AMERICAN UNIVERSITY OF BEIRUT

THE DYNAMICS OF GENDER AND LEADERSHIP IN HEALTHCARE MANAGEMENT IN LEBANON: REFLECTIONS IN TIMES OF CHANGE

by
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AN ABSTRACT OF THE PROJECT OF

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Title: The Dynamics of Gender and Leadership in Healthcare Management in Lebanon: Reflections in Times of Change.

The aim of this study is to explore several healthcare organizations in Lebanon from a gender and leadership perspective and identify strengths and weaknesses in promoting gender equity in their management, focusing on gender disparities (if any) and the reasons for them. It will further delve into the different processes and initiatives that healthcare organizations in Lebanon work on and adopt to promote gender equity. This study will tap on Joan Acker's 'gendered organization' framework and the four processes attributed to the framework to further examine if healthcare organizations create a synergy between the concept of gender equity and senior management. The analysis that was carried out reflects the situation of the healthcare organizations in the Lebanese context and portrays how these organizations view and identify with gender-related concepts in the work place. The results indicate that the notion of gender equity is well accepted and implemented by the healthcare organizations despite nuances specific to each organization in the sample.

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To

My Beloved Family

CHAPTER I

INTRODUCTION

Context and Background

The Global Competitiveness Report (GCR) for the year 2014-2015 published by the World Economic Forum showcases the competitive performance of 144 countries measured on 12 different pillars entering the composition of the Global Competitiveness Index (GCI). The seventh pillar that discusses "Labor Market Efficiency" highlights the efficiency and flexibility of the labor market that are "critical for ensuring that workers are allocated to their most effective use in the economy and provided with incentives to give their best effort in their jobs. Efficient labor markets must also ensure clear strong incentives for employees and efforts to promote meritocracy at the workplace and they must provide equity in the business environment between women and men" (Schwab & Sala-i-Martin, 2014, p. 7). Lebanon, a member of the Arab Middle East cluster, ranks 138 out of the 144 countries mentioned in the report, on women in the labor force, ratio to men. This disappointing position highlights the importance and efforts that need to be done to enhance Lebanon's position on this factor among many others. According to Karam and Jamali (2013), despite the varied manifestations of gender ideology across the Arab Middle East, the region has repeatedly ranked among the worst in the world in terms of gender rights and equality (Hausmann, Tyson & Zahidi, 2011; Metcalfe, 2007; Moghadam, 2004). Karam and Afiouni (2014) used a gender-based lens to examine macro level contextual structures across thirteen countries in the Arab Middle East region and found that the "most salient of these structures include: (1) socioeconomic factors; (2) demographic factors; (3)

family networks and interpersonal connections; (4) government, legal frameworks, and legislation; (5) Islam; (6) patriarchy; and (7) Urf (i.e., a custom in establishing a framework of acceptable norms of behavior for any specific Muslim community)". While there have been some changes in these structures in recent years they continue to dictate stringent social norms favoring a more traditional division of labor responsibilities (i.e. with women being required to perform more domestic duties than men) and therefore tend to further anchor career choices and patterns in a gender-congruent manner (Karam & Jamali, 2013). Cultural values, societal practices, and stereotypical viewpoints towards the role of women in Arab countries, in general, are seen to impact the structures and practices of organizations that employ these women. Moreover, cultural and societal norms in this region are still regarded as highly patriarchal with clear gender role differences (Metle, 2002; Khattab, 1996; Kausar, 1995).

The Human Capital Theory assigns gender differences in investments in human capital such as levels of educational attainments, training and development of skills and competencies. The theory is based on the premise that educational investments translate into economic advantages (Langelett, 2002; Becker, 1971). The theory predicts that continuous investment in human capital leads to better job opportunities and thus offering positive rewards for the individual (Becker, 2002; Drucker, 2001). The theory views investment in human capital as a consequence of an individual's rational calculations of the costs associated with acquiring education, skills and experience and benefits in terms of having better jobs and advancements in careers. According to this theory, men and women differ in terms of their investment in human capital, with men more likely to invest in further education and development of new skills. Therefore, Human Capital Theory argues that the differential treatment of men and women at work

is a natural outcome of their position in the labor market (Becker, 1971). Several studies have attempted to inspect the status of Lebanese women managers (Tlaiss & Kauser, 2010, 2011; Jamali, Safieddine & Daouk, 2006; Jamali, Sidani & Safieddine, 2005). These studies have shown that there is a prejudice clustering of educated and well experienced women in the lower levels of management across a wide range of organizations in several industries. There is also evidence for the lack of access of women to the workplace at all (Karam & Afiouni, 2014)

Another explanation for why women are prevented from advancing to the top has to do with gender discrimination (Blau & Ferber, 1987). Drawing from research conducted largely in the West, this view suggests that discrimination against women managers is reinforced by the negative attitudes of others which may result in personal and organizational barriers that women encounter in their career development (Davidson & Burke, 2000, 2004). These attitudes reinforce gender role stereotyping that define women via their domestic and reproductive chores, and perceive women as inadequate managers. This sort of gender discrimination is also embedded in the organizational policies and practices that often limit women's advancement.

Despite the global proliferation of diversity research and diversity training programs in the past years and the decades of Western-based anti-discrimination legislation and affirmative action programs, women, minorities, and other non-dominant group members remain woefully underrepresented in key organizational positions, confined by glass ceilings and walls; held to higher performance standards; and sometimes subjected to virulent harassment, discrimination, and exclusion (Bell & Berry, 2007). This underrepresentation and confinement is echoed and, some would argue, drastically augmented in the Arab Middle East (Metle, 2002; Abdalla, 1996).

Diversity and Career Mobility

Diversity as a lexicon in human resource management furnishes immediate access to a large pool of knowledge, skills, and abilities required in the accomplishment of organizational goals and objectives (Ewoh, 2013). According to Cox (1993), diversity is seen as the collective, all inclusive, mixture of human differences and similarities, including educational background, geographic origin, sexual preference, profession, culture, political affiliation, tenure in an organization, and other socioeconomic, psychographic, and ethnic-racial characteristics. Gender, one form of diversity, is produced and reproduced in organizations by means of processes, practices and actions taking place in organizational contexts, resulting in phenomena such as the glass ceiling and the low representation of women at all management levels (Mensi-Klarbach, 2014). Gender is a primary cultural frame helping people in establishing and sustaining relations with others (Sidani *et al*., 2015).

Sexual orientation is another form of diversity worth taking into consideration when discussing upward career mobility. According to Miller (1995), the business community defines and places value judgments on gender and sexual identity, attributing positive values toward masculinity and heterosexuality and negative values toward femininity and homosexuality. Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) people continue to face developmental challenges caused by workplace hostility, harassment, and less access to promotional and developmental programs than heterosexuals (Bierema, 2002).To improve the work-lives and careers of the LGBTQ population, and in doing so helping an organization to become more socially conscious and equitable, the cognitive, psychological, and social processes within an LGBTQ person's life, such as identity development, identity management, discrimination, and prejudice, can play a large part in shaping and influencing practices and policies within

the remit of the HR practitioner (McFadden, 2015).

Tilcsik (2011) finds that mentioning previous experience in an LGBTQ campus organization would actually hinder one's career development process in many parts of the United States, rather than help it. In scenarios such as this, sexual and gender identities can become entwined with the career development process, and the LGBTQ person must forgo mentioning a possibly beneficial aspect of their former career or run the risk of discrimination, both formal and informal, when their LGBTQ identity is made known.

Women and Career Mobility

Powell and Graves (2003) argue that management is seen as a career only for men, and the majority of top management positions are filled. Barriers to the promotion of women into middle- and upper-level management positions still persist (Konrad, 2003; Pomeroy, 2007). At almost every level, women managers globally are described as having to deal with blocked mobility, discrimination and stereotypes (Omair, 2008). For example, Catalyst (2014) reported that the representation of women in executive officer positions at Fortune 500 companies has stagnated at approximately 14.5% since 2010.

As Ali, Kulik and Metz (2011) suggested, there is a need for more research to examine firm-level effects of gender diversity. Most of the extant research links firm performance with gender diversity of top-management teams (Roost & Osterloh, 2010) and boards of directors (Ali, Ng & Kulik, 2014; Carter, D'Souza, Simkins & Simpson, 2010). A research review of gender diversity on corporate boards suggested that boards with at least three female directors outperform firms with all-male boards (Terjesen, Sealy & Singh, 2009). Carpenter's (2002) review of gender diversity on the top-

management teams reported positive effects of gender diversity on a firm's financial performance. Combined, these results suggest that gender diversity at the highest levels of an organization tends to improve firm performance.

Scholars of women and work in the 1980s and 1990s were concerned with the slow progress of women entering management and senior management in specific. The various descriptions fell into two basic types: those emphasizing characteristics of the individual employees themselves and those focusing on the work environment (Kanter, 1977; Reskin, 1993). Metcalfe (2008) argues that the reasons for women's limited advancement in the public sphere, particularly in the Middle East, are due to the prevalence of "the patriarchal work contract within public and private institutions, as well as cultural and ethical values which create strongly defined gender roles (p.1)". Mensi-Klarbach (2014) discusses that the *societal context* needs to be explored first, as organizations operate in a certain societal environment, which result in certain degrees of vertical and horizontal sex segregation. Second, the *organizational level* needs to be taken into account, when it comes to analyzing top management behavior, because as Acker (2006) stated, "gender, as socially constructed differences between men and women and the beliefs and identities that support difference and inequality, is also present in all organizations (p. 444)." Third, the *top management team* must be looked at, to understand how individual team members can bring in their skills and competences. Forth, *individual characteristics* have to be considered to capture top managers' individual impact and thereby identify the potential contribution of female top managers. At first glance, research suggests that gender discrimination has decreased with the increased representation of women in management and professional positions (Catalyst, 2014). However, a more careful investigation suggests that these gains are largely at lower levels of management and with non-managerial professional

positions (Schwab & Sala-i-Martin, 2014).

Gender and Leadership

Leadership theories are not generalizable over all individuals, regardless of their gender or culture. Britton and Logan (2008), focused on three important trends in research employing gendered organizations paradigms. These paradigms are (a) the connections between intersectional perspectives and gendered work, (b) the increasing focus on the influence of organizational context, and (c) the exploration of strategies for change. Further, they informed that the body of research on mechanisms that produce inequality at work tells us that inequalities of gender, race, class, and sexuality are deeply entrenched in workplace cultures, interactions, and even the identities of workers. Before change strategies are identified or implemented, inequality processes must be made visible. To this end, we cannot merely note the consequences of working within gendered organizations or the characteristics of gendered organizations, we must see the processes whereby organizations maintain and reproduce inequalities (Britton & Logan, 2008). Looking at the intersections of gender, race, class, and sexuality, as well as organizational context are central to making inequalities visible. Further, leadership is seen as a social interaction between leaders and their supervisors, peers, and subordinates. Korabik & Ayman (2007) have concluded that leadership is not universal; rather, it can vary as a direct function of either gender or culture. Furthermore, both gender and culture can moderate the relationship between leadership behaviors and outcomes.

Gender stereotypes are used by both men and women to categorize and frame themselves and others. Said stereotypes are based on social norms and expectations of how men and women are, and how they should be (Eagly & Karau, 2002). Thus, they

are not only descriptive but also prescriptive features, producing an idea of how men and women must behave. As such they function as "gender-scripts" (Hanappi-Egger, 2011). Studies show that while men who adopt masculine managerial styles are accepted and praised, women who adopt such styles have much lower approval ratings (Kent & Moss, 1994; Kolb, 1997; Rhode, 2003). Such findings ratify the view that stereotypical ascriptions work against women in professional life (Rhode, 2003). According to Eagly *et al*. (2000), aspects of gender roles that are especially relevant to understanding leadership pertain to agentic and communal attributes. Agentic characteristics, which are ascribed more strongly to men than women, describe primarily an assertive, controlling, and confident tendency. For example, aggressive, ambitious, dominant, forceful, independent, daring, self-confident, and competitive. In employment settings, agentic behaviors might include speaking assertively, competing for attention, influencing others, initiating activity directed to assigned tasks, and making problem-focused suggestions. Communal characteristics, which are ascribed more strongly to women than men, describe primarily a concern with the welfare of other people. For example, affectionate, helpful, kind, sympathetic, interpersonally sensitive, nurturing, and gentle. In employment settings, communal behaviors might include speaking tentatively, not drawing attention to oneself, accepting others' direction, supporting and soothing others, and contributing to the solution of relational and interpersonal problems. Managers and other leaders occupy roles defined by their specific position in a hierarchy but also simultaneously function under the constraints of their gender roles (Eagly & Johannesen-Schmidt, 2001).

Female leaders' efforts to accommodate their behavior to the sometimes conflicting demands of the female gender role and their leader role can foster leadership styles that differ from those of men. Gender roles thus have different implications for

the behavior of female and male leaders, not only because the female and male roles have different content, but also because there is often inconsistency between the predominantly communal qualities that perceivers associate with women and the predominantly agentic qualities that they believe are required to succeed as a leader. People thus tend to have similar beliefs about leaders and men but dissimilar beliefs about leaders and women (Eagly & Johannesen-Schmidt, 2001). Consistent with this reasoning, Gutek and Morasch (1982) argued that gender roles spill over to organizations, and Ridgeway (1997) maintained that gender provides an "implicit, background identity" in the workplace.

Women and Leadership

The growing interest in the study of women in management has been triggered by the increasing role that women have taken in public activities (Omair, 2008). In line with the increasing role that women play in the economy, more women globally are pursuing careers in management (Omar & Davidson, 2001).The status of research on the career success of women managers seems to be rather ignored in the third world countries as explained by Counsell and Papova (2000). The dearth of research in this area could be perhaps attributed to the lack of consensus on the definition of career success (Tlaiss & Kauser, 2011; Karam & Afiouni, 2014).

While potential conflicts based on gender diversity are explained through social categorization processes and group phenomena (Tajfel, 1982), the implied benefits are rationalized by the underlying assumption that women possess different skills to their male colleagues, and these might add value to the management (Bernardi, Bosco & Vassill, 2006). Bernardi *et al*. (2006) also reason in terms of the "greater social responsibility" for a higher appointment rate of females to boards of directors and senior

management positions.

In their article, “Women in Power: Undoing or Redoing the Gendered Organization”, Stainback, Kleiner and Skaggs (2015) explored the implications of women in leadership positions for the opportunities and experiences of subordinates. They utilized Cohen and Huffman’s (2007) conceptualization of women leaders as either change agents or cogs in the machine to examine competing theoretical expectations regarding the association between women in leadership positions and gender segregation. They specifically questioned if women’s representation in more powerful decision-making jobs simply re-creates gendered organizations by maintaining the status quo or if they function as agents of change by challenging inequality regimes and reducing gender segregation below. Their findings generally support the “agents of change” perspective. Women’s representation among corporate boards of directors, corporate executives, and workplace managers is associated with less workplace gender segregation. Hence, it appears that women’s access to organizational power helps to undo the gendered organization.

While research examining working women in the Middle East remains scarce, a number of interesting contributions have been made in recent years. Exploring cultural dimensions of management and gender, Metcalfe (2006, 2007) found that women have made progress into managerial positions across the region but that they face career and development constraints due to the strong gender roles present in their local cultures. Childcare responsibilities, the lack of role models, limited organizational support and training possibilities, and the general business culture were reported as barriers to the advancement of female managers (Metcalfe, 2006).

Over the past two decades Arab societies have witnessed dramatic economic, political and social changes (Abuznaid, 2006; Ali, 1999). One of these important

changes has been the opening up of economies to foreign investments which have increased the need for skilled labor. This has transformed the composition of the workforce, changed the nature of women's employment and paved the way for improving the general economic, political, and social status of women in a large number of Arab nations (Metcalfe, 2008; MENA, 2007). The organizational reality in Arab countries is that women struggle with patriarchal, male-dominated hierarchies which have a conservative orientation towards women. Moreover, in Arab countries, women have only recently began to join the rank of managers and are grossly under-represented at the lower, middle and senior levels (Jamali *et al*., 2005).

Women managers working in the Arab countries have reported that their roles and status are very much influenced by traditional ideas, institutions and Arabic culture (Tlaiss & Kauser, 2010, 2011). The majority of Arab women report that patriarchal attitudes are highly salient within the culture, and significantly impact gender role attitudes (Kauser & Tlaiss, 2011). The majority of Arab women still seem to cluster at the lower levels of management. Arab women are continuously marginalized and excluded from rising to managerial roles (MENA, 2007; Al-Lamki, 2006; World Bank, 2003). El Ghannam (2002), for example, reported, across 22 Arab countries, that the number of women holding managerial posts was substantially lower than what their level of education and experience would warrant. In Lebanon, the country under study, Jamali *et al*. (2006) reported that most women managers were clustered at entry level positions with very few reaching senior management positions. Moreover, the authors report that some women only after 20 years of service are finally reaching middle management positions with men dominating decision-making positions. However, this does not eliminate the fact that a few exceptional women have been able to penetrate senior executive echelons. However, in the majority of cases women are clustered in

secretarial departments and administrative positions and junior levels of management (Tlaiss & Kauser, 2010; Jamali *et al*., 2006; Kattara, 2005).

There is little evidence to suggest that Arab men are equipped with personal characteristics that make them more suitable than women for management (Kauser & Tlaiss, 2011). However, the "think male/think manager" attitude continues to prevail in Arab cultures. The evidence suggests that stereotypical attitudes towards women managers are salient within Arab organizations (Jamali *et al*., 2005).The limited evidence suggests that as in developed countries, Arab women have to deal with male orientated behavior; work harder than men and consistently exceed performance expectations to counter negative assumptions (Kauser & Tlaiss, 2011).

Heightened transnational feminist dialogue, the mobilization of women's networks and the requirement of Middle Eastern (ME) societies to expand into new markets have made gender a salient issue and placed women's empowerment on policy agendas of international organizations and national governments (Edwards & Kurivilla, 2005; Hearn, Metcalfe & Piekkari, 2006). However, the participation of Arab women in the labor force is still low compared to other regions in the world, not reflecting their educational attainment and capabilities (Omair, 2008). This low participation is complicated by the fact that the woman is subject to a number of coded and unwritten social mores in a patriarchal, male-dominated society (Omair, 2008).

CHAPTER II

BRIEF BACKGROUND ABOUT LEBANON AND THE STATUS OF LEBANESE WOMEN

Geographical and Political

Lebanon is a small country located along the Eastern shore of the Mediterranean Sea bounded on the North and East by Syria and on the South by Israel, with a total area of 10,452 km^2 and a population of around 4 million inhabitants (Jamali, Abdallah & Hmaidan, 2010). Lebanon qualifies as a parliamentary republic with a centralized, multi-religious, and multiparty government. Its quasi-democratic political system is based on power-sharing between the country's confessional groups (EIU, 2007). Women's participation in political life and public life in the Lebanese context has consistently been marginal (Jamali *et al*., 2010).

Economic

The Lebanese economy is small, open and largely services based. In the wake of the civil war (1975-1990) primary attention has been accorded to reconstruction, causing significant budgetary strain, and recurrent budget deficits averaging more than 12 percent of GDP in the five years until 2006 (EIU, 2007). Women's participation rate in the labor force has remained rather modest in the Lebanese context at 23.3% in 2015 (HDR, 2015) compared to the labor participation rate of men reaching 70.9%. The women estimated earned income (GNP per capita) was USD 7,334 in 2011 compared to USD 25,390 for males (HDR, 2015).

Education

Lebanon is characterized by a highly literate, multi-lingual workforce, which reflects the country's relative strength compared with its regional neighbors in the field of education (EIU, 2007). Overall adult literacy stood at 87 percent in 2003 with literacy rates nearing 98 percent for boys and girls aged 15-24, well above the regional norm of 82 percent (EIU, 2007). Lebanese society values and accords primary attention to education which is also reflected in steady improvement in women's educational enrollment, with women's post-secondary educational enrollment nearing 50 percent in both public and private educational sectors (Jamali *et al*., 2010).

Culture

Although Lebanon is an Arab country and a founding member of the Arab league, it also differs significantly from Arab countries particularly in the domain of culture (Jamali *et al*., 2010). Lebanese culture is a blend of conservatism and liberalism, individualism and collectivism, masculinity, and high power distance (Sidani, 2002). This is no doubt attributed to the history of Lebanon and its greater openness to the West than its neighboring Arab counterparts. Lebanese culture has thus retained important residues of masculinity, patriarchy, and collectivism, which are counter-balanced by liberal values particularly in the capital Beirut and in Christian communities (Jamali *et al*., 2010). This contradictory mix is felt by women, who despite increasing rates of economic activity (32.4 percent in 2007) report salient cultural constraints hindering career advancement (Jamali *et al*., 2005, 2006, 2007, 2008; Jamali, 2009).

Religion

Lebanon is a pluralist multi-confessional country. The Lebanese communities are commonly divided into two religious categories: Christian and Muslim. However, cleavages in Lebanese society far exceed the traditional Christian-Muslim divide as there are several complex sub-divisions within these two general classifications (Jamali *et al*., 2010). Within this complex segmentation, Muslim women in general tend to report more frequently the salience of cultural and patriarchal type constraints affecting their career choices, progression, and fulfillment (Jamali *et al*., 2005).

CHAPTER III

LEBANESE WOMEN IN MANAGEMENT: AN OVERVIEW

Lebanon's cultural and economic factors have significantly shaped the experiences of women in the workplace and in management. Some argue that Lebanon is a pioneering country in the Arab world, allowing women to assume nontraditional roles outside the family and traditionally allocated roles (Sidani, 2002) and to enjoy relaxed codes that encourage their participation in political and economic activities (Sidani, 2005). However, despite their strong presence in the services sector (81 percent, including 63 percent in health and social services and 62 percent in education), women continue to earn less than men in Lebanon (Bayt.com, 2007; MENA, 2007; UNDP/POGAR, 2009; Association of Lebanese Banks, 2000). The increased levels of educational attainment and involvement in the workforce have not reflected positively in the presence of women in decision-making positions as highlighted by a number of studies in Lebanon (Jamali *et al*., 2005; Tlaiss & Kauser, 2010, 2011a). To further explain, despite their high levels of education and their "majority" status in a number of sectors— such as the services sector at 81 percent —women in Lebanon suffer from gender discrimination in accessing jobs and experience a gender pay gap and discrimination in accessing managerial positions (Tlaiss, 2013b).

Women in Lebanon enjoy wide social freedoms and they are perceived to be more emancipated (Jamali *et al*., 2005). Yet the 2014 gender gap report ranked Lebanon at 135th out of 144 countries (WEF, 2014). In the telling sub-indicator of political empowerment, Lebanon ranks a depressing 141st place among 144 countries. Lebanese women are clustered at the lower levels of management (Eid, 2002; Jamali *et al*., 2005;

Tlaiss & Kauser, 2010), earning significantly less than their male colleagues (Association of Lebanese Banks, 2000), and occupying less than five percent of senior management positions (Eid, 2002), as senior decision-making positions continue to be dominated by men (Jamali *et al*., 2005).

In a study that looked at the managerial experiences of 52 women managers in Lebanon, Jamali *et al*. (2005) reported that the women managers face attitudinal and structural constraints in the Lebanese workplace. Women managers were often perceived as a higher employment risk than their male counterparts because of their family commitments. Women were often discriminated against because of the negative perceptions held by organizations regarding their commitment and professional capabilities. These findings were confirmed by a more recent study that looked at the organizational barriers faced by more than 410 Lebanese women managers during their managerial careers. This latter study by Tlaiss and Kauser (2010) found evidence of a glass ceiling in Lebanese organizations, with more than half of the study's participants clustered at lower levels of management despite their levels of education and years of experience.

In another study done by Jamali *et al*. (2010), the researchers capitalized on in-depth interviews with eight Human Resource (HR) managers and 18 women managers to explore their perceptions and interpretations of diversity management in the Lebanese context. One HR manager noted the limited tracking of progress in the Lebanese context in relation to women issues and concerns, 'unlike the US, in Lebanon different aspects of female labor force participation are not tracked or measured. In the USA, women's organizations work to prove that women are well represented and fight for their rights especially if there is a discrepancy in pay' (Jamali *et al*., 2010). The Lebanese culture is characterized as a collectivist culture with a large power distance (Ayyash-Abdo, 2001)

and these women may therefore be reluctant to challenge (male) authority in their organizations (Jamali *et al*., 2010). Most HR managers expressed on the other hand a level of appreciation that women are active and valued participants in the Lebanese labor force today, and that they bring a unique set of skills/expertise (Jamali *et al*., 2010).

Another perspective or explanation is that Lebanese women have clearly internalized low expectations stemming from a patriarchal environment where they have always been treated as second class citizens and unequal partners. It is well documented that Lebanese women have always faced a discriminatory legal climate in terms of laws governing inheritance, marriage and children custody, as well as citizenship rights (CEDAW, 2005). These discriminatory practices permeate the workplace directly and indirectly, consciously or less consciously which in turn leads to the disempowerment of women as they internalize the low expectations and lower power status. This reflects in turn the complex interplay between individual expectations and aspirations, organizational processes and macro national structures, which collectively mold patterns of power parity and advantage within employment contexts (Syed & Murray, 2009).

CHAPTER IV

ACKER'S GENDERED ORGANIZATIONS FRAMEWORK

Feminists have looked at the gendering of organizations and organizational practices to comprehend how inequalities between women and men continue in the face of numerous attempts to erase such inequalities (Acker, 1990; Collinson & Hearn, 1996; Ferguson, 1984; Kanter, 1977).

The topic of "gendered organizations" has been studied from different perspectives. While reading and analyzing the literature available on "gendered organizations", it is striking to note that most of the articles have cited the work of Joan Acker as an organizational model, notwithstanding the use of the following words "gender-scripts", "intersectionality", "glass ceiling" and "culture" in a high frequency. Furthermore, understanding the dynamics that exist between gender norms and culture is a frequent theme that crosses the articles. Gender in itself is studied as a dependent factor taking its identity from external elements (culture, organization, society, economics, etc.…) to which it owes most of its understanding. Acker (1990) wrote that to identify an organization as gendered means attributing masculine and feminine patterns and meanings to organizational norms, policies and procedures.

Examining class and gender (Acker, 1988), Acker has argued that class is constructed through gender and that class relations are always gendered. The structure of the labor market, relations in the workplace, the control of the work process, and the underlying wage relation are always affected by symbols of gender, processes of gender identity, and material inequalities between women and men. To say that an organization, or any other analytic unit, is gendered means that advantage and

disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction between male and female, masculine and feminine. Gender is not an addition to ongoing processes, conceived as gender neutral. Rather, it is an integral part of those processes, which cannot be properly understood without an analysis of gender (Acker, 1990).

A systematic theory of gender and organizations is needed for a number of reasons. First, the gender segregation of work, including divisions between paid and unpaid work, is partly created through organizational practices. Second, and related to gender segregation, income and status inequality between women and men is also partly created in organizational processes; understanding these processes is necessary for understanding gender inequality. Third, organizations are one arena in which widely disseminated cultural images of gender are invented and reproduced. Fourth, some aspects of individual gender identity, perhaps particularly masculinity, are also products of organizational processes and pressures. Fifth, an important feminist project is to make large-scale organizations more democratic and more supportive of humane goals (Acker, 1990).

Within the field of gender and organizational research, Acker's (1992) "gendered organizations" framework has been widely cited as an important heuristic for the study of how organizations become gendered. What is perhaps novel and interesting about Acker's work is that it provides a relatively clearly defined lens through which to view gender in organizations. Acker calls for a new perspective that would analyze how "... advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction between male and female, masculine and feminine" (1992, p. 146). She lists four 'gendered processes' which researchers can study to examine how organizations are gendered.

The first involves “production of gender divisions”, including “the gender patterning of jobs, wages and hierarchies, power and subordination” (1992, p. 252), and the practices surrounding the reproduction and resistance of it. Although there are great variations in the patterns and extent of gender division, men are almost always in the highest positions of organizational power (Acker, 1990). For example, Cynthia Cockbum (1983, 1985) has shown how the introduction of new technology in a number of industries was accompanied by a reorganization, but not abolition, of the gendered division of labor that left the technology in men's control and maintained the definition of skilled work as men's work and unskilled work as women's work. The second process is “...the creation of symbols, images, and forms of consciousness that explicate, justify, and, more rarely, oppose gender divisions” (1992, p. 253). These include “language, ideology, popular and high culture, dress, the press, television” (Acker, 1990, p. 146). Even if the production is not obvious like in the case of an advertising agency, most organizations reproduce gender by defining success in terms of male values (1992, p. 253), since for most corporations being “lean, mean, aggressive, goal oriented, efficient, and competitive” is more important than being “empathetic, supportive, kind, and caring” (1992, p. 253). For example, as Moss Kanter (1975), among others, has noted, the image of the top manager or the business leader is an image of successful, forceful masculinity. The third includes “interactions between individuals . . . that enact dominance and subordination and create alliances and exclusion” (1992, p. 253). Sexuality plays an important role in interaction (1992, p. 253) as do subtle mannerisms that normally go undetected. For example, conversation analysis shows how gender differences in interruptions, turn taking, and setting the topic of discussion recreate gender inequality in the flow of ordinary talk (West & Zimmerman, 1983).The fourth process is an internalization of the effects of gendered organizations by the individual

that can change their behavior (1992, p. 253). Perhaps then, we may be able to identify those activities in and around organizations that maintain, support, or oppose the gendered nature of organizations through Acker's system of processes. It is predicted that it is through understanding of these processes that successful change can be addressed.

Acker (2006, 2009) describes several bases for inequality, some of which are interesting to assess in organizations. First, she mentions the steepness of hierarchy, which is most pronounced in traditional bureaucracies and flattest in organizations with team structures (Acker, 2006). Because "hierarchies are usually gendered and racialized, especially at the top" (Acker, 2006), the steeper the hierarchy the more likely it is to find evidence of gender inequality. Further, she suggests that "the degree and pattern of segregation by race and gender is another aspect of inequality that varies considerably between organizations" (Acker, 2006). Thus, a holistic picture of the impact of women in a company can be gained by considering the steepness of hierarchy and the degree and pattern of segregation.

In Acker's (2012) article, "*Gendered organizations and intersectionality: problems and possibilities*", Acker dealt with issues concerning theorizing gender and intersectionality. Two particular dilemmas stood out as important in this article and they relate to the most appropriate methods to conceptualize the (a) gendering of organizations; and (b) intersectionality. Acker noted that the gendered substructure of organizations consists of processes and practices of organizing that continually recreate gender inequalities. These processes and practices are supported by organizational cultures and reproduced in interactions on the job, shaped in part by the gendered self-images of participants (Acker, 2012). These *gendering processes* are, at a less visible level, supported by gender subtexts of organizing and a gendered logic of organization

that link the persistence of gender divisions to the fundamental organization of capitalist societies. Further, intersectionality is the idea that social identities such as race, class, and gender interact to form qualitatively different meanings and experiences (Warner, 2008, Acker, 2012). In particular, Acker (2012) adopted a reflexive approach to consider how gender theorizing itself has become more complex as captured in the notion of intersectionality when gender process interacts with other forms of inequality. As for *intersectionality,* the analysis of gender is incomplete because it ignores racial and class processes that are also essential elements in the ongoing reproduction of inequalities (Acker, 2012). The concept of intersectionality is a way to conceptualize the complex interweaving of analytically separated processes (Acker, 2012).

Following Acker's 'gendered processes' that allow researchers to examine how organizations are gendered, the current research unfolds. The research will explore several healthcare organizations operating in Lebanon from a gender and leadership perspective and identify strengths and weaknesses in promoting gender equity in their management, focusing on gender disparities (if any) and the reasons for them. Employing Acker's four 'gendered processes', four main research questions materialize and intertwine with these processes and frameworks. These questions tap on numerous thoughts and thinking notions. The first asks, *where the issue of gender equality enters into the equation of management processes in the healthcare sector in Lebanon,* the second probes into *gender differences, if any, in aspirations for senior management positions in the healthcare sector in Lebanon*, the third questions *if there are unique conditions for career advancement in healthcare management and what are the factors that may be impeding gender equity*, and the last question wonders *if there are any supportive practices and policies designed to counter organizationally embedded gender biases in the healthcare sector in Lebanon*.

By identifying these four main research questions, specific research inquiries are sketched out. These inquires, asked in the form of an interview, probe deeper into the above mentioned processes in order to draw a clearer image pertaining to the current stand of healthcare organizations to gender and leadership. Some of these questions include notions such as '*In what ways do you think your organization is a gender-equal employer? What kinds of efforts does the organization make to consider other forms of diversity? Are there differences between women and men managers in project size or visibility? Does the medical center have clearly developed competency definitions on gender equality for use in recruitment interviews or performance appraisals? How is the sex balance of staff within your department/office promoted and maintained, if at all: by positive or affirmative action, additional facilities, targets, and training?'*

CHAPTER V

WOMEN IN THE HEALTHCARE SECTOR IN LEBANON

As the underrepresentation of women in management positions continues to persist globally, little is known about the experiences of women in the healthcare sector in the context of the developing Middle Eastern nations, particularly in the context of a Middle Eastern country, Lebanon (Tlaiss, 2013a). The healthcare sector in Lebanon has traditionally been known as a "feminine" sector, with women at its core. According to the Ministry of Public Health (MOPH), the number of women in the healthcare workforce is increasing; women currently comprise 79% of the public workforce in the healthcare system, with the private sector providing 80.5% of the total employment. However, the positons that women hold in this sector are mainly administrative positions for support functions. The increased participation of women in the workforce in general, including the healthcare sector, has been driven by their increased educational attainment and the shortage of educated people as a result of the migration of young, educated Lebanese males to neighboring countries (Jamali *et al*., 2005).

By undertaking this attempt, the current study is contributing to knowledge in several ways. First, it is a step towards improving our understanding of the problems that working women in the economically developing non-Western nations face, as the plethora of seminal research remains predominantly clustered in the economically developed Western countries. Second, by focusing on the healthcare sector in Lebanon in particular, this study is exploring the specific experiences of women in a sector that we know very little about; a sector that has troubling statistics on the lack of gender

diversity in management positions and a gender pay-gap despite traditionally being perceived as “feminine” or female-friendly (Tlaiss, 2013a).

CHAPTER VI

RESEARCH AND THEORY SIGNIFICANCE

Knowledge on women managers in the Arab region is limited, precluding reliable conclusions on how the causes of gender differences in managerial advancement differ from those in developed countries (Tlaiss & Kauser, 2011a). Globally, women have been entering the workforce and joining the managerial hierarchy at an unparalleled rate. However, the picture in the Arab Middle East does not seem to parallel that in the Western countries. Despite the dramatic improvements in the status of women in many aspects of life in the Arab Middle East, their progress in management and decision-making positions remains slow when examined in the global context.

Lebanon's prevailing turbulent and unstable economic, political, and administrative situation has significantly impacted the direction, focus, and findings of research in the healthcare sector. In other words, as a result of the toll of problems in the Lebanese healthcare sector, the majority of currently available studies are primarily grounded in finding ways to improve the quality of healthcare services (Sfier, 2009, MOPH, 2000). Those who are interested in the experiences of employees in the healthcare sector continue to highlight the high level of employee dissatisfaction with salaries and working conditions (El Jardali, Alameddine, Dumit, Dimassi, Jamal & Maalouf, 2011). They also stress the high intent of the health sector's employees to leave their employers and migrate to other countries with better pay scales and working conditions (El Jardali, Dimassi, Doumit, Jamal & Mouro, 2009). Hence, few studies have considered the status of women in the healthcare industry in Lebanon, the root of

their dissatisfaction, and their overall experiences; thus further research in this area is needed. Lebanon, as one of the few Middle Eastern countries that accommodate strong religious and cultural norms as well as modern values, presents an interesting study of female managers. Exploring the overall status of women managers in an industry that is overpopulated with women employees, under-populated with women managers, and poorly researched, particularly in the context of developing Middle Eastern countries (Tlaiss, 2013a) is of interest to management researchers.

Within the above context, this study is initiated to contribute to the ongoing debate regarding the career success of women managers in the healthcare sector in Lebanon through exploring the success of women managers in a locale that has traditionally not been researched. By using Acker's theoretical framework of inequality regimes which examines the interrelations of practices, processes, actions and meanings that result in, and maintain, gender inequalities in organizations (2006, p. 443), we can acknowledge that inequalities are interconnected to the surrounding society, politics, history and culture.

However, it is interesting to note that Acker's argument has an opposite and equally valid interpretation that would produce a more robust theory of gender in organizations. Instead of conceptualizing organizational principals as derived from existing gendered structures, she could conclude that the outcomes of these processes and structures reflect gendered structures present beyond organizational boundaries. This interpretation would allow Acker to include gender as construct through which organizational behavior is filtered without needing to ascribe gender to the processes and structures themselves. These structures may reflect, and even reinforce, gendered processes that exist beyond organizational boundaries without having to be masculine or feminine structures. Re-conceiving Acker's argument in this way would allow it to be

applied to other oppressive structures like race and class. Also, this interpretation would account for change in organizational composition and structures, which Acker's current framework does not. When organizational gender composition changes and the organizing principles of the organization do not, Acker's argument as conceived would break down. Re-interpreting her argument to say that organizational processes and structures reflect patterns beyond organizational boundaries would help account for and perhaps explain such changes.

Research Methodology

This study began by compiling relevant information to help set the scene for gender management in Lebanon, with specific reference to the healthcare industry and its respective institutions. This was important to better examine healthcare organizations in Lebanon from a gender perspective and to identify specific strengths and weaknesses in promoting gender equity in their management, focusing on gender disparities and the reasons for them, if any.

The specific empirical methodology is qualitative in nature. Qualitative research, based on data from narratives and observations, requires understanding and co-operation between the researcher and the participants, such that texts based on interviews and observations are mutual, contextual and value bound (Lincoln & Guba, 1985; Mishler, 1986). According to Agar (1986), a different language is needed to fit the qualitative view, one that would replace reliability and validity with such terms as credibility, accuracy of representation, and authority of the writer. Similarly, Leininger (1985) claimed that the issue is not whether the data are reliable or valid but how the terms reliability and validity are defined. She recast the term validity in a qualitative sense to mean gaining knowledge and understanding of the nature (i.e., the meaning,

attributes, and characteristics) of the phenomenon under study. She contrasted this to the common usage of validity in a quantitative sense, in which it refers to the degree to which an instrument measures what it is designed to measure.

Sample

Our sample was comprised of three hospitals/medical centers operating in Lebanon. We initially contacted four hospitals/medical centers and received a response rate of 75% (3 hospitals/medical centers). The below table provides a profile of the hospital/medical center sample. The managers who took part in the interviews were selected by their organizations, and occupied mostly senior positions within their respective firms.

Table 1

Sample Profile

Interviewee Position	**Medical Center/ Hospital**	**Nature**	**Gender**	**Location**
Medical Center Director and Chief Medical Officer	Medical Center 1	Private	Male	Beirut, Lebanon
Chief Planning and Transition Officer	Medical Center 1	Private	Female	Beirut, Lebanon
Director of Human Resources	Medical Center 1	Private	Female	Beirut, Lebanon
Chief Quality and Compliance Officer	Medical Center 1	Private	Female	Beirut, Lebanon
Deputy Director of Patient Affairs	Medical Center 1	Private	Female	Beirut, Lebanon
Chairman of the Board and General Director	Hospital 2	Private	Male	Outside of Beirut, Lebanon
Director of Development and General Affairs	Hospital 2	Private	Female	Outside of Beirut, Lebanon
Chairman of the Board and General Director	Hospital 3	Governmental/ Public	Male	Beirut, Lebanon
Head of Planning and HR	Hospital 3	Governmental/ Public	Female	Beirut, Lebanon
Head of Internal Audit	Hospital 3	Governmental/ Public	Female	Beirut, Lebanon
Chief Financial Officer and Chief Operating Officer	Hospital 3	Governmental/ Public	Female	Beirut, Lebanon

The IRB approved (see Appendix I) study made use of semi-structured interviews, which were conducted with the senior management of different medical centers and hospitals of relatively the same size in Lebanon. The hospitals were from urban (2) and rural (2) areas and of a private and public nature. The advantage of interviews lies in the interviewer's ability to pursue in-depth information around the topic using follow-up questions to further probe responses (McNamara, 1999). A semi-structured interview guide comprising four sections was developed (see Appendix II). The interview questions focused on identifying the division of labor, and access to and control over resources and benefits by men and women respectively, identifying constraints and opportunities in the larger context, and reviewing the capacities of the relevant organizations in promoting gender equality. The interviews were conducted in a private setting where the participants were informed of the study's purpose, and confidentiality policy. Interviews were recorded upon approval of the participant.

For interviewing purposes, the interview guide was divided into four major parts. The first part probed on the gender equality and management processes in the medical center/hospital. The second part dwelled into any gender differences in senior management positions in the medical center/hospital. The third tackled any contributing factors for career advancement in the medical center/hospital and the fourth part explored any practices and policies designed to counter organizationally embedded gender biases in the medical center/hospital. The interview framework can be found in Appendix. The interview guide was sent to the managers concerned, and a meeting was scheduled to discuss the research questions. The interviews consumed on average 45 minutes, were conducted in English, tape-recorded, and transcribed.

Data Analysis

The analysis of the data relied on the content analysis methodology as it is a

method that provides a systematic and objective means to make valid inferences from verbal, visual, or written data in order to describe and quantify specific phenomena (Mayring, 2000). Through content analysis, it is possible to distil words into fewer content-related categories. The aim is to attain a condensed and broad description of the phenomenon, and the outcome of the analysis is concepts or categories describing the phenomenon. Content analysis offers researchers several major benefits. One of these is that it is a content-sensitive method (Krippendorff, 1980), and another is its flexibility in terms of research design (Harwood & Garry 2003).

The qualitative research method involves the systematic collection, organization, and interpretation of textual material derived from talk or observation. It is used in the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context (Malterud, 2001). Using Acker's gendered organization framework and after transcription, the transcribed interviews were analyzed using excel features to determine the recurring words, phrases or sentences that created new emerging themes that fed into our research questions. The aim is to produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system. The method of thematic content analysis has been adapted from Glaser and Strauss' "grounded theory" approach and from various works on content analysis. Thematic analyses seek to unearth the themes salient in a text at different levels, and thematic networks aim to facilitate the structuring and depiction of these themes (Attride-Stirling, 2001).

According to Attride-Stirling (2001), thematic networks systematize the extraction of: (a) lowest-order premises evident in the text *(Basic Themes);* (b) categories of basic themes grouped together to summarize more abstract principles

(Organizing Themes); and (c) super-ordinate themes encapsulating the principal metaphors in the text as a whole *(Global Themes).*Using an inductive approach for analysis of the qualitative data, we were able to (a) condense raw textual data into a brief, summary format; (b) establish clear links between the evaluation or research objectives and the summary findings derived from the raw data; and (c) develop a framework of the underlying structure of experiences or processes that are evident in the raw data (Thomas, 2006).In brief, the data analysis followed the following steps.

After the interview transcription, the data was imported to an excel document. Each question had its respective answer from all 11 participants. The answers were contrasted under each other in order to find common words, trends and actions which will reflect both common and divergent themes. Furthermore, following the order that was previously used in the literature review, the data findings are analyzed and explained within the context of the theoretical model (Joan Acker's Gendered Organization Framework). The questions followed a particular logical order that feeds into Acker's four 'gendered processes' which researchers can study to examine how organizations are gendered. The answers to these questions where highlighted and entered in an excel sheet; aligning the respective answers and insights from all 11 participants with regards to each 'process'. After this step, we started with the coding part. The coding entailed accurately analyzing across all 11 participants the most recurrent words, ideas and insights shared by them. This method allowed us to generate a particular code for each question/ group of questions which accordingly resulted in a particular global and sub themes. The analysis and coding were done by the student investigator and were reviewed by the principal investigator accordingly.

One of the principal reasons for using this method is, precisely, to bring to light the meaning, richness and magnitude of the subjective experience of social life

(Altheide & Johnson, 1994).The purpose of qualitative research is not to generalize to other subjects or settings, but to explore deeply a specific phenomenon or experience on which to build further knowledge or to develop a more patient-focused practice that is sensitive to the research participants (Thomas & Magilvy, 2011).

Research Rigor

To ensure research rigor, researchers need alternative models appropriate to qualitative designs without sacrificing the relevance of the qualitative research (Krefting, 1991). Different models are available that address how to build trust in qualitative research, such as the model of trustworthiness of qualitative research proposed by Lincoln and Guba (Thomas & Magilvy, 2011).

The research utilized Guba's (1981) model. The model is based on the identification of four aspects of trustworthiness that are relevant to qualitative studies: (a) truth–value (credibility); (b) applicability (transferability); (c) consistency (dependability); and (d) neutrality (confirmability). Below is a brief overview of the four aspects. The trustworthiness of the data and research conducted was founded on the below.

- *Truth value* asks whether the researcher has established confidence in the truth of the findings for the subjects or informants and the context in which the study was undertaken (Lincoln & Guba, 1985). It establishes how confident the researcher is with the truth of the findings based on the research design, informants, and context. Credibility is the element that allows others to recognize the experiences contained within the study through the interpretation of participants' experiences. To establish credibility, a researcher will review the individual transcripts, looking for similarities within and across study participants (Thomas & Magilvy, 2011).

- *Applicability* refers to the degree to which the findings can be applied to

other contexts and settings or with other groups; it is the ability to generalize from the findings to larger populations (Krefting, 1991). To establish transferability is to provide a dense description of the population studied by providing descriptions of demographics and geographic boundaries of the study (Thomas & Magilvy, 2011).

- *The consistency* of the data, that is, whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context. Unlike the relatively controlled experimental environment, the qualitative field setting may be complicated by extraneous and unexpected variables (Krefting, 1991). Qualitative research emphasizes the uniqueness of the human situation, so that variation in experience rather than identical repetition is sought (Field & Morse, 1985).Strategies used to establish dependability include having peers participate in the analysis process, providing a detailed description of the research methods, or conducting a step-by-step repeat of the study to see if results might be similar or to enhance the original findings (Thomas & Magilvy, 2011).

- *Neutrality* occurs when credibility, transferability, and dependability have been established. The qualitative research must be reflective, maintaining a sense of awareness and openness to the study and unfolding results. The term reflexivity requires a self-critical attitude on the part of the researcher about how one's own preconceptions affect the research. Immediately following each individual interview, the researcher will write or audiotape record field notes regarding personal feelings, biases, and insights. In addition, the researcher should make a conscious effort to follow, rather than lead, the direction of the interviews by asking the participants for clarification of definitions, slang words, and metaphors (Thomas & Magilvy, 2011).

The value of qualitative research lies in its exploratory and explanatory power, prospects that are unachievable without methodological rigor at all stages of the

research process – from design, to field work, to analysis (Attride-Stirling, 2001).

Data Findings

Several interview questions (IQ) helped identify any strengths and weaknesses in promoting gender equity in healthcare management. By using the four "gendered processes" listed by Acker, each high level research question folds under one of these processes in order to examine how organizations are gendered.

- *First Process: Production of gender divisions, including the gender patterning of jobs, wages and hierarchies, power and subordination.*

Research Question: Where does the issue of gender equality enter into the equation of management processes in the healthcare sector in Lebanon?

- IQ 1: In what ways do you think your organization is a gender-equal employer? What kinds of efforts does the organization make to consider other forms of diversity?

We noted that the concepts of "recruitment processes", "diversity policies" and "key leadership positions lead by women" were present among the three medical centers/hospitals, the nature of the "healthcare industry" was tapped on by two medical centers/hospitals and the notion of "promotion and retainment" was discussed by one medical/hospital. The senior managers explained how their respective organizations are gender-equal employers and the efforts the organizations are applying to promote diversity within their jurisdictions. The below statements reflect each concept respectively.

Medical Center 1 pointed out how *"The recruitment process is well-set by HR for any position"* and *"In our recruitment tasks, gender is never pre-determined for the specific job."* As for hospital 2, one senior manager mentioned that *"These heads were recruited through extensive interviews. The*

people who chose these heads were not biased to gender when making the recruitment decisions." Something to note is that in some cases, governmental regulation plays a role in the recruitment process. One senior manager noted that *"The institution has no say when it comes to the gender of the employee that is picked. The applicant who passes the exam and gets the highest score gets recruited."* Another thought was pitched by an HR Director that noted *"In our interviews, we always ask competency-based questions that never tap into any personal aspect of the applicant (religion, marital status, sexual orientation)."* The Medical Center Director of one of the hospitals noted that *"The majority of individuals who enter the nursing sector are females. That practically puts us as a gender-equal employer; however, if you ask me about what is it that we do to enforce such practices is by focusing on diversity."* Three senior managers from two different medical centers/hospitals tapped on the healthcare industry and its effect on recruitment. One of them noted *"In a medical center setting, you usually have more women than men taking into consideration the nursing profession."* Another mentioned *"The nature of the work attracts more women. Women are more patient to work in a healthcare setting."* Worth noting also is the concept of promotion and retainment that was highlighted by only one senior manager who remarked that *"Now focusing on the promotion and retainment of the employees, I guess we can really probe further into that in terms of gender equity."*

- IQ 2: What initiatives have been taken by the medical center's management to promote capacity building on gender?

For this inquiry, several themes emerged. The main ones are "culture and empowerment", "training", and "active participation in decision-making".

One of the senior managers noted that *"There is nothing that prohibits any female to reach a key position because of the supportive culture present at the medical center."* Another senior manager highlighted the role of empowerment. *"In the senior administration you see that there are a lot of women involved and some of the reasons for that is that the previous heads of the different units that fall under the administration were led by women so they brought more females into their respective units."* One of the medical centers/hospitals explained its rationale behind actively initiating actions to promote capacity building on gender by mentioning *"Some initiatives include encouraging women to participate in the decision-making process at the hospital and assigning them large-scale projects that are responsible for in terms of delivery, meeting deadlines, etc."* and that *"The leadership makes sure to provide authority and responsibility to the heads of departments and divisions irrespective of gender. They are assigned visible and large projects that take full responsibility for."* It was interesting to notice that four senior managers from two medical centers/hospitals mentioned that their organizations "lack any initiatives" to promote capacity building on gender. Some of the thoughts are *"I really cannot speak of any initiative in particular as targeted to promote capacity building on gender", "Not really. Because of the phases the hospital went through in the past years, recruitment was done haphazardly"* and *"If you ask me if the hospital did something to promote diversity, I would have to say no. It comes naturally to have both genders equally represented in the hospital."*

- IQ 3: Are initiatives encouraged to be taken by managers to help women break through the glass ceiling? If so, what are they?

The majority of senior managers in all three medical centers/hospitals emphasized several initiatives. These fell into four main themes which are "staff development plan", "employee's qualifications", "management support", "trainings" and "flexible schedules". One of the managers stated *"We also request a development plan for all the employees who report to every manager and then as HR we follow-up with each manager when it comes the time for a staff member, irrespective of gender, to get promoted or rewarded."* Another senior manager mentioned that *"By providing new challenges and opportunities, the women at the hospital can grow and hold higher positions."* One of the medical centers/hospitals stressed that *"You have women like X, Y, Z in the c-suite and other women as executive administrators who are doing a tremendous job. The women in these positions are there not because of their gender but because of the qualifications they have and what they bring to the table."* All three medical centers/hospitals agreed that management support is instrumental in encouraging women to break through the glass ceiling. *"I am well-known to be a women's advocate in the hospital. I have a very strong administration team led by women", "I believe that if a manager doesn't encourage his/her employees to break the glass-ceiling, then he/she is not confident and is afraid to lose his/her job", "I encourage everybody to move up and I am an example of that and it is so rewarding"* are some of the statements uttered by senior managers at the three medical centers/hospital. As for training, one medical center/hospital discussed the importance of attending trainings and workshops for the development of staff members. *"I encourage my employees to seek trainings and certifications to improve their knowledge and skill set." "We have a training course for managers entitled 'ABC for*

Supervising' whereby senior managers learn the tools to motivate and encourage their subordinates to move up the career ladder." Only one manager brought up the notion of providing flexible schedules as a notion to help women break the glass ceiling; she stated *"I discuss with them how we can make their schedule more flexible or even make a career shift."* One thing to notice is that two senior managers from two different medical centers/hospitals believed that their respective institutions lacked any glass ceiling. They explained their reasoning by stating that *"I don't believe there is glass-ceiling in this medical center. I have been working for 11 years in this institution and I have never felt it"* and *"I don't believe there is a glass-ceiling in this hospital. The only unit that is not led by a women is my position"* respectively. Two other senior managers from the same medical center/ hospital held the belief that their institutions lacked any initiatives that help break the glass ceiling in the institution. One them attributed the reason to the already present diversity in the hospital; *"Because of the already present diversity, we don't have any initiative to neither encourage nor discourage recruiting more women"* and the other senior manager attributed the reason to the official nature of the institution; *"However, working in a governmental institution, the opportunities to move up the career ladder are limited."*

- *Second Process: Creation of symbols, images, and forms of consciousness that explicate, justify, and, more rarely, oppose gender divisions.*

Research Question: Are there unique conditions for career advancement in healthcare management and what are the factors that may be impeding gender equity?

- IQ 1: Does the medical center have clearly developed competency definitions on gender equality for use in recruitment interviews or performance

appraisals?

All three medical centers/hospitals indicated that their respective institutions “lacked any clear competency definitions” that are used during recruitment interviews or performance appraisals. One senior manager mentioned that *"No, however, it doesn’t favor a specific gender over the other during the interviews or performance appraisals."* Another senior manager also stated *"Not at all. However, it doesn’t favor a gender over the other. An employee is assessed based on performance and delivery."* Despite the lack of definitions, the two senior managers highlighted the role HR plays in the “creating such definitions”. One noted that *"That I don’t know the answer for. I think the director of HR is in the best position to answer."* Other two themes are “recruitment” and “effectiveness of appraisals”. Even though the senior managers noted their respective institutions lacked any clear definition, one of the senior managers stated that *"I did recruitment for five years for high positions and I didn’t sense that I should recruit a woman or a man for a specific position. I have seen very poor capabilities and it can be a male or a female."* However, a senior manager from Hospital 3 emphasized that *"The performance appraisals done are only for formality reasons and accreditation purposes. You don’t get promoted nor rewarded based on them. Maybe nobody reads them."*

- IQ 2: Are initiatives taken to recruit more men for administrative tasks that are traditionally undertaken by women?

One senior manager from Medical Center 1 noted the “absence of initiatives” to recruit more men for administrative tasks; *"I wouldn’t say we have active initiatives but we do have men in administrative positions in the*

medical center." Another senior manager from the same medical center stated that *"No. We recruit solely based on capabilities irrespective of gender."* All three medical centers/hospitals highlighted that the "recruitment process" is gender-blind. *"Positions are never pre-selected to be filled-out by females or males. It depends on the characteristics of the applicant." "No. We announce that we are recruiting for an administrative position and whomever score the highest in the exams get the position. We don't even think of the gender."* Two senior managers from different medical centers/hospitals discussed the "difficulty to recruit more men for administrative positions". One of those senior managers mentioned that *"So really despite the institution's effort to recruit more men, the male himself doesn't accept to hold such a position. There are some positions, the client look to hire women and I don't think it is wrong."* Three senior managers from two different medical centers/hospitals attributed the low number of men recruits in administrative positions to "culture" and "personal characteristics" of the individual. Statements ranged from *"For these positions, normally when you mention such a position you directly say 'she'. Even for the man himself he doesn't see himself as a secretary or administrative assistant. It is based on the culture of the society. The majority of men don't even apply to such positions although these positions are well-paid"* to *"I don't know if our culture dictates what jobs men would like to apply to. This needs further studying"* and *"I work with men who are in management and occupy high positions and they do have a problem with having me a female as their boss. Some explicitly address their discomfort and some talk about it in closed circles."*

Also, four senior managers from the three medical centers/hospitals

discussed the “nature of the job” that sometimes plays a role in attracting specific gender. *"For example we have a group of employees that work in carrying boxes and delivering items. Because of the nature of the job, usually men apply to it for than females. When we looked at the pool the majority of the applicants are men." "I think men prefer to work in technical jobs more than administrative ones." "Usually for physical intensive positions (in the medical records department for example) we prefer to higher men but that is not a criterion we base on for selection." "I asked that question to my father who was a hospital administrator. Why do you take your administrative assistants as females? His answer was quite interesting. He said that if someone barges into your office yelling and shouting, a woman is more capable than a man to calm him down. Whether that is true or not, I don’t know."* Despite that, all three medical centers/hospitals do have men in administrative positions as highlighted in the following statements *"We have around 3 male clinic assistants and they are doing a good job in handling administrative tasks", "We have a lot of male clerks across different units", "We used to have a male filling an administrative position in our unit and he didn’t have a problem with that. We also have a lot of clerks who are males"* and *"My previous administrative assistant was a male and we had a very good working relationship. He never had a problem with having a female boss."*

- *Third Process: Interactions between individuals . . . that enact dominance and subordination and create alliances and exclusion.*

Research Question: Are there any supportive practices and policies designed to counter organizationally embedded gender biases in the healthcare sector?

- IQ 1: What is the current sex balance of staff within your

department/office?

Six senior managers from the three medical centers/hospitals mentioned that the “majority of the employees who report to them are females”. *"The majority is women but it was not done on purpose (five men and 10 women)." "The majority is women and that is not done on purpose. As discussed earlier, we receive the applications based on who passed the CSC's exams and is qualified for the positions." "All of them are women except for one man. The women are head of quality, safety, communications and customer service."* One female senior manager at Medical Center 1 also stated that the majority of her staffs are females but wished to have a more well-adjusted sex balance. She noted *"Now, the majorities are females (11) and I am a bit suffering from this although I champion diversity. I feel that we need to recruit more men for the department (currently we have only 1) for it to be more balanced in terms of input at work, type of conversations held, way of distribution of work, managing patient complaints and conflicts, sometimes you need the sweetness of a female and the rudeness of a male. I prefer a mixture of both."* Only two senior managers from Medical Center 1 noted that they have an “equal distribution” of sex within their respective department. As one of them mentioned *"I have 5 men and 5 women directly reporting to me. So it is equal and balanced in terms of sex balance."* Two senior managers from Hospital 2 stated the “majority of their subordinates are males” *"It is almost 50-50 (seven men and five women)."* Only one senior manager from Hospital 3 mentioned that “all of his direct reports are women”. He stated that *"All the employees who directly report to me are women."* The same senior manager from Hospital 3 noted that the “healthcare industry” needs to be taken into

consideration when thinking about this question. He stated *"A thing you should take into consideration that the health care industry is usually female oriented."*

- IQ 2: How is the sex balance of staff within your department/office promoted and maintained, if at all: by positive or affirmative action, additional facilities, targets, and training?

All three medical centers/hospitals highlighted the importance of "training" with it comes to promoting and maintaining staff members. Some of the statements from the three medical centers/hospitals include *"Everybody has the chance to participate in trainings, workshops", "This could be self-initiated by the staff member or sometimes through me. It might be something I read or know about and I think one of my staff members will benefit from it", "Of course. Being a governmental institution, our employees are eligible to attend training sessions at the Institute des Finances Basil Fuleihan", "I also search for trainings that are targeted to meet the future demand of the expansion and ask my employees to attend them", and "We work on an annual training plan that we present to the administration"* among others. Another concept that emerged from the interviews is the presence of a "staff development plan" for each employee. Two medical centers/hospitals this importance. A senior manager in Medical Center 1 discussed that *"I would put a staff development plan based on the employee's capability, performance and interest and also on what the organization needs."* Another senior manager from Hospital 2 stated the importance of presenting the new acquired information from trainings. She said *"I also request from the employee who goes for a training to present what he/she has acquired to his/her colleagues in order for all the department to*

learn how they can use these new skills in their jobs". All three medical centers/hospitals agreed that “management insight” plays a role with it comes to identify ways to promote and maintain staff members. A senior manager from Medical Center 1 said *"Sometimes, staff members wish to participate in a training, etc. and that because my experience think it is doesn’t match what we are looking for I feel that at this time we can find something better."* Another senior manager from the same medical center noted that *"You have to align the employee's ambitions and interest with the organization's needs."* Two senior managers from Hospital 2 emphasized that *"Training has to be aligned with the hospitals strategic goals and objectives. It has to be within what we are working on. If I saw the topic of the training is not relevant to our current work, I would put it on hold"* and *"The trainings and workshops need to be aligned with the strategic mission and vision of the hospital"* respectively. As for Hospital 3, one senior manager had the following to say *"I approve training requests that align with the hospital's strategic plan."* Furthermore, 10 senior managers from all three medical centers/hospitals highlighted “management’s support” as pivotal for the development of the employees. Few of their statements include, *"I encourage training and we have an ongoing internal training that tackles lean management in healthcare", "Also for other training opportunities, I always encourage juniors to attend them in order to help them grow",* and *"I encourage my employees to pursue higher educational degrees such acquiring a Master’s in Public Health, MBA, etc."* Falling under “management’s support” emerges two sub themes. The first is providing “educational leave” as one senior manager from Hospital 3 noted *"We support them by giving them educational leave"* and the second is offering “financial

support" as one senior manager from Hospital 3 said *"Of course. Before, the hospital used to cover the training expenses. Now and because of the crisis the hospital went through, the priorities are shifted a bit"* and a senior manager from Hospital 2 noted *"I also cover the expenses of these degrees."* One senior manager from Hospital 3 noted, however, that "schedule restrictions" may play a role in hindering female employees attend trainings that are outside the working hours. She stated *"It is difficult for some women to attend training sessions that are outside their working schedule due to their family commitments."*

- IQ 3: Who is always included in decision-making? Is this selection related to functions, hierarchical position or other factors?

When asked this question, all senior managers from the three medical centers/hospitals agreed that all team members are involved in decision-making. Two senior managers from Medical Center 1 noted *"All of the members are included. We have monthly meetings to discuss everything that is going on (HR's strategy, departmental meetings, etc.)"* and *"The whole team if the decision affects the entire department"*. One senior manager from Hospital 2 said that *"We think and brainstorm as a team. I listen to the employees input and recommendations."* As for Hospital 3, three senior managers highlighted *"Everybody is involved. In my nature I don't like when something is imposed to me hence I don't impose anything on my employees without discussing the decision with them", "I am the type of person that wants to involve the employees in discussions and give them a chance to express their view points and how to go about achieving a goal" and "Overseeing multiple units, sometimes, I need to gather all the needed employees in order to discuss a*

certain decision in order to make sure it is applicable across the different units." Another concept raised is the "decision spectrum". Based on that, the senior managers from all three medical centers/hospitals can properly identify the employees that should be involved in the decision-making process. Statements ranged from *"I don't operate based on hierarchy. Our decision making process depends more on what are the areas involved in that decision"* to *"It depends on the decision to be taken. When it is multidisciplinary, I encourage everyone to be there"* to *"The most critical function in management is to know whom to invite to the meeting because inviting so many people can be disruptive. Picking the right people to the meeting depending on the topic is very critical and this needs a lot of experience"* to *"It depends on the type of decision to be made. If the decision affects them, then of course they are involved. If not, I make the decision as the head of the unit."* Two medical centers/hospitals also raised the idea of "function". *"We go by functions. Whoever has that information/knowledge will be involved in the decision-making process regardless of rank or title"* mentioned one senior manager from Medical Center 1. *"I believe that a successful decision is reached when a leader listens to his/her team members as they are more involved in the day to day activities"* noted a senior manager from Hospital 3. As for who gets to make the final decision, seven managers from two medical centers/hospitals noted that the final decision is theirs. *"I hear from everybody but then I have to decide", "I listen to everybody through brainstorming sessions but then I make the decision based on my judgement, intuition and what I gathered from the employees", "I believe in consultations. I consult with my team. However, one of the main problems of this hospital is order, so at the end of the day, the*

decision goes back to me", "We deliberate and talk but at the end of the day it is my decision. It is not based on voting", and *"Unfortunately, the people in this particular governmental hospital don't have ownership of jobs and don't hold accountability for their decisions so in the end I have to make the decision."* Only one senior manager from Hospital 3 highlighted the "culture" of the institution by saying *"Of course the culture in the hospital is that of participative and collaborative."*

- IQ 4: Are both women and men decision-makers involved in developing the budget for the department/office?

For all three medical centers/hospitals, "both women and men" are involved in developing the budget. For a senior manager in Medical Center 1, she noted *"Yes. I send an email to all of the team that it is time to work on the annual department's budget."* For a senior manager in Hospital 2, he stated *"For sure. They submit their draft budgets for review and approval. We have an open discussion were we go over the details and figures and make appropriate decisions."* Another theme that was shared among all three medical centers/hospital is how the institution goes by "creating the budget." Below are three statements from each medical center/hospital tackling this theme. *"Our budget is a combination of top-down and bottom-up approaches. Mostly is bottom-up." "It starts with the managers themselves submitting the budget plans." "All employees have an equal say when it comes to developing the budget."* One senior manager from Hospital 3 highlighted that "fund allocation" changes with the circumstances the institution goes through. She noted *"Due to the crisis the hospital went through, a lot of cuts were done to the budget including the amount dedicated to learning, development and*

training. The hospital's priority now is to keep its 9 month record of paying on time to its employees, suppliers, etc."

- *Fourth Process: Internalization of the effects of a gendered organization by the individual that can change its behavior.*

Research Question: Are there gender differences in aspirations for senior management positions in the healthcare sector in Lebanon?

- IQ 1: Are there differences between women and men managers in project size or visibility?

When asked this question, four senior managers from two medical centers/hospitals stated that their respective institution "lacked any difference" when assigning projects to senior managers. One of the senior managers said *"I can't recall of time where we assigned projects based on gender"* another senior manager believed *"As an executive, when you want to assign projects, you want to assign it to whomever delivers. Whether that person is a female or a male is not my concern."* Another theme that emerged is the "management support" that drives both women and men managers to lead large and visible projects. One of the senior managers put it this way *"I fully trust my senior administrators and their input on key decision processes. For example, the Director of Development and General Affairs, who is a woman, presented the strategic plan for 2016-2020. She worked closely with all the heads in order to gather important information to develop the plan. She leads the steering committee who is responsible to oversee the implementation of the tactics"* another senior manager from a different medical center/hospital also emphasized the importance of empowerment *"In every project, I assign a senior member with a junior member in order for the senior member to lead*

the project and for the junior member to learn more how to handle a specific project." The majority of senior managers in all three medical centers/hospitals agreed that an "employee's capabilities" is the main criteria for giving that employee a specific project.

Few of the statements mentioned during the interviews are from three different senior managers and they stated *"Managers are chosen based on competencies, ability to deliver and perform", "When I assign somebody to a project it is only based on the employee's capabilities" and "The projects are assigned to team members based on the qualifications and expertise of each member irrespective of gender."* Two unique concepts also emerged when this question was raised. One of them is "patient's preference" whereby only one senior manager mentioned that *"Let us say if this is a patient-care concern and we have women who like to be seen by women and men who like to be seen by men this is where a certain type of project will be assigned to a woman or man. It is based on the patient's preference. But we didn't face such a thing. I am just thinking outside of the box."* The second concept is the prevalence of "feminine traits" as two senior managers from different medical centers/hospitals stated that *"Usually the females are more emotional and attentive to details and the males are less attentive to details"* and *"In general, you sense that women are more meticulous in their jobs. They are more patient and accurate. I prefer working with women more than working with men. However, I don't take that into consideration when assigning projects"* respectively.

CHAPTER VII

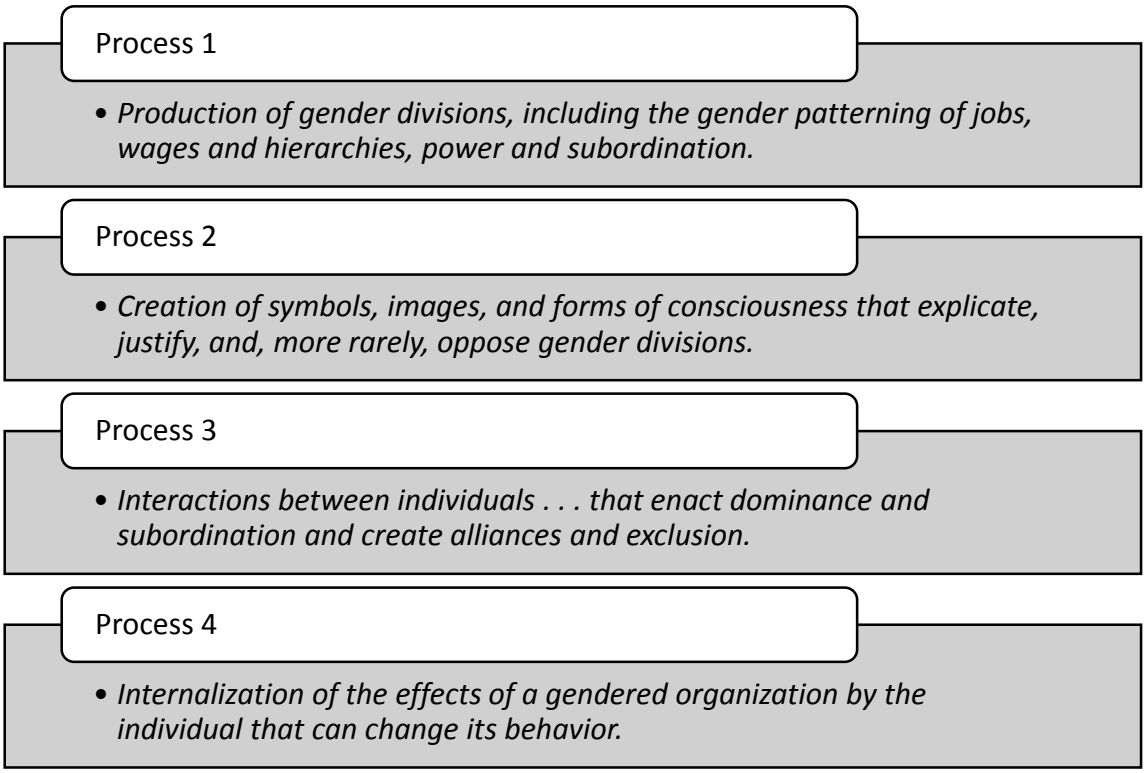
DISCUSSION OF FINDINGS

This study sought to explore several healthcare organizations in Lebanon from a gender lens and to try to identify any strengths and/or weaknesses in promoting gender equity in their management, focusing on gender disparities and the reasons for them, if any. Despite considerable scholarly interest in the study of healthcare organizations and institutions and their work to stimulate gender equity within their processes and management, the literature in this field is still limited especially when it comes to the research outcomes from the Middle East region. In this section, we re-examine our findings analytically and try to assess the usefulness of Acker's framework when studying gender equity in the healthcare context. The findings presented in the earlier section, will help us better illustrate their significance with regards to the literature and explore their alignment with the current research. The relationship between Acker's four processes illustrated in Figure 1 will help us better understand how the three healthcare organizations operating in Lebanon approach the subject of gender equity within their borders.

The results of this research suggest that the medical centers/hospitals in Lebanon are gender-equal employers'. This is surprising because with only 23.3% of women participating in the Lebanese labor force (HDR, 2015), we see a lot of women holding senior and executive positions in the Lebanese healthcare sector. These women have access to resources, be it financial and human, to help them successfully achieve the mission and vision of their respective institutions.

Figure 1

Joan Acker's Four Processes



Based on the data collected, it appears that the healthcare organizations exert serious efforts to consider diversity under their jurisdiction. In the data findings presented above, senior managers agreed that the "recruitment process" and the "diversity policy" instilled within their respective organizations play a substantial role in attaining a gender-equal atmosphere. Moreover, medical centers/hospitals overseen by the Lebanese government adhere to a unique recruitment process and other government regulated processes that do not consider gender as an important aspect of the recruitment efforts rather they focus on the applicant's test results and capabilities. Also, according to the findings, the nature of the healthcare industry participates indirectly in the substantial number of women present in senior positions.

It was interesting to know also that despite having a large number of women in senior management positions, some managers view that few initiatives have been done to promote and retain these women. Furthermore, it was evident that the medical centers/hospitals in Lebanon create a unique culture that drives women to move up the career ladder. Well-put HR policies and trainings accelerate the career advancement of women in these organizations. However, none of the medical centers/hospitals in the sample have well-articulated initiatives that promote capacity building on gender which raises few enquiries regarding HR's roles in developing such initiatives that stimulate capacity building on gender. Nonetheless, multiple initiatives are implemented to encourage women to break through the glass-ceiling. These initiatives that span from creating development plans for each employee to providing and financially sponsoring trainings to having management's full support to providing flexible schedules show how the medical centers/hospitals in Lebanon are serious towards helping women reach higher positions and achieve their full potential. Along those lines, some senior managers don't believe there is a glass-ceiling in their respective hospitals. It would be interesting to further explore this notion to see what are the reasons and causes driving such a perception. For example, does the healthcare industry attract more women? Is the lack of intense competition between managers a factor that fosters a flexible working atmosphere whereby the glass-ceiling is almost non-existent? Does the culture at a Lebanese hospital/medical center passionately drive a cohesive and welcoming environment for women and provide them with the necessary support to move up the career ladder? The answers to these questions and many others help us explain the remarkable and unanticipated results reached in this study.

When the discussion came to the project size handled by senior managers, the majority of the senior managers interviewed agreed that there is no difference between

women and men managers in project size and visibility. Nine of the interviewees attributed the selection of a specific manager over the other on the employee's capabilities and qualifications and how he/she can add value to the project. Also, management's support was seen to positively contribute to the just way in assigning large and visible projects based on an employee's merit rather than his/her gender. One interesting notion, although hypothetical, was raised by one of the senior managers. This notion highlights that sometimes patients request to be seen by a man or a woman and the medical center/hospital needs to take the patient's preference into account. Although, this study does not explore gender inequalities, if any, from the physician's point of view, I believe further research needs to be carried to examine if there is any differences between women and men physicians in performances.

Our sample viewed that the medical centers/hospitals in Lebanon struggle a bit to recruit more men for administrative tasks that are traditionally undertaken by women. This might be due to the "feminization of healthcare" that labels such positions, and many others, as "feminine" positions. This in turn poses austere implications on the healthcare sector in general especially when zooming in and realizing that the majority of industry's workforce is females. The concept of "feminization of the labor force" is explained in the upcoming sections. Some senior managers attribute this difficulty to the society's culture that labels such positions for women and to the fact that the nature of the job usually attracts more women than men. Despite that, some senior managers argued that they have worked with men who hold administrative positions although their number was minute. Nonetheless, the approached medical centers/hospitals highlighted that the recruitment processes do not pre-assign a specific job to a specific gender rather they focus on the candidate's capabilities to decide whether to offer him/her a job be it an administrative or a senior one. Furthermore, the majority of the

senior managers interviewed manage a group of staff members were the majority are females with some nuances of equal gender distribution within the department/unit. One senior manager supposed that this large number of women in a specific department/unit is ascribed to the healthcare industry that appeals more to women than men. Interviewing these staff members, females and males, will help us better understand if equal opportunities for career advancement for both genders are also available, applicable and achievable by low and middle-level managers and by non-managerial employees. Do the positive and promising results we reached to in our study pertaining to women handling large and visible projects, requesting and controlling budgets, etc. have a ripple effect on the lower management and non-management levels? These reflections need further research and exploration.

As for the ways the medical centers/hospitals in Lebanon employ to promote and retain their employees, it was exciting to hear the senior managers discuss how the employees have access to attend trainings and workshops and to work with their respective manager on developing his/her own development plan in accordance with HR. Senior management's insight is also important in assessing what training needs employees' require to attend to perform their duties and fulfill the vision of his/her organization. Combined with the support employees receive from senior management be it financial or non-financial, employees in healthcare organizations are always encouraged to continuously educate themselves in order to professionally grow within the institution. Notwithstanding all these efforts, the notion that some female employees can't attend trainings outside their working hours raises interesting questions as to the reasons behind such claims. These reasons can be attributed to a woman's domestic duties that she need to attend to after her working hours such as taking care of her children and/or her parents. Other reasons might be the need for a woman to take

another job to provide more financial safety to her nuclear family. These reasons and many others can be the basis for several hypotheses for new research avenues.

Our sample showed also that both genders are involved in the decision making process. Senior managers call for employees' presence when they need to discuss new decisions to be made. They involve the concerned employee(s) based on the type of decision to be made. However, despite having a participatory and collaborative atmosphere within the medical centers/hospitals, some senior managers retain the right to make the final decision that is in the best interest of the senior manager's department/unit. Continuing with the same outlook, employees from both genders are involved in developing the budget for their respective departments/units. Employees of various seniorities work together to submit a draft budget that is discussed further with their respective managers in order to share it with upper management for approval and sign off.

In the past 20 years, more and more women have entered the paid workforce. This comes in addition to the informal work they do (small scale, home-based production) as well as the subsistence work they provide for free to their families. This increase in the number of women in paid employment is referred to as the *feminization of the labor force* (Monnier, 2011). It simply means that, by and large, the proportion of female workers has increased in different sectors of the economy, beyond household-based production. This trend is directly related to globalization. The feminization of the workforce is also part of a general shift toward a service economy which is divided into a well-paying and male-dominated sector (such as the law, financial services and information technology) and a low-paid, highly feminized sector (such as home-care, elder-care, child-care, retail or domestic labor and cleaning services). Because of the greater numbers of female professionals in the high-paying sector in core countries has

immensely increased the demand for women from semi-peripheral and peripheral countries needed to do the housework and care work (Monnier, 2011). Having this phenomenon stretched out, more research is needed to investigate whether the healthcare sector is considered to be a "highly feminized sector" and if so, does it motivate women to apply more to healthcare organizations to increase their chances of being promoted to senior positions within the healthcare institution? Do there career intentions differ from that of their male counterpart? Should HR policies be amended to reflect a more women-friendly approach towards offering flexible working hours, longer maternity leave, partial and full telecommuting job opportunities, etc.?

In addition to the above, more issues should be tackled in order to produce a more holistic paper. These include increasing the sample size to more than three hospitals/medical centers in order to validate the above findings and interviewing low and middle-level managers to check if they also have the same intuition regarding their respective institutions and the strides being done to achieve a more gender-equal organization. An effort should be done also to gather quantitative figures about salaries, years of experience, benefits, etc. for the above sample in order to see if these women who are in senior management are getting fairly paid and provided with equal opportunities as their male counterparts. Here the notion of 'cheap labor' comes to mind. Is it possible that these hospitals/medical centers are hiring more females because it is cheaper for them? Is there a pay gap within these institutions? If so, how can we decrease that gap? Maybe a gender audit can be carried out in order to identify any challenges in integrating gender in the organization's systems and operations and in programs and projects. More research needs to be done on these fronts. Perhaps conducting a similar research tackling another industry in Lebanon such as the construction or education industries can show us if the healthcare industry in Lebanon is

an outlier when it comes to promoting gender diversity within its senior management or other industries are following suit.

CHAPTER VIII

CONCLUSION

The healthcare institutions appear to be leading the way in promoting gender equity in their senior management positions and understanding the importance of such a step. Studies on gender equity in the healthcare sector tap into different theories within varied contexts and explore numerous variables that might positively or negatively affect the implementation of just gender equity practices by healthcare organizations. Our study highlights the importance of establishing management processes within the healthcare organization in order to mandate practices and initiatives that call for a gender equal culture at the organization. In our study we also realized that healthcare organizations do not assign different project sizes based on gender. Assignments are done based on the capabilities and competencies of the employee. We also recognized that to date healthcare organizations do not have well-defined factors within their system that contribute positively to the career advancement of women. These factors include clearly developing competency definitions on gender equality for use in recruitment interviews or performance appraisals and taking initiatives to recruit more men for administrative tasks that are traditionally undertaken by women. Nonetheless, the organizations in our sample were vocal about the solid practices being designed to counter organizationally embedded gender biases within their walls. In particular, gender equity strategies still need further development and proper integration within the organization's overall strategy. The organizations in our sample are aware that the topic of gender equity is that of crucial importance and one that will soon render itself as an inevitable factor for business operations. Numerous organizations are materialistically

viewing the benefit of having a diverse workforce, especially in the senior management level, on their bottom line, patient satisfaction and operation cost. These benefits from an economic perspective are highly sound for the business and evoke leaders to consider promoting gender equity as a tool that can increase the organization's competitive advantage.

APPENDIX I

IRB APPROVAL LETTER

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Institutional Review Board | لجنة الأخلاقيات
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APPROVAL OF RESEARCH

December 9, 2015

Dr. Charlotte Karam
American University of Beirut
01-350000 Ext.3764
ck16@aub.edu.lb

Dear Dr. Karam,

On December 9, 2015, the IRB reviewed the following protocol:

Type of Review:	Initial; Expedited
Project Title:	The Dynamics of Gender and Leadership in Healthcare Management in Lebanon: Reflections in Times of Change
Investigator:	Charlotte Karam
IRB ID:	OSB.CK.25
Funding Agency:	None
Documents reviewed:	Received December 8, 2015: Amended IRB Application, Amended Email Invitation Script, Amended Consent Form. Received October 6, 2015: Proposal, Interview Guide.

The IRB approved the protocol from December 9, 2015 to December 8, 2016 inclusive. Before October 8, 2016 or within 30 days of study close, whichever is earlier, you are to submit a completed "FORM: Continuing Review Progress Report" and required attachments to request continuing approval or study closure.

If continuing review approval is not granted before the expiration date of December 8, 2016 approval of this research expires on that date.

Please find attached the stamped approved documents:

- Proposal (received October 6, 2015),
- Interview Guide (received October 6, 2015),
- Consent Form –English version (received December 8, 2015),
- Email Invitation Script – English version (received December 8, 2015).

Kindly, use copies of these documents to document consent.

Beirut POBox 11-0236 (F15), Riad El Solh 1107 2020, Beirut, Lebanon | Tel: +961-1-350000 Ext: 5445 | Fax: +961-1-738025 | Email: irb@aub.edu.lb
New York 3 Dag Hammarskjold Plaza, 8th Floor | New York, NY 10017-2303, USA | Tel: +1-212-583-7600 | Fax: +1-212-583-7651

Institutional:

Please note the IRB sought approval from AUBMC administration based on the following standard clause:

"The INSTITUTION, the INVESTIGATOR and COMPANY will, and will cause their Subcontractors and agents to, obtain prior written permission from AUB / AUBMC before using the name of AUB or AUBMC, symbols and/or marks in any form of publicity in connection with this study, besides stating that AUBMC is a participating site."

Specifically for this study, data collectors cannot report or comment on data collected from the AUB site when interacting with participants and third parties at other sites.

Thank you.

The American University of Beirut and its Institutional Review Board, under the Institution's Federal Wide Assurance with OHRP, comply with the Department of Health and Human Services (DHHS) Code of Federal Regulations for the Protection of Human Subjects ("The Common Rule") 45CFR46, subparts A, B, C, and D, with 21CFR56; and operate in a manner consistent with the Belmont report, FDA guidance, Good Clinical Practices under the ICH guidelines, and applicable national/local regulations.

Sincerely,

Michael Clinton, PhD
IRB Vice Chairperson
Social & Behavioral Sciences

Cc: Fuad Ziyadeh, MD, FACP, FRCP
Professor of Medicine and Biochemistry
Chairperson of the IRB

Ali K. Abu-Alfa, MD, FASN
Professor of Medicine
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APPENDIX II

INTERVIEW GUIDE FRAMEWORK

The Dynamics of Gender and Leadership in Healthcare Management in Lebanon: Reflections in Times of Change

Part 1: Gender equality and management processes in the medical sector/hospital:

1. In what ways do you think your organization is a gender-equal employer? What kinds of efforts does the organization make to consider other forms of diversity?
2. What initiatives have been taken by the medical center's management to promote capacity building on gender?
3. Are initiatives encouraged to be taken by managers to help women break through the glass ceiling? If so, what are they?

Part 2: Contributing factors for career advancement in the medical sector/hospital:

1. Does the medical center have clearly developed competency definitions on gender equality for use in recruitment interviews or performance appraisals?
2. Are initiatives taken to recruit more men for administrative tasks that are traditionally undertaken by women?

Part 3: Practices and policies designed to counter organizationally embedded gender biases in the medical sector/hospital:

1. What is the current sex balance of staff within your department/office?
2. How is the sex balance of staff within your department/office promoted and maintained, if at all: by positive or affirmative action, additional facilities, targets, and training?
3. Who is always included in decision-making? Is this selection related to functions, hierarchical position or other factors?
4. Are both women and men decision-makers involved in developing the budget for the department/office?

Part 4: Gender differences in senior management positions in the medical sector/hospital:

1. Are there differences between women and men managers in project size or visibility?

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