Advancing Women in Leadership Online Journal
Volume 21, Summer 2006

Women in Hospital Chief Executive Officer Positions:

Fact or Fiction

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Abstract

Are women represented in hospital CEO positions? Twenty-three hospitals in three counties were surveyed to answer this question. Surveys were done to determine the number and percentage of women in hospital CEO positions. Also identified were the beds controlled by women hospital CEOs within each county. From the county with the lowest percentage of women in CEO positions, an American College of Healthcare Executives survey, Gender and Career in Healthcare Management (GCHM), was conducted.

Two counties were above the national average for women CEOs at 23.3%. One county was at 25% and the other county was at 33%. The first county was at 52% and the second county was at 27% for control of percentage of beds by women hospital CEOs. The third county which was below the national average for women was at 11% with 1.3% of the beds controlled by women. In the results of the GCHM, women respondents were satisfied with advancement, infrequently engaging in informal networking within their current organizations, and perceived male stereotyping and preconceptions of women's roles and abilities as the primary barrier to advancement. More research needs to be conducted on the counties with women hospital CEOs to identify the strategies that helped make these women in CEO positions a fact.

Women in Hospital Chief Executive Officer Positions:

Fact or Fiction

Women in senior executive management positions have been a topic written about for many years. The barriers preventing women from executive management have been referred to as the "glass ceiling." The literature for healthcare has mirrored business in regards to women obtaining senior executive management positions. This study looks at three counties for women in hospital CEO positions. This study initially sought

to look only at Spokane County in Washington. It was expanded to include two additional counties, one within the state of Washington and one midwest county in Ohio. The percentage of women as hospital CEOs and number of beds controlled by women were determined for all three counties. Women in leadership positions in the hospitals and healthcare systems in the past and currently in Spokane County in Washington were surveyed to determine their thoughts regarding gender and careers in healthcare management. The responses of women surveyed from Spokane were compared with national results from the surveys conducted by the Foundation of American College of Healthcare Executives (2002).

Background

Spokane, Washington is located in the heart of the Inland Northwest and serves as the medical hub for Eastern Washington, Eastern Oregon, North Idaho, Western Montana, and Southern portions of Alberta and British Columbia in Canada. Spokane is on the eastern side of Washington bordering Northern Idaho. Healthcare plays an important role in the Spokane economy. The hospitals serve as large employers within the community. A recent study stated that "health care is the leading industry in Spokane County," and that healthcare accounts for 22 % of the county income (Bunting & Jones, 2004, p. 4). Statistics from the State of Washington Employment Security Department for the first quarter of 2004 showed that 78% of the hospital and clinic workforce for Spokane County were women. The city of Spokane is home to some 195,500 residents. There are around 416,000 residents in the metropolitan area. The median household income in the county in 2003 was $36,446 according to the US Census Bureau 2003 American Community Survey. Spokane is the second largest city in the state of Washington and is the largest city between Seattle and Minneapolis. Within Spokane County there are nine hospitals. Four of these hospitals are specialty hospitals, one is a rural hospital, and four are acute care hospitals. The CEO category for all areas in the 2000 census from Spokane County, in the detailed occupations of the civilian labor force, identified 1,165 individuals. Of those identified, 964 were male and 204 were female. The females in this category made up 17.5% of the total identified.

Snohomish County is located in northwestern Washington just north of King County where Seattle is located. Everett is the largest city in the county. In the US Census Bureau 2003 American Community Survey Snohomish County had a population of 629,672 and a median household income of $50,886. Within Snohomish County there are four hospitals. The CEO category in the 2000 census from Snohomish County, in the detailed occupations of the civilian labor force, identified 2,260 individuals. Of those identified, 1,829 were male and 429 were female. The females in this category made up 19% of the total identified.

Lucas County is located near the northwestern section of Ohio bordering Michigan and the western tip of Lake Erie. Toledo is the largest city in the county. The US Census Bureau 2003 American Community Survey showed Lucas County as having a population of 443,913 and a median household income of $36,804. Within Lucas County there are ten hospitals. Lucas and Ottawa Counties report their occupation data results jointly. The CEO category in the 2000 census from Lucas-Ottawa Counties, in the detailed occupations of the civilian labor force, identified 1,905 individuals. Of those identified, 1,555 were male and 245 were female. The females in this category made up 13.4% of the total identified.

CEO Facts

In her book entitled *Women and Leadership in Health Care,* Robinson-Walker (1993) points out that 85% of the US health care workers are female, yet women simply are not present in the most senior management positions. Ninety-two percent of the seventy-five respondents to the question "Do you think gender plays a major role in leadership practice in health care?" responded yes in a 1997 Gender and Leadership in Healthcare Study by Robinson-Walker. Fifty-five of the respondents were female and 20 respondents were male. Males responded yes at 90% and females responded yes at 91%.

The American College of Healthcare Executives (ACHE) has published results of a survey conducted every five years on Gender and Leadership in healthcare. In the 2000 ACHE survey, 1,601 affiliates were selected with 906 responding. Major findings indicated that while "both gender groups could ascend the organizational hierarchy, about 11% of women, compared to 25% of men healthcare executives, achieved CEO positions" (p. 2).

In salary, women tended to earn about 19% less than men in comparable positions. In education, more men than women majored in healthcare management, and women more than men had clinical backgrounds. In networking, the study demonstrated that "men continue to interact with other executives informally to a greater extent than women do" (ACHE, 2000, p. 4). ACHE also has tracked hospital CEO turnover rates since 1981. The 2004 rate for short term, general-service, and non-federal hospitals showed a turnover rate of 16% for 4,566 hospitals. Turnover rates for hospital CEOs are an important aspect for women attaining these senior executive positions. If the turnover rate is low, it decreases the accessibility of these positions. Washington was rated a low-turnover state at 36th with a turnover rate of 14%. Ohio was rated a high-turnover state at 10th with a turnover rate of 20% (ACHE, 2004). In a report by Garman and Tyler (2004) on CEO succession planning in freestanding hospitals in 2004, the issue of gender was not reviewed. Seven hundred twenty-two institutions of 1,651(44%) identified or completed the survey. This question was asked, "Who was considered as a potential successor?" One hundred fifty-four institutions responded to this question, 62(56%) indicated that "only internal candidates were considered" with 34(31%) considering both internal and external candidates.

Literature Review

In an article by Weil and Mattis (2003), a recent national survey of healthcare executives has shown that 90% of women but only 53% of men favored efforts to increase the proportion of women in senior healthcare management positions. The study states that women have made some progress in entering the managerial ranks of US healthcare but not at the highest levels: "There was nearly universal agreement among women that special efforts should be made to advance their careers" (p. 4). Various reasons were given for this:

Women are a large part of the available talent pool. Women possess valuable leadership skills that complement those of men. Women have a unique perspective to contribute to decision making and problem solving.

It's the right thing to do. (p. 4)

Social responsibility and share and stake holders demanding greater representation were also cited. Weil and Mattis state,

When questioned about possible factors that prevent women from achieving high level positions in their current organizations, both men and women agreed with three major existing hurdles:

- Male stereotyping and preconceptions of women's roles and abilities
- Exclusion of women from informal networks of communication
- Failure of senior leadership to assume accountability for women's advancement (p. 6)

Weil & Mattis included this quote from a male respondent:

For many years, healthcare leadership (including ACHE) has been an old boys' network. I don't necessarily mean that in a disparaging way, but that has been the face of healthcare leadership. In our organization, 85% of the workforce is female and that is consistent throughout the care delivery system. The designated healthcare decision maker in most families is a woman. Other healthcare professions have advanced greater

diversity than executive management…It is long past time that senior executive leadership in healthcare better reflect the rich diversity of our customers and our workforce in all ways. (p. 7)

Weil and Mattis conclude that

Research shows that the majority of CEO's (64%) believe that a significant barrier to women's advancement is the length of time they have spent in the organization pipeline. However, an even larger percentage of CEO's (82%) responding to the same survey cited women's lack of significant management and line experience as a major barrier….As one CEO ...stated: "It's not that women haven't been in the pipeline long enough, it's what they have done in the pipeline." Organizations will have to take deliberate steps to address women's lack of experience in core business functions-experience that will enable them to compete with men for top-level positions. (p. 7-8)

The United States has examples of women who have been able to achieve senior executive positions. Haugh (2002) discussed a women management team in a 107 bed facility, Round Rock Medical Center 20 miles north of Austin, Texas: "In the male-dominated C-suites of health care, a small Texas hospital is bucking the trend with an all-female executive team" (p. 22). The CEO, CFO, and CNO were all women and did not consider their style or the situation unique. Three of the four of Austin's hospitals had women CFO's.

In an interview with Susan Stout Tamme, President of Baptist Hospital East in Louisville, Kentucky, Kelly (2002) stated that " In Kentucky, 20 percent of the hospital chief executive officers are women" (p. 30). Con Sue Lo Diaz, CEO of Rancho Los Amigos National Rehabilitation Center in Downey, California expressed this view: "The health care industry is still controlled by men who, for the most part, instinctively gravitate toward candidates who look like themselves and in whom they see a little (or a lot) of themselves - other white males" (p. 30).

In a doctoral dissertation titled, "Managing Gender Expectations: A Competency Model for Women in Leadership" by Mitchell (2000), findings suggested that executive men have a general discomfort with their female colleagues, and that women therefore must carefully manage their relationships with men. This managing of relationships by women may be the cause of not engaging in informal networks at the same rate as men.

Sloane (2003) discussed the push by the American College of Healthcare Executives, the National Association of Health Services Executives, the American Hospital Association, and other groups to bring healthcare closer to the national business averages on minority hiring. The old boys' network in health management is alive and thriving: "Diversity remains an uncomfortable topic for most businesses, but for healthcare, it's a particularly pinched nerve" (Sloane, 2003, p. 25). Sloane's comments lead one to question what the national statistics are for women CEOs in all areas.

The term "glass ceiling" was coined by the Wall Street Journal 20 years ago to describe the apparent barriers that prevent women from reaching senior management positions. Ten years ago, the US government specially appointed "glass ceiling" opinion Commission published that the barrier remains (Economist, 2005). The main issues identified for lack of attainment are exclusion from informal networks, stereotyping of women's capacity, and lack of role models. From a 1999 Society of Human Resources Management's 1,999 Barriers to Advancement Survey, "a corporate culture that favors men was the top barrier to career advancement, followed by stereotyping or preconceptions based on race or ethnicity" according to Sappal (2000, ¶ 2) in an article on women taking a backseat in business. Exclusion from informal networks is also mentioned in the top five barriers to advancement. The issues reported for business in general are also those reported in healthcare.

Chief Executive Officer statistics are found through the Bureau of Labor Statistics Division of Labor Force

Current Population Survey Table of Employed Persons by Detailed Occupation and Sex 2000-2004 (Department of Labor, 2005) under management, professional, and related occupations. In 2000, the percentage of women holding these positions was 18.8%. In 2004, the percentage of women holding these positions was 23.3%. This four year period has shown an increase for women of 4.5%

This Study

Given the information in the literature, the present study seeks to look at specific counties through phone surveys and internet searches to determine hospital CEO gender and gender control of beds. The study identified percentages of women hospital CEOs. The study also sought to identify for the three counties surveyed if the percentage of women hospital CEOs is similar to the national average of women CEOs. For the county not achieving the national average more information was sought to look at the issues of advancement, networking, and barriers.

Methodology

Sample

The Spokane Regional Health District was contacted to identify other counties similar to Spokane that could be identified within and outside the state of Washington for review of hospital CEO leadership. The Assessment Center for the Spokane Regional Health District identified Snohomish County in Washington and Lucas County in Ohio. Information was gathered through phone interviews, state records, and internet sites to determine type of hospital, licensed bed size, and gender of CEO in each identified hospital in all three counties, and whether or not the hospitals were part of a healthcare system or network. This was completed in the spring of 2004 for 23 hospitals. In the spring of 2005 a follow up phone survey was conducted to determine if there was a change in leadership during the year and the gender of the current leader. This was done with all 23 hospitals. After the initial hospital survey was completed, the Gender and Careers in Healthcare Management survey was sent to Spokane women in healthcare leadership positions.

Questionnaire

Permission was obtained from the American College of Healthcare Executives to use the Gender and Careers in Healthcare Management (GCHM) survey tool used in their 2000 survey. The GCHM is an 18 page survey with 5 sections. The sections include the following:

Career Origins and Current Position

Current Organization

Career Aids and Aspirations

Work, Rewards, Separations and Discrimination

Background and Personal Information

Also used in this survey was a portion of Appendix C from *Leadership in Healthcare: Values at the Top* by Carson Dye (2000). This questionnaire assessed one's professional and personal values. The survey contained 17 questions. An Institutional Review Board (IRB) expedited review was conducted through the Eastern Washington University IRB committee for this study identifying survey tools.

CommentsonMethodology

Initially information from one county was obtained. The study was expanded to three counties. Means were used to obtain percentages of women hospital CEOs and percentage of beds controlled by women hospital CEOs. On the GCHM survey and questionnaires given, means were used to obtain the average for responses. These are reported out in the results section.

The data set is not overly large with 23 hospitals reviewed in 3 counties and 14 women respondents for the survey and questionnaire. As the number of women in hospital CEO positions in one county was low, it was difficult to identify possible respondents. This work provides a starting point from which further studies might continue.

Results/Discussion

Sample

In December 2004 a small group of women with previous executive management experience in Spokane hospitals met to identify women who had worked or currently were working in Spokane in healthcare, having had or currently had a title of chief operating officer, executive director, vice president, or administrator. All those women who could be identified were included in the survey mailing. In January 2005 letters, along with the two survey documents, were sent to 20 women who had been identified. The letter identified the researcher, the purpose of the study, and identified that the responses were not to be signed so identification would not be made. A return stamped and addressed envelope was enclosed for information to be sent back to the researcher. The letter also identified that there would not be a follow up to the initial request. It also stated that everyone who had received the letter and surveys would receive a copy of the study results whether the survey was completed or not. Because of the format of the surveys, the researcher was not able to identify the respondents. By the end of January, 13 responses had been received. One additional response was received in February for a total of 14. One survey was returned without being completed as the individual was out of the country for an extended period of time. Five sets of surveys were not returned. The completed return rate with no follow up and with one person not accessible was 14 of 19 or 74%. Based on the number of women who could be identified it was felt that the return rate was adequate.

Survey responses

From the phone survey and internet search regarding the hospitals in three counties and the representations of women, Tables 1-5 show the information obtained. Table 1 identifies the hospitals in Spokane County. Table 2 identifies the hospitals in Snohomish County. Table 3 identifies the hospitals in Lucas County. Table 4 compares the three counties by number of hospital beds, women CEOs, and percentage of beds controlled by women in 2004. Table 5 gives the same comparison for 2005.

Table 1 shows that Spokane County has nine hospitals with a total of 1,872 beds. All hospitals are part of a healthcare organization system. In Table 2 Snohomish County has four hospitals with a total of 699 beds. Only one hospital is part of a healthcare organization system. Snohomish County borders King County where Seattle Washington is located. This county has a greater population than the other two counties and it has fewer hospital beds.

Lucas County has ten hospitals with a total of 2,954 beds. Nine of the hospitals are part of a hospital system as shown in Table 3.

Table 4 compares the three counties in number of hospitals, bed size, and percentage of women as hospital CEOs, and the percentage of beds controlled by women CEOs. Snohomish and Lucas County have a higher percentage of women as CEOs than the national healthcare statistics, and women control a higher percentage of the hospital beds in these counties. Spokane County demonstrates a lower percentage of women as CEOs

than the national healthcare statistics, and a relatively low percentage of hospital beds are controlled.

A change in leadership occurred in both Spokane and Lucas counties. For Spokane, there was no change in percentage of beds controlled. For Lucas, there was a percentage change from 40% controlled by women in 2004 to 27% in 2005 as shown in Table 5.

From the mail survey, the following information was obtained (Table 6). The Spokane women surveyed had an average of 24.6 years of experience in healthcare management with an average of 17.6 years at their current organization. A series of questions on the GCHM survey addressed the issues of satisfaction in current position, networking with individuals within the current organization, and barriers that prevent women from advancing to the highest levels. This information is provided in Tables 6, 7, and 8.

In Table 6, respondents to the survey expressed a high level of satisfaction. Highest rated was overall advancement and lowest rated was recognition/awards.

Respondents were not highly involved with other executives in non-work activities as shown in Table 7. This confirms information state earlier in national ACHE gender and leadership surveys.

Respondents agreed that male stereotyping and preconceptions of women's roles and abilities were barriers to advancing to the highest levels of organization leadership as shown in Table 8. The findings were consistent with the information presented by Weil and Mattis (2003). Respondents disagreed that women's lack of desire/ability to do what it takes to get to the top was a barrier.

The information in Table 7 on networking and in Table 8 on the barrier of male stereotyping and preconceptions of women's roles and abilities was further demonstrated in the additional survey mailed with the GCHM. In the evaluation of professional and personal values from the two highest and lowest rated responses were discussed. The two highest *Leadership in Healthcare: Values at the Top* rated questions were: "To what extent do you keep your word?" and "To what extent are you a highly dedicated person?" The lowest rated questions were: "To what extent are you willing to trust others?" and "To what extent do you seek to develop positive and wholesome relationships with others?" The highest rated responses are the self-perception of the individual and how they relate their own efforts in the work place. The lowest rated responses discussed relationships and trust issues with others in the work place. As indicated in the discussion, women do not communicate informally and network as men do.

One section of the GCHM asked questions about discrimination. Three of 14 respondents stated that they had experienced or personally witnessed sexual harassment. Four of 14 stated that they failed to receive fair compensation because of gender. Three of 14 stated they were evaluated with inappropriate standards. This information is similar to that found in earlier ACHE gender and leadership surveys (ACHE, 2000; Sloane, 2003; Weil & Mattis, 2003).

A part of the GCHM survey discussed the reasons for organizations to increase their representation of women. Ninety-three percent of the respondents felt there should be an effort made to increase the women in senior healthcare management. They strongly agreed that women possess valuable leadership skills as well as a unique perspective to contribute to decision-making. They disagreed that shareholders/stakeholders are demanding greater representation of women.

In an open-ended question regarding whether gender affected career progression in the last five years, there were six comments. Four felt that because of their individual skill set, gender had not influenced their career path. Two felt that gender had influenced their career with one stating, "I have observed that women can progress to the Vice President level without significant difficulty. However, if a woman aspires to a COO position, particularly in a large organization, I have very little optimism that she will be successful."

The last question of the survey related to general comments about gender issues in a career progression of healthcare executives. The following were the comments made:

- The female gender in the healthcare systems across the country are proving their capabilities daily and everyone is taking notice.
- I see major need for reality based leadership "training." Women don't usually speak the three languages needed: nursing, Dr. (medical), and CEO (organization). NSG=best for patient, DR=good outcome (for me), CEO=RD (research and development), investment, & other. I see most women taking no for an answer and not "sorting" well how to come back again – no sense of politics – no planning to plan – no thinking about how/what it will take to get someone to buy an idea – not able to express self in fewer words.

Summary/Conclusions

This research contributes to the advancement of women to senior executive positions. Two of three counties surveyed for women's hospital CEO leadership demonstrated that women have obtained these positions. Percentages are above reported county and national norms. One county was substantially lagging behind national norms. When surveyed regarding gender and careers in health management, female respondents from Spokane County responded that they were satisfied with advancement, infrequently engaged in informal networking in their current organizations, and perceived male stereotyping and preconceptions of women's roles and abilities as a barrier to advancement. These results were similar to the results obtained from national surveys.

The challenge for areas not meeting national norms lies in identifying how to advance women. This means that steps must be taken to adequately prepare women for senior executive management positions regarding work experience, challenges, networking, and actively advocating within organizations and with governing boards for female hospital CEO successors. The two counties with women hospital CEOs above the national average need to be studied further to identify the strategies that helped advance these women to CEO positions making women hospital CEOs a fact.

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Table 1

Hospitals in Spokane, Washington

Hospital	Type	Size	Part of System
Deaconess	Nonprofit	388	Yes
Deer Park	Nonprofit	25	Yes
Eastern	Government	273	Yes
Holy Family	Nonprofit	272	Yes
Sacred Heart	Nonprofit	623	Yes
Shriners	Nonprofit	30	Yes
St. Luke's Rehab	Nonprofit	102	Yes
Valley Hospital	Nonprofit	123	Yes
Veteran's Hospital	Government	36	Yes
Total Beds:		1,872	

Table 2

Hospitals in Snohomish, Washington

Hospital	Type	Size	Part of System
Cascade Valley	Nonprofit	48	No
Providence Everett	Nonprofit	362	Yes
Stevens	Government	217	No

Valley General	Government	72	No
Total Beds:		699	

Table 3

Hospitals in Lucas, Ohio

Hospital	Type	Size	Part of System
Flower	Nonprofit	313	Yes
Greene Memorial	Nonprofit	200	Yes
Medical College of Ohio	Nonprofit	319	Yes
Mercy Children's Hospital	Nonprofit	64	Yes
St. Anne Mercy Hospital	Nonprofit	96	Yes
St. Charles	Nonprofit	390	Yes
St. Luke's Hospital	Nonprofit	314	No
St. Vincent Mercy Medical Center	Nonprofit	556	Yes
Toledo Children's Hospital	Nonprofit	161	Yes
Toledo Hospital	Nonprofit	541	Yes
Total Beds:		2,954	

Table 4

Women Leadership in 2004

County	Hospital/Licensed Beds	Female CEOs/ Perecentage of Female CEOs	Percentage of Beds Controlled by Female CEOs
Lucas	10 Hospitals / 2954 Beds	4 CEOS / 44%	1188 or 40 %
Snohomish	4 Hospitals / 699 Beds	1 CEO / 25%	362 or 52 %
Spokane	9 Hospitals / 1872 Beds	1 CEO / 11%	25 or 13.3 %

Table 5

Women Leadership in 2005

County	Hospital/Licensed Beds	Female CEOs / Percentage of Female CEOs	Percentage of Beds Controlled by Female CEOs
Lucas	10 Hospitals/ 2954 Beds	3 CEOs / 33%	798 or 27%
Snohomish	4 Hospitals / 699 Beds	1 CEO / 25%	362 or 52 %
Spokane	9 Hospitals / 1872 Beds	1 CEO / 11%	25 or 1.3 %

Table 6

Satisfaction in Current Position

Type of satisfaction	Scale of 1-4 4 Meaning Very Satisfied
Recognition / Awards	3.14
Availability of Mentors	3.2
Job Opportunities	3.2
Balance Between Work and Family	3.28
Compensation	3.5
Overall Satisfaction	3.64
Overall Advancement	3.71

Table 7

Non-Work Activities with Other Executives

At Least Every 2 Months	At Least Every 3 Months	Less Than Every 3 Months
Informal Lunches	Informal Dinners	Sporting Events
	Health / Fitness Clubs	Sports Activities
	Bars, Restaurants	Family Activities
	Cultural Events	

Table 8

Barriers to Advancing to Highest Levels of Organizational Leadership

(1 – Strongly Disagree to 4 – Strong Agree)

Barriers	Rating
Women's Lack of Desire/Ability to Do What It Takes to Get to the Top	1.71
Discrimination by Male Supervisors or Colleagues	2.21
Inhospitable Organizational Culture Toward Women	2.29
Lack of Awareness of Organizational Politics	2.36
Lack of Opportunities for Visibility Within the Organization	2.36
Women's Lack of Significant General Management/Line Experience with Profit and Loss Responsibilities	2.43
Exclusion of Women from Informal Networks of Communication	2.57
Lack of Professional or Executive Development Opportunities for Women	2.57
Lack of Mentoring for Women	2.64
Commitment to Family Responsibilities	2.64
Failure of Senior Leadership to Assume Accountability for Women's Advancement	2.79
Male Stereotyping and Preconceptions of Women's Roles and Abilities	3.15