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A Phenomenological Study of the Glass Ceiling Obstacles Faced by Minority Women Leaders in Healthcare Organizations

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Abstract

Despite increasing attention to diversity in healthcare leadership, minority women remain significantly underrepresented in senior positions. This phenomenological study explored the lived experiences of minority women leaders in healthcare organizations who have overcome glass ceiling barriers. Guided by two research questions, the study examined the obstacles these women faced in achieving senior-level leadership roles and the strategies they employed to surmount these challenges. Data were collected through semistructured interviews with eight current and former senior-level minority women leaders from healthcare organizations in the southcentral United States. Participants—African American, multiracial, African, and Caribbean women with 5 to 19 years of healthcare experience—were selected through purposive sampling. Interviews were conducted via Zoom, transcribed verbatim, and analyzed using thematic analysis and the constant comparative method, following Kiger and Varpio's six-step framework. Findings revealed recurring barriers, including racial and gender bias, excessive scrutiny, lack of promotion opportunities, unethical supervisory behaviors, and feelings of inadequacy—hallmarks of the glass ceiling phenomenon. Participants overcame these obstacles through resilience, professional competence, ethical leadership, and strategic self-advocacy. Thematic saturation was achieved by the eighth interview. Trustworthiness was reinforced through member checking, audit trails, and reflexive analysis. This study contributes to the limited scholarship on intersectional challenges in healthcare leadership and offers actionable insights for organizational change. By promoting inclusive cultures, transparent promotion practices, and leadership development pathways for minority women, healthcare institutions can mitigate structural inequities. These findings have implications for practitioners, researchers, and policymakers seeking to foster equity and gender diversity

in healthcare leadership.

Keywords

Glass Ceiling, Inequality, Equity, Gender Diversity, Racial Bias

1. Introduction

Despite advancements in gender equity, the *glass ceiling* remains a formidable barrier in healthcare, influencing identity formation, professional development, and career progression for women (Alobaid et al., 2020; Mittal & Kaur, 2021). The enduring nature of this barrier is underscored by findings that systemic bias continues to shape women's access to leadership despite legal and organizational reforms (Parker-McCullough, 2020; Siemiatycki, 2019). Although women constitute a significant majority of the global healthcare workforce, they are underrepresented in senior leadership roles, particularly at the executive and board levels (Dean & Perrett, 2020; Rivera-Romano et al., 2020). This disparity persists despite increasing awareness of the organizational and pragmatic capabilities women bring to the healthcare sector. While researchers have documented gender-based inequities in governance roles, there remains a lack of empirical studies exploring the unique challenges faced by minority women aspiring to senior leadership positions (Kowalewska, 2020).

This qualitative study employed a phenomenological approach to investigate the lived experiences of minority women leaders in healthcare organizations located in the southcentral United States. Through in-depth, semistructured interviews and thematic analysis, the study revealed key barriers—such as organizational culture, gender stereotyping, exclusion from informal networks, and limited access to mentorship—and explored the strategies these minority women leaders employed to overcome them. The research is grounded in the conceptual frameworks of sexism and gender conflict theory, which help contextualize the intersection of structural inequality, power dynamics, and professional advancement (Starks, 2021; Webb, 2022). The findings offer critical insights into the intersectionality of gender and minority status, with implications for policy, practice, and future research aimed at fostering equitable and inclusive leadership structures in healthcare organizations.

2. Background of the Study

Despite comprising nearly 78% of the global healthcare workforce, women—particularly minority women—remain significantly underrepresented in senior leadership positions within healthcare systems (Rivera-Romano et al., 2020). This leadership disparity persists despite ongoing advocacy for gender equity, underscoring the entrenched influence of the *glass ceiling*—a metaphor for the invisible, yet persistent, barriers that impede women's advancement regardless of merit or

qualifications (Alobaid et al., 2020; Espinosa & Ferreira, 2022). These obstacles are often embedded in organizational cultures that normalize male-dominated leadership and reinforce gendered stereotypes in promotion and decision-making processes (Bloch et al., 2021).

Although gender diversity initiatives have resulted in incremental progress—such as increasing women's presence on corporate boards—significant disparities endure. Women comprise only 20% of board seats among top publicly listed firms across OECD countries, and fewer than 5% of CEOs are female (Kowalewska, 2020; Nili, 2019). These statistics are even more stark for minority women, who experience compounded barriers rooted in both gender and racial discrimination (Nekhili et al., 2022; Thomas, 2018). The intersectional nature of these challenges has been described as facing a "concrete wall with a glass ceiling on top", particularly for Black and other women of color (Bloch et al., 2021: pp. 321-322).

Effective healthcare leadership is essential to building equitable, resilient, and innovative systems (Pounder & Greaves, 2020). Yet, the continued marginalization of minority women from executive roles not only undermines diversity but may also limit organizational responsiveness and outcomes (Azad et al., 2021; Nambiar et al., 2022; Potvin et al., 2018). Addressing these disparities necessitates a deeper examination of the structural, cultural, and institutional forces that impede minority women's advancement, as well as the implementation of inclusive leadership models that promote equity and representation.

3. Research Methodology

This qualitative study employed a descriptive phenomenological design to explore the lived experiences of minority women leaders in healthcare organizations across the Southcentral United States who encountered and overcame the glass ceiling effect. Descriptive phenomenology was selected for its ability to capture the essence of subjective experiences and to illuminate the meaning participants assign to their realities (Mason, 2019). A qualitative approach was appropriate for examining complex social phenomena such as race and gender-based leadership barriers, enabling participants' voices to guide the interpretation (Horstmann & Remdisch, 2019; Wei et al., 2020). Purposeful sampling was used to recruit participants who met the selection criteria—minority women in senior healthcare leadership with direct experience of overcoming the glass ceiling (Alobaid et al., 2020). Snowball sampling extended the reach by inviting referrals from initial participants, helping to build a robust yet homogeneous sample aligned with phenomenological requirements (Strange, 2018). Eight participants were ultimately interviewed, which is methodologically sufficient for capturing depth within this design. All participants provided informed consent and were assured of confidentiality, voluntary participation, and the right to withdraw at any time (Parker-McCullough, 2020; Sørensen et al., 2020).

Data collection involved one-on-one, semistructured interviews conducted via Zoom audio conferencing, each lasting 45 to 60 minutes. The interview protocol,

developed in alignment with the research questions, encouraged open discussion around participants' leadership journeys, barriers faced, and strategies used to overcome them (Sharma & Kaur, 2019). All interviews were Zoom audio-recorded, transcribed verbatim, and returned to participants for member checking to validate accuracy and enhance credibility (Mason, 2019). Thematic analysis was employed using the six-phase model by Kiger and Varpio (2020), which included data familiarization, initial coding, theme generation, theme review, theme definition, and final interpretation. This analytic approach was appropriate for identifying shared meanings and recurring patterns while preserving individual nuances (Starks, 2021). Data saturation, defined as the emergence of no new themes, occurred by the eighth interview.

Trustworthiness was established through several strategies: credibility via member checking and triangulation with literature; dependability through consistent data collection and analysis procedures; transferability through detailed contextual descriptions; and confirmability through reflexive journaling and alignment of findings with participant narratives (Parker-McCullough, 2020; Starks, 2021). The study was delimited to minority women leaders in healthcare settings within the Southcentral region of the United States, excluding men and other regions. Limitations included the self-reported nature of data, potential biases in participant recall, and restricted generalizability due to the purposive sampling strategy. However, the methodological rigor applied in sampling, data collection, and analysis enhances the credibility and relevance of the findings. This study contributes meaningful insight into the strategies minority women employ to navigate and transcend institutional barriers, adding to the growing literature on inclusive leadership and equity in healthcare (Dean & Perrett, 2020; Rivera-Romano et al., 2020).

4. Results

The findings of this descriptive phenomenological study illuminated the multifaceted barriers experienced by minority women leaders in healthcare organizations, as well as the strategies they employed to navigate and overcome the glass ceiling. Eight participants, purposefully selected for their lived experiences, represented diverse racial and ethnic backgrounds, including African American, multi-racial, African, and Caribbean heritage, with professional experience ranging from 5 to 19 years. Most held senior leadership roles, while others were in supervisory or aspirational positions. Thematic analysis, conducted using Kiger and Varpio's (2020) six-phase framework, yielded consistent themes across interviews. A central barrier identified was the presence of organizational and systemic bias, manifested through exclusion from influential networks, lack of mentorship, and restricted access to high-visibility leadership opportunities. Participants reported experiencing both overt and covert forms of discrimination based on intersecting identities of gender and race. The recurring need to outperform peers to counteract negative stereotypes was particularly salient, underscoring the cumulative im-

pact of intersectional bias. These findings are consistent with existing literature documenting the compounded challenges faced by minority women in leadership positions (Dean & Perrett, 2020; Rivera-Romano et al., 2020).

4.1. Findings by Research Question

The research questions (RQs) for the study were:

RQ1: What obstacles did minority women leaders who have achieved senior-level positions in healthcare organizations despite the glass ceiling face?

RQ2: How did minority women leaders who achieved senior-level positions in healthcare organizations despite the glass ceiling overcome the obstacles they faced?

4.2. Research Question 1—Obstacles

Research Question 1 examined barriers to senior leadership advancement among minority women in healthcare. Thematic analysis of the interview data revealed nine primary obstacles—each mentioned by over 50% of the participants—racial and gender bias, heightened scrutiny, denied promotions, unethical supervisory practices, and feelings of inadequacy, reflecting entrenched systemic inequities.

RQ1. Theme 1: Racial Bias

All the participants identified racial bias as a central barrier, citing exclusion from leadership, stereotyping, and prejudicial assumptions. One noted that race and youthful appearance undermined her authority, with colleagues refusing to follow directives or engage. Another described being addressed patronizingly, reflecting intersecting racial and gender bias that reduced her professional standing. A third reported that colleagues frequently questioned her competence and delegation ability, resulting in task failures and impaired team function. Collectively, these accounts underscore how racial bias diminishes credibility and obstructs leadership advancement for minority women in healthcare.

RQ1. Theme 2: Gender Bias

All the participants reported experiencing gender bias, including assumptions of inferior leadership ability and inequitable evaluations. One described a colleague's condescending behavior and the absence of institutional response to her formal complaints, attributing both to gender bias. Another noted resistance and dismissal of her procedural input, which she linked to being a Black woman. A third shared that a physician reacted negatively to her inquiries, also perceived as rooted in racialized gender bias. These accounts demonstrate how intersecting gender and racial prejudices diminish minority women's credibility and authority in leadership roles.

RQ1. Theme 3: Heightened Scrutiny

Seventy-five percent of the participants reported experiencing heightened scrutiny and disproportionate consequences for mistakes, reflecting unequal performance expectations. One described repeated disparaging remarks from a White physician, including accusations of insubordination and demeaning references to

working under his license—behavior she attributed to racial and gender bias. She emphasized that similar conduct toward others would likely have resulted in disciplinary action. Another noted that her cost-saving proposals were met with persistent criticism rather than constructive dialogue, casting her as confrontational. A third shared that a colleague's demeaning behavior diminished her professional identity and discouraged participation. These accounts reveal a consistent pattern of excessive oversight and critical judgment, disproportionately targeting minority women leaders and eroding their authority and professional standing.

RQ1. Theme 4: Denied Promotion

Five participants reported being denied promotions despite surpassing the stated qualifications, often in the absence of mentorship. One, though praised for enhancing efficiency, was reassigned to a less prestigious role rather than promoted—an outcome she viewed as professionally diminishing. Another described colleague behavior that undermined her value, discouraging advancement. A third experienced repeated rejection across application cycles, despite comparable expertise, raising concerns about the visibility of Black women candidates. These accounts highlight how systemic bias and insufficient mentorship restrict career progression for qualified minority women leaders.

RQ1. Theme 5: Unethical Behavior by Supervisors

Five participants described unethical supervisory conduct marked by favoritism, discrimination, and lack of accountability. One reported her colleagues' refusal to follow her directives, which undermined her leadership. Another recounted a supervisor's attempt to seize student records in violation of privacy laws, followed by retaliatory actions when challenged. A third noted persistent criticism and resistance to her efficiency efforts, framing her as oppositional. These patterns reflect how unchecked supervisory misconduct reinforces discriminatory and hostile work environments for minority women leaders.

RQ1. Theme 6: Made to Feel Inadequate

Five participants reported feeling professionally inadequate due to unequal standards and systemic bias. One described discouraging comments from a supervisor seemingly aimed at prompting her departure. Another recalled a mentor suggesting a less ambitious career path, questioning her capability. A third cited societal perceptions that devalue Black professionals regardless of merit. These accounts demonstrate how both overt and covert bias diminish confidence and reinforce perceptions of inadequacy among minority women leaders.

4.3. Research Question 2—Strategies

Research Question 2 investigated the strategies used by minority women leaders to overcome barriers to achieving senior roles in healthcare. Thematic analysis identified four primary strategies—mentorship, networking, resilience, and advocacy. Each was reported by over 50% of the participants as critical in navigating systemic and organizational obstacles.

RQ2. Theme 1: Demonstrating Resilience

All participants emphasized resilience as vital to navigating racial bias and leadership exclusion. One described intrinsic motivation and patient care as sustaining factors amid adversity. Another reported that changing mentors enhanced confidence and led to career success. A third cited self-belief, skill-building, and leveraging her immigrant background to pursue advancement. Collectively, participants illustrated how self-efficacy, mentorship, and purpose-driven commitment underpin resilience in minority women leaders.

RQ2. Theme 2: Taking an Ethical Stance

Seven participants emphasized ethical integrity as crucial for navigating systemic barriers. One adhered to professional standards despite pressure, reflecting ethical resolve. Another addressed undermining behavior through formal reporting, reinforcing accountability. A third highlighted humility and mentorship to support collective progress. These accounts illustrate how commitment to integrity fosters credibility and leadership efficacy among minority women.

RQ2. Theme 3: Proving Capability

Seven participants emphasized the importance of consistently exceeding expectations to counteract bias. One created a financial recovery division, improving hospital performance and showcasing leadership. Another requested a new preceptor to demonstrate competence in a hostile environment, enhancing organizational credibility. A third founded a business to assert autonomy and serve her community, reflecting proactive resistance to structural barriers. These efforts reflect how demonstrable expertise and strategic initiative enable minority women to redefine leadership perceptions and advance professionally.

Despite the obstacles they faced, participants demonstrated agency and resilience through various adaptive strategies aimed at professional advancement. Key approaches included pursuing advanced education, maintaining high ethical and professional standards, and proactively seeking mentorship and sponsorship. Several participants emphasized the importance of cultivating relationships with mentors both within and outside their organizations, which served as critical sources of guidance, advocacy, and validation. Additionally, the development of supportive professional networks and alignment with organizational values were described as instrumental in building credibility and gaining trust. Participants also highlighted the strategic use of self-advocacy and political navigation to secure leadership visibility and influence. These strategies echo recommendations in the literature on inclusive leadership development and underscore the importance of institutional accountability in fostering equitable advancement pathways (Horstmann & Remdisch, 2019; Starks, 2021; Wei et al., 2020). Overall, the results contribute meaningful insight into how minority women in healthcare leadership overcome systemic inequities and provide practical implications for advancing diversity and equity in organizational leadership structures.

5. Discussion

This study examined the enduring influence of the glass ceiling in healthcare or-

ganizations, particularly as it affects minority women in leadership. Employing a qualitative, phenomenological approach, the research explored the lived experiences of these leaders and illuminated the complex interplay of gendered, racialized, and structural obstacles they face. The findings align with and expand upon existing literature on intersectionality and leadership inequity, providing insight into both entrenched barriers and the strategic responses of minority women navigating systems not originally designed for them.

Participants reported systemic impediments to career advancement, such as opaque promotion practices, exclusion from informal leadership pipelines, and discriminatory stereotypes (Espinosa & Ferreira, 2022; Nili, 2019). These challenges reflect structural inequities embedded in organizational culture, supporting Alobaid et al. (2020), who noted that gender biases often persist within seemingly neutral processes. The intersection of race and gender emerged as a defining theme of the study. All the participants described the compounded challenges this presents, echoing Bloch et al.'s (2021) concept of a *concrete wall* that intensifies the challenges of the traditional *glass ceiling*.

Stagnant organizational cultures were cited as a key factor in perpetuating inequities. Participants emphasized that, while awareness around gender bias has increased, this has not always translated into transformative policy or practice. This aligns with Potvin et al. (2018), who found that many organizations resist substantive diversity efforts, and with Young (2022), who reported slow progress toward boardroom diversity. The finding that women in leadership are less likely to be succeeded by other women (Nili, 2019) further underscores the systemic nature of exclusion and the fragility of representation gains in leadership roles.

Despite these challenges, participants employed a range of adaptive strategies, such as cultivating professional excellence, strategic self-advocacy, and pursuing mentorship and professional networks—tactics that identified as key to minority women's leadership development (Wei et al., 2020). Several also embraced servant leadership principles, emphasizing humility, ethical decision-making, and community-building, which have been shown to enhance inclusivity and organizational commitment in healthcare environments (Segovia-Pérez et al., 2021).

The study's limitations include its qualitative design and the purposeful sampling of eight participants from a specific U.S. region, which may limit generalizability. Self-reported experiences may also be subject to recall bias or influenced by social desirability (Mason, 2019). These constraints highlight the need for future research employing larger, more diverse samples across different contexts.

To address persistent inequities, healthcare organizations should implement deliberate, evidence-based interventions. Structured mentorship programs for minority women (Nekhili et al., 2022) and transparent, bias-mitigating promotion systems (Thomas, 2018) are crucial. Adopting servant leadership principles can foster inclusive cultures (Segovia-Pérez et al., 2021). Policymakers should consider incentives or accountability measures to increase minority women's representation in executive roles (Cunningham et al., 2021).

Ultimately, this study reinforces the urgent need for structural and cultural re-

form within healthcare leadership. Equitable representation is not only a matter of fairness but also a strategic imperative for healthcare quality, innovation, and organizational resilience (Horstmann & Remdisch, 2019). Addressing the root causes of inequity and institutionalizing inclusive leadership practices will enable healthcare organizations better serve their diverse patient populations and workforces.

6. Implications

The findings highlight the urgent need for healthcare organizations to implement evidence-based interventions that address gender disparities in leadership. These should include transparent promotion pathways, bias-mitigation strategies, and the cultivation of inclusive workplace cultures. Future research should examine the effectiveness of these interventions across various healthcare contexts and further investigate the compounded barriers faced by women of color in leadership. In practice, organizations are encouraged to adopt structured mentorship programs, leadership development initiatives, and regular equity audits to support minority women's advancement. These strategies can contribute to more inclusive organizational cultures and inform policy reforms aimed at supporting the advancement of minority women into senior leadership roles. Policymakers are also urged to promote gender equity through legislative mandates or incentive-driven mechanisms aimed at increasing representation on executive teams and governing boards. Critically, policies must be developed through an intersectional lens to address the compounded inequities experienced by women of color, who often face systemic barriers at multiple levels. Advancing equity in leadership is not only a matter of justice but also correlates with improved organizational performance and patient outcomes (Espinosa & Ferreira, 2022), reinforcing the imperative for sustained institutional commitment.

7. Conclusion

The persistence of the glass ceiling remains a significant impediment to equitable leadership in healthcare, disproportionately affecting women—particularly those from underrepresented racial and ethnic backgrounds. While progress has been made in recognizing gender bias, systemic transformation is required to eliminate entrenched structural barriers (Bloch et al., 2021). This study reinforces the imperative for inclusive leadership models that actively dismantle discriminatory practices and support diverse talent pipelines (Nekhili et al., 2022). Achieving sustainable gender equity will require data-informed strategies, intentional reforms, and policy interventions tailored to organizational contexts. As Kowalewska (2020) argued, such efforts are not only ethically warranted but strategically vital for cultivating adaptive, resilient, and high-performing healthcare systems.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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