women as mediators: Disputant perceptions. *International Journal of Conflict Management, 19*(3), 249-261. https://doi.org/10.1108/10444060810875804.

Tannen, D. (1999). *The argument culture: Stopping America's war of words*. New York, NY: Ballantine Books.

Taylor, B. (2017). True leaders believe dissent is an obligation. *Harvard Business Review* (2017, January 12). Retrieved from https://hbr.org/2017/01/true-leaders-believe-dissent-is-an-obligation.

The Joint Commission. (2008). Behaviors that undermine a culture of safety. *Sentinel Event, 40*(2008, July 9). Retrieved from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_40.pdf.

U.S. Bureau of Labor Statistics. (2021, January 22). *Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity*. Labor Force Statistics from the Current Population Survey. https://www.bls.gov/cps/cpsaat11.htm.

Ulrich, B. (2010, January 1). Gender Diversity and Nurse-Physician Relationships. Journal of Ethics | American Medical Association. https://journalofethics.ama-assn.org/article/gender-diversity-and-nurse-physician-relationships/2010-01.

United States Census Bureau. *U.S. Census Bureau QuickFacts: United States -Vintage Year 2019*. Census Bureau QuickFacts. https://www.census.gov/quickfacts/fact/table/US/RHI125219.

University of Missouri School of Medicine- Center for Health Ethics. (2020). Physician and Nurse Relationships. Physician and Nurse Relationships - MU School of Medicine. https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/physician-nurse-relationships.

Vartia, M., & Hyyti, J. (2002). Gender differences in workplace bullying among prison officers. *European Journal of Work and Organizational Psychology, 11*(1), 113-126. doi: 10.1080/13594320143000870

Warning, R., & Buchanan, F. R. (2009). An exploration of unspoken bias: Women who work for women. *Gender in Management, 24*(2), 131-145. Retrieved from https://doi-org.ezproxylocal.library.nova.edu/10.1108/17542410910938817

Weiss, D. C. (2011). *Not one legal secretary surveyed preferred working with women partners; Prof offers reasons why*. Retrieved from http://www.abajournal.com/news/article/not_one_legal_secretary_surveyed_preferred_working_with_women_lawyers_prof_/.

Williams, J. C., & Dempsey, R. (2014). *What works for women at work: Four patterns working women need to know*. New York University Press.