MENTORING, JOB COMPETENCE, AND PERCEPTIONS OF BARRIERS ON CAREER ADVANCEMENT AMONG SENIOR WOMEN ADMINISTRATORS IN HEALTHCARE ADMINISTRATION

Danita F. Hunter, MSA, MPM, PMP

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Dissertation Committee:

Steven Berkshire, Ed.D.	Committee Chair
Lawrence Fulton, PhD.	Faculty Member
Frances Finley, D.H.A.	Faculty Member
February 3, 2011	Date of Defense
Roger Coles, Ph.D.	Dean College of Graduate Studies
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This dissertation is lovingly dedicated to my husband Pernell D. Hunter and daughter, Alexis D. Hunter. Without the unconditional love and support of my husband and daughter, this journey would have never been accomplished.

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ABSTRACT

MENTORING, JOB COMPETENCE, AND PERCEPTIONS OF BARRIERS ON
CAREER ADVANCEMENT AMONG SENIOR WOMEN ADMINISTRATORS IN
HEALTHCARE ADMINISTRATION

by Danita Hunter

The purpose of this study was to examine the effects of formal and informal mentoring on the perceived barriers to career advancement of women in middle level and senior level positions in healthcare administration. This quantitative study examined the role of mentoring in achieving job competence among female healthcare administrators and to examine whether formal or informal mentoring relationships contribute to more positive career outcomes for women in healthcare administration. This study derived support from previous studies that suggest mentoring yields several benefits such as the attainment of salary increase, increase in managerial promotions, and greater career satisfaction. At present, there is scant literature on how mentoring impacts women's career advancement in healthcare administration. This study contributes to literature on mentoring and its increasing impact in women's career advancement particular in healthcare settings.

This study used a survey instrument designed to answer three primary research questions 1) Is there a relationship between type of mentoring relationship (formal or informal) and perceived career advancement barriers among women healthcare administrators? 2) Is there a relationship between type of mentoring relationship (formal or informal) and job competence success among women healthcare administrators? 3) Is there a relationship between current position and perceived career advancement barriers among women healthcare administrators?

Results of the study revealed there is no significant difference between the respondents' current position and perceived barriers towards career advancement. Results also revealed no significant difference between type of mentoring relationship and perceived barriers towards career advancement; however the results supported a correlation between the type of mentoring relationships and job competence. Respondents reported that mentoring improved knowledge of healthcare administration.

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CHAPTER I

INTRODUCTION

Background of the Study

Generally, healthcare is a woman's domain (Borkowski & Walsh, 1992). Baker and Koplan (2002) opined that the healthcare system lacks the diversity that its constituents and clientele requires as far as top-level leadership is concerned. Despite the fact that 78 percent of the healthcare workforce are women and that women are also healthcare's largest consumers, they are severely underrepresented in top management. The American College of Healthcare Executives (ACHE) studied the patterns of executive leadership from 1990 to 2006 and came up with the conclusion that women's presence in executive positions is laggard and slow-paced. Clearly, healthcare employs a substantial population of women. Surprisingly, the disparity in career advancement toward managerial positions between males and females that exists in business is likewise reflected in healthcare administration.

Despite assertions that there have been considerable gains in achieving gender equity in the workplace, the fact remains that women in the twenty-first century have to break through the "glass ceiling" as did their earlier counterparts (Adair, 2002). The "glass ceiling" is a phrase that denotes the invisible and multilayered barrier that women encounter as they seek to advance in their careers within the organization. It is true that women are now comparable to men in terms of chances of getting accepted into the workforce. However, the process of getting promoted is an altogether different matter. At present, there are women occupying management positions but only a handful of them

have succeeded in achieving top-level positions. Adair (2002) explains that there are complex and varied barriers that hinder the advancement of careers among women.

These barriers are particularly true in healthcare. Statistics on the number of senior executives who are women in the United Sates healthcare system indicate the presence of the glass ceiling. According to ACHE, out of over 6,000 hospitals surveyed in 2005, merely 20 percent of them had female Chief Executive Officers (CEO) s (Eiser & Morahan, 2006). The same report suggested that salary differentials among men and women in healthcare are apparent. Women were compensated 19 percent less than men despite possessing approximate credentials. Moreover, men were more likely to begin their managerial careers in healthcare as vice presidents and higher before eventually taking the position of chief operating officer (COO) or chief executive officer (CEO).

Female executives in healthcare were likely to be in a staff position or head of the department while male executives were CEO, COO, or vice president (VP). Furthermore, the number of women executives populating the ACHE remained virtually unchanged (Eiser & Morahan, 2006). Concerns on quality, equality and the presence of structural and cultural barriers in healthcare prompt the need for meaningful change. Determining what these barriers are and formulating policies and mechanisms to destroy such barriers should be the foremost agenda in healthcare. Among the often cited barriers to career advancement of women include gender stereotyping, sex discrimination, exclusion from formal and informal networks, lack of organizational support, inexperience, lack of strategy, motherhood and parenting responsibilities and even sexual harassment (Catalyst, 2006; Blake-Beard, 2003; Sophia Associates, 2007). These barriers may include the difficulty to manage home and family responsibilities with career goals

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(Zimmerman & Mitchell, 2000); lack of organizational commitment for women career advancement (Blake-Beard, 2003); structural barriers that hinder the promotion of women such as job assignment or job tracking (Collison & Hearn, 2001; Wright et al., 2003); and organizational culture that excludes women from interacting with and being at equal footing with male managers (Roemer, 2002). A special report by Business Week stated that scores of women earn graduate degrees from prominent business schools and earn mid-level positions in major companies in the United States; however, minority of top-level executive positions are occupied by women. Of the 1,000 corporations studied in the report, only six of them were led by female CEOs (Business Week, 2009). The report further stressed that the most powerful barriers for women are sometimes beyond their control such as organizational culture and structural considerations. Succession in top-level management positions traditionally go to the men. Moreover, they opined that women are situated far from the peak of corporate hierarchy because they are far too concentrated in staff and human resource positions.

The prospects for women's career advancement in healthcare seem promising but men still claim more top management positions than women. In order to break the "glass ceiling," mentoring has been a widely suggested tool in assisting career development of women. This is particularly significant for women because they encounter more hindrances than men do in terms of career advancement (Siegel et al., 2002; Blake-Beard, 2001).

Mentoring in its simplest definition is the process where a more experienced person (mentor) provides counsel and encouragement to someone less experienced (mentee) (Kram & Higgins, 2001). The mentoring relationship in the workplace is

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essentially a combination of the professional relationship and the personal relationship. The professional aspect of the relationship involves the career support function of mentoring while the personal aspect involves the psychosocial support function of mentoring (Allen & Eby, 2010). Career support out of mentoring could be received in many ways; protection, sponsorship, enhancing the mentee's visibility or exposure, and securing challenging work assignments (Allen et al., 2004). Psychosocial support is derived when the mentoring dyad leads to increased feelings of competence and self-identity within the organization. By providing a protégé support on these two aspects, mentoring is said to contribute to the mentee's self-confidence, rapport, decision-making skills, and a better understanding of organizational culture and structure (Allen et al., 2004).

Mentoring relationships are said to produce positive career outcomes. This explains why more and more private companies are now establishing their own mentorship programs as a human resource development strategy (Noe, Greenberger, & Wang, 2002). In fact, one of the criteria for selecting the "Best Companies to Work For" include the presence and strength of a company's mentoring program (Allen et al., 2004). Earlier studies on mentoring suggest a correlation with managerial mobility (Roche, 1979, as cited in Scandura, 1992). One of the earliest factorial analysis conducted by Kram (1985) found that mentoring enhanced work performance. Hence, this study expects that the extent to which managers experience a mentoring relationship results to greater career mobility and more positive career outcomes. Scandura (1992) defines *career mobilit*y in three separate measures: a) salary; (b) promotions or rate of advancement; and c) supervisory performance and evaluation. Several studies have

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indeed suggested that the manifold benefits of a mentoring program for employees include increase in job satisfaction (Mobley, Jaret, Marsh & Lim, 1994); higher rate of advancement (or promotion) (Dreher & Ash, 1990), and greater compensation in terms of salary, benefits, and bonuses (Dreher & Ash, 1990). In order to advance to top-level executive positions, women need to undergo mentoring as a way of seeking career and psychosocial support. In fact, the present situation highlights this case. Eiser and Morahan (2006) cite the ACHE study to explain that women executives perceive the need for mentoring to assist them in professional advancement.

It is asserted that the establishment of mentoring relationships is more important to women's career development than to men's (Ruben & Halperin, as cited in Ragins & Cotton, 1999). Walsh and Borkowski (1992) report that women healthcare managers were more inclined to have mentors than male managers.

Mentoring programs operate under the concept of a senior professional promoting or assisting in the career development goals of a newcomer. Mentoring programs could either be of a formal or informal nature. Formal mentoring relationships occur when mentor and mentee are assigned into the relationship by third-party involvement (Murray, as cited in Chao et al., 1992). Informal mentoring relationships occur spontaneously and as a result of motivation and mutual identification of career development needs. Studies have suggested that formal and informal mentoring relationships produce different outcomes among mentees. Ragins and Cotton (1999) consider it crucial that the two types of mentoring be distinguished because the kinds of mentoring functions provided in each differ. Previous studies have generally favored informal mentoring relationship as a greater contributor to positive career mobility, outcomes, and advancement (Ragins &

Cotton, 1991; Chao et al., 1992). Mentees under informal mentoring relationships are more likely to report higher salary increase and higher rates of advancement than those under formal mentoring programs (Ragins & Cotton, 1991). Although it is clear that formal and informal mentoring relationships differ in the mode of establishment and its length, there remains very little empirical research to examine the difference in formal and informal relationships in producing career outcomes for protégés for the duration of the mentoring relationship. Ragins and Cotton (1999) state that it is a mistake for many organizations to simply conclude without empirical basis that formal mentoring is just as good or as effective as informal mentoring when it comes to enhancing career development among employees. Kram (1985) similarly warns organizations not to offer formal mentoring programs as substitute to employees.

The support for formal mentoring relationships has gained ground and is actually more popular among organizations. Corporations spend billions of dollars on formal mentoring programs and trainings to benefit prospective managers. Empirical research has also been conducted to prove that formal mentoring reaps the same positive outcomes as informal mentoring relationships. Weinberg and Lankau (as cited in Monserrat et al., 2009) conducted a longitudinal evaluative study of several formal mentoring programs and found that when formal mentoring relationships become long-term, it leads to the dissipation of cross-gender differences and greater psychosocial support.

Given these findings, it is uncertain which type of mentoring relationship is more effective in producing positive career outcomes. This study is particularly concerned with how the effects of mentoring relate to the career mobility and possibility of breaking the "glass ceiling" among women healthcare managers. Presently, the literature on the

differences in outcome of informal versus formal mentoring relationships is scarce especially as it relates to women healthcare administrators. If formal mentoring relationships are indeed less effective than informal mentoring relationships, then healthcare corporations and organizations may not be assisting women managers meaningfully in career advancement if they provide only formal mentoring opportunities.

Based on these premises, this study was conceptualized. The study aimed to investigate the effects of formal and informal mentoring relationships on the job competence and advancement of women in healthcare administration and identify possible differences in barriers that these women managers encounter in the course of the mentoring relationship.

Statement of the Problem

The aim of this study was to examine the effects of mentoring on middle level and senior level female administrators in various healthcare organizations. First, it intended to determine the barriers that women healthcare administrators face in their career advancement. Second, it aimed to assess whether or not mentoring support has contributed to their job competence and success. Lastly, it sought to examine whether significant differences exist in the career outcomes of women involved in informal and formal mentoring relationships. Specifically, the research problems are hereby presented:

1. What is the profile of women healthcare administrators in terms of managerial level and type of mentoring received?

2. What are the barriers to career mobility as perceived by women in mid-level and senior-level healthcare administration positions?

3. Do women healthcare administrators who are mentees of formal mentoring programs report similar barriers in career advancement compared to those who are mentees of informal mentoring?

4. Do mid-level women healthcare administrators report similar barriers compared to senior-level healthcare administrators?

5. Does a correlation exist between the type of mentoring program received by women healthcare administrators and their job competence?

Purposes of the Study

This study aimed to evaluate the effect of formal and informal mentoring programs on the career advancement of women administrators in healthcare settings. The study proceeded to fulfill three purposes, which are:

1. To determine if there is a relationship between type of mentoring relationship (formal or informal) and career advancement barriers among women healthcare administrators.

2. To determine if there is a relationship between type of mentoring relationship and job competence among women healthcare administrators.

3. To determine if there is a relationship between current position and career advancement barriers among women healthcare administrators.

Hypotheses Development

The study posits the following hypotheses:

Mentoring and perceived barriers

$H1_o$: There is no statistically significant relationship between type of mentoring

relationship and career advancement barriers among women healthcare administrators.

H1$_a$: There is a statistically significant relationship between type of mentoring relationship and career advancement barriers among women healthcare administrators.

Organizational rank and perceived barriers

H2$_o$: There is no statistically significant relationship between current position and career advancement barriers among women healthcare administrators.

H2$_a$: There is a statistically significant relationship between current position and career advancement barriers among women healthcare administrators.

Job competence

H3$_o$: There is no statistically significant relationship between type of mentoring relationship and job competence among women healthcare administrators.

H3$_a$: There is a statistically significant relationship between type of mentoring relationship and job competence among women healthcare administrators.

Assumptions

The study assumed that mentoring is related to career outcomes. Due to its nature as a purposeful relationship that aims to bring about individual development and growth, theories related to mentoring have linked the process to career success (Kram, 1985). There are many specific processes that could explain why mentoring can bring about mentee success (Dreher & Ash, 1990). Mullen (as cited in Ragins & Cotton, 1999) posits that mentoring is a process where information is exchanged and knowledge is acquired. In terms of providing meaningful and practicable work-related knowledge, career support that comes from mentoring allows individuals to access social networks and knowledge

repositories that cannot be provided by formal channels of communication (Dreher & Ash, 1990). Gaining access into these social networks provides the mentee with the venue to present her skills and talents to powerful decision-makers within an organization. Since the career component of mentoring prepares the mentee for career advancement, logic would suggest that the mentee should achieve greater career outcomes than those without mentors.

The present study aimed to examine the effect of formal or informal mentoring experiences of women in career success and to identify perceived barriers to career advancement among those in middle management and senior management positions. As presented in Chapter 3, the study is descriptive-correlational in nature. It aimed to describe the perceptions of female healthcare administrators occupying mid-level and senior-level positions on the barriers that prevent them from advancing to the top-level management or executive positions. It also intended to examine whether the type of mentoring programs women healthcare administrators experience could be attributed to particular career outcomes such as higher salary increases and higher rate of advancement or promotion.

<center>Operational Definitions</center>

The following operational definitions were utilized for the purpose of this study:

Mentoring refers to the process wherein a higher-level employee provides career guidance and psychosocial support to an employee of a lower organizational rank (Ragins & Cotton, 1999). For the purpose of this study, mentoring refers to the self-reported type of mentoring program presently received by the participants.

Protégé or *mentee* refers to a person under the guidance of a more experienced individual who possesses power, experience or influence (Ragins & Cotton, 1999). The *mentees* in this study are mid-level and senior-level women healthcare administrators involved in either a formal or informal mentoring relationship.

Formal Mentoring Relationship refers to a relationship where a more experienced employee is assigned to a mentee who is junior in rank and who has considerably lesser experience to teach, guide, and sponsor to enhance career outcomes (Ragins & Cotton, 1999).

Informal Mentoring Relationship refers to a relationship that is developed spontaneously out of mutually compatible goals and characterized by a mentee viewing the mentor as a role model (Ragins & Cotton, 1999).

Mid-level Position is a management position that requires an individual to ensure the execution plans of senior management through delegating tasks to subordinates (Washington, 2007). In this study mid-level positions include Executive Director, Administrative Officer, Associate Administrator, and Vice President.

Senior-level Position an individual who is partially responsible for setting the long-run priorities for the organization, for deciding how to allocate resources effectively to achieve long-run goals, and for the efficient use of the human, financial, and material resources employed in that business or business segment, including some profit responsibility (Kotter, 1986). In this study senior-level positions include Chief Executive Officer, Chief Operating Officer, Executive Vice President, and Administrator.

Career Barriers are factors that negatively impact or hinder a mentee's career advancement (Frisby, 1991). Career barriers for this study include lack of mentors,

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exclusion from informal networks, lack of role models, work/life balance issues, and lack of cultural fit into the organization, unsupportive supervisors, gender discrimination and lack of meaningful feedback on job performance.

Job Competence is the knowledge, skills and abilities, and other requirements necessary to perform a job successfully.

CHAPTER II

LITERATURE REVIEW

Chapter II will consist of a review of literature pertinent to this study including a history of mentoring, the barriers for women in career advancement, the relationship between mentoring and career advancement, mentoring in healthcare administration, and the advantages and disadvantages of formal and informal mentoring.

History of Mentoring

The history of mentoring dates back to "The Odyssey" in Greek mythology wherein Athena, the goddess of wisdom, assumed a mortal male form as Mentor. Athena acted as proxy parent for Telemachus when the boy's father, Odysseus, fought in the Trojan War. Athena provided guidance and instruction to the boy as the latter assumed the leadership of the household and became an independent young man. Hence, the concept of mentoring has been shaped by the notion of a relationship where a more experienced adult guides a youthful individual (Kram, 1985). More specifically, Kram (1985) describes mentoring as "a relationship between a younger adult and an older, more experienced adult [who] helps the younger individual learn to navigate the adult world and the world of work" (p. 2). Lacey (2001) states that the term "mentor" has since evolved to represent either a counselor, teacher, or friend and the mentoring relationship now connotes a partnership where the primary purpose is the exchange of information and knowledge distinct to a given industry or organization. Other authors refer to mentoring relationships as "sponsor, patron, and godfather" relationships (Rowe, 1978, as cited in Kram, 1985). A literature review on mentoring across various disciplines by

Hayes (2001) produced the definition of mentoring "as a process of building trust between two people, one is experienced and the other is a newcomer" (p. 112). Roberts and his colleagues expanded on the concept of mentoring and referred to it as "the offer of a confidential, professional and supportive relationship by an experienced colleague, able and willing to share his or her knowledge and experience to a protégé or mentee" (Roberts, Moore & Coles, 2002, p. 107).

Extant mentoring literature subdivides its functions into two: those which are considered "career-enhancing" or geared towards career development and those which are considered "psychosocial" or geared towards the mentee's personal development (Siegel et al., 2002; Allen et al., 2004). Siegel and colleagues (2002) considered that the career development component of mentoring emphasizes on how to boost the career of entry-level workers and middle-level professionals. Activities considered as career-enhancing include counseling and forming friendships and networking. On the other hand, the psychosocial component emphasizes on enhancing the self-concept and self-identity of the mentee and to provide mechanisms that elevate the mentee's managerial competence and evaluation (Allen et al., 2004).

Herbohn (2004) opined that the career-enhancing functions of mentoring are those which allow the mentee to "learn the ropes and prepare for advancement" (p. 34). He enumerated several career development activities such as coaching, sponsoring, creating opportunities for visibility and exposure within the organization, securing more challenging assignments, and providing career protection when necessary. Essentially, the idea of career development is that due to the mentor's influence and high status, experience, and leadership position in the organization, the mentee receives the best

hands-on training and gets assistance on learning more about the organization itself and its inner workings, receives exposure to the mentor's social networks, and acquires promotions. In this regard, the mentor sees him or herself in the mentee's shoes and desires to groom a future executive in his or her fashion. Allen et al. (2004) viewed that mentors and mentee alike benefit from the mentoring relationship and that mentors are fueled by the desire to ensure the success of the next generation of leaders.

Wanberg et al. (2003) view the psychosocial function of mentoring to be those that guide the mentee in gaining acceptance within the organization and increasing their self-perceptions on competence and leadership. The two main activities falling within this component are individual development and role-modeling, the latter considered as the most important. Furthermore, the psychosocial aspect of mentoring also involves providing counseling and advice when the mentee faces professional dilemmas or crises.

Kram (1985) theorized the mentors can provide five specific career development functions (as cited in Ragins & Cotton, 1999):

1. Sponsoring promotions and lateral moves (sponsorship);

2. Coaching the protégé (coaching);

3. Protecting the protégé from adverse forces (protection);

4. Providing challenging assignments (challenging assignments); and

5. Increasing the protégé's exposure and visibility (exposure). (p. 530)

The second mentoring function is psychosocial in nature. The psychosocial function of mentoring addresses "those aspects of a relationship that enhance an individual's sense of competence, identity, and effectiveness in a professional role"

(Kram, 1985, p. 32). Kram's mentor role theory (1985) suggests that there are four components of psychosocial support that mentors can provide to mentees (as cited in Ragins & Cotton, 1999):

1. Helping the protégé develop a sense of professional self (acceptance and confirmation);

2. Providing problem-solving and a sounding board (counselling);

3. Giving respect and support (friendship); and

4. Providing identification and role modelling. (p. 530)

Where career support is dependent upon the mentor's power and influence within the organization, psychosocial support focus on the emotional bond and the interpersonal relationship underlying the mentoring relationship. Career support aims at advancing the protégé's career while psychosocial support is geared at improving the protégé's personal development.

In summary, career support is distinguished from psychosocial support in that the former focuses on the mentor's influence and prestige within the company to further the career goals of the mentee while the latter focuses on the emotional bond and the interpersonal relationship underlying the mentoring relationship. Career support aims at advancing the protégé's career while psychosocial support is geared at improving the protégé's personal development.

Barriers for Women in Career Advancement

Compared to several decades past, women have made leaps in terms of advancing toward senior executive positions formerly monopolized by men. However, career

advancement opportunities for women still lag considerably compared to the men. Tharenou (1999) estimates that although women in developing countries make up almost half of the entire workforce, only 5 percent of them are situated in top executive positions. A worrisome fact is that while there seems to be equal opportunities for men and women in entry-level positions, the road toward the more senior levels are unfortunately blocked for women. While is undeniable that the greater workforce composition of women is one of the most positive social changes in the twenty-first century, struggle for equal opportunity persist as women are still excluded from the top positions in the organizational hierarchy.

This phenomenon has been referred to as the "glass ceiling," a term originally used in 1986 by a Wall Street journalist to connote the status of women in the corporate world. The term was coined as a description of the complex barriers that block women's opportunities to break through the top levels in the organization. This "glass ceiling" is especially evident when one looks at rarity of female senior executives in organizations of virtually all disciplines.

The concept of the glass ceiling was recognized and accepted as a public term when the 1992 Federal Glass Ceiling Commission concluded that there were indeed several barriers that hindered women and other minority groups to achieve their full potential within the career ladder. The same study confirmed that "gendered" structural and organizational barriers prevented women from attaining the most senior level positions in several companies. Moreover, it lamented on the so-called "hegemonic masculinity" that is pervasive in the organizational culture in corporate America (Woody & Weiss, 1994).

It is important to note however, that there is some progress, but a disconcerting

fact remains that salary differences among women and men are disproportionate as well

as their chances of advancing to the top positions in the organization (Catalyst, 2006).

This seemingly indestructible and invisible barrier has been referred to as the "glass

ceiling" (Parsons & Reiss, 2004), "marble ceiling" (Norris & Inglehart, 2008) or

"labyrinth" (Eagly & Carli, 2007). These words have come to connote the complex

barriers that block women's opportunities to break through the top levels in the

organization and have been widely used to explain why there are very few women senior

executives in almost all fields today.

However, the fact remains that women remain underrepresented in the upper

echelons of corporations, government, the academe, and healthcare delivery

organizations (Carnes & Bland, 2007). A comprehensive report by women's group

Catalyst listed the most common barriers identified in a study investigating the

experiences of women CEOs in Fortune 500 corporations. Some of the barriers included

(Catalyst, 2006):

1. gender-based stereotyping;

2. exclusion from informal networks of communication;

3. lack of role models;

4. lack of access to influential colleagues;

5. limited flexible work arrangements;

6. lack of mentors; and

7. lack of stretch assignments. (p. 12)

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The work of researchers Henderson and Bialeschki (1995) has been influential in comprehensive studies that aim to identify the different barriers that women face in their pursuit of upward career mobility. They conducted a nationwide survey among women practitioners in the recreation and leisure industry. The researchers grouped the different barriers into three broad categories: individual, organizational, and home/family. By examining career patterns, family situations, career satisfaction, and equity in the workplace issues, they found that stereotyping and gender-based discrimination remains the greatest barrier for women that prevent them from advancing to the top tier of the corporate ladder. More than half of them also reported being sexually harassed. Other identified barriers include the lack of training, lack of mentors, and women's exclusion from "male-only" networks.

Another study by Frisby and Brown (1991) surveyed 30 women mid-level managers belonging to leisure-oriented organizations in order to examine their career experiences as they struggled their way to the top. Consistent with previous findings, women in middle management reported that the most common barriers they encountered from advancing in their careers include career interruptions due to pregnancy or family issues, the lack of role models or mentors, the lack of support from senior executive to promote women, exclusion, gender stereotyping, personal factors, and exclusion from male-dominated social networks.

Frisby (1992, as cited in Arnold & Shinew, 1996) did a follow-up study to examine in a more comprehensive manner the factors that hinder the career development of women in leisure organizations. Using a descriptive-quantitative design, Frisby grouped the various barriers reported by women managers that have influenced their

career direction and mobility. There were legislative factors such as gender discrimination, pay equity, and laws on sexual harassment; organizational factors such as patriarchy, exclusion from networks, flexible work options, difficulty in dealing with male-dominated organizational culture, lack of training and mentoring opportunity; and individual factors such as gender, education, and geographical mobility; and lastly, family factors that include lack of support from spouse and difficulty balancing work-family responsibilities.

Moreover, Sophia Associates (2007) divulged the prevalent reasons that women cite for leaving their jobs in the private sector. In a study conducted by women's group Catalyst in conjunction with the National Foundation for Women Business Owners, the most oft-cited reason why women leave their jobs are "lack of flexibility (51 percent); glass ceiling (29 percent); unhappiness with work environment (28 percent); feeling unchallenged in their jobs (22 percent)" (p. 2). A minority of them reported being sexually harassed as a reason for leaving. Moreover, data collected also revealed that the five most common barriers to women's career advancement are the following: "1. Stereotypes and preconceptions of women's roles and abilities; 2. Lack of senior, visibly successful female role models; 3. Lack of significant general management experience; 4. Commitment to family, personal responsibilities; and 5. Lack of mentoring" (p. 8).

Parsons and Reiss (2004) identified the different barriers that women face in their pursuit of upward career mobility in the health profession. They said that achieving career advancement presents difficulties for women and nurses. Despite strong motivation to excel in the workplace to achieve top-level executive positions, women in the health profession are hindered by lack of role models and the existence of the "glass

ceiling" phenomenon. According to the researchers, despite the predominance of women in the nursing profession, very few of them get to climb toward the management positions in their companies or organizations.

Zimmerman and Mitchell (2000) recognized that career advancement for women in healthcare lags behind that of men. They came up with two theories to explain this occurrence. The first is the "glass ceiling" explanation in which structural factors within the healthcare field itself and the attitudes embedded within the organization marginalizes women and hinders their promotion. The second explanation is that "supply side" argument which suggests that women have personal characteristics that lead to the laggard progress of their career. However, an interesting theory advanced by the researchers is that the age of women influences the type and number of barriers they encounter in their climb to the top. Additionally, career barriers become more significant after the early stages of the career.

Carnes, Morrissey and Geller (2008) also concluded the existence of the "glass ceiling" as a major barrier to women's advancement in medicine. Carnes and colleagues recognized that opportunities for women to lead in academic medicine must be opened but progress in achieving this goal has been slow. Several factors have stalled career progress among women in medicine, specifically deep-seated gender bias and unfair assumptions about capability and desirability of women occupying high-level executive positions.

Monserrat et al. (2009) examined the experiences of women in corporate America in an effort to identify the challenges that women faces as they struggle to move up. The researchers grouped the different barriers into three broad categories: individual,

organizational, and home/family. By examining career patterns, family situations, career satisfaction, and equity in the workplace issues, they found that stereotyping and gender-based discrimination remains the greatest barrier for women that prevent them from advancing to the top tier of the corporate ladder. More than half of them also reported being sexually harassed. Other identified barriers include the inexperience, being without mentors, and being excluded from "male-only" networks.

As cited in Allen and Eby's book *The Blackwell handbook of mentoring* (2010), several barriers have hindered the career direction and mobility of women administrators in the leisure industry. These included legislative factors such as gender discrimination, pay equity, and laws on sexual harassment; organizational factors such as patriarchy, exclusion from networks, flexible work options, difficulty in dealing with male-dominated organizational culture, lack of training and mentoring opportunity; and individual factors such as gender, education, and geographical mobility; and lastly, family factors that include lack of support from spouse and difficulty balancing work-family responsibilities.

Eiser and Morahan (2006) presented the top five barriers preventing women from advancing in their careers in healthcare. These major barriers include organizational culture, gender stereotyping, exclusion from informal networks, the challenges of work-life balance, and lack of effective mentors. The authors suggested that some of the mechanisms which could be implemented to overcome these barriers are modifying culture within the organization, enhancing leadership competency among women through training, ensuring equal access to promotion opportunities, increasing women's visibility within the organization, and developing effective mentoring programs.

Individual factors as barriers

Individual traits and skills are often attributed for laggard career advancement among females. Individual factors such as age, educational attainment, skills, experience, proficiency, or ability are related to advancement. There remains gender stereotypes on what men can do that women cannot that justifies greater upward mobility for males. Some express that women lack the necessary attributes such as assertiveness, motivation, or networking skills to advance in careers (Pringle, 1999). The simple fact of "being female" thus becomes a potent barrier for career advancement among women. For instance, there is a double standard when it comes to appreciating leadership in females. Morrison, Greene and Tischler (1985) opine that when women display competence in leadership, they are viewed negatively while men who visibly lead are appreciated. Similarly, succession in vacated executive positions is usually based on the gender of the previous occupant of the position or the job. Since most senior executive positions are dominated by males, women are immediately excluded from consideration. Moreover, females are placed in "traditionally-female" positions such as staffing and human resources and cannot be promoted to higher positions that are "traditionally-male" in nature.

Norris and Inglehart (2008) of the Harvard School of Government studied the barriers experienced by women in the public sector. Accordingly, the four main obstacles why women remain underrepresented in government are very similar to those experienced by women in the private sector. The most commonly reported barriers were a) gender stereotyping; b) lack of support from superiors to pursue career advancement; c) blatant gender-based discrimination; d) lack of political experience; and e) lack of mentoring support.

Despite assertions from leadership researchers and theorists that women are just as competent as men in leadership, Ackah and Heaton (2004) contended that the notion of leadership is still very much "gendered." As a result, succession within the organization is expected only to run only within the male network because females are considered to possess inadequate skills or motivation to be senior executives. This leads to a lack of encouragement and guidance among women to climb the career ladder from their superiors. Moreover, there is also a limited time provided to females for constructive feedback and evaluation.

Age can also be a barrier as individuals who are deemed "too young" or "too old" may not be deemed suitable for senior executive positions. Allen and Finklestein (2003) suggest that women do not follow a linear career path like men. Women develop their careers by taking on multiple jobs or careers in a lifetime that require various mentoring sources. The inability of some women to have access to mentors is especially true for older professional women. Obviously, because the "younger" protégé concept is the traditional notion of the mentor-mentee relationship, mentors may refuse to take on older women mentees. Some women cannot get a mentor because "people [executives] don't like to have a subordinate who is older than them" (Allen & Finklestein, 2003, p. 191).

Organizational factors as barriers

Most research studies conclude that the biggest barriers to career advancement among women are beyond their personal control. The Glass Ceiling Commission indicts organizational and structural barriers as the most predominant barrier toward women's upward climb in the career ladder (Woody & Weiss, 1994). Eagly and Carli (2007)

wrote that the glass ceiling has been supplanted with what they call 'labyrinth of leadership.' In their article for the *Harvard Business Review*, Early and Carli (2007) stipulated that the glass ceiling notion was applicable twenty years ago but not at present. In describing the labyrinth, the authors suggested that it "conveys the complexity and variety of challenges that can appear along the way" for women and their careers (p. 3). What lies ahead for women are not just simple barriers, but forks, twists, and turns. They cited that gender-based prejudices remain, dilemmas on leadership style, and parenthood are among the few challenges. Pressures of the rapidly modernized world subject mothers-professionals even more toward commitment to family work and child care than ever before. This leaves mothers with little time to form networks, socialize and gather social capital which is essential for professionals to climb up.

Cooper Jackson (as cited in Klein, 2007) contended that the scarcity of women role models might hinder women from advancing in their careers. Organizational leadership is predominantly patterned after the male form of leadership. Since acquiring senior executive positions are blocked, developing women role models that would inspire and motivate women and neutralize male-dominate culture in the organization becomes challenging. Moreover, because women lack opportunities for role modeling or mentoring relationships, they often fail to plan their career and build effective networking strategies.

Neubert and Palmer (2004) contended that the reality of stereotyping has been found to affect women's career advancement deeply. Because of gender stereotyping, women feel isolated and discouraged because they perceive themselves unable to blend

well or fit in with the patriarchal culture of senior executive leadership. Sometimes, this perception leads them to believe that have to change considerably in order to suit the male-dominated culture of the top hierarchy.

Klenke (1996, as cited in Pringle, 1999) suggests that women face an exclusion policy that prevents them from penetrating the "old boys" network. Access to such networks is considered a significant step to gaining upward mobility in organizations. One can access information and learn more about the organization not possible in regular communication channels.

Gendered expectations of leadership are prevalent in today's organizations. Even women themselves, if given the chance, have been found to prefer the male leader as the "ideal" leader (Carnes & Blande, 2007). Male leadership has been commonly equated to strong leadership; hence, career succession would only be possible if women themselves possess characteristics of the "strong leader" – which are stereotypically male characteristics (independence, assertiveness, and high achievement expectations). Male executives tend to undermine female employees because the gender stereotypes attribute to the female aggressiveness instead of assertiveness, indecision instead of independence, and low career focus. The greater dilemma arises because even when females start to demonstrate strong leadership characteristics, they are maligned for it because they are perceived to go out of bounds with their conventional roles.

Powell and Butterfield (as cited in Collinson & Hearn, 2001) state that stereotyping also leads to social isolation among female managers and their heavy dependence on formalized relationships for career advancement. Female administrators put a prime on their professional portfolio and credentials when they pursue promotional opportunities whereas men can depend on informal networks to advance in their careers.

Another barrier cited by women is the lack of mentoring opportunities from male superiors. For instance, Dreher and Cox (1996) found that females find it difficult to gain informal mentors who are male. If they do find a male mentor, they also face challenges in the course of the mentoring relationships especially in relation to its nature and possibility of misinterpretation. Some female managers even report being subjected to sexual harassment.

Davidson and Cooper (1986, as cited in Collinson & Hearn, 2001) report that gender stereotyping in the organization leads to higher stress levels among women than men. This is because gender stereotyping often pressures women to exert extra effort or to work harder and perform better than their male counterparts in order to prove themselves equal to them. Women tend to believe that in order to achieve their career goals; they have to over-perform to counter the effects of negative gender stereotyping. Even when women are promoted and do acquire senior executive status, there is a prevailing norm that they have to perform even better than their male colleagues to prove themselves worthy of the position.

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Zhong (2006) stated that one of the problems women face in career advancement is the lack of social and professional networks. More often than not, women may be "excluded" or banned from being a member of "male-only" networks. Hence, networking as a career strategy is something women find difficult to do. Because many women are excluded from men's networks, this contributes to their invisibility and their names are scarcely remembered when the topic of promotions is laid on the table.

Walsh and Borkowski (2006) contend that women's invisibility in the organization can be attributed to their lack of networking skills. A networking association is crucial for advancement among women because it is in this circle where women professionals can share and give advice and guidance on career decisions. Networking benefits career advancement because it provides women with access to information, resources, and knowledge of opportunities for promotion.

Pringle (1999) contends that female managers lack access to networks, trainings, and mentoring programs because they are usually gender-based and male-gendered. The domination of men in organizations is sustained with constant identification with one another. Perpetuating a gendered organizational culture leaves women managers isolated and places them in a situation where executive leadership feels very much like engaging in constant "physical combat" (Sinclair, as cited in Pringle, 1999, p.8).

Home-related factors as barriers

The barriers that women encounter extend far beyond the confines of the workplace to the home. For many female managers, the home environment presents several obstacles that must be overcome in order to achieve upward mobility.

One obstacle is that some women managers, especially, those with families, experience the so-called "second shift syndrome" where they must work on the first shift in the workplace and continue on the second shift in the home environment. The burden of juggling work-related goals with family responsibilities is a serious concern for some women. Women who find themselves in this circumstance are also called "dual career women" where performance at work and at home are necessary. To perform this balancing act between professional development and personal life may prove too difficult for some women in many ways. Some of them eventually may find inadequate support from their respective families to pursue career advancement goals (Burke & Mattis, 2005).

Buddeberger et al. (2010) studied the professional of experiences of women in the medical profession particularly the effect of parenthood on career and professional development. Over 579 residents participated in the longitudinal study which started in 2001 and ended in 2009. The study found that women physicians were more likely to be unemployed than their male counterparts particularly those who are married and have children. Moreover, female doctors experienced lower advancement in their careers and perceived lower support for their careers compared to male doctors. The respondents reported a negative impact of parenthood on their careers. Because of responsibilities to the home and family, female physicians were less motivated with career advancement

and opted to choose part-time for greater work-life balance. In a sense, parenthood becomes associated with lower level of career-orientation and greater preference for part-time career. Moreover, compared to male physicians, female physicians were less likely to pursue the more prestigious field of surgery.

Being saddled with additional responsibilities also creates different motivations among men and women as far as advancement is concerned. In a sense, because of additional responsibility at home and with their families, women do not perceive career mobility as "a methodical rise to power" (Aburdene & Naisbitt, as cited in Klein, 2007, p. 43). Unlike the men, women do not focus on the singular objective of professional advancement but struggle to "do it all" and come up with more creative ways to reap professional success.

Research also reports that women managers continue to bear the brunt of carrying the "double burden" of family and work. They have to be successful equally in the home and at work. In the home environment, they need to assume the manifold tasks of wife and homemaker and struggle to become equals with men in the workplace at the same time. Sue Newell opines that so long as women continue to juggle these dual roles, they may never achieve the parity they need and deserve in relation to men in the work environment (as cited in Woody & Weiss, 1994).

However, studies have also found the home and family-related barriers do not necessarily interfere with motivation and career success among many women. The problem with having the additional burden of family responsibility for women is that it is viewed as a negative thing. Research has suggested that many companies look at women with home-related commitments with disfavor (Swiss & Walker, as cited in Klein, 2007).

What is worse is that some women may even be penalized career-wise for having commitments outside of the professional realm. Having marital and family responsibilities may not interfere in terms of commitment among women but these factors might slow down the promotional opportunities of woman managers. Some women have reported that the workplace was inviting and conducive to success when they were single and changed considerably to a more unwelcome environment when they got married and had children.

In an article, management expert Douglas T. Hall (1990, as cited in Klein, 2007) suggested that in order to provide more access for women in terms of career advancement, companies need to come up with strategies that promote balance between work and family responsibilities. Among the strategies he recommend were more flexible work schedules and expanded use of home-based work option.

In a study on professional women in the academe, findings underscore parenting as a potent variable that may limit the career advancement opportunities for women. Kamler and Rasheed (2006) explain that women face the complex task of dividing their time between career and family responsibilities whereas men can devote their time fully to their professional commitments. While it may not completely discourage women from pursuing career advancement, family responsibilities are a significant factor that influences their decisions. Even when so many women have obtained far higher educational degrees than men, some would opt for part-time employment to be able to achieve their rearing and nurturing responsibilities to children. Men do not carry this burden because traditionally, they are allowed to remove themselves from parenting responsibilities in favor of a purely "professional focus" (Chandler, as cited in Kamler and Rasheed, 2006, p. 16).

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Eagly and Caldi (2007) was able to link the burden of family responsibilities to the career advancement of women executives in healthcare. In their study, married women managers tended to have spouses who also had full-time jobs than were married male managers. They also found that women executives invest a significant amount of time tending to caring for their families than male executives. As a result, women managers were more likely than male managers to file a leave of absence due to responsibilities in the home. Moreover, the culture towards "intensive parenting" coupled with the attendant pressures of being an executive led to a decrease in networking opportunities, time for socialization, and building social capital needed to advance further in their careers.

Mentoring and Career Advancement

The relationship of mentoring toward career success has received a great deal of attention. Studies have tended to conclude that there is a positive relationship between mentoring and career outcomes, measured in terms of mobility, job satisfaction, as well as "objective" and "subjective" career success. Career success of managers is traditionally defined based on commonly-held success symbols, which are organizational rank and money (Hall, as cited in Scandura, 1992). Studies on management and organizational behavior make use of three variables to measure career success, namely: "(1) rate of advancement, (2) salary attainment, and (3) supervisory ratings of performance, success and contributions" (Scandura, 1992, p. 171).

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Ragins and Cotton (1999) indicated that mentoring relationships benefit the outcomes of protégés by providing advice and guidance in career development and promoting the advancement of the protégé within the organization. Moreover, the mentoring relationship contributes to greater exposure and visibility for the protégé that increases her changes in attaining upward mobility. Mentoring also enhances the professional development as well as personal development of the protégé.

Hegstad and Wentling (2005) believed that the nature of mentoring itself leads to positive professional outcomes. This is because any mentoring program is modeled so that those within the mentoring relationship can cooperate more, interact more, and communicate with openness and clarity. As a consequence, the harmonious and intimate relationship between individuals in a mentoring relationship fosters rapport and higher career satisfaction. Greater psychosocial support and guidance with networking, visibility, and coaching may also result to positive career advancement outcomes for the mentee.

Baugh and Scandura (1999, as cited in Blake-Beard, 2003) found that employees who had support from a mentor were more likely than those who did not to obtain promotions, gain salary increases, and experience greater degree of career satisfaction. Following this conclusion, this study argues that mentoring too can impact the advancement of female healthcare managers positively.

Scandura (1992) performed a correlation analysis to examine the relationship of mentoring and protégé career outcomes. Using salary, promotion, and performance evaluation as measures of career mobility, Scandura conducted hierarchical regression analysis to look for possible correlations between mentoring functions and career

measures. Scandura used company records to describe the compensation and rate of advancement among the subjects. A 16-item evaluation scale was distributed to the supervisors of the subjects to evaluate their performance. The study found that mentoring functions positively influence career outcomes. Scandura suggests that there is a link between mentorship and career outcomes for protégé managers and made recommendations to further explore this link.

Empirical studies that aimed to examine the relationship of mentoring with career advancement have also conceptualized career success as composed of two components: the objective (real) career success and the subjective (perceived) career success (Fagenson, 1989). Objective career success is operationalized as career accomplishments based on objective criteria and is evaluated using organizational constructs of failure or success. Subjective career success is the individual's personal evaluation of his or her career achievements.

Research studies have pointed to a positive relationship between mentoring and objective career success. Dreher and Ash (1990) concluded that mentoring led to a greater number of promotions obtained by protégés. Salary progression was also higher for managers with mentors than those who had no mentors. Mentoring was also found to be positively correlated to higher salary levels. Moreover, mentoring could also be attributed to subjective career success such as job satisfaction on protégés.

Chao et al. (1992) examined the outcome of mentoring relationships on engineer protégés. Using a 21-item scale developed by Noe (1988), Chao and his colleagues concluded that there was a significant positive correlation between the two mentoring functions (career and psychosocial) to salary increases, socialization opportunities, and

intrinsic job satisfaction. Mentees who reported that mentors devoted more time to career mentoring support obtained higher job satisfaction scores and better socialization outcomes than those mentees who did not report such. Chao and his colleagues were able to provide support that mentoring enhances protégé outcomes because it increases the possibility of socialization, exposure, and visibility.

In a study on the effect of mentoring on women lawyers, Riley and Wrench (1985) categorized the group into those who have been "truly mentored" and those whose mentoring experience did not pass the strict conceptualization of mentorship. Truly mentored groups were those that received actual career and psychosocial support from their mentors. Riley and Wrench (1985) concluded that women lawyers belonging to the "truly mentored" group reported obtaining significantly higher salary increases, promotions, and subjective career satisfaction than the non-mentored group.

Studies also separated the study of the two categories of mentoring functions and examined the career support function as a correlate of objective career success. A meta-analysis study conducted by Allen et al. (2004) examined various empirical studies that examined the relationship between mentoring and protégé career success or outcomes. In their meta-analysis, Allen and colleagues focused on studies that examined mentoring outcomes with job satisfaction as variable for analysis. Allen and his colleagues concluded that greater guidance in career support was more positively correlated to career success than the performance of psychosocial functions of mentoring. This finding is consistent with the conclusions of Kram (1985) and Ragins and Cotton (1999).

Studies have also shown how women need mentors or sponsors more than men do especially in male-dominated industries. In a study on the effect of mentoring on women

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in high-tech firms, Burt (as cited in Blake-Beard, 2003) concluded that women had greater chances in grabbing the top-level executive positions when they are involved in a strong relationship with a "strategic sponsor" (p. 15). In this way, women can directly compete and even overwhelm men who depend on informal and large "weakly-connected networks." Burt's study reinforced the finding that in order to achieve career success, women need to obtain credibility and legitimacy from external sources – something that a strategic mentor can provide for them. This does not apply to men because the organization already recognizes their credibility and legitimacy to occupy the top positions in the company. Burt (as cited in Blake-Beard, 2003) comes up with the conclusion that given the present organizational culture today, women need mentorship programs more than men do if they want to move up.

In a study on the effects of mentoring relationships on women CPAs, Johnson and Scandura (1994) noted the disparities between men and women on their need for mentor coaching to promote career mobility. They found that mentor coaching correlated positively with the salaries of women accountants while this was not the case for the men. However, role modeling and friendship functions provided by mentors was not significantly associated with higher salaries for both women and men accountants. Johnson and Scandura (1994) interpreted this finding to mean that the positive correlation of the coaching function with career success was because it related directly to career advancement. Coaching provides the mentee with hands-on training. They explain that the coaching function in mentoring relationships may have allowed women to move ahead of the career ladder because it helped them "learn the ropes" and being acclimated to the executive environment.

Schor (as cited in Blake-Beard, 2003) concluded in his study of women executives that women valued mentoring more than did the men. Women were more likely to report mentoring as an important advancement tool that will aid them throughout their professional lives. Women valued both career mentoring and psychosocial functions more than the men did. An interesting finding was reported when women described mentors as their "advisors, sponsors, teachers, path pavers, and career guides" (p. 16) but failed to describe them in relation to psychosocial functions. Schor (as cited in Blake-Beard, 2003) explains that women recognize mentorship mainly as a tool of career advancement and did not value to a great extent the emotional and interpersonal processes associated with mentoring.

Mentoring in Healthcare Administration

Compared to existing literature on the role of mentoring in business, education, and technology, studies concentrating on the role of mentoring on healthcare are relatively scarce. However, like almost all of the industries in the twenty-first century, mentoring in the world of health is just as popular. Finley et al. (2007) suggests that in general, the most popular activity being carried in hospitals all over the United States is informal mentoring. Moreover, those who act as mentors to junior executives are usually healthcare executives moved by personal satisfaction.

Mentoring as a paradigm has been especially popular in health administration education. Residencies and internships are a pivotal component of the academic experience among healthcare practitioners (Finley et al., 2007). Most of these "preceptor-student relationships" take on a temporary nature but other relationships ensure and go beyond the confines of the medical institution.

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Mentoring is said to have acquired increasing legitimacy within healthcare administration. Zey (as cited in Barnes, 2004) that healthcare settings need to develop new generations of leaders as much as any corporate environment. Senior executives of hospitals and healthcare institutions need to promote a team of individuals who will succeed and enhance organizational effectiveness in the years to come. At present, healthcare administration is establishing its own set of mentoring programs and encouraging healthcare executives to become part of informal mentoring relationships.

Finley et al. (2007) state that mentoring participation among healthcare executives is gaining ground. The survey they conducted suggests that executives in healthcare administration view formal mentoring more than informal mentoring. Finley and her colleagues suggest that the benefits of mentoring in healthcare administration go both ways. Executives who have become mentors also reported acquiring longer tenure than executives who did not become mentors or supported mentoring initiatives.

Dolan (1993) expressed that establishing mentoring relationships in the healthcare settings is crucial. He addressed the need for mentorship, saying, and "Mentorship means teaching what textbooks and teachers cannot-how to be successful in the healthcare management profession" (p. 3). In a literature review conducted by Dolan (1993), he cited several studies that have shown the positive effects of mentoring on the career outcomes of protégés. These include higher employee motivation, specifically; mentoring has been shown to have a positive effect on employee motivation, higher job retention and reduction of stereotypes in certain sectors in healthcare administration.

Linda Roemer (2002) described the experiences of 35 women CEOs in various healthcare organizations to determine the importance of the mentoring process in overcoming barriers toward their career success. Roemer indicated the mentoring advocacy to promote career advancement was widespread. Of the 35 women CEOs interviewed, 19 of them reported having mentors to provide them career direction and advice. Women CEOs in healthcare believed that being guided by a mentor was helpful but not a prerequisite to climb the career ladder.

Barnes (2004) conducted a quantitative analysis to examine the influence of mentoring relations on the career satisfaction among dental hygiene directors. The study found that mentoring relationships contributed to greater job satisfaction and subjective career satisfaction. Dental hygiene directors recommended mentoring to their counterparts and further suggested having not just one mentor, but a "network of mentors". Mentoring networks are said to diversify relationships, enhance the mentoring relationship, and produce more meaningful career outcomes.

Within public health nurse administrators, mentoring relationships have afforded many benefits. In a qualitative study conducted by Kirk and Reichert (1992), mentoring has paved the way for more promotions, career development, socialization opportunities within the field of nursing, and personal growth. Moreover, nurse administrators who were at the same time mentees reported growth of psychosocial skills such as self-esteem, confidence, self-control, and political savvy.

Tharenou (2005) was able to conclude that mentoring contributed significantly to the career advancement of women. Interviewing a large sample of Australian female employees in the public and private sectors, Tharenou investigated whether males and

females differ on how mentoring career and psychosocial support functions affect their career outcomes. The study proceeded on the assumption that focusing on career support rather than psychosocial support will be more beneficial in enhancing career advancement. The study found that a career support-focused mentoring program enhanced career advancement more among women than men whereas psychosocial support negatively impacted career advancement. It also found that mentoring had a significant impact on the career advancement of women but not for men.

Formal and Informal Mentoring Relationships

As stated earlier, there are two types of mentoring relationships: formal mentoring and informal mentoring. While some contend that there are blurry distinctions between the two, Ragins and Cotton (1999) say that the distinction has to be made nonetheless. These differences are said to impact the outcomes of protégés in a mentoring relationship differently. The origin of mentoring as suggested in the Greek mythological story of Telemachus indicates an informal type of mentoring relationship. Formal mentoring did not gain recognition until 1931 where the first formal mentoring program was established in The Jewel Tea Company. The company implemented a program where each MBA graduate who got accepted into the firm was immediately assigned to a more senior professional and served as his or her mentor during the start of his career (Russell, as cited in Finley et al., 2007). Today, formal mentoring programs in various industries are common, the primary *raison'd'etre b*eing the development of new leaders and the sustainability of organizational effectiveness and goals.

Ragins and Cotton (1999) say it is important to distinguish formal and informal mentoring. Ragins and Cotton (1999) identifies that informal and formal mentoring relationships differ along three areas: *relationship initiation*, *relation structure*, and the *processes involved* within the relationship.

First, Ragins and Cotton (1999) explain that formal mentoring relationships are initiated by an external source. Usually, there is a program coordinator that matches the suitability of mentor/mentee assignments. On the other hand, informal mentoring relationships are spontaneously initiated by two people who share or are attracted to each other on the basis of perceived goal similarities.

Second, Ragins and Cotton (1999) distinguish that formal mentoring programs have clearly established goals and are timed to a specific duration. Moreover, frequency of meetings is predetermined and the location of meetings between mentor and mentee and specified. Conversely, informal meetings could go on for years and the relationship evolves beyond a specific professional setting.

Finally, interpersonal processes are different in formal and informal mentoring relationships. Ragins and Cotton (1999) argue that the mentor's motivation and willingness to act in the interest of the mentee is greater in informal settings. They suggest the formal mentors take on the role of "good organizational citizens" rather than the promoter of professional and psychosocial development of mentees.

Wright et al. (2003) suggested that informal mentoring can consist of various activities and conditions which all aim to form a stronger mentor-mentee bond such as:

1.   Building rapport early to build friendship and camaraderie.

2.   Meetings conducted as suitable, for instance, done on a biweekly basis.

3. Coming up with routine mechanisms to check up on the mentee and inquire on his personal or professional life.

4. Building open communication channels so the mentee can easily ask for guidance or advice.

5. Planning intimate activities to form a stronger bond such as dining at the mentor's home.

Johnson & Ridley (2004) lauded informal mentoring for bringing about greater psychosocial benefits in favor of mentees. These benefits enable mentees to "receive more career and psychological functions [support] from mentors and report greater effect from, and satisfaction with, the mentorship" (Johnson & Ridley, 2004, p. 89) compared to formal mentorships.

One of the asserted rewards of formal mentoring programs is that it contributes to more for entry-level professionals (Singh et al., 2002). When a protégé is under a formal mentoring program, he or she gets better acquainted with the norms and culture of the organization and the profession. This will eventually lead to a more in-depth understanding of organizational goals, mission, and vision as well as the structures within the organization itself. Through enhanced socialization, formal mentoring is said to contribute to better performance, stronger commitment to organizational goals and low turnover rate.

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Another benefit of formal mentoring is that it allows the company to pinpoint prospective leaders early on and consider them for succession (Siegel et al., 2002). Under this condition, the establishment of formal mentoring programs is expected to lead to faster rates of promotion, stronger professional development and increased organizational commitment and performance.

With its benefits come the attendant risks to formal mentoring. Allen et al. (2004) opined that formal mentoring relationships can be vulnerable to conflict and difficulty because of the great possibility that mentor and mentee are inappropriately matched, do not possess the "chemistry" for a successful mentoring dyad, or that mentors assigned are ineffective.

A recent study by Tennent et al. (2004) examines empirical studies of formal mentoring programs based on a wide collection of articles from different disciplines. Tennent et al. (2004), found that several challenges are associated with formal mentorships, namely "lack of time," and professional mismatch" (p. 525). Moreover, formal mentorships also suffer from inadequate financial support from organizations. Tennent et al. (2004) concluded that the implementation of formal mentorships across various disciplines are often done without planning, design, and evaluation, and could be the cause behind perceived ineffectiveness of formal mentoring programs.

Jackson et al. (2003) cautioned against relying on formal mentoring relationships to address the advancement needs in academic medicine. When no established formal mentoring program is present in the institution, Jackson and colleagues recommended forming informal relationships with colleagues and peers for mentoring purposes. However, if possible, mentoring is best when formalized and considered a professional endeavor.

Assigned mentoring can be useful but the environment must support the mentee in finding another mentor if the current one is not meeting his or her needs. Institutions should make women and minority mentors available to faculty members, but not assume that all mentees would prefer a mentor who is of the same gender or race. (p. 330)

Summary

Based on the literature reviewed, it could be gleaned that the various barriers that women face in career advancement has resulted in many recommendations and strategies on how to overcome them – chief of which is mentoring. In healthcare administration, as in any field or industry, the trend is that women are still underrepresented and without proper intervention, they will continue to occupy less and less of the top executive positions which are currently dominated by males. Women in healthcare face individual, organizational, and home-related barriers which must be prevailed upon in order to advance in their careers. The literature showed that mentoring indeed promises positive outcomes in terms of career advancement for women. However, studies remain limited on whether or not formal and informal mentoring produce significantly different outcomes among women. While the most accepted mentoring type has been informal mentoring, an increasing number of companies are supporting or are currently building their own formal mentoring programs to stimulate career advancement and job competence among women.

CHAPTER III

METHODOLOGY

This section presents the purpose, design, procedures, a description of the sample population and a description of the instruments used for this study.

Purpose of the Study

This study aimed to evaluate the effect of formal and informal mentoring programs on the career advancement of women administrators in healthcare settings. The study proceeds to fulfill three purposes, which are:

1. To determine if there a relationship between type of mentoring relationship (formal or informal) and career advancement barriers among women health administrators.

2. To determine if there is a relationship between current position and career advancement barriers among women health administrators.

3. To determine if there is a relationship between type of mentoring relationship and job competence among women healthcare administrators.

Hypotheses

The study posits the following hypotheses:

Mentoring and perceived barriers

$H1_o$: There is no statistically significant relationship between type of mentoring relationship (formal or informal) and career advancement barriers among women healthcare administrators.

H1$_a$: There is a statistically significant relationship between type of mentoring relationship (formal or informal) and career advancement barriers among women healthcare administrators.

Organizational rank and perceived barriers

H2$_o$: There is no statistically significant relationship between current position and career advancement barriers among women healthcare administrators.

H2$_a$: There is a statistically significant relationship between current position and career advancement barriers among women healthcare administrators.

Job competence

H3$_o$: There is no statistically significant relationship between type of mentoring (formal or informal) relationship and job competence among women healthcare administrators.

H3$_a$: There is a statistically significant relationship between type of mentoring relationship (formal or informal) and job competence among women healthcare administrators.

Design

This is a quantitative study which takes on a descriptive and correlational nature. It is descriptive because is it concerned with determining the status and nature of a particular situation, "as it exists at the time of the study" (Creswell, 1994, p. 87). It is concerned with describing present conditions based on the perceptions and views of particular respondents. This study's first purpose is to identify the barriers experienced by mid-level and senior-level women healthcare managers in their pursuit of career

advancement. It is also correlational because it intends to examine possible relationships among variables (Creswell, 1994). This quantitative study was designed in order to assure that findings will be able to be generalized to a particular population of healthcare administrators.

The study utilized primary research data in order to provide substantial discussion and explanation of the findings derived. Employing multiple sources for discussion will guide readers and researchers who are looking for a more in-depth understanding of mentoring relationships and how it relates to the career advancement of women administrators, particularly in the healthcare sector. Primary data for this study was derived from survey results.

Procedures

As stated earlier, primary data for this study was obtained using the survey method. The survey method was chosen because of speed, ease of use, and economy. Moreover, Creswell (1994) view the survey method as the most favorable form when the study aims to "identify attributes of a population from a small group of individuals" (p. 115).

Before data collection commenced, the instrument used for this study was pre-tested to evaluate the competency of the questionnaire, the length of the survey or time to take the survey the appropriateness of the items, and the ease of accomplishment or completion (Iraossi 2006). The instrument was reviewed by ten individuals in the healthcare administration field. The average length of time it took the test participants to

complete the survey was eleven minutes. Participants reported that the survey was easy to read and the wording was clear, and the items did not require them to think too long or hard before responding.

The researcher obtained the approval of the University's Institutional Review Board (IRB) at the Research Risks Protection of Human Subjects Office. This was to establish the study's adherence and conformity to acceptable ethical guidelines for scientific research.

Data was collected using an online survey protocol fashioned after the protocol by Dillman (2000). Self-administered questionnaires were chosen because of its capacity to provide rapid rate of responses and high levels of survey return. Compared to mail- and telephone-based surveys, Internet-based surveys are more convenient to administer and less time-consuming. Moreover, e-mail surveys have an economical advantage because it removes several costs such as postage, printing, and possible interview costs.

However, the study also recognized that response rate on pure email surveys might be low. Some studies have suggested that the traditional survey methods have higher response rates than Internet-based surveys. In a study on federal employees, e-mail responses gather a response rate of more than 40 percent while traditional mail surveys can gather response rates of up to 70 percent. However, this study trusts the conclusion by some studies that Internet-based surveys were more desirable than the traditional methods because "e-mail was ... more carefully examined when it arrived" (Dillman, 2000, p. 15).

Description of the Sample

The target population for this study was women healthcare administrators occupying mid-level and senior-level positions. A purposive sample of female healthcare administrators who meet the following criteria were eligible to participate in the study: (a) be female; (b) occupy at least middle management level positions; (c) have been mentored during career. The purposive sampling method used in this study was a form of non-probability sampling that involves selecting research participants based on predefined criteria with a specific intent in mind (Trochim & Donnelly, 2007). Sampling was purposive because the study is selective in its choice of respondents. Singleton and Straits (2005) noted that although purposive sampling limits generalizability, it "offers stronger, less tenuous inferences than convenience sampling" (p. 134).

In research, it is important to establish a priori the sample size necessary for the statistical analysis with considerations of power, population effect size, and level of significance (Cohen, 1992b). G*Power 3.1.0 was used to calculate sample size of 133. A medium effect size is appropriate for the proposed study and was used in the determination of the sample size for a chi square analysis. Considering the medium effect size of .30, a generally accepted power of .80, a significance level of .05, and four degrees of freedom required for a 2 x5 chi square analysis, the desired sample size to achieve empirical validity is a total of 133 participants (Faul, Erdfelder, Buchner, & Lang, 2008).

This study used the Internet as its primary mode of data collection; the researcher's accessible population was female healthcare administrators who have active Internet or email addresses. The e-mail addresses were obtained from a mailing list purchased by SK&A Information Services, Inc.

Description of the Instrument

The primary instrument used in this study is a 30-item self-constructed survey questionnaire (Appendix A) with items based on previous studies and items indicated in the literature review. The survey instrument used is composed of five parts, (I) the Mentoring Experiences Section, (II) the Career Barriers Section, (III) the Job Competence section, (IV) the Career Satisfaction Section and (V) the Profile Section.

A cover letter (Appendix B) for the survey was provided to participants, the cover letter contained a brief introduction of the nature and purposes of the study. Issues on confidentiality and protection of human subjects were addressed in the letter to assure respondents that their responses would be used in any way that will compromise their professional or personal lives.

I.   Mentoring Experiences

The first part of the survey is the Mentoring Experiences section. Respondents were asked if they were mentored during their career. They were also asked if they participated in a formal or informal mentoring relationship.

II.   Career Advancement Barriers

In this section the respondents were asked to what extent perceived barriers had on their career advancement in healthcare administration. The following items were

included; lack of mentors, exclusion from informal networks, lack of role models, lack of fit into the organization's culture, work/life balance issues, gender discrimination, not receiving meaningful feedback on job performance, difficulty obtaining developmental assignments, and having unsupportive supervisors.

III.   Job Competence

In this section the respondents were asked if mentoring has benefited their careers in several domains such as gaining knowledge in healthcare administration, acquiring stronger leadership skills, developing communication skills, enhancing problem-solving skills, and learning how to be business savvy.

IV.   Career Satisfaction

In this section, respondents were asked to rate their level of satisfaction on areas such as compensation, mentors, work-life balance, overall career satisfaction, and assignment.

V.   Profile

In this section, the following details were gathered: Demographics that would ask for information on 1) Gender, 2) Age, 3) Current position in present organization, 4) Highest educational attainment, and 5) Current salary.

Data Analysis

Data gathered was analysed using appropriate statistical tools. Descriptive statistics were conducted on demographic data to describe the sample. Descriptive statistics were conducted on the healthcare administrator survey to describe participant's responses to the survey question. Frequency and percentages were calculated on nominal

(categorical/dichotomous) data and means/standard deviations were calculated on continuous (interval/ratio) data (Howell, 2010). Chi-square analyses were conducted to test the hypotheses posed by this study. The chi-square is an appropriate statistical measure when the purpose of the research is to test the relationship between two nominal or dichotomous variables.

Research Question 1

RQ1: Is there a relationship between type of mentoring relationship (formal or informal) and perceived career advancement barriers among women healthcare administrators?

$H1_o$: There is no statistically significant relationship between type of mentoring relationship and career advancement barriers among women healthcare administrators.

$H1_a$: There is a statistically significant relationship between type of mentoring relationship and career advancement barriers among women healthcare administrators.

To examine research question 1, nine 2 x 5 chi square analyses were conducted to assess whether or not there is a statistically significant relationship between type of mentoring relationship and career advancement barriers. Type of mentoring relationship is a dichotomous variable (formal vs. informal) obtained from question 2 of the survey. Table 1 demonstrates how the data was presented for research question 1. Career advancement barriers was obtained from Section II of the survey in which participants were asked to rate the perception of the barriers to their advancement in healthcare administration using the following scale: 1= strongly disagree, 2= disagree, 3= undecided, 4= agree, and 5= strongly agree. There were nine items in this section of the

survey (items 3-11). These variables have five levels.

Table 1. Sample Data Table for Research Question 1

Variable	N	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	X^2	P
Mentoring Relationship							10.18	.038
Formal	4	2	3	3	15	1		
Informal	6	4	2	2	8	0		
Totals	10	6	5	5	23	1		

Research Question 2

RQ2: Is there a relationship between current position and career advancement barriers among women healthcare administrators?

H2$_o$: There is no statistically significant relationship between current position and career advancement barriers among women healthcare administrators.

H2$_a$: There is a statistically significant relationship between current position and career advancement barriers among women healthcare administrators.

To examine research question 2, seven 2 x 5 chi square analyses were conducted to assess whether or not there was a statistically significant relationship between current position and career advancement barriers. Current position was a categorical variable (Chief Executive Officer, Chief Operating Officer, Executive Vice President, and Administrator and mid-level managers will include Executive Director, Administrative Officer, Associate Administrator, and Vice President and other) obtained from question 28 of the survey. This variable was dichotomized for analysis into two levels (senior-level women administrators and mid-level women administrators). Senior level managers included Chief Executive Officer, Chief Operating Officer, Executive Vice President, and

Administrator and mid-level managers included Executive Director, Administrative

Officer, Associate Administrator, and Vice President. The responses of participants who

selected "other" were reviewed; they were placed into one of the two categories based on

the researcher's knowledge about that vocational position.   Table 2 demonstrates how

the data was presented for research question 2. Career advancement barriers were

obtained from Section II of the survey in which participants are asked to rate the

perception of the barriers to your advancement in healthcare administration using the

following scale: 1= strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, and 5 =

strongly agree. There are seven items in this section of the survey (items 3-11). These

variables have five levels.   A tabular summary of the statistical tools to be used for this

study is presented (Table 4).

Table 2. Sample Data Table for Research Question 2

Variable	N	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	X^2	P
Current Position	20						10.18	.038
Mid-level	4	2	3	3	15	1		
Senior-level	16	4	2	2	8	0		
Totals	40	6	5	5	23	1		

Research Question 3

RQ3: Is there a relationship between type of mentoring relationship (formal or

informal) and job competence among women healthcare administrators?

H3$_o$: There is no statistically significant relationship between type of mentoring

relationship and job competence among women healthcare administrators.

H3$_a$: There is a statistically significant relationship between type of mentoring

relationship and job competence among women healthcare administrators.

To examine research question 3, seven 2 x 5 chi square analyses were conducted

to assess whether or not there was a statistically significant relationship between type of

mentoring relationship and job competence among women healthcare administrators.

Table 3 demonstrates how the data was presented for research question 3. Type of mentoring

relationship is a dichotomous variable (formal vs. informal) obtained from question 3 of

the survey. Job competence was obtained from Section III of the survey in which

participants were asked to rate the outcome of their mentoring using the following scale:

1= not at all, 2 = slightly, 3 = moderately, 4 = considerably, and 5 = great extent. There

are seven items in this section of the survey (items 12-18). These variables have five

levels.

Table 3. Sample Data Table for Research Question 3

Variable	N	Not at All	Slightly	Moderately	Considerably	Great extent	X^2	P
Mentoring Relationship							10.18	.038
Formal	24	3	15	2	3	1		
Informal	16	2	4	8	2	0		
Totals	40	5	19	10	5	1		

Table 4. Tabular Summary of Statistical Tools to be Used

Research Questions	Statistical Tool To Be Used
(1)　　Is there a relationship between type of mentoring relationship and perceived career advancement barriers among women healthcare administrators?	Chi square
(2)　　Is there a relationship between current position and perceived career advancement barriers among women healthcare administrators?	Chi square
(3)　　Is there a relationship between type of mentoring relationship and job competence success among women healthcare administrators?	Chi square

Summary

Building on existing literature that supports mentoring as an effective developmental tool for career advancement among women, this study aimed to identify the barriers that hinder career advancement among women in healthcare administration and investigate the role of mentoring in breaking these barriers. Moreover, this study also sought to determine the effect of the type of mentoring relationship that promotes career competence among female healthcare administrators. This study is a quantitative study specifically of a descriptive and correlational nature. A self-constructed survey questionnaire served as the primary instrument of the study. Data gathering commenced following ethical standards and standard research protocols for the protection of human research subjects. Descriptive statistics and chi square analysis were conducted to analyze data gathered.

CHAPTER IV

RESULTS

Preliminary Treatment of Data

The targeted population of the study was comprised of female senior and mid-level healthcare administrators. Of the 4,807 surveys emailed, 356 surveys were received resulting in a 7.5% response rate. Prior to conducting the statistical analyses, the survey data was examined with descriptive statistics to assess the data for accuracy. Outliers (data that was not consistent with the survey coding system) were deleted and treated as missing data. Some participants were excluded from the final analysis, including participants that endorsed the male gender or did not provide a gender response and participants that failed to complete the end of the survey. Item 1 of the survey asked participants if they had been mentored during their career, and if not, were instructed to skip the follow-up item (item 2). Even though they reported having not been mentored during their career, eleven participants responded to the follow-up item *(What type of mentoring relationship did you benefit from most?)*. For consistency, their responses were deleted. The "other" responses to education level and current position were examined and coded to be consistent with the survey categories (when possible). All of the "other" positions were re-coded, but "other" education responses that did not fit into categories were not recoded.

Sample Characteristics

The final sample consisted of 328 female healthcare administrators. G*Power 3.1.0 was used to calculate sample size of 133. A medium effect size is appropriate for this study

and was used in the determination of the sample size for a chi square analysis. Considering the medium effect size of .30, a generally accepted power of .80, a significance level of .05, and four degrees of freedom required for a 2 x5 chi square analysis, the desired sample size to achieve empirical validity is a total of 133 participants (Faul, Erdfelder, Buchner, & Lang, 2008). Raw data pertaining to participants' position level was re-coded so that respondents were categorized as senior level or middle level administrators. Senior level positions included Chief Executive Officers, Chief Operating Officers, Executive Vice Presidents, and Administrators. Middle level positions included Vice Presidents, Administrative Officers, Associate Administrators, and Directors. One-hundred and ten (33.5%) participants selected the "other" position response option; these responses were examined one by one and coded by the researcher as either senior level or middle level administrators based on knowledge of positions in the field. There were 165 (50.3%) women in senior level positions and 163 (49.7%) women in middle level positions. Frequencies and percentages of senior and mid-level women administrators' positions are presented in Table 5.

Table 5. Frequencies and Percentages of Senior and Mid-Level Women Administrators' Positions

Position	n	%
Hierarchical administrative position		
Senior level position	165	50.3
Middle level position	163	49.7
Total	328	100.0%
Current Position		
Chief Executive Officer	40	12.2
Chief Operating Officer	39	11.9
Executive Vice President	16	4.9
Administrator	18	5.5
Vice president	57	17.4
Associate Administrator	7	2.1
Director	41	12.5
Other	110	33.5
Total	328	100.0%

Further examination of the 110 "other" position responses revealed that 58

(17.7%) of these participants identified themselves as Chief Nursing Officers, 9(2.7%)

were Senior Vice Presidents, 7(2.1%) were Chief Nurse Executives, and 7 (2.1%) were

Assistant Vice Presidents. Lower frequencies were found for other positions. A listing of

"other" positions is presented in Table 6.

Table 6. Frequencies and Percentages of Senior and Mid-Level Women Administrators'
"Other" Positions Responses (N=110)

"Other" positions	n	%
Chief Nursing Officer	58	17.7
Senior Vice President	9	2.7
Assistant Vice President	7	2.1
Chief Nurse Executive	7	2.1
Director of Nursing	4	1.2
Chief Information Officer	2	0.6
Consultant	2	0.6
Director of Patient Care Services	2	0.6
Executive Director	2	0.6
President	2	0.6
Agency Nurse Executive	1	0.3
Assistant Administrator	1	0.3
Chief Administrative Officer	1	0.3
Chief Compliance Officer	1	0.3
Chief Patient Care Officer	1	0.3
CIO	1	0.3
Dean	1	0.3
Educator	1	0.3
Director of Information	1	0.3
Informatics Coordinator	1	0.3
IT Manager	1	0.3
Manager, Patient Safety/Regulatory	1	0.3
Nurse Manager	1	0.3
Nursing Coordinator	1	0.3
Program Analyst	1	0.3

The mean age of the respondents was 53.38 ($SD = 6.94$); the youngest participant

was 30 years old and the oldest was 74 years old. However, 74 (22.6%) of the

participants did not report an age. Categorically, the greatest number of participants (139,

42.4%) was noted in the 50-59 year old age group. The majority of the respondents (238,

73.2%) reported a Master's degree as their highest education level attained. Seventeen

respondents (10.7%) reported "other" education levels, which included: Associate's

degrees, certifications without mention of a degree, nursing diplomas, some college, or

no degree. Salary levels ranged from $75,001 to more than $500,000 annually, and the

majority of respondents (231, 74.5%) reported salaries below $200,001. Less than 1%

earned more than $400,000 annually. Frequencies and percentages for senior and mid-

level women administrators' age, education level and salary range are presented in Table 7.

Table 7. Frequencies and Percentages of Senior and Mid-Level Women Administrators'
Age, Education Level and Salary Range

Characteristic	*n*	%
Age range		
30-39 years	12	3.7
40-49 year	54	16.5
50-59 year	139	42.4
60-69 year	48	14.6
70 years or older	1	.3
No response	74	22.6
Highest education level		
Bachelor's degree	47	12.2
Master's degree	238	70.9
Doctorate degree	21	5.5
Professional degree	2	0.6
Other	17	10.7
Current annual salary		
$75,001 – $100,000	67	20.4
$100,001 - $150,000	87	26.5
$150,001 – $200,000	77	23.5
$200,001 - $250,000	38	11.6
$250,001 - $300,000	19	5.8
$300,001 - $350,000	12	3.7
$350,001 - $400,000	5	1.5
$400,001 - $450,000	2	0.6
$450,001 - $500,000	2	0.6
Over $500,000	1	0.3

Mentoring Experiences

The data pertaining to the respondents mentoring experiences, including whether or not they had been mentored during their career (yes vs. no) and if they received mentoring, what type of mentoring relationship they benefited from most (formal vs. informal) was examined with descriptive statistics. Formal mentoring is defined as *when an experienced employee is assigned to a mentee who is the junior in the organization* (Ragins & Cotton, 1999). Informal mentoring is defined as *a relationship developed out of mutually compatible goals* (Ragins & Cotton, 1999).

Of the 328 respondents in the study, 278 (85.0%) had been mentored during their career, and 49 (15.0%) received no mentoring, (one participant did not respond to this item). For those mentored, the majority reported that they benefited most from informal mentoring (229, 83.0%), while 47 (17.0%) benefited most from formal mentoring (there were three missing responses). Frequencies and percentages for senior and mid-level women administrators' mentoring experiences are presented in Table 8.

Table 8. Frequencies and Percentages of Senior and Mid-level Women Administrators' Mentoring Experiences

Mentoring Experiences	*n*	%
Were you mentored during your career?		
Yes	278	85.0
No	49	15.0
What type of mentoring relationship did you benefit from most?		
Formal	47	17.0
Informal	229	83.0

Career Advancement Barriers

The data pertaining to the respondents' career advancement barriers was examined with descriptive statistics. Prior to analysis, the data file was split by position

type (senior level vs. mid-level). Career advancement barriers were measured in Section II of the survey, questions 3-11. Participants were asked to rate each question based upon barriers to their advancement in healthcare administration (1 – *strongly disagree*, 2 – *disagree*, 3 – *undecided*, 4 – *agree*, 5 – *strongly agree*).

The measures of central tendency included the median and the mode. Participants in both administrative groups (senior level vs. mid-level) received similar median scores on questions 3-11. A median score of 2.00 (*disagree*) was found on items 3, 5, 6, 8, 9, 10 and 11, where 50% of the scores were above the median value and 50% were below the median value. A median score of 4.00 (agree) was found on items 4 and 7. The mode offers an indication of the score in the distribution that occurred most often. The modes were similar to the median for every item with the exception of item 9 (*You experienced gender discrimination*) for the middle level administrators, which had a mode of 1 (*strongly disagree*). However, examination of the frequency counts shows that responses to strongly disagree (n = 49) and disagree (n =48).

The median and mode for career advancement barriers among senior level and mid-level administrators are presented by group in Table 9.

Table 9. Median and Mode for Career Advancement Barriers among Senior Level and Mid-Level Women Administrators by Position (Senior Level and Middle-Level)

Career Advancement Barriers	Senior Level			Middle Level		
	N	Mdn	Mode	N	Mdn	Mode
3.You experienced a lack of mentors	63	.00	.00	162	2.00	2.00
4.You were not excluded from Informal Networks	63	.00	.00	163	4.00	4.00
5.You experienced a lack of role models that were similar to you	65	.00	.00	161	2.00	2.00
6.You did not fit into the organization's culture	64	.00	.00	163	2.00	2.00
7.You experienced work-life balance issues	65	.00	.00	62	.00	4.00
8.You had unsupportive supervisors	64	.00	.00	61	.00	2.00
9.You experienced gender discrimination	65	.00	.00	60	.00	1.00

10.You did not receive enough meaningful feedback on performance	65	.00	.00	63	.00	2.00
11.You experienced difficulty obtaining developmental assignments	64	.00	.00	62	.00	2.00

Research Question 1: Mentoring and Perceived Barriers

Is there a relationship between type of mentoring (formal or informal) and perceived career advancement barriers among women healthcare administrators?

To test the hypothesis that there is a relationship between type of mentoring (formal or informal) and career advancement barriers among women healthcare administrators, nine chi-square analyses were conducted. Career advancement barriers were measured in Section II of the survey, questions 3-11. Participants were asked to rate each question based upon barriers to their advancement in healthcare administration (1 – *strongly disagree*, 2 – *disagree*, 3 – *undecided*, 4 – *agree*, 5 – *strongly agree*). Type of mentoring relationship was measured with survey question 2; participants who selected formal were coded 1 and those that selected informal were coded 2. The analysis of research question 1 involved nine chi square tests; with the more tests conducted, there is a greater probability that one or more of the tests will be statistically significant due to chance alone Type I error (Abdi, 2007). A Bonferroni correction (α/n) was calculated to hold the familywise error rate .05 where $\alpha = .05$ and $n = 9$. For this set of analysis, the corrected alpha level of .006 was employed for interpretation.

Survey question 3 asked respondents to rate their perception of the barrier *experienced a lack of mentors* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 4.26, $p = .372$, suggesting that there was not a significant relationship between the *lack of mentors* and type of mentoring relationship.

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Results of the chi-square on mentoring relationship (formal vs. informal) by lack of

mentors are presented in Table 10.

Table 10. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Lack of Mentors

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	X^2	p
							4.26	.372
Formal	47	12	22	1	9	3		
Informal	26	38	103	13	3	9		
Totals	73	50	125	14	12	12		

Note. df = 4

Survey question 4 asked respondents to rate their perception of the barrier, *not*

excluded from Informal Networks to their advancement in healthcare administration. The

chi-square was not significant, x^2 (4) = 4.15, *p* = .386, suggesting that there was not a

significant relationship between *not being excluded from the Informal Networks* and type

of mentoring relationship. Results of the chi-square on mentoring relationship (formal

vs. informal) and exclusion from Informal Networks are presented in Table 11.

Table 11. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Exclusion from Informal Networks

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	X^2	p
							4.15	.386
Formal	47	4	6	5	8	4		
Informal	28	11	52	19	17	29		
Totals	75	15	58	24	45	33		

Note. df = 4

Survey question 5 asked respondents to rate their perception of the barrier *a lack*

of similar role models to their advancement in healthcare administration. The chi-square

was significant, x^2 (4) = 13.42, *p* = .009, suggesting that there was a statistically

significant relationship between the experience of *a lack of similar role models* and type

of mentoring relationship. Participants who had a benefited from a formal mentoring

relationship tended to reply *disagree* or *strongly disagree* to the experience of *a lack of*

similar role models while participants who benefited from an informal mentoring

relationship had more varied responses on the rating scale, including agree and disagree

responses. The results were not statistically significant based on the Bonferonni-corrected

alpha. Results of the chi-square on mentoring relationship (formal vs. informal) and

experienced *a lack of similar role models* are presented in Table 12.

Table 12. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs.
Informal) and Experienced a Lack of Role Models

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	X^2	p
							13.42	.009
Formal	47	11	26	1	4	5		
Informal	28	31	93	11	5	18		
Totals	75	42	119	12	9	23		

Note. df = 4

Survey question 6 asked respondents to rate their perception of the barrier *did not*

fit into the organization's culture to their advancement in healthcare administration. The

chi-square was not significant, x^2 (4) = 1.89, *p* = .756, suggesting that there was not a

statistically significant relationship between *did not fit into the organizations' culture* and

type of mentoring relationship. Results of the chi-square on mentoring relationship (formal

vs. informal) and *did not fit into the organizations' culture* are presented in Table 13.

Table 13. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Did Not Fit in the Organization's Culture

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							1.89	.756
Formal	47	16	25	1	5	0		
Informal	28	79	115	9	19	6		
Totals	75	95	140	10	24	6		

Note. df = 4

Survey question 7 asked respondents to rate their perception of the barrier *work life balance issues* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 0.71, p = .950, suggesting that there was not a statistically significant relationship between the *work life balance issues* and type of mentoring relationship. Results of the chi-square on mentoring relationship (formal vs. informal) and *work life balance issues* are presented Table 14.

Table 14. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Work Life Balance Issues

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							.71	.950
Formal	47	4	15	2	20	6		
Informal	29	16	78	16	91	28		
Totals	76	20	93	18	111	34		

Note. df = 4

Survey question 8 asked respondents to rate their perception of the barrier *had unsupportive supervisors* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 5.07, p = .218, suggesting that there was not a statistically significant relationship between having *had unsupportive supervisors* and the

type of mentoring relationship. Results of the chi-square on mentoring relationship

(formal vs. informal) and had unsupportive supervisors are presented Table 15.

Table 15. *Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Unsupportive Supervisors*

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							5.07	.281
Formal	47	12	21	4	0	0		
Informal	27	60	110	10	4	13		
Totals	74	72	131	14	4	13		

Note. df = 4

Survey question 9 asked respondents to rate their perception of the barrier *gender*

discrimination to their advancement in healthcare administration. The chi-square was not

significant, x^2 (4) = 6.12, p = .190, suggesting that there was not a statistically significant

relationship between the experience of *gender discrimination* and the type of mentoring

relationship. Results of the chi-square on mentoring relationship (formal vs. informal)

and experienced *gender discrimination* are presented Table 16.

Table 16. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Experienced Gender Discrimination

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							6.12	.190
Formal	47	15	11	6		4		
Informal	27	56	92	16		12		
Totals	74	71	103	22		16		

Note. df = 4

Survey question 10 asked respondents to rate their perception of the barrier *did*

not receive enough meaningful feedback on job performance to their advancement in

healthcare administration. The chi-square was not significant, x^2 (4) = 1.93, p = .749,

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suggesting that there was not a statistically significant relationship between *did not receiving enough meaningful feedback on job performance* and the type of mentoring relationship. Results of the chi-square on mentoring relationship (formal vs. informal) and *did not receive enough meaningful feedback on job performance* are presented Table 17.

Table 17. Chi Square on Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Meaningful Feedback

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							1.93	.749
Formal	47	8	22	3	0	4		
Informal	29	38	102	17	2	10		
Totals	76	46	124	20	2	14		

Note. df = 4

Survey question 11 asked respondents to rate their perception of the barrier *experienced difficulty obtaining developmental assignments* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 1.64, p = .803, suggesting that there was not a statistically significant relationship between difficulty obtaining developmental assignments and the type of mentoring relationship. Results of the chi-square on mentoring relationship (formal vs. informal) and *experienced difficulty obtaining developmental assignments* are presented in Table 18.

Table 18. Chi Square of Type of Mentoring Relationship Benefit from Most (Formal vs. Informal) and Experienced Difficulty Obtaining Developmental Assignments

Mentoring Relationship	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	P
							1.64	.803
Formal	47	12	22	4	8	1		
Informal	28	61	121	11	1	4		
Totals	75	73	143	15	9	5		

Note. df = 4

Nine chi square analyses were conducted to test the hypothesis that women administrators in informal mentoring relationships will report more barriers encountered toward career advancement than those in formal mentoring relationships. With the Bonferroni correction applied, none of the analyses were statistically significant, and the null hypothesis, that no relationship exists between barriers encountered toward career advancement and type of mentoring relationship cannot be rejected. However, there was a statistically significant relationship between the *experience of a lack of role models* and the type of mentoring relationship; participants who benefited from a formal mentoring relationship tended to disagree to the *experience of a lack of role models*, whereas women who had informal mentoring relationships had more varied responses.

Research Question 2: Organizational Rank and Perceived Behaviors

Is there a relationship between current position and perceived career advancement barriers among women healthcare administrators?

To test the hypothesis, that there is a statistically significant relationship between current position and career advancement barriers among women healthcare administrators, nine chi-square analyses were conducted. Career advancement barriers were measured in Section III of the survey, questions 3-11. Participants were asked to rate each question based upon barriers to their advancement in healthcare administration (1 – *strongly disagree*, 2 – *disagree*, 3 – *undecided*, 4 – *agree*, 5 – *strongly agree*). Current position was measured with survey question 28; participants who replied Chief Executive Officer, Chief Operating Officer, Executive Vice President or Administrator were considered senior level and coded as 1. Participants who replied Vice President,

Administrative Officer, Associate Administrator or Director were considered mid-level

and coded 2. The analysis of research question 2 involved nine chi square tests; with the

more tests conducted, there is a greater probability that one or more of the tests will be

statistically significant due to chance alone Type I error (Abdi, 2007). A Bonferroni

correction (α/n) was calculated to hold the familywise error rate .05 where α = .05 and n

= 9. For this set of analysis, the corrected alpha level of .006 was employed for

interpretation.

Survey question 3 asked respondents to rate their perception of the barrier,

experienced a lack of mentors to their advancement in healthcare administration. The

chi-square was not significant, x^2 (4) = 1.29, p = .863, suggesting that there was not a

significant relationship between lack of mentors and administrators' current position.

Results of the chi-square on the *experienced lack of mentors* and administrators' current

position (senior level vs. middle level) are presented in Table 19.

Table 19. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level)
and Experienced of a Lack of Mentors

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							1.29	.863
Senior-level	63	27	66	9	0	11		
Mid-level	62	25	66	7	8	16		
Totals	125	52	132	16	8	27		

Note. df = 4

Survey question 4 asked respondents to rate their perception of the barrier, *not*

excluded from Informal Networks to their advancement in healthcare administration. The

chi-square was not significant, x^2 (4) = 2.04, p = .728, suggesting that there was not a

significant relationship between *not excluded from Informal Networks* and

administrators' current position. Results of the chi-square not excluded from Informal

Networks and administrators' current position (senior level vs. middle level) are

presented in Table 20.

Table 20. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level)
and Exclusion from Informal Networks

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							2.04	.728
Senior-level	63	7	36	16	7	17		
Mid-level	63	9	30	21	52	21		
Totals	126	16	66	37	69	38		

Note. df = 4

Survey question 5 asked respondents to rate their perception of the barrier, *a lack

of similar role models* to their advancement in healthcare administration. The chi-square

was not significant, x^2 (4) = 1.16, *p* = .885, suggesting that there was not a significant

relationship between experienced *a lack of role models* similar to you and administrators'

current position. Results of the chi-square between experienced a lack of role models

similar to you and administrators' current position (senior level vs. middle level) are

presented in Table 21.

Table 21. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level)
and Experienced a Lack of Role Models

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							1.16	.885
Senior-level	165	24	68	9	7	17		
Mid-level	161	19	68	7	2	15		
Totals	326	43	136	16	9	32		

Note. df = 4

Survey question 6 asked respondents to rate their perception of the barrier *did not fit into the organization's culture* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 5.43, p = .246, suggesting that there was not a significant relationship between did not fit into the organizations' culture and administrators' current position. Results of the chi-square between did not fit into the organizations' culture and administrators' current position (senior level vs. middle level) are presented in Table 22.

Table 22. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level) and Did Not Fit in the Organization's Culture

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							5.43	.246
Senior level	64	54	87	9	11	3		
Mid-level	63	55	82	3	19	4		
Totals	127	109	169	12	30	7		

Note. df = 4

Survey question 7 asked respondents to rate their perception of the barrier *experienced work life balance issues* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 1.45, p = .835, suggesting that there was not a significant relationship between *experienced work life balance issues* and did not fit administrators' current position. Results of the chi-square between *experienced work life balance issues* and administrators' current position (senior level vs. middle level) are presented in Table 23.

Table 23. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level) and Work Life Balance Issues

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							1.45	.835
Senior-level	65	16	52	11	4	22		
Mid-level	62	11	55	11	7	18		
Totals	127	27	107	22	31	40		

Note. df = 4

Survey question 8 asked respondents to rate their perception of the barrier *had unsupportive supervisors* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 2.36, *p* = .670, suggesting that there was not a significant relationship between *had unsupportive supervisors* and administrators' current position. Results of the chi-square between participants had unsupportive supervisors and administrators' current position (senior level vs. middle level) are presented in Table 24.

Table 24. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level) and had Unsupportive Supervisors

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							2.36	.670
Senior-Level	64	44	77	11	24	8		
Mid-Level	61	37	75	10	33	6		
Totals	125	81	152	21	57	14		

Note. df = 4

Survey question 9 asked respondents to rate their perception of the barrier *experienced gender discrimination* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 7.90, *p* = .095, suggesting that there was not a significant relationship between *experienced gender discrimination* and administrators'

current position. Results of the chi-square between *gender discrimination* and

administrators' current position (senior level vs. middle level) are presented in Table 25.

Table 25. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level)
and Gender Discrimination

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							7.90	.095
Senior-level	65	33	69	15	6	12		
Mid-level	60	49	48	18	7	8		
Totals	125	82	117	33	13	20		

Note. df = 4

Survey question 10 asked respondents to rate their perception of the barrier *did

not receive enough meaningful feedback on job performance* to their advancement in

healthcare administration. The chi-square was not significant, x^2 (4) = 3.08, *p* = .545,

suggesting that there was not a significant relationship between *did not receive enough

meaningful feedback on job performance* and administrators' current position. Results of

the chi-square between *did not receive enough meaningful feedback on job performance*

and administrators' current position (senior level vs. middle level) are presented in Table

26.

Table 26. Chi Square on Administrators' Current Position (Senior Level vs. Mid-Level)
and Did not receive Enough Meaningful Feedback

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	p
							3.08	.545
Senior-level	65	25	69	9	52	10		
Mid-level	63	23	74	14	40	12		
Totals	128	48	143	23	92	22		

Note. df = 4

Survey question 11 asked respondents to rate their perception of the barrier *experienced difficulty obtaining developmental assignments* to their advancement in healthcare administration. The chi-square was not significant, x^2 (4) = 1.82, *p* = .770, suggesting that there was not a significant relationship between experienced difficulty obtaining developmental assignments and administrators' current position. Results of the chi-square between *experienced difficulty obtaining developmental assignments* and administrators' current position (senior level vs. middle level) are presented in Table 27.

Table 27. Chi Square of Current Position by Developmental Assignments

Current Position	N	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	χ^2	*p*
							1.82	.770
Senior-level	164	43	78	11	28	4		
Mid-level	162	37	85	14	22	4		
Totals	326	80	163	25	50	8		

Note. df = 4

Nine chi square analyses were conducted to test the hypothesis that senior level women administrators will report more barriers toward career advancement than mid-level women administrator. None of the analyses were statistically significant, and the null hypothesis, that no relationship exists between barriers encountered toward career advancement and administrative position level cannot be rejected.

Research Question 3: Mentoring and Job Competence

Is there a relationship between type of mentoring relationship (formal or informal) and job competence among women healthcare administrators?

To test the hypothesis, that there is statistically significant relationship between type of mentoring relationship and job competence among women healthcare administrators, seven chi squares were conducted. Job competence and professional success were measured in Section III of the survey, questions 12-18. Participants were asked to rate each question based upon to what extent being monitored has enhanced their job competence (1 – *not at all*, 2 – s*lightly*, 3 – *moderately*, 4 – *considerably*, 5 – *great extent*). Type of mentoring relationship was measured with survey question 2; participants who selected formal were coded 1 and those that selected informal were coded 2. The analysis of research question 3 involved seven chi square tests; with the more tests conducted, there is a greater probability that one or more of the tests will be statistically significant due to chance alone Type I error (Abdi, 2007). A Bonferroni correction (α/n) was calculated to hold the familywise error rate .05 where α = .05 and n = 7. For this set of analysis, the corrected alpha level of .007 was employed for interpretation.

Question 12 asked respondents to rate the outcome of mentoring in enhancing job competence through the *improved knowledge of healthcare administration*. The chi-square was significant, x^2 (4) = 15.06, p = .005, suggesting that there was a statistically significant relationship between the *improved knowledge of healthcare administration* and the type of mentoring relationship. For participants with formal mentoring relationships, they tended to reply that being mentored had enhanced job competence by improving knowledge of healthcare administration *considerably* or to a *great extent*. For participants with informal mentoring relationships, they tended to reply with *moderately, considerably*, or a *great extent*. Results of the chi-square are presented in Table 28.

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Table 28. Chi Square Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Improved Knowledge of Healthcare Administration

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							15.06	.005
Formal	47	3	4	1	26	13		
Informal	228	4	26	54	100	44		
Totals	275	7	30	55	126	57		

Note. df = 4

Question 13 asked respondents to rate the outcome of mentoring in enhancing job competence through *enhancing leadership capabilities*. The chi-square was significant, x^2 (4) = 10.96, p = .027, suggesting that there was a statistically significant relationship between *enhanced leadership capabilities* and the type of mentoring relationship. For participants with formal mentoring relationships, they tended to reply that being mentored had enhanced job competence by enhancing leadership capabilities *considerably*. For participants with informal mentoring relationships, they tended to reply with *moderately, considerably*, or a *great extent*. The results were not statistically significant based on the Bonferonni-corrected alpha. Results of the chi-square are presented in Table 29.

Table 29. Chi Square on Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Enhanced Leadership Capabilities

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							10.96	.027
Formal	47	3	2	4	25	13		
Informal	228	2	19	46	101	60		
Totals	275	5	21	50	126	73		

Note. df = 4

Question 14 asked respondents to rate the outcome of mentoring in enhancing job competence through *improving critical thinking and problem solving skills*. The chi-square was significant, x^2 (4) = 11.59, p = .021, suggesting that there was a statistically significant relationship between improving critical thinking and problem solving skills and the type of mentoring relationship. For participants with formal mentoring relationships, they tended to reply that being mentored had enhanced job competence by improving critical thinking and problem solving skills *considerably*. For participants with informal mentoring relationships, they tended to reply with *moderately, considerably*, or a *great extent*. The results were not statistically significant based on the Bonferonni-corrected alpha. Results of the chi-square are presented in Table 30.

Table 30. Chi Square on Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Improved Critical Thinking and Problem Solving Skills

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							11.59	.021
Formal	47	5	3	5	22	12		
Informal	228	6	30	53	94	45		
Totals	275	11	33	58	116	57		

Note. df = 4

Question 15 asked respondents to rate the outcome of mentoring in enhancing job competence through *enhancing communication skills*. The chi-square was not significant, x^2 (4) = 7.99, p = .092, suggesting that there was not a statistically significant relationship between *enhancing communication skills* and the type of mentoring relationship. Results of the chi-square are presented in Table 31.

Table 31. Square on Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Enhanced Communications Skills

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							7.99	.092
Formal	47	4	1	9	25	8		
Informal	228	6	22	58	98	44		
Totals	275	10	23	67	123	52		

Question 16 asked respondents to rate the outcome of mentoring in enhancing job competence through *improved job performance.* The chi-square was not significant, x^2 (4) = 3.83, p = .429, suggesting that there was not a statistically significant relationship between *improved job performance* and the type of mentoring relationship. Results of the chi-square are presented in Table 32.

Table 32. Chi Square on Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Improved Job Performance

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							3.83	.429
Formal	47	3	2	10	22	10		
Informal	228	5	22	54	102	45		
Totals	275	8	24	64	124	55		

Note. df = 4

Question 17 asked respondents to rate the outcome of mentoring in enhancing job competence through *improved business acumen.* The chi-square was not significant, x^2 (4) = 3.96, p = .411, suggesting that there was not a statistically significant relationship between *improved business acumen* and the type of mentoring relationship. Results of the chi-square are presented in Table 33.

Table 33. Chi Square Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Improved Business Acumen

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							3.96	.411
Formal	46	3	4	6	22	11		
Informal	228	5	25	47	99	52		
Totals	274	8	29	53	121	63		

Note. df = 4

Question 18 asked respondents to rate the outcome of mentoring in enhancing job competence in that mentoring *led to a new position with greater responsibility.* The chi-square was not significant, x^2 (4) = 9.12, p = .056, suggesting that there was not a statistically significant relationship between mentoring leading to a new position with greater responsibility and the type of mentoring relationship. Results of the chi-square are presented in Table 34.

Table 34. Chi Square Type on Mentoring Relationship Benefit from Most (Formal vs. Informal) and Led to a New Position with Greater Responsibility

Mentoring Relationship	N	Not at all	Slightly	Moderately	Considerably	Great extent	χ^2	p
							9.12	.056
Formal	47	4	0	6	18	19		
Informal	229	9	31	36	78	75		
Totals	276	13	31	42	96	94		

Note. df = 4

Seven chi square analyses were conducted to test the hypothesis there is statistically significant relationship between the type of mentoring relationship senior women healthcare administrators receive and their job competence. When the Bonferroni correction was applied, one of the seven analyses was statistically significant, and the null hypothesis, that no relationship exists between job competence and type of

mentoring relationship, cannot be rejected. While there is a significant relationship between the type of mentoring relationship received and improved knowledge of healthcare administration, the relationship between type of mentoring received and the other job competence variables was not statistically significant.

Regarding the improved knowledge of healthcare administration, participants with formal mentoring relationships tended to reply that being mentored had enhanced job competence by improving knowledge of healthcare administration *considerably* or to a *great extent* and participants with informal mentoring relationships tended to reply with *moderately, considerably*, or a *great extent*.

CHAPTER V

DISCUSSION

The purpose of this study was to explore the correlation between type of

mentoring relationship (formal or informal) and perceived career advancement barriers

among women healthcare administrators who hold senior and mid-level positions, the

relationship between type of mentoring relationship (formal or informal) and job

competence success among female health administrators who hold senior and mid-level

positions, and the correlation between organizational rank and perceived career

advancement barriers among female health administrators.

Results of the study revealed there is no significant difference between the

respondents' organizational rank and perceived barriers towards career advancement.

Results also revealed no significant difference between type of mentoring relationship

and perceived barriers towards career advancement; however the results supported a

correlation between the type of mentoring relationships and job competence.

Respondents reported that mentoring improved knowledge of healthcare administration,

enhanced leadership capabilities, and improved critical thinking and problem solving

skills.

The results of the study conducted can be related to previous studies conducted by

a variety of career analysts. A comprehensive study conducted by the women's group

Catalyst as published in the journal also called Catalyst (2006) listed the most common

barriers identified in a study investigating the experiences of women that have held high

level positions in many corporations. The barriers reported include limited flexible work arrangements; lack of mentors; gender-based stereotyping; exclusion from informal networks of communication; lack of stretch assignments; lack of access to influential colleagues; and limited flexible work arrangements.

Different barriers that women face in their pursuit of upward career mobility in the health profession were also discussed in a study conducted by Parsons and Reiss (2004). They identified specific barriers that affect women in their work performance. They commented that achieving career advancement presents difficulties for women and nurses. It was found in their study that women in the health profession are hindered by lack of role models and the existence of the "glass ceiling" phenomenon. This barrier hinders them to reach a management level position.

Other related studies discussed several barriers that have hindered the career direction and mobility of women administrators in their respective professions. Barriers included family factors that include lack of support from spouse and difficulty balancing work-family responsibilities. Furthermore, they also included legislative factors such as gender discrimination, pay equity, and laws on sexual harassment; organizational factors such as patriarchy, exclusion from networks, flexible work options, difficulty in dealing with male-dominated organizational culture, lack of training and mentoring opportunity; and individual factors such as gender, education, and geographical mobility.

As shown in the results there is no significant relationship between not being included in informal networks and type of mentoring relationship. Informal networks as defined by Ragins and Cotton (1999) refer to a relationship that is developed

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unexpectedly as a result of commonly perceived goals. It is for this reason that most of the mentoring programs are informal because they were constructed on the basis of mutually identified career needs, requiring to be fulfilled.

In this study, most of the respondents did not view this barrier as a noteworthy one since informal networks can still be generated in the informal type of mentoring program. Results of the study also showed that there was a significant relationship between the perception of lack of role models and the type of mentoring employed in an organization. The respondents who benefited from formal mentoring relationships perceived that lack of role model was not a hindrance to their advancement in the organization. On the contrary, respondents who benefited from informal mentoring relationships perceived the need of these role models in their career advancement. Those who underwent the formal type of mentoring already had a concrete individual who would be their guide in their career advancement. This is not similar to the informal type of mentoring since it involves self-selection and mutual identification to fulfill career goals. In the self-selection process, he or she will choose who will be their mentor. Therefore, it is necessary for them to choose those individuals who they already build a trusting relationship and who epitomize success. Moreover, informal mentoring involves greater level of coaching as compared to the formal one. As a coach, the mentor leads the mentee by example of professional behaviors, and this significantly affects the perception that the lack of a role model is a barrier for career advancement during informal mentoring (Clutterback, 2004).

Work-life balance issues are a major concern among managers of different organizations (Amble, 2006). The study revealed that work-life balance issues are

insignificantly related to one's advancement in career position. Respondents believe that their life issues do not have a crucial impact on the type of mentoring relationship they have in the workplace. According to Martin (2009), women nowadays know how to harmonize their personal life with the professional one. They are able to manage their life issues outside the bounds of their work. They are able to put a demarcation line to separate their personal life from their jobs, which may be a hindrance in achieving their goals if allowed to go beyond the limit. They do not let personal issues unfold in the workplace since they are aware of the consequences that may occur. Thus, the results gathered pertaining to this form of barrier is perceived to have some impact on respondents' career advancement.

Another finding in the study is that there was no statistically significant relationship between having had unsupportive supervisors and the type of mentoring relationship. Unsupportive supervisors had been viewed as a motivation by most of the individuals with an optimistic perception in life (Mage, 2003), making the quality insignificant in the working relationship. However, some individuals lose their motivation to work when they have disobliging supervisors. Previous studies even showed that having a mentor that is unsupportive creates an unsettling and demoralizing environment, making the working relationship uncomforting to both parties. On the contrary, this conception was proven insignificant if the results of this study are to be used as basis since the respondents perceive unsupportive administrators as not having a dramatic impact on the mentoring relationship, be it formal or informal.

The experience of gender discrimination from work showed no significant relationship with the type of mentoring relationship as exhibited by the response coming from the subjects of the study. Previous studies had found that stereotyping and gender-based discrimination remains the greatest barrier for women that prevent them from advancing to the top tier of the corporate ladder. However, it was found in this study that gender discrimination does not affect the type of mentoring relationship being utilized by the mentor of the respondents.

Meaningful feedback is also part of the mentoring process. When a mentor does not provide sufficient feedback, he or she is viewed by his or her mentee as biased. On the contrary, when the mentor provides feedback, perceptions to mentor as a biased individual disappear (Sanchez & Colon, 2005). However, it was found on this study that there was no significant relationship between the type of mentoring relationship and the perceived barrier which is lack of meaningful feedback.

The study also suggested that there was no statistically significant relationship between experiencing difficulty in obtaining developmental assignments and the type of mentoring relationship to one's advancement in the healthcare administration. Each mentee works and correlates with his/her mentor the various methods necessary in obtaining developmental assignments, which is a part of every organization. Open communication is necessary in accomplishing the tasks and assignments provided by the mentor (Karcher and Dubois, 2005). Previous studies had found that lack of support in accomplishing a certain task or assignment does not merit an individual's hostility towards the type of working relationship existing in a specific setting (Egan and Song,

2008). In the same manner, the results of the study showed that having difficulty obtaining assignments does not affect the working relationship of the mentor and the mentee in the advancement of career in the healthcare administration.

Mentors are important, to those individuals who are starting their career; however, the situation becomes different when he or she is already in an administrative position. In this study, it was found that there is no significant relationship between the administrator's current position and their experience of lack of mentors.

In this study, gender discrimination was found to have no significant relationship on the administrator's current position in the healthcare administration. Thus, it can be concluded that gender discrimination is not perceived by the respondents as a barrier in acquiring a higher level of position in the workplace environment. Some employers undervalue the women's quality of work. However, the study only proves that there are still some women who are able to overcome such barrier and prove to the corporate world that women can do what men can do equally.

The type of mentoring relationship showed significant relationship with the improved knowledge of health care administration as exhibited in the results of the study. The respondents replied that their knowledge regarding healthcare administration is being greatly influenced by the type of mentoring relationships that their mentors are utilizing. The type of mentoring relationships not only improves the respondents' knowledge but it also improves their competence and skills in healthcare administration.

Job competence is also important in career advancement and it can be aided through improvement in critical thinking skills and problem solving skills. In this study, it was found that there is significant relationship between the identified skills and both

types of mentoring relationships. With critical thinking skills, the mentee also has the ability to identify which arguments are logically strong and possess true premises. A mentee will also have the ability to interpret things, to verify them against sound evidences and to reason or weigh the presented reasons to come up with a good decision (Hughes & Lavery, 2004).

Critical thinking skills come hand in hand with problem solving skills. The latter enables the mentee to provide or choose the best option if confronted with a variety of choices. These array of options make it difficult for an individual to do or choose the right thing. However, when he or she possesses problem solving skills, solving problems regarded as unsolvable is easy. Availability of these two skills, critical thinking skills and problem solving skills therefore enables an individual to advance in his or her career path (Hughes & Lavery, 2004).

The type of mentoring relationship has been found to have no significant relationship to the enhancement of communication skills. Communication is necessary to enhance the mentoring connection. It is significant in creating an open and comfortable relationship.

The results of the study revealed that enhancing job competence through enhancement of one's communication skills has no effect to the outcome of the type of mentoring relationship being utilized. The respondents believe that the outcome of mentoring relationship can be affected by a more significant variable, aside from communication itself. The flow of communication occurring between two significant bodies is not merely influenced by any type of mentoring relationship being utilized in an organization.

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The type of mentoring showed no significant relationship with the improved job performance as shown in the results of the study conducted. It can therefore be inferred that the improvement in the job performance is not influenced by the type of mentoring relationships alone but by many other related factors. Work related relationships, organizational policies, knowledge and skills improvement greatly influence the improvement of one's job performance. Also, personal difficulties and work related difficulties such as discrimination may affect the improvement of one's performance in her work.

Business acumen has been found essential in most of the companies for its improvement and development. Utilizing one's knowledge has proven to be significant in generating decisions for the benefit of the entire organization (Karcher, 2005). Business acumen was recognized one of the major contributors to the organization's traditional profitability.

However, enhancing job competence through the improvement of business acumen has been found to have no significant relationship to the type of mentoring relationship being utilized, as perceived by the respondents of the study. It can therefore be inferred that the type of mentoring relationship has no influence in the improvement of one's corporate learning or decision-making skills in the workplace.

Limitations of the Study

This researched focused on a population of female healthcare administrators occupying senior and mid-level positions; however, the results cannot be generalized for all women in other career fields.

The limitations that follow are based on the nature of the study and the highly subjective experiences of mentoring relationships. The first limitation to this study was the majority of respondents (83%) benefited the most from informal mentoring relationships; therefore it is heavily weighted by female healthcare administrators who engaged in informal mentoring relationships.

The second limitation of the study was the research participants were limited to women who hold senior and mid-level healthcare administration positions. Therefore, this study did not examine mentoring relationships of women in entry level healthcare administration position. Future research could correct this limitation by considering a study included all women who hold positions in healthcare administration. The third limitation is the probability that one or more of the tests chi tests conducted in the study would be statistically significant due to chance alone, Type I error. When a series of significance tests is conducted, the familywise error rate (FER) is the probability that one or more of the significance tests results in a Type I error (Abdi,2007). Lastly, the study was limited to the email list of female healthcare administrator provided by SK&A Information Services, Inc., which is inclusive of all senior to mid-level healthcare administrators.

<center>Future Research Recommendations</center>

There are several recommendations that can be made for future research based on this study. The first recommendation is to conduct a similar study in healthcare organizations that offer formal mentoring programs to obtain a larger sampling of female healthcare administrators who have had formal mentoring relationships.

An additional recommendation is to conduct a longitudinal study evaluating female and male healthcare administrators, who have engaged in mentoring relationships and compare their perceptions on mentoring relationships on career advancement and job competence.

Finally the methodology in this study can be applied to entry level and mid-level females in healthcare administration.   This study would provide additional research in healthcare administration regarding the impact of informal and formal mentoring relationships on career advancement in junior positions.

APPENDICES

SURVEY

A Survey of Middle and Senior Level Female Healthcare Administrators

I.   MENTORING EXPERIENCES

1. Were you mentored during your career?
__ Yes
__ No

If no, proceed to section III. CAREER ADVANCEMENT BARRIERS

2.What type of mentoring relationship did you benefit from the most?

___ Formal (when an experienced employee is assigned to a mentee whojunior in the organization)

___ Informal (a relationship developed out of mutually compatible goals)

II. CAREER ADVANCEMENT BARRIERS
This section refers to your perception of the barriers to your advancement in healthcare administration. Please rate each barrier on a 1 to 5 scale.

1 – Strongly disagree   2 – Disagree   3 – Undecided   4 – Agree   5 – Strongly Agree

3. You experienced a lack of mentors: 1 2 3 4 5

4. You were not excluded from Informal Networks: 1 2 3 4 5

5. You experienced a lack of role models that were similar to you: 1 2 3 4 5

6. You did not fit into the organization's culture: 1 2 3 4 5

7. You experienced work life balance issues: 1 2 3 4 5

8. You had unsupportive supervisors: 1 2 3 4 5

9. You experienced gender discrimination: 1 2 3 4 5

10. You did not receive enough meaningful feedback on job performance: 1 2 3 4 5

11. You experienced difficulty obtaining developmental assignments: 1 2 3 4 5

III. JOB COMPETENCE

To what extent has, being mentored enhanced your job competence. Please rate each outcome of mentoring on a 1 – 5 scale.

1 – Not at all   2 – Slightly   3 – Moderately   4 – Considerably   5 – Great Extent

12. Improved my knowledgeable of healthcare administration: 1 2 3 4 5

13. Enhanced my leadership capabilities: 1 2 3 4 5

14. Improved my critical thinking and problem solving skills: 1 2 3 4 5

15. Enhanced my communication skills: 1 2 3 4 5

16. Improved job performance: 1 2 3 4 5

17. Improved my business acumen: 1 2 3 4 5

18. Led to a new position with greater responsibility: 1 2 3 4 5

IV. CAREER SATISFACTION

This section refers to the level of satisfaction you receive from you career as a healthcare administration; please indicate how satisfied you are with each of the following aspects of your position. Please rate on a 1 to 5 scale.

1 – Very Satisfied   2 – Somewhat Satisfied   3 – Undecided   4 – Somewhat Unsatisfied
5 – Very Unsatisfied

19. My career in healthcare administration: 1 2 3 4 5

20. Availability of mentors in your current organization: 1 2 3 4 5

21. Your views and participation are valued: 1 2 3 4 5

22. Work gives you a feeling of accomplishment: 1 2 3 4 5

23. Your ability to balance between family life and work life: 1 2 3 4 5

24. The compensation you in your current position: 1 2 3 4 5

25. Availability of developmental assignments that improve depth of knowledge: 1 2 3 4 5

V: PROFILE

26. Gender
__ Female
__ Male

27. Age _____ years

28. Current Position
__ Chief Executive Officer
__ Chief Operating Officer
__ Executive Vice President
__ Administrator
__ Vice President
__ Administrative Officer
__ Associate Administrator
__ Director
__ Other _____

29. Highest Education Level Attained
__ Bachelor's Degree
__ Master's Degree
__ Doctorate (e.g., PhD, DHA, DBA)
__ Professional degree (e.g., JD, MD, DDS)
__ Other_____

30. What is your current salary?
___ $75,001 – $100,000
___ $100,001 – $150,000
___ $150,001– $200,000
___ $200,001– $250,000
___ $250,001– $300,000
___ $300,001– $350,000
___ $350,000– $400,000
___ $400,001– $450,000
___ $450,001– $500,000
___ More than $500,000

APPENDIX B

COVER LETTER

Dear Healthcare Professional,

I am a doctoral candidate in Health Administration at Central Michigan University. For completion of my doctorate, I am currently gathering research data for my dissertation. I am conducting a study to examine the effects of formal and informal mentoring on the perceived barriers to career advancement of women in mid-level and senior-level positions in healthcare administration.

I am inviting you participate in my research study. Your participation is voluntary. I realize that time is a precious commodity for you and your willingness to participate in this study is appreciated. I am hopeful that the results can be useful in educating the next generation of women who aspire to higher levels of healthcare administration.

An internet survey format will be used to collect data. The survey should only take 15 minutes to complete. In lieu of signing a consent form, the act of your going to the web site of the survey will be considered your consent to complete all or party of the survey. Your responses will be handled in a confidential manner and will not be identified with you personally. You are encouraged to stop taking the survey at any time. The survey will be available from September 1, 2010 – September 15, 2010.

You are free to refuse to participate in this research project or to withdraw your consent and discontinue participation in the project at any time without penalty or loss of benefits to which you are otherwise entitled. Your participation will not affect your relationship with the institution(s) involved in this research project. If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989-774-6777, or addressing a letter to the Institutional Review Board, 251 Foust Hall Central Michigan University, Mt. Pleasant, MI 48859.

To take the survey please visit: xxxxxxxxxxxxxxx

If you have any questions or concerns about completing the survey or about being in this study, you may contact me at 703-681-0039 or send me an email hunte1df@cmich.edu. As an alternative, you may contact my advisor, Dr. Steven Berkshire and he can be reached at 989-774-1640 or berks1sd@cmich.edu. Thank you in advance for your participation.

Respectfully,
Danita F. Hunter
Doctoral Candidate
Central Michigan University
College of Health Administration

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