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Top Female Hospital Executives in Las Vegas, Nevada: An in Depth Case Study

Caroline R. Copeland
University of Nevada Las Vegas

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Prepared By

Caroline R. Copeland.

University of Nevada, Las Vegas

December 2001

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Abstract

This paper will review the findings of in depth interviews with the four top female executives for the acute care hospitals in Las Vegas, Nevada, with regards to the 'Glass Ceiling' phenomenon, stereotyping and gender role behaviors, and how these elements have affected their careers. Out of seventeen (17) local senior executive positions, women hold four of these positions, or twenty-three percent (23.5%), compared to six percent (6%) nationally. The healthcare system changes were also a consideration for theses female executives, and how these changes have influenced their careers.

This paper, prepared for the Department of Public Administration, University of Las Vegas Nevada, to complete the professional degree requirements for a Master's in Public Administration, with a Health Care concentration.

Chapter 1

Introduction

"There's nothing like a dream to create the future. Utopia today, flesh and blood tomorrow". - Victor Hugo (1802-85).

Empirical studies published between 1980 and 1995 have identified that women in healthcare management and administration have not played an active nor as visible a role as their male counterparts. This is contrary to the practice from a century ago, where women played an active role in both the development and management of acute healthcare facilities or hospitals. Yet, college graduation statistics for the period between 1984- 1995, through the University of Kansas study, in conjunction with American College of Healthcare Executives (ACHE), indicate that men and women, in equal numbers graduate from Masters of Health Service Administration programs (Zimmerman, Fall 2000).

Gender inequality in healthcare appears to be more pronounced than in other industries, and this is supported by a national study conducted by the American College of Healthcare Executives (ACHE) on data collected from 1990-1995. The study published in 1995 found that 93% of all hospital administrators were males. In contrast more than 60% of the administrators in religious based hospitals were males (Haddock and Aries, 1989; Zimmerman and Hill, 1999). In comparison, over three-quarters of the healthcare work force is female (Robinson-Walker, 1999).

Researchers have questioned women's inability to succeed in healthcare industry related jobs, especially in light of the fact that both women and men graduate in equal numbers from Healthcare programs. Researchers have also questioned why men ascend faster and more easily than women to executive positions. The U.S. Department of Labor study, 1994, indicated that 29% of all management, professional and executive

level jobs were populated by females (U.S. Department of Labor, 1994). A more recent

report from the Department of Labor, "The 20 Leading Occupations for Employed Women,

1999 Annual Averages," indicates that women hold 30.5% of the management and

administrative positions, when compared to men (U.S. Department of Labor, 1999). Sadly,

there is no significant statistical gain, when comparing the two reports, during the five-year

period. The management positions evaluated in both studies, within healthcare, are

predominately clinically based, and reflected in the overall statistic.

A study of the Fortune 500 companies published in1995, found that just under 4%

of top executive positions were held by women (Meyerson and Fletcher, 2000). An

assumption is made that 'top executive positions' are those of Chief Executive Officer, Chief

Operating Officer and company Presidents.

The newest statistical report from Catalyst Census published in 2000, in regards to

executive positions, indicated that 10%, or 50 of the Fortune 500 companies now have

women in top leadership role (Catalyst census, 2000). This demonstrates a 100% growth over

the five-year period from the prior published report. Although this growth is significant,

women still appear to cluster at the lower end of the management ladder even though there is

no measurable differences in work traits, abilities, professional education, or motivation

towards attaining managerial positions for either men or women (Wiggins, 1991).

In light of the national and statistical data, the southern Nevada hospitals top

management positions appears "female rich". The executive positions of Chief Executive Officer

(CEO), Chief Operating Officer (COO) and/or Senior Vice President of Operations were

selected for this case study. Out of the seventeen (17) defined positions for the acute care
hospitals in Las Vegas, Nevada, four (4) leadership positions indicating, or 23.5% of the

total, are currently held by females. Universal Health System (UHS) hospitals have two

Chief Executive Officers, Healthcare Corporation of America (HCA) has one female Chief

Operating Officer (COO), and Catholic Health West (CHW) has a female Senior Vice

President of Operations (Sen. V.P.).

Each of the hospitals in Las Vegas has a leadership team comprised of a CEO and COO.

The finance department has a Chief Financial Officer, but was not included in this case study,

secondary to the delineation of leadership positions in the research literature (ACHE, 1995).

This leadership structure applies to all the Las Vegas hospitals, with the exception of Catholic

Health West, where there are three positions; CEO, COO, and a Senior Vice President of

Operations. This team serves both the Boulder Highway and the Siena campuses.

The percentage of 23.5% is statistically different from the published reports by the

American College of Healthcare Executives (ACHE), 1995, and further evaluation appeared

necessary. The statistical number for Las Vegas more closely reflects the national percentage for

all management levels, rather than the percentages for the top executive positions.

Chapter 2

Literature Review

Although there is limited literature available, there are three relevant studies that

assisted with forming the core concepts and structure for this paper. The American College of

Healthcare Executives (ACHE, 1995) study; the 1997 Gender and Leadership in

Healthcare Study-GLHS (Robinson-Walker, 1999), and A Solid Investment: Making Full Use

of the Nation's Human Capital, Recommendations of the Glass Ceiling Commission, 1995

(U.S Government Reports, 1995). The commission was comprised of twenty-one members and

developed in 1991, by appointment of the President and the Congressional leaders. The

commission was chaired by the Secretary of Labor. The role of the commission was developed,

secondary to Title II of the Civil Rights Act, 1991amendment, to investigate minority and

women's inability to advance through corporate hierarchies. The commission was disbanded

once the report was completed.

Common threads were identified in all three reports, which were supported by

additional published literature, and substantiated through the personal interviews. Issues

relating to the 'glass ceiling phenomenon', gender behavior roles and stereotyping were

discussed in depth in both the reports and literature. The effect of these barriers on minorities

and women were clearly identified. Recommendations were delineated that outlined the need

for change if women are to succeed in, and lead the business world.

When reviewing the healthcare related studies, the changing dynamics of the healthcare

delivery system, and diversification were also emphasized as an opportunity for women to

enter previously male dominated roles. The necessity to develop a strong sense of self through

confidence and ego building, was identified as an area that women should enhance if they
want to succeed.

In light of the studies, and for the purpose of this case study, the supporting

literature, regarding the role that women play in hospital leadership, can also be

broken into four specific concerns:

1). Education and background;

2). Presence of the 'glass ceiling';

3). Perception of women as leaders, stereotyping and gender role behavior; and;

4). Changing dynamics in the healthcare industry, and what is necessary to succeed within

an industry in the midst of change.

Historical Background

Historically, women had a much more visible and powerful role in healthcare

leadership. At the start of the twentieth century many hospitals were managed by nuns and

when the philosophy of healthcare shifted from charitable primary care to a business model

 in the early 1920's, men started to enter the field of hospital administration. A case in point,

 is the history of the Cottage Hospital in Santa Barbara. California (Gilbertson, 1997). Upon

filing the articles of incorporation for Cottage Hospital, Santa Barbara, the election of Officers

confirmed a woman, Mary Ashley, to serve as the elected president, a post which she held for ten

years. The establishment and setting up of hospitals a century ago was viewed as philanthropic

'women's work'. Women volunteered primarily as board members and fund-raisers. The example

of Cottage Hospital, Santa Barbara, is used solely to demonstrate how some of the hospitals were

originally established in America.

ACHE conducted the first survey of hospital administrators in 1935, which
showed that 56% of hospital CEO's were women, many of whom were in religious

orders (ACHE, 2000). "Nuns were considered to be 'sweet' little things, who couldn't run a

healthcare facility", stated Sister Mary Jane Ryan, President and CEO of SSM Health Care

Systems, St. Louis, Missouri (Robinson-Walker, 1999, p. 9). The majority of the remaining

percentage of hospital administrations had physicians in the CEO role.

The "military model" and governmental policy for hospital administration was

initiated during World War II, when hospital leadership transitioned to non-

physician males filling the CEO role (Weil, 1994). When the armed forces downsized, men

with experience and developed leadership skills re-entered the civilian workforce. This was the

impetuous that shifted the statistical majority of female hospital administrators into the

minority.

With the business model came a structured method of management easily

recognized and often defined as 'mechanistic'. The model is a hierarchical structure, or pyramid

model, with a dominant leadership role. Workers must conform to rules, regulations

and procedures that form the backbone of the organization (Wiggins, 1995). Even today, this

is the typical model used in hospital operational management, and present in all the acute care

hospitals in Las Vegas, regardless of 'for-profit' or 'not-for-profit' status. Associated with this

model, is the misconception that there is only 'one right way' to administer and lead (Robinson-

Walker, 1999).

Traditional delivery of in-patient hospital care is rapidly shifting to an outpatient

setting and to in-home care due to financial constraints, and with direction from managed care

and health management organizations (Dowling, 1999). Based on these current changes in the

healthcare industry, administrators are challenged to provide care differently. Other
contributing factors that affect change in today's healthcare market include the slowing

population growth, with a concomitant slowing of the economy. Managed care organization

and its effect on reimbursement reductions, has challenged the 'mechanistic' organizational

model of hospitals. The astute CEO must become an inspirational leader with the ability to

recognize the need for change. They must also influence that change while maintaining values,

and supporting both facility and corporate philosophies (Shur-Bilchik, 2001).

Flexibility, innovation and the ability of the healthcare industry to promote a

lateral management model rather than using the traditional hierarchal structure will

determine success or failure (Walsh, 1995). According to the Glass Ceiling Commission,

"Most organizations still prefer to find senior executives from within their own ranks,

perpetuating the 'old school network' in which a limited range of job titles and experiences

artificially restricts the candidate pool" (The Glass Ceiling Commission Report, 1995). The

door of opportunity is opening for women, allowing them to become more active in acute

healthcare leadership. Women's leadership style of collaboration, team playing and consensus

is meaningful with that of lateral management styles (Walsh, 1995). At the current time,

women are more likely to be in senior administration roles with managed care organizations,

insurance companies, non-acute care hospitals, and some may function as independent

consultants (Robinson-Walker, 1999).

'Glass Ceiling'

The presence of the 'glass-ceiling', is discussed freely in both professional and popular

literature. The 'glass-ceiling' as defined is "an unseen, yet unbreachable (sic) barrier that keeps

minorities and women from rising to the upper rungs of the corporate ladders, regardless of

their qualifications or achievements".(Glass Ceiling Commission Report, 1995). 'Glass
ceiling' is also a phrase that was coined to describe the barriers and difficulties that women

have encountered in attaining higher management positions. In fact, women are still viewed as

less desirable management candidates when compared to men (Wiggins, 1991).

In 1991, the Department of Labor published a report based on a twenty-five year study

(U.S. Department of Labor, 1991). Its continuous investigation confirmed the existence of the 'glass ceiling'. The weakness of this study was that it was conducted with entry level managerial professionals who had limited tenure in management positions. The findings of this study, when evaluated with a similar population group, was supported by a 1990 study conducted by the UCLA Anderson Graduate School of Management and Korn/Kerry International (Martin, 1991).

Even when men and women have completed comparable degrees, women are more likely than men to stay in lower or middle management. Factors that influence this decision for women include lack of mentoring, and neither knowing nor playing the visibility game within the corporate world. Statistically, more women than men enter graduate programs with clinical backgrounds, and attend college on a part-time basis (ACHE 1991). Women do make conscious decisions to merge family and career, which may in turn impede their ability to reach the higher echelons in healthcare administration, secondary to parenting responsibilities (Olarte, 2000; Weil & Mattis, 2001).

Discrimination comes in other forms when applied to a woman's career path. A break in a women's career to have children may be viewed negatively, although not verbalized, by a prospective or current employer. This time out is referred to in the published literature as the 'Mommy tract' (Borkowski, 1992). Deciding to put family before career can be detrimental for an ambitious female who is faced with the decision of having children, or advancing up the corporate ladder (Robinson-Walker, 1999; Weil & Mattis, 2001).

Personal sacrifices have been made by women who chose career paths rather than a stereotypical family path. These sacrifices are significant, with survey results indicating a 52% divorce rate for top female executives compared to 5% amongst males (Wiggins, 1991;

Walsh, 1995). Women in senior leadership also had a much higher percentage of

childlessness when compared to men in like roles; 79% women versus 32% men.

(Borkowski & Walsh, 1992).   Published data indicates that women take career advances and

opportunities as seriously as men, but women in large have made more personal sacrifices while

attaining their goals (ACHE, 1991; Walsh, 1995).

Hospital administration structure is traditionally a 'pyramidal' structure, with the

ultimate goal of attaining the peak position. The single peak limits the number of leaders,

and since the leadership for hospital administration is male dominant, it is nearly impossible for

women to reach the pinnacle. Traditionally, the gender of the incumbent influences the

gender of the successor (Zimmerman, 2000; ACHE 1991). Both the male domination of

healthcare leadership and the fact that senior executive positions are extremely limited

provides another barrier for women to breach.

In an effort to break this cycle, it is necessary that women become more visible,

decision makers and board members, and more visible as contributing participants in legislative

issues and as high level policy makers (Wiggins, 1991). Apparently, if women want to succeed

they must learn the structure of business, without appearing aggressive, they must understand the

rules of the game, and strengthen net-working frames both within their companies and in their

community (Phillips, 1993; Robinson-Walker 1999).

Men develop higher visibility profiles than women, both in the corporate

organizational and societal structures associated with the business world (Wiggins, 1991;

Zimmerman, 2000; Robinson-Walker, 1999). The career visibility factor is attained through

networking, mentoring and career development, knowing and engaging in the rules of the

corporate games rather than hanging back, 'playing the field' and not allowing others to

seize the opportunities (Vergara, 1989). Hanging back and not having sufficient self

confidence are two of the strongest detriments in a woman's ability to succeed. Men will

assume a management position if they know only 50% of a job, whereas women need to know

75% of a job before they feel comfortable accepting the same position (Robinson-Walker, 1999).

In order to break through the 'glass-ceiling' successfully women require mentors within

the healthcare corporate world. "Mentoring affects the professional life of the protégé by

fostering insight, identifying needed knowledge, and expanding growth opportunities"

(Hollister, 2001). Mentoring can be traced back to Ancient Greece, where Athena helped

Telemachus recognize his father, Odysseus by assuming the shaper of Mentor. And, so the

foundation of today's fostering of growth and development for leaders began (Pinsent, 1970).

Mentors do not necessarily need to be another woman, and the benefits of

mentoring, and being mentored cannot be ignored by a woman who wants to attain the top level

executive positions.(Wiggins, 1991; Robinson-Walker 1999; The Glass Ceiling Commission

Report, 1995). Although the value of mentoring cannot be underestimated, it is important that a

mentor is selected with care, and that the relationship remains professional and does not cross

into paternalistic (Robinson-Walker, 1999). A fine line exists in mentoring. "Cross-pollination

must occur" from men to women, and visa versa for mentoring to be truly successful (Robinson-

Walker, 1999, p.151). "Cross-pollination" is the exchange of information, where women and
men share and exchange information as colleagues. Sharing perspectives and learning from

each other is invaluable.

Another way to break the 'glass-ceiling' is to avail of a career development program.

These programs are offered by all four of the for-profit healthcare corporations in Las Vegas in

various forms, both informal and formal, as determined through the interview process. Career

development presents itself in various forms. It can be combination of post-graduate internships,

seminars attendance, professional membership, formal and informal education and mentoring,

and also community involvement. Career development can include education reimbursement,

which is offered to incumbent employees who are ascending the promotional ladder. The need

for formal education cannot be overlooked, nor underestimated. This concept is continuously

threaded through all the published articles on leadership.

In fact, a 'have master's will travel' attitude is necessary for any woman who wants

to ascend the promotional ladder into an executive leadership position. Clinical knowledge,

in conjunction with formal education has an advantage over formal education exclusively. A

common medical language is understood and spoken by the executive and the client when

a clinical background is present. Credibility is founded. It is important though, that the

clinician does not revert to the comfort zone of familiarity, once a higher level of education

and a degree is attained (Robinson-Walker,1999). The necessity of the essential educational

requirements to aid advancement are also supported by collaborative studies conducted by the

ACHE, Kansas State and Iowa State University Healthcare graduate programs (ACHE,1995)

Stereotyping and Gender Role Behavior

'Gender as a sociological concept is nothing more than a set of beliefs and perceptions

about what is feminine and what is masculine' (O'Malley, 1991). Stereotypical traits for

women include the perception that women cannot be strong leaders and respected without

loosing their feminine qualities. Feminine qualities, unfortunately, are seen to include

those of compliance, passivity and dependence, as well as supportiveness of others and

compassion. Compliance, passivity and dependence, are defined as 'follower' qualities rather

than leader qualities, and are viewed negatively by men and women equally, for those women

who seek top executive positions (Fagenson, 1990).

Men recognize the benefit of having a drink with colleagues after work, or playing a round of golf on the weekend. Sociologists refer to this as 'tribal' membership, which in turn affects the values and behaviors within an organization (Robinson-Walker, 1999, p.29). The most basic tribes, of course, are males and females. Competition and pressure to perform drive males, whereas perfectionism and the desire to please drive women (Neuhauser, 1988). The qualities of neither perfectionism nor the desire to please are not those necessarily associated with getting results.

Title VII of the Civil Rights Act of 1964 (amended by the Equal Employment Opportunity Act of 1972) provides the most comprehensive protection against employment discrimination on the basis of race, color, gender and national origin (Hartman, Homer & Menditto, 1998). In 1991, Title II of the Civil Rights Act was amended to ensure that women and minorities do not encounter barriers, which may prevent them from advancing in corporations and businesses. Cultural diversity programs and training are an integral part of all healthcare corporations, at both staff and administrative levels. Even with intense diversity training, some inference had been given to 'token' women at the top, referring to a forced heightened visibility and boundary heightening. This practice appears to perpetuate gender inequity, rather than deter it (Zimmerman & Mitchell, 2000).

Any business with greater than fifty (50) employees, must complete and file an annual federal report (EEO-1 Annual Survey) regarding male and female employees totals (Hartman, et al., 1995). Upper management positions are still grouped together with all other management positions, but the separation of upper management from lower management positions was recommended by The Glass Ceiling Commission in 1991.

The ability to negotiate plays an important role in how leaders are perceived. Women

collaborate more, and their decision making process tends to forge connections for a shared

sense of destiny (Marcus,1995). This has been described as the 'Creator Model'. Men

thrive on conquest and winning, and are classified as 'Claimers' (Marcus, 1995). If gender

stereotyping is to be dispersed with, or even reduced; women must develop 'claimer'

characteristics without jeopardizing their nurturing and feminine qualities.

The most admired leadership characteristics in any industry, including healthcare, is

the ability for the CEO/ leader to produce results (Robinson-Walker, 1999). The qualities

of collaborative decision making, which turns a situation into a 'win-win' for all

involved is a dependable way to produce results. This is especially true when related to the

dynamic changes that are now occurring in healthcare.

In the arena of healthcare, women have been viewed as nurturers, usually working as

nurses, and advancing through the ranks of nursing into the Chief Nurse position or the Nurse

Executive role (Wiggins, 1991). ... This structure is also pyramidal and closely mimics

that of the hospital administration promotion tract. Female nurses, with comparable degrees to

males, are hesitant to step from a clinical setting into leadership roles for various reasons,

including the fear of loosing consensus and friendship or approval. This inability to step from
clinical to operations, opens the door and allows men with limited clinical experience and

knowledge, with the comparable college degree, to advance into senior management positions.

Stereotypical studies, and the public's cultural perception associates women with nurses

and men with doctors. This gender-dynamic study was conducted by Floge and Merrill (1986),

using male nurses and female physicians. Patients selected and called the male nurse 'Doctor'

and the female physician 'Nurse'. The results of this study indicates that there is an association

of authority with males (Zimmerman, 2000). Women's ability to leave these stereotypical

roles will only happen when they develop sufficient self-confidence in their own ability to

perform.

Changing Dynamics of the Healthcare Industry

During the 1990's, the healthcare industry has undergone multiple changes both with the

delivery of healthcare, and the payment for services. The Balanced Budget Act, 1996,

a slowing economy, and the healthcare industry becoming more competitive have contributed to

the changes. This leads to the need for re-structuring (Zuckerman, 2000). Future financial

viability is now a pressing concern for the healthcare industry, especially for hospitals that are

witnessing a reduction in profit margins. Hospitals have a labor-intensive infrastructure, with

annual rising salaries in an attempt to retain staff. Combine all this with the financial impact of

 a highly regulated industry, and the reality of continuing to practice medicine in a traditional

manner spells trouble.

What previously worked no longer does, and this includes how hospitals are managed.

Thinking 'outside-the-box' is a common day expression, and every leader is challenged to find a

more efficient and effective way to lead and to manage. Healthcare is straggling behind other

industries who have faced and managed this problem, namely the airline industry with
de-regulation and information technology industries (Zuckerman, 2000).

A recently published perspective determined that there are six problems in healthcare

management that require solving. Three of the six problems are related to the education and

preparation of all healthcare leaders. Two of the remaining three problems refer to attracting

intellectual people into health care management and recognizing their contribution to the

industry. The remaining problem refers to healthcare corporations developing a vision that

supports the community and its people. If men and women want to achieve success within the

complex organization of healthcare, the training and education of its leaders cannot be under

evaluated (Warden, Griffith, 2001).

To survive during this time of change, and transition, hospitals and healthcare industry

leaders must examine operations, project short and long term goals, and institute change

successfully. This is equally true in the not-for-profit sector as it is in the for-profit sector of

healthcare. Leaders will have to engage employees emotionally as well as rationally (Shur-

Bilchik, 2001). Healthcare organizations of the future will become more

fluid, less hierarchical, with an orientation to teamwork and lateral management.(Walsh, 1995).

When describing characteristics of men and women, terms such as teamwork, team players,

participatory, supportive and motivational are those most closely associated with the

management style of women (Robinson-Walker, 1999). This sentiment is exemplified by

the following quote: "Gone are the days of women succeeding by learning to play men's games.

Instead the time has come for men on the move to learn to play women's games"(Peters, 1990).

Team schema and gender role orientation studies suggest that when comparing

gender performance in judgment making and decision-making tasks, the results showed

that women outperformed men, performed equally as well as males, or performed worse (Scherer
& Petrick, 2001). More importantly, it was the overall ability of the team to perform cohesively,

 with a shared task commitment that performed the best (Scherer & Petrick, 2001). Women

see problem solving as a collaborative effort. Women form 'webs' to connect with people and

build relationships in an effort to solve problems or make decisions. Men are inclined to see

problem solving and decision making in a hierarchical structure, which is described as 'ladders'

rather than 'webs' (Robinson-Walker, 1999).

Nevada's Hospital History

Nationwide, the 1998-99-turnover rate for hospital administrators, regardless of sex, is 10.6%, whereas the Nevada turnover rate for the same period was 12.85% (ACHE, 2000). Unfortunately, women have a higher turnover rate in executive positions as compared to men. (Wilson, 2000).

With a population of nearly 1.5 million people, Las Vegas, Nevada, has a limited number of acute care hospitals(Census 2000). There are eight such facilities. For the purpose of this case study, Henderson and North Las Vegas are included in the survey due to geographic proximity and shared affiliations amongst the hospital groups. Only three of the eight acute care hospitals are classified as a not-for-profit status, two of which are religious (with two separate campuses), and the other facility, University Medical Center is the Clark County government facility, funded by the tax payers, and governed by Clark County Board of Commissioners. There are a total of 2,476 acute care licensed beds in Las Vegas, North Las Vegas and Henderson, Nevada.

Six of the eight acute care hospitals in Las Vegas are owned by four large healthcare corporations. Universal Healthcare Inc.(UHS), with headquarters in King of Prussia, Pennsylvania, owns three hospitals, for a total of 695 beds, which is 27.3% of all acute care beds. Healthcare Corporation of America/HCA, with headquarters in Nashville, Tennessee, owns two hospitals, with a total of 799 beds, which is 32.2% of the market.

Tenet Corporation owns Lake Mead Hospital, in North Las Vegas, with a total of 178 acute care beds, which constitutes 7.1% of the market. There are a total of 198 beds at Lake Mead, and licensed psychiatric beds are not classified as acute care. The headquarters for Tenet Healthcare Corporation is located in Santa Barbara, California.

The remaining two facilities are grouped in a not-for-profit status: Catholic West

Healthcare, St Rose Dominican' Siena and Boulder Highway campuses, with a total of 279 beds, which is 11.2% of the total market, owned and administered by Catholic West Healthcare. At the current time, the administrative leadership for both hospitals is under one leadership team, sharing the responsibilities for both hospitals. This shared practice of administration is common in Southern California amongst the Kaiser Healthcare group, and Scripps Healthcare facilities, but relatively new to the Las Vegas market.

The second not-for-profit hospital is University Medical Center. There are 542 licensed beds (7 behavioral health beds), for a total of 535 acute care beds at UMC which is 21.6% of the market share.

Two of the three Universal Healthcare Corporation (UHS) hospitals have female Chief Executive Officers (CEO). The Healthcare Company/ HCA, with its corporate wide 'Flag-ship hospital' in Las Vegas, Nevada, has a female Chief Operating Officer.(COO). Both of these large healthcare corporations run Chief Operating Officer or Leadership programs in various forms. HCA has developed a two-year mentoring program to prepare eligible candidates, with a Master's degree, for the role of COO. UHS conducts a more informal program, where senior leadership personnel spend time at corporate headquarters attending seminars and education programs. The fourth female executive holds the position of Senior Vice President of Operations (Sen. V.P.) with Catholic West Health (CWH). At the present time, CWH does not offer a formal training program, but acknowledges its benefits.

Chapter 3

Research Methodology

The top four female executives were interviewed to determine what role education and backgrounds, the 'glass ceiling', stereotyping, gender role behavior, , and the changing dynamics in healthcare have played in their career paths as hospital executives.

A letter of introduction was developed and mailed to each of the four top executives, A follow-up phone call was made to schedule the interview time. The plan was to conduct the qualitative research through interviews using the same set of open-ended questions. Detailed notes at the time of interview were taken, with prior obtained permission.

A questionnaire of twenty-two (22) questions was developed, and this functioned as

the basis for all four of the interviews (Appendix 2). In an effort to gain comparable

information, this questionnaire was forwarded to each participant before the interview. This gave

the participant an opportunity to review the questions, and each one had approximately 1-2

weeks to do so. At the time of interview, all of which were conducted over the telephone at the

request of each of the participants, the same format was used with each person.

The questions were grouped into corresponding categories directly relevant to the

research sections: background, education and career; the 'glass-ceiling', gender

role behavior and stereotyping, and the changing dynamics in the health care industry.

The interviews lasted from one (1) hour to one and a half hours each. Detailed notes

were taken at the time of interview and then the information was compared for similarities and

differences for all twenty-two questions. Several traits were apparent throughout all four

interviews and will be discussed in the next portion of the paper.

Chapter 4

Discussion and Findings

Background and Education

Common trends were threaded throughout the interview responses in regards to education

and backgrounds for all four executives. Commonalities are delineated in Table 1.

Table 1.

Work Experience and Education

Hospital	Position	Degree	Career Influences	Work/College	Hospital Background
CHW	Sen. VP	MPA	Male CEO	P/T-P/T	Nursing
HCA	COO	MBA	Male CEO	P/T-P/T	Nursing.

Male Physician

UHS-1	CEO	MBA	Male CEO	F/T-P/T	Dietary
UHS-2	CEO	MHA	Male CEO	F/T-P/T	Information Services

Note. CHW - Catholic Healthcare West; HCA - Healthcare Company of America;

UHS - Universal Healthcare System.

P/T- part-time

F/T - fulltime

There were many shared traits among each of the four female executives of the healthcare hospitals in Las Vegas. All four executives hold a master's degree and credits formal education, though not exclusively, as a key factor to their successful ascent into leadership. Although none set out with the specific goal, each executive made a conscious decision to pursue a career in healthcare administration after holding lower management positions within hospitals.

Clinical experience, the value of combining formal education and 'paying one's dues' was emphasized by all four. In explaining this, each female executive credits the experience gained by coming up through the ranks, with her ability to lead successfully today.

Two of the four executives came up through the ranks of nursing. Another executive started her career in health information services, and worked her way up through the ranks. The final executive started her career as a Registered Dietician, and progressed up the management ladder into administration.

All four executives attended college on a part-time (P/T) basis. Two of the four executives continued to work in a fulltime (F/T) management position while attending college. The other two executives worked part-time while attending college. The executives who worked

either fulltime and attended college part-time, or worked part-time and attended college part-time did this simultaneously with child rearing. All facilities provide tuition reimbursement for any employee pursuing higher education.

Each one discussed the importance of making a career path known to senior administrator/executives, and being prepared to take on projects. For these women, opportunities presented themselves in hospital leadership rather than nursing ranks. With the support of respective male CEO's, both of these females transitioned successfully into top executive positions in a hospital.

'The Glass Ceiling'

The questions related to the presence or absence of the 'glass-ceiling' concept, and how this has affected family and career choices produced different and distinct responses. The differences and similarities are outlined in Table 2.

Table 2.

Glass Ceiling

Hospital	Presence of Glass Ceiling	Hospital Structure	Mentoring	Personal Sacrifice
CHW	Aware, but hasn't interfered with career goals	Hierarchal	Important	No
HCA	Aware, but hasn't interfered with career goals	Hierarchal	Important	No
UHS-1	Local level No effect	Hierarchal	Important	By choice
UHS-2	Corporate level	Hierarchal	Important	By choice

Note. CHW - Catholic Healthcare West; HCA - Healthcare Company of America;

UHS - Universal Healthcare System.

Personal Sacrifice- family and career choices.

All four executives are aware of the 'glass ceiling' phenomenon and it's effects on women's ability to succeed. They acknowledged the concept and all but one executive felt that this barrier in varying degrees, had been a factor in her personal ability to succeed. One of the executives experienced this phenomenon at a local level, assured by her male boss that her gender, age and attractiveness would limit her ability to succeed.

Another executive had encountered the 'glass ceiling' effect with her inability to advance further up the corporate ladder. Both of the female executives have used the interactions as an impetus to their success. In fact, both women stated that she had the self-confidence to disallow the comment. Neither one let it interfere with their career goals. Incidentally, both females share the same parent company.

Leadership style within the hospitals is still hierarchical in fashion. The female executives discussed the necessary changes for organizational structure. For change to occur within the hospital hierarchy related to management, a more collaborative approach is needed. This requires strong communication skills, soliciting and respecting ideas, gaining insight, employing a collaborative style and a team approach. The respect for one's peers and subordinates were also emphasized.

The sense of collegiality, the ability to communicate on a same level as their male counterparts, and the ability to produce results are other key elements for success. Undertaking and volunteering for projects was emphasized as another essential factor on the road to success.

The absence of women in the boardrooms both locally and at the corporate level is conspicuous. This pattern is not considered as intentional, but rather circumstantial based on

male and female ratios within healthcare leadership. All four executives maintained that as women became more proficient in leadership, that the number of women in boardrooms and corporate level management would reflect this. Heightened hospital and corporate level visibility is also necessary for these changes to occur.

Another trend linking all four interviewees emphasized the importance of mentoring, being mentored by key people within their respective companies, and in turn sharing their knowledge and expertise. The female executives spoke with passion in regards to the necessity of women mentoring women.

Both male and female mentors played parts in grooming these executives for their respective roles. In support of the published data, male mentors were more prominent than females for this group, which is also statistically reflective of the data. None of the female executives saw the role that their male mentors played as detrimental to their feminine styles or development . Male mentoring has not impacted their ability to maintain strong female management traits of collaboration, consensus and team playing.

The female executives have all made personal sacrifices at one time or another during their career. Each one has learned to balanced career and families. Personal sacrifices bear relevance in that fact that three are married, and one is divorced. These executives have raised families, sometimes as a single parent, while continuing with their education and maintaining career goals. Two executives worked part-time and attended college part-time. Both practices reflect the findings from the national studies, where women worked part-time and pursued college degrees, taking longer to complete their degrees than men, who generally attend college fulltime.

The healthcare executives who worked fulltime while raising children felt that they have raised very independent children. Both verbalized that the time spent with their children was

limited. Each one would have liked to spend more time with the children, although each one

also recognized the necessity to stay on a career path, both from a financial and promotional

necessity. Both these female executives feel that their corporate philosophy would not have fully

supported an extended period away from work. Each one stated that to do so would have

compromised their credibility as a serious career woman. Ultimately, these choices have

been personal, and none of the executives are aware of being 'mommy tracked'.

A third executive returned to work on a fulltime basis when her youngest child started

school, and feels that it was advantageous for her family to choose this path. And, finally the

fourth female executive credits her corporation's 'family values' with her ability to balance

family and career.

Goal setting and career planning also featured in the executive's ability to balance career
and family. Each one had a three to ten year plan, both personal and professional. The

hospital where that plan was laid was not always the one where the goal was completed.

Family and personal choices formed these decisions, but each female executive determined that

her choice proved more profitable both financially and professionally.

Rather than focusing on the 'glass-ceiling' as barrier, each of these highly professional

women discussed ways to surmount any obstacle; look upon an obstacle as an opportunity

to showcase their skills, and their abilities to produce results. Self-confidence is a necessary

element but not an exclusive one. Education and the ability to 'talk-the-talk' and 'walk-the-

walk' features strongly as a recommendation to ascend the professional ladder.

Stereotyping and Gender Role Behaviors

Consensus on stereotyping and gender role behaviors was evident amongst the four

executives. The findings are outlined in Table 3.

Table 3.

Stereotyping and Gender

Hospital	Ability to Perform	Ability to Communicate	Team Player Vs. Hierarchal	Gender gap in Hospital Leadership
CWH	Strong	Essential	Team player	No
HCA	Strong	Essential	Team player	No
UHS-1	Strong	Essential	Team player	No
UHS-2	Strong	Essential	Team player	No

Note. CHW - Catholic Healthcare West; HCA - Healthcare Company of America;

UHS - Universal Healthcare System.

All four female executives interviewed felt that her gender was as asset, rather than a liability. None have encountered any behavior that could be classified as gender stereotyping, and stressed the fact that at some point or another, they all had a very supportive male boss who encouraged and guided their efforts to succeed. Without this liaison all acknowledged that they most likely would not be in their current positions.

Each female executive felt that her clinical knowledge, ability to produce results, and communicate in a recognized model resulted with her promotion to her current position. Communication is essential in any undertaking. The female executives stated that they communicate in a respectful, efficient and kind manner, which has benefited their careers. This strength has assisted them in maintaining strong collaboration relationship, gaining consensus and team participation.

To some extent, each executive discussed volunteering for special projects as the vehicle that carried her to higher levels within the hospital structures. Producing quality work, and volunteering for these projects helped the female executive gain the attention of senior

leadership within the organization.

Each executive credits her success, in part, with the passion for her work. Emphasis was also placed on the ability to network, remaining flexible, listening to suggestions and then formulating a decision incorporating ideas and opinions. This is classically described as 'team-playing'. Each saw the ability to implement change, with grace and direction, as an advantage rather than a problem. The changing healthcare arena was acknowledged as an opportunity for the executive to showcase her skills, promoting herself as a key leader, and helping her remain at the top.

The corporate cultures and philosophical values were acknowledged, and each female executive cited overall positive experiences with their respective corporate leadership, while acknowledging the lack of a strong female presence at the corporate level. The administrative structures are traditional hierarchal at the hospital and corporate level. The female executives shared the feeling that as more women enter and influence hospital leadership, the influence will cross into the corporate structures and affect change at that level.

The female executives were aware of the federal requirements in regards to the annual reporting of employee status (EEO-1), but felt assured that it had not factored into their career promotional path. None felt that she had been promoted to meet a statistical value, nor as a 'token' female in senior management.

The executives identified a 'gender-gap' in nursing rather than any identified gender gap in hospital administration or senior leadership. The role of nursing is changing, with more men entering nursing. Stereotyping was identified in the field of nursing only, where nurses tend to stay in clinical nursing, even when higher education and a degree may offer the nurse a different route.

As more women enter the field of healthcare administration, things would become easier

for the next generation of female executives to access the top rungs of the leadership ladder. The

challenge for these women will be to develop a career path early in life, as a hospital executive,

and follow it. Women will have to enter the healthcare profession with clearer career paths and

visions, rather than allowing their career to 'just happen'.

The distinct absence of longitudinal studies with relevance to healthcare leadership,

changing leadership roles, and how women can affect this change concerned these female

executives. Qualified leaders are essential amidst change. The female executives are confident

in their roles as hospital leader who can influence and direct some of the changes.

Changing Dynamics

In respect to the Las Vegas market, each of the female executives felt it was advantageous

being a healthcare leader at this time. The overall explosive population and demographic

growth of Las Vegas is seen as a unique opportunity for career advancement.

The fact that Las Vegas has added three new acute care hospitals within the past five

years has contributed to the need for additional talented leaders. This is a unique occurrence in

the current healthcare climate. Two of the executives moved to Las Vegas within the same

time period, approximately five years ago. One came specifically as the CEO for a new facility,

whereas the other executive has been promoted into a COO position since her arrival. The

challenges of managing such rapid population growth, the financial constraints, providing

healthcare services for a diverse population, are perceived as an opportunity to excel by each of

the four executives.

Other advantages of being a healthcare leader in Las Vegas include the fact that there

is a limited resource pool of talented leaders. This allows those with exceptional talent and

skills the opportunity to move into leadership positions more quickly. In other demographic areas

where large resource pools reside, competition is greater, and where tenure and politics may

influence decisions in lieu of talent. The retention amongst female healthcare executives appears

high in Las Vegas at the present time contradictory to the published report (ACHE, 2000).

Corporations value a high caliber of leadership. All these executives have spent five years or

greater with their respective corporations.

Las Vegas is also a 'blue-collar' town, where women work in non-traditional

jobs, and this is an asset to all women in leadership roles. Acceptance is easier. The female

executives stated that women bring a different perspective to problem solving, and this is
essential in light of the changes happening in healthcare.

The female healthcare executives interviewed felt that women are an untapped pool of

talent. The recruitment of talented and skilled executives is not as competitive within the

demographic structure of the Las Vegas valley due to its isolation from other communities. The

larger corporations have identified talent within their own structures, and promoted from within,

which has favored the female executives. Finally, the female executives determined that women

with the knowledge and education must move into positions of power and leadership, to

complete the circle of advocacy for industry while providing quality healthcare.

Chapter 5

Conclusion

In conclusion, the findings indicate that the Las Vegas female executive healthcare

leaders are successful. They have embodied the necessary characteristics for success. Each one

has the educational requirements, recognizes the importance of mentoring as the way to succeed.

Each has 'paid her dues' and worked up through the ranks. The executives have played the

leadership game according to today's rules recognizing the importance of both corporate and

community visibility.

The importance of formal and informal education was identified as essential for

advancement in healthcare leadership. Education is necessary to support career advancement.

Women are encouraged to develop career goals. Based on these goals, women must determine

whether to advance in either a clinical or hospital leadership career tract. Once the path is

selected, a determination to succeed is essential.

Identification of the 'glass ceiling' phenomenon was acknowledged, but it was not

acknowledged as an issue for these female executives. The importance of mentoring, and being

mentored by key leaders within an organization is another important element for success. Women need to play an active role in the preparation and grooming of future leaders, both male and females. Perhaps the healthcare corporations have taken direction from the Microsoft Corporation statement on diversity, and have applied it the healthcare. The diversity statement is as follows "One of our main goals at Microsoft is to have a positive impact in the number of under-represented minorities, women,… in the technology industry." Only time will tell if this is indeed a permanent change for female healthcare executives in Las Vegas.

Stereotyping and gender role behavior was seen as an advantage rather than a problem for the female executives. The general consensus was that women are different than men with regards to leadership, and this should be accented rather than denied.

The explosive population growth in Las Vegas, Nevada, has proven advantageous for these executives, providing them with opportunities for advancement. The changing dynamics in healthcare has provided each one of the female executives with opportunity to excel and showcase her individual skills in leadership. These opportunities may not have presented themselves in a different environment.

One weakness of this study lies with the limitations in sample size. Specific empirical data related to women in healthcare leadership roles is also limited. More longitudinal research is needed to evaluate the role of women in healthcare leadership roles, comparing this information to other industries.

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Appendix -I

Introductory Letter:

1731 Mount Tremblant Avenue
Las Vegas, NV 89123

September 09, 2001.

_____, CEO
Desert Springs Hospital Medical Center
2075 East Flamingo Road
Las Vegas, NV 89119.

Dear _____:

I had the pleasure of interviewing you in March 2001, in regards to the role that women play in Las Vegas hospital administration.

As the completion of my Master's degree approaches, from the Department of Public Administration at University of Las Vegas, Nevada, I have elected to write an in depth case study on the above topic. In order to research the paper, I would like to re-interview you at your convenience.

I will call your secretary during the week, to check on your willingness and availability. In respect of your time, I will gladly conduct this interview over the phone, if you are agreeable.
I have attached a copy of the questionnaire, for your review.

I appreciate your involvement in my round of interviews, and would appreciate your insight and input in regards to the new questions.

I can be contacted through my paper at 699-1705, or my cell phone 278-0047.

Thank you,

Sincerely,

Caroline Copeland,

Appendix 2- Questionnaire

"Why is hospital leadership different in Las Vegas, Nevada, when comparing local to national percentages and trends, in relationship to the 'Glass Ceiling, stereotyping, gender role behaviors, and the changing dynamics in healthcare?

Background:

1.   Why did you choose hospital administration for your career?

2.   Who influenced your decision?

3.   Did you attend college as a full-time student or a part-time student, while continuing to work?

4.   Did you set out with a 'five-year' plan or a 'ten-year' plan? Did anyone encourage you to develop a plan when you started your healthcare career?

5.   Did any healthcare corporation offer you management training? If so, what did this entail?

Glass Ceiling:

6.   The 'glass ceiling' effect is evident in professional journals, in your career have you experienced the 'glass-ceiling' in your career rise?

7.   Please describe the facility philosophy in regards to organizational structures?
         (i.e. team players vs. traditional hierarchical for which hospitals are well known.)

8.   Do you mentor?

9.   How do you mentor?

10.   Are you currently mentoring any females in your organization for leadership roles?

11.   Corporations are hesitant to promote women, who may want to combine family and career. This is defined as the 'Mommy tract'. In your opinion, has this effected your

ability to advance in hospital administration? How have you balanced personal choices with career choices? Have you made any personal choices? (Discuss marriage, divorce and childlessness stats).

Gender and Stereotyping?

12.   Did you have a female mentor or role model?

13.   What are the advantages of being a female administrator in a female dominant work market?

14.   What are the <u>disadvantages</u> of being a female administrator in a female dominant work market?

15.   Do you perceive a 'gender-gap' in hospital administration?

16.   What changes are necessary to change this 'gender-gap' if you perceive one?

17.   What difficulties did you encounter changing from a 'clinical-based' career into the administrative sector?

18.   Are there any dominant traits identified with male versus female administrators?

19.   In your opinion, do females manage or administrate differently than males? Female styles versus male styles?

20.   How are decisions made within your organization both at a local and corporate level? Team approach versus individual decisions?

Changing dynamics in the healthcare industry:

21.   Las Vegas is a limited market in regards to healthcare, with three large healthcare corporations. The majority of the market is also 'for-profit'. What other unique characteristics/ challenges do you feel Las Vegas provides you as a hospital administrator?

22.   How has this helped/hindered your career achievements?