

The Understanding the Career Trajectory of Black Women in the UK Healthcare Sector from an Intersectional Lens

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Abstract

This study presents how multiple social factors affect Black women's career advancement in the UK's healthcare sector. The intersectionality framework is used in this study to indicate that the restraints Black women face pursuing career progression are not identical and are influenced by various societal and structural factors. Ultimately, this study advocates for inclusive practices within the workplace. This study reviewed literature that highlighted how Black women's early socialisation into caregiving roles, systemic and cultural barriers, in conjunction with intersectionality, shape why they are underrepresented in senior management healthcare positions in the UK. It explored the glass ceiling and the subsequent overrepresentation of white male employees in leadership roles, and the exclusion of Black women from the glass escalator effect, demanding deeper analysis for equity. This study adopted interpretivism to explore participants' healthcare experiences, using focus group interviews. The focus groups were held with 20 Black women in various healthcare occupations, facilitating an understanding of their shared and individual experiences with microaggressions, workplace harassment and limited upward mobility. The findings chapter determined that the intersection of gender, race, class and education profoundly shapes Black women's careers in UK healthcare. Participants highlighted that their race presented them with unconscious bias, underrepresentation, and racism in their workplaces. In addition, they

faced gender disparities, unequal pay and limited mentorship as a result of social class. Recommending tailored mentorship, detailed DEI reporting, and equitable practices and contributing a deeper understanding of intersectionality and systemic barriers in career trajectory for Black women

Keywords: Intersectionality, Black women, Healthcare sector, Career advancement, Glass Ceiling, Glass Escalator.

Introduction

Intersectionality was conceived by Crenshaw (1989) to examine how marginalised women's experiences are neglected in legal, political, and social practices. The 'Glass ceiling' illustrates how unseen barriers exclude women from upper management levels in most organisations (Hull and Umansky, 1997). The 'Glass escalator' was introduced by Williams (1992) as a concept where men in traditionally female-dominated professions are more likely to be promoted into higher-paying positions or positions with more authority at a faster rate than their female colleagues. This research study aims to explore how intersectionality affects Black women's career progression within the United Kingdom (UK) healthcare sector.¹ Regarding the glass ceiling and glass escalator. The literature review will use relevant literature to recognise the distinct experiences created by intersectionality for Black women working in the UK healthcare sector. Followed by the research methodology chapter, which will explain and justify why qualitative methods were used to collect and analyse data. The data analysis and discussions chapter will examine the experiences of the study participants and how intersectionality affects Black women's career trajectories in their

¹ The Healthcare sector is an amalgamation of all the organisations and professionals involved in delivering medical care, preventive services, and health-related products to individuals and communities. It comprises: Doctors, Nurses, Pharmacists, Dentists, Social Workers, Occupational therapists, etc.

healthcare occupations.

Background to Study

According to the World Health Organisation (2020), women comprise about 70% of the health and social care workforce worldwide. Despite their substantial representation, women frequently work in lower-status, lower-paying positions and hold only 25% of healthcare sector leadership positions worldwide. Across various global healthcare professions, women, especially Black women, encounter systemic barriers to leadership and higher-paying positions. The UK aligns with patterns seen in the United States (US), India, Japan, and China, where women are overrepresented in lower-paid healthcare occupations and underrepresented in senior positions.

United Kingdom

Despite the overall increase in Black female staff in the NHS, their representation at very senior management levels remains disproportionately low (NHS England, 2024). The Milner et al. (2020) study into the differences in gender-racial representation in the NHS found that Black women were largely represented in lower-paid healthcare occupations like Nurses, midwives, health visitors, and support staff to doctors as opposed to higher-paying medical professions, Doctors and consultants.

United States

Similarly, the US Bureau of Labour Statistics (2023) reported that nearly 25% of certified practical nurses and aides, and 10.2% of registered nurses are Black women. Yet make up only 5.4% of doctors.

India

According to a report by Dasra (2023), the Indian philanthropic organisation, Women constitute 80% of nurses and midwives and 29% of medical Doctors. Despite their significant presence, women only hold 18% of leadership roles in the healthcare sector and, according to the International Labour Organization (2018), earn 34% less money than their male colleagues.

Japan

The OECD (2022) reports that Japan's gender pay gap in 2022 was 22.1%, twice as high as the OECD average (Appendix 1). A study on female physicians in Japan found women made 25% less than their male colleagues, increasing to 37.2% for female doctors with children, indicating a clear "motherhood penalty" (Nishida et al., 2024).

China

In 2021, the National Bureau of Statistics of China (2023) reported that 320 million women were employed nationwide, accounting for 43.1% of the workforce. However, women are under-represented in higher-paying sectors, and this feminisation is primarily seen in lower-paid occupations like nursing (Li et al., 2024).

Importance of the Study

Although this topic has been widely discussed over the last thirty years, it is still a critical issue that needs re-examination. The exposure of Black women and all minority women to discrimination and marginalisation cannot solely be understood through the lens of race or gender separately, but through an intersectional lens. Their various social identities: gender, race, class, age, religion, and sexuality are considered to shape their experiences with

privilege and oppression. This lens is important when examining the inequality of Black women in healthcare occupations, as they are more susceptible to racism and sexism in their workplaces. They are also three times more likely than their peers to contemplate regularly leaving their jobs (Chand, 2023). This underscores the urgency for transparent disclosure of gender-ethnic DEI initiatives and consideration of the specific barriers to career progression faced by Black women, as well as all minority women in the UK. Aside from the prevalent racism and sexism that ethnic minority women endure, Black women are more frequently subjected to anti-Black sentiments in addition to limited access to mentorship and professional networks.

Aim of Research Study

This study aims to present how multiple social factors contribute to Black women's career advancement in the UK healthcare sector. Exploring how race, age, class and education intersect to shape women's experiences in their workplace, particularly concerning the glass ceiling and glass escalator. This research study will emphasise that the restraints and advantages faced by women looking for career progression are not homogeneous and are influenced by various societal and structural factors. Ultimately, advocating for inclusive practices within the workplace

Research Objectives

- To Examine how Intersectionality Affects Black Women's Career Trajectory in the Healthcare Sector.
- Evaluating the Glass Ceiling and Glass Escalator concerning Black Women working in Healthcare occupations.

Literature Review

Relevant literature will be reviewed in this chapter to recognise how distinct experiences of discrimination are created by the intersection of their social identities, how their race, gender, culture, and education continue to influence the constraints and opportunities that they encounter in the UK healthcare sector. How early socialisation assists in driving gender disparity from infancy, and though the statistical presence of women in healthcare may be at an all-time high, the implications of the glass ceiling and glass escalator create barriers to Black women's representation in leadership positions.

Socialisation and Early Life Influences

Gender-based disparity begins through primary socialisation occurring in childhood, where individuals learn norms, values and behaviours from their family members. Boys are raised to display 'masculine traits' such as independence, directness, assertiveness and competitiveness (Bussey & Bandura, 1999), whilst being socialised to suppress emotional expression and displaying strength (Pollack, 1998). Girls are generally encouraged to exhibit empathy, submission and softness, supporting societal ideals of 'femininity' (Eccles, 1994). Subsequently, each sex develops behavioural tendencies appropriate to their primary socialised roles (Wood & Eagly, 2002). Evans and Diekmann (p. 235, 2009) contend that the assignment of gender roles in childhood leads individuals to endorse gender-stereotypic goals, which then lead to interest in occupations that afford the pursuit of these goals.' Secondary socialisation occurs later in life, whereby individuals are additionally influenced by education, their peers and the media. These factors can have a detrimental impact on the career and leadership development of female executives (Fitzsimmons et al., 2014), as socialisation encourages men to take risks and encourages self-confidence, whilst women's level of societal independence is reliant on men was linked to traditional attitudes as shown in Baxter and Kane's (1995) cross-national survey.

Socialisation of Black Women into Healthcare

Cultural values can greatly impact women's experiences in the workplace, as demonstrated by Hofstede's Cultural Dimensions theory (2001). Women are likely to experience more traditional gender roles, fewer prospects for professional advancement, and gender inequity in cultures with high power distance and low individuality. As a way to conform to cultural norms, values and societal expectations, Black women are frequently socialised from a young age to embody nurturing and caring characteristics. Black women from African and Caribbean cultures, for instance, are repeatedly urged to support the needs of their families and communities, which reinforces caregiving as an inherent part of who they are (Parker, 2003). Patricia Hill Collins (2000), in 'Black Feminist Thought', presents that many African American women believe it's their cultural obligation to care for their families, elderly relatives, and neighbours on a physical, emotional, and financial level. They see this role of providing care as a fundamental component of who they are, influenced by historical necessity² and cultural pride. This makes them more likely to pursue jobs in healthcare, where compassion and understanding are essential.

The Intersectional Effect on Black Women's Career Trajectory

Crenshaw's introduction of intersectionality explains how social identities interact to produce distinct types of discrimination that cannot be fully comprehended by focusing on one axis of identity at a time (e.g., race or gender individually). Black women encounter

² African American women served crucial roles as carers during and after slavery, not just for their own families but also for other members of their communities. Entrusted with running homes, bringing up children, and creating social support systems in the face of systemic oppression (Hill Collins, 2000).

discrimination that is both racial and gendered, and this combined prejudice is different from what Black males or white women experience.

Systematic Barriers

Reports have shown that Black women are underrepresented in senior management positions in the healthcare sector. This is a result of unconscious bias, systemic racism, and restricted access to networking and mentoring opportunities (NHS Confederation, 2020). These discriminatory actions progress from minor harassment, or microaggressions, to overt macroaggressions. These systemic barriers occur for Black women before they can even ascertain which vocational avenue to venture down. As a result of racialised and gendered discrimination about their academic ability, Black girls are not encouraged to pursue STEM disciplines due to systemic barriers in education (Evans-Winters & Esposito, 2010). Early socialisation in underfunded and marginalised school systems often limits Black women's access to STEM, which prevents them from advancing into higher-paying or leadership roles in the healthcare industry (Crenshaw, 1991). Likupe and Archibong's (2013) study on Black African nurses' experience within the NHS quintessentially draws on how intersectionality unfavourably affects Black women's career trajectory in the healthcare sector. Their report highlights how, under the 1997-2006 Labour government regime, there was a focus on international recruitment to provide relief from the 1980s NHS nurse shortage, under Margaret Thatcher's government (Nursing Times; O'Dowd, 2021). This was instead met with ingratitude, as Black international nurses recounted being met with racism, hostility and harassment in NHS hospitals and the private sector.

Cultural Challenges

The inherent cultures of women can also factor in the challenges they face in seeking career progression within the workforce. Black African and Caribbean women in their home countries or the diaspora (Europe, USA and Canada) often find themselves subject to cultural values which adhere to traditional gender roles and societal expectations, placing significant pressure on them to prioritise their family responsibilities over their career aspirations. A South Asian example by Think Global Health (Ignacio et al., 2024) found female Pakistani Community Health Workers' (CHW) ability to go on their rounds was dependent on the availability of a husband, brother, or mother to go with them. In contrast, male CHWs in Nigeria were provided with motorcycles, whilst their female colleagues were not allowed to use them, given the conservative beliefs about women exposing their legs. Restricting women's mobility is also a barrier to their career progression in the healthcare sector.

The '4B Movement', a South Korean feminist opposition to the systemic barriers, rigid gender roles, economic disparities, and cultural pressures rooted in patriarchal traditions (Lee and Jeon, 2021), is a conceivable solution to the systemic barriers that impede the career advancement of Black women, by rejecting societal expectations of marriage, childbirth, dating, and sexual relationships, women are empowered to redefine autonomy and resist entrenched norms that perpetuate inequality.

The Effects of the Glass Ceiling

The paper 'A Maze of Metaphors Around Glass Ceilings' (Smith et al., 2012) revisits the 'glass ceiling' concerning workplace gender disparity for women. The writers question the oversimplifications of the glass ceiling, curating "Maze of metaphors", suggesting that gender inequality is not simply a single obstacle but a network of interconnected and often unseen barriers affecting their endeavours in senior management roles. Social class plays a role in shaping Black women's experiences with the glass ceiling. Working-class Black

women in the UK often face stereotypes regarding their capabilities, subsequently halting their career progression due to conscious and unconscious bias rather than their lack of merit to achieve senior positions. Consequently, Black women are disproportionately represented in lower-paying jobs with fewer opportunities for advancement within the healthcare sector. This subsequently affects Black women's access to mentorship or leadership training programs, creating occupational segregation in comparison to middle-class white women and men in the healthcare sector (Warren et al., 2024).

Figure 1.

Source: Milner, Baker, Jeraj and Butt (2020)

	Table 1 Sample size for those in the highest band in the medical profession by race/ethnicity: women and men														
	Black			Asian			Mixed race/ethnicity			Chinese			White		
	Total	Women	Men	Total	Women	Men	Total	Women	Men	Total	Women	Men	Total	Women	Men
Total	64967	49424	15543	106033	67338	38695	18270	13209	5061	6234	4157	2077	909886	723692	186194
Profession															
Doctor	4252	1860	2392	30301	11742	18559	3265	1512	1753	2674	1316	1358	61593	30209	31384
Consultant	1301	421	880	12775	3795	8980	992	364	628	894	347	547	28341	11032	17309
Nurses and health visitors	23931	20513	3418	26789	22551	4238	4038	3487	551	1118	1023	95	237304	214067	23237
Grades 6 to 9	11096	9227	1869	10139	8223	1916	1992	1668	324	615	553	62	135107	120995	14112
Support to doctors, nurses and midwives	18156	14166	3990	18754	13842	4912	4279	3500	779	513	433	80	224295	197311	26984
Grades 5 to 9	825	646	179	953	672	281	238	180	58	63	41	22	10457	8681	1776

The Milner et al. (2020) quantitative study regarding race-ethnic and gender differences in the NHS found that across all racial and ethnic groups, men are more likely to be in higher pay bands than women. Figure 1 shows that in comparison to Black and Asian staff, white employees are overrepresented in higher-pay positions; Doctors, Consultants and grades 6–9 pay band among nurses and health visitors. For Black women, the likelihood of attaining Consultant positions was shown to be considerably lower within the NHS. This quantitative analysis is consistent with recent literature regarding Black women and the glass ceiling. Black females who ‘conquer’ the glass ceiling in some aspects by becoming Doctors are then less likely to be promoted to Consultants compared to their white and male

counterparts (HCSA, 2021). Although Black women are oversaturated in Nursing and support positions in the NHS, as shown in Figure 1, their access to prominent positions in medicine is restricted by institutional racism, gender bias, and a lack of mentorship opportunities (University of Manchester, 2021).

The Effects of the Glass Escalator

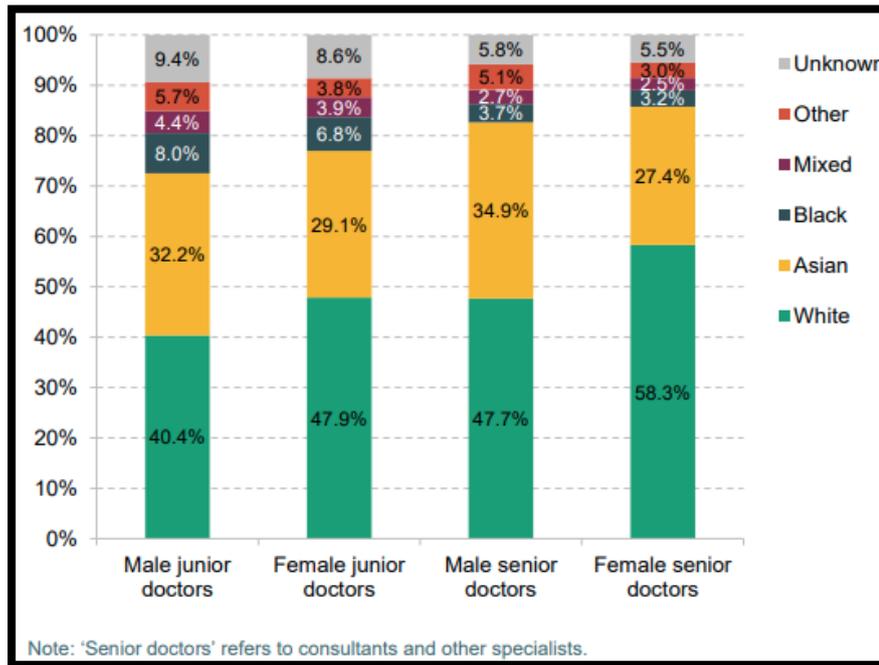
Joan Acker's (1990) research on 'gendered organisations' argues that workplaces are inherently structured by gender. This upholds gender-based social hierarchies, which consequently impact the distribution of authority, the division of labour, and the allocation of resources. The author draws attention to how workplace norms and expectations, such as dress codes for women or leadership qualities for men, sustain unequal power dynamics by masculinising or feminising particular roles. This is relevant to the glass escalator assumption that men are regarded as better suited than women for leadership positions.

Women and men in the medical and healthcare professions are frequently treated differently, particularly concerning leadership opportunities, equal pay, and career development. The research in this literature review has indicated that even in female-dominated occupations, such as nursing, men are more likely to experience the "glass escalator" effect, which allows them to move more swiftly into higher-paying and leadership positions. However, the Glass Escalator frequently disregards the experience of Black women. The Hospital Consultants and Specialists Association (HCSA) (2021) urged immediate action to address gender and ethnic pay disparities in medicine, as available data revealed substantial challenges faced by female and ethnic minority surgeons in the NHS. The authors cited research by the University of Surrey that showed Black female junior surgeons in 2010 were 42% less likely to be promoted to Consultants than their white male colleagues by 2020. Black women in the UK healthcare sector face systemic obstacles like a

lack of mentorship opportunities, sexism, microaggressions and racial discrimination, preventing them from advancing to leadership roles, higher salaries, and promotions.

Figure 2.

Percentage of Doctors in each ethnic group by gender



Source: IFS (2024)

The Institute for Fiscal Studies (2024) found data from 2021 that showed that within the NHS, there are more Asian and Black male doctors in comparison with their female counterparts at each level of seniority. Figure 2 shows that 32.2% of male junior doctors were Asian and 8% were Black, compared with 29.1% and 6.8% of female junior doctors, respectively; similarly, 34.9% of male senior doctors were Asian and 3.7% were Black, compared with 27.4% and 3.2% of Asian and Black female senior doctors, respectively.

However, Williams (2013) herself addresses the limitations of the glass escalator by identifying its failure to adequately address intersectionality, specifically, its inability to theorise race, sexuality, and class.

Research Gaps

The primary focus on Black women presents a significant challenge in finding relevant information on Black women in the UK healthcare sector. Though DEI (Diversity, Equity and Inclusion) initiatives are available for many UK healthcare and medical providers, they are not entirely reflected in the number of Black and other ethnic minority women in senior positions in comparison to white men and women. Despite the NHS having implemented several DEI initiatives, including the Workforce Race Equality Standard (WRES³) and the Equality, Diversity, and Inclusion (EDI)⁴. Their reports rarely distinguish statistics by gender and racial-ethnic group. Similarly, BUPA, Circle Health Group and Ramsey Health Care have DEI initiatives, but there is no comprehensive disclosure of demographic data regarding their workforce compositions. The glass ceiling and glass escalator both assume gender as the sole barrier preventing women from attaining senior management, criticised by Rafaia Zakaria (2021) that these feminist frameworks fail to advocate for the diverse needs of all women and fail to address the intersections of race, class and colonial history, in this case, Black women in the UK. A deeper understanding of the multifaceted barriers is necessary for meaningful progress.

³ The WRES ensures BME employees have equal access to career opportunities and receive fair treatment in the workplace. (NHS Equality and Diversity Council (2016))

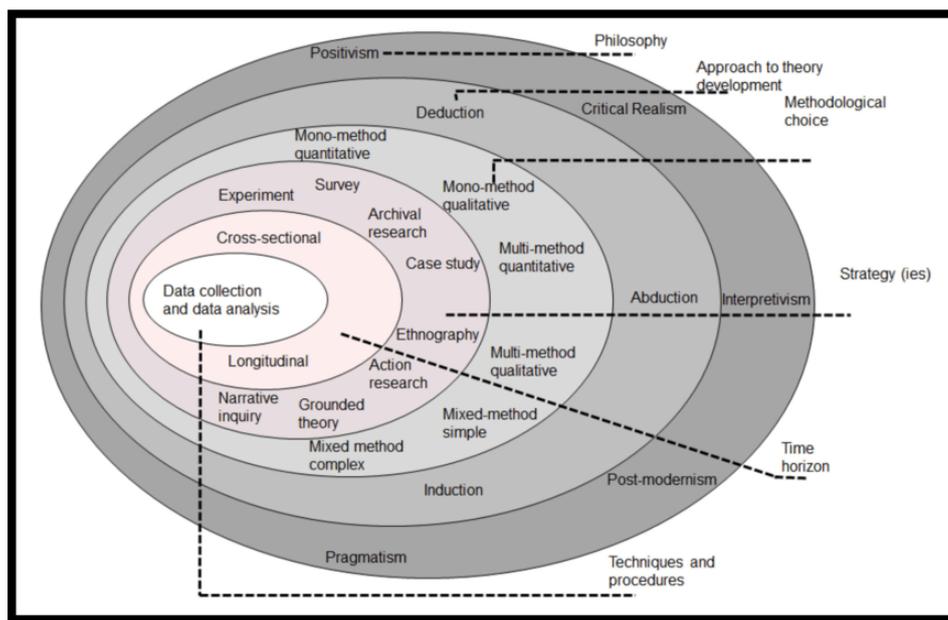
⁴ The EDI Support is essentially the provision of resources and guidance to NHS trusts to create fairer and more diverse workplaces, NHS Employers (2023).

Methodology

Research Philosophy

Figure 3.

The Research Onion



Source: Saunders, Lewis and Thornhill, (2009, p.108).

Saunders et al. (2009) provide a comprehensive understanding of research philosophy through the ‘research onion’ (Figure 3). Research philosophy refers to the belief systems and assumptions that reinforce a researcher's approach. Alharahsheh and Pius (2020) define positivism as a philosophical stance based on the principles of natural science, coincident with the assumption that reality is objective and independent of the researcher. The authors additionally describe interpretivism as a focus on the understanding of meanings and variables assigned to social phenomena, based on the assumption that reality is subjective and a social construct. Interpretivism is the chosen research philosophy for this study as it enables

this study to consider behavioural aspects as a result of participants' experiences in healthcare professions in the UK.

Research Methodology

As defined by Ryan (2018), inductive reasoning draws from specific observations to broader generalisations and identifies patterns within the data to make a probable conclusion and deductive reasoning starts with a general premise, applies it to specific cases and uses observations to test for a logically certain conclusion. Inductive reasoning, allows for flexibility and real-world application, making it ideal for this study as it will allow this study to explore patterns and provide practical insight that reflect the experiences of Black women in the UK healthcare occupations. Quantitative, Qualitative and Mixed methodologies are defined by Creswell and Crewell (2018) as: Quantitative research involves the collection and analysis of numerical, measurable data to identify trends, patterns and relationships. Qualitative research focuses on the exploration and understanding of the experiences of individuals. Mixed methods research combines both quantitative and qualitative methods. Qualitative research data is the most logical choice, specifically using focus group interviews, for the discovery of emerging themes and allows the study to adapt based on participant responses.

Research Methods

Focus group interviews will be the qualitative research method of choice for this study, with 20 total participants, 5 focus groups conducted with 4 participants per focus group to engage in a guided discussion about their experiences in healthcare professions. The discussion will be moderated by the researcher. This setup will create a more relaxed

environment, allowing participants to feel less pressure than in 1 on 1 interviews. It will be useful in identifying emerging themes and understanding collective attitudes.

Sampling Criteria

Participants were selected by contacting healthcare professionals on social media within my network to be a part of the study. After attaining consent, additional participants were contacted through snowballing, where the confirmed participants recruited colleagues and individuals within their network to join the research study.

The criteria for selecting participants:

- A self-identifying woman of Black racial identity.
- Currently in a healthcare or medical occupation in the UK.

This study will have no stipulations concerning age, number of years within career, ethnicity or nationality. Participants will be identified under a pseudonym, i.e. P1, P2, P3... etc., with their age, occupation, position and total years of experience.

The Process

The ethical consideration form in Appendix 2 was sent and received back from all participants. The focus groups were scheduled outside of working hours, at a time and date convenient for all participants. A poll choosing online focus groups received unanimous favour. Participants all received the interview questions (Appendix 3) prior to the scheduled focus groups, which took place on Zoom for approximately 100 minutes per group. The

discussions were recorded and later transcribed using the software ATLAS.ti, which provided useful assistance in thematic analysis, grouping patterns and key themes from the discussion. Data from the focus groups was locked in a storage file only available to the researcher. The use of online focus groups allowed accessibility for participants irrespective of geographical location, reduced logistical costs, e.g. travel, lunch and venue costs. Being online allowed for more open discussions on sensitive topics.

Ethical Considerations and Discussions

In conducting the focus groups, several ethical considerations were prioritised to ensure the protection of all participants. First, gaining ethical approval from CCIR (Cambridge Centre of International Research), along with their input on the best ways to conduct research ethically during the process. Informed consent was obtained from each participant, consistently making them aware that their participation was optional and they could withdraw from the study at any time. Ensuring participant anonymity and confidentiality were maintained in the analysis and discussion chapter, with no mention of personal information that could lead to identification. Audio and video recordings were securely stored and made available only to the researcher and discarded once the study was complete. The atmosphere was kept respectful and inclusive, discouraging group pressures that could influence responses. As a Black female researcher, my identity and positionality could have positively influenced participants' responses, fostering relatability and trust. My shared identity might have reduced hesitancy, enabling more honest and reflective discussions about sensitive topics of racism and sexism. However, it was essential to ensure my positionality did not unintentionally influence the neutrality of the research. Building trust by establishing a safe, respectful environment likely played a vital role in shaping the depth and authenticity of participants' contributions.

A potential limitation of this methodology is that input from all participants may vary, with some individuals contributing more than others. To combat this, the group sizes were kept the same, preventing over-talking, and each participant was asked to respond to each interview question in Appendix 3 concurrently. Technology issues could pose an additional barrier, as some participants may have limited technical skills or face internet connectivity issues. To contend with these potential technical issues, technical support and training were provided prior to the focus group, and the choice of Zoom was intentional, as participants were familiar with the platform.

Findings

Figure 4.

Participant occupation(s)

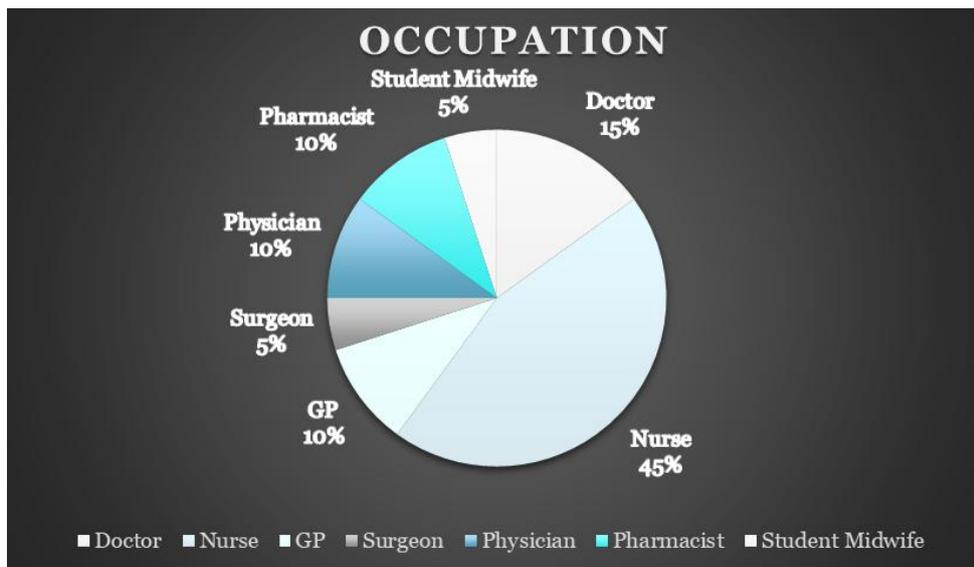


Figure 5.

Participant years in occupation(s)

This study follows the experiences of 20 Black women across 7 UK healthcare occupations (Figure 4), ranging from 2 to 30 years of experience (Figure 5), highlighting themes such as systemic barriers, workplace microaggressions, harassment, limited upward mobility, and resilience strategies. Using purposive sampling to ensure participants met the criteria: Self-identification as a Black female and currently employed in the UK healthcare sector. Participants were approached through social media platforms and referrals, with invitations emphasising confidentiality and voluntary participation. Participants will be identified under a pseudonym, i.e. P1, P2, P3... etc., by their age, occupation, position and total years of experience.

Early Influences

- i. Did you always want to pursue a career in healthcare/medicine?

90% of respondents always aspired to healthcare careers, citing early influences like family caregiving or observing relatives in healthcare, while the remaining 10% decided later on in life after taking care of ailing family members. Consistent with Parker's (2003) inference,

Black women are repeatedly urged to support the needs of their families and communities, reinforcing caregiving as an inherent part of who they are.

- ii. Whilst in education, how represented did you feel as a Black woman pursuing your career?

Two participants who studied abroad shared their experiences regarding Black female representation during their education:

P1:

Pharmacist, 24 Years in occupation.

“I undertook my degree in Finland due to the demographic profile there- I was always the sole Black woman. There was also no representation in the profession at that time.”

P2:

Nurse, 2 Years in the occupation.

“During my education, while there weren't as many Black women in the healthcare programs I pursued, I was fortunate to find a strong sense of community with other people of colour. We supported each other, shared experiences, and built lasting connections. Over time, I noticed more diversity in the classrooms, which was encouraging. I felt proud to be part of that shift, and it motivated me to keep pushing forward. The presence of other people of colour made me feel more empowered and helped me realise that my success could inspire others to follow in similar footsteps.”

Objective 1: To Examine how Intersectionality Affects Black Women’s Career Trajectory in the Healthcare Sector.

Intersectionality severely influences Black women’s career trajectories in healthcare, highlighting both challenges and strengths. Systemic barriers like racial bias, microaggressions, and being labelled ‘diversity hires’ hinder advancement. However, many

show resilience through advocacy, mentorship, and support networks, promoting representation and institutional change. While intersectionality reveals disparities, it also showcases these women's vital contributions to progress, paving the way for equity and inclusion. Participants shared insights on how race, age, and gender shaped their career paths and perceptions.

iii. How do you feel your race has impacted your career progression?

P3:

Surgeon, 20 Years in occupation.

“Race has been both an obstacle and a driving force. There have been moments of bias, where I had to work twice as hard to prove my worth. But rather than letting that break me, I let it refine me. My success is my response. I have turned challenges into stepping stones, and in doing so, I have opened doors for those coming after me.”

P4:

Pharmacist, 25 Years in occupation.

“As a Black female pharmacist in the UK, I have encountered both challenges and opportunities due to my race. At times, I've felt underrepresented in senior roles, with few role models who share my background. This lack of diversity can sometimes create a sense of isolation or hinder networking opportunities. However, I've also seen my race as a source of strength, motivating me to excel and advocate for greater inclusion within the profession. While certain barriers have been present, they have fuelled my determination to succeed and contribute to making the pharmacy field more diverse and accessible for future generations.”

P5:

District Nurse, 19 Years in occupation.

“It has impacted my progression a lot because I've had to continuously look to further education to give me an added edge for progression when compared with my white

colleagues, who have the face and voice that fit the senior management make-up. I have also had to refrain from putting myself forward for roles in parts of the country where there might be less diversity because of the possible biases.”

P6:

Nurse, 2 Years in the occupation.

“As a Black woman, I’ve faced challenges that others of different races might not experience. There’s the subtle and sometimes not-so-subtle racism that can make you feel like you have to work harder to prove yourself. You get overlooked, or people doubt your expertise based on assumptions. But at the same time, I’ve seen how my lived experiences bring a unique perspective to patient care. It’s a double-edged sword: there are hurdles, but there’s also strength in overcoming them.”

iv. How do you feel your age has impacted your career progression?

P7:

Pharmacist, 25 Years in occupation.

“In all my years as a pharmacist, I’ve only faced age-related discrimination once. After returning from maternity leave at 43, I was transferred to a busy store that required two pharmacists. It seemed the management wanted to pressure me into resigning, likely to hire a younger, cheaper replacement. However, my resilience helped me overcome this challenge, and I was eventually able to persuade management to make the necessary changes, including hiring more staff to ensure smooth operations.”

P8:

Community Nurse, 10 Years in Occupation

“I was a mature student, so there may have been some impact. However, I was able to progress fairly quickly and still achieve the required experience and maturity that is essential in my current role.”

P9:

Student Midwife, 2 Years in Occupation

“My age hasn’t been a major factor in my career. Midwifery is a field where experience matters, but as long as I’m competent and continue to learn, I feel respected by colleagues and patients alike.”

P10:

GP, 30 Years in occupation

“Age is often a double-edged sword. When I was younger, I was underestimated, questioned, and challenged more than my peers. Now, with experience, my voice carries more weight.”

- v. How has your culture impacted you in your career?

P11:

Physician, 29 Years in occupation.

“Nigerian culture has greatly influenced my career as a Black female physician in the UK. The focus on education, hard work, and resilience has motivated me to excel and overcome challenges. It has also encouraged me to seek mentorship and build a supportive network. Overall, Nigerian values have given me the strength to push for greater inclusivity in the pharmacy profession.”

- vi. Do you feel social class has any impact on healthcare/medical employees?

P12:

Doctor, 2 Years in occupation.

“Yes, absolutely, there is still an over-representation of privately educated and Oxbridge alumni in senior clinical leadership positions, especially at Very Senior Management levels in the NHS.”

Objective 2: *Evaluating the Glass Ceiling and Glass Escalator concerning Black Women working in Healthcare occupations.*

Glass Ceiling

vii. Do you feel there are any barriers you face just being a woman in this industry?

P1:

Pharmacist, 24 Years in occupation.

“I think there are still elements of old boys' networking at play. A lot of female leaders still have to work harder, be more self-aware and actively develop and maintain a professional persona that is as respected as that of male colleagues. Some barriers may not be easily identifiable. For example, a colleague was recently asked if she was sure she wanted to take on a more senior role as she “has a child”. These sorts of attitudes/comments are rarely shared openly but still exist and drive some decision-making.”

P2:

Surgeon, 20 Years in occupation.

“Yes, without question. The surgical field, like many others, was built on a foundation that did not always include women. There are unspoken expectations, biases, and resistance to change. But barriers exist to be broken. I have learned to take up space unapologetically.”

P3:

Pharmacist, 25 Years in occupation.

“As a Black female in the pharmacy industry, I don't feel that access to promotions has always been equal. While I've gained experience and worked hard, there are still limited opportunities for diversity in leadership roles. I have faced certain barriers. One of the key

challenges is the underrepresentation of women in senior management and leadership roles, which can limit opportunities for career advancement. Additionally, balancing work and family responsibilities can be difficult, especially for women who are juggling demanding careers with caregiving roles. However, I see the industry improving, with more focus on inclusion. Despite these challenges, I continue to work on my skills and advocate for change, hoping for more opportunities for people from diverse backgrounds.”

P4:

Student Midwife, 2 Years in Occupation.

“Midwifery is a female-dominated field, so I don’t face the same gender-related barriers that women in other professions might. However, leadership roles in healthcare can still be male-dominated, so breaking into senior positions might be more challenging.”

P5:

Senior Mental Health Nurse, 25 Years in the occupation.

“Yes, I’ve seen quite a lot of work and family balance struggles. Gender inequalities and poor human resources. Policies hindering the professional growth of my Black female colleagues and myself included.”

viii. Do you feel you have equal access to promotions in your industry?

P6:

Nurse, 24 Years in Occupation.

“While there are still gender disparities in pay and promotions in healthcare, I’ve been fortunate to work in environments that recognise and value women’s contributions. Although men, particularly in certain medical roles, often advance more easily, women, especially women of colour, sometimes have to work harder to gain the same recognition. However,

I've seen more opportunities for women to take on leadership roles and feel increasingly supported in pursuing their goals, and I'm proud to be part of that progress."

P7:

Nurse, 20 Years in Occupation.

"From my experience, equality in gaining a promotion in the nursing and healthcare industry as a whole has been dependent on the facility, employer and management. For the most part, discrimination does exist."

ix. Do you feel you have access to mentoring and networking opportunities?

P8:

Doctor, 30 Years in Occupation.

"I have had to seek them out intentionally. Early on, I realised that doors do not always open unless you knock or build your own. I now ensure that I create spaces where others can find mentorship more easily than I did."

P9:

GP, 25 Years in Occupation.

"As a Black female in the medical industry, access to mentoring and networking opportunities can be limited due to a lack of diverse role models. However, I've actively sought out connections through professional groups and events. While challenges remain, I believe initiatives focused on diversity will continue to improve access to these opportunities in the future."

4.3.2. Glass Escalator

x. Do you believe there are differences in how you are treated in comparison to your male colleagues?

P10:

NHS Nurse, 10 Years in Occupation

“Experiencing racial and gendered discrimination in the workplace from patients and colleagues does affect my physical and mental well-being; as I have to restrict how I can react, which I believe is different to how my male colleagues are allowed to express themselves, as they rarely face gendered discrimination.”

P11:

Physician. 22 Years in Occupation.

“Yes. Women are often held to higher standards, expected to be more "likeable," and scrutinised more harshly. Assertiveness in men is seen as leadership, while it can be misinterpreted as difficult in women. But I have learned to stand firm, to own my space, and to make no apologies for my ambition.”

P12:

Doctor, 20 Years in Occupation.

“Yes, I believe male colleagues are still inherently more respected, regardless of their competence or diligence.”

- xi. Do you think it is easier for men in your field to be promoted or receive higher pay than women?

P13:

Nurse, 29 Years in Occupation

“I do feel that, though women and Black women are overrepresented in nursing, in some cases, men in the nursing profession might find it easier to get promoted or receive higher pay than women. Although things are improving, there are still times when gender bias plays

a role in career advancement and salary differences. Men are often more represented in senior positions, and women, especially those balancing family and work, can face extra challenges.”

P14:

Nurse, 19 Years in Occupation

“Yes, I do. Women like me primarily take more time out from their careers for family responsibilities, which can decelerate their progress and pay advancements. These burdens don’t necessarily fall on men. I have seen with senior management that men can wholly focus on their career.”

Chapter Summary

The effects of intersectionality on the respondent’s career trajectory identified race as having the most significant impact on their career progression in the healthcare sector, presenting both challenges and opportunities. Participants have discussed facing systemic biases, underrepresentation, and subtle racism, but many have used these obstacles as catalysts for resilience, striving to excel and advocate for diversity. Age presents mixed effects, with younger professionals often being underestimated, although discrimination remains a concern for older employees. Cultural values, resilience, and hard work strongly shape career development, while social class disparities reinforce privilege in senior leadership roles, particularly within the NHS.

The responses indicate that the Glass Ceiling significantly impacts Black women’s career progression in the UK healthcare sector, with many facing barriers to leadership, unequal access to promotions, and difficulties balancing work and family responsibilities. Gender bias remains prevalent, particularly in senior roles, where male colleagues often advance more

easily. Limited mentorship and networking opportunities further hinder career mobility, necessitating self-driven advocacy and resilience. Regarding the Glass Escalator, participants highlight that men, even in female-dominated fields like nursing, tend to receive promotions and higher pay more readily. As Black women, they feel they are held to a higher standard and scrutinised more harshly, reinforcing systemic inequalities. Despite gradual improvements, structural barriers persist, demanding continued efforts towards equity and inclusion in healthcare leadership.

Discussion

This study has identified four themes that all the women have faced firsthand or identified within their professions.

Systemic Barriers

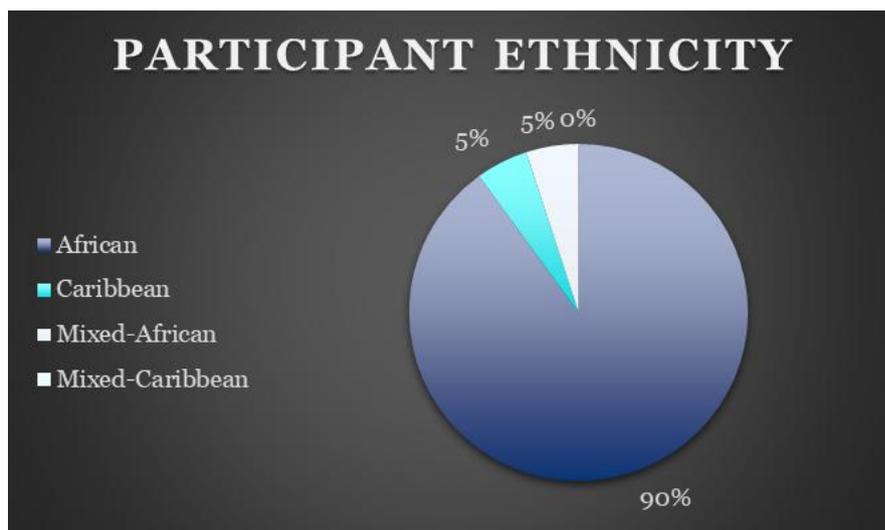
The underrepresentation of Black women in leadership positions, the restricted access to mentoring and networking opportunities were the main systemic barriers respondents of this study identified. The existing and available statistics, as detailed in the literature review, show Black women are significantly underrepresented in senior management and clinical leadership positions in the NHS and UK private medical sector. **P4**, a Pharmacist, discussed her roles at Boots, Superdrug and Rowlands. She noticed an underrepresentation of women in senior management and little to no Black female presence in leadership. In her 25-year career, **P4** recounts how the demands of balancing motherhood and her desire to progress in her career have encouraged her to foster inclusivity and diversity in her profession.

Black women in the UK healthcare sector often lack access to mentorship and networking initiatives tailored to their needs. This arises due to the lack of role models in senior positions who are women of colour and the exclusive professional spaces dominated by individuals

from affluent or private educational backgrounds. **P3**, a Surgeon, draws on “...Those from privileged backgrounds often navigate the system with ease”.

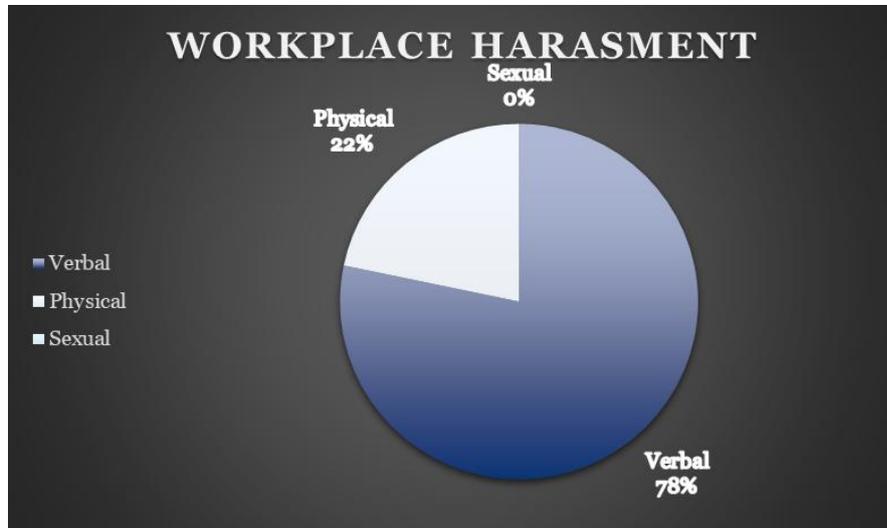
Figure 6.

Participant Ethnicity



Microaggressions

Black women in the healthcare sector are faced with more scrutiny and harsher criticisms than their male counterparts and white women. This comes in conjunction with facing microaggressions based on their gender, in addition to their race. 95% of participants in this study are first-generation African or Caribbean descent (Figure 6), and discussed facing ridicule because of their accents. **P9**, a Physician, detailed: “Many people’s idea of a doctor is a middle-aged Caucasian male, so the treatment experience as a Black woman of Nigerian descent is different; being assertive is interpreted as anger.”

Figure 7.*Workplace Harassment***Workplace harassment**

Respondents acknowledged the existence of sexual, physical and verbal harassment faced significantly more people of colour in healthcare. Figure 7 shows that 78% of participants have experienced verbal harassment and 22% physical harassment. **P16**, a newly qualified Nurse, has been in this field for 10 years previously as a healthcare assistant. She narrated how the racial berating is constant from patients, in addition to colleagues, and it takes a toll on individuals' mental well-being and morale.

Limited upward mobility

Despite Black female overrepresentation in nursing and support staff roles, studies presented in the literature review suggest that diversity diminishes as positions become more senior. The limited vertical mobility comes from implicit biases and structural inequities in promotion processes, often perpetuating the "old boys' network" culture. **P2**, a private sector Nurse, believes as a mature nurse, "There's sometimes an unconscious bias that older nurses are less adaptable or tech-savvy. I've had to prove that I'm just as capable, if not more, than

my younger colleagues. While I've faced some age-related challenges, I see them more as opportunities to showcase my expertise." An increase of support networks for women of colour, returners programmes for women returning after long-term leave would assist in mitigating insecurities for mature female staff.

Black women in the UK healthcare system are disproportionately impacted by wage disparities and are paid less than their white counterparts for performing similar roles. **P11**, a senior mental health nurse, details how race has significantly impacted her career in a predominantly white field. Despite repeatedly receiving praise in her performance reviews, she is constantly overlooked in regard to remuneration. **P3**, a surgeon, similarly discussed how "The statistics speak for themselves. Pay gaps and unequal promotions remain real issues in medicine. But change is happening, and I am committed to being part of that shift. Women belong in leadership. We belong in surgery." This inequality reflects broader issues of the undervaluation of minority workers and inadequate pay transparency.

All the women who participated in this study have subsequently adopted resilience strategies as a result of the barriers they face within their profession. Many of the women have been able to create spaces for Black women and women of colour to feel supported in ways they did not. **P7**, a Student Midwife and a recipient of such mentorship, details how she feels represented and seen when her lecturers and supervisors are Black women.

Challenges and Limitations

A few challenges arose during data collection. Trying to get as many consenting participants as possible was a challenge; though many women were enamoured of the idea, few had the spare time to participate in the study. The qualitative nature of this study also meant that the responses varied in depth, requiring careful thematic analysis. Though this

study provides critical insight into the experiences of Black women and their career progression in the UK healthcare sector, the sample size reflects a variety of healthcare occupations; however, it does not capture the full diversity across all specialities and institutions. Despite these constraints, this study remains persistent in highlighting the intersectional challenges and the subsequent resilient response to promote inclusion and equity.

Conclusion

This study reviewed literature that highlighted Black women's early socialisation into caregiving roles. Intersectionality offers a multifaceted approach to understanding how social identities (race, age, social class, education, etc.) interact to create distinct experiences of discrimination. These intersecting identities influence systemic and cultural barriers that shape the underrepresentation of Black women in senior UK healthcare positions. Finding the 'glass ceiling' contributes to the overrepresentation of white employees in leadership roles. The 'glass escalator' excludes Black women from the benefits of upward mobility that are frequently granted to men in female-dominated professions due to racial and gender biases, demanding a deeper analysis for equity. This study adopted interpretivism to explore participants' healthcare experiences, using inductive reasoning and qualitative methods. Focus groups with 20 Black women facilitated shared insights, supported by informed consent, anonymity, and data security. The findings chapter ascertained that intersectionality profoundly shapes Black women's careers in UK healthcare, with race presenting systemic challenges like bias, underrepresentation, and racism. Participants highlight gender disparities, limited mentorship, and unequal pay while using their personal experiences to support patients and advance inclusion and diversity in the industry, demonstrating resilience through advocacy. The Glass Ceiling and Glass Escalator further underscore structural inequalities, demanding sustained efforts for equity and inclusion.

Limitations

This study is limited by its relatively small sample size of 20 participants across 7 healthcare occupations, which may not be entirely enough to represent the full spectrum of Black women's experiences across the UK healthcare sector. The use of online focus groups may have restricted interaction as opposed to in-person interviews. Additionally, the use of

semi-structured interviews introduced variations in responses, which can be challenging for conducting thematic analysis. Despite these limitations, this study provides necessary insight into the intersectional challenges within healthcare professions in the UK.

Recommendations

NHS trusts and private providers should invest in mentorship programmes tailored to Black women, with organisations creating initiatives supporting the career progression of Black women and women of colour, including returners programmes and a safe space to address microaggressions and workplace harassment. Additionally, mandatory DEI reporting with transparent gender-ethnic breakdowns and equitable recruitment and promotion practices to encourage gender-ethnic parity in leadership. Future research should adopt a larger, diverse sample across healthcare professions using longitudinal methods, enabling broader generalisations and understanding of the long-term effects of intersectionality on career trajectory.

Contributions

This study has contributed a comprehensive theoretical understanding of discrimination and advocates for consideration of how gender and race, in addition to other social identities, interact to influence the lives of Black women. Providing an understanding of intersectionality and its impact on the glass ceiling and glass escalator concerning Black women's career trajectories in the UK healthcare sector. It highlights systemic barriers; the underrepresentation of Black women in leadership and the lack of available networking and mentoring opportunities, additionally, microaggressions, workplace harassment, limited upward mobility, alongside the resilience strategies employed by participants.

It has contributed empirical data to the literature on Black women's careers within the healthcare industry in the UK, with additional worldwide examples for additional context. The findings contribute to existing discussions on equity, diversity, and inclusion, offering practical recommendations for healthcare organisations. By amplifying the voices of Black women across various healthcare professions, this study adds depth to existing literature and provides a valuable resource for policymakers, educators, and researchers seeking to dismantle inequalities and promote inclusive leadership in healthcare environments.

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References

- Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender and Society*, 4(2), 139–158. <http://www.jstor.org/stable/189609>
- Alharahsheh, H. H., & Pius, A. (2020). A review of key paradigms: Positivism vs interpretivism. *Global Academic Journal of Humanities and Social Sciences*, 2(3), 39–43. https://gajrc.com/media/articles/GAJHSS_23_39-43_VMGJbOK.pdf
- Baxter, J., & Kane, E. W. (1995). Dependence and independence: A cross-national analysis of gender inequality and gender attitudes. *Gender and Society*, 9(1), 193–215.
- Bussey, K., & Bandura, A. (1999). Social cognitive theory of gender development and differentiation. *Psychological Review*, 106(4), 676–713.
- Chand, R. (2023, January 21). Discrimination is the biggest career obstacle for women of colour in the NHS. University of Manchester. <https://www.manchester.ac.uk/about/news/discrimination-is-the-biggest-career-obstacle-for-women-of-colour-in-the-nhs>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139–167. <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf>

- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241–1299.
- Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage Publications.
- Dasra. (2023). An unbalanced scale: Exploring the female leadership gap in India's healthcare sector. <https://www.dasra.org/individual-resources/136>
- Eccles, J. S. (1994). Understanding women's educational and occupational choices: Applying the Eccles et al. model of achievement-related choices. *Psychology of Women Quarterly*, 18(4), 585–609.
- Evans, C. D., & Diekmann, A. B. (2009). On motivated role selection: Gender beliefs, distant goals and career interest. *Psychology of Women Quarterly*, 33(3), 235–249.
<https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=147de8b2fcd8a039fde91b74c85f4424ee11b5c7>
- Evans-Winters, V. E., & Esposito, J. (2010). Other people's daughters: Critical race feminism and Black girls' education. *Educational Foundations*, 24(1–2), 11–24.
- Hill Collins, P. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Routledge.

Hofstede, G. H. (2001). *Culture's consequences: Comparing values, behaviors, institutions and organizations across nations* (2nd ed.). Sage.

Hospital Consultants and Specialists Association (HCSA). (2021). HCSA calls for action on 'glass ceiling' for ethnic minority and women surgeons, in light of striking new data. <https://www.hcsa.com/news-views/news/2021/09/hcsa-calls-for-action-on-%E2%80%98glass-ceiling%E2%80%99-for-ethnic-minority-and-women-surgeons%2C-in-light-of-striking-new-data.aspx>

Hull, R. P., & Umansky, P. H. (1997). An examination of gender stereotyping as an explanation for vertical job segregation in public accounting. *Accounting, Organizations and Society*, 22(6), 507–528. [https://doi.org/10.1016/s0361-3682\(96\)00028-1](https://doi.org/10.1016/s0361-3682(96)00028-1)

Ignacio, A. R., Sales, K., & Tamayo, R. L. (2024). Seeking gender equality in the global health workforce. *Think Global Health*. <https://www.thinkglobalhealth.org/article/seeking-gender-equality-global-health-workforce>

Institute for Fiscal Studies (IFS). (2024). Ethnic diversity of NHS doctors. <https://ifs.org.uk/sites/default/files/2024-01/IFS-Report-R294-Ethnic-diversity-of-NHS-doctors%20%281%29.pdf>

International Labour Organization (ILO). (2018). India wage report: Wage policies for decent work and inclusive growth. <https://www.ilo.org/publications/india-wage-report-wage-policies-decent-work-and-inclusive-growth>

Lee, J., & Jeong, E. (2021). The 4B movement: Envisioning a feminist future with/in a non-reproductive future in Korea. *Journal of Gender Studies*, 30(5), 633–644.
<https://doi.org/10.1080/09589236.2021.1929097>

Li, M., Raven, J., & Liu, X. (2024). Feminization of the health workforce in China: Exploring gendered composition from 2002 to 2020. *Human Resources for Health*, 22(15).
<https://doi.org/10.1186/s12960-024-00898-w>

Likupe, G., & Archibong, U. (2013). Black African nurses' experiences of equality, racism, and discrimination in the National Health Service. *Journal of Psychological Issues in Organizational Culture*, 3(S1), 227–246.
<https://onlinelibrary.wiley.com/doi/epdf/10.1002/jpoc.21071>

Milner, A., Baker, E., Jeraj, S., & Butt, J. (2020). Race-ethnic and gender differences in representation within the English National Health Service: A quantitative analysis. *BMJ Open*, 10(2), 1–6. <https://doi.org/10.1136/bmjopen-2019-034258>

National Bureau of Statistics of China. (2023). Press release on employment statistics.
https://www.stats.gov.cn/english/PressRelease/202305/t20230508_1939254.html

NHS Confederation. (2020). The NHS workforce race equality standard: 2020 data analysis report for NHS trusts. <https://www.nhsconfed.org/>

NHS Employers. (2023). NHS equality, diversity and inclusion (EDI) improvement plan. <https://www.nhsemployers.org/articles/nhs-equality-diversity-and-inclusion-edi-improvement-plan>

NHS England. (2024). Workforce race equality standard 2023: Data analysis report for NHS trusts. <https://www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts>

NHS Equality and Diversity Council. (2016). Workforce race equality standard (WRES) 2015 data analysis report for NHS trusts. <https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf>

Nishida, S., Usui, E., Oshio, T., Masumori, N., & Tsuchihashi, K. (2024). Motherhood penalty for female physicians in Japan: Evidence from a medical school's alumni data. *BMC Health Services Research*, 24(1), 1–8. <https://doi.org/10.1186/s12913-024-11622-8>

O'Dowd, A. (2021, October 11). A history of nursing in Britain: The 1980s. *Nursing Times*. <https://www.nursingtimes.net/history-of-nursing/a-history-of-nursing-in-britain-the-1980s-11-10-2021>

OECD. (2022). Gender wage gap. <https://www.oecd.org/en/data/indicators/gender-wage-gap.html>

Parker, L. (2003). Critical race theory and its implications for methodology and policy analysis in higher education desegregation. *Counterpoints*, 195, 145–180.
<http://www.jstor.org/stable/42978085>

Pollack, W. (1998). *Real boys: Rescuing our sons from the myths of boyhood*. Random House.

Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. *Nurse Researcher*, 25(4), 41–49. <http://oro.open.ac.uk/49591/>

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students* (5th ed.). Pearson Education Limited.

Semu, L. L. (2020). The intersectionality of race and trajectories of African women into the nursing career in the United States. *Behavioral Sciences*, 10(4), 69.
<https://doi.org/10.3390/bs10040069>

Smith, P., Caputi, P., & Crittenden, N. (2012). A maze of metaphors around glass ceilings. *Gender in Management: An International Journal*, 27(7), 436–448.
<https://core.ac.uk/download/pdf/37017820.pdf>

U.S. Bureau of Labor Statistics (BLS). (2023). Race and ethnicity in the labor force, 2023.

<https://www.bls.gov/opub/reports/race-and-ethnicity/2023/home.htm>

University of Manchester. (2021). ‘Concrete ceiling’ in career progression for Black women

in the UK. <https://www.manchester.ac.uk/about/news/concrete-ceiling-in-career-progression/>

Warren, T., Torres, L., Lyonette, C., & Tarlo, R. (2024). Class, gender and the work of

working-class women amid turbulent times. *The British Journal of Sociology*, 76(1), 96–113. <https://doi.org/10.1111/1468-4446.13147>

Williams, C. L. (2013). The glass escalator, revisited: Gender inequality in neoliberal times.

Gender & Society, 27(5), 609–629. <https://doi.org/10.1177/0891243213490232>

Williams, C. L. (1992). The glass escalator: Hidden advantages for men in the “female”

professions. *Social Problems*, 39(3), 253–267. <https://doi.org/10.2307/3096961>

Wood, W., & Eagly, A. H. (2002). A cross-cultural analysis of the behavior of women and

men: Implications for the origins of sex differences. *Psychological Bulletin*, 128(5), 699–727.

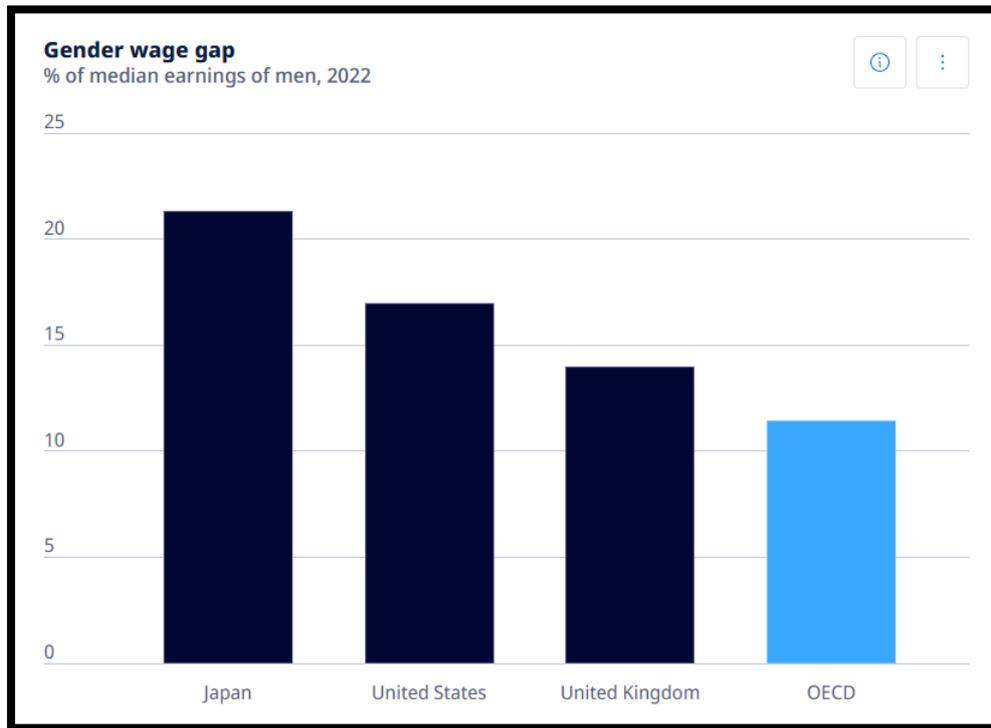
World Health Organization (WHO). (2020). Delivered by women, led by men: A gender and

equity analysis of the global health and social workforce.

https://cdn.who.int/media/docs/default-source/health-workforce/delivered-by-women-led-by-men.pdf?sfvrsn=94be9959_2

Zakaria, R. (2022). *Against white feminism*. Penguin Books Ltd.

Appendix 1 – OECD (2022) Gender wage gap



Appendix 3 - Participant Interview Questions

- i. Participant Occupation:
- ii. Years within healthcare occupation:
- iii. Participant(s) date of birth:

Socialisation

1. Did you always want to pursue a career in healthcare/medicine?
2. What influences from your childhood have contributed to your choice to pursue your healthcare/medicine occupation?
3. Whilst in education, how represented did you feel as a black woman pursuing your career?
4. What is a positive experience surrounding your healthcare/medicine occupation?

Intersectionality

5. How do you feel your race has impacted your career progression?
6. How do you feel your age has impacted your career progression?
7. How has your culture impacted you in your career?
8. Do you feel social class has any impact on healthcare/medical employees?

Glass Ceiling

9. Do you feel there are any barriers you face just being a woman in this industry?
10. Do you feel you have equal access to promotions in your industry?
11. Do you feel you have access to mentoring and networking opportunities?

Glass Escalator

12. Do you believe there are differences in how you are treated in comparison to your male colleagues?
13. Do you think it is easier for men in your field to be promoted or receive higher pay than women?