Journal of Business Studies Quarterly
2021, Volume 11, Number 2
ISSN 2152-1034

Journal of Business Studies Quarterly jbsq.org

Research Proposal

Does Gender Influence the Leadership Style of Healthcare Administrators?

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Abstract
Over half of the world's population are women. However, for many women, their job is to work inside the home. Cultures and the healthcare industry need to add a transformative approach to encourage more women to get outside of their houses and take a better position in the outside world. As society progresses forward with equal employment opportunities for both genders, women can enter into positions that were previously unobtainable. For example, leadership positions in both public and private corporations. This potential transformative approach motivated our group to research how gender influences leadership style, especially in the healthcare system.

Key Words: Leadership, gender, healthcare, and discrimination.

Introduction

Gender discrimination is a problem in various industries, especially the healthcare system. Women must overcome a variety of cultural and traditional barriers. However, women have made slight progress over the years. According to Hoyt (2010), there is a gender gap between male and female leaders at the executive level. In 2009, female leaders occupied "a mere 3% of [the] Fortune 500 CEO seats" (Hoyt, 2010, p. 485). This discrepancy is not limited to corporate leadership. In the political world, women hold approximately 17% of the seats in

Congress (Hoyt, 2010). In both corporate and political leadership, female leaders are in the minority. The ratio of women working in executive positions such as CEO, corporate office, etc., is much less than men. Only 20% of women are top-level, and this percentage ratio has remained stagnant since 2002 (Hoyt, 2010). Women forgo climbing the corporate ladder because they may leave the workforce due to other responsibilities and self-imposed limitations, such as not believing in themselves. This also occurs in the healthcare industry.

Although the number of women employed in the healthcare industry has increased, there is little progression of women in leadership positions in healthcare. According to Lantz (2008), the American College of Healthcare Executives (ACHE) conducted a survey comparing male and female healthcare employees in different years. The results indicate that women tend to fill staff positions whereas the CEO was more likely to be male. Therefore, women earned a lower salary than men in the healthcare system. Lantz (2008) discovered that "men earned 18 percent more than women in 1990, 17 percent more in1995, 19 percent more in 2000, and 18 percent more in 2006. In 2006, nearly one-third (29 percent) of women said they did not receive fair compensation because of gender, compared to only 1 percent of men" (p. 292). Another study held by the University of Michigan analyzed the gender in the top 100 hospitals. Their results revealed that nearly one-third (30 percent) of the Top 100 Hospitals employed no female chief administrators, and another third (34 percent) employed one female chief administrator (Lantz, 2008). These results draw attention to a problem in the healthcare system. It can be inferred that women are less likely to hold a leadership position in healthcare. In addition, the salary inequality between men and women can be influenced by the fact that women are not employed in the highest paid positions. As stated earlier, over half of the world's population are women, but many leaders, across all industries, are male. Since there are fewer female leaders than male

leaders, this has led our group to consider whether gender influences the leadership style of healthcare administrators.

Literature Review

Throughout history, society has created gender norms centered on cultural beliefs and ideology. Gender norms dictate that males would focus on providing for the family while a female's circle of influence restricted her to operating within the household. After World War II, American modern society became more receptive to women entering the workforce. However, women in the workforce are the minority in leadership positions. The healthcare industry is not exempt from this pattern of events. According to Kirchheimer (2007), approximately 78% of the healthcare workforce comprises of women. Although most of the healthcare workforce are women, approximately only 13% of healthcare CEOs are women (Women in Leadership, 2020). Women face barriers to entry regarding leadership positions. These barriers stem from cultural, societal, and personal choices. For many cultures, a woman's role focuses on childbearing and other domestic responsibilities, which deters them from taking "up leadership opportunities, and their selection and appointment as leaders" (Muraya et al., 2019, p. 249). In a two-year study done in Kenya, information was gathered from 25 individuals employed in the healthcare industry. At the end of the study, results indicate that unless women had a strong support system, including support from her spouse and relatives, and domestic assistance, they were less likely to pursue advancing into leadership positions (Muraya et al., 2019). If a woman were to successfully gain employment in a leadership position, she would have to endure increased scrutiny and criticism by society and her peers (Women in Leadership, 2020). Additionally, women will restrict themselves from entering leadership roles. Often, women will feel guilty if work responsibilities and duties take priority over family needs, such as quality time with

children (Fontenot, 2012). Unlike men, women tend to value inner peace, happiness, selfrespect, and a comfortable life (Rokeach, 1973). The traits that women most value do not align with climbing the corporate ladder. Women tend to find success in their current roles and are hesitant to advance into leadership roles (Women in Leadership, 2020). While women may be hesitant to progress forward in their careers, men tend to be the opposite. According to Rokeach (1973), the study revealed that men ranked values such as ambition, sense of accomplishment, and freedom higher than women did. Those values positively correlate and support career development and advancement. All these factors serve as impediments for women to advance into leadership positions in the healthcare industry and explain why males dominate leadership positions.

Although women in healthcare encounter challenges towards progressing to a leadership position, women have made progress. Women can obtain formal educations that is necessary to lead healthcare organizations (Fontenot, 2012). Female leadership styles differ from male leadership styles. According to Lantz (2008), female leaders tend to be transformational by motivating, inspiring, and stimulating their subordinates to collaborate with one another. Conversely, male leaders often utilize a transactional leadership style, where they set the vision and make the decisions (Lantz, 2008). The contrast between male and female leadership approaches is further exemplified by how they address subordinates. Giles (2012) recalls that male leaders were advised to begin speeches with emotional stories that focused on children or topics that many could relate to, such as a sports game. On the other hand, female leaders were encouraged to speak the "facts that [would] substantiate them and give them credibility" (Giles, 2012, p. 3). The dichotomy is clear between the societal perception of how a male versus female leader expresses themselves. However, female leaders are uniquely positioned to leverage

inherent personality traits as the healthcare delivery system transitions into a partnership between hospitals and physicians (Fontenot, 2012). Personality traits that were seen as feminine, such as

"nurturing, multitasking, communication, and collaborating are [viewed as] vital for today's … healthcare leader[s]" (Fontenot, 2012, p. 12). Healthcare is a dynamic and ever-changing industry that will require healthcare leaders to quickly pivot and adapt their leadership style to the environment. There are many leadership styles that both male and female leaders can employ. No one leadership style is superior to the other, but rather, the effectiveness of a particular leadership style is dependent on the situation and environment.

Leadership Style

A leadership style is most effective when subordinates are receptive to the style. A study conducted by Jensen et al. (1990), indicates that employees prefer participatory leadership styles. Female leaders are more likely than male leaders to incorporate a team building approach into their leadership style. Relationship-oriented leadership focuses on work culture, building a relationship with their employees, and maintaining a work-life balance (Ferry, 2021). Before deciding, relationship-oriented leaders consider their colleagues' ideas and perspectives. They choose the most appropriate and optimal course of action by listening to others' perspectives, regardless of the opinions being similar or different from their own (Greenberg & Sweeney, 2005). On the other hand, task-oriented leadership prioritizes completing and meeting organizational targets (Ferry, 2021). Female leaders describe "effective leadership [as]... behaviors and actions that focus… on helping or improving the team" (Hopkins et al., 2006, p. 266). Increased collaboration between colleagues encourages participation and discussion Compared to male leaders, female leaders tend to engage in frequent active listening and share information with colleagues (Greenberg & Sweeney, 2005).

For an organization to be successful, it is important that the leader motivates their staff to contribute to the team and maintain a high morale. However, to receive recognition, female leaders tend to take on more risks compared to male leaders (Greenberg & Sweeney, 2005). They learn from their mistakes and move on. A key point for females' leadership style is strengthening themselves to strengthen others. Female leaders depict a strong profile "as they are assertive, persuasive, empathic, willing to take risks, outgoing, flexible and have a need to get things done" (Greenberg & Sweeney, 2005, p. 36). It takes more than having these characteristics to become a good leader. If male and female leaders utilize different leadership styles, "both genders need to embrace what makes them unique to advance the mission of … the organization" (Price & Howard, 2012, p. 35). A good leader will have the perception and foresight to envision a desirable outcome, garner colleagues to believe in their vision, and motivate others to have a can-do mindset.

Methodology

By using a questionnaire method, the suggested methodology for our research question is both quantitative and qualitative, which is called a mixed-methods study. Benefits of this study include understanding the contradictions between the results of both methods. The data results would complete the story of the research by providing statistics and descriptive data (Wisdom & Creswell, 2013). A research study was conducted on 140 females in the healthcare industry holding a position in administration, clinical, and other positions. The questionnaire was conducted to obtain results from women in healthcare on their viewpoints on leadership and career advancement. The questionnaire consisted of a mixture of quantitative and qualitative questions (Hopkins et al., 2006).

Our group has decided to conduct a digital questionnaire. Statistical analysis will be conducted on the responses from the digital questionnaire. Questions will focus on answering our research question: Does gender influence the leadership style of healthcare administrators? (Northouse, 2004). The digital questionnaire will consist of five questions pertaining to the volunteer's leadership style and to infer their superior's leadership style. Our sample population will consist of 240 total participants, 120 males and 120 females between the ages of 20 years old and 60 years old. The male and female participants will both consist of 30 participants between the ages of 20–29-year-old working professionals, 30 participants between the ages of 30-39 working professionals, 30 participants between the ages of 40–49-year-old working professionals, and 30 participants between the ages of 50–60-year-old working professionals. We chose 240 total participants for this study because it is a manageable number to get a response to represent the entire category. If the number of participants is too small, the results will be less meaningful and inaccurate (Jones et al., 2013).

This methodology was chosen to receive feedback from both male and females in different age groups. We believe the answers from different age groups will be quite different due to their experience working from different management superiors. Older participants who have worked for decades may have worked for both task-oriented superiors and relationshiporiented superiors and prefer one over the other. Younger participants who have less experience may have only been exposed to one type of leadership style. This questionnaire will determine if gender influences leadership styles in the healthcare industry. Questionnaires are the recommended method when conducting a study on a large group of participants, which consists of a couple of questions that can best answer our research question. Questionnaires are cost effective, quick, simple, and easy to navigate for the participants. Another benefit of digital questionnaires is the

ability to get participants throughout the world, and in our case, it would be throughout the Bay Area. Due to the large number of participants in this study, automated data collection can save time. For example, researchers can focus on other tasks, while waiting for participants to complete the questionnaire (Wright, 2005).

Data Collection

To determine whether gender influences leadership style, we will conduct a digital questionnaire to gather data and information from individuals in the healthcare field. The beginning of the questionnaire will contain demographic questions such as age, gender, and occupational title. However, no personal information such as name, address, and background information will be asked. Participants will remain anonymous.

The questionnaire would focus on obtaining responses regarding the following:

1. Is your leadership style relationship-oriented or task-oriented? Please explain why.
2. What life events or professional challenges helped you develop your leadership style?
3. Think of your direct supervisor. Do you think their leadership style is relationship-oriented or task-oriented?
4. When you think of effective leadership, do you think leaders in the healthcare industry should be more relationship-oriented or task-oriented focused?
5. In your opinion, do you think male healthcare leaders are relationship-oriented or task-oriented? What about female healthcare leaders? Please elaborate on your answers. We are aware that not everyone will be able to identify if they are relationship-oriented or taskoriented, so along with the questionnaire, we would provide an attached worksheet that they can complete. Their answers on the worksheet will help our participants identify if they are relationship-oriented or task-oriented.

Our team, and many of our classmates are currently employed in the healthcare field. We would extend a request to our colleagues, our classmates, and our classmates' colleagues to fill out our digital questionnaire. As mentioned in our methodology, we are looking for a total of 240 responses, 30 responses from each gender per age group. Therefore, our data collection will be based on first come, first serve. The first 30 properly filled out digital questionnaires from each gender per age group will be accepted in our study. A digital questionnaire is economical, convenient, and practical because it eliminates physical waste, participants can respond via smartphone or computer in a timely manner, and less financial resources will be spent towards sending and receiving a physical questionnaire.

Limitations to the Questionnaire

There are limitations to our proposed data collection. We operate under the assumption that our colleagues and classmates are willing and able to fill out the questionnaire with no financial incentive. Another assumption is that we will receive at least 30 responses from each respective age group and gender. If the number of responses received from one gender's age group is significantly higher than the other respective age group, the results of our data may be skewed due to insufficient sample size. Additionally, we assume that we will receive responses from a diverse population pool that includes entry level employees to healthcare executives.

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