Barriers to advancing women nurses in healthcare leadership: a systematic review and meta-synthesis

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eClinicalMedicine
2024;67: 102354
Published Online 11 December 2023
https://doi.org/10.1016/j.eclinm.2023.102354

Summary

Background Women comprise the majority of the nursing profession, yet nurses are underrepresented in healthcare leadership. We aimed to explore barriers for women nurses to advance in healthcare leadership to inform organisational interventions for career advancement.

Methods In this systematic review and meta-synthesis, studies examining advancing women nurses and midwives in leadership within healthcare and academia in the international literature were included. Six databases (MEDLINE, EMCARE, EMBASE, PsycINFO, PubMed, and CINAHL PLUS) were searched for studies published in English between January 1 2000 and October 17 2023. The Grading of Recommendations Assessment, Development, and Evaluation tools (GRADE) was followed to assess confidence in the findings. Retrieved full texts were assessed for methodological rigour using the Critical Appraisal Skill Programme Qualitative Studies checklist and the Joanna Briggs Institute Cross-sectional and Prevalence Studies checklists. Reported barriers for women nurses' leadership attainment were identified and generated themes were mapped to the Abilities, Motivation, and Opportunities (AMO) framework.

Findings There were 32 eligible studies; 18 qualitative, 11 quantitative, and 3 mixed-methods. Studies included high-income countries (n = 20), middle-income countries (n = 7) and across countries (n = 3) with two unspecified. Samples included registered nurses, nurse academics, executives, and leaders. The key barriers highlighted were related to: role modelling and leadership development (ability); multiple complex and interacting factors, including gender stereotyping, perception of professionalism, human relations policies, and gender bias (motivation); and systemic issues, such as organisational setting, structure, and support (opportunity).

Interpretation The prevailing belief in the literature is that caregiving is a feminine occupation and along with societal expectations of women's subordinate position, these present substantial obstacles that limit women nurses from advancing into healthcare leadership. Ultimately, these factors restrict women nurses in career advancement and need to be addressed at a systems and organisational level.

Funding The National Health and Medical Research Council (NHMRC), Australia.

Keywords: Nursing; Women; Healthcare leadership; Barriers

Introduction

Women comprise the majority of the nursing profession, and overall, nurses are underrepresented in healthcare leadership roles. Nearly 70% of the global health workforce is women, and 89% are nurses; yet, only 25% of senior healthcare roles are filled by those identifying as women.[1] Gender stereotypes, bias, discrimination, power imbalance, and privilege contribute to the leadership division between men and women.[2] Cultural gender norms and stereotypes of occupations such as "women's" or "men's" work and the social view of caring as a feminine role also contribute to

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Research in context

Evidence before this study

Nursing is a profession dominated by women. Despite this, women in nursing encounter substantial challenges when aspiring to attain leadership roles in healthcare. Individual studies have explored barriers to advancing women in nursing into leadership, but no meta-synthesis has been conducted. This systematic review and meta-synthesis aimed to explore the barriers that women in nursing face in the advancement to healthcare leadership, in order to inform organisational interventions. This is part of a large-scale international research initiative on implementation, evaluation and scale-up of interventions to enable advancement of women in nursing into leadership roles.

Added value of this study

This is the first study to systematically review the literature and undertake a meta-synthesis. This comprehensively aggregated data provides insights into the myriad of impediments, challenges, and barriers confronting women in nursing from advancing into leadership across healthcare settings.

Implications of all the available evidence

The results of this study offer a holistic perspective on impediments faced by individual women in nursing when aspiring to leadership roles and informs intervention development to overcome these. It is recognised that interventions need to rise above the individual to organisational and systems change. These findings serve as a foundation for implementation research, codesign and adaptation of effective organisational and systems level strategies, tailored specifically to the needs of women in nursing.

devaluing nurses in leadership.[1] Patriarchal views of leadership and the stigmatisation of nursing as women's work contribute to unconscious gender bias, defined as "unintentional and automatic mental associations based on gender, stemming from traditions, norms, values, culture and/or experience" (p. 3).[3,4] Women in nursing experience unconscious bias alongside barriers impacting on their credibility, capacity and capability, contributing to poor job satisfaction and attrition. These factors collectively both demotivate women from seeking leadership opportunities due to feelings of inadequacy, and overlook qualified women nurses for leadership roles.

Strengthening the nursing profession is key to providing cost-effective and accessible healthcare globally. Effective nursing leadership practices across settings, have critical implications for improved healthcare quality and patient outcomes.[5,6] Enabling nurses to practice to their full extent of training, skills and knowledge, expanding scope of practice, and investing in leadership are identified strategies to strengthen the nursing profession.[6,7] The Sustainable Development Goal of "leaving no one behind" (p. xii), improving health for all, and strengthening the primary healthcare workforce towards universal health coverage is impossible without maximising nursing contribution.[7]

Alongside strengthening the nursing profession and nursing leadership to optimise healthcare delivery, improving gender diversity and equality in healthcare leadership is also crucial to address health disparities.[8] Yet gender inequity in healthcare leadership remains and is attributed to barriers including societal beliefs and stereotypes, discrimination and bias, lack of leadership training, limited organisational support and mentoring, and work-life balance issues.[4] Understanding and addressing these barriers is essential for promoting gender diversity in healthcare leadership, improving career opportunities for women nurses, and improving overall equitable care and health outcomes.

In advancing this field, it is recognised that individual-level solutions to overcome unconscious bias and advance women into healthcare leadership, have proven ineffective to date, with recognition of the need to move from "fixing women" to organisational-level intervention.[9,10] Addressing these barriers may also lead to more feminine aspects of leadership style to become more accepted and utilised within male-dominated healthcare leadership roles. This systematic review aimed to explore the barriers for women in nursing to advance in healthcare leadership, in order to inform organisational interventions as part of a large-scale national initiative to advance women in healthcare leadership.

Methods

Theoretical framework

According to the Ability, Motivation, and Opportunity (AMO) framework, individuals' performance is determined by their ability, motivation, and opportunity.[11] Employees perform optimally, when they have the necessary abilities (knowledge, skills, and aptitudes), adequate motivation (internal and external motivation), and sufficient opportunities.[11,12] Employees' abilities and motivation are meaningless within a system that limits their opportunity to participate.[12]

Study design and ethics

In this systematic review and meta-synthesis, reported barriers for women nurses' leadership attainment were identified from the literature. Generated themes were mapped to the AMO framework to understand the

interplay between ability, motivation, and opportunity-limiting organisational barriers. As this study involved a meta-synthesis of previously published, ethical approval was deemed unnecessary.

Search strategy

The Peer Review of Electronic Search Strategies (PRESS) guidelines were followed to develop a search strategy.[13] Two guidelines were implemented to report the findings; the Preferred Reporting Items for Systematic Reviews Guidelines (PRISMA)[14] and Enhancing Transparency in Reporting the synthesis of Qualitative research (ENTREQ) statement.[15] Eligibility was based on the Population, Phenomena of Interest and Context (PICO) framework (Table 1) since a background search for eligible papers revealed most were experiential.[16]

Searches using search terms listed in Table S1 were conducted across: MEDLINE (OVID), EMCARE (OVID), EMBASE (OVID), PsycINFO (OVID), PubMed, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL PLUS via EBSCO host) (MSDSPB). The search was limited to the English language and studies published between 1, January 2000 and 17, October 2023. The Grading of Recommendations Assessment, Development, and Evaluation- The Confidence in the Evidence from Reviews of Qualitative Research (GRADE-CERQual) approach was followed to assess the level of confidence in the evidence produced by the included studies,[17] including methodological limitations, coherence, adequacy, and relevance (Table S10).[17]

Key study data were extracted and tabulated, including author, year of publication, journal, country, methodology, population characteristics, and methods of data collection and analysis (Table 2), followed by data synthesis and analysis. The six-step thematic analysis process defined by Braun and Clarke was used to identify themes in the meta-synthesis (Table S5).[18] Results and conclusion sections of primary studies were coded in Dedoose 9.0.85 software.[19] MSDSPB conducted the initial coding. BG reviewed the initial codes and these were then discussed with the senior authors. Line-by-line open coding was conducted in the first few papers, and a coding framework was developed. A deductive approach was then used which was flexible enough to capture additional relevant data. Similar codes were grouped together for the derivation of themes. Primary themes were then mapped to the constructs of ability, motivation, and opportunity as defined by the AMO framework.[11,12] Here, barriers to women nurses' advancement were identified and factors contributing to employee performance were used to identify motivations and opportunities that influence actions. Quotes were taken from the participant's or author's interpretations.

Role of the funding source

The funder was not involved in study design, data collection, data analysis, and data interpretation, in the writing of this report; or in the decision to submit the paper for publication.

Results

Searches were merged by exporting results to the COVIDENCE web-based software[20] for initial screening and data extraction (MSDSPB) (n = 4114). Duplicates were removed (n = 1130). Titles and abstracts were screened by two independent reviewers (MSDSPB and KJ) (n = 2984), and the relevant full texts (n = 140) were screened against the eligibility criteria (MSDSPB and KJ). Consensus was reached; 108 papers were excluded with justification (Fig. 1). Thirty-two papers met eligibility criteria and were included (Table 2).

Retrieved full texts were assessed for methodological rigour using the Critical Appraisal Skill Programme (CASP) Qualitative Studies checklist[21] and Joanna Briggs Institute (JBI) Cross-sectional[22] and Prevalence Studies checklists[23] by two independent reviewers (MSDSPB and JP). Four categories of concern were created (Tables S3, S4, S6 and S7).[17,24–26] No studies were excluded based on methodological limitations.

Description of included studies

Qualitative (n = 18), quantitative (n = 11), and mixed-method studies (n = 3) were included in the final review. The sample included registered nurses, nurse academics, nurse executives, and nurse leaders. One study examined nursing journals. One study examined the nursing gender pay gap and sample size was not specified. Studies were conducted in upper- and lower-middle-income countries (n = 7) and in high-income countries (n = 20). The country income classification is based on the World Bank's 2022 report.[27] Three studies were conducted across multiple countries, and two did not specify the country in which the study was conducted.

Quantitative studies outlined in Table S9, demonstrated gender bias in the system, more career breaks and part time roles for women perceived to impact capacity and capability.[28–33] Women had less access to networks, training and promotion opportunities.[28] There were negative perceptions around capability and

Population (P)	Phenomena of interest (I)	Context (CO)
Women nurses or women midwives	Advancing women nurses in healthcare leadership	Healthcare or academia internationally

Table 1: **PICO (population, phenomena of interest, context).**

Authors & year	Journal	Country	Sample size	Population	Methodology	Data collection & analysis	Theoretical underpinning
Abbas et al., 2022	International Nursing Review	Pakistan	25	Nurses	Qualitative	One-to-one semi-structured interviews including inductive and deductive approaches	Hermeneutic interpretative phenomenology
Aspinall et al., 2021	Journal of Clinical Nursing.	New Zealand	31	(female n = 26)	Qualitative	Semi-structured interviews including inductive and deductive approaches	
Brandi, 2000	Journal of Nursing Administration	USA	17	female nurse executive	Qualitative	Semi-structured interviews Dimensional analysis	Feminist-grounded theory
Brandi et al., 2006	International Nursing Review	Japan	16	female nurse admin-hospital	Qualitative	Interviews-Telephone dimensional analysis	
Canli et al., 2023[a]	Hispanic Health Care International	USA	17	Latina nurse leaders	Qualitative	Descriptive approach. One-by-one interviews. Thematic content analysis	
Corn, 2020	Journal of National Black Nurses Association	USA	19	(10 females)	Qualitative	Members of nursing associations in the New York City has been interviewed-A semi-structured Interview Descriptive and thematic analysis	Hermeneutic approach
Deschaine et al., 2003	Policy, politics & nursing practice	Not specified	8	Female	Qualitative	Semi-structured interviews Longest's model (2002) framework thematic analysis	
Etherington et al., 2021	BMC Health Services Research	Canada	66	36 (55%) women, 23 nurses	Qualitative	Semi-structured interviews Thematic analysis	
Gauci et al., 2022	Journal of Advanced Nursing	Australia	10	Registered Nurse academics	Qualitative	Guided by the work of Anderrson and Jack (1991); Thematic analysis	Feminist perspective and social constructionism
George et al., 2022[a]	Journal of Advanced Nursing	USA	16	Nurses were providing direct patient care-inpatient hospital settings	Qualitative	Semi-structured interviews Nowell et al.'s (2017) 6-step thematic analysis	
Hill et al., 2023[a]	Journal of Emergency Nursing	USA	19	Nurses from 5 emergency department within 1 hospital system	Qualitative	One-on-one interviews Braun and Clarke's qualitative thematic analysis 6-phase	Organisational Support Theory
Im et al., 2018	Journal of Transcultural Nursing	South Korea, Taiwan, Japan, Thailand, and the United States	12	Nursing leaders (deans/ presidents)	Qualitative	Inductive and deductive approaches	Integrative approach- by Meleis (2017)
Hollup, 2014	International Journal of Nursing Studies	Mauritius	47	(20 female)	Qualitative	In-depth, semi-structured interviews	
McIntosh et al., 2015a	Journal of Psychological Issues in Organizational Culture	UK	32	registered female nurses	Qualitative	In-depth interviews	
Pannowitz et al., 2009	Contemporary Nurse	Australia	8	middle-level female nurses	Qualitative	Observation, the researcher's field notes and journal,semi-structured critical conversations trifocal analytic methods	
Ring, 2002	Journal of Advanced Nursing	UK	6	Female nurses	Qualitative	Semi-structured Interviews Thematic analysis using Maxwell and Maxwell's 1980 framework	
Shrestha et al., 2010	Journal of the Nepal Medical Association	Nepal	11	female nurses	Qualitative		
Wardani et al., 2019	Journal of Nursing Management	Indonesia	20	female nurses including 8 nursing leaders	Qualitative	Semi-structured face-to-face interviews Thematic analysis	
Wojczewski et al., 2015	PLoS ONE	Multiple-Botswana, South Africa, the UK, Belgium, and Austria	34	HCW (21 nurses/women)	Qualitative	Interviews Content analysis	
Halcomb et al., 2016	Journal of Nursing Management	Australia	23	early career nurse academics (20 female)	Mixed-methods	Descriptive statistics for quantitative data Thematic analysis for qualitative data	

(Table 2 continues on next page)

Authors & year	Journal	Country	Sample size	Population	Methodology	Data collection & analysis	Theoretical underpinning
(Continued from previous page)							
Mwetulundila et al., 2022	SAGE Open Nursing	Namibia	22	(15 females)	Mixed-Methods	Descriptive statistics for quantitative data Qualitative data analysis- Five-step approach to theming and sub-theming	Social role theory
van der Heever et al., 2019	International Journal of Africa Nursing Sciences	South Africa	573 survey 45 interviews with managers and 5 executives	All nurses (Quantitative data a nd demographic characteristics of participants has not been presented)	Mixed-methods	Quantitative data-each question were compared with concepts fundamental to the study framework i.e. race, class and gender Qualitative data- open-ended questions analysed using the steps proposed by Terre Blanche et al., 2006. Meta-inferences from the qualitative and quantitative data using Venkatesh, Brown, and Bala (2013) approach.	
Berkery et al., 2014	Journal of Nursing Management	Ireland	171	nurses & midwives (160 female)	Quantitative	Schein's Descriptive Index- for survey development Intra-class correlation coefficients factorial analysis Duncan's Multiple Range test for unequal sample size	
Buhr, 2010	Journal of Continuing Education in Nursing	Canada	27,934	Female RNs = 26,458	Quantitative	Binary probit model Regression analysis	
Khader et al., 2022[a]	Leadership in Health Services	Jordan	N = 2082 female health professionals	317 physicians, 1429 nurses/midwives, 336 pharmacists	Quantitative	Data collected via paper questionnaires. Data described using means for continuous variables, medians for discrete variables and frequencies and percentages for categorical variables. Types of statistical analyses used: • Chi-square test • Factor analysis • Bartlett's test of sphericity • Inter-item correlations Cronbach alpha	
Punshon et al., 2019	International Journal of Nursing Studies	UK	England 321,758 (by head count) Northern Ireland 15,924 (by head count) Wales 22,534.5 (by whole time equivalent) Scotland 40,853.2 (by whole time equivalent)	Female percentage in England 88.7% Northern Ireland 90.3% Wales 93.4% Scotland 89.4%	Quantitative	2ry analysis/data mining/inductive method descriptive stat	
Roberts et al., 2002	Collegian: Journal of the Royal College of Nursing, Australia	Australia	109		Quantitative	Survey on databases	
Rozani et al., 2023[a]	BMC Nursing	Israel	526	Registered nurses with at least 3 months of nursing experience and employed in various healthcare settings throughout Israel	Quantitative	Self-administered structured questionnaire with three parts. Analysis via descriptive statistics, one-way analysis of variance, Pearson's correlation analysis and multivariate linear regression,	
Sarna et al., 2020	Journal of the American Pharmacists Association	Not specified	5309 editorial board members and 312 editorial leadership positions	high-impact medical, nursing, and pharmacy journal	Quantitative	Pooled cross-sectional evaluation of 21	
Shields, 2011	Journal of the Royal Society of Medicine	International USA/UK/Australia	8	generalist journals	Quantitative	Top 20 nursing journals by impact factor Chi-square and Fisher exact tests	
Westphal, 2012	Journal of Nursing Management	USA	10,150	Nurses and nurse leaders	Quantitative	Archival research methodology and secondary data analysis	

(Table 2 continues on next page)

Authors & year	Journal	Country	Sample size	Population	Methodology	Data collection & analysis	Theoretical underpinning
(Continued from previous page)							
Whittock et al., 2002	Sociology of Health and Illness	NHS-UK Outer London trusts	51-line mangers & 385 nursing staff	line mangers & nursing staff (314 female)	Quantitative	Survey/interviews/archival data	

[a]Women were defined for this study as anyone who identified themselves as a woman or where relevant, as a man. Sex or gender terms reflect those used in the original studies.

Table 2: **Overview of included studies.**

credibility in leadership and management for women and disproportionately less women were in senior roles, at older ages with noted gender pay gaps.[28,32–34] These studies were primarily in high income countries.

Barriers to advancing women nurses to leadership were identified across eleven overarching themes and mapped to the AMO framework (Fig. 2 and Table S8). They include: i) ability-limiting organisational factors hindering skills and knowledge to lead, ii) motivation-limiting organisational factors hindering the desire to lead, and iii) opportunity-limiting organisational factors hindering the opportunity to lead.

Ability-limiting: organisational factors hindering skills and knowledge to lead

A lack of organisational capacity to facilitate women nurses' leadership aptitudes was identified, specifically: i) lack of nurse role models in leadership, ii) lack of formal and informal leadership training, and iii) inadequate orientation to leadership roles.

Nurses especially in upper- and lower-middle-income countries had inadequate role models,[28,35–37] limiting effective management and leadership.[35] For example, in Indonesia the 'head nurse' role modelled high-control directive leadership, giving orders,[36] rather than role modelling collaborative leadership to build capability in others.[36] There was little guidance on how to lead effectively, with a lack of formal and informal leadership training, and minimal orientation to leadership roles, leaving employees to familiarise themselves through trial and error.[28,38]

Motivation-limiting: organisational factors hindering the desire to lead

Organisational factors hindering women nurses' motivation to assume leadership roles included: i) Social and cultural expectations, and nursing as a gendered profession, ii) perceptions of leadership, iii) hierarchical leadership, iv) workplace policies and processes, v) gender-related bias in leadership attainment, and vi) lack of support for work-family integration.

Social and cultural expectations and nursing as a gendered profession

Societal and cultural expectations around women as nurturers and men as leaders influenced perceptions of i) women's role in the home as primary caregiver, and ii) nursing as women's work. Gender stereotypical beliefs that a "women's place is at home" (p. 675) as a dedicated "housewife", were still prevalent within many cultures,[36] restricting access to legitimate leadership positions, and reducing motivation to pursue leadership. Primary child carer expectations have led to parenting conflicts impacting career advancement[39]; and while women often interrupted or limited work for childcare, men with children advanced relatively unhindered in their careers. Cultural expectations around women's roles in society have contributed to beliefs that nursing is dirty or menial work, inconsistent with concepts of leadership,[40–42] adversely impacting on confidence. Women reported being socialised to believe that opportunities were for men.[41,42]

In workplaces, gendered power structures were reinforced and maintained.[43] Gender role stereotyping in leadership negatively affected women's entry or advancement opportunities,[28,44,45] and in patriarchal cultures women were considered "less qualified than men for managerial positions" (p. 717).[28,44] Lack of recognition and respect for women nurses was a recurring theme. Women nurses believed they must constantly assert their authority and fight for independence, compared to men counterparts.[39] Further contributing to men's authority in the workplace, women nurses experienced higher levels of scrutiny and were examined more than their men counterparts during routine activities.[28,43,45] A similar sentiment was found between medical and nursing professions, where physicians received more credit than nurses, despite working together for patient care.[40] Nurses expressed a need for recognition and respect from co-workers and patients, noting the lack of awareness of professionalism in nursing.[35,46]

Perceptions of leadership

The nursing profession faced gender bias and societal expectations, hindering the ability to succeed in leadership roles. Nurse executives often struggled being recognised in leadership roles, especially with "old-guard physicians" (p. 374) who were often change-resistant, yet highly vocal and influential.[47] Limited differentiation of leadership from management also presented barriers with perceptions that nurse

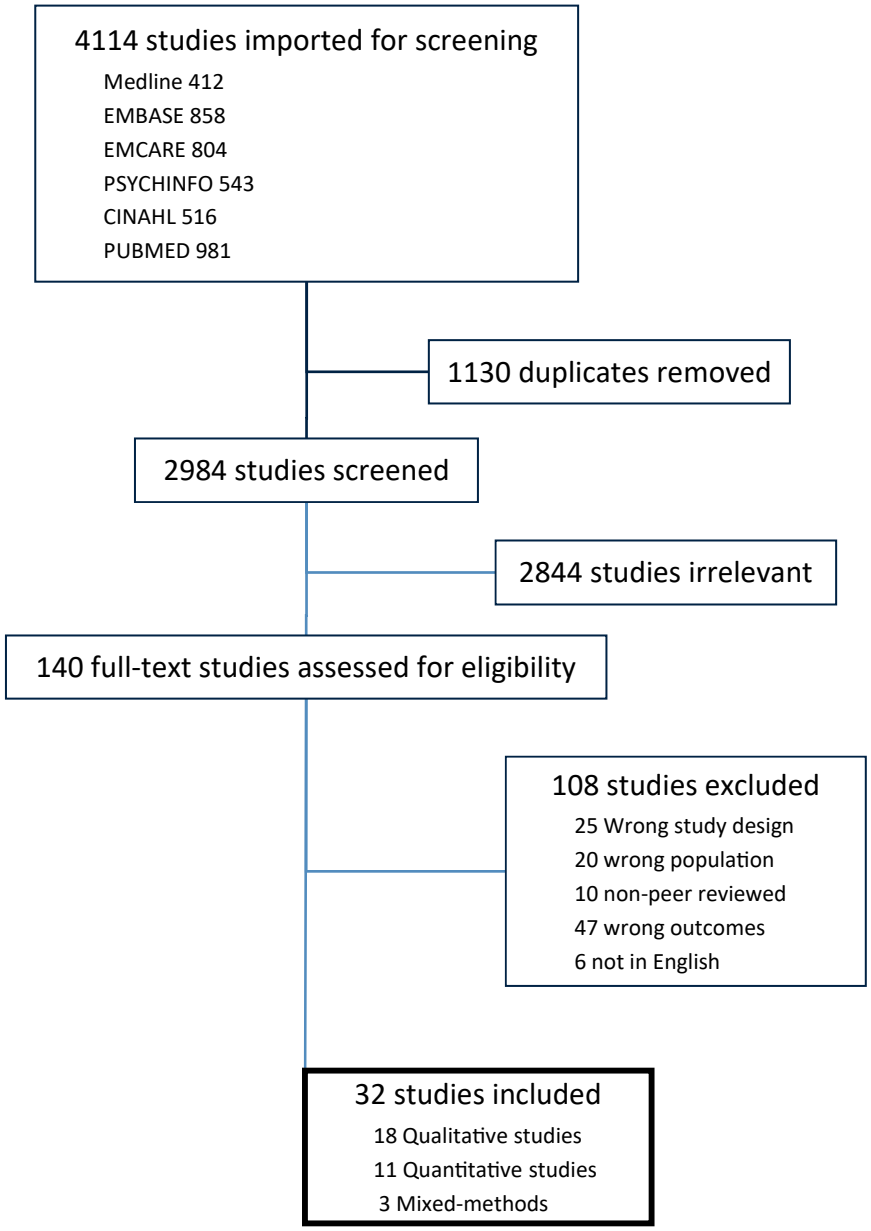

Fig. 1: PRISMA flow chart for the screened, excluded, and included papers.

managers were simply conduits for more powerful organisational leaders.[36,43] Likewise, workplace behaviours engendered disempowerment in interactions with nurse executives, leaving nurses feeling isolated, marginalised, bullied, undervalued and silent.[48] Traditional task-oriented work schemes overshadowed the development of leadership among nurses.[36] Overall, societal expectations based on gender stereotypes, translated into informal tracking of women into leadership positions, further perpetuated the cycle of gender bias in the nursing profession.[43]

Lack of awareness of the nature of nursing leadership roles combined with narrow career pathways, contributed to the perception that progressing to leadership would mean giving up clinical roles, which they were reluctant to do.[49,50] Conversely, organisational systems often delayed career progression, as practical nursing skills and experience were prioritised. Non-nurse managers often viewed nurses in leadership as "ex-nurses," who have abandoned their clinical portfolio[50] and now focused primarily on fiscal matters, rather than on the importance of patient care. Nurses feared

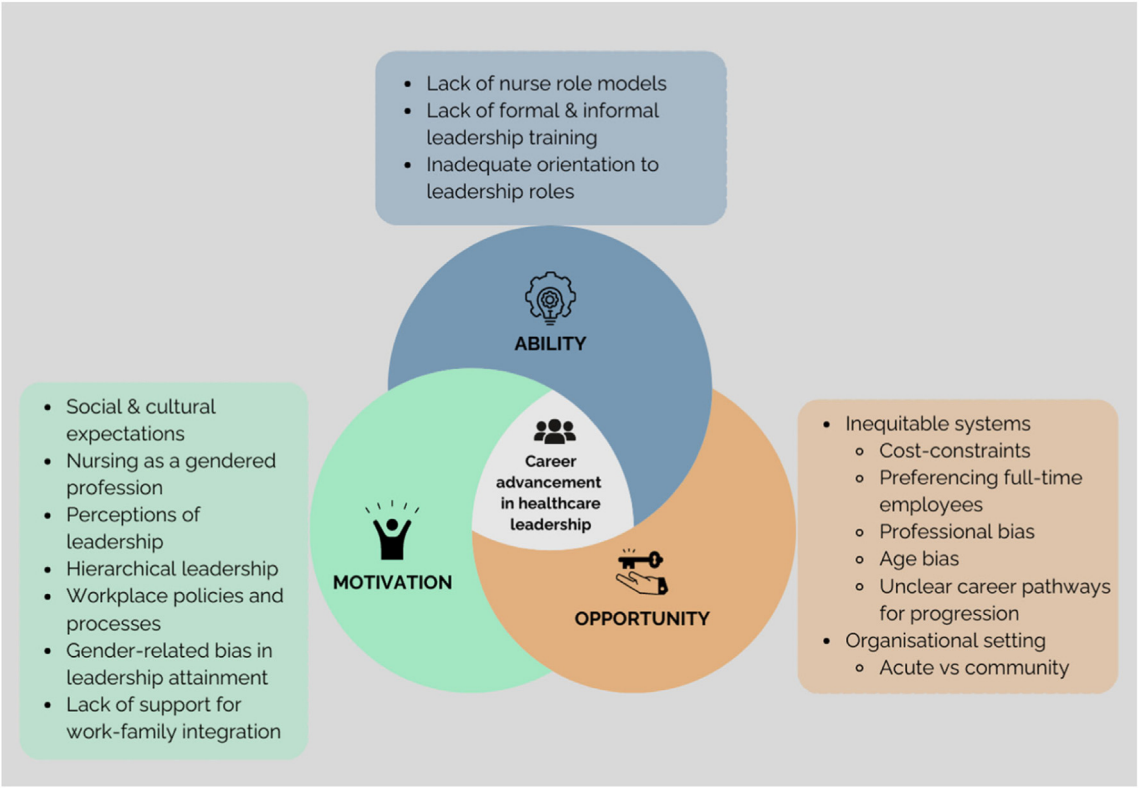

Fig. 2: Organisational barriers to Advancing women nurses in healthcare leadership.

that becoming a leader meant losing touch with clinical skills and connection with patients.[50] This is in stark contrast to medical pathways into leadership, where clinicians often retain both leadership and clinical roles.[50]

Hierarchical leadership

Power disparity in healthcare institutions impacted nurses' motivation for career advancement in leadership. Hierarchical leadership structures perpetuated medical dominance in senior leadership roles, with nurses placed in the middle-to-bottom, and nursing voices perceived as lost in the "stratified layers above them" (p. 1936).[50] Nurse leadership position descriptions were lengthier than their medical counterparts,[50] and nurses lacked official authority or participation in decision-making processes.[40,48] This sense of disempowerment led to tension and conflict between the two professions, and the lack of recognition and respect for nursing expertise and knowledge further perpetuated the perceived subordinate position of nurses within the organisational hierarchy.[36,46,48,50,51]

The overrepresentation of men in healthcare leadership further reduced women nurses' motivation to apply for leadership roles. Leadership opportunities were perceived as limited[38,40,47] and there were concerns about a pervasive patriarchal culture favouring men-men partnership in selection processes.[45,47]

Workplace policies and processes

Flexible work arrangements, family-friendly policies, and transparent selection processes all featured as organisational practices that have the potential to support women nurses' career progression, however limitations around accessing these hindered women nurses' motivation to lead.

Advancing in nursing leadership often meant inflexible working arrangements, needing to work full-time, and losing the flexibility of part-time shift work.[43,50] For some this meant leaving their career or changing workplaces.[50] Part-time nurses had limited access to promotion and training, and inflexible scheduling of work and training. Moving from full-time to part-time also led to reduced recognition for their skills and expertise.[32,52] The full-time work required to advance in nursing leadership, together with working long and extra hours, demotivated nurses to attain leadership roles.[43,50]

Nurses who received return-to-work training and support after a period of parental leave experienced rapid career growth, as up-to-date technical skills were a criterion for advancing nursing careers. However,

access to training while on parental leave and upon return to work was limited.[52] Family-friendly policies such as maternity, sick, and compassionate leave were available, but gaps included the absence of paternity leave policies.[41] Implementation of breastfeeding policies such as additional breaks for breastfeeding mothers was challenging when the workplace physical environment was not supportive.[41,53]

Lack of transparency and uniformity in selection processes for leadership appointments was identified, which created concern around inequality and discrimination.[28,38] Some participants were uncertain about the criteria that were used for their current appointments.[38]

Gender bias in leadership attainment

Despite significantly more women than men in nursing, senior positions were disproportionately held by men,[32,45] maintaining the *glass ceiling* which marginalises and undermines women's efforts to advance in their careers.[43,50] This reduced women's motivation to lead. Men nurses were more likely to be promoted and take on leadership roles[32,43,45]; earn more[30,34]; attend leadership conferences and be approached for committees and management positions[43,54]; were substantially younger than their women counterparts[55]; received preferential treatment, e.g., excused for making mistakes, offered more opportunities for professional development, and achieved more senior positions than their women counterparts.[43,49] Rising in their careers faster than women co-workers was attributed to informal men networks, societal gendered expectations, and a men-dominated system underscoring ongoing patriarchy and sexism rather than considering merit.[28,42,43,45,47,50] Some men nurses acknowledged their gender gave them greater opportunities for career advancement.[50]

When women nurses did aspire to leadership positions, they reported having to work harder to prove themselves, felt undervalued and invisible in their workplaces,[43,50,51] and were held to higher standards than their men counterparts.[43] This resulted in women feeling frustrated, marginalised, discouraged and disempowered.[39,43] Women who were also mothers faced additional challenges, as co-workers and employers presumed their disinterest in career advancement and excluded them from leadership opportunities.[28,43,50]

Lack of organisational support for work-family integration

A complex interplay was identified between domestic duties and professional advancement for women in nursing. Women's success in leadership often relied on strong family support, particularly from partners, and personal strategies that foster self-empowerment, self-esteem, and confidence.[38,40,48,50] However, cultural expectations and practical challenges, e.g. the time required for postgraduate education and the demands of long working hours, made it difficult for women to balance family and career priorities.[41,50] Privileging men partners' careers exacerbated these challenges, with women reducing hours or taking career breaks.[49,50] Financial stability, and anxiousness can also contribute to hindrances in career advancement for women nurses.[41,54]

Opportunity-limiting: organisational factors hindering the opportunity to lead

Opportunities for women nurses to advance to leadership was hindered at a systems and organisational setting level.

Inequitable systems

Cost constraints, a preference for permanent and full-time employees and professional and age biases were all opportunity-limiting for women nurses to attain leadership roles. The impact of centralised cost constraint policies on the nursing profession, where the value of caring was overridden by fiscal needs,[48] meant graduates were employed in favour of experienced nurses, and agency nurses were not hired during staff shortages–compromising the skill mix for patient care. Insufficient funding also led to inadequate staff development, professional ongoing nursing education, and new graduate nurses' preceptorship programmes. Budget management was also a challenge.[48]

Full-time work has been regarded as the most efficient, productive, and cost-effective approach to delivering high-quality patient care.[52] Part-time nurses were perceived as less committed, less motivated, and having less career interest by their managers.[32] This led managers to prioritise full-time staff for training and development opportunities, resulting in part-time nurses feeling marginalised and experiencing downward career mobility.[32,43,52] Opportunities for developing leadership capability were often restricted to permanent and full-time nurses.[36,52] Compounding the challenges for non-permanent nurses were variable work shifts and potential loss of grading and educational opportunities, further reducing the chances of returning to permanent employment or re-joining often on a lower grade than previously.[32] Nurses working full-time were afforded more opportunities to advance in their career than those working part-time. Resourcing restrictions led to rationing training and prioritising full-time nurses, who were assumed to make a greater contribution to patient care and remain for the long-term.[52]

There was a clear gender disparity in opportunities to progress in nursing leadership given women formed the majority of the part-time nursing workforce. Whittock et al. found no significant difference in the percentages of men (45%) and women (46%) nurses who had children under 18, but very few men worked part-time (n = 9).[32] Part-time work was often chosen to accommodate domestic responsibilities associated with childcare; combining caring with work was more challenging

for part-time staff and, in particular, for women.[32] Whilst ward nursing roles offered flexibility to balance childcare, such flexibility was lost with more senior and leadership roles.[50] Despite the promotion of equal opportunities, rigid systems approach offered little support.[32]

Lack of training and advancement opportunities for nurses who worked part-time or took career breaks was attributed to labour market demand and supply, including the preference for cheaper new staff and prioritising full-time workers.[52] The absence of appropriate training for returning nurses produced a negative cycle of no-promotion and no-incentive to change working conditions or patterns.[52] While this highlights the need to upgrade nursing skills to allow returning nurses to perform the whole task, this opportunity was restricted for part-time workers.

Professional biases and gender equality policies at the macro-level were also opportunity-limiting and contributed to power imbalance. Hospital administration, primarily run by doctors, limited nursing administration opportunities.[46] Placed in more submissive roles, nurses felt disempowered and were perceived as "battle axes" by physicians (p. 3).[46] Human resource policies and organisational structures further impeded career progression for women in nursing[41] with organisational structures creating narrow career progression and pathways for nurses, and inequitable selection or assigning of leadership positions, e.g., assigning leadership roles based on age or length of service, rather than ability as a leader.[40] Unclear pathways to leadership also hindered progression to leadership roles.[35]

Age bias was opportunity-limiting, with older women registered nurses experiencing limited opportunities for advancement,[43] leading to the perception they are not competent enough for challenging roles. Women nurses on wards aged over 40 were offered fewer opportunities for training and progression, while men registered nurses were given equal opportunities to progress regardless of age.[43]

Organisational setting

Leadership opportunities for nurses differed between acute and community settings. Community clinics focused on primary healthcare and prevention, with few leadership opportunities[41]; hospitals focused on acute care and offered more leadership opportunities and senior positions around curative aspects of care. Additionally, acute clinical experience was often a prerequisite for leadership roles.[49] Consequently, nurses working in community clinics and sub-acute settings had fewer opportunities for progression than those in hospitals.

Discussion

The aim of this study was to explore barriers to advancing women nurses in healthcare leadership. This systematic review revealed that barriers to advancing in leadership for women nurses are cultural, professional, organisational, and individual. These barriers were mapped to the AMO framework: abilities, opportunities, and motivations. The lack of role models, the paucity of formal and informal leadership training, and the minimal orientation to leadership roles were revealed as ability-limiting factors. Systemic issues such as organisational settings, structures, and supports created barriers and limited the motivation of women nurses to seek leadership opportunities. Organisational capacity limited the opportunities of women nurses to lead. The biggest barriers related to nursing as a stereotyped women-gendered profession, including issues relating to the perception of leadership, gender-related biases, hierarchical notions and gender, workplace culture and policies, and work-family integration.

Through intentional modelling, aspiring clinical leaders can better understand the qualities and skills they need to cultivate to reach their full leadership potential.[56] Our current systematic review, revealed that lack of nurse leaders serving as role models affected the growth of future nurse leaders.[35,36,47,57] These results highlight the urgent need for greater exposure and opportunities to close this gap and develop the next generation of nurse leaders. Lack of formal training and minimal orientation for leadership roles was highlighted in our review.[38] Strategies to enhance gender diversity in leadership roles include mentoring, leadership development, career planning and coaching, networking opportunities, sponsorship, and targeted hiring procedures.[58]

In terms of motivation barriers, the presence of gender stereotypes and cultural beliefs is a major obstacle to gender equity in nursing leadership.[4,59] Nursing has traditionally been considered a womens' career, as caring is culturally considered "feminine" (p. 6).[4] Such misconceptions create obstacles for both genders, discouraging men from entering nursing and fostering discriminatory behaviour against women nurses' career advancement.[59] Cultural expectations of women caring for families and children further burden women nurses, who were demotivated to seek career advancement opportunities, and left to juggle between paid and unpaid work.[4]

Power imbalances, gender stereotypes, discrimination, and systems that provide opportunities for one gender to thrive while others remain in subordinate positions are the main causes of the current gender inequalities in leadership.[1] Cultural perceptions of dominant masculinity and patriarchal leadership attribute advantage to men; they are heard, visible, and respected more than women nurses.[28,43,51] The perception of women nurses as submissive to traditionally men-dominated medical professionals was not recognised.[60] However, men nurses did not appear to

encounter bias with regard to career advancement.[60] While women experience the "Glass Ceiling" (p. 6)[4] and "leaky pipeline" (p. 40)[1] to the top managerial careers, men experience the "glass escalator," (p. 6)[4] where they advance faster than their women counterparts. Gender bias is a factor in opportunity and promotion in nursing.[60] Obstacles to professional growth for nurses that are related to gender are also visible.[34] Gender imbalance in nursing can result in lower job satisfaction, more work-related stress, and even burnout in both men and women nurses, which results in higher rates of attrition and absenteeism,[61] and needs to be recognised and addressed.

Workplace difficulties are a significant additional obstacle; women nurses frequently experience unconscious bias and gender-related discrimination when it comes to leadership positions in nursing, which causes gender inequities within the industry.[4,60,62] The convergence of additional factors, such as race, religion, caste, class, and ethnicity, further disadvantage women with more than one marginalized identity.[1] Forging an inclusive and diverse nursing workforce, including addressing cultural ideologies, requires overcoming these obstacles. Another key factor that affects motivation related to the perception of nursing professionalism. Nurses' unique skills and expertise make them valuable healthcare team members, and their leadership can help improve the overall quality of care. Nurses are transforming into an autonomous and well-educated workforce. Nurse education is at least a three-year programme in 97% of countries.[7] However, a lack of recognition and support from other healthcare professionals and organisational leadership demotivates nurses.[36,46,49] These barriers were reported as a lack of opportunity, power, and autonomy, which undermine nurses' performances and competencies. A negative image of nursing was detrimental to nurse leaders' participation in leadership activities like health policy development.[63] Despite the advances in nursing education and the evolution of the profession, there is a prevailing perception that nurses primarily provide supportive roles rather than leadership roles. This creates a culture that undervalues nurses' abilities and expertise, affecting motivation and opportunities for career advancement and involvement in decision-making processes.

In terms of opportunity barriers, organisational structural issues have negatively affected nurses' career advancement.[49] Industrial agreement portability of qualification allowances presents financial barriers to career transitions. Clinical nurse specialist role criteria require substantial clinical skills, professional development, and professional behaviour, including support and contribution of quality improvement work and research projects within the area of practice.[64] Moving workplaces may result in losing these roles and grades. These have not been adequately studied or reported and more research is needed. Other barriers to leadership opportunities included prioritisation of full-time over part-time roles.[65] This can be demotivating for part-time nurses who work flexibly. Acute care experience was regarded as a requirement for leadership roles, leaving behind community, sub-acute, and aged care nurses.[41,49] Additionally, non-permanent staff have been excluded from career advancement opportunities.[32,36] We confirmed barriers for older nurses, with a lack of opportunities for education and advancement, a lack of acceptance and recognition, and being bullied.[43,66]

In the current systematic review, women reported that returning to work after a career break was associated with a lack of support and recognition.[52] McIntosh et al. found that career breaks were detrimental to women's careers, especially for the more senior grades.[67] These barriers were consistent with the broader literature showing career breaks and parental care roles compounded the other barriers to opportunity.[37,60,67,68]

The limitations of this review include any research discussing the career advancement of men in nursing. We were unable to align to Sex and Gender Equity in Research (SAGER) guidelines[69] on sex and gender terminology as we aggregated primary studies that did not specify how they defined their language used. Moreover, since the review exclusively focused on English-language articles, it is possible that it did not encompass all pertinent studies and might not reflect the range of experiences from non-English speaking countries. The limited application of findings in a global setting may result from the exclusion of non-English studies. There were also limited studies in upper- and lower-middle-income countries. The distinct circumstances, cultural differences, and medical customs of various areas might not be fully captured by synthesis. This might make it more difficult to extrapolate results to nations with diverse socioeconomic, healthcare structures or populations who do not speak English.

This systematic review focuses on identifying barriers hindering women nurses' progress in healthcare leadership at an organisational level. We have categorised these barriers into ability, motivation, and opportunity. We have shown that women nurses face barriers in their career advancement including organisational capacity not enabling women to know *how* to lead, not enabling women to *want* to lead, and not enabling women *to* lead. In terms of ability, role modelling and leadership development are key. For motivation, multiple complex and interacting factors including gender stereotyping, perception of professionalism, workplace policies, and gender bias were reported. For opportunity, key factors included systemic issues, organisational settings, structures, and support. From the findings, it is evident that the

prevailing belief that caregiving is a feminine occupation and the societal expectation of women's subordinate position are both significant obstacles preventing women nurses from attaining advancing healthcare leadership. Ultimately, these factors restrict the ability of women to become leaders in healthcare. These factors inform a national initiative funded to advance the careers of women in healthcare leadership with a dedicated stream on advancing the nursing profession.

The results of this systematic review can provide valuable insights for the development of workplace policies aimed at addressing the barriers identified in this study. Mid-career nurses, particularly those returning from parental leave and those working part-time, reported receiving inadequate support and experiencing limited opportunities for career advancement. Implementing industry-wide measures can be instrumental in alleviating these challenges and promoting progression in the career paths of mid-career nurses.

Contributors

MSDSPB: conceptualised the study, carried out database searches, data collation, analysed, and manuscript preparation. HJT and LB conceptualised the research, acquisition of funds for the necessary materials, contributed to its interpretation, contributed ideas, and managed the manuscript's scope. KW: obtaining funding, study design input and revision and intellectual input into the manuscript. BG: contributed to the interpretation of the analysis. KJ: contributed with 100% title, abstract, and full-text screening as an independent reviewer. JP: critical evaluation as second appraiser. MSDSPB and BG accessed and verified the underlying data. Prior to submission, the manuscript's final draft was approved by all co-authors.

Data sharing statement

All the data used for the study are included in the manuscript and supplementary material.

Declaration of interests

Research Training Program by the Australian Government Department of Education, Skills, and Employment, and Eastern Health, Melbourne, Australia provides funding for MSDSPB for her Ph.D. study. This work was supported by the NHMRC Investigator fellowship for HJT and NHMRC Partnership Grant to the institution. We can confirm that there are no conflicts of interest with the funders.

Acknowledgements

This work contributes to a competitively funded project by the Australian NHMRC as a national initiative, which aims to enable systems and organisational change to advance women into leadership in the healthcare sector. We thank Thuy Vy Nguyen, research assistant at Monash Centre for Health Research Implementation, for her invaluable contribution in the data extraction for this review.

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.eclinm.2023.102354.

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