Perceptions, Evaluations, and Effects of Resource and Demand Inequality in the Workplace

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ABSTRACT

PERCEPTIONS, EVALUATIONS, AND EFFECTS OF RESOURCE AND DEMAND INEQUALITY IN THE WORKPLACE

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Inequality in our society has been shown to have a negative effect on social, health and well-being outcomes, but inequality in the workplace is much less understood (Magee & Galinsky, 2008). Although perfect equality of distributions in the workplace is neither practical nor desirable, too much inequality of job resources (aspects of work that are needed to do one’s job or contribute to personal development) and job demands (aspects of work that require sustained effort) can lead to negative outcomes for both employees and organizations. The main purpose of this dissertation is to build a theory of workplace inequality, identify factors that feed into it, and explore what its consequences are.

To explore how employees understand and make sense of the inequality they perceive in the workplace, I conducted qualitative interviews with 30 medical faculty at a pediatric health sciences centre. The purpose of the interviews was to determine which resource and demand inequalities are most important in the workplace, how employees judge the legitimacy of the inequality they perceive, and the valence of their attitudes towards it. In order to draw more general conclusions beyond individual participants’ experiences, I conducted a thematic analysis of the data. I supplemented this analysis with a matrix analysis to determine whether those higher in the hierarchy perceived or reacted to workplace inequality differently than those lower in the hierarchy.

There were several resource inequalities that participants were particularly sensitive to, including research and clinical equipment, administrative support, training opportunities, formal
recognition, and the leadership of division heads. On the demand inequalities side, participants were sensitive to scheduling flexibility, clinical workload, conflict climate, and the pressure to perform academically. The matrix analysis showed that even though participants at all levels felt affected by inequality, those at the bottom of the hierarchy perceived more inequality and were more negative towards it than those at the top. Participants also reacted more negatively towards inequality among individuals compared to inequality among divisions, and resource inequality compared with demand inequality. Implications of these findings for theory, practice, and future research are discussed.
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Introduction

An article was recently published in Time Magazine on the worst companies to work for in the United States (Frohlich & MacIntyre, 2014). Common complaints among individuals who worked for these companies were differences they observed among employees in various areas, including the scheduling of shifts (for retail workers), the number of hours they were required to work, and the amount of money they were paid. One way to understand these complaints is that employees are responding negatively to inequalities they perceive at work. It is unclear how most employees would perceive and react to such inequalities or differences in the amount of respect they are shown, work they have to complete, and salary they receive from their employers. There is some evidence showing that pay dispersion has a negative effect on workers’ job satisfaction (Bloom & Michel, 2002; Pfeffer & Langton, 1993). However, the issue of how people respond to inequality in the workplace per se has received less research attention (Magee & Galinsky, 2008). The focus of this dissertation is to examine how people perceive and respond to workplace inequality.

Research has shown that greater inequality in aspects of the workplace such as power, formal rank, pay, and status may negatively affect organizational performance and employees’ wellbeing and relationships with each other (Chen & Huang, 2007; Christie & Barling, 2010; Peters & Waterman, 1982; Shaw et al., 2002). However, previous research has not examined employees’ views about the legitimacy of the degree of inequality that they perceive in their workplaces. The current research will address this issue to help provide a greater understanding of the relationship between workplace inequality and negative employee outcomes. Furthermore, I have investigated how people describe the effect that inequality has on their stress, engagement and job satisfaction in the workplace. This allowed me to build a theory of how perceptions and
evaluations of inequality in the workplace affect employees. Although research in psychology
and sociology has been done on the effects of inequality in the workplace, it has focused on
outcomes related to individuals being high versus low in the hierarchy (Magee & Galinksy,
2008; DiTomaso, Post & Parks-Yancy, 2007), and has not addressed the effects of people’s
judgments of the degree of inequality that exists. The current research extends previous work by
examining perceptions of and reactions to the degree of inequality that exists in the workplace.
Because I was interested in employees’ lived experiences of inequality in the workplace, I used
qualitative interviews rather than a quantitative approach in my investigation. This allowed me to
build a theory of workplace inequality, identify factors that feed into it, and investigate what
some of its consequences.

The following sections will discuss how the concept of degree of inequality within a
hierarchy builds on work that has been done on the effect of one’s position within a hierarchy
(Magee & Galinksy, 2008), how it is related to the notion of justice (Törnblom & Vermunt,
2007), and why it stands to reason that people would be concerned about and react negatively to
high levels of perceived inequality. I will then use the job demands-resources model to frame my
conceptualization of workplace inequality (Bakker & Demerouti, 2007). This will lead into the
research questions for the current study. I will then go into detail about the context for the
specific sample I used (medical faculty at a pediatric academic health science centre in Canada),
and explain the sample, study design and methodology.

**Theoretical Background**

**What is Inequality?**

I define workplace inequality as the degree of disparity that exists among individuals or
groups within a collective in the distribution of resources and demands. *Job resources are*
aspects of the work that help to reduce the physical or psychological effects of a job, are needed to do one’s job (e.g., equipment, training, social support), or contribute to personal development (Bakker & Demerouti, 2007). Job demands are aspects of the work that require sustained physical, mental or emotional effort, and therefore can be exhausting (e.g., work pressure, challenging physical work environment, irregular work hour; Bakker & Demerouti, 2007). For instance, employees may attend to inequalities that exist in their workplace regarding resources such as equipment needed to do work (e.g., are senior managers given better laptops and phones than other employees?) or salary (e.g., how much does the CEO earn compared with entry-level workers?), or demands such as irregular work hours (e.g., which employees are asked more often to work undesirable shifts such as weekends and holidays?)

There are multiple aspects of inequality that may be examined including the objective level of inequality that exists, perceptions of inequality, and evaluations of inequality. It is likely that people naturally conflate these different aspects of inequality, that is, they are not clearly distinguished in people’s minds. However, they can be theoretically disentangled, and for the purpose of conceptual clarity I do so here.

First, there is an objective level of inequality of resources and demands that can exist within a collective. For instance, perfect equality exists when a resource or demand is distributed among people so that they have equivalent shares, regardless of their contributions to the group (Deutsch, 1975). As inequality grows, the distribution moves further from perfect equality. For material resources, such as income, clear metrics can be used to measure the degree of inequality that exists, such as the Gini coefficient, which is often used to measure income inequality at the national level. A Gini coefficient of zero represents perfect equality (everyone has the same income), while a Gini coefficient of one indicates maximum inequality (one person has all of the
income and everyone else has none). For resources or demands that are more social in nature (e.g., respect), it is more difficult to measure the objective level of inequality. However, conceptually, it is still possible.

Second, people can form perceptions of how much inequality exists within their collectives. Perceptions of inequality are one’s own judgements about the degree of inequality that exists, which may not always line up with the objective level of inequality. These perceptions are likely somewhat anchored to objective levels of inequality, but given their limited perspective, individuals are often poor judges of the objective degree of inequality. For example, studies on perceptions of wealth inequality in the United States have found that respondents can both underestimate or overestimate the actual level of wealth inequality in the United States (Chambers, Swan, Heesacker, 2014; Norton & Ariely, 2011). In the workplace, factors such as level of transparency or cohesion may affect employees’ perceptions of inequality. As with other psychological phenomena (Ross, 1977), it is likely that people respond to their perceptions of inequality, rather than the objective level of inequality that exists. Perceptions drive attitudes, emotions and behaviour (e.g., Rundmo & Iverson, 2004; Wright, Taylor & Moghaddam, 1990), so rather than concentrating solely on the objective level of inequality, it is also important to investigate employees’ perceptions of inequality in the workplace as a consequential phenomenon.

Third, people are likely to form evaluations of the inequalities that they perceive. This refers to how positive or negative they feel toward inequality, and their judgements of its legitimacy. This is important to examine, as subjective judgments can drive people’s attitudes, emotions and behaviour (Bandura, 1989; Ross, Lepper, Ward, 2010). For example, individuals can make judgements about inequality in their workplaces when they perceive it to be too high or
too low. When confronted with the same objective level of inequality or even when perceiving the same subjective level of inequality, some people may respond negatively to it, while others may be indifferent or even approve of it. Various factors may influence employees’ judgments of the legitimacy of the inequality they perceive, including norms within their industry, and the culture of their organization, department or division. For instance, multimillion-dollar salaries for executives are accepted more readily in large, private corporations than in universities (Lorsch & Khurana, 2010; Reevly, 2015).

Perfect equality of distributions in the workplace is neither practical nor may it be desirable. Tournament theory (Lazear & Rosen, 1981) suggests that inequality in resources such as pay and promotions can motivate individuals and organizations to perform better (Hamann & Ren, 2013). However, too much inequality can have several negative effects, which will be outlined in this section. Therefore, it is the degree of inequality that is of concern. I suggest that at some point, inequality ceases to be useful and begins to have detrimental effects on individuals and the collective. The current research investigated how employees describe and evaluate the degree of inequality they perceive in the workplace.

What Inequality Is Not

There are two concepts that equality is closely related to and often mistaken for: equity and social rank. In this section I will define these concepts and explain how inequality differs from them.

Inequality differs from inequity. The concept of equality is often confused with equity, because they are both components of distributive justice. Distributive justice concerns the allocation of resources in a just manner (Deutsch, 1975). People are sensitive to violations of distributive justice (Lerner, 1977). They use it to judge the outcomes of interactions, and it can
have a strong effect on emotions, attitudes and behaviours (Lerner, 2003). Equality is concerned with outcomes being absolutely equal regardless of each individual’s inputs, while equity refers to maintaining equivalent input-to-output ratios among individuals (e.g., every employee is paid based on the amount of work they put in). When the equity principle is employed properly, an individual’s inputs (e.g., hard work) determine their outcomes (e.g., promotion) relative to others, so there is a meritocracy (Son Hing et al., 2011). It should be noted that equity is at the individual level (e.g., an employee’s input-to-output ratio is either the same or different than that of his/her co-worker), while equality is a group-level phenomenon (e.g., the difference in decision-making power between people at the top and people at the bottom of the hierarchy in an organization). It would be extremely rare, if not impossible, for an organization to have a resource or demand that is distributed both equally and equitably. Equity and equality are both considered to be important, but in different contexts.

Generally, in workplace settings, distributive justice is thought to be determined through equity rather than equality (Greenberg, 1990). More specifically, equity is more likely to be preferred over equality when a task requires low interdependence and the goal is productivity (Chen, Meindl & Hui, 1998). It has been proposed that equity is the best distribution rule for maximizing productivity (Deutsch, 1975). Indeed, perceptions of equity predict job satisfaction, productivity and organizational citizenship behaviours (Cohen-Charash & Spector, 2001; Cook & Hegtvedt, 1983; Deutsch, 1985). Because of the focus on profits and productivity, most organizational research has equated distributive justice with equity, and mostly ignored the role of equality (Colquitt et al., 2001).

Although equity is typically the most common element considered when judging distributive justice in the workplace, people also value equality when forming perceptions of
distributive justice (Leventhal, 1980). This is especially true when fostering positive social relations and group harmony is important (Deutsch, 1985). For example, it has been found that when a task is highly interdependent, or the goal is solidarity, people prefer to allocate rewards according to equality rather than equity (Chen, Meindl & Hui, 1998). Furthermore, it has been found that when children working together were defined as team members, they showed greater preference for distributing outcomes equally rather than equitably (Lerner, 1974). However, when they were defined as co-workers rather than team members, they distributed outcomes based on equity (Lerner, 1974). Because people work in groups and teams in the workplace (Devine et al., 1999), and because they are motivated to have social needs fulfilled at work (Maslow & Stephens, 2000), it is important to study experiences of inequality in addition to inequity.

Other evidence that people care about equality comes from studies based on the ultimatum game. This game involves a proposer suggesting a particular split of a given amount of money, and a responder accepting or rejecting the offer. If it is accepted, the money is split as offered, and if it is rejected both players receive nothing. In many studies, the modal offer (approximately 30% of participants) is a 50-50 split (Camerer & Thaler, 1995; Fehr & Schmidt, 1999). This indicates that many individuals are averse to inequality, sacrificing their own welfare to ensure a more equal outcome (Bolton & Ockenfels, 2000). However, a potential critique of ultimatum studies is that a 50-50 offer might not reflect a preference for equality by proposers but rather a strategy to increase the likelihood that the receiver accepts the offer.

Other studies have made use of a similar type of activity, called the dictator game, to attempt to determine people’s true preferences for equality. This game involves a proposer offering a split of the money, but the responder has no choice but to accept the proposal. Even
when given absolute control over outcomes, approximately 20% of individuals show a preference for equality rather than maximizing their own outcomes (Forsythe et al., 1994; Korenok et al., 2012). Other studies have shown similar results, with participants reacting negatively to being over or underpaid, compared with being paid an equal amount (Bazerman, White & Lowenstein, 1995; Markovsky, 1998). Taken together, these findings indicate that a significant number of people believe that equality is the preferable way to distribute resources, even when distributing them to a total stranger who they will never interact with again.

Cross-cultural research has found that countries outside North America differ in their preference for equity over equality. For example, research has found that Turkish and Colombian subjects preferred equity versus equality to a greater extent than American subjects (Aral & Sunar, 1977; Marin, 1981). Another study found that Chinese subjects prefer equity in the allocation of both financial and socio-emotional resources, while Americans prefer equity for financial resources, but equality for socio-emotional resources (Chen, 1995). This is counter to the popular perception that Eastern cultures are more collectivist while Western cultures are more individualistic. Cross-cultural research has demonstrated that even though the preference for equality versus equity can vary by nation or culture, inequality is clearly important in the North American context.

The ultimatum and dictator game studies reviewed here also indicate that not everyone has the same preference for equality. Equality is a component of distributive justice, and this implies that when confronted with the same objective level (or perception) of inequality, some people will view it as unjust and respond negatively to it, while others will see it as just and view it positively. This notion that people may react differently to the same level of inequality and view it as more legitimate or illegitimate was explored in the current study.
**Inequality differs from individual social rank.** A second construct that inequality is often confused with is social rank, which refers to an individual’s position within a hierarchy. Social rank refers to both an individual’s social status and their rank by power (Magee & Galinsky, 2008). Power is situated within social relationships and can be defined as the relative control one has over resources or demands valued by another (Fiske & Berdahl, 2007). Social status on the other hand, is a structural position (formal or informal) based on respect and esteem, but does not necessitate control over resources and demands (Fiske & Berdahl, 2007).

In any social system, there are multiple formal and informal hierarchies that are salient based on resources and demands that are valued by that particular group (Magee & Galinsky, 2008). For instance, within the workplace, there is a formal organizational structure that connotes power and reporting relationships (e.g., job titles). Those higher in the hierarchy hold more power and report to fewer others than those lower in the hierarchy. Informal hierarchies in the workplace might order people along the lines of their relative respect, expertise, size of their personal network, popularity, etc. Hierarchies with greater spread between those at the bottom and those at the top create more inequality. Thus, inequality is an inherent property of the differences in the position of individuals within social hierarchies (Saunders, 2006).

The issue of social rank is viewed from the perspective of the individual (i.e., one’s own place in the hierarchy), whereas inequality is a property of the collective (i.e., the amount of spread between those at the bottom and those at the top of the hierarchy). A great deal of research has been conducted on the effects of social rank. Because the degree of inequality is contingent on the existence of different social ranks, I will review the research on the effects of social rank in more detail.
Social rank at the societal level has many important and wide-ranging effects. Socioeconomic status (SES), comprised of level of income, education, and occupational status, is one of the most well-known measures of social status used in sociological research. Children of families lower in SES have lower language acquisition, literacy development, and poorer performance in school (Benson & Borman, 2010; Aikens & Barbarin, 2010). This is part of the reason that it is also generally difficult for individuals to break out of their strata and improve their social rank (Morris & Western, 1999). Lower SES has also been linked to a lower level of political and civic participation (Verba, Schlozman & Brady, 1995). There is a positive correlation between socioeconomic status and health that is called the SES-health gradient (Adler et al., 1994). Lower SES is linked to higher rates of stress, diabetes, heart disease, and cancer (Wilkinson, 2000). There is also evidence that subjective social status (i.e., the place that an individual believes he/she falls in the social hierarchy of a group) is more strongly linked to psychological functioning and health-related outcomes than objective indicators of social status. For instance, it has been found that those who perceive themselves as lower in social status feel more shame, have lower self-esteem and a worse physiological response (lower cortisol response) to a stressor than those who perceive themselves as high status (Gruenewald, Kemeny & Aziz, 2006; Hellhammer et al., 1996). This suggests that the psychological perception of social status is a major contributor to the relationship between status and health (Adler et al., 2000).

Lower social rank in the workplace has also been linked to many negative outcomes. The Whitehall study found that among office-based civil servants, those with lower status had higher rates of mortality from coronary heart disease than those in higher status grades (Marmot et al., 1984). Status was defined by employment grade (i.e., unskilled workers, clerical, professional,
and executive). Status in the workplace has important effects beyond physical health. For example, it has been found that those lower in status experience more workplace bullying, including derogatory and exclusionary behaviour (Hoel, Cooper & Faragher, 2001). Those who are lower in status also have lower job satisfaction and lower participation in work teams (Lichtenstein et al., 2004). Taken together, these studies indicate that being lower in status in the workplace is related to several unfavourable outcomes.

In addition to status, those lower in power also suffer negative outcomes in the workplace. Those lower in power are dependent on those higher in power to receive rewards and avoid punishments (French & Raven, 1959). Power can transform an individual’s outlook, with those higher in power perceiving more opportunities in their environment and those lower in power more likely to see potential hazards (Keltner et al., 2003). Those higher in power also have less appreciation for what others think and feel, are less likely to see their subordinates as individuals, and more likely to manipulate them (Galinsky et al., 2006; Goodwin et al., 2000; Kipnis, 1976). Those lower in power are also less confident and are more easily influenced by attempts at persuasion (Briñol et al., 2007; Petty & Cacioppo, 1986). Power can also have an influence on group participation; those lower in power are less likely to express their true opinions and influence situations than those higher in power (Anderson & Berdahl, 2002).

There is much research demonstrating the negative effects of being low versus high in the hierarchy (which the current study examined with a secondary analysis), but it is important to keep in mind that effect of position in the hierarchy is a separate (but related) concept from the effect that the degree of inequality itself has on the collective. The effect of people’s judgments of the degree of inequality in the workplace, (i.e., the amount of spread between those at the top and bottom of the hierarchy) was the primary focus of the current research.
Effects of Inequality at the Societal Level

The effects of inequality at the societal level have been studied extensively. Although there are issues associated with applying data at one level to theory at another level (Klein, Dansereau & Hall, 1994), the research on the effects of inequality at the societal level is reviewed here because it is useful in informing research at the organizational level. Income inequality refers to the amount of dispersion in the distribution of assets, wealth or income, and is often measured with the Gini Index. There is a great deal of evidence that degree of income inequality at the societal level has a negative impact on several social and health-related outcomes at the population level (e.g., Subramanian & Kawachi, 2004).

At the population level, income inequality has been linked to diverse social outcomes including community support, depression and stress (Brunner, 1997; Lorant et al., 2003). It has been suggested that community cohesion or “social capital” (cooperation and trust among the various sections of society) may play role in the relationship between income inequality and well-being; a larger gap between rich and poor leads to disinvestment in social capital, which in turn leads to higher mortality (Kawachi et al., 1997; Subramanian & Kawachi, 2004). It has also been proposed that relative deprivation may mediate these relationships (Kawachi & Kennedy, 1997), that is, frustration and resentment caused by being disadvantaged by excessive inequality may lead to negative social outcomes. It is unclear how or if these factors that have been speculated upon would manifest in a workplace setting, and I have further investigated them in the current study.

With regard to physical health, societal income inequality has been linked to diverse outcomes including population levels of cardiovascular disease, mental illness, obesity, and general mortality (Crepaz & Crepaz, 2004; Khan et al., 1998; Pickett, James & Wilkinson, 2006;
Wilkinson & Pickett, 2006). At the individual level, societal income inequality has been shown to affect social, well-being and health outcomes, even when controlling for the individual’s socioeconomic status (Chiang, 1999; Kawachi et al., 1997; Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998; Lochner, Pamuk, Makuc, Kennedy, & Kawachi, 2001; Macinko, Shi, Starfield, & Wulu, 2003; Wilkinson, 1996). This suggests that being in a social environment with a higher level of inequality may have negative consequences for all, regardless of where one falls in the hierarchy. Although the majority of studies show an effect, there have been mixed findings on this issue. Other studies have found that individual-level health was not associated with income inequality when controlling for individual income (Mellor & Milyo, 2001; Osler et al., 2002; Shibuya, Hashimoto & Yano, 2002).

It is important to note that the link between income inequality, and health and well-being outcomes has received other criticism as well. A systematic review of the literature found that 33 studies demonstrated a significant relationship between income inequality and health outcomes, whereas 12 studies found no such link (Macinko et al., 2003). It has been suggested that significant results found in some studies may have been caused by poor quality income distribution data, or publication bias (Judge et al., 1998). It has also been suggested that the relationship between income inequality and population health may be, in part, due to a statistical artifact caused by the use of population data rather than individual data (Gravelle, 1998). That is, a significant correlation between income inequality and mortality at the population level may be observed, even if inequality has no effect on the risk of mortality at the individual level.

In response to these criticisms, researchers in this area performed a literature review and found that 70% of studies supported the notion that health outcomes are worse in societies where income inequality is greater (Wilkinson & Pickett, 2006). Further, they suggest that many of the
studies that showed non-significant results were done in geographic areas that were too small to reflect the scale of SES differences in a society, or that the factors that these studies controlled for likely mediated the relationship between inequality and health, rather than being actual confounding variables. Given the debate over these findings, it is important to continue studying if and how inequalities at the collective level can affect individual-level outcomes.

**Effects of Inequality in the Workplace**

This section will review the research on the effect of inequality in the workplace. Before that can be done, it is important to address the specific forms of workplace inequality to which employees would be most sensitive. Likely, the inequalities that have the most bearing on employees’ own outcomes (i.e., well-being, and the achievement of personal and work goals) would be the ones that are attended to the most. The job demands-resources model provides a suitable framework for categorizing the workplace inequalities that employees would attend to because they have consequences for one’s well-being and/or ill-being. This model considers how stress and employee well-being are driven by a variety of both demands and resources in the workplace (Demerouti & Bakker, 2011).

**Job Demands-Resources model.** Recall that job demands are aspects of work that require sustained physical, mental or emotional effort, while job resources are aspects of work that are needed to do one’s job, reduce the physical or psychological effects of a job, or contribute to personal development. I propose that people will attend to the distribution of job resources and job demands because both are consequential for people’s well-being and ill-being.

Resources can be structural in nature, such as training or development opportunities, or they can be psychosocial, such as support from colleagues. The availability of job resources can lead to engagement in work (Schaufeli & Bakker, 2004) and help mitigate the negative effects of
high job demands (Bakker & Demerouti, 2007). For example, job resources buffer the impact of job demands on burnout (Bakker, Demerouti & Verbeke, 2004). People are better able to cope with the pressures of high workloads when they have greater resources to draw on, such as autonomy and social support (Bakker, Demerouti & Verbeke, 2004). Furthermore, work environments that offer a lot of resources for staff, foster their willingness to dedicate effort to their work (Meijman & Mulder, 1998). In this way, job resources can stimulate work engagement, which in turn can lead to positive organizational outcomes such as performance and job commitment, through a motivational process (Schaufeli & Taris, 2014). Conversely, a lack of resources makes it difficult to cope with work pressures and ensure work goals are met, which can lead to decreased motivation and disengagement from work (Bakker, Demerouti & Euwema, 2005; Xanthopoulou, 2009). See Figure 1 for the Job Demands-Resources (JD-R) model.

However, only focusing on resources, as previous work on SES, income, power, and status has done, ignores the potentially significant effect that demands can have on employees. People may attend to the distribution of job demands because dealing with chronic job demands can lead to stress (Karasek, 1979), job dissatisfaction (Lewig & Dollard, 2003), psychological strain, including burnout (Bakker et al., 2003), and physical health problems (e.g., exhaustion and repetitive strain injuries; Bakker, Demerouti & Schaufeli, 2003). Because burnout can lead to health problems such as cardiovascular disease (Melamed et al., 2006), the Job Demands-Resources model expects burnout to mediate the relation between job demands and negative health outcomes in a health impairment process (see Figure 1; Schaufeli & Taris, 2014).

Several studies have found support for the job demands-resources model, and the interactive effect of resources and demands on important organizational outcomes including absenteeism, turnover intentions, exhaustion, well-being, performance (Bakker et al., 2003,
2004; Hakanen et al., 2006) For example Xanthopoulou et al. (2007) found that, among home care professionals, autonomy, social support and professional development opportunities could buffer against the effects of emotional demands, physical demands and workload on burnout. It has also been found that when job demands are high, resources such as appreciation were most predictive of work engagement (Hakanen et al., 2007).

Research on the job demands-resources models suggests that employees should be sensitive to the amount of resources and demands they have in the workplace because they both affect well-being, and the achievement of work and personal goals. According to Magee and Galinsky (2008), hierarchies form around the distribution of valued resources. I propose that it is likely that hierarchies form around the resources and demands that are most valued by employees. However, it is important to note that the job demands-resources model (and the research supporting it) concerns the effects of a person’s level of absolute demands and resources (e.g., how do people with more social support fare compared to those with less social support). The current study investigated the effect of people’s judgments of the degree of inequality that exists within a workplace, that is, the relative distribution of valued resources and demands among people. I used the job demands-resources model as an organizing structure for the types of inequalities that employees would be sensitive to. Inequality of resources and demands will not necessarily lead to the same outcomes as possessing or lacking those same resources and demands. People’s judgements of the degree of workplace inequality affects employees through different mechanisms than their personally held demands and resources (see Mediating Mechanisms section). By examining the effect of the distribution of resources and demands that are important to people, it was possible to develop a more relevant and complete theory of workplace inequality.
**Effects of inequality.** Previous research in my supervisor’s lab has linked several types of workplace inequality to negative outcomes, for both employees and organizations. For example, in a set of three studies involving adult workers, student work groups, and students with work experience, inequality of resource distribution was measured in terms of evaluations of too much disparity of the following resources: status, power, influence, respect and job control. Judgments of greater workplace inequality were found to be related to higher levels of stress, worse group relations, and lower job satisfaction, affective commitment, well-being, and self-rated health (Son Hing et al., 2019). The effect of inequality on health was mediated by psychological empowerment and subsequently well-being. Importantly, these effects held when controlling for factors such as people’s own individual level of resources, their position in the organizational hierarchy, income, and level of education. This section will review research that has been done on the effects of inequality of resources such as power, rank, pay and status in the workplace.

**Power and power centralization.** Inequality of power, whereby some have power and others do not, can be termed centralization of power. Too much centralization of power or authority in one place can have negative effects on the entire group or organization. In a study of Taiwanese firms, it was found that more centralization of decision-making power was related to less favourable social interactions among employees. Social interactions were defined as the extent to which employees interacted with each other to communicate, coordinate and build trust (Chen & Huang, 2007). Another study found that greater power centralization was related to lower conflict resolution in the group (Greer & van Kleef, 2010). A possible reason for this is that when there is a clear power hierarchy, members are more interested in competing to gain power than they are in ensuring the health of the group. Schminke et al. (2000) found that greater
centralization of decision-making power with regard to policy making and performance of tasks, was negatively related to perceptions of procedural fairness. It has also been found that greater power centralization encourages executives to engage in more politics, that is, covert actions intended to enhance their own power (Eisenhardt & Bourgeois, 1988). The implication here is that these political actions are likely not in the best interests of the organization or employees (Vigoda, 2000). Taken together, these findings indicate that too much power in the hands of a few has negative consequences for all.

**Rank and vertical complexity.** Vertical complexity refers to the number of levels in the structure of an organization. More levels in an organization translates into more inequality of status and power. Formal hierarchies develop as organizations grow and become more complex. Organizational charts are a good example of formal hierarchy, usually consisting of a small group of top-level managers, at least one layer of middle managers, and a large number of workers in the lower ranks (Mintzberg, 1979). Moving up from a lower rank is greatly desired, as those higher in rank generally have greater control over resources, receive more pay, and command greater respect. It has been observed that greater vertical complexity creates more distractions in organizations and lowers performance (Peters & Waterman, 1982). Carillo and Kopelman (1998) found a similar negative relationship between vertical complexity and productivity. These findings suggest that less vertical complexity will lead to higher performance and better relationships among employees.

**Pay and pay dispersion.** Pay dispersion refers to the amount of inequality in salary. In a workplace context, greater pay dispersion has been related to several negative outcomes. It is usually measured with a statistic similar to the Gini coefficient, or with the Robin Hood index (the proportion of income that would have to be taken from the richer half of the group and be
given to the poorer half in order to achieve equality). It has been shown that greater monetary inequality within small groups or teams can lead to negative outcomes. One study looking at participants’ reactions to social dilemmas, which refers to situations where an individual’s interests are pitted against those of the group. It was found that, even when inequality in the distribution of money is justified on the basis of equitable allocations, it can lead to lower group identification and cooperation (Smith, Jackson & Sparks, 2003). However, previous studies have found mixed results on the relationship between inequality and cooperation in groups (e.g., Rapoport, Bornstein & Erev, 1989; Van Dijk & Wilke, 1995).

One study found that among Major League Baseball teams, greater pay dispersion was significantly related to lower individual and team performance (Bloom, 1999). However, it is important to note that similar studies in other sports have found mixed results. In hockey, there was no relationship between pay dispersion and team performance, and in basketball a positive relationship was actually found (Frick et al., 2003). Possible explanations for this finding are that these sports have smaller team rosters and are more sensitive to the performance of “star players.”

In technology firms, greater pay dispersion among senior executives was found to be related to poorer organizational performance (as measured by market value; Shaw et al., 2002). It has also been shown that organizations with greater pay dispersion have lower tenure and higher turnover among their managers (Bloom & Michel, 2002). Another study found that in a sample of university faculty, greater pay dispersion was negatively related to job satisfaction, collaboration among faculty, and research productivity (Pfeffer & Langton, 1993). Similarly to research on societal-level income inequality, it is not clear what interposing mechanisms, such as
perceptions of inequality, may be playing a role in the relationship between pay dispersion and the outcomes mentioned here. I investigated this issue with the current research.

**Status.** A study done on cross-functional teams, found that greater status inequality among members can lead to suppression of participation among lower status members, and poorer team functioning (Lichtenstein et al., 2004). In this case, social status was measured by occupational status and ranged from 1 (nurse aide) to 12 (psychiatrist). The current research further investigated the adverse effect that status inequality may have on group functioning.

Another study looked at the relationships between status, performance and physical health among NBA players (Christie & Barling, 2010). Status was measured through salary, number of games started, tenure, awards/recognition, and celebrity status. The researchers found that status inequality was related to poorer individual performance and more absences due to ill-health for low-status players, but only for the ones who also showed more uncooperative behaviour (suspensions from play, ejections from a game, et cetera). It was also determined that player performance decreased over time for low-status players on teams with a higher degree of status inequality, but remained the same for low-status players on teams with a lower degree of status inequality. The authors suggested that this occurred because low-status players on teams with a higher degree of status inequality are evaluated more harshly, given fewer developmental opportunities, and have lower confidence and motivation compared with low-status players on teams with a lower degree of status inequality. The current research investigated this notion of an inequality spiral in more detail.

**Mediating Mechanisms**

In the previous section, evidence was presented that greater inequality in resources such as power, formal rank, pay and status has negative consequences for employees and
organizations as a whole. There are several possible mechanisms through which inequality might exert these negative effects, which are described in detail below.

**Status pressure, competition and uncertainty.** Aside from violating their perceptions of justice, there are several other reasons individuals may react negatively to too much inequality. Large inequalities mean that there is greater variability in positions in the hierarchy. This would likely lead to more competition and status pressure because there is potentially more variability in an individuals’ rank. Those at the top have more to lose, and those at the bottom have more to gain. Competition is less efficient than cooperation, and can lead to increased stress (Stanne, Johnson & Johnson, 1999; Wittchen et al., 2012). For example, in his review of studies on the influence of social hierarchy on health in primates, Sapolsky (2005) found that animals both higher and lower in rank suffered negative health effects from competition. This included stress, anxiety, immune response, fertility, and miscarriages. Sapolsky suggested that these findings should also apply to humans. And indeed, research with human participants has borne this out. In a study using a car racing game, it was shown that playing in a competitive environment led to increased blood pressure and heart rate, compared with playing cooperatively (Harrison et al., 2001). Additionally, uncertainty, which would be expected in a workplace with high inequality, is related to increased stress and decreased cooperation (Monat, Averill & Lazarus, 1972; Wit & Wilke, 1998). Therefore, the competition and status pressure associated with greater inequality would likely lead to greater stress for individuals.

**Group relations and social identity.** Inequality could also lead those who are higher versus lower in resources or demands (i.e., the “haves” and the “have nots”) to perceive themselves as being different from each other. Social identity theory suggests that people who are the same along a certain dimension (such as their rank in the organization, or having to work
the same undesirable evening shift) are likely to feel closer to each other (their in-group) than they are to people who are different from them (their out-group; Tajfel & Turner, 1986). They do not view themselves as belonging to the same social category as members of the out-group (Turner, 1978). In relation to inequality, those at the top of the hierarchy see others at the top as the in-group, and those at the bottom of the hierarchy as the out-group. Similarly, those at the bottom of the hierarchy see others at the bottom as the in-group, and those at the top as the out-group. As the different groups begin to stabilize, they may show favouritism to those in their own group and discriminate against those in the out-group (Taylor & Doria, 1981; Ahmed, 2007). Part of the reason for this is that the different groups may have opposing interests (e.g., maintaining versus obtaining resources), which can lead to increased competition and social conflict, and decreased cooperation, trust and cohesion (Abrams & Hogg, 2006; Austin & Worchel, 1979). This division among groups has negative effects on employees and can also hurt organizational performance (De Drew & Weingart, 2003; Jehn, 1995).

**Relative deprivation.** The effect of too much inequality may be especially strong for those who are lower in the hierarchy because of the phenomenon of relative deprivation. This refers to feelings of frustration and resentment that individuals experience when they perceive that others possess valued economic, social or political resources that they themselves are illegitimately deprived of (Walker & Smith, 2002). When inequality is greater, those lower in the hierarchy will experience more relative deprivation when they compare themselves with those higher in the hierarchy. This could be true even for those who are near the top of the hierarchy. A meta-analysis has linked greater feelings of relative deprivation to greater anger and resentment, and poorer physical and mental health (Smith et al., 2012). In sum, inequality in organizations would likely have a negative impact on employees because it violates distributive justice, creates
more competition and status pressure, divides those who are higher and lower into different social groups, and increases feelings of relative deprivation among those lower in the hierarchy.

The Current Research

It is not readily apparent which dimensions of inequality (i.e., which resources and demands) are most important in the workplace. There are likely multiple social hierarchies that would be of consequence to employees, which could develop along both formal and informal paths (Magee & Galinsky, 2008). The current research will attempt to determine which of those hierarchies employees respond most strongly to and what makes them perceive inequality as being too high (or low). Furthermore, the study will investigate why employees may react negatively to too much inequality and what their psychological responses are when they perceive inequality to be too high.

Specifically, the research questions that my study addressed are as follows:

1. Which resource and demands do employees value the most?
2. Which resource and demand inequalities are employees most sensitive to?
3. What makes employees perceive there to be higher versus lower levels of inequality?
4. What makes employees perceive the level of inequality to be more legitimate or more illegitimate?
5. What makes employees judge or evaluate the inequality more positively or more negatively?

Study Setting

To address the research questions, I chose to use a sample of medical faculty at a pediatric academic health science centre in Canada (the hospital). The hospital is comprised of several different departments; I conducted the research with only one specific department.
Medical faculty are doctors who do clinical work in the hospital, but also have appointments at a local university, and therefore engage in research and teaching as well. There are four different job profiles at the hospital that were included in the sample: academic-clinician, clinician-educator, clinician-scientist, and clinician-investigator. The profiles differ in the relative amount of time they are expected to engage in teaching, research, clinical and administrative work. The department itself is divided into seventeen separate divisions that practice a different type of medicine, each with its own division head.

This sample was high in the hierarchy within the hospital, as they had more status compared with most other employees (e.g., nurses, administrative staff, social workers). They would also be considered higher in social rank within society, as physicians tend to fall within the high socioeconomic status category (Hodge, Siegel & Rossi, 1964). Many negative effects of inequality may be mediated by relative deprivation, that is, feelings of frustration and resentment that individuals experience when they perceive a lack of resources that others have (Smith et al., 2012). Because of this, inequality is often assumed to affect only those who are low in status. However, if it can be demonstrated that judgments of greater inequality is an issue even within such a high-status group, it will provide support for the importance of inequality for all individuals in the workplace, regardless of their status.

The literature on the sociology of medicine tells us that healthcare professionals, and physicians in particular, have an idealistic attitude towards their work (Becker et al., 1961). They value the work that they do because of the sense of fulfillment they gain from helping their patients. Through their socialization in medical school, physicians are taught to accept and endure the pressure and demands their workplaces on them (Roberts et al., 2005). Hospital culture encourages physicians to work long hours, keep erratic schedules, and to put their
patients’ and students’ needs above their own (Lundgren et al., 2001; Maslach & Goldber, 1998). Furthermore, workaholism is prevalent among physicians, and causes them to have difficulty disconnecting themselves from their work (Schaufeli, Shimazu & Taris, 2009). Burnout is another known issue among healthcare professionals, and is caused by various stressors including shift work and daily interactions with patients (Mateen & Dorji, 2009; Wisetborisut et al., 2014). Taken together, these findings suggest that physicians may not be as sensitive to demand inequality as those in other occupations because significant demands are an accepted part of the industry they work in.

The medical profession has almost complete autonomy to determine who is legitimately allowed to practice in the field, and how the work should be done (Friedson, 1970). This degree of freedom is unusual among occupations, and is likely to be a resource that is highly valued by physicians. Furthermore, physicians are unusual in that, although they have a great deal of demands placed on them (e.g., emotional load), they also have many resources at their disposal (e.g., high occupational and societal status, and well-above average salary; Allen, 2005; Swanson, Power & Simpson, 1998). Given how highly valued these resources are by most people, it is likely that physicians will be very sensitive to inequalities in their distribution. Although there are likely to be several demands and resources that are particular to the healthcare profession or to this specific organization (e.g., support from allied health professionals, pressure to publish), it is likely that many will be applicable across a wide array of workplace contexts (e.g., pay, workload, recognition).
Methodology

Interviews

I interviewed 30 medical faculty (19 women, 11 men) in the department at the hospital. Thirteen participants were assistant professors (43.4%), nine were associate professors (30%), seven were full professors (23.3%), and one was a lecturer (3.3%). Seventeen participants were academic-clinicians (56.7%; spend the majority of time doing clinical-related activities), five were clinician-educators (16.7%; spend about half the time doing teaching and educational development), four were clinician-scientists (13.3%; spend the majority of time doing research-related activities), and four were clinician-investigators (13.3%; spend about half the time doing research-related activities). The participants varied in their job profiles, professorial rank, tenure, leadership status, division affiliation, gender, and parental status. Eleven divisions were represented in the sample. Eleven participants (36.7%) were division heads or occupied a comparable leadership role in the hospital. The participants ranged in tenure from less than one year to over 30 years. Twenty participants were employed at the hospital for 15 years or less (66.7%), and ten (33.3%) have worked there for 16 years or more.

Most of the interviews lasted between 40-60 minutes. Interviews were audio recorded, and then transcribed into text by a professional transcriber. To develop a rapport with participants, I probed them about their general experiences working in the hospital (e.g., “What do you like most/least about your work?”). They were then asked to speak about the resources and demands that are most valued in their organization, as well as their perceptions and evaluations of the inequality in the distribution of resources and demands. It was sometimes difficult to get direct responses to these questions. In these cases, participants were asked directly about specific resources and demands (e.g., pay, training opportunities). Other questions were
intended to more indirectly address issues of interest. For example, to establish participants’ views on what is valued in the organization, they were asked to describe colleagues in the organization who are admired the most. Where possible, interviewees were asked to provide specific examples rather than talk about concepts in the abstract. This was done to help ensure that participants understood the questions and were addressing the issues of interest (e.g., not talking about equity instead of equality). As the interviews progressed, some interview questions were modified to make them clearer, and new questions were introduced to address issues of interest that were brought up in earlier interviews. The final version of the interview script is included in the Appendix.

**Thematic Analysis**

I posed open-ended research questions to guide my study because I was interested in how employees understand and make sense of the inequality they perceive around them, and especially what makes them view the inequality as being legitimate or illegitimate. Therefore, a qualitative approach was more appropriate than making specific hypotheses and testing them quantitatively. Qualitative methods can provide rich accounts of complex phenomena (Sofaer, 1999). Qualitative approaches differ from quantitative approaches in that they foster a better understanding of a phenomenon from the perspective of the participants. Qualitative interviews were the most appropriate approach to address the research questions because they enable participants to communicate their experience and the meaning that they ascribe to them (Butler, 2006). This was advantageous for the current research, as I hoped to identify the types of inequalities that employees saw in their workplace and how fair they believed these distributions were.
Given that I was interested in drawing more general conclusions regarding inequality in the workplace beyond individual participants’ experiences, thematic analysis was the most appropriate approach to analyze the data (Guest, 2012). A theme is something important identified in the data in relation to the research question(s). Researchers can use thematic analysis to detect and classify patterns in qualitative data (Braun & Clarke, 2012). Thematic analysis also allows for a deeper analysis of interviews beyond the words of the participants; it can help researchers interpret the meaning behind what participants say, in order to gain a deeper understanding of the research topic (Boyatzis, 1998).

I used Braun and Clarke’s (2006) approach to thematic analysis, which is widely accepted, and has the benefit of being more clearly delineated than previous approaches. The analysis process involves six phases: familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The analysis does not necessarily occur linearly, moving directly from one phase to the next. It is an iterative process that involves moving back and forth through the phases. The identification of themes is somewhat related to the prevalence of that theme in the data, both within each interview and across the entire data set. It is ultimately left to the discretion of the analyst to determine sufficient evidence for the inclusion of a theme. A theme’s relation to the research questions is considered to be of greatest importance. A theme is significant if it addresses the research question(s) in a meaningful way (even if it is relatively under-discussed in the interviews).

In general, there are two different levels at which themes can be identified: the semantic (or explicit) level, or the latent (or interpretative) level. At the semantic level, themes are identified based on the surface meaning of the data, and the researcher does not look deeper than
what the participants have said. I conducted my analysis at the latent level, which goes beyond the explicit data and attempts to identify the underlying ideas and concepts that shape the semantic data.

Because of the interpretation involved with thematic analysis, it is unavoidable that the researcher’s own perspective, values and beliefs will colour the thematic analysis. This is not necessarily a disadvantage, but it is important to acknowledge that the results of the analysis will be just one of several possible interpretations. One of the advantages of thematic analysis is that the written report can include vivid examples of participants’ experiences to help engage the reader. Another element of thematic analysis that I took advantage of are visual representations of the data, including tables and concept maps. These visual representations assist in sorting the codes, and can also help readers to understand the key themes.

**Critical Realism**

In my analysis, I adopted a critical realist philosophy. Critical realism assumes that social structures exist and that it is possible to study them in the same way as natural phenomena (Bhaskar, 1975). It seeks to explain social structures by identifying causal pathways and determining under which conditions they are activated. Therefore, it is an appropriate approach for theory generation and developing causal explanations. The current study, in part, attempts to determine why people perceive higher or lower levels of inequality and why they react negatively to it, so critical realism fits well with the objectives of the study.

The critical realist philosophy and methodology can be used as the basis for an explanatory theory building method (Danermark et al., 2002). There are two dominant approaches to this method: emergent theory building and confirmatory theory testing. Given that the goal of the research was to develop a theory of workplace inequality based on the
experiences of participants, emergent theory building was used. This approach uses predominantly inductive forms of reasoning to move from empirical observation and inquiry toward the development of theoretical concepts.

Critical realism distinguishes between four modes of inference: deduction, induction, abduction and retroduction (Eastwood, Jalaludin & Kemp, 2014). In alignment with the emergent theory building approach, the current research primarily used induction, which involves drawing universally valid conclusions about a whole population from a number of observations. This is done by noting similarities across various observations, and drawing conclusions from them. The current research also used deductive forms of inference, as the planning of the study, as well as the analysis of data were informed by previous research and theory regarding workplace inequality, job demands and job resources.

**Analysis Process**

Because of the exploratory nature of the research, I attempted to partially analyze broad themes in the interviews as data was being collected. This led to the addition of several questions to the interview script to address issues that were revealed to be of particular importance to the research questions and to participants’ experiences of inequality (e.g., the performance evaluation process). The full thematic analysis began with reading through the interview transcripts. The transcripts were then read again, and the research questions were used to guide initial code generation. See Table 1 for a list of initial codes and data excerpt examples for each code. Themes were then generated from the codes. This phase involved grouping codes together that were related to each other and relevant to the research questions, while dropping codes that were irrelevant or extraneous. I used my own interpretation of the interviews, as well as issues that were identified as particularly salient by participants, to identify themes. In presenting the
results, I distinguish between the data and my own interpretation of it by using phrases such as, the physicians “spoke of,” “noted” etc. when referring to what participants actually said in the interviews.

During the coding process, I met regularly with my advisor and another graduate student (who was performing a qualitative content analysis on the same set of interviews to address a different set of research questions) to help reach consensus on the codes and themes that were developed, and to help ensure a more well-rounded analysis. After the themes were identified, I named and defined them using the same language that participants used to describe their experiences. As a result of my training as a positivist researcher, I was biased towards looking for causal relationships between the identified themes. Therefore, I identified connections among the themes and arranged them into concept maps.

Development of the themes and concept maps was an iterative process where I received feedback and guidance from my committee, advisor, and members of my lab. The process involved going back and forth between the themes and codes (and supporting data excerpts), looking for: areas of overlap where they should be combined, relevance to the research questions and theory being developed, areas of divergence where they should be separated, and causal pathways where themes should be connected to each other.

Given the previous literature review I had completed on the job demands-resources model before data collection, it became quickly apparent to me as I analyzed the data that participants perceived and responded differently to resource versus demand inequality. When thinking about inequality, participants also seemed to perceive inequality among individuals and inequality among divisions differently. Although there was some overlap, each level of inequality had differing roots, types, outcomes and responses. Inequality among individuals
refers to inequality that people believe exists among individuals, regardless of which division they are in. Inequality among divisions is inequality that people believe exists among the various divisions within the department. Resource inequality, demand inequality, inequality among individuals, and inequality among divisions became the overarching themes, which subsumed the secondary themes that were identified (e.g., roots of inequality, outcomes of inequality, responses to inequality). Under these secondary themes, I grouped the more specific themes that served to explain and exemplify the secondary themes (e.g., negotiation skills, salary, frustration). As the concept maps were developed, they allowed me to examine more closely the differences between demand and resource inequality, and inequality among individuals and divisions.

Matrix Analysis

After collecting the data and beginning the preliminary thematic analysis, based on the feedback of my committee, I decided to conduct a supplemental analysis by sorting the data into matrix display tables (Miles, Huberman & Saldana, 2013). It has been suggested that matrix analysis can be a valuable complementary analytic strategy in qualitative research that can be used to display, interpret and evaluate study findings (Averill, 2002). Furthermore, matrix analysis can confirm or strengthen conclusions that are drawn, and in this way assist in assessing the trustworthiness of qualitative research (Marsh, 1990).

Although it has been found that those who have more resources and are higher in status have significantly better outcomes than those who have fewer (e.g., Marmot et al., 1991), previous research on societal level income inequality has suggested that those higher in the hierarchy do not differ in their perceptions of the level of inequality from those who are lower in the hierarchy (Norton & Ariely, 2011). To investigate whether these findings held true for the
participants in my study, I performed a supplementary matrix analysis on the interview data. This approach shares some similarities with thematic analysis and allows data to be reduced into thematically similar categories.

The specific groups I studied with the matrix analysis were those higher versus lower in level of demands, those higher versus lower in level of resources, and leaders versus non-leaders. I chose to examine level of resources because those who have more resources can use them to their advantage and therefore may be motivated to see less inequality and respond less negatively to it. Level of demands was chosen for much the same reason; those with fewer demands may experience less stress and be able to devote more time and energy to achieving work goals, and may be motivated to see less inequality and respond less negatively to it. Finally, I chose to examine leadership status because those in leadership positions may want to maintain their control over resources and demands, and therefore be motivated to see less inequality.

The analysis process involves three stages: data reduction, displaying the data, and drawing conclusions. Because the data reduction stage is very similar to thematic analysis, I reused the codes that were created in the previous thematic analysis of the interview data. There are various ways that the data can be displayed including graphs, network maps, and charts. Because my goal was to organize the data and look for patterns, matrices were the most appropriate visualization tool to use. The last step is to draw conclusions from the displayed data based on reoccurring patterns of clusters of variables that seem to fit together. See Thurlings et al. (2014) and Roberts (2007) for examples of research using meta-matrices for data analysis.

I used case-ordered descriptive meta-matrices, which organize cases (i.e., participants) according to specific criteria in order to compare outcomes of interest (Miles, Huberman & Saldana, 2013). They are useful when looking for possible relations between variables that the
researcher understands well (i.e., level of resources, level of demands, leadership position), and understands less well (i.e., perceptions of inequality, evaluations of inequality, stress). Level of resources, demands and leadership position were well-understood because participants spoke about them clearly, and they are tangible and easily measurable compared to the lesser understood variables. Perceptions and evaluations of inequality are by their nature less understood because they refer to internal mental and emotional processes that usually cannot be directly observed. Although stress is grouped with the lesser known variables, it was actually quite well-understood, as the interview guide contained questions directly asking participants how stressful their work was. It was included with the lesser known variables because from research and practical standpoint, it is useful to explore how it relates to level of resources, demands and leadership position.

I rated each participant on their perception of the level of inequality, their evaluation of the level of inequality, and their level of stress. Each participant usually had four to six relevant data excerpts that I used to categorize them along each variable of interest, so my confidence in the categorizations is fairly high. An important caveat to note is that, in reality, these variables exist on a continuum (except for leadership status). However, the analysis necessitated that medical faculty be divided into groups based on the variables. This is somewhat akin to performing a median split in quantitative statistics.

Participant 7 was not included in the matrix analysis because the audio of their interview did not record properly. Although the notes about what they said during their interview was included in the thematic analysis, there was not enough detail to include the participant in the matrix analysis. Participant 25 was excluded from the analyses shown in Tables 3a-c, 4b, 5b, 5d,
6a, and 6c because not enough information was present in their interview to give accurate ratings on one or both of the variables in the table.

To determine each participant’s perception of the level of inequality, I reviewed all of the data excerpts from each participant that referenced their perceptions of the level of demand or resource inequality. I then rated each participant as having a perception of more, moderate, or less inequality of demands and resource in the hospital. The ratings of perception of level of inequality were relative. By that I mean those who were rated as perceiving more inequality perceived more in relation to those who perceived less inequality. There was not enough information to confidently distinguish between perceptions of resource inequality and perceptions of demand inequality, nor between inequality among individuals and inequality among divisions. Therefore, I grouped all of the data excerpts related to perceptions of the level of inequality together, and rated participants on their perception of the overall level of inequality.

As an example, one participant who was rated as having a perception of more inequality noted that there are clearly preferred divisions and individuals in the hospital:

“There’s no question that there are preferred divisions and there’s no question that there are preferred people within those preferred divisions and there’s no question you can predict…who’s going to get supported.”

When asked about their perception of the extent to which demands are distributed unequally, a medical faculty interviewee who was rated as moderate in their perception of inequality responded, “I would say more than a little but definitely not a lot.”

To rate each participant on their evaluation of the level of inequality, I used a similar process. I reviewed all of the quotes from each participant that referred to their attitudes towards inequality. Based on this, I rated each participant as being positive, neutral, or negative towards
the inequality they perceived. Ratings of evaluations of inequality were relative. Those who were rated as positive were only positive in relation to those who were rated as being negative. None of the participants were fully positive towards inequality. Again, there was also not enough information to differentiate between resource inequality and demand inequality, nor between inequality among individuals and inequality among divisions. Therefore, I gave each participant an overall rating of their attitude towards inequality in the organization. As an example, one participant who was rated as negative towards inequality, stated:

“There’s something about the dynamic about being a [physician in my division]…the way that’s perceived is that you’re less important than me…I have not had warm fuzzies, I don’t feel like I’m equal playing field with these colleagues.”

Conversely, a medical faculty interviewee who was rated as positive towards the inequality said of their attitude, “100% [that group membership plays a role in distribution of resources] and that’s appropriate cause every institution you have to have priorities.”

Finally, to rate participants’ levels of stress, I reviewed all of the data excerpts from each participant that referenced their own level of job stress, that is, work-related factors that negatively affect psychological or physiological condition (Newman & Beehr, 1979). I also included excerpts where participants talked about their sense of their own well-being. I chose to examine stress because concern about it was the main impetus for the hospital to undertake this research in the first place. Furthermore, stress is an important outcome in the framework I used to examine workplace inequality, the job demands-resources model (Bakker & Demerouti, 2007). I gave each participant a rating of lower, moderate, or higher on their overall level of stress. Those who were rated as lower had less stress relative to those who were rated as higher. One participant whose stress was rated as lower stated, “The amount of stress here, I don’t find
overwhelming. I can’t say that it has a major impact [on my well-being].” In contrast, a medical faculty interviewee whose stress was rated as higher talked about how stressful balancing all of the research, clinical work and education they had to do was:

“[I find my work] extremely stressful…balancing the research, clinical and education is very stressful…there just is a lot of clinical work and when I am on service, I won’t even make it to my office…So checking email happens on my phone or at night after my kids go to bed…well the research is not happening. The teaching I’m doing is sort of unplanned and on the fly…So yeah, that’s stressful.”

Trustworthiness

As qualitative research continues to become more popular, a need has been identified to ensure the transparency and credibility of the analysis methods and process. Nowell et al. (2017) have identified several trustworthiness criteria for thematic analysis. These criteria, as well as a brief explanation of how they were applied to the current study, are described below:

- **Credibility**: Refers to the fit between participants’ views and the researcher’s representation of them. To ensure credibility, I coded the interviews along with another grad student who was using the same data set, which helped to reach consensus on the codes and themes that were developed. The matrix analysis also helped to confirm some of the findings and conclusions of the thematic analysis. For example, the thematic analysis found that resource inequalities were more salient and meaningful to medical faculty than demand inequalities. The matrix analysis supported this by finding that although there were no differences in perceptions or evaluations of inequality between those lower in individual demands and those higher in individual demands, those higher in individual resources perceived less inequality and responded to it less strongly than
those lower in individual resources. Furthermore, I held a follow-up session with some of the interviewees where some of the initial findings were presented and confirmed. Session participants were informed about the types of demand and resource inequalities that interviewees identified as well as their reactions to inequality. They were asked to provide their reactions to the information presented, which bolstered the credibility of the study by confirming participant agreement with the data analysis and main findings.

- **Dependability:** Refers to ensuring the research process is traceable, clearly documented, and logical. To promote dependability, I met with my advisor, committee, and members of my lab to discuss the themes and concept maps as they were being developed to ensure that they were logical and coherent. Notes that were taken during these meetings and the coding sessions helped to ensure the research process was traceable and documented.

- **Transferability:** Refers to the generalizability of the inquiry and findings. Unfortunately, transferability cannot be confirmed until follow-up studies are done with other organizations or employee groups. However, the detail presented in this paper regarding the study’s findings should be sufficient to enable transferability to be confirmed in the future.

- **Confirmability:** Refers to ensuring the researcher’s interpretations and findings are clearly derived from the data. Confirmability is demonstrated when *credibility, transferability, and dependability* are achieved (Guba & Lincoln, 1989). As described above, these criteria have been met as best as possible at this time.

- **Audit trails:** Refers to providing evidence of decisions that were made regarding theoretical and methodological issues during the study. The description of the data collection and analysis process presented in this Methodology section, including
decisions that were made (e.g., rationale for choosing to add a matrix analysis during the analysis process), as well as the raw interview transcripts and coding and meeting notes should provide sufficient detail for the audit and decision trail.

**Results**

The results of the thematic analysis of the interview data are summarized in the concept maps in Figure 2 and Figure 3. The maps are divided into resource inequality (Figure 2) and demand inequality (Figure 3).

There were five main themes identified for resource inequality:

- Personal, Social and Organizational Roots of Resource Inequality
- Types of Structural Resource Inequalities
- Types of Psychosocial Resource Inequalities
- Performance-Related Outcomes
- Psychological Responses to Resource Inequality

There were four main themes identified for demand inequality:

- Personal, Social and Organizational Roots fo Demand Inequality
- Types of Structural Demand Inequalities
- Types of Psychosocial Demand Inequalities
- Psychological Responses to Demand Inequality

Each main theme had several associated sub-themes, divided between inequality among divisions and inequality among individuals. These sub-themes will be discussed in further detail in this Results section. Sometimes participants described how they felt an identified theme or sub-theme directly lead to another, and other times these connections were made during the data analysis process. For example, inequality in the amount of respect or status that divisions have
(psychosocial resource inequality) can lead to inequality in how much funding they receive (structural resource inequality). The arrows in Figure 2 and Figure 3 denote these connections between the themes. See Table 2 for examples of data excerpts that demonstrate each connection. The number labels on the arrows in Figure 2 and Figure 3 correspond with the connection numbers in Table 2.

Research questions one and two about the resources and demands that participants valued the most and the inequalities they were most sensitive to are addressed in boxes for types of structural and psychological resource and demand inequalities. Research question three regarding what makes employees perceive there to be higher or lower levels of inequality is explored in the matrix analysis in Section III of the results. Research questions four and five, which asked what affects employees’ perceptions of the legitimacy of inequality and what makes them view inequality more positively or negatively are addressed in the differences in outcomes and responses to resource versus demand inequality, and inequality among individuals versus divisions. Based on my reading of the interviews, I also offer my own perspective on these two questions in the theoretical implications section of the discussion.

I allowed participants to define the context in which they perceived inequality. The majority of participants identified other medical faculty within the department (both inside and outside their own division) as their main comparison group. A few participants also mentioned other staff in the hospital (e.g., nurses), or physicians at other hospitals. However, it was clear that comparisons with other medical faculty within the department were by far the most salient. This makes sense because medical faculty compete with each other for securing grants, donations, and resources from the hospital, and they are directly or indirectly compared with each other in performance evaluations. Therefore, unless otherwise specified, when referring to
participants’ talk of inequality, I specifically mean inequality among medical faculty within the department.

Section I: Resource Inequality

Structural resource inequality. There were many different types of resource inequalities that participants identified as salient. This was true for both inequality among individuals and among divisions. Some of the salient inequalities were specific to this particular organization and group of employees, while others would likely apply to a wider range of work contexts. I sorted them into two main categories: structural resources and psychosocial resources.

I defined structural resources as those that are valued because they are seen as assisting in achieving work goals (e.g., publishing research papers; Bakker & Demerouti, 2007); these may be functional, material, financial, or physical in nature and are often provided by organization and its agents. For medical faculty, work goals were usually related to the three main aspects of their job: research, clinical work, and teaching. Some structural resources were seen as being unequal among individuals, others were unequal among divisions, while most were viewed as being unequal among both.

Structural resource inequality that exists among individuals. With regard to inequality among individuals, participants noted that there are differences between medical faculty based on physical resources such as research equipment and lab spaces (see Figure 2 – Types of Structural Resource Inequalities – Inequality Among Individuals). Some medical faculty were also given time and resources by the hospital to attend training for professional skills development, while others were not. Participants also noted differences in the quality of the administrative support they had. They believed that the administrative staff assigned to some medical faculty were more skilled than others, and were able to take on more paperwork and
other tasks, which reduced the workload of the faculty they worked under. This in turn allowed those faculty members more time to devote to research and teaching.

Faculty also perceived there to be differences among individuals based on the amount of funding and grants they receive for their research. This is an especially important resource because research productivity is highly valued at the hospital, and grants allow faculty to purchase research equipment and hire research assistants. Related to this, some medical faculty also had more protected time than others; this is time when they do not have responsibilities such as clinical work or teaching, and that the organization grants them specifically to do their research.

**Structural resource inequality that exists among divisions.** With regard to inequality among divisions, participants observed disparities in access to many of the same types of structural resources as they did with inequality among individuals (see Figure 2 – Types of Structural Resource Inequalities – Inequality Among Divisions). For example, some divisions had more administrative support staff assigned to them than others. As mentioned above, having more administrative support is seen as a very valuable asset. Faculty were also acutely aware that some divisions received much more donations than others. Related to this point, some divisions had more attractive clinical areas, more space and better equipment to treat patients. One participant stated:

“The divisions that get more donations and more money have…more toys to play with and more goodies…the classic example is [division A]. They were given [many millions of dollars] for a [redacted] centre. That’s awful nice, isn’t it?...so when you’ve got that kind of money…which has to be used for academic things obviously but you know, can buy a new [piece of equipment]. Can build a new centre for [medical specialty]…But, it’s
much, much harder for the other groups like [my] group, that we don’t get a lot of
donations.”

Some divisions also had greater numbers of clinical support staff (e.g., nurses), residents, and medical faculty than others. All of this helped to ease the clinical workload that each physician was under.

**Psychosocial resource inequality.** The second type of resources that medical faculty perceived to be distributed unequally were psychosocial resources, which are cultural, social, and psychological factors that are valued positively (e.g., support from a supervisor; Bakker & Demerouti, 2007). These resources may be valued because they are seen to contribute to: employees’ psychological well-being and job satisfaction, and/or indirectly achieving work goals. Similarly to structural resources, some psychosocial resources were seen as being unequal among individuals, others were unequal among divisions, while most were viewed as being unequal between both.

**Psychosocial resource inequality that exists among individuals.** Medical faculty spoke about how they perceived there to be differences among individuals based on their level of status (the extent to which they are respected; Magee & Galinksy, 2008; see Figure 2 – Types of Psychosocial Resource Inequalities – Inequality Among Individuals). For example, one participant felt that physicians with higher status received more support from the organization:

“I think it comes from the medical leadership at the top. There’s no question that there are preferred divisions and there’s no question that there are preferred people within those preferred divisions and there’s no question you can predict who’s going to get supported…there’s palpable preferences within our faculty, particularly within our
department, within our medical divisions as opposed to the [divisions in a different department].”

Although some faculty were highly respected for their teaching and clinical work, participants felt that status was mostly based on how prolific their research portfolio was. Closely related to status and respect, formal recognition was also perceived to be unequally distributed among individual faculty. Formal recognition often took the form of acknowledgement (both from within and outside the hospital) for research success and grants received.

Participants also mentioned that they perceived differences in the quality of support that medical faculty received from their mentors. The mentorship program in the department was seen as inconsistent. Some faculty were assigned mentors when they joined the department, others were not. Those who wanted a mentor but were not assigned one (as well as some of those who were, but did not feel like they were a good fit with their mentor) were forced to find an informal mentor on their own. Some medical faculty rarely met with their mentors (e.g., once every six months) while others met with their mentors on a weekly basis during which time they were provided with valuable support and advice when starting out their careers. For example, one participant noted:

“In terms of my own growth, having this hour meeting every week [with my mentor] …that’s a huge luxury…having access to a senior [faculty physician] to talk about anything I want every week [is very helpful]… in terms of how it works out for other people, I’m not too sure. I know for some people, they meet with their mentors maybe every six months. I meet every week”

Differences in the quality of medical faculty’s networks also caused inequality in access to various resources and support, such as research collaboration opportunities:
“The people you know and your network of support people definitely has a huge impact in terms of finding opportunities, in terms of forging collaborations, opening doors. If you have good mentors that are very pro-active that can really make a big difference.”

**Psychosocial resource inequality that exists among divisions.** With regard to inequality among divisions, some participants noted that there was a difference in the leadership abilities of the division heads (see Figure 2 – Types of Psychosocial Resource Inequalities – Inequality Among Divisions). Some division heads provided more social support and some were better able to manage interpersonal conflicts within divisions than others. This helped to mitigate the psychosocial demands placed on members of those divisions.

Another type of psychosocial inequality that was perhaps the most salient to participants was the hierarchy of status among the different divisions. These differences in status were based on the fact that some specializations were perceived to be more prestigious, require more knowledge/skill, receive more donations/funding, and have greater research productivity than others. These “have” divisions received more respect and resources such as additional medical faculty. For example, one medical faculty interviewee noted:

“There are clearly preferred divisions…how does that translate into reality? They’re the ones who get the extra faculty. They’re the ones who get constantly quoted as being centres of excellence and providing…top notch care. They’re the ones that get touted by the research foundation as being one of the best programs in the hospital…there are very, very definite levels of preference or preferred status.”

Because of this, some participants believed that medical faculty from the higher status divisions would sometimes act in a superior manner towards faculty from the lower status
divisions, and faculty from the lower status divisions would act in a resentful manner towards those from higher status divisions. One participant observed that:

“I think there’s sometimes a tone of condescension…as a generalist physician, I can’t possibly know as much about any one specialty as they know themselves. So when you call for a consultation and ask another service [for] their opinion of something, it’s very easy for them to be condescending to you…I think to act that way seems very unprofessional and inconsiderate. And so I’ve always been surprised because a lot of interactions I’ve had, I find that there’s that tone of condescension and I’m not sure where it comes from because it’s certainly not collegial.”

Another participant noted that they believed physicians from the better paid divisions felt that they were more important and could push around physicians from lower paid divisions:

“It’s always been my sense that how much money you’re paid reflects on people’s general thoughts of their importance…for example, [division C physicians] gets paid more and they seem to be able to feel like sometimes they can bully the [my division] people around a little bit and I feel like that’s been the culture that’s been here. The same with some of the other specialties. That was very different than what I came from. Where I trained everything was very much collegial. There was nobody that really pushed anybody else around or felt that way.”

In addition to the inequality of status and respect among divisions, some medical faculty mentioned that there is also a disparity regarding the amount of formal recognition that divisions receive. This recognition came in the form of being featured more often in advertisements to solicit donations, and in media coverage for research and clinical work.
Performance-related outcomes of resource inequality. Both structural resource inequalities and psychosocial resource inequalities were perceived to be related to several outcomes that I grouped together as performance-related outcomes. I defined performance-related outcomes as consequences of resource inequality that are directly associated with job performance. This includes formal outcomes that factor into performance evaluations (e.g., research productivity), performance evaluations themselves, and the outcomes of performance evaluations (e.g., bonuses and promotions). It does not include informal outcomes that may still be valued by medical faculty such status and respect. The thematic analysis showed that performance-related outcomes were important, not only because differences in spread of these outcomes were a direct result of resource inequality, but also because they were highly valued by medical faculty.

Performance-related outcomes of resource inequality that exists among individuals. With regard to inequality among individuals, participants noted that the structural resource inequality enabled some medical faculty to achieve a higher level of research productivity than others. For example, having more funding or research grants enabled faculty to hire research assistants and obtain research equipment, which would help increase research productivity. Also, some faculty who were already well-regarded for their research were able to have even more of their time protected for their research work (i.e., they would be given less clinical and teaching responsibilities). This would allow them to produce even greater research output. Greater research productivity is important, not only because the research itself is valued highly by the hospital and medical faculty, but also because it is associated with all of the other valued performance-related outcomes; performance evaluations, promotions and salary/bonuses are all contingent on success in research.
Indeed, many participants noted differences in the salary and bonuses that individual medical faculty received (see Figure 2 – Performance-Related Outcomes – Inequality Among Individuals). In general, individual faculty did not complain that they made too little salary, but found it unjustifiable that there were such differences in pay when all faculty are doing important work. One participant observed, “I think those with greater seniority…certainly have financial advantages for equivalent workload,” while another noted, “[I know] because our salaries are published…there is a vast discrepancy in how well people are paid.”

**Performance-related outcomes of resource inequality that exists among divisions.** With regard to inequality among divisions, the only outcome that participants linked to inequality was salary (see Figure 2 – Performance-Related Outcomes – Inequality Among Divisions). Participants noted that it was unfair that there is a disparity in salary among divisions, with faculty in some divisions being paid more than those in other divisions based on the type of medicine they specialize in:

“There’s a little bit of institutional injustice. The fact that [division B], for example, gets paid more than [my division] and yet the training is the same. The billables are the same…I think things like that weigh on people, especially people that are new. They ask…why is that…why are they getting paid more when the risk we accept is greater. Our training is the same.”

**Inequality spiral.** The thematic analysis of the interviews revealed that it is possible for performance-related outcomes to feed into each other, as well as into structural and psychosocial resource. This creates a greater and greater cycle of inequality, or an inequality spiral. This idea is illustrated by the aphorism “the rich get richer and the poor get poorer.” For example, because research productivity is so highly valued, a medical faculty interviewee who is successful in their
research will get better performance evaluations. This will lead to more promotions and a better salary, which, along with the research success itself, will help the medical faculty member to secure even more resources. These resources will enable the medical faculty member to be even more successful in their research, and thus continue the spiral. With regard to the inequality spiral being a root cause of inequality, one participant noted:

“I think people would say that this institution in general values research and research productivity, research recognition and then less so, education and then less so, clinical care…I think the people that have made big achievements in the research end of things are highly valued. And I think people in the other areas are less valued and when they’re less valued, they’re given less opportunity to actually achieve in those other areas, so it’s a self-fulfilling prophecy.”

Given the cyclical nature of the inequality spiral, it is difficult to determine how much of the inequality that participants perceived was caused by the spiral itself versus how much of it was caused by personal, social and organizational roots of inequality (which are reviewed in the next section):

“What’s cause and effect is often hard to distinguish…Our most successful clinician scientists bring in grants that allows them to expand their group, they bring in more grants. That gets attention outside, they get connect[ions]…then you start to see [more] dollars come in…People who are less successful have less resources so…I’m not sure that there’s inequality at the outset.”

The inequality spiral described by participants is represented by the bidirectional arrows between types of structural resource inequalities, types of psychosocial resource inequalities, and performance-related outcomes in Figure 2. Those who have more resources are able to use them
to increase their productivity, get better performance evaluation, and get more promotions. This in turn, allows them to get even more resources; those with fewer resources are unable to perform research at the same level as those who have more resources, and are left at a significant disadvantage. In this way, performance-related outcomes are both a consequence and a cause of resource inequality.

**Psychological responses to resource inequality that exists among individuals and divisions.** Participants responded in a mostly negative manner to the various structural resource inequalities, psychosocial resource inequalities, and differences in performance-related outcomes they perceived. Responses to inequality among individuals and among divisions were quite similar (see Figure 2 – Psychological Responses to Resource Inequality). Therefore, unless otherwise stated, assume that the responses described here apply to both inequality among individuals and divisions.

Many of the responses to resource inequality could be characterized as negative attitudes, that is, feeling frustrated, resentful and undervalued in response to perceived inequality. Speaking about their frustration with salary inequality, one participant stated:

“So whether you are in [specialty E], whether you’re in [specialty F]…because our salaries are published, [we know] that there is a vast discrepancy in how well people are paid. I’m pretty even tempered but that’s a real frigging frustration for me because I know that I personally, do have a very high energy, work extremely long hours, and do intensive care but I sure as heck am not financially rewarded for – compared to my colleagues who do similar intensive care and are equally busy and equally engaged but get double my salary. You know, so that’s a frustration, no question.”
Furthermore, participants discussed feeling underappreciated due to differences they perceived among medical faculty. In response to inequality in formal recognition for achievements, one interviewee stated:

“There’s emails that go out regularly when someone has an article published and so everyone is shared in that information and that’s sort of more publicly announced…it’d be nice [if] maybe those emails are sent more [often] to the group for other work that people are doing…That would probably be nice to see. I think a lot of people would appreciate that. I do think some of my colleagues probably find their work is undervalued.”

Another participant spoke about similarly feeling undervalued in response to inequality in the quality and usability of their clinic space:

“Everybody [knows our clinic space is bad], even the most senior leadership…and yet, nobody will do anything about it…that’s extremely frustrating to our faculty members…and our staff in general because it just makes them feel like they’re third class citizens essentially. And, it’s true…It just makes…the people on our program feel incredibly undervalued because nobody is willing to really…do what it takes to give us the space that we need and we’re not picky at all. We’re not asking for beautiful space like the [other division] clinic…We’re just asking for something that’s livable.”

Participants also spoke at length about how the inequality they perceived led to feelings of unfairness. These feelings were associated with perceived violations of three main types of organizational justice: distributive justice, procedural justice, and interactional justice. Distributive justice is concerned with outcomes, specifically the allocation of goods in a socially just manner (Deutsch, 1985). One would expect those who are lower in status to react negatively
to violations of distributive justice (Kramer & Tyler, 1996). However, even participants from higher status divisions acknowledged that the distribution of resources was unfair:

Interviewer: Do you think it’s fair the way resources are distributed?

Interviewee: Well, I don’t…the very basic understanding I get though is that when someone comes to take a leadership position, as a division head, part of their contract negotiation is to bring resources to their division to do more and…now that we’re looking for a new division chief in [my division], I find it troubling to think that they could bring more resources to bear into [my division] that already has so many resources.

Another medical faculty interviewee from a higher status division felt the opposite. They believed that that others’ perception and resentment of their division was not always fair or accurate, and they had to sometimes fight for needed resources:

“I do think there is a not always an accurate sense of the have divisions and the have not divisions in the hospital, and sometimes some conflict or resentment about that, with [my division] being seen as a rich division that has all of these things, and I don’t think people necessarily have an accurate view of that…sometimes we do get comments…we’re fighting for a trainee say to be funded and it’s like, but you already have that and because it’s not always reality, I do think it sometimes makes it more difficult for people to believe that what I’m asking for I really do need, and I really don’t have my own resources for it.”

Interviewees also discussed how they felt the inequality of resources was unfair because it violated their sense of procedural justice, which refers to the fairness of the process through which decisions are made or resources are distributed (Folger & Konovsky, 1989). Regarding the promotion process, one participant noted that the promotion process was unfair and made them
feel undervalued because educators are promoted at a lower rate than researchers:

“I think as an educator, [it’s] much harder to get promoted than a researcher. So, I think if you look at the number of educators who would go to promotion for full professors, it’s probably a lot less than researchers and it takes a lot longer to get promoted. And, I don’t think that some of the stuff that we do in education is as valued. We don’t have that you know, high impact journal that you get published, whatever. So, I’m not sure it’s as a fair process.”

Informational justice (a component of interactional justice) refers to the quality and accuracy of information given to employees about why certain processes were used or how certain outcomes came about (Greenberg, 1993). Some participants were unsatisfied with the lack of informational justice with regard to the bonus and promotion process, with one interviewee claiming that:

“I think there’s always been a question as to whether your bonus reflected your work for the year, achieving your goals, outstanding work…it’d be nice if it was just more transparent and is it about clinical excellence, is it about academic excellence, is it about the whole thing?”

Perceived resource inequality among divisions also had an effect on participants’ commitment towards their organization. When asked about the effect of differences between their division and higher-status divisions, one interviewee stated that they thought it was so bad that it forced many medical faculty in their division to leave the hospital and seek other opportunities:

“It has had a big effect for some people in [my division], and their effect is shared with other people, which then has its own follow-through effect. We actually had…in the last
three and half years, we had…it’s a third of our staff, [they] left for opportunities that were paid better, had better professional opportunities and all of them had better quality of life, all of them across the board. They either went to primary care, or they went to a hospital that offered no nights, weekends, double the salary, some of the offers had all of those things.”

Inequality among divisions also affected medical faculty’s sense of well-being by negatively impacting interpersonal relationships. Specifically, medical faculty from lower-status divisions felt they were not being recognized and respected by faculty from higher-status divisions:

“I think that internal recognition and respect…and respect from colleagues in similar positions outside this institution, all that is incredibly motivating and driving. I think that’s a lot of what academic medicine is about…it goes back to that institutional injustice here where there are tiers of respect and I think that has been reflected in how people deal with other people. So for example, [division G] gets paid more. I think they have an inherent sense that they are worth more. [It] was shocking to me when I arrived that that’s how people behaved here…Because I think that does permeate and it does erode at the sense of well-being here.”

However, some participants responded somewhat positively to inequality among divisions. For example, some faculty, while acknowledging that the distribution of resources, such as donations, among divisions was unequal, believed that it was justified for the most part. They felt that people chose their own specialization knowing that some would be more well-resourced than others:

Interviewer: Do you think it’s appropriate the difference between the divisions?
Interviewee: I think it’s the way it works…should I not take money for [my division] because it’s not fair to the guys in [division D]? Of course not. It’s just bad luck you chose the wrong organs. If you really want your money…go into a different [specialization]…it’s just the nature of the way things are. You got to accept that.

Some interviewees also reasoned that the hospital has no choice but to prioritize some areas over others, and as a result some people and divisions will benefit from it and others will lose out:

Interviewer: Do you think that any group membership (e.g., division, job profile) comes into play in terms of who gets what?

Interviewee: 100% and that’s appropriate cause every institution you have to have priorities…institutionally you are going to get recognition if you are in line with an institution’s goals and then funding-wise whenever there is a crunch obviously the institution has to prioritize…nobody can be everything to everybody. So every institution has pick priorities…I’m not sure if the [right] word is…fair, but you have to as an institution pick priorities, you have no choice.

Some other participants from higher status divisions also acknowledged that the distribution of resources was unfair, but were reluctant to complain about the situation because they directly benefited from it:

Interviewer: Do you feel it’s appropriate the way things are distributed?

Interviewee: No. But, I’m not gonna complain because I’ve been the lucky recipient of some of those things. You know what I mean? I don’t think it’s fair but I think that I’m benefiting from it.

Overall, many participants felt that the resource inequality they perceived among individuals and divisions was unfair. Although some medical faculty did see it as appropriate and
unavoidable, many others believed that it was unjustified. In response to the resource inequality, many interviewees talked about being frustrated, resentful, and feeling undervalued by the institution. They also felt that the inequality negatively impacted commitment towards the organization, and damaged interpersonal relationships among medical faculty in different divisions.

**Personal, social and organizational roots of resource inequality.** It is clear that many participants responded quite negatively to the resource inequality they perceived. To understand why and to create solutions to reduce the effects of excessive inequality, it is important to first try to understand where the inequalities come from. Understanding the sources of inequality may also help shed light on why people respond differently to different types of resources and where those responses come from. Interviewees spoke about many different causes of the resource inequality they perceived. Some of them are quite specific to this particular organization, while others could apply to a broader range of workplaces. The sources of inequality among individuals compared to divisions were quite distinct, so they will be reviewed separately.

**Personal, social and organizational roots of resource inequality that exists among individuals.** Some of the causes of inequality among individuals were related to individual differences among medical faculty (see Figure 2 – Personal, Social and Organizational Roots of Inequality – Inequality Among Individuals). First of all, medical faculty acknowledged that some of the resource inequality they observed is simply based on merit. Some faculty are very talented researchers and are very good at writing grant proposals which would lead to more respect, recognition, funding and grants. Differences in individuals’ negotiation abilities also led to inequalities in the resources they had available to conduct their research:
“If someone is able to negotiate start-up money for their research, then you’re able to hire assistants [etc.]…it’s all about what you can get for yourself and I think some people are better at advocating or negotiating those things.”

There were also sources of resource inequality among individuals that were rooted in the structure of the organization. The first was that, depending on their job profile, medical faculty had different levels of financial support for their research. Inequality in salary, which many participants reacted quite negatively to, was also thought to be rooted, at least partly, in bias in the evaluation process. Faculty felt that evaluations focused too strongly on research, and ignored other important things they did to support the organization and care for patients:

“The tri-annual [review], I’m a little bit less convinced about how well it is really able to recognize non-research accomplishments…I think if you’re doing a lot of great things in your own institution and really supportive of your institution as a whole…it’s almost like it’s not good enough…if you don’t get to that national and international [level]…that’s always struck me as a bit unfair…The only way to go up on the salary scale is through the tri-annual review process.”

Participants felt that research success was over-represented in the evaluation process, partly because research success is easier to quantify than clinical success:

“The evaluation process for the annual performance review is fairly subjective. There are precious few formalized guidelines about what defines a person who is doing…an excellent job versus people who are performing below [expectations]…it may be that people who do research are more easily recognized as being exceptional because of the very easy matrix around…citation index, impact factors, the numbers of grants, the
amount of money that’s brought in, [etc.]…it’s harder to identify the people who are
doing exceptional work in the clinic.”

Some participants also felt that division heads can be a source of inequality, as performance
evaluations may be biased by an individual’s relationship with their division head or by
characteristics of the division head. Therefore, the individual characteristics of both medical
faculty and division heads can contribute to resource inequality.

“I do recognize that [the annual review process] is quite dependent to some extent on the
characteristics of the division head and could be subject to individual relationships with
division heads. I think that’s a bit of a danger almost in the system.”

Overall, there were a variety of perceived causes of resource inequality among
individuals. Some were related to individual differences among medical faculty, such as
negotiation skill, merit, and political savvy. Others were related to bias in the structure of the
organization, including perceived bias in the performance evaluation system, preference for
those with higher status, and job profile.

**Personal, social and organizational roots of resource inequality that exists among divisions.** Most of the root causes of resource inequality among divisions were quite different
from the causes of resource inequality among individuals (see Figure 2 – Personal, Social and
Organizational Roots of Inequality – Inequality Among Divisions). Medical faculty indicated
that the quality of division heads could have a significant effect on inequality among divisions in
several ways. They noted that there is a difference in the social support provided by division
heads:

“I had an extremely fine division chief…they were really good, they were really
supportive. A division chief is really, really important, they got to have really good
people skills and be really good themselves, that takes a special person, somebody balanced…but I certainly know [the quality of division chiefs] varies.”

Some division heads were also better than others at advocating for their divisions within the hospital and securing more resources for them:

“I think that [the inequality] is probably something to do with clinical revenues in those areas that generate more revenue for the hospital tend to be better resourced I think. It is probably a personality style as well with the leadership and those who will not tolerate less tend to get more.”

Participants also felt that some division heads are better connected than others, and can use those connections to promote their division:

“It’s, you know, how powerful is the division chief? How good a friend is he or she of the department chair? Who do they know on the board? You know, how well connected are they? I mean those things do matter. I’m afraid at [this hospital] they do matter.”

It was also noted that some division heads did not do a good job of motivating and encouraging their divisions to perform at a high level, which led to status inequality:

“I think our division is not seen as highly in this department as other divisions and our division head you know, is not really pushing the productivity like other division heads are and because of that, we’re not succeeding as well. And, there is a clear distinction between our division and like academic productivity than compared to other small divisions.”

One source of resource inequality among divisions that was unrelated to the characteristics of division heads was competition. Although many medical faculty emphasized
the good relations among divisions, it was also acknowledged that competition among divisions led to increased resource inequality:

“There is a very deep siloed and hierarchical structure within all the divisions…that make working together somewhat difficult because it becomes quite competitive; competitive for resources, prestige …I think [the unfair distribution of resources is] a result of that silo nature. If you are really successful, [you] grab [and hold onto the resources], even within the department. You can grab and hold on to more stuff. If you are successful bringing money into the hospital, a lot of it is your money because you brought it in as opposed to saying okay well that’s nice, bring the money in and we’ll split it up. So that’s not fair but again it’s a systematic thing that’s been around [for a long time].”

Overall, participants felt that differences among division heads in their ability to advocate, their connections, and the social support they provided, in addition to competition led to inequality of resources among divisions.

**Section II: Demand Inequality**

**Structural demand inequality.** I now turn my analysis to the inequality of demands. I again categorized the demand inequalities that were most salient to participants into two main groups: structural demands and psychosocial demands. I defined structural demands as physical or organizational aspects of the job that are undesirable, and are associated with physical, mental or emotional costs (e.g., working overnight; Bakker & Demerouti, 2007). Some structural demands were seen as being unequal among individuals, while others were viewed as being unequal among both individuals and divisions.

**Structural demand inequality that exists among individuals.** Many participants noted differences in the amount of workload that individual faculty had (Figure 3 – Types of Structural
Demand Inequalities – Inequality Among Individuals. Aside from talking about overall workload, they described perceiving workload inequality in the three specific areas of clinical, teaching, and administrative work. For example, with regard to inequality in clinical workload, one participant noted that some faculty who had great achievements in research were able to avoid work that was undesirable:

“I think some faculty members are very good at being very clear about what they will not do. So they’re very good in dividing their time and saying I will not deal with this issue, I will only deal with this issue…that behaviour is accepted because they have certain achievements that may or may not have anything to do with that.”

A second type of structural demand inequality among individuals that participants observed was flexibility in scheduling. Some faculty members had less control over their schedules than others. Because of this, the demands and stress associated with childcare and other personal responsibilities were intensified, compared with those who had more control over their scheduling.

**Structural demand inequality that exists among divisions.** Among divisions, participants identified similar discrepancies in structural demands (Figure 3 – Types of Structural Demand Inequalities – Inequality Among Divisions). The various divisions had different levels of clinical workload depending on the type of medicine they practiced. Some divisions needed to see a higher number of patients than others, or were required to take on more complex and demanding cases. For example, one participant mentioned: “Some clinical areas are more demanding than others, just the patient volumes are huge and patients are very unwell, that are very, very, very demanding, so that would be another [type of demand inequality] as well.” The issue of scheduling flexibility at the division level was also brought up by participants. They noted that,
based on the type of medicine they practiced, medical faculty in some divisions had more freedom than faculty in other divisions to set their work hours around commitments in their personal lives.

**Psychosocial demand inequality.** Participants also highlighted several psychosocial demand inequalities among medical faculty that they perceived. Psychosocial demands are environmental, social and psychological factors that required sustained effort and are valued negatively (e.g., interpersonal conflict; Bakker & Demerouti, 2007).

**Psychosocial demand inequality that exists among individuals.** Participants talked about how there are differences among individual medical faculty in the expectations put on them to perform academically (Figure 3 – Types of Psychosocial Demand Inequalities – Inequality Among Individuals). Some of this pressure is tied to the individual job profiles of medical faculty and how much of their time they are supposed to be devoting to research. All medical faculty felt pressure to perform academically, but those with job profiles that were focused on research felt this pressure even more. Related to this point, many participants noted that they felt the hospital values research much more than clinical or educational work, and this caused inequality among faculty in the pressure and stress they felt to achieve a good rating on their performance evaluations.

**Psychosocial demand inequality that exists among divisions.** Participants felt that there were differences in conflict climate among divisions (see Figure 3 – Types of Psychosocial Demand Inequalities – Inequality Among Divisions). Conflict climate refers to patterns of attitudes and behaviours that encourage or discourage conflict. Some participants noted that, in general, interpersonal relationships among faculty in their divisions were quite good, while
others reported that their divisions seemed to be prone to interpersonal conflict among medical faculty. For example, one participant said:

“There’s two really strong camps [in my division] and they’re [at] very extreme ends of the spectrum…and the political animosity between those two groups is quite intense and for those of us that are trying to walk the line in the middle it can be really challenging…I don’t want to be labelled as being in one camp or another but there is this constant tension, it’s toxic between these two camps.”

**Psychological responses to demand inequality that exists among individuals and divisions.** Just as with resource inequality, participants responded similarly to both demand inequality that exists among individuals and among divisions. Medical faculty felt frustration and resentment in response to demand inequality (Figure 3 – Psychological Responses to Demand Inequality), but it was not to the same degree as with resource inequality. Regarding workload inequality one participant commented that medical faculty felt frustrated when they had to do work that they knew other faculty did not have to do:

“We talk the talk about…portfolios being equivalent, and everybody working hard, and everybody [being] in it together for the good of the whole, but the reality is that, that is not the case and I’m well aware that that causes more frustration for some people than for others to the point that it’s not unusual for me to hear why should I do that because he’s not doing it and she’s not doing it.”

Perceived inequality in clinical load also caused some interviewees to burn out and feel resentment towards their colleagues:

“Some of the burnout I had earlier was when the clinical demands were so constant and there was such an imbalance between…my clinical load and colleague’s clinical load.
Especially when you’re new…there’s like resentment that builds up and you don’t feel like it’s of your choosing. Those are the times when it was more negative psychologically.”

Another participant spoke about how they felt it was unfair that some medical faculty had less clinical demands placed on them because of their achievements in research:

“I’ve seen…examples of people that are not willing to do certain clinical care because they’re some big hot shot in the research institute for example…So are some people treated differently? Yes some people are treated differently…it’s probably not appropriate or fair.”

Interviewees also commonly responded to demand inequality by justifying it in a manner that appeared to make excuses for it, that is, they attempted to explain the demand inequality they perceived in a seemingly plausible manner. Individuals may engage in this type of excuse-making to prevent anxiety and protect self-esteem (Bateman & Holmes, 1995). For example, some participants felt that differing demands would balance out in the end, even if some faculty used their status to avoid certain undesirable demands such as administrative workload:

“Specifically related to…providing assistance and advice with administrative service delivery and quality, some people just manage to completely avoid that. They’re not interested and they have other things. They’re seen as having other important things going on so it’s sort of okay to not ask for their time. They probably have a whole bunch of other demands I don’t know about that I don’t help with so I assume that everyone is pulling their weight in different ways.”
Another participant acknowledged that even though medical faculty with different job profiles will have differing levels of clinical and research demands, they all equally feel the stress of those demands:

“[I think] in the past…there has been misperceptions [that] maybe the people who do most clinical work, they might have thought that…they are doing a lot of really busy clinical work, and they have it really tough, and then [those who do clinical work think that] the researchers, it’s a little bit easier for them. And then, on the other side, the researchers think…it’s such a challenging environment. [The researchers think that] the clinical people just get to do the work and then go home. But, I think there’s a much better understanding now. Everybody understands [that] even though we all have very different job descriptions, everybody is very stressed because there’s a lot of demands on all sides.”

Regarding clinical workload and scheduling flexibility differences among divisions, participants felt that differences were inevitable due to the unique characteristics of each specialization of medicine, and that medical faculty knew what they were getting into when they chose their specialization. They also felt that demands were inevitable in medicine and there was little sense in complaining about the differences:

Interviewer: Do you think it’s fair the way these different demands are distributed?
Interviewee: I mean sure. I guess I could say I think it’s fair…I’m not happy about it but it’s fair…I think I certainly would enjoy more time to do the non-clinical things that I do. On the other hand, then someone has to do the clinical work and who’s going to do it. It’s not going to be the scientists. Who is that going to be? Has to be someone.
Overall, although participants responded to demand inequality with frustration and resentment, they did not do so to the same degree as with resource inequality. Medical faculty also seemed motivated to make excuses for the demand inequality they perceived as simply being part of their jobs.

**Personal, social and organizational roots of demand inequality.** It is important to understand where demand inequality comes from. Knowing what people believe to be the sources of the demand inequality they perceive will help to understand why they respond to it differently (e.g., resource vs. demand inequality, inequality among individuals vs. divisions) and where those responses come from. This understanding may also help guide the development of any potential solutions to decrease demand inequality. Many of the sources of demand inequalities that participants talked about were quite similar to the sources of resource inequalities. This is not surprising, as many of them are rooted in the structure of the organization and the practice of medicine itself. As with resource inequality, the sources of demand inequality among individuals and among divisions were quite distinct, so they will be reviewed separately.

**Personal, social and organizational roots of demand inequality that exists among individuals.** There were several distinct sources of demand inequality among individuals (Figure 3 – Personal, Social and Organizational Roots of Inequality – Inequality Among Individuals). Due to their specific job profiles, some medical faculty were required to take on a bigger part of the clinical workload, which could be quite taxing, especially during busier times. Participants also felt that some medical faculty use their higher status or negotiation skills to avoid undesirable work tasks (e.g., clinical care responsibilities). Another cause of demand inequality
among individuals was individual differences in engagement, which led to an unequal
distribution of workload:

“There is most definitely not the same level of engagement across faculty…some of my
colleagues…are always whining about how much work they have to do and the ones that
there’s no point even asking them to do something because they will say they will do it
but they don’t follow through…that old adage if you want something done ask a busy
person is never truer than with medical faculty.”

A final source of demand inequality among individuals was interpersonal conflict. Some
division heads were less able to manage conflict within their divisions. This led to greater
workload for some of the employees in those divisions:

“I don’t think [demands are] equally distributed, no. I think some people are conflict
averse especially in my division and because of that, things aren’t spreading evenly
because you know, my leader may not want to confront the person that they are in
conflict with so they just kind of leave [the individual they are in conflict with] to do their
own thing and then, the other demands get spread amongst the people that [the leader] is
able to work with. So, I feel like personal conflict affects equal spread of workload.”

**Personal, social and organizational roots of demand inequality that exists among
divisions.** Demand inequality among divisions had quite different causes than among individuals
(Figure 3 – Personal, Social and Organizational Roots of Inequality – Inequality Among
Divisions). With regard to inequality in conflict climate within divisions, some division heads
had the necessary interpersonal skills to manage conflict within the division, while others did
not:
“There are divisions I think that are far more dysfunctional than the division that I’m in…we’ve got a strong division chief who values everybody within the division. Values people’s individual contributions and who’s a good peacemaker when there are disputes. There are divisions where there are very strong personalities that don’t get along with each other and where the division chief has not been able to reach any kind of accord within the division and so there’s great stress within those divisions.”

An additional source of demand inequality among divisions was the specific specialization of medicine that each division practiced. Patient volume and difficulty of cases varied among divisions. Participants made a clear connection between each specialization of medicine, and the clinical and schedule demands they had:

I think people make choices about their specialty and how they do their work. For example…I think trainees when they’re making choices…I always tell them, you know certain specialties you will sleep in a hospital. You will be here late. You will come in on the weekends and some you won’t. So, to some extent it is appropriate. It’s you’re choosing a busier field or not.

Overall, participants felt that differences in the quality of division heads and their ability to manage conflict, as well as the unique nature of the type of medicine each division practices caused demand inequality among divisions, while differences in engagement and status caused demand inequality among individuals.

Section III: Differences in Perceptions of and Responses to Inequality

In this section, I will present the results of the conceptually clustered matrix display table analysis which examined how level of resources, level of demands, and leadership position affect perceptions of inequality, evaluations of inequality, and stress. The section concludes with an
examination of the relation between perceptions of inequality, evaluations of inequality, and stress. Researching question three regarding what makes employees perceive there to be higher versus lower levels of inequality is addressed in Tables 3a, 4a, and 5c. Research question five concerning what makes employees evaluate inequality more positively or negatively is explored in Tables 3b, 4b, 5d, and 6a.

Individual level of resources. I first wanted to explore whether medical faculty who were higher or lower in their individual level of resources differed in how they perceived or responded to inequality. People who have more resources can use those resources to alleviate work and personal demands, complete their daily work, achieve long-term work goals, and get better performance evaluations. Therefore, those with more resources may be motivated to maintain the status quo, and see less inequality and respond less negatively to it.

To determine participants’ individual level of resources, I reviewed all of the data excerpts from each participant that referenced the resources they had available to them. I used this information to rate each participant as being higher or lower in the individual level of resources they each had. Ratings of individual level of resources were relative. Those who were rated as higher in resources had noticeably more resources than those who were rated as lower, but all participants had the necessary basic resources to complete their various job functions. As an example, one of the participants who was placed in the higher individual resources group spoke about all of the research equipment they had access to through their mentor:

“I have a good relationship with my mentor and they have a big lab, big operation, lot of funds and [they] have access to equipment that is far beyond the reach of any junior investigator and [they have] granted me access to these resource for free essentially.”
In contrast, a participant who was lower in their level of resources detailed how they never had the equipment and supplies they needed:

“When it comes to equipment and supplies, you never have what you need. You’re always fighting for new and improved technology because we are a technology driven specialty…and we don’t have the necessary capital to purchase the equipment that we need when we need it.”

*The relation between individual level of resources and perceived level of inequality.*

The matrix display tables for individual level of resources are shown in Tables 3a to 3c. It was quite apparent that participants who were lower in their own level of individual resources perceived there to be more inequality than those who had higher levels of individual resources (see Table 3a). The majority of those higher in individual resources were rated as having moderate perceptions of the level of inequality. It is also interestingly to note that very few participants, regardless of their individual level of resources, were rated as having a perception of less inequality in the hospital; most perceived the level of inequality as being moderate or higher.

*The relation between individual level of resources and evaluations of inequality.*

Participants who were lower in individual resources also responded more negatively to inequality than those who were higher in individual resources (see Table 3b). Most participants who were lower in individual resources were negative toward the inequality, while the majority of those higher in individual resources were either neutral or positive towards inequality. Again, it is notable that most participants were rated as either negative or neutral towards inequality they perceived, with only a handful being positive towards it.

*The relation between individual level of resources and stress.* Most participants were rated as having a moderate level of stress, while some others were either higher or lower. In
general, participants who were lower in individual resources had higher stress than those who were higher in individual resources (see Table 3c). Most participants who were lower in individual resources, were rated as having higher or moderate stress, while most of those higher in individual resources were either lower or moderate.

**Individual level of demands.** Next, I examined whether medical faculty who were higher or lower in their individual level of demands differed in how they perceived or responded to inequality. People who have fewer demands will likely experience less stress, better well-being, and have more time and energy to devote to achieving their work goals (Bakker & Demerouti, 2007). Therefore, just like those who have more resources, people with fewer demands may want to keep things the way they are, and be motivated to see less inequality and respond to it less negatively.

I adopted a similar approach to the one used for individual level of resources to rate each participant as higher or lower in their individual level of demands. Ratings of individual level of demands were relative. Those who were rated as higher in demands had noticeably more demands than those who were rated as lower, but given the type of work that they do, all participants faced significant demands in their day-to-day jobs. One participant in the higher demands group said of their workload:

“The downside is to do this work optimally requires long hours, a lot of on call and a lot of work beyond the end of the typical day. It’s normal for me to take work home every night of the week and it’s very normal for me to work every weekend at some point.”

In comparison, a participant who was lower in their individual level of demands said the only main negative part of their job was long meetings:

Interviewer: “What do you like least about your job?”
Interviewee: “I actually have a hard time finding a negative…well meetings…it’s not so much that the meetings are bad, but…meetings take up a lot of time so it’s probably more the time.”

**The relation between individual level of demands and perceived level of inequality.** The matrix display tables for individual level of demands are shown in Tables 4a to 4c. There did not seem to be any differences in perceptions of the level of inequality between those lower in individual demands and those who were higher in individual demands (see Table 4a). Most participants, regardless of their individual level of demands, tended to perceive a moderate or higher level of inequality. This finding is in agreement with the results of the thematic analysis, which suggested that medical faculty tend to make excuses for the demand inequalities they see and attempt to legitimize it because they believe demands are inevitable in medicine.

**The relation between individual level of demands and evaluations of inequality.** Similarly, medical faculty who were higher in individual demands did not differ in their evaluations of inequality from those who were lower in individual demands (see Table 4b). Most were either neutral or negative towards the inequality.

**The relation between individual level of demands and stress.** However, medical faculty’s level of stress did differ based on their individual level of demands. Most participants who had a lower level of individual demands had moderate to lower levels of stress, while the majority of those who had a higher level of individual demands had higher or moderate stress and well-being (see Table 4c).

**Leadership status.** Finally, I wanted to determine whether medical faculty who were in leadership positions differed in how they perceived or responded to inequality compared to those

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1 This analysis was added at the request of a committee member, who was specifically interested in the effect of leadership status on perceptions of and reactions to inequality.
who did not hold leadership positions. Leaders are in a more desirable position than non-leaders because they have more power, status and respect, and they usually also have access to more resources. Resources are important because they can be used to achieve work goals and avoid demands. Therefore, those in leadership positions may be motivated to see less inequality and view inequality as being less important because that will help them to maintain their position. Participants clearly indicated when they were a division head or the director of a specific program or group within the hospital; those participants were put in the leader group. All other participants were placed in the non-leader group.

The relation between leadership status and individual level of demands. The matrix display tables for leadership status are shown in Tables 5a to 5e. Leaders appeared to have somewhat lower individual level of demands than non-leaders, although the pattern was not very clear (see Table 5a). It could be argued that leaders should have lower demands than non-leaders because they can use their position or their resources to avoid undesirable demands. On the other, it could be that leaders have higher demands than non-leaders because of the additional responsibilities and pressure associated with their leadership position. These findings do not clearly provide support for one supposition or the other.

The relation between leadership status and individual level of resources. Unlike demands, leaders should clearly be expected to have access to more resources than non-leaders. Surprisingly this was not the case for medical faculty; leaders did not seem to differ from non-leaders in their individual level of resources (see Table 5b). This finding may be unique to this organization. The interviews suggested that most leaders in the hospital have little direct control over resources, and that their main role is to advocate for their division or team.
The relation between leadership status and perceptions of level of inequality. Leaders did, however, appear to perceive less inequality than non-leaders, although again the pattern was not very clear (see Table 5c). Most leaders perceived a moderate level of inequality, while most non-leaders perceived more inequality.

The relation between leadership status and evaluations of inequality. Leaders did not seem to differ from non-leaders in their evaluations of inequality (see Table 5d). Both groups had a range of reactions from positive to negative, although most were neutral or negative, regardless of leadership status.

The relation between leadership status and stress. There also did not appear to be any differences in stress between leaders and non-leaders (see Table 5e). Given that leaders in the department do not seem to have access to more resources than their subordinates, it makes sense that they would not have less stress than their subordinates. This may also explain why leaders did not significantly differ from non-leaders in their perceptions and evaluations of inequality. The findings from the matrix display tables for individual level of resources suggest that those with fewer resources perceive more inequality and evaluate it more negatively than those with more resources (see Tables 3a and 3b). So, if leaders do not differ from non-leaders in their individual level of resources, then it is not surprising that their perceptions and evaluations of inequality are quite similar.

Perceptions and evaluations of inequality. Research questions three and five concerned what makes employees perceive and evaluate inequality differently. This raises the question of how or if perceptions and evaluations of inequality are related. Perceptions can drive attitudes and emotions (e.g., Rundmo & Iverson, 2004; Wright, Taylor & Moghaddam, 1990). Participants who were lower in individual resources perceived more inequality and responded to
it more negatively than those who were higher in individual resources (see Tables 3a and 3b), suggesting that perceptions of inequality may affect evaluations.

**The relation between evaluations and perceptions of level of inequality.** Those who perceived more inequality tended to be negative toward it, while those who perceived a moderate level of inequality were mostly neutral or positive toward it (see Table 6a). Too few participants perceived less inequality to draw firm conclusions about them, but it also appears that they were neutral or positive toward it.

**The relation between evaluations and perceptions of level of inequality, and stress.** Medical faculty’s who perceived more inequality seemed, in general, to have higher stress than faculty who perceived a moderate or lower level of inequality (see Table 6b). Similarly, medical faculty who were negative towards inequality had higher stress than those who were neutral or positive towards inequality (see Table 6c). However, it should be noted that both of these patterns are relatively weak compared to some of the other findings presented in this section, and they are also partly based on matrix display tables that had very few participants assigned to some of their groups.

**Discussion**

This study found that, although differences exist (e.g., those at the bottom of the hierarchy perceive more inequality and are more negative toward it than those at the top, reactions to inequality are stronger among divisions than among individuals), regardless of their relative level of resources, employees in general reacted negatively to too much perceived inequality in the workplace. In particular, employees are sensitive to perceived inequalities in structural resources (e.g., research equipment) that help them to achieve valued performance-related outcomes (e.g., research productivity, bonuses). These outcomes were often related to
perceived psychosocial resource inequalities that participants were sensitive to, such as status and formal recognition. This relationship between structural resources, psychosocial resources and outcomes led to the unexpected finding of an inequality spiral, that is, a greater and greater cycle of inequality that feeds into itself. These perceived inequalities in resources and outcomes led to low job satisfaction and employees feeling undervalued and frustrated. Perceived structural (e.g., clinical workload) and psychosocial (e.g., conflict climate) demand inequalities did not lead to an inequality spiral, as employees did not strongly link them to valued work outcomes. Therefore, although they did respond with feelings of resentment and frustration, it was not as strong as with resource inequality. Surprisingly, interviewees tended to make excuses to legitimize perceived demand inequalities, which they did not do for resource inequalities. This discussion will expand on these main findings, theoretical implications, and practical recommendations for this research.

**Main Findings**

Despite efforts to carefully word the interview questions, participants at times spoke about their experiences of inequity rather than inequality, especially in relation to performance evaluations. They sometimes talked about inequity and inequality in a confused manner (e.g., citing an example of what they thought was inequality, when in fact it was about inequity). This meant that the analysis of the interviews had to be done carefully to differentiate between participants’ talk of inequity and inequality. This study includes only findings that were interpreted as participants’ talk of inequality rather than inequity. Despite the fact that it was clear that participants were sensitive to workplace inequality and understood what it was, the interviews also made it apparent that inequality and inequity are closely entwined in the minds of many people. Although care was taken to ensure that participants understood the study was about
inequality rather than inequity, this finding is not surprising given that the two concepts are both components of distributive justice and often confused with each other, and that in workplace settings distributive justice is often thought to be determined through equity rather than equality (Greenberg, 1990).

**Resource inequality.** The thematic analysis found a number of structural and psychosocial resource and demand inequalities that medical faculty both valued the most and were most sensitive to when they perceived them to be distributed unequally. Some important structural resource inequalities participants identified were access to research/clinical equipment necessary to do their work well, being provided with high-quality administrative support, and access to formal training opportunities for professional development. Salient psychosocial resource inequalities included formal recognition from the organization (e.g., email highlighting accomplishments), and the leadership abilities of division heads.

Reactions to perceived resource and demand inequalities were both negative. However, reactions toward resource inequality were stronger than toward demand inequality. It is possible that (at least in this organization) resources are more important than demands in completing daily work, achieving long-term work goals, getting positive performance evaluations, receiving promotions/raises, etc. This conclusion is bolstered by the fact that the inequality spiral emerged for perceived resource inequality, but not demand inequality. Participants clearly made a link between resource inequality and the outcomes that they valued, but did not make the same connection for demand inequality. Therefore, it is unsurprising that participants were more sensitive to resource inequality compared to demand inequality.

**Demand inequality.** On the demands side, participants talked about structural demand inequalities such as scheduling flexibility and clinical workload (both number and difficulty of
cases), and psychosocial demand inequalities such as conflict climate within divisions, and the pressure to perform academically. Interestingly, while the leadership ability of department heads was seen as a resource, it was also a cause of perceived demand inequality. Some employees were more difficult to work with than others (e.g., abrasive with leaders and other staff, feel entitled to avoid undesirable tasks because of high status) and this created more inequality in conflict climate and workload unless a good leader was present who could manage these issues.

The finding that demand inequality is less salient than resource inequality may not be applicable to all organizations or professions. Physicians may be less sensitive to demands and demand inequalities because they are taught to endure the pressure and demands their work places on them (e.g., long work hours, erratic schedules, putting patients’ needs above their own; Lundgren et al., 2001; Maslach & Goldber, 1998; Roberts et al., 2005). The interviews also made it clear that this is a highly engaged, achievement-oriented group of employees, so they may be more willing to put up with demands than other employees. Individuals in other occupations or organizations will undoubtedly have different specific resources and demands that they place particular value on, and they may be more sensitive to demand inequalities compared to this sample. For example, retail employees may be very sensitive to inequalities in demands such as the number of weekend/holiday shifts they are required to work.

It is notable that excuse-making occurred in response to perceived demand inequality, but in general did not occur in response to resource inequality. Participants attempted to legitimize demand inequality by making excuses for it, but did not do so for resource inequality. It is possible that participants tried to make excuses for some of the demand inequalities they perceived in order to avoid the negative emotions associated with being treated unfairly (Bateman & Holmes, 1995).
Demand inequalities may have also been seen to be inevitable, whereas resource inequalities were not. That is, participants may have felt that resource inequalities could and should be addressed by the organization, whereas demand inequalities were seen to be an inherent part of the practice of medicine. This is supported by the finding that those higher in level of demands did not differ in their evaluations of inequality from those lower in level of demands. Medical faculty presumably attributed perceived differences in demands (e.g., clinical workload between divisions) as being uncontrollable (i.e., due to the nature of medical practice), or made internal attributions about it related to their own choice of specialization (e.g., choosing a specialization that requires overnight or weekend shifts). Therefore, they may have responded to these attributions with a sense of passivity or helplessness (Campbell & Martinko, 1998) and concluded that little could be done to address demand inequality.

With resource inequality, participants may have made external attributions, blaming the inequality on the policies or culture of the hospital. For example, the hospital has no control over which divisions must see more patients, or tackle more difficult or emotionally draining clinical cases. On the other hand, the organization may be seen to have control over the distribution of resources such as salary, clinical space, and formal recognition. Therefore, it may be that employees believed the organization was more directly responsible for resource inequality compared to demand inequality, so they felt more frustration and anger in response to resource inequality. This would be in agreement with attribution theory (Aquino, Douglas & Martinko, 2004; Heider, 1958).

Inequality among divisions vs. inequality among individuals. It was observed that when participants viewed inequality to be illegitimate, they evaluated it negatively. There are several conclusions that can be drawn regarding the factors that affect employees’ evaluations
and judgments of the legitimacy of the inequality they perceive. First, it is interesting to note that although they had overlapping roots, types, and responses, participants readily differentiated between inequality that exists among individuals and inequality that exists among divisions, with negative reactions toward inequality among divisions being stronger. It may have been easier for participants to explain or justify perceived differences between individuals compared to differences between divisions. If an individual has better research equipment than her colleagues, it could be justified because she has many publications in top journals or she is very good at writing grant proposals. However, if all medical faculty in one division have better research equipment than those in other divisions, it is easier to see the difference and more difficult to explain it as being fair.

The finding that negative reactions toward perceived inequality among divisions was stronger than among individuals is consistent with attribution theory, which concerns how people assign causes to behaviours and events they see (Fiske & Taylor, 1991). Internal attributions refer to assigning the cause of a behaviour or observation to some internal characteristic, rather than an outside force (Heider, 1958). External attributions are made when the cause is believed to be outside of the person’s control (Heider, 1958). Controllability of an attribution refers to the extent to which an individual believes they can influence an outcome (e.g., skill vs luck; Weiner et al., 1971). Attributions made about outcomes can influence subsequent cognitions, emotions and behaviour (Weiner, 1985). Participants may have internally attributed differences in individuals’ resources to legitimate differences in medical faculty’s skills or accomplishments. Even though the outcomes may be viewed as legitimate, attributing negative outcomes to internal causes can produce feelings of shame, guilt and helplessness (Weiner, 1985), which have been linked to decreased motivation, withdrawal and passivity (Douglas & Martinko, 2001). On the
other hand, differences between divisions in resources may have been externally attributed by medical faculty to unfair policies or favouritism by the organization. Although the current study did not specifically investigate the attributions participants made about inequality they perceived, it may be of interest in future research to study whether externally attributed inequality is related to more negative outcomes compared to internally attributed workplace inequality.

**Effect of individual rank.** The matrix analyses were conducted to see if those who were higher versus lower in their individual resources/demands, and those who were leaders versus non-leaders perceived and responded to inequality differently. The analysis showed that most participants who were lower in individual resources were rated as having moderate or higher stress, while most of those higher in individual resources were either moderate or lower in stress (Table 3c). Most participants who had a lower level of individual demands had lower or moderate levels of stress, while the majority of those who had a higher level of individual demands had moderate or higher stress (Table 4c). Furthermore, those who were neutral or negative towards inequality were higher in stress than those who were positive towards inequality (Table 6c). These findings provide support for the job demands-resources model, which states that job demands are associated with physiological and psychological costs, and job resources buffer against the negative effect of job demands (Bakker & Demerouti, 2007), as well as the previous finding that judgments of greater workplace inequality are related to higher levels of stress (Son Hing et al., 2019).

People at the bottom of the hierarchy perceived more inequality and were more negative toward it than people at the top. Therefore, the argument could be made that participants’ perceptions of and reactions to inequality are merely a byproduct of their rank. However, several other findings from this study refute that notion. First, not all participants higher in the hierarchy
perceived less inequality or were neutral/positive toward it, and not all participants lower in the hierarchy perceived more inequality or were negative toward it (see Tables 3a and 3b). This demonstrates that perceptions and evaluations of inequality are based on more than just individual rank. Furthermore, many participants, regardless of their rank, were able to talk about their perceptions of and feelings toward inequality with very little prompting. This, coupled with the fact that their comments made it clear that the inequality greatly affected them, demonstrates that people do indeed experience inequality as a unique phenomenon apart from their own position in the hierarchy. That is, the effects of the perceived level of inequality are not caused by employees’ relative level of resources and demands. Employees care, not only about their own individual outcomes, but they outcomes of the entire collective.

The matrix analysis also demonstrated that the more inequality participants perceived, the more negatively they evaluated it (Table 6a). The results shown in Tables 6b and 6c also provide some support for the finding that perceptions of too much inequality in the workplace are associated with greater stress and worse self-reported health (Son Hing et al., 2019). These findings strengthen the conclusion of this study that, in addition to the objective level of inequality, perceptions of inequality are important because they can drive attitudes and other important outcomes.

**Theoretical Implications**

For many years, research has focused on how employees’ own individual positions in their organizations affects their attitudes and wellbeing (e.g., Marmot et al., 1991; Robie et al., 1998). The current research has demonstrated that employees focus not only on their own level of resources and demands, but are also affected by outcomes for the entire collective. That is, people both higher and lower in the hierarchy attend to the outcomes of all employees.
Individuals do not only notice when they have less than others; they perceive and respond to the degree of inequality in the workplace.

The current research has successfully drawn linkages between roots of workplace inequality and specific types of resource and demand inequalities. These in turn were associated with valued workplace outcomes, psychological responses to inequality, and even stress and wellbeing outcomes. Participants in this study directly connected personal, social and organizational roots of inequality that they identified with structural and psychosocial resources and demand inequalities. These links seemed especially strong for structural demand inequalities, where for example, medical faculty strongly linked their specific medical specializations with their clinical workloads and scheduling flexibility.

Perceived demand, and especially resource inequalities were then linked by participants to inequality in the work outcomes they valued. Many perceived demand inequalities stemmed from differences between divisions based on the type of medicine they practiced and differences between individuals based on their job profiles. For example, some staff with heavy clinical loads felt burnt out and frustrated with the amount of work they had to do, and these feelings were exacerbated when they observed that colleagues did not have to suffer under the same workload. On the resources side, participants seemed to make especially strong connections between individual-level psychosocial and structural resource inequalities and performance-related outcomes. For example, inequality in funding, equipment, protected time, et cetera led to differences in research success (a valued work outcome that was in turn related to other valued outcomes such as salary, promotions, etc.) Although this observation was specific to this hospital, it is likely that in most organizations, regardless of job type or industry, employees are likely to be sensitive to inequalities that affect their ability to achieve desired outcomes or goals.
For example, in consulting or law firms, the specific projects that employees are put on and the number of billable hours they log may largely determine how resources and performance-related outcomes (e.g., promotions and salary) are distributed.

Finally, participants linked inequalities they perceived in resources, demands and valued work outcomes to largely negative psychological responses. These responses tended to be stronger for resource inequality than demand inequality, and this was especially true for division-level inequality. Participants reported strong feelings of frustration and resentment in response to perceived inequalities in levels of respect and financial support their divisions received.

**Achieving desired work outcomes.** It is important to note that some of the resource and demand inequalities that participants were particularly sensitive to are likely specific to the hospital and job role sampled in this study. However, the linking of resource inequalities to performance-related outcomes and the emergence of the inequality spiral suggests that the specific inequalities that employees are particularly sensitive to are the ones that directly affect the work outcomes they value. For example, it is likely that many employees highly value salary (and bonuses) and promotions in their workplaces. Assuming that organizations are structured to reward merit, these outcomes are usually linked to performance evaluations. Therefore, employees will pay close attention to inequalities of demands and resources that can help them achieve better evaluations. Regardless of job type or industry, employees are likely to be most sensitive to the specific resource and demand inequalities that affect their ability to achieve desired work outcomes or goals.

**Effect of individual rank.** As noted in the Main Findings section, participants responded differently to inequality based on the specific type of inequality, and their own job profile, division affiliation, and research success. Participants lower in the hierarchy generally perceived
there to be more inequality and were negative toward it (although there was some variation in responses; see Tables 3a and 3b). Participants higher in the hierarchy were more mixed in their perceptions of inequality and their attitudes toward it. The varied responses of those higher in the hierarchy may be similar to other situations where some individuals are advantaged over others. For example, when confronted with White privilege, responses of White individuals can vary, ranging from avoidance of discussing its existence (in order to not feel threatened; Goodman, 2001) to actively engaging with the issue and attempting to address it (as a response to feelings of anger and guilt; Leach et al., 2006). In both instances, it is in individuals’ self-interest to minimize or ignore privilege in order to avoid negative feelings. Laboratory studies on inequality have found that when inequality was ingroup focused and legitimate, participants experienced more pride, while participants experienced more guilt when inequality was ingroup focused and illegitimate (Harth, Kessler & Leach, 2008). Similarly, participants higher in resources may have responded to the privilege they enjoy in multiple ways leading to their varied responses to inequality recorded in Tables 3a and 3b.

One goal of this study was to determine what makes employees perceive there to be a lower versus higher level of inequality. The matrix analysis suggested that those lower in the hierarchy perceive more inequality than those higher in the hierarchy (Table 3a). Conservation of resources theory provides a possible explanation for this finding. The theory posits that resource loss is significantly more salient to people than resource gain (Hobfoll, 2011). Therefore, it may be that higher-status individuals are motivated to avoid resource loss, so they perceive less inequality in order to maintain the status quo. This phenomenon is known as loss aversion where people prefer to avoid a loss rather than acquire an equivalent gain (Kahneman & Tversky, 1984). Medical faculty in higher status divisions may have been motivated out of self-interest to
hold on to their research funding and other resources, so perceived less inequality in order to avoid acknowledging that the issue of inequality exists and needs to potentially be addressed.

With regard to those lower in the hierarchy, it may be that they selectively attend to cues or examples of inequality in their workplace and therefore perceive more inequality than people higher in the hierarchy because it confirms their previously held belief that too much inequality exists in their organization. This may be due to motivated social cognition, that is, information acquisition and processing directed towards self-enhancing (i.e., seeing oneself in a positive manner; von Hippel, Lakin & Shakarchi, 2005) or confirming one’s own attitude or opinion (Kimmerle et al., 2017). This is especially true when it involves an issue that is personally relevant to the individual (Petty, Cacioppo & Goldman, 1981). It may also be that people lower in the hierarchy encode (form and store memories; Gerrig & Zimbardo, 2002) or retrieve (recall from memory; Gerrig & Zimbardo, 2002) information related to inequality differently than people higher in the hierarchy. Instances of inequality may evoke more negative qualitative assessments or emotions by people lower in the hierarchy compared to those who are higher, making these events more prominent in their memories. It is not clear what, if any, role these processes play in differences in perceptions of inequality, but they would be of interest to investigate in a future study.

**Comparison groups for inequality.** Participants almost exclusively talked about inequality among faculty members at the hospital, and did not talk about other employees at the organization (e.g., nurses), or physicians at other hospitals. This suggests that people adjust their comparison group to include those who are most similar to them, and are then sensitive to inequalities they perceive among those similar others. Nurses at the hospital will likely compare their situations to that of other nurses, rather than doctors or administrative staff. Or graduate
students will notice and respond to inequalities among other graduate students, but not among graduate students and faculty. This is consistent with social comparison theory, which states that the more different an individual is from another person, the less likely the individual is to compare himself to that other person (Festinger, 1954). People do this for the purpose of self-evaluation, that is, they choose a comparison target similar to themselves so that they can get an accurate estimate of their own standing (Tesser, 1988). This is also in line with Tversky and Kahneman’s (1992) prospect theory, which explains how people react to gains and losses. They do this based on reference points, which are comparisons made to similar others around them. For example, a medical faculty would likely be less satisfied with a $50,000 research grant if she knows that her colleague received a $100,000 grant, compared to knowing that her colleague received a $30,000 grant. Employees need an appropriate comparison group to develop perceptions and judgements of workplace inequality.

**Inequality spiral.** An unexpected finding from the study was the emergence of an inequality spiral. This refers to the observation that performance-related outcomes of resource inequality (i.e., research productivity, performance evaluations and promotions) seemed to feed into each other, as well as back into structural and psychosocial resource inequalities (e.g. funding/grants, research equipment/space, status and formal recognition). This would create a cycle of greater and greater inequality. This is similar to a phenomenon termed the Matthew effect by sociologist Robert Merton (1968), which describes how those at the top use their resources to gain even more resources through accumulated advantage. Thus performance-related outcomes were both a consequence and cause of resource inequality.

It is also interesting to note that the inequality spiral may contribute to increasing inequity as it could allow those with more resources to use those resources to further enhance their skills...
(e.g., using protected time and funding to take additional training courses). These individuals can, in turn, use these additional skills to secure even more resources. Therefore, on the surface, it may appear to be equitable because these higher-resource individuals may be significantly more skilled and qualified than their lower-resource peers. However, in actuality, the outcomes are the result of the inequality spiral rather than individual merit.

Although the specific resources and performance-related outcomes will differ, it is likely that an inequality spiral will be observed in most organizations. The strength of the inequality spiral would likely be moderated by the extent to which performance reviews are used to distribute resources within the organization. To mitigate the effects of inequality spirals, organizations would need to ensure that staff are provided with the resources they need to succeed, and carefully evaluate their performance review process to ensure that top performers aren’t being rewarded with resources that should go to all employees. This would likely lead to better outcomes for employees as well as the organization as a whole.

**Strengths of the Study**

The current study had the unique benefit of examining workplace inequality using a qualitative approach. This allowed participants to provide rich accounts of this complex phenomenon. The interview questions were structured in an open manner to allow medical faculty to discuss a large range of experiences and examples of inequality, and its effect on them and their colleagues. This coupled with an in-depth thematic analysis of the data allowed for insights that might have otherwise gone unnoticed. For example, it is unlikely that a quantitative approach would have discovered the role that the inequality spiral plays in the development of resource inequality.
Furthermore, conducting a supplemental analysis using matrix display tables allowed the verification of some of the conclusions drawn from the thematic analysis. For example, there were no differences in perceptions or evaluations of inequality between those lower in individual demands and those higher in individual demands (Tables 4a and 4b). However, those higher in individual resources perceived less inequality and responded to it less strongly than those lower in individual resources (Tables 3a and 3b). These findings provide support for the conclusion from the thematic analysis that resource inequalities were more salient and meaningful to medical faculty than demand inequalities.

Studies have shown that both laypeople and medical professional believe there is a hierarchy in the prestige associated with medical specializations based on salary, the type of organ/medicine practiced, the type of patient treated, the amount of training necessary, and how “scientifically” grounded the specialization is (Norredam & Album, 2007; Rosoff & Leone, 1991). Therefore, the specific sample chosen for this study (medical faculty at a research hospital) was particularly appropriate for studying workplace inequality because the clearly established hierarchy of medical specializations that already exists helped to ensure that this issue was one that would be attended to and reacted to by participants.

Limitations of the Study

One limitation of this study is that some of the findings may be limited to this specific hospital or to organizations that are very similar in nature. For example, the interviews and the matrix analysis suggest that experiences of inequality are quite similar for leaders and non-leaders. However, in other organizations where leaders have more power or access to resources, non-leaders may perceive more inequality and respond more strongly to it than leaders. This study also suggests that resource inequalities are more impactful on employees than demand
inequalities. Part of the reason for this may be that physicians are taught to accept and endure the demands their work places on them (Roberts et al., 2005). The same may not be true for most other job types.

Another possible limitation to this study was that the sample may not have been representative of all medical faculty at the hospital. It may be that faculty who were feeling stressed, pressed for time or burned out (i.e., those most likely to be affected by inequality) felt they did not have the time or energy to participate in a study of this nature. Therefore, the study sample may have been skewed towards those who have more resources (or less demands), perceive less inequality in the workplace, or who are less affected by inequality. It should be noted that if this was the case, then the findings of the study would likely have been even stronger if the sample was representative of all medical faculty at the hospital.

Another potential caveat to this study is that it only examined inequality between employees in the same job role. The most striking examples of inequality tend to involve salary comparisons between senior leaders and entry-level employees. For example, the 100 highest paid CEOs in Canada earn over 200 times the salary of the average worker in their companies (Macdonald, 2018). Given the restricted sample of the current study, it was not possible to examine perceptions of and reactions to inequalities between those near the top and near the bottom of an organization. However, the fact that such strong impressions were found even among participants in the same job role speaks to how salient workplace inequality is for employees, regardless of their level within the organization. Furthermore, participants mostly made comparisons with other medical faculty in the department, suggesting that inequalities among similar others are what matter the most to employees (see Theoretical Implications).
Given that previous research has demonstrated that perceptions of inequality can differ from the objective level of inequality (Chambers, Swan, Heesacker, 2014; Norton & Ariely, 2011), it would have been of interest to examine how closely participants’ perceptions of inequality lined up with the objective level of inequality in the organization. Unfortunately, objective data on the level of inequality in this organization was not available.

A sample of 30 medical faculty were interviewed as part of this study. Although it has been studied empirically (e.g., Guest, Bunce & Johnson, 2006), there is little agreement on what sample size is needed in qualitative research and emphasis is more often put on ensuring the sample is able to address the research questions of interest (Emmel, 2013). Given that data collection for the current study continued until saturation was reached and the research questions were appropriately addressed with the available data, there is little concern regarding sample size. Another potential issue was that the data was analyzed by a single coder, which can raise concerns regarding bias. However, it should be noted that because thematic analysis involves interpretation, it is unavoidable that the researcher’s own perspective, values and beliefs will affect data collection and analysis. To help ensure a more well-rounded analysis, I regularly met with my advisor and another graduate student (who was analyzing the same data set to answer different research questions) to help reach consensus on the codes and themes that were developed.

**Future Directions**

This study provided insight into the perceptions, evaluations and outcomes of resource and demand inequalities among medical faculty. These findings will be used to inform a follow-up survey study with the same organization. The survey will be administered to a wider array of medical faculty at the hospital, rather than just physicians from the single department sampled in
this study. This, coupled with the fact that a survey is a much less onerous commitment than a 60-minute one-on-one interview, will hopefully allow many more medical faculty to participate, producing a more robust sample.

One of the goals of the follow-up study is to quantitatively test some of the patterns that were identified in the current study. It is predicted that because of the frustration and resentment that participants felt when perceiving too much inequality, medical faculty who perceive more resource and demand inequality will experience more stress and less positive group relations. The findings of the matrix analysis suggest that these negative outcomes may have been stronger for those participants who had a negative attitude towards the inequality they perceived. Therefore, it is predicted that the relation between perceived level of inequality and stress and positive group relations will be stronger for faculty who feel negatively about the inequality they perceive compared to those who feel neutral or positive about it. It is also predicted that medical faculty who perceive more inequality of resources will experience lower job satisfaction and engagement due to feeling undervalued and feeling resentment towards the organization and colleagues. Many participants were upset by the inequality they perceived because they felt it violated their sense of fairness in the distribution of outcomes as well as the processes that led to those outcomes. Therefore, it is predicted that these relations will be mediated by perceptions of fairness.

Research questions one and two identified the specific resources and demands that faculty members valued the most, and the inequalities they are most sensitive to. Undoubtedly, some of the resource and demand inequalities identified are specific to this organization or similar healthcare/academic facilities (e.g., research equipment). Others are likely more broadly applicable to many job roles and organizations (e.g., conflict climate). To develop a more robust
model of workplace inequality, it would be valuable to investigate other types of jobs and industries to determine which resource and demand inequalities a broad range of employees are sensitive to. Furthermore, resource inequalities may have been more salient to employees in this organization because they feel that the organization has more control over the distribution of resources, compared to the distribution of demands. However, other organizations may be seen by their employees to have more control over the distribution of demands (e.g., assigning of patrol routes for police officers). In those cases, demand inequalities may be more salient to employees than resource inequalities.

Given the time and effort involved with interview studies, a survey administered through a crowdsourcing service (e.g., Mechanical Turk) would be more appropriate and sufficient to investigate inequality in other job types and organizations. The resource and demand inequalities identified would likely be the ones that strongly affect outcomes that are valued in most job roles, such as performance, promotions/raises, work stress, and work-family conflict. The current study demonstrated that employees directly connect demand, and especially resource inequalities to inequality in the work outcomes they value. Therefore, regardless of job type or industry, employees are likely to be sensitive to inequalities that affect their ability to achieve desired outcomes or goals.

Differences in evaluations of inequality among divisions, inequality among individuals, resource inequality and demand inequality could also be explained, in part, by differences in how information is attended to, encoded or retrieved. It could also be that people make different attributions about the different types of inequality they perceive, and react more negatively to inequality attributed to external causes (e.g., organizational policies or structures) compared to inequality attributed to internal causes (e.g., employees’ skills and merit). Attributions regarding
outcomes can affect the way people feel, think and behave in response to those outcomes (Weiner, 1985). For example, attributing negative outcomes to internal causes can result in shame, guilt, helplessness and decreased motivation (Weiner, 1985; Douglas & Martinko, 2001). In this way, attributing inequality to external causes could be seen as a form of self-protection for one’s sense of worth. A future study could examine the role that attributions play in the differences in evaluations of inequality among divisions versus individuals, and resource inequality versus demand inequality.

However, the finding that resource inequality is more salient than demand inequality may not applicable to all organizations or professions. To further explore the research questions regarding employee reactions to the level of inequality, a future study could investigate if and how employees in different job types and industries respond differently to resource and demand inequality. It is likely that for jobs where employees are taught to highly value the needs of their clients (e.g., healthcare, social work, teaching), they will be less sensitive to demands and demand inequality than for other jobs. They may be more willing to accept demand inequalities if they believe they are serving the best interests of their clients. Also, it is likely that for jobs where employees tend to have low work centrality or do not view their jobs as long-term careers, resource inequality will be less salient than demand inequality. For example, employees who are working services jobs to support themselves during school will likely be more concerned about completing their daily work, and less concerned about long-term work goals and career or professional development. In these instances, demands and demand inequalities (such as the distribution of evening and weekend shifts which could affect their school and social schedule) may be more important than resources and resource inequalities.
The sample for this study was high in the hierarchy within the hospital and would also be considered high in socioeconomic status (Hodge, Siegel & Rossi, 1964). The fact that inequality was such a salient issue, even among such a high-status group, suggests that individuals in lower status groups could perceive and respond to inequality even more than the medical faculty in this sample. However, it may also be that participants in this sample were more sensitive to inequality than most other employees because they are so high status. Participants may have been particularly sensitive to potential loss of status, and therefore primed to perceive and respond to even small inequalities in their work environment, given loss sensitivity (Kahneman & Tversky, 1984). In economics research, this is referred to as loss aversion. People prefer to avoid a loss rather than to acquire an equivalent gain (Kahneman & Tversky, 1984). To further investigate this issue, a future study could address how socioeconomic status and position in the organizational hierarchy affect perceptions and evaluations of workplace inequality, and whether those higher in status are more sensitive to inequality than those lower in status.

Practical Recommendations

The current study demonstrated that when employees perceive too much inequality in their workplace, they tend to respond negatively to it, and it may also be associated with worse job satisfaction and well-being. Therefore, it would be prudent to explore ways to reduce inequality, or at least improve employees’ reactions to it.

Resource inequality. Using the roots of inequality identified in this study, it is possible to generate strategies that can be used to reduce resource and demand inequality. To address resource inequality, organizations should make sure that their evaluation and promotion systems properly reflect the work that employees do, and avoid using a one-size-fits-all approach to performance management. Where possible, performance reviews should be tailored to the
specific job functions that employees perform, with proportional weighting placed on each aspect of their jobs based on how their time and effort are divided. This will help to ensure that specific departments or employees in specific job roles are not unfairly disadvantaged. For example, depending on their specific job profiles, the hospital in the current study could put more weight on the teaching, clinical and administrative work that medical faculty do. Furthermore, when organizations give formal recognition to employees for doing good work, they should take care to recognize them for all aspects of the work they do within their defined job roles, rather than just focusing on the specific aspects that are most valued by the organization. For example, companies could recognize salespeople for providing good customer service, rather than just for their sales numbers.

**Demand inequality.** One the demands side, organizations should ensure that department heads and other leaders have sufficient training, skills and support to effectively manage their subordinates. This will help to ensure that no departments have to deal with excessive interpersonal conflict, which can lead to additional stress and unequal distribution of workload. This is especially important for organizations such as healthcare facilities or academic institutions, where leaders often work their way up through the ranks and have little formal management training. This could also help alleviate resource inequality, as leaders can be trained on how to create more collegial, collaborative environments in their departments. Leaders can also be given knowledge and information about how to use proper channels to secure resources (e.g., public donations), so that departments are on a more level playing field.

**Transparency and perceptions of fairness.** For many organizations, some of the roots of inequality are likely to be systemic or embedded in the culture of the organization or industry. For example, the status differences found among specializations in the hospital can be attributed
to the culture of medicine. It would be time-consuming and difficult, if not impossible to address the roots of inequality that are embedded in an organization or industry’s culture. In these cases, there are other strategies that may help alleviate the effects of excessive inequality by improving employees’ perceptions and reactions to it. For example, more transparency and clarity around the performance review process could improve the justice perceptions of the inequality that employees observe.

Some level of inequality is desirable to motivate employees to work hard, perform well, and reap the rewards. But this study has clearly shown that when people perceive that there is too much inequality in their workplace, they react negatively to it because it violates their sense of organizational justice, and they feel that it unfairly affects people at the bottom of the hierarchy. To avoid the negative effects of too much inequality and to improve perceptions of fairness, organizations should provide more transparency around how decisions are made about the distribution of resources and demands among individuals and departments. To lessen the impact of inequality, organizations should ensure that employees understand why the inequality exists, and how the decisions that led to it were made. This should help employees feel less resentful and frustrated about the inequality they perceive.

Conclusion

This study has drawn from previous literature on inequality, inequity, social status, justice, and the job demands-resources model to provide a foundation and justification for examining perceptions, evaluations and effects of resource and demand inequality in the workplace. The study investigated workplace inequality among a group of medical faculty at a pediatric academic health science centre in Canada. It was found that participants did not focus only on their own level of resources and demands, but they perceived and responded to the
degree of inequality in their workplace. They generally felt that the inequalities the perceived were unfair, and responded to them with frustration and resentment. No participants were fully positive toward the resource and demand inequalities they saw, although some felt that they were necessary and inevitable. Because some level of workplace inequality is necessary and unavoidable, in order to lessen negative evaluations and outcomes of inequality, organizations should ensure that employees understand why the inequality exists, and how the decisions that led to it were made.
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Table 1

Examples of Initial Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Example Data Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative support</td>
<td>Different divisions have stronger administrative support. Even within our division depending on who is providing the administrative support is better more or less skilled individuals</td>
</tr>
<tr>
<td>Always available</td>
<td>Because we all have these Smartphones, BlackBerrys, or such, iPhones, et cetera, and because everybody knows we have these, there’s an expectation that you are checking your email constantly and responding to it immediately. That is a frustration. It’s the biggest bane of my existence.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>I think that is as a physician you have quite a bit of freedom to either do research or education or clinical work and it makes the job dynamic and interesting as opposed to this is my job. That’s what I would say I would like best about it.</td>
</tr>
<tr>
<td>Burnout</td>
<td>In this particular area of work, I think people cope with it differently. So, a few years ago, one of our colleagues left the team because the - - they just didn’t fit well for their personality or it’s just wasn’t what they enjoyed doing when they actually started doing it for a few years, so you do see some people burn out of this field.</td>
</tr>
<tr>
<td>Clinical Work (Importance)</td>
<td>From the clinical side of things, I mean the children here are the main reason that I am in medicine so that is never going to change.</td>
</tr>
<tr>
<td>Collegiality</td>
<td>Interviewer: How do you think faculty in the hospital get along with each other? Interviewee: Not fantastically, like I don’t think it is a tremendously collegial place. You know I think everyone works in their own little silo. I don’t think...in comparison to other places, I think that it tends to be a lot less collaboration, a lot less mutual support</td>
</tr>
<tr>
<td>Communication (Organizational)</td>
<td>A lot of things that sometimes go on in the department, I don’t know if we always know about. Like we have an email list. I think we’re on it but somehow it doesn’t seem like maybe we’re included on everything. And that’s generally how I find out about things are through emails, or something that, say, is posted on the website.</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>Interviewer: Who is your comparison group when you compare yourself to others? Interviewee: Other people in a similar profile. Similar level of seniority, similar job profile</td>
</tr>
<tr>
<td>Coworker Support</td>
<td>So, there’s many facets to my job. That’s one of the things that I like. I like to be able to support other people doing their work. Particularly, young investigators, new hires.</td>
</tr>
<tr>
<td>Culture</td>
<td>Interviewee: Many people are friendly, it doesn’t mean that they are unfriendly, but it doesn’t go to the point of helping out. Interviewer: Would you say that is more down to the function of the job or people?</td>
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<td>Example Data Excerpt</td>
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<tr>
<td>Interviewee: I think it is the culture. I think that is the culture of the hospital. Sort of every man for himself</td>
<td></td>
</tr>
<tr>
<td>Demands Inevitable</td>
<td>I think for me it would be work, sometimes workload but again it’s cyclical and I don’t think there’s anything anyone can do about that, it’s just the nature of work that we do in medical education</td>
</tr>
<tr>
<td>Department / Hospital Leadership</td>
<td>I think that that’s particularly palpable in the last decade here…and I think it comes from the medical leadership at the top. There’s no question that there are preferred divisions and there’s no question that there are preferred people within those preferred divisions and there’s no question you can predict who’s going to get…well, who’s going to get supported.</td>
</tr>
<tr>
<td>Division Head Quality</td>
<td>There are divisions I think that are far more dysfunctional than the division that I’m in…you know, we’ve got a strong division chief who values everybody within the division. Values people’s individual contributions and who’s a good peacemaker when there are disputes.</td>
</tr>
<tr>
<td>Division/Program Funding</td>
<td>Certainly program funding. The hospital made it clear there’s certain areas that are areas of focus…and those are probably the programs that are gonna get more money. Which leads to you know, more personnel and more equipment and things that make your life easier</td>
</tr>
<tr>
<td>Education – Student Training</td>
<td>I stress less over the education stuff unless I have a student who is struggling and then I stress over how to make that better for them but that is part of the fun of the job as well. To see if it works out.</td>
</tr>
<tr>
<td>Emotional Load</td>
<td>It’s stressful. Looking after sick patients, a proportion of whom I know are going to die from their disease is stressful and I stress over decisions that I make in their care. That’s just stressful. So part of the job has been learning how to live with that and living with uncertainty because a lot of the decisions that we make are not black and white.</td>
</tr>
<tr>
<td>Employee Assistance</td>
<td>I think the other benefit of the hospital is that there are resources. If you’re in trouble, there are very good employee assistance set up here…I referred a lot of people to that because people do get depressed and unhappy and sad. You can always use the college and the OMA. There’s lot of ways of doing it quietly, anonymously…you do have those kinds of resources available to you.</td>
</tr>
<tr>
<td>Engagement</td>
<td>We want to be proud of the work we do and that means everybody has to pull the, you know, to pull – toe the line together. We know at the end of the day, you know, equivalent faculty get paid equivalent rates. So why should the level of engagement or commitment be different? Of course it’s frustrating</td>
</tr>
<tr>
<td>Equity</td>
<td>So if I go back 30 years, the discrepancies between how hard the junior faculty worked compared to the senior faculty and the palpable differences in salary structure and scale were enormous and they themselves were very definitely a cause of frustration. Twenty years ago it was a little better. I think today it’s – it’s like night and day in that the junior faculty versus senior faculty generally work equivalent numbers of hours, weeks of service</td>
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<tr>
<td><strong>Evaluations and Promotions</strong></td>
<td>I was told that I would never get promoted unless I started giving international talks but I have three young children at home, I don’t want to travel abroad to be giving talks all the time. There is already enough travel in this job for research purposes and I already require enough of my husband to look after the three boys in my 12 hour work day some days, right? And so I don’t want to travel but there is a very clear message that unless that happens you are not going to get promoted even though I am quite involved in teaching</td>
</tr>
<tr>
<td><strong>Formal / Institutional Resources</strong></td>
<td>What I like least about the work is that there are too many instances of the organization not giving its employees the tools they need to do their jobs well every day. So, in that way the institution fails... probably informatic tools is my biggest [complaint]. I waste a lot of time, all of my colleagues waste a lot of time or nurses, you know, other allied health professionals or administrative staff, so many people waste so much time because the IT infrastructure here is not up to the job.</td>
</tr>
<tr>
<td><strong>Inequality – Interdivisional</strong></td>
<td>I think certain divisions are much more well-resourced than others. Their support staff takes on a much greater burden of their clinical and administrative load</td>
</tr>
<tr>
<td><strong>Inequality – Interpersonal</strong></td>
<td>And it’s getting that level of cooperation from people, that they see this as as important as you do and that they are willing to work with you, that they’re flexible and they are willing to go above and beyond and go the extra mile so that the service is covered. That’s a very very stressful part of the job. And not everybody sees it as important as I do and not everybody’s as flexible and not everybody’s willing to work an extra hour or an extra shift or fill in someone when they’re sick or whatever. So, you know, there are varying levels of commitment or engagement. So it’s working with people that are less engaged, that’s very frustrating.</td>
</tr>
<tr>
<td><strong>Inequality – Negative Attitudes</strong></td>
<td>We talk the talk about, you know, portfolios being equivalent and everybody working hard and everybody, you know, in it together for the good of the whole, but the reality is that that is not the case and I’m well aware that that causes more frustration for some people than for others to the point that it’s not unusual for me to hear why should I do that because he’s not doing it and she’s not doing it.</td>
</tr>
</tbody>
</table>
| **Inequality – Neutral Attitudes** | Interviewer: Do you think it is fair how it is determined how the demands are distributed?  
Interviewee: I don’t think it is unfair right now, it probably depends on the division you are in but I certainly feel like I have a voice in how that is determined. I don’t have the final say, but I have a voice |
<p>| <strong>Inequality – Positive Attitudes</strong> | So, my experience at Sick Kids is that people have equal access to the resources and so much of this is intrinsically driven...And, I’m sure that view is not shared by people who are less successful say that they just get less. |</p>
<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>Inequality – Roots</td>
<td>I think those with greater seniority probably have some protection in terms of workload and certainly have financial advantages for equivalent workload.</td>
</tr>
<tr>
<td>Inequality – Types</td>
<td>I think certain divisions are much more well-resourced than others. Their support staff takes on a much greater burden of their clinical and administrative load</td>
</tr>
<tr>
<td>Inter-divisional Relationships</td>
<td>There’s certain people between my division and [other division] who do the same kind of work...and don’t necessarily always agree on how [the work] should be done and it does sometimes create a little bit, I mean it could just create a friendly way of thinking, let’s think outside the box but sometimes it hasn’t over the years it’s created animosity and people jockeying for who’s way of doing it is better, that would be an example of some of the kinds of things that happen here</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td>You feel like every, if you’re the kind of person who is trying to get along with everyone and judge each issue on its own individual merit and not just take this stance we just have to be in one camp or the other then there is a constant judgment from the other camps as to you know, oh ok, who’s talking to who and who’s aligned with who and what are people saying so it permeates everything in this division, everything</td>
</tr>
<tr>
<td>IT</td>
<td>IT infrastructure is really important and if they were – if the hospital was to provide us with a more appropriate IT for our intensive care areas, we would be greatly enhanced.</td>
</tr>
<tr>
<td>Job Profiles</td>
<td>I think you job profile also determines it. Someone who is spending half a day in the clinic seeing patients with an equivalent amount of post clinic follow-up versus someone who spends a similar half day doing procedures with no follow-up required, that doubles your protected time. You have given the same clinical time to it</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>I think that’s where people complain and talk about lack of life-work balance, feel that they are compromised personally because of the amount of time and energy that they have to put into their work. I don’t think this is about – really, I don’t think it’s about time and energy. I think it’s about how committed you are to your work because if you are committed and passionate and truly engaged and love what you do and you get up every morning looking forward to going to work, it’s not stressful. You can be tired but not stressed</td>
</tr>
<tr>
<td>Medical Profession</td>
<td>You make choices. And if this is – if you feel that your life-work balance is completely screwed, then don’t work in an academic institution doing tertiary care medicine, particularly intensive care work. Like come on. Get real. You can’t do this work part time. You can’t – you can’t provide optimal care 40 hours a week. It’s just – it doesn’t work like that. So if that’s what’s important to you, then you should make different choices. You know you could have been a radiologist and have far less on call. You, you know, you could have gone into psychiatry. You could have done all kinds of things. Medicine’s a hundred different jobs. And so I don’t have a lot of time</td>
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<td>Example Data Excerpt</td>
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<tr>
<td>Mentorship and Training</td>
<td>I think mentoring is something that is often talked about and it is exceedingly difficult to find individuals who are both available and good at it.</td>
</tr>
<tr>
<td>Pace of Work</td>
<td>The pace I think to, we work at a frenetic pace in medicine and you don’t have time to think and reflect so that, I wonder if I’d be more efficient if I had that time.</td>
</tr>
<tr>
<td>Pay and Bonuses</td>
<td>[I know] because our salaries are published...there is a vast discrepancy in how well people are paid.</td>
</tr>
<tr>
<td>Physical Resources</td>
<td>The second thing is we are desperately hampered for space. We need double the footprint that we currently have in order to operate the number of patients we currently have.</td>
</tr>
<tr>
<td>Politics</td>
<td>Always a certain amount of political tension and there definitely people that I would think you know that I think some of us perceive as being they’re benefiting from their political alliances disproportionately to the value they bring</td>
</tr>
<tr>
<td>Protected Time</td>
<td>I think it reality, the time that is labelled as clinical, it is a small portion of what is actually required to carry out the clinical activities. It’s physical time spent interacting with patients and doesn’t account for a lot of the time outside of clinic whether that be reviewing charts, doing dictations, filling out paperwork, making phone calls, responding to phone calls or emails and so whatever time is labelled as clinical is probably increased by 50-100% which comes out of the supposed protected time. So I think that is probably an area of stress that although you are identified to have so much protected time and expected to achieve based on that identified protected time, it really equals much less than that.</td>
</tr>
<tr>
<td>Recognition</td>
<td>I think there is a lot of pressure on faculty to produce documented evidence of accomplishments and lack of recognition of quality of care effort. Of how much time one spends doing the less quantifiable things and I don’t think the institution recognizes or acknowledges people’s accomplishments all that well</td>
</tr>
<tr>
<td>Research / Academic Work</td>
<td>The sort of constant publish or perish, the sense of the constant publish or perish phenomenon is significant for some or at least you have to learn to live with it, right? There is always stuff hanging over your head</td>
</tr>
<tr>
<td>Research Funding</td>
<td>If someone is able to negotiate start-up money for their research then you’re able to hire assistance or do whatever so I think...it’s all about what you can get for yourself and I think some people are better at advocating or negotiating those things</td>
</tr>
<tr>
<td>Respect – Competence</td>
<td>A lot of it has to do with personality, some of it has to do with academic accomplishment but certainly those that have engaged either as a well-respected clinicians, those who make themselves available to colleagues, to trainees tend to be respected. And certainly those that have distinguished themselves academically</td>
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<td>Code</td>
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<tr>
<td>Respect – Warmth</td>
<td>The kind of person...that is pleasant, agreeable, caring, available, makes others feel as though they are not imposing on their time but rather that they are available to people. I think that earns respect</td>
</tr>
<tr>
<td>Role Conflict</td>
<td>I think the inability to compartmentalize different components of one’s job. So if you are trying to write a manuscript, the phone is ringing and the emails are coming, someone is knocking at your door and there is a committee that need to be met and that really places a lot of...it is really hard to focus and to protect your time</td>
</tr>
<tr>
<td>Scheduling</td>
<td>For me personally, some flexibility in hours is helpful. Yeah, that has been very helpful. So that’s good</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>I think for so many people here, you know, our jobs are a great part of who we are so you know, my self-esteem is pretty intact.</td>
</tr>
<tr>
<td>Self-Imposed Choices</td>
<td>The demands are different demands and a lot of them have to do with self-imposed you know ambitious targets</td>
</tr>
<tr>
<td>Social Comparison – Approach Behaviour</td>
<td>The stress is probably the big thing. But, in a weird way, it’s also something that if you rationalize it in a positive way, it can also be a very good source of momentum and drive for...lead you accomplish much more in perhaps you would if you didn’t have as much high expectations because the expectations here are quite high. And, also seeing how well everybody else is doing is sort of pushing you further I think and probably you thought you were able to.</td>
</tr>
<tr>
<td>Social Comparison – Avoidance Behaviour</td>
<td>I think there’s again anxiety about feeling the need to prove yourself, the fear of looking like you’ve done something wrong which I think is very common in the medical field</td>
</tr>
<tr>
<td>Staff</td>
<td>On the clinical side, all the support staff is like -- like absolutely critical. The nursing staff and the occupation clinic, on the ward and all that and all the other allied health social worker and -- without them, you know, you could not accomplish anything, like occupational therapists, physical therapists</td>
</tr>
<tr>
<td>Status</td>
<td>There’s something about the dynamic about being a [my division] physician, we are always asking people for help and it’s not right, but the way that’s perceived is that you’re less important than me, and perhaps stupider than me</td>
</tr>
<tr>
<td>Stress</td>
<td>There are a lot of stressors that come out with an academic career so along with sort of looking after children you have to keep up to date with all the new advances coming out, you are expected to be involved in research which I enjoy as well and always teaching. But that pressure of all that other stuff never really goes away right? So it extends from work to home and back again.</td>
</tr>
<tr>
<td>Teamwork</td>
<td>I think I work in an amazing team so we are very supportive of each other and sometimes not. But for my immediate clinical team, we are very supportive of each other</td>
</tr>
<tr>
<td>Transparency</td>
<td>Which division you’re in determines it because it dictates kind of just where you are in the pile, in the hierarchical pile of programs within the hospital. I mean at some level, you know, and again, there isn’t</td>
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<td>Code</td>
<td>Example Data Excerpt</td>
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</tr>
<tr>
<td>Wellbeing</td>
<td>Interviewer: How do you think the stress affects your well-being in general? Interviewee: So it definitely at times has a negative effect on my well-being. It tends to go in waves I find. So I have had to over the...I haven’t been doing this that long but I have had to sort of develop very pointedly stress management mechanisms</td>
</tr>
<tr>
<td>Women and Minorities</td>
<td>In terms of gender, you know, certainly I think women who -- it’s not even women, I think you know because if they have kids, you know, probably the feeling of being torn between meeting to get to daycare on time and being at work is probably quite challenging</td>
</tr>
<tr>
<td>Work-Family Conflict</td>
<td>Every once or every month or so I have to give up a weekend with my family to be here at the hospital</td>
</tr>
<tr>
<td>Workload / Time Pressure</td>
<td>Juggling a lot of balls and you don’t have enough time to do, to feel necessarily that you’re doing you know a good job in all the different areas that you are expected to work, so I think it’s lack of time</td>
</tr>
</tbody>
</table>
Table 2

Example Data Excerpts for Connections Between Themes

<table>
<thead>
<tr>
<th>Connection #</th>
<th>Example Data Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If someone is able to negotiate start-up money for their research then you’re able to hire assistants or do whatever so I think you know it’s, there’s no, no one’s I think there’s a very, like it’s all about what you can get for yourself and I think some people are better at advocating or negotiating those things</td>
</tr>
<tr>
<td>2</td>
<td>Interviewer: Do you think that any group membership (e.g., division, job profile) comes into play in terms of who gets what? Interviewee: 100% and that’s appropriate cause every institution you have to have priorities...institutionally you are going to get recognition if you are in line with an institution’s goals</td>
</tr>
<tr>
<td>3</td>
<td>Certainly program funding. Some, I mean, the hospital made it clear there’s certain areas that are areas of focus...and those are probably the programs that are gonna get more money. Which leads to you know, more personnel and more equipment and things that make your life easier</td>
</tr>
<tr>
<td>4</td>
<td>Our most successful clinician scientists bring in grants that allows them to expand their group, they bring in more grants. That gets attention outside, they get connect[ions]...then you start to see [more] dollars come in</td>
</tr>
<tr>
<td>5</td>
<td>The individual leadership has to make decisions about allocation of people's time within their division. So in order to allow researchers the time they need to do their research, you have to allocate clinical time for the other people within the division. That can be a source of concern I think.</td>
</tr>
<tr>
<td>6</td>
<td>Interviewee: I think people would say that this institution in general values research and research productivity, research recognition and then less so, education and then less so, clinical care, even though that may or may not be true, that’s the mythology, that’s the story here, so and it probably is true. So I think the people that have made big achievements in the research end of things are highly valued. Interviewer: Right. Interviewee: And I think people in the other areas are less valued and when they’re less valued, they’re given less opportunity to actually achieve in those other areas, so it’s a self-fulfilling prophecy. Interviewer: When you say they’re given less opportunity what do you mean? Interviewee: Time.</td>
</tr>
<tr>
<td>7</td>
<td>It’s always been my sense that how much money you’re paid reflects on people’s general thoughts of their importance...for example, [division C physicians] gets paid more and they seem to be able to feel like sometimes they can bully the [my division] people around a little bit and I feel like that’s been the culture that’s been here. The same with some of the other specialties. That was very different than what I came from. Where I trained everything was very much collegial. There was nobody that really pushed anybody else around or felt that way.</td>
</tr>
<tr>
<td>8</td>
<td>The people you know and your network of support people definitely has a huge impact in terms of finding opportunities, in terms of forging collaborations, opening doors. If you have good mentors that are very pro-active that can really make a big difference</td>
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<td>Connection #</td>
<td>Example Data Excerpt</td>
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<tr>
<td>9</td>
<td>So whether you are in [specialty E], whether you’re in [specialty F]...because our salaries are published, [we know] that there is a vast discrepancy in how well people are paid. I’m pretty even tempered but that’s a real frigging frustration for me because I know that I personally, do have a very high energy, work extremely long hours, and do intensive care but I sure as heck am not financially rewarded for – compared to my colleagues who do similar intensive care and are equally busy and equally engaged but get double my salary. You know, so that’s a frustration, no question.</td>
</tr>
<tr>
<td>10</td>
<td>Everybody [knows our clinic space is bad], even the most senior leadership...and yet, nobody will do anything about it...that’s extremely frustrating to our faculty members...and our staff in general because it just makes them feel like they’re third class citizens essentially. And, it’s true...It just makes...the people on our program feel incredibly undervalued because nobody is willing to really...do what it takes to give us the space that we need and we’re not picky at all. We’re not asking for beautiful space like the [other division] clinic...We’re just asking for something that’s livable.</td>
</tr>
<tr>
<td>11</td>
<td>There’s something about the dynamic about being a [my division] physician, we are always asking people for help and it’s not right, but the way that’s perceived is that you’re less important than me, and perhaps stupider than me and yes, I’m stupider than they are on that particular more specialized domain, we have a very different job...And when you’re always asking for help from people by the way, less trained then you, because they’re residents and fellows who are our first contact, what does that make the staff person feel about the person, even a staff person asking the question. I don’t think they do it inadvertently, I really don’t...So I have not had warm fuzzies, I don’t feel like I’m equal playing field with these colleagues</td>
</tr>
<tr>
<td>12</td>
<td>Some clinical areas are more demanding than others, just the patient volumes are huge and patients are very unwell, that are very, very, very demanding, so that would be another [type of demand inequality] as well.</td>
</tr>
<tr>
<td>13</td>
<td>There are divisions I think that are far more dysfunctional than the division that I’m in...we’ve got a strong division chief who values everybody within the division. Values people’s individual contributions and who’s a good peacemaker when there are disputes. There are divisions where there are very strong personalities that don’t get along with each other and where the division chief has not been able to reach any kind of accord within the division and so there’s great stress within those divisions.</td>
</tr>
<tr>
<td>14</td>
<td>Some of the burnout I had earlier was when the clinical demands were so constant and there was such an imbalance between...my clinical load and colleague’s clinical load. Especially when you’re new...there’s like resentment that builds up and you don’t feel like it’s of your choosing. Those are the times when it was more negative psychologically.</td>
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<td>15</td>
<td>Interviewee: I don’t think they’re equally distributed, no. I think some people are conflict averse especially in my division and because of that, things aren’t spreading evenly because you know, my leader may not want to confront the person that she’s in conflict with so she just kind of leaves her to do her own thing and then, the other demands get spread amongst the people that she is able to work with. So, I feel like personal conflict affects equal spread of workload.</td>
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<td>Connection #</td>
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<td><em>Interviewer:</em> Same with the clinical workload?</td>
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<td></td>
<td><em>Interviewee:</em> Yeah.</td>
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<td></td>
<td><em>Interviewer:</em> And, do you feel it’s appropriate?</td>
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<td></td>
<td><em>Interviewee:</em> No. I feel like there should be more accountability and more -- like you know, it doesn’t matter that you have a problem with somebody, if this is what the division needs clinically to do the care that we need to do, then it should be done fairly and it’s not.</td>
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</tbody>
</table>
Table 3a

*Individual Level of Resources and Perceptions of Level of Inequality*

<table>
<thead>
<tr>
<th>Lower Individual Level of Resources</th>
<th>Perception of Level of Inequality</th>
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<tbody>
<tr>
<td>Participant 2</td>
<td>More inequality</td>
</tr>
<tr>
<td>Participant 4</td>
<td>More inequality</td>
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<tr>
<td>Participant 10</td>
<td>More inequality</td>
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<tr>
<td>Participant 15</td>
<td>More inequality</td>
</tr>
<tr>
<td>Participant 18</td>
<td>More inequality</td>
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<tr>
<td>Participant 19</td>
<td>More inequality</td>
</tr>
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<td>Participant 21</td>
<td>More inequality</td>
</tr>
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<td>Participant 26</td>
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<td>Participant 27</td>
<td>More inequality</td>
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<td>Participant 30</td>
<td>More inequality</td>
</tr>
<tr>
<td>Participant 11</td>
<td>Moderate inequality</td>
</tr>
<tr>
<td>Participant 17</td>
<td>Moderate inequality</td>
</tr>
<tr>
<td>Participant 24</td>
<td>Moderate inequality</td>
</tr>
<tr>
<td>Participant 13</td>
<td>Less inequality</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Higher Individual Level of Resources</th>
<th>Perception of Level of Inequality</th>
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Table 3b

*Individual Level of Resources and Evaluations of Level of Inequality*

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**Individual Level of Resources and Level of Stress**

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## Table 4a

*Individual Level of Demands and Perceptions of Level of Inequality*

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**Table 4b**

*Individual Level of Demands and Evaluations of Level of Inequality*

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Table 4c

*Individual Level of Demands and Level of Stress*

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Table 5a

**Leadership Status and Individual Level of Demands**

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Table 5b

*Leadership Status and Individual Level of Resources*

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Table 5c

Leadership Status and Perceptions of Level of Inequality

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*Leadership Status and Evaluations of Level of Inequality*

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**Table 5e**

*Leadership Status and Level of Stress*

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Table 6a

*Perceptions of Level of Inequality and Evaluations of Level of Inequality*

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Table 6b

**Perceptions of Level of Inequality and Level of Stress**

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Table 6c

Evaluations of Level of Inequality and Level of Stress

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Figure 1. Job Demands-Resources (JD-R) model

Figure 2. Concept map of resource inequality
Figure 3. Concept map of demand inequality
APPENDIX: INTERVIEW GUIDE

Hello, my name is Vishi Gnanakumaran. I’m a PhD student in the Industrial-Organizational Psychology program at the University of Guelph. In this interview I’m going to ask you some questions about your experiences working at the Hospital for Sick Children. The purpose of the research is to help understand some of the stress and work-life interference experiences of faculty members in the Department of Pediatrics.

It is your choice to take part in this study. You may withdraw from the study at any time without consequence. If you choose to withdraw, all data you have provided will be discarded. The audio recording of your interview will be deleted, as will any transcription of it.

The interview will last approximately one hour. You will also be asked to participate in a focus group session at a later date, where you and other interviewees will be asked to confirm and expand on the information provided in the interviews.

Participating in this research will give you the opportunity to reflect on your work and its meaning to you. You will also be able to identify stressors in your personal and work life, and identify ways the department could help to address these issues. For some people, talking about stress and triggers that lead to stress can make them somewhat anxious. You may refuse to answer any questions you are uncomfortable with.

All information you provide will be kept strictly confidential. No one outside of the researchers will be made aware of who chose to participate and who did not. Results will be presented to the department in aggregated form only. No individual identifying information will be provided.

Before you sign the consent forms, do you have any questions or is anything unclear?

**Job Description and Status**
Can you describe the work that you do? What role do you play in the hospital?

*Probe for seniority (e.g., full professor), role (i.e., academic clinician, clinician-scientist, clinician-investigator), full/part-time, and tenure (how long they have been at the hospital)*

**Personal and Organizational Values**
Please describe some of the faculty members that are admired the most around here. Why do people feel this way about them? There is no need for you to use names.

**Job Satisfaction**
How do you feel about your job and the work that you do? What do you like most about it? What do you like least? Can you give an example?

What were you hoping your work would look like when you started here, and has it lived up to that?
**Job Engagement**
What about your work is particularly motivating for you? What gets you excited? Can you give me an example? How do you think this affects your well-being in general?

**Job Stress**
How stressful do you find your work to be? What is particularly stressful for you? Can you give me an example? How do you think this affects your well-being in general?

*Probe for strain, physical and psychological effects*

**Success and Promotion**
Do you feel that you are successful at your job? How do you think this affects your well-being?

Can you tell me about how the evaluation and promotion process works here? When was your last CDCP (Career Development and Compensation Program)? Do you believe the process is fair?

What about promotions within the university? Are both positions (hospital and university) valued and respected?

**Major Demands**
What are some of the challenging demands at work that make it more difficult to achieve your work goals? These could be personal, or job-task related. It could include things like workload, undesirable or difficult tasks, or things of a more social or emotional nature.

*Prompts (only if they can't think of anything):*
poor equipment, insufficient office space, abusive supervisor, difficult colleagues, tough cases, dealing with troublesome patient families, long work hours, undesirable tasks (e.g., paperwork), dual role of clinicians and academics

Are there other demands that are really challenging for other people?
*Follow-up: Who are you talking about? Pediatrics faculty at SickKids? Your division?*

**Perceptions and Evaluations of Distribution of Demands (** probe deeply for this question **)**
Do some people face more demands than others? To what extent are they unequally distributed? Can you give an example? Do you feel this is appropriate? Why or why not?

What determines the demands each person faces? Do you think this is fair? Do you think that any group memberships come into play in terms of who gets what? (e.g., gender or ethnicity) Why or why not?
*Follow-up: Who are you talking about? Pediatrics faculty at SickKids? Your division?*

**Essential Resources**
What personal needs or goals does work help you to fulfill?
What kind of resources can you access at work that makes it easier for you to achieve your work goals? These could be personal, or job-task related. Think of things the organization or leaders can give you to make it easier for you to do your work, like material resources or social resources.

Prompts (only if they can’t think of anything):
equipment, training opportunities, mentoring, bonuses, access to information, support from coworkers, respect, and recognition from leaders in the hospital.

Are there other resources that are really important for other people?
Follow-up: Who are you talking about? Pediatrics faculty at SickKids? Your division?

Perceptions and Evaluations of Distribution of Resources (*probe deeply for this question)
Do some people have more resources than others? To what extent are they unequally distributed? Can you give an example? Do you feel this is appropriate? Why or why not?

What determines how much essential resources people have? Do you think this is fair? Do you think that any group memberships come into play in terms of who gets what? (e.g., gender or ethnicity) Why or why not?
Follow-up: Who are you talking about? Pediatrics faculty at SickKids? Your division?

Work-Life Contextual Information
Do you have any young children or other relatives that you are caring for? Are there any other major commitments in your personal life that create a drain on your time or resources?

Work-to-Life Interference (*probe deeply for this question)
Does your work interfere with your non-work life? In what way? Can you give me an example? How many hours do you work at the hospital, and how much do you have to work at home? What effect does this have on you and your family?

prompts: children, elder care, behavioural, cognitive, time, strain?

Life-to-Work Interference (*probe deeply for this question)
Does your non-work life interfere with your work? In what way? Can you give me an example? What effect does this have on you and your family?

prompts: children, elder care, behavioural, cognitive, time?

Coping Strategies
Can you tell me about some specific strategies that you use to cope with the stress caused by your job or by work-life interference? What resources do you draw on to help with work-life interference?

prompts: alter your schedule to spend more time away from work, partner that enables you to work more at the hospital, employ nanny or helpers at your home
What resources outside of work do you draw on to help manage demands in your personal life? Have you used any of the hospital’s wellness-related programs or services (e.g., book club, gym)? If so, how effective are they?

Do you think these issues are inevitable, or could something be done to improve it? What do you think could be done?

**Work vs. non-work demands/resources**
What do you find more stressful, demands at work or demands at home? Why?

How do you find yourself dealing with demands at work versus demands at home? Are you more successful with one over the other?

**Work-Life Facilitation**
Have your work and non-work lives had any positive effect on each other? Can you provide an example?

**Relevant Comparison Group**
When responding to the questions today, who were you thinking about: people in the hospital in general, just the faculty, just the pediatrics department, just your division? Or some blend?

**Group Dynamics**
How do people in X (depending on answer to previous question) get along? Can you give examples?

**Final Comments**
Is there anything else that you would like to share about the areas we’ve discussed today?

We greatly appreciate you sharing your experiences with us and for taking your valuable time to contribute to our research. I also want to remind you that it is normal to feel stress at work sometimes, and that everyone struggles to balance their work and personal lives. If you’re struggling with stress or other issues at work, the Ontario Medical Association has a physician health program which offers services that may help. You can access it by going to [php oma.org](http://php.oma.org)

When we have finished data collection, we will hold small focus groups with participants to share our findings and to get your feedback on them. Thanks again!