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# Career Inflection Points of Women Who Successfully Achieved the Hospital CEO Position

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## EXECUTIVE SUMMARY

Women are significantly underrepresented in hospital CEO positions, and this gender disparity has changed little over the past few decades. The purpose of this study was to analyze the career trajectories of successful female healthcare executives to determine factors that generated inflections in their careers. Using qualitative research methodology, we studied the career trajectories of 20 women who successfully ascended into a hospital CEO position. Our findings revealed 25 inflection points related to education and training, experience, career management, family, networking, and mentorship and sponsorship. We found substantial differences in the career inflection points by functional background. Inflections were more pronounced early in the careers of women in healthcare management, while clinical and administrative support executives experienced more inflections later as they took on responsibilities outside of their professional roles. Only two inflections were common among all the executives: completing a graduate degree and obtaining experience as a chief operating officer. More importantly, our findings show that organizational support factors are critical for the career advancement of women. We conclude with recommendations for individuals in an effort to enhance their career trajectories. We also provide recommended activities for organizations to support the careers of women in healthcare leadership.

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## INTRODUCTION

Historically in healthcare, women were entrusted with providing care to the sick and injured, and this norm ultimately created what is considered a gendered healthcare work environment (Hasenfeld, 1992). Today, the majority of the healthcare workforce is made up of women. According to the U.S. Bureau of Labor Statistics (2013), 75.8% of those employed in hospitals in 2011 were women. Furthermore, women occupied nearly 71.3% of first- and mid-level officer and management positions and 53.3% of executive and senior officer positions in the private hospital industry in 2012 (EEOC, 2012).

Although women make up the majority of the healthcare workforce, they often experience career advancement challenges and remain significantly underrepresented in hospital chief executive officer (CEO) positions (Lantz, 2008; Hoss, Bobrowski, McDonagh, & Paris, 2011). The most recent periodic survey conducted by the American College of Healthcare Executives (ACHE) shows that only 11% of women achieved the hospital CEO position in 2012, compared to 22% of men in the study. More importantly, ACHE's periodic surveys have shown that this gender disparity in the CEO position has changed very little over the past few decades (ACHE, 2012; Athey, 2014).

Previous research (see Background section) has identified potential factors that affect the career advancement of women in the hospital industry. For example, researchers have shown that gender disparities in CEO positions are associated with differences in education, experience, career aspirations,

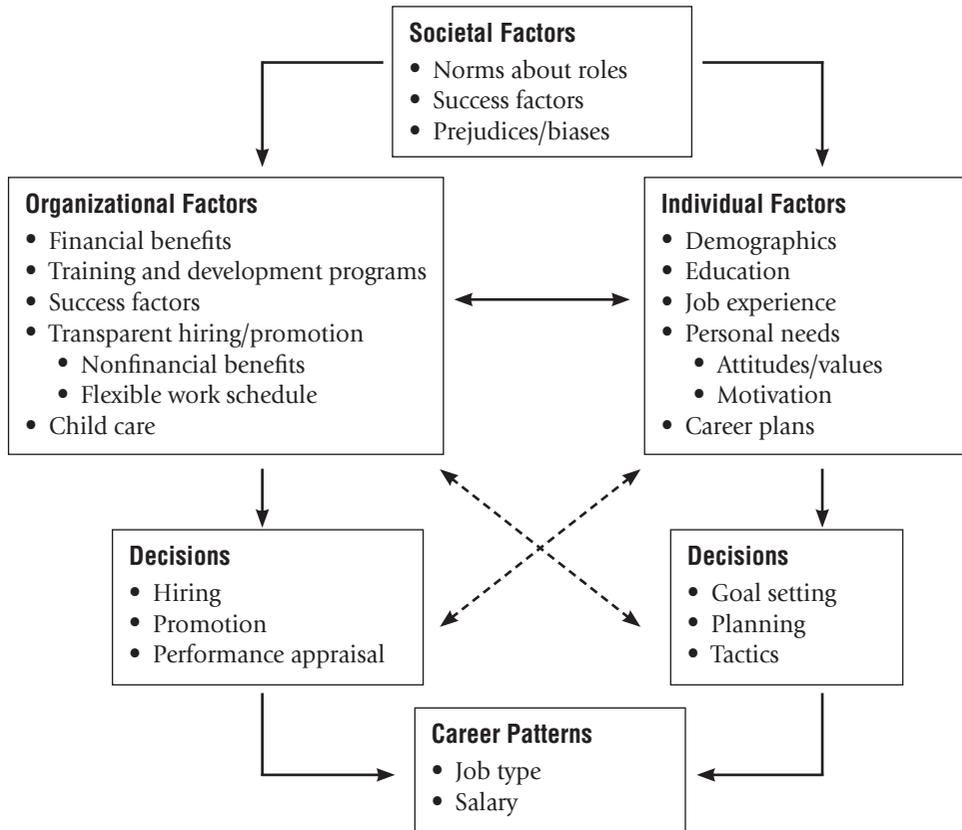
mentorship, and organizational support, to name a few areas. Existing research, however, is primarily cross-sectional and often does not contain sufficient information to determine causality. Much of it also lacks careful theorizing about the impact of the factors over time.

The purpose of this study was to analyze the career trajectories of successful female healthcare executives to determine the factors that generated inflections in their careers. This study drew on qualitative research methodology to cultivate a deeper understanding of how women have achieved the hospital CEO position and how organizations support the careers of women in healthcare leadership.

## BACKGROUND

Studies attempting to understand gender disparities in hospital CEO positions have largely focused on individual, organizational, and societal factors that influenced the career development of women (Figure 1; Walsh & Borkowski, 1995). Individual factors often include education, experience, career plans, and family responsibilities. The findings within this area are often mixed or inconclusive. For example, studies have historically suggested that career advancement inequalities are associated with gender differences in education and experience (Walsh & Borkowski, 1995; Weil & Kimball, 1996; Weil, Haddock, & Barowsky, 1996; Weil & Mattis, 2001). In contrast, recent research shows that women are completing graduate degrees in healthcare administration at equal rates to men (ACHE, 2012; Hoss et al., 2011), and obtaining equivalent experience in

**FIGURE 1**  
**Model of Career Development in the Healthcare Professions**



Source. Adapted from Walsh & Borkowski (1995).

healthcare management positions (LaPierre & Zimmerman, 2012), yet they fail to progress into CEO positions at equal rates.

Another stream of research suggests that organizational factors account for gender inequalities in career advancement. As with the individual findings, however, the results appear to be mixed. Some research indicates that mentors are important, but not a requirement, for career advancement (Roemer, 2002); other studies show that mentoring relationships, especially those with men,

appear to positively influence the career advancement of female managers (Walsh & Borkowski, 1999; LaPierre & Zimmerman, 2012). Several authors suggest that women have enough mentors but lack sponsorship by a highly placed person who advocates on their behalf (Ibarra, Carter, & Silva 2010; LaPierre & Zimmerman, 2012).

Other studies report similar findings and suggest that local hospital biases have an impact on the gender inequalities. For example, Haddock and Aries (1989) found that female executives

perceived their hospitals' boards were mostly composed of males. Weil and Mattis (2001, 2003) stated that gender stereotypes and male discrimination contributed significantly to gender disparities. Nearly a decade later, Hoss et al. (2011) reported that gender imbalance at the top was due to leadership biases that favor men.

There remain gaps in the literature regarding gender disparities in health-care leadership. For instance, it is unclear which factors create career changes, or inflection points, for women who successfully ascend to the CEO position. In addition, little research has analyzed inflection points across the span of a successful female executive's career. For example, we do not know how family and work demands have affected early careers versus later careers.

Furthermore, there is no research that differentiates how inflection points may vary by functional background (where *functional background* refers to an executive's past work experience in jobs within functional areas of organizations). For instance, some hospital CEOs start their careers in nursing while others start in healthcare management. How do career trajectories differ for those who began their careers in a clinical area versus management?

This study was designed to fill in these gaps and answer the following questions: What are the career inflection points of women who reached the hospital CEO position? Do the inflection points differ across the career trajectory? Do the inflection points vary by functional background? A thorough analysis and deeper understanding of

these career inflections could help explain the mixed or inconclusive findings of previous research. It could also provide new insights and help identify innovative strategies to reduce the CEO gender disparity.

## METHODS

This is a case-based, qualitative study of 20 female hospital CEOs. The study was deemed exempt by the University of Michigan Institutional Review Board. This research was focused on executives' perspectives on their lived career experiences. We specifically targeted inflection points, or career changes, and the phenomenology surrounding them. We defined an inflection point as a turning point after which a dramatic change, with either positive or negative results, is expected to result. For each respondent, we constructed a career narrative presenting her work history, the contextual factors, and the career choices she made.

The study sample was systematically chosen in an effort to maximize both the diversity of the executives and their specific contextual factors. Specifically, we considered executives from throughout the United States who were hired or promoted to a CEO or equivalent position within the past five years. This final criterion was to ensure that the executives had current labor market experience. We included female CEOs of nongovernment general medical and surgical hospitals or health systems, both for-profit and nonprofit, with more than 50 inpatient beds. Using this sampling approach, we selected 40 successful female executives. Of this group, 24 female executives agreed to

participate in the study. The final sample consisted of 20 executives from 14 different states. We stopped interviewing after reaching a point of saturation, where no new information was provided by the participants.

The background characteristics of the study participants can be found in Table 1. The majority of the participants were Caucasian, and their ages ranged from 36 to 66 years old, with a mean of 55. Ten participants started their career in a clinical profession, and three started in administrative support, while seven started in healthcare management. Eighteen of the executives were in a CEO or equivalent position when the interview was conducted. These roles ranged from a local hospital CEO to a large healthcare system CEO. The remaining

two executives were in chief operating officer (COO) positions, but both had previously held CEO positions. The majority of the women we interviewed worked in nonprofit organizations. The background characteristics were very similar between those who participated and those who did not, with one exception: slightly more women in investor-owned organizations declined to participate.

We conducted semistructured interviews from August 2012 to January 2013. The interviews were completed over the telephone and typically lasted 1 hour. The interviews were recorded, later transcribed, and then reviewed and analyzed against interview notes.

We used a grounded theory approach to identify the inflection points

**TABLE 1**  
**Background Characteristics of the Study Participants**

Race	<i>n</i>	%	Advanced Degrees	<i>n</i>	%
Caucasian	15	75%	MHA or MPH	8	36%
African American	3	15%	MBA	6	27%
Hispanic	2	10%	Doctorate	3	14%
			MSN	3	14%
			MHA and MBA	2	9%
Age	<i>n</i>	%	Hospital Ownership Type	<i>n</i>	%
65–69	2	10%	Not-for-profit, other	10	50%
60–64	3	15%	Not-for-profit, religious	6	30%
55–59	8	40%	For-profit	4	20%
50–54	4	20%			
35–49	3	15%			
Functional Background	<i>n</i>	%	Highest CEO Leadership Level	<i>n</i>	%
Clinical	10	50%	Hospital or medical center	10	50%
Healthcare management	7	35%	Market or large system	6	30%
Administrative support	3	15%	Region or small system	4	20%

across the career trajectories (Glaser & Strauss, 1967; Strauss & Corbin, 1998). This approach allows for the emergence of concepts from the data, or from the “ground up,” rather than starting with a preconceived theory and hypothesis. The inflection-point codes were derived inductively from interviews and ultimately agreed upon by the authors. We purposefully chose this method to ensure that multiple perspectives were offered on each transcript, helping alleviate researcher bias.

To standardize the analysis of the inflection points over time, we divided them into three career stages: (1) pre-career, (2) early and mid-career, and (3) senior. These stages were selected because the inflection points were clustering in patterns around them.

Following the analysis of the aggregate cases, we used a comparative method to determine the differences in the inflection points by functional background: (1) healthcare management and (2) clinical or administrative support (we consolidated the clinical and administrative support into one group because they had similar inflections). The healthcare management group consisted of executives who began their careers in a “traditional” way with a master’s degree in healthcare management. The second group consisted of executives who started their careers in either a clinical profession (e.g., medicine or nursing) or an administrative support area (e.g., accounting).

## FINDINGS

In this section we describe the findings of our qualitative analysis. The implications of these findings are presented later. For

maximum clarity and parsimony, we interweave the three research questions throughout this section. In sum, we identified 25 inflection points related to (1) education and training, (2) experience, (3) career management, (4) family, (5) networking, and (6) mentorship and sponsorship. Table 2 compares the similarities in inflection points by career stage, and Table 3 compares the differences in inflections by functional background group (that is, healthcare management versus clinical/administrative support). Exemplary quotations for each of the inflections are available online at <http://www.ache.org/Publications/SubscriptionPurchase.aspx#jhm>.

### Education and Training

The inflection points under the theme of education and training generally aligned with the previous literature. That is, women obtained graduate education and completed fellowship training in order to advance their careers. However, the timing of the career inflections varied greatly by functional background. For example, all of the executives completed either a professional or graduate degree to start their careers. However, the executives who started in a clinical or administrative support area also completed a master’s degree later in their careers to advance into senior executive positions. Additionally, most of the executives in this group mentioned they had received on-the-job training and mentorship from the COO or CEO in lieu of completing a residency or fellowship.

On the other hand, the executives who started in healthcare management first completed a master’s degree in

**TABLE 2**  
**Similarities in Career Inflection Points by Career Stage**

<b>All Executives (n = 20)</b>		
<b>Pre-career</b>	<b>Early and Mid-career</b>	<b>Senior Career</b>
<b>Mentorship and sponsorship</b>	<b>Education and training</b>	<b>Education and training</b>
Mentored by instructor or graduate school faculty	Leadership training	Executive coaching
	<b>Experience</b>	<b>Experience</b>
	Broad work experience	COO experience
	<b>Career management</b>	Hospital board experience
	Career plan	<b>Career management</b>
	Voice	CEO aspirations
	<b>Family</b>	Voice
	Moved for spouse	<b>Family</b>
	Partner support	Turned down position
	<b>Networking</b>	Commuted to work
	Women's group	Partner support
	High-visibility position	<b>Networking</b>
	Professional organization	Women's group
	<b>Mentorship and sponsorship</b>	Professional recruiter
	Sponsor mentioned name	Community volunteer
		<b>Mentorship and sponsorship</b>
		Sponsor mentioned name

healthcare administration or public health and then immediately completed residency or fellowship training. During this training, they were closely mentored and sponsored by the COO or CEO and worked on projects around the hospital. These experiences gave them a broader understanding of the hospital's operations. In fact, all of these executives were offered full-time administrative positions after completing their residency or fellowship. The inflections of this group were mainly discussed in previous studies by male executives.

We also found two areas that were not previously identified: leadership

training and executive coaching. Leadership training was described as an executive training program, such as COO training that was specific to the executive's organization. Two executives were involved in this type of activity during their early- and mid-career stages. On the other hand, nearly one third of the executives received one-on-one executive coaching services that were paid for by their hospital. This type of support was not specific to functional background. These executives mentioned they received coaching to enhance their performance as a senior executive. One of these executives also hired her own

**TABLE 3**  
**Differences in Career Inflection Points by Career Stage and Functional Background**

<b>Healthcare Management (n = 7)</b>		
<b>Pre-career</b>	<b>Early and Mid-career</b>	<b>Senior Career</b>
<b>Education and training</b> MHA or MPH Admin. residency or fellowship	<b>Career management</b> CEO aspirations <b>Mentorship and sponsorship</b> Mentored by COO or CEO Sponsored to higher position by CEO	<b>Mentorship and sponsorship</b> Mentored by CEO Sponsored by CEO
<b>Experience</b> Broad work experience Hospital board experience		
<b>Networking</b> High-visibility position		
<b>Mentorship and sponsorship</b> Mentored by CEO/COO Sponsor mentioned name		
<b>Clinical or Administrative Support (n = 13)<sup>a</sup></b>		
<b>Pre-career</b>	<b>Early and Mid-career</b>	<b>Senior Career</b>
<b>Education and Training</b> Professional or admin. degree	<b>Education and training</b> MSN, MBA, or MHA <b>Experience</b> Clinical experience <b>Career management</b> Risk taking <b>Mentorship and sponsorship</b> Mentored by functional-area executive Sponsored to higher position by functional-area executive	<b>Career management</b> Risk taking Change organizations <b>Mentorship and sponsorship</b> Mentored by COO, CEO, or other senior executive Sponsored by CEO or other senior executive

<sup>a</sup>Clinical and administrative-support executives were grouped together because the inflection points were similar across their career stages.

coach in an effort to enhance her competitiveness for advancement to a CEO position in a larger facility.

**Experience**

A variety of work experiences were mentioned by the female CEOs. With a

few exceptions, the majority fell within the executive’s primary functional area until the women entered the senior executive ranks. For example, most of the healthcare management executives started as associate administrators (one started as a consultant). All of them had

follow-on management positions within the core business areas of the hospital or as consultants for health systems. As they ascended in the leadership hierarchy, most reached the positions of director or vice president of operations on the trajectory toward becoming COO.

The clinical and administrative support executives followed a slightly different career trajectory. All of them started as professional staff members and moved into management positions within their functional area (e.g., night supervisor). During the mid-career phase, several took risks by moving into positions within and outside of their primary functional area (e.g., quality assurance or medical operations) in order to expand their knowledge of operations and management. With the exception of one executive (who transitioned into healthcare management as an early careerist), most appeared to be ascending toward the senior executive position within their functional area.

After entering the executive suite, however, all of the experiences converged at the COO role. This was the only inflection point that aligned with the previous literature. Although the type of COO experience and length of time in the position varied considerably, nearly all of the executives (95%) had to successfully serve as COO in order to be considered for the CEO position. In more than one case, the executives were part of growing hospital systems, and as hospital CEOs became system CEOs, women ascended into hospital CEO jobs.

We also identified additional inflection points under this theme. The first was broad work experience, which was commonly described as work

experience within a variety of areas of the organization or across several hospitals in a system. The executives who mentioned these experiences suggested the activities increased their understanding of the operations as a whole and prepared them for promotion to the next level. Several executives obtained this experience during the mid-career and senior executive stages as they worked in cross-division roles or positions that supported the entire organization. Most of the health management executives obtained this experience during their residency or fellowship training, which appeared to enhance their career trajectory earlier.

There were also specific types of work experience that created inflections. Several of the executives suggested that having clinical experience early on was an important factor in their eventual promotion to higher management roles. More specifically, they mentioned that clinical acumen and ability to interface with fellow clinicians set them apart for a CEO position. Another specific type of experience mentioned was working with the hospital's governing board. Several executives reported that working with the hospital's governing board was important for building a better understanding of governance structure and the community served. While most reported this occurred later in their career, several healthcare management executives obtained this experience during their residency or fellowship training.

### **Career Management**

Career plans were generally described as deliberate long-term plans to achieve career goals. Although several executives

mentioned having specific goals over their career, such as obtaining a graduate degree, only three had purposefully developed a career plan (one said that a female mentor helped her initiate and develop a career plan as an early careerist). We also found that women who started their careers in healthcare management had a better sense of their career trajectory than those who started in the other professions.

Moreover, as previous literature suggests, most of the executives in this study aspired to be the CEO later in their career. In fact, most of them stated that this aspiration developed after they were in the executive suite working closely with the CEO (as they developed a better understanding of the role). Additionally, several indicated they had never had an aspiration to be the CEO and had simply ascended into the position "by chance." By contrast, two executives aspired to be a CEO at earlier stages of their careers and said it was because they were closely mentored by the CEO.

We identified several other inflections related to career management, including risk taking, voice, and changing organizations. Risk taking was described as proactively moving into a position that was potentially unfavorable for a person's career. For instance, in order to build her knowledge of nursing operations, one executive moved from the intensive care unit into women's and children's services. Another executive purposefully applied for a CEO position at a failing hospital in order to make the transition from chief nursing officer to CEO. The latter type of risk taking is also known as a "glass cliff" (Ryan & Haslam, 2005). Most of these inflections were experienced by clinical

and administrative support executives during later career stages.

Voice, on the other hand, was generally described as proactively talking with a supervisor or senior leader about career aspirations or job placement desires. As one of the executives explained, "It is important to tell your senior leaders what you want so they can take it into consideration when important hiring decisions are being made." Nearly half of the executives mentioned this in mid- and senior career stages; however, the inflection point appeared to be more uncertain for clinical executives who voiced their aspirations to take a role outside their functional area.

The final inflection point identified under this theme was "changing organizations," that is, proactively moving to another organization for career advancement. Seven of the executives, mainly clinicians, changed organizations because they experienced bias and felt they could not advance any higher without an organizational move—they perceived a glass ceiling (Hymowitz & Schellhardt, 1986). Three specifically mentioned they could not progress from COO to CEO, and four said they experienced challenges transitioning into the COO role.

## Family

The stresses of family and work often disproportionately affect the careers of women. Several of the inflection points we identified supported these findings; however, the timing within career trajectory was paramount. For example, during their early- and mid-career periods, three executives quit their job

and moved to another state because of their husband's job. In contrast, as senior careerists, two executives turned down a promotion to CEO and six executives commuted long distances for a CEO position because they didn't want to disrupt their family and move to another state. Several of these executives mentioned they were able to relocate their family at a later time because their children finished school or their husband retired.

Furthermore, every executive mentioned she had to juggle family and work responsibilities at one point or another, and nearly all of them stated their spouse or partner helped to make their career a success. In fact, one third of the executives said their husband put his career on hold or changed jobs so these executives could focus on a senior executive position. For example, several husbands stopped working and others telecommuted in order to take care of children. A few also relocated to a different area to accommodate their wife's promotion. These findings represented the largest differences from previous research—typically the wife sacrificed her career for family responsibilities.

### **Networking**

Network ties, or interpersonal relationships within a network of individuals, are important for enhancing information flow and career opportunities. Previous research has shown that establishing these ties with senior executives is important for career mobility (Podolny & Baron, 1997). More recent research has shown there are three different types of network ties

established throughout a career, each type having a specific contribution to career mobility (Ibarra & Hunter, 2007). As such, networking was a prominent theme across all the career stages. The type of networking venues and the people involved, however, varied.

A common networking venue is within an organization. In fact, 16 of the executives held high-visibility positions or worked on organization-level projects that expanded their network of peers and enhanced their visibility with senior executives—also known as operational networking. Most of the experiences took place during the early- and mid-career stages as the executives were establishing themselves within the organization. However, the healthcare management executives talked about these experiences during their residency or fellowship training. In all instances, the executives stated this type of networking had enhanced their upward mobility. For example, one executive pointed out that, as a young administrator, she worked on system-level acquisitions and mergers with the CEO. This newly established relationship led to her first COO position.

We also identified several networking inflection points not previously mentioned in the literature. For example, the most commonly mentioned venue to establish a personal network, or contacts outside the organization, was through a professional organization. Most executives mentioned they were involved in these during the early- and mid-career stages at the local or national level. In fact, two of the executives specifically mentioned they were promoted to a higher position

because of a network tie they developed during an annual conference.

Women's groups were another area of networking mentioned frequently by the executives. Five of the executives were a part of a women's group, which often included female executives from the local area. Although none of the participants suggested these relationships directly advanced their careers, several mentioned these types of personal networks provided social support and professional development. For example, one executive lived in a male-dominated area, and she regularly met with other female executives to discuss the common issues they faced.

We found that social networks started to become more strategic and expand outside the organization as the executives ascended into senior executive positions. For example, all the executives were involved with local governing boards and other community activities as part of their CEO responsibilities. A few, however, were involved in these types of volunteer activities in other executive suite positions, and they mentioned that these relationships had positively affected their selection as CEO. To illustrate, one executive worked in an area with a male-dominated business community. She suggested that the hospital's governing board was composed of these local area leaders, and they were responsible for selecting the CEO. Because of her volunteer work in the community while COO, however, the leaders of the local area got to know her, and she was ultimately selected as CEO.

Networking with recruiters was important for nearly half (45%) of the executives when they advanced as a

senior careerist, regardless of background. Several of the executives mentioned they actively managed these strategic relationships throughout their career in the event they "needed them later." These relationships proved to be especially important for the executives who moved to other organizations.

### **Mentorship and Sponsorship**

It is important to understand the differences between a mentor relationship and a sponsor relationship. A mentor can be anyone inside or outside the organization who provides advice, passes on information, or helps someone get acclimated. A sponsor, on the other hand, is a highly placed person who helps people get promotions or helps place them in visible and developmental assignments. Sponsoring is a targeted activity and has to do with actions such as mentioning a person's name in closed-door meetings or advocating on behalf of a specific individual (Ibarra et al., 2010).

Several (20%) of the clinical and administrative support executives underwent early mentoring during their graduate education or professional training, although few of them mentioned that this experience had a profound impact on their career trajectory. In contrast, the healthcare management executives mentioned they were closely mentored and sponsored by the hospital COO or CEO during their residency or fellowship, which had a considerable influence on their career trajectory. Additionally, several of these executives said they had faculty from their graduate program mention their name to a colleague to sponsor them into a highly

sought-after residency or fellowship program.

During early and mid-career, most (70%) of the executives mentioned having a mentor. These relationships were typically developed with a direct supervisor or a senior staff member in the executive's functional area. Additionally, more than half (60%) of the executives revealed that a sponsor had promoted them to a higher position or paid for their graduate education. The sponsors were typically senior leaders from the executive suite in the executive's primary functional area (occasionally, the COO or CEO mentored across functional areas). For example, executives in nursing were often sponsored to a new position by the CNO.

We also found instances of sponsorship activities outside of the organization. For example, a few executives mentioned reaching out to influential healthcare leaders, often women, when they were moving to a new area. These sponsors then mentioned their name to colleagues to get them hired into the labor market where they were not well known. This support activity was not specific to functional background and was mainly attributed to mid- and senior career stages.

The mentor and sponsor relationships began to converge as the executives ascended into the executive suite. The majority (75%) of the executives mentioned they were mentored to be a COO or CEO, and more than half (55%) mentioned they were sponsored to a higher position by the hospital CEO or a system-level executive. Nevertheless, considerable disparities were evident in these relationships by functional

background. For instance, the healthcare management executives were typically mentored and sponsored into the COO position by the hospital CEO. Conversely, the clinical and administrative support executives were still primarily mentored and sponsored by the senior executives in their functional area. Depending on the organization, they also may have been mentored or sponsored by the COO, the CEO, or a system-level executive. Without this additional support, however, it was harder for these executives to move into COO and CEO positions. As previously mentioned, several of the executives indicated this type of professional bias influenced them to move to another organization.

## DISCUSSION AND RECOMMENDATIONS

In this study, we analyzed the career inflection points of women who achieved the hospital CEO position. While the themes generally aligned with previous studies and the model of career development (see Figure 1), we found a larger number of inflections within each theme and considerable variation across career stages. We also found differences in the career inflection points by functional background. Specifically, inflections were more pronounced early in the careers of women in healthcare management, while clinical and administrative support executives experienced more inflections later on as they assumed responsibilities outside their professional roles. We found two inflections that were common among the executives: completing a graduate degree and obtaining experience as a COO. More importantly, perhaps, our

findings show that organizational support factors are critical for the career advancement of women.

The gender disparity in hospital CEO positions has changed very little over the past few decades (ACHE, 2012; Athey, 2014). Short of some unanticipated development, this disparity is likely to continue. We encourage the use of evidence-based practices to support the careers of women in healthcare leadership, including the following activities for individuals and organizations (see also Table 4).

First, individuals, regardless of career stage, should develop a formal career plan and meet with senior leaders on a regular basis to voice aspirations. Our study suggests women should seek out training opportunities, take risks, and volunteer for positions that could increase experience and visibility with senior leaders. New healthcare managers should seek out and complete a residency or fellowship training program to start their careers. If applicable, career planning should include family members and focus on opportunities for promotion or training and future family responsibilities (e.g., children in high school). The plan should include research on employment and growth opportunities with future employers (e.g., Does the organization have senior leader diversity, training opportunities, and family-friendly policies?).

Individuals should also understand the different forms of networking and have a strategy to leverage each type as their career develops. For example, early in their career, they should build strong operational and personal relationships and reach out to contacts who can

provide network referrals. As one's career advances, and as the network grows, women should use strategic network connections to position themselves for future career opportunities. Furthermore, women should seek out mentors and sponsors and understand the different functions of each type of relationship. Sponsors can provide opportunities for career advancement, such as promotions (e.g., selection for a management role in another area) or other training opportunities (e.g., graduate education).

The following activities, on the other hand, are recommended for organizations to support women leaders. First, hospital and system leaders should directly cultivate career aspirations of female associates and encourage early careerists to proactively manage their careers, regardless of functional background. This can be achieved by developing career plans and discussing a range of potential future positions. Second, organizations can develop formal mentoring programs to enhance career management activities and encourage a wide range of senior leaders to get involved in the development of future leadership talent. We specifically found that administrative residency and fellowship programs were instrumental in the eventual career success of women leaders. Organizations should encourage the development of new training programs and the continued support for these programs in hospitals.

In addition to residency and fellowship programs, hospitals and health systems can provide training opportunities in a variety of settings (e.g., across divisions) and expand team

**TABLE 4**  
**Recommendations for Individuals and Organizations by Inflection Point Theme**

<b>Inflection Point Theme</b>	<b>Individual</b>	<b>Organization</b>
Education and training	Complete a graduate degree in healthcare management or business administration. New healthcare managers should complete an administrative residency or fellowship training program. Proactively seek out training opportunities.	Sponsor administrative residencies or fellowships for new healthcare managers. Offer leadership development programs for a range of career stages and functional backgrounds (e.g., COO training, mid-career offerings, and executive coaching).
Experience	Take risks and volunteer for positions to broaden experience and increase visibility with senior leaders.	Provide cross-divisional or departmental training opportunities; expand membership for high-visibility projects.
Career management	Develop a formal career plan and voice career aspirations to senior leaders. Conduct research on potential leadership positions or future employers (e.g., gender diversity strategies or senior leader diversity).	Cultivate career aspirations and encourage career planning for women and men at all career stages, regardless of functional background.
Family	Include family when developing career plans. Seek out organizations that have family-friendly policies.	Develop flexible work schedules for managers and executives (e.g., out-of-area commuting or telecommuting).
Networking	Understand the different types of networks. Develop network connections inside and outside the organization and leverage these relationships to create opportunities.	Support women’s groups and networking events for women inside organizations and in the local community.
Mentorship and sponsorship	Seek out mentors and sponsors and understand the differences between these relationships.	Develop a formal mentorship program with senior leaders in the organization. Mentor across functional areas. Sponsor fellowships, graduate education, on-the-job training, and executive coaching.

membership for high-visibility projects. Organizations can consider developing job rotation or leadership development programs that expose female staff members to areas outside their specific expertise. Chief learning officers and talent directors can encourage and recommend junior women and men for projects that will support this critical type of inflection. Furthermore, leaders can proactively sponsor talented employees with opportunities for growth, such as advanced education, on-the-job training, or executive coaching. Finally, systems and hospitals can work with leaders at all levels to support (financially and structurally) the development of women's groups or other networking events for women. This includes supporting the participation of women in community women's groups as well as programs that occur within the hospital or health system itself.

While this study is extensive, there are a few limitations. First, although we identified a variety of inflection points, it was impossible to capture all of the individual variation in this study. Second, our analysis of functional background differences was based on patterns that appeared to be unique to the groups. This did not mean, however, that the inflection points were distinct. Additionally, as with all qualitative research, our study suffers from sample bias, which could limit the generalizability of these findings.

Our goal was to shed some light on the subject of gender diversity and augment the already existing literature. This study provides a deeper understanding of the career inflections of successful women in healthcare.

## ACKNOWLEDGMENTS

This project was conducted by the National Center for Healthcare Leadership with investigators from the University of Michigan. Funding was provided by Hospira. The authors are grateful to the project's advisory group and the study participants.

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## PRACTITIONER APPLICATION

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**S**exton et al. have qualitatively explored a longstanding concern in healthcare—the underrepresentation of women in the chief executive role. By studying the career paths of 20 women who have successfully achieved the CEO position, the authors identified inflection points and recommended strategies for both female executives and healthcare organizations to facilitate the ascension of women into the CEO role.

Each woman interviewed held a master's degree, identifying advanced education as a critical success factor. Organizations need to identify ways in which to help early- and mid-career female administrators continue their education. Early in my career, I had a female mentor who pushed me to earn my master's degree, and my workplace provided the flexibility to work day, evening, or part-time hours as needed to complete my studies.

Seven of the 20 female executives interviewed (35%) reported changing organizations to escape a perceived glass ceiling, which they believed prevented them from

advancing in their organization. Consistent with this finding, in April 2014, Strategy& (formerly Booz & Company) released its 2013 study of incoming and outgoing CEOs from 2,500 of the largest public companies (Favaro, Karlsson, & Neilson, 2014). Women represented just 3% of incoming CEOs, and those women who were selected for the role were more often hired from outside the organization compared to their male counterparts (35% women versus 22% men). Becoming CEO as an outsider is more challenging than as an insider, and this finding may account for the fact that more women than men are forced to leave their CEO position (38% versus 27%). Considering that the educational and experiential backgrounds of women did not differ from men in this study, more needs to be done to encourage the continued growth and development of women in an organization.

Sponsoring female executives may be the single most important factor in helping women advance to CEO. My observation has been that many high-achieving females tend to hold themselves back, assuming they are not smart enough or qualified enough for expanded assignments, a trait first identified as the imposter phenomenon (Clance and Imes, 1978). Women greatly benefit from the solid backing of an executive sponsor providing encouragement and guidance. The sponsor offers new opportunities and encourages the individual to take risks and move outside the boundaries of her traditional clinical, professional, or administrative role.

My sponsor, the female CEO of our organization, offered me my first administrative role outside my area of clinical expertise. Through the years, I was encouraged to assume nonclinical responsibilities, including in the architecture and construction services area. When the CEO position opened in our psychiatric hospital, I accepted it to achieve the CEO title. Although it may have been a risky move, it provided me the opportunity to work directly with a governing board, expand my community network, and demonstrate my ability to turn around a struggling hospital. Following a recent system merger, I was promoted to CEO of the newly acquired acute care hospital, and because I had mentored my successor, she was well prepared to assume the CEO position at the psychiatric hospital.

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