PERCEIVED BARRIERS TO THE PROMOTION OF FOOD SERVICE DIRECTORS TO HIGHER ADMINISTRATIVE POSITIONS IN HOSPITAL ORGANIZATIONS

by

Leonor U. Maro

Dissertation Committee:

Professor Isobel R. Contento, Sponsor
Professor Randi Wolf

Approved by the Committee on the Degree of Doctor of Education

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ABSTRACT

PERCEIVED BARRIERS TO THE PROMOTION OF FOOD SERVICE DIRECTORS TO HIGHER ADMINISTRATIVE POSITIONS IN HOSPITAL ORGANIZATIONS

Leonor U. Maro

The purpose of this study was to understand why food service directors are not being promoted to higher administrative positions in hospital organizations. This was a cross-sectional survey design using total sampling of hospital administrators and food service directors from the New York City tri-state area from the Directory of Healthcare Professionals and the membership rosters of the American College of Healthcare Executives and the American Society of Healthcare Food Service Administrators. A self-administered, mailed questionnaire determined whether the two hospital executives differed with regards to "self," "work," and "family" factors, hiring considerations, and desire for advancement. The "self" factors included: gender, ethnicity, age, education, marital status, etc. "Work" factors entailed the importance of organizational goals and stakeholders, the value of executive characteristics and skills, and leadership skills. "Family" factors involved issues related to balancing work and non-work related activities and childrearing responsibilities, etc.

From the 152 valid returned questionnaires (response rate = 21.49%), the average mean scores showed similarities between the two hospital executives in the parameters studied. The general linear model showed no significant differences in the importance of most of the 112 variables assessed. Significant differences were found in two executive

characteristics: willing to mentor (<.05) and academic credentials (<.05); five executive skills: negotiation/compromise/conflict resolution ($p<.05$), facilitating positive medical staff relations ($p<.01$), facilitating positive board relations ($p<.01$), political savvy ($p<.001$), and having a total organizational view ($p<.01$); use of transformational leadership style ($p<.01$), use of charismatic leadership skills ($p<.05$) and importance of four stakeholders: department managers ($p<.01$), professional employees (<.05), white collar employees (<.05), and elected public officials (<.001);

The results suggest that there are no major differences between the two hospital executives with regard to the key factors investigated. With the right mentoring or master's degree, the food service directors may aspire for a higher position.

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L.U.M.

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Chapter I

INTRODUCTION

The importance of women in society can be best expressed by the former President Bill Clinton's opening address to the United Nations' Fourth World Conference on Women:

> It is time for us to recognize a simple but profound truth: by improving the lives of American women, we are making a vital investment in America's future. By investing in women, we enable them to reach their fullest potentials as individuals and as members of our society. When women thrive, their families thrive. When families thrive, communities flourish, and our nations reap the benefits (Peters, 1997, p.6).

With this, women's transition from traditional roles of daughter, wife and mother to full participation in American society as a working woman can be traced to the fight for the right to vote, to the workplace during World War II, to the passage of anti-discrimination laws in the 1960's and 1970's, and to the wide range of opportunities available to women in the 1990's (Harrison, 1997).

In 1920, with the ratification of the 19th Amendment, American women were given the right to vote. Carrie Chapman Catt noted the importance of this event as she declared: "In the adjustment of the new order of things, we women demand an equal voice; we shall accept nothing less" (Harrison, 1997, p.10). In spite of Congress passing a law that eliminated pay discrimination between men and women and the presidential appointments of a few women to court positions and federal commissions, no significant evidence of the effects of women's suffrage was seen. In 1930, only 13 women got elected to Congress; and only 150 (2%) of the 7500 state legislature seats were taken by them. However, because of prevailing unemployment and poverty nation-wide, the

changes in the roles of women in the 1920's and 1930's till the Great Depression were driven more by economics rather than by politics. Women worked in the farms to help in the family business, combining this with childrearing and homemaking. Working class women in the city, especially African-Americans, worked domestic or factory jobs for wages. Many single women worked. Once married, they stayed home if economically feasible.

The Great Depression displaced both male and female workers. With unemployment at a high of 25%, working wives stepped aside so that men could have their jobs. This proved problematic for those women who needed their own pay checks, with their husbands and/or fathers out of work, too or those who were working at jobs those men did not want anyway.

World War II increased employment of women to 38%. However, this proved to be temporary as returning soldiers replaced women workers. Moreover, preferential employment and educational benefits given to veterans further widened the gap between men and women workers. Disappointed, many working women left the labor force, turning their full attention to raising families.

Fortunately for women, the business and public sectors expanded in most of the areas that traditionally offered jobs to them. These included teaching, nursing and office work. By 1960, about a third of married women worked part time, earning money that constituted a quarter of the family income. This additional income also helped pay the house, car, and children's college education. Despite all this women faced all kinds of discrimination on the job; the most overt was the preference given to male applicants over them in both the private and government sectors because of women's family

responsibilities.

With women making up a third of the labor force and with the country competing with its foremost rival, Russia, in the effective utilization of resources, a federal commission on the status of women was created in 1961 by President John Kennedy to help women cope with their roles at work and at home. Chaired by Eleanor Roosevelt, the commission made proposals for several government and private measures to assist women. This inspired the creation of similar local commission in each of the 50 states to deal at the local level with discrimination of female workers. Thus, in 1963, Congress passed a legislation prohibiting differentials by sex in wage rates in the private sector. This was followed by the creation of independent feminist organizations like the National Organization of Women, which carried on the work aimed at complete equality for men and women. Due to this and the various women's movements affiliated with the civil rights, the anti-war movements in campuses, and the movement for social justice in most of the cities, women then became the center of social reform. All these challenged the standard idea about the relationship of men and women to each other, to children, and to the state.

This period politically favored women, who once again started getting seats in the state legislature and Congress but at a slow pace. Congress continued to pass laws favoring women. These included: laws that prohibit unequal treatment in credit and educational programs; a 1978 law that bars employment discrimination against pregnant women; a 1984 law that strengthens child support laws and pension rights of widows and divorced women; a 1990 law that provides federal funds for child care; and the latest 1993's Family and Medical Leave Act that requires employers to offer some

accommodation to workers to meet family responsibilities aside from those of the workplace. Even the Supreme Court reconsidered its understanding about women's roles in society from 1971 onward. It began imposing the classification of sex as "arbitrary". Aside from granting women substantial control over their reproductive lives in the famous 1973 Roe versus Wade case, it also gave rise to a powerful opposing movement that supported traditional values.

Female employees, including those in management, have eventually taken strides to fight for their rights. They fought for equal promotion and pay through the United States Equal Employment Opportunity Commission. Some of the high profile cases that female employees won include the $81.5 million settlement against Publix Supermarkets in 1997, the $35 million settlement against Pacific Bell/Nevada Bell in 1999, and the latest was in 2004, in the amount of $54 million settlement against Morgan Stanley, a Wall Street brokerage firm (Mason-Draffen, 2004). Additionally, female employees have been victorious in their struggle for parity at work, even without the Equal Employment Opportunity Commission's intercession, as shown by the $240 million sex-bias settlement against State Farm Insurance in 1992 and the $2.2 million settlement in 2004 by Merrill Lynch. To date, the outcome on the class-action suit brought by female employees against Wal-Mart, America's largest private employer is being eagerly awaited (Dusky, 2004).

Thus, the twentieth century saw the changes in the woman's role from a pure homemaker to a working woman who divides her time between her family and work. This was facilitated not just by the events mentioned earlier but also the following factors: (1) technological innovations like the washing machine and dishwasher which

have freed women from time-consuming tasks needed to manage the home. Additionally, advances in food technology has made available more choices of reasonably- priced convenience food that has shortened time spent in meal preparation for the family. Furthermore, the affordability of computers and internet access have enabled women to manage their time effectively, completing many of transactions and business tasks without leaving home and/or work; (2) the steady decline of fertility; (3) advances in medicine which have shortened the time spent for caring for sick children and extended family members like elderly parents; (4) availability of some child care; (5) the growing number of single-parent families; and (5) increased need for dual-income household to maintain higher living standards (Daily, 1993; Bond, Thompson, Galinsky, and Prottas, 2002).

Today, the proportion of women and men in the 16 years and above wage and salaried workforce is now nearly equal, with women at 47% and men at 53% (Edwards, Laporte, and Livingston, 1991; Occupational Outlook Quarterly, 1999-2000; U.S. Department of Labor's Women in the Labor Force in 2003, 2005). Women's labor force participation rate is expected to increase from 57% in 1988 to 62% by 2008 while men's is projected to decrease from 76% in 1998 to 74% in 2008, even though the population growth for both sexes is similar (Fullerton, 1999). The continued increase in women's labor force participation rate is largely accounted for by working mothers who have been well-established in the marketplace before they had their newest child; thus, it is easier for them to return to their job after maternity leave or look for new employment if returning is not feasible (Hayghe, 1997). Most women are employed in the service-producing industry while most men are in the goods-producing industry. Women

continue to be over-represented in administrative support and service occupations and under-represented in precision production, craft, and repair occupations, and transportation and material moving occupations (U.S. Census Bureau, 2000; Bureau of Labor Statistics, 2002). Furthermore, women continue to earn less than men: 76 cents for every dollar (Epstein, 1997; Bureau of Labor Statistics, 2001).

Whereas in the early 1900's women were largely considered a reserve work force to fill positions that were either undesirable because of low pay status, or temporarily needed in times of crisis such as wars, today's women have made significant organizational gains. With the inroads that women had in the past since they first started working outside the home and with their currently achieving increasingly higher educational levels, they are now more likely to hold managerial and professional positions, an indication of the changing cultural perception of women's role in society and reflecting their contribution to the economy (Hamilton, 1993; Bond, Thompson, Galinsky and Prottas, 2002). The most recent fact sheet of the Department of Labor (2005) reports that the largest percentage of employed women (38%) are in management, professional specialty positions compared to the 34.8% noted by Bowler in 1999. The Institute for Women's Policy Research (2003), however, indicated, that only 1% of women managers have earnings in the top ten per cent for all managers.

In corporate America, the Catalyst, an organization dedicated to the advancement of women in business, in their January 2, 2002's issue of their newsletter, Perspective, reported that women made up 49.5% of managerial and professional specialty positions. For the top positions, the Catalyst in its 2003 Census of Women Board Directors, pointed out that women held 13.6% of the board seats in the Fortune 500, compared to 9.6% in

1995 (2003). Only 54 companies had no women board directors, compared to 96 companies in 1995. Fifty-four companies also had 25% or more women directors, compared to 11 companies in 1995. Women of color held 3% of board seats at the 415 companies that Catalyst had data on, compared to 2.5%of board seats held at 341 companies in 1999.

All the above show that although there seems to be an upward trend in the number of board seats held by women and the number of companies with one or more women directors, the rate of increase appears to be slow. The figures are even smaller with the study done by Catalyst on the women board directors of the Fortune 1000 in 2001 or its collaborative studies of the same nature with the United Kingdom (2000), Canada (2002), and Australia (2003). Thus, there is still a dearth of women in top management as reported by the Department of Labor, executive recruiters, and researches conducted by non-profit organizations and universities (Von Glinow and Krzyczkowska-Mercer, 1988; Davies-Netzley, 1998; Korn/Ferry, 2002).

By industry, the highest percentage of board seats held by women are in soaps and cosmetics (20%); savings institutions (19%); publishing and printing (17%); and toys and sporting goods (17%). On the other hand, women held the lowest percentage of board seats in airlines, computer software, food services, engineering, and construction (6% each); securities (5.5%); and mail/package/freight delivery (3%) (Catalyst, 1998). Interestingly, by location, the Northeast has the highest percent of companies with women on boards (93%); followed by those in the Midwest and South (84% and 81 % respectively); and the lowest would be those in the West (78%).

A similar picture is seen in healthcare, a major employer of women. Women make up 75% of total healthcare workers (Haddock and Aries, 1989). This figure may even be bigger in certain healthcare job categories that are considered as part of "traditional female occupations" like nursing, nutrition and food service, pharmacy, and dental hygiene.

Historically, working in health and human services became a source of career advancement for women in the 1920's. As hospital matrons, directresses or lady superintendents, these women executives or managers got into recognized high positions of decision-making because of their wealth, influence, religious orders, or job seniority (Friedman, 1986). Later on, the chief executives of health services were "nuns or ministers, well-weathered nurses or aging physicians who had to be prudently removed to a safe distance from patients" (Kinzer, 1982). From 1950 onward, men have largely captured the top administrative positions in most hospitals and other healthcare organizations in spite of the fact that majority of the graduates of health administration programs are females (Plant, 1985) and the female membership of the American College of Healthcare Executives is now 40.2% (ACHE, 2005). This shift in management may be due to: the onset of modern administrative practices; the post-World War II phenomenon supporting women as homemakers; and consequently, the segregations of women from lines leading to decision-making positions to routine office or direct service work like secretarial or nursing or just having them confined to middle management positions. Thus, women's historical administrative niche is less often available to them now, at a time when females have become more conscious of the lack of females in top decision-making positions; when women constitute a large number of those educated in

administration and other fields; and at a time when women continue to represent a substantial healthcare experience pool eager to follow their career ladders. They, including the food service directors, still face barriers to being gainfully employed and promoted from middle management to top-level positions.

Statement of the Problem

Very few food service directors get promoted to higher administrative positions in hospital organizations in spite of their technical, management, and leadership skills. The majority of food service directors are women. The problem of their not being promoted may stem from the fact that women are not well represented in top hospital management. The literature has shown that one of the many reasons for this is that men usually occupy top-level hospital management. They are the ones who make the decisions on who is to be mentored, promoted, or hired to the higher positions in administration. Also, those in a position to hire and promote usually do so based partially on a perception of similarities and shared understandings between themselves and those being hired or promoted. These similarities may result from previous socialization and different mentoring and work experiences.

Purpose of the Study

This study aimed to determine why food service directors (dietitians) are not being promoted to higher administrative positions in hospital organizations. It also described how the managerial role behavior and executive and leadership skills of female and male food service directors compare to those of the female and male hospital administrators.

Also, it determined how these two groups of hospital executives balance their work and non-work-related activities, their desire for career advancement, and what factors they considered were they to hire top level administrators.

Statement of the Question

What are the barriers to the promotion of food service directors to higher administrative positions in hospital organizations as perceived by the food service director themselves and the hospital administrators?

Sub-Questions:

1. a. How do the personal or "self" factors (such as the person's gender, race, age, education, marital status, job and career interest, need to have more time for oneself and significant others, etc) differ between the food service directors and those in higher administrative positions in the hospitals?

b. How do female and male food service directors respectively differ from female and male hospital administrators respectively on personal or "self" factors?

2. How do the "work" factors (such as managerial, role behaviors, values and executive and leadership skills, mentoring, staff and line work experience, etc) differ between the two positions and gender mentioned?

3. a. How do "family" factors (such as the size of the family, ages of children, spouse's work schedule and work location, the need to spend more time with the family, etc) differ between the two positions and gender mentioned?

4. How do food service directors differ from hospital administrators on desire for advancement and reasons for choosing higher-level positions?

5. How do food service directors differ from hospital administrators when choosing candidates for top-level administrative positions in the hospitals?

Significance of the Study

This study is important for many reasons. There appears to be a dearth of research in food service management, particularly in the health care setting (Lipscomb and Donaldson, 1964; Palacio, Spears, Vaden and Dayton, 1985). Most of the studies available in the literature deal with clinical nutrition research and the application of the principles of food science and technology. Very few deal with management issues; and much more with issues pertaining to women managers. As Canter (1994) points out in the Research Agenda Conference of the American Dietetic Association in 1994, "management research is critical to the future growth and development of dietetics. Without it, there will be no firm foundation to base entry-level education and training, dietetic practice, or continuing education for the profession."

An insight on how female food service directors and hospital administrators manage and lead differently from their male counter parts will enrich each individual's perspectives on the better way of running her or his organization. The individual may consider and adopt the best techniques used by each gender group rather than concentrate on their weaknesses. By doing so, each individual can develop her/his style, benefiting from the data on the two gender groups under study. By learning and appreciating the personal or "self," "family," and work factors that affect a manager's performance, one

would be able to handle them to her/his advantage rather than let these factors curtail her/his productivity and her/his chances for promotion later on. Furthermore, the manager or executive would develop a better understanding of her/his immediate boss and today's diverse employees.

For the food service directors who have already achieved job success in their present position and who are strongly considering advancement in the hospital organization, this study should provide insight from the hospitals' chief executives themselves on the meaningful considerations they use in the selection of top administrators, and the prospective candidates for said positions; the graduate education they should pursue; the years of minimal work experiences they should have, and the hospital departments which would provide them the best exposure to these experiences

Finally, whatever findings the study will derive can serve as basis for developing continuing education programs and further training objectives for future food service directors and hospital administrators.

Chapter II

LITERATURE REVIEW

One of the most striking developments in the labor market is the continued progress made by women. They have considerably increased their participation and have expanded their employment over time, causing the narrowing of the wage gap relative to men. They are getting more and more educated; and have stayed in the labor market throughout their lives. Many have combined paid work with raising children. Moreover, the shift of employment from agriculture and manufacturing to services has favored women, where women are over-represented.

Women's transition from home to the labor market has also been facilitated by several factors. These include: diversified employment and working-time arrangements; changes in family patterns that highlight the importance of women's earnings in household income; increasing aspirations of women for the independence and fulfillment that paid work can bring and for further progress towards gender equity; and the increasing realization by the government that increasing female employment rates can be an important policy goal which can provide a basis for funding social protection systems. In spite of all the progress in female employment, there is still much to be done. For the largest percentage of employed women (38%) who work in management, professional and specialty occupation (Bowler, 1999; U.S. Department of Labor, 2005) who want to

advance to top- level positions in their organizations, the barriers are numerous. For the purpose of this study, they will be grouped as follows: (1) personal or "self" factors, (2) "work" factors and (3) "family" factors. These groups of factors may possibly overlap with one another.

Personal Factors

The personal or "self" factors which may prevent women from being promoted to top level administrative positions in organizations may include: gender, education, marital status, job and career goals, age, race, and desired time for self and significant others. Race and age in relation to women in management will be discussed very briefly due to limited studies on this in the literature. Many of the available studies deal with both women and minorities, with minorities broadly referring to male blacks and all other ethnic groups of both sexes.

Gender

Gender appears to be the most controversial "self" or personal factor and one of the biggest barriers to the advancement of women in the workplace. Gender roles, in particular (e.g. role of wife, mother, and caregiver), will be discussed under "family" factors later on.

Several theories in psychology and labor economics have been offered as to why sexual differences exist within management. Some psychological researchers have emphasized person-centered variables to explain women's low job status (Morrison and Von Glinow, 1990). Women's traits, behaviors, attitudes (Harragan, 1978; Heim, 1995) and socialization (Gilligan, 1982; Cummings, 1995) are said to make them inappropriate

or deficient as managers. They are not considered tough enough. They are also considered as "too emotional" to handle an all-male or predominantly male group. More often than not, they are viewed as followers whereas men are seen as leaders; therefore, women are viewed as incapable of running an organization (Moss, 1995). Instead of being seen as aggressive and assertive, men label these women as "shrews" or "bitches" (Harragan, 1978). Additionally, women are stereotyped as having their primary responsibilities and allegiance to their families and not for success in a career. A major issue is the perceived lack of career commitment in women which affects their development opportunities, even long before they become parents (Hamilton, 1993; Daft, 1994).

It is not uncommon then for a male manager to refer to a woman as: Oh, here is one of those women. She is good and has terrific credentials; but she won't stay. Pretty soon, she will get married and have kids. Even if I train and invest on her, she is going to quit once she has a baby.

Gilligan (1982) in her classic In A Different Voice relates the theory of person-centered variables to how women have been socialized since childhood as dictated by society's cultural mores and mandates. For example, infant girls develop and are treated differently from infant boys. Girls usually wear something pink or yellow while boys wear something blue or green. Girls play with dolls and learn to negotiate and get along; seek win-win solutions; and focus on what is fair for all instead of just winning. Meanwhile, boys usually play team sports where they compete, are aggressive, strategize, take risk, mask emotions, and focus on the goal line.

In a questionnaire survey study of 500 females and 500 males in health services management positions, O'Hara and Abramson (1983) found that women focused more on measures of their performance and technical accomplishments whereas men moved beyond the threshold of task accomplishment and spent time in "contribution areas", where they obtain, sort, or trade data so as to attain the objectives of the organization.

On the other hand, many field studies conducted since the 1980's have refuted this theory on differences between male and female managers (Ritchie and Moses, 1983; Dobbins and Platz, 1986; Noe, 1988; Haddock and Aries, 1989; Rosener, 1990). In a more positive light, some of these experts believe that women have begun to meet the qualifications and challenges of ideal managers. Moreover, many of these studies have also shown considerable evidence that women and men in management roles have similar aspirations, values and other personality traits as well as job-related skills and behaviors.

Related to the theory on person-centered variables are those referred to by labor economists as the human capital and occupational-crowding theories (Blau, 1996; Blau and Khan, 2000; Boraas and Rodgers III, 2003). The human capital theory suggests that the traditional division of labor by gender in the family results into women accumulating less labor market experience than men. Since they expect shorter and more discontinuous work lives, they are not strongly motivated to invest in market-oriented formal education and on-the-job training. Because of this, women tend to have smaller capital investments that negatively impact their earnings compared to those of men. The human capital theory appears to point out that women tend to choose occupations that require small investments in human capital and skills that remain the same even if not used for quite a

period of time. These are the occupations that suit their schedules better and their intentions regarding long-term labor force participation.

The occupational-crowding hypothesis explains that individuals are socialized from childhood to note that some occupations are more suited as women's work while others are men's. Thus, individuals must choose the occupation appropriate to their sex. Since this socialization obviously influences human capital development and causes the congregation of women in limited number of occupations, wages and salaries of both females and males employed in said "female" occupations tend to be lower. A more extensive discussion of this will be done later in relation to gender pay difference.

The theory of discrimination by the white men in power, the majority population in management, is also cited to account for the slow progress of women and minorities (Morrison and Von Glinow, 1990). Daft (1994) confirms this when he states that "top-level corporate culture evolves around white American males who tend to hire people who look, act, and think like them". This is compounded when the organization's governing boards are composed of older men with more traditional spouses who do not work and just stay at home (Haddock and Aries, 1989; Davies-Netzley, 1998). All these explain why compatibility in thought and behavior play an important role at higher levels of the organization.

Davies-Netzley (1998) explored the perceptions on corporate mobility and strategies for success in elite positions in a face-to-face interview of nine white female and seven white male presidents or chief officers in Southern California. She found that the white men discounted the existence of gender discrimination; and believed that corporate success is due to individual effort and talent. At the same time, the women

believed that gender discrimination accounts for so few women at the top. They also confirmed the importance of social networks and peer similarities for succeeding in elite positions that may include obtaining advanced educational degrees or modifying speech and behavior.

All these studies appear to point to the existence of a "glass ceiling "which, deliberately constructed or otherwise, serves as an effective barrier to the mobility of women to top-level jobs (Morrison, White, and Van Velsor, 1987; Faludi, 1991; Dalton and Kesner, 1993; and Wiggins, 1995; Morgan, 1998). Women can look up through the ceiling and see top management but prevailing attitudes serve as invisible obstacles, which frustrate their efforts to being promoted to higher managerial positions in organizations. Lopez (1992) further suggests the additional existence of "glass walls", which serve as invisible barriers to lateral movement within the organization. Glass walls are said to bar experience in areas such as line supervisory positions, which would enable women to advance vertically. Because of the rising complaints about glass ceiling related issues among women and later on, among minorities especially with promotions and pay gap, the Department of Labor, through the creation of the Glass Ceiling Commission, began a multi-faceted investigation into the glass ceiling in corporate America in 1989 although the initial studies on this started in 1986 by Catalyst, a private organization dedicated to the advancement of women in business. Since then, the Glass Ceiling Commission collaborated on studies on issues about glass ceiling with universities and other private organizations in government and non-government settings.

Aside from access or promotion to top-level positions, another controversial glass ceiling issue that is gender-related is the disparity in pay. It is important to note that that

although women's real earnings rose while those of men declined in the last 20 years, women remained more concentrated in relatively lower-paying jobs than did men (Bowler, 1999; Bureau of Labor Statistics, 2002). Within the managerial and professional specialty category for example, women were most likely to be teachers (except college and university) and registered nurses whose average median weekly earnings were between $671 and $739. Male professionals would most likely be engineers and mathematical and computer scientists with an average median weekly earning between $900 and $1,000. However, in spite of the modest improvement in the earnings of women since 1983 in the executive, administrative and managerial occupation from 64% in 1983 to 68% in 1998, women generally earned less in the same occupation (Bowler, 1999; Fullerton, 1999; Bureau of Labor Statistics, 2002; U.S. Census Bureau, 2002).

Boraas and Rodgers III (2003) used micro data from the Outgoing Rotation Group files of the 1989, 1992, and 1999 Current Population Survey to show that the share of women in an occupation is still one of the largest contributors to the gender wage gap. This happens because women tend to work in female dominated jobs, which usually have a below average wages. Without controlling for workers' characteristics, the research showed that a woman working in a predominantly female occupation in 1999, earned 25.9% less than a woman working in a predominantly male occupation. A similar pattern is noted for a man working in a predominantly female occupation earned 12.5% less than a man working in a predominantly male occupation. These appear to be the negative consequences of occupational "crowding". Thus, occupational crowding usually results to lower wages of men and women in these occupations.

Very few women are able to bolt through the "glass ceiling" to top positions, especially in healthcare (Wiggins, 1996). Earlier studies like Caplan, Le Rey, Rosenthal and Shyavitz (1988) examined the economic and employment profile of about 60 female healthcare managers in middle or senior management jobs in Massachusetts through a questionnaire. Their findings revealed that there were only a few women occupying top positions. The survey also indicated the women's serious ambivalence about whether they were paid competitive salaries and were afforded equal opportunity in their positions. Additionally, the study also pointed out the need for executive search firms in the area and hospital governing boards to examine their attitudes about women in top executive positions.

Another study by Haddock and Aries (1989) consisted of a focused interview of 13 female senior level managers from various health settings in New York and St. Louis metropolitan areas about their career development and expectations. The interview showed the women health care administrators did not perceive themselves to be different from their male counterparts in terms of motivation, commitment, or talent. However, these women perceived two key areas of differences between their career experiences and those of their male colleagues: the effect of family and home on career and the ultimate organizational possibilities available to them. The women interviewed felt that family responsibilities fell disproportionately on them. Also, all of them believed that definite gender-related limits to their potential career advancement exist.

The career patterns of 210 Maser of Business Administration (MBA) graduates of a medium-sized university and currently employed in health care administration were

determined through a 4-page mailed questionnaire(Walsh, and Borkowski, 1995). The questionnaire was meant to show how female and male healthcare executives differ in terms of organizational (financial benefits, training and development programs, success factors, and non-financial benefits like on-site child care and flexible schedule), individual (age, sex, education, job experience, personal values and attitude) and societal factors (norms about roles, cultural influencers, prejudices) that affect career development. With a 46% response rate, the results of the study showed that the initial post-master's salaries are comparable for both female and male graduates. However, as their respective careers progressed, opportunities for promotion and financial benefits for the women decreased but expanded for men. With the same educational background, men earned an average of $61,491 annually versus women's $50,839. Organizational factors appeared to have influenced the salary differential.

In 1996, Weil and Kimball surveyed through a mailed questionnaire 600 men and 600 women non-religious members of the American College of Healthcare Executives (ACHE), the leading professional association for U.S. health care managers. Data on salary, education, work experience, personal, and institutional variables that might account for gender differences were collected. The subjects were grouped into 6 cohorts whose first job in health care administration began in each of the three 5 year periods from 1971 to 1980 to better estimate and control the effect of length of experience in the field on rewards. Other variables that were controlled were race, region, and age.

With a 67% response rate, the study showed that men earned about $16,000 more

than women. The multivariate analysis showed age and work experience accounting for the significant difference in salary. It was also shown that women earned significantly more if they had male mentors; a spouse willing to relocate for their career advancement; or an employer whose policies accommodated families such as flextime; and if they themselves socialize informally with other health care executives.

A more recent related study assessing the impact of gender on salary involved all the 395 graduates of the Master in Public Health program majoring in Health Care Administration (MHA)) a at Yale University between 1991-1997 (Bradley, White, Anderson, Mattocks, and Pistell, 2000). It was a cross-sectional survey consisting of 201 final respondents; 70 % of whom were females. The graduates' reported salary in the first job post-graduation and reported salary in their current position were determined. Bivariate and multivariate analyses were used to assess the unadjusted and adjusted associations between gender and salary. Results showed that salaries in both the first job post-graduation differed significantly by gender, with women earning less than men (p-values<.05). Unlike the previous studies involving MBA and MHA graduates, this study did not show that the gender-related salary gap widened as the years since graduation increased.

Finally, the American College of Healthcare Executives (2000) did a follow-up study in 1999 of their 1995 study in collaboration with the Catalyst, Inc to compare the attainments of men and women in managerial careers in general business to those in health care. About 906 (57%) of the 1,601 ACHE members to whom questionnaires were sent, responded. Data from the business executives were those obtained from the researches of the Catalyst's "Women in Corporate Leadership: Progress and Prospects"

published in 1996 and "Women and the MBA: Gateway to Opportunity" published in 2000.

The ACHE-Catalyst's study revealed that only 11% of the female and 28% of the male healthcare executives achieved Chief Executive Officer (CEO) positions compared to 18% of the women and 24% of the men in business. It was also shown that female healthcare executives, in spite of equal levels of education and experience, earned 19% less than their male counterparts, which is not far from the 17% difference of 1995. In business, the salary gap for 1999 between male and female executives was even bigger at 25%. Nevertheless, the majority of both study groups of women, in general, were not satisfied with their compensation. While female health care executives favor upgrading educational credentials and obtaining breadth of experience with different functional roles as means of advancing at work, the business women felt that the way to advance is to seek out difficult or highly visible job assignments and to develop a style with which senior managers are comfortable with. Both groups of female executives agreed that female stereotyping and preconceptions of women's roles and abilities and women's exclusion from informal network of communication hamper their advancement.

It appears that a double-pane glass ceiling hampers women's progress in the workplace. One pane refers to the promotion of women to senior management positions and soon, hopefully, to top-level positions. The second consists of commensurate pay. Although women have started to be developed and promoted to senior level, and some to top-level management positions by cracking the glass ceiling, there is still a lot to be done to increase their number. The work seems even bigger when it comes to breaking the second glass pane, the barrier of disparate pay.

Interestingly, Dr. Roy Adler, Executive Director of the Glass Ceiling Research Center and Professor of Marketing at Pepperdine University, in an extensive study of 215 Fortune 500 firms from 1980 to 1998, showed a strong correlation between a strong record of promoting women into the executive suite and high profitability (2001).

Race

White non-Hispanics will continue to have the largest number of people in the labor force (Occupational Outlook Quarterly, 1999-2000). Since whites are the majority of the population, they will account for close to half of the labor force growth in the coming decade (1998-2008) despite their low growth rate. Hispanics will have one-third of the growth; while blacks and Asians will contribute one-eighth each.

On the other hand, the labor force growth rate of each group of minorities outpaces that of whites. Hispanics and Asians and others (non-black minorities) have an increased labor force growth rate, primarily due to high levels of immigration. For the blacks, the higher birth rates accounts for their greater labor force growth compared to whites. By 2008, the labor force will be 71% white non-Hispanic, 13% Hispanic, 11% black non-Hispanic, and 5% Asian and others.

Gender-wise, however, the Institute for Women 's Policy Research's analysis of data from the Current Population Survey for 1998-2000 shows that the labor force participation rate of women aged 16 years and older is 60.5% (2003). By race, the labor force participation rate of women shown earlier by the Institute for Women's Policy Research (2003) still reflect the same pattern as the one released by the U.S. Department of Labor most recently (2005). Blacks have the highest labor force participation rate at

61.9%; followed by the white non-Hispanics (59.2%) and Asians and others (59.2%). The Hispanic women have the lowest participation rate at 55.9%.

In general, white women earned more than any of the minority groups at about 17% more than the blacks and 39% more than the Hispanics (Fullerton, 1999). Asians were the highest earning minority group (Institute for Women 's Policy Research, 2002) although no comparative data to the other women groups were available. Differential earnings may be accounted for by education, work experience, being a non-native speaker of English, occupational distribution, and other factors. Besides being at an educational disadvantage and usually, foreign born, many Hispanic women's English language skills were very limited; thus, compounding more their earning ability. There was twice as much black and Hispanic women than white women working in service jobs like cleaning services, food services, and health services or working as fabricators, operators, and laborers. Moreover, there are more white women than black and Hispanic women holding managerial and professional specialty jobs. In said jobs, white women also earned the most.

Most female managers are not in the private for profit sector. They are usually employed in the public sector and "third" sector"-non-governmental agencies in health, social welfare, and education; legal service, professional service, membership organizations; libraries, museums, and art organizations.

The Catalyst conducted a multi-phase study of the impact of racial/ethnic background on opportunities and barriers for women in management. The first phase provided a statistical picture of the U.S. Census-based study of minority women in managerial positions in the private sector (Catalyst, 1997) as reported earlier. The study

also showed that each group of minority women earned less than their male counterparts. Aside from having the highest average earnings among female managers, Asians and other female managers also had the highest educational levels.

The second phase of Catalyst's (1998) study of colored women managers dealt with the barriers they faced. Data were obtained from 1,700 returned questionnaires, 60 focus groups held, and more than 80 in-depth interviews of minority women managers: 54% African Americans, 24% Hispanics and 21% Asians. Majority of the group are in mid-management. Only 11% were senior managers, who were 0-3 levels below the chief executive. The findings of the study showed that only 34% of the minority women managers are satisfied with their advancement opportunities in spite the fact that a majority (57%) of them are satisfied with their jobs. About a fourth of the respondents expressed their intention to leave their current employer, seeing no advancement opportunities in the past 5 years as favorable as what white women have. They consider the following as major barriers to their advancement: not having an influential mentor or sponsor (46%), lack of informal networking with influential colleagues (39.8%), lack of company role models of same race/ethnic group (29.4), and lack of high visibility projects (27.9%). Most (46%) of the minority women felt that affirmative action helped them "get into the door"; while some (31%) said that affirmative action helped with their promotion.

White women managers agree that they have made some movement through the glass ceiling. Optimistic as they are, they do not perceive, though, that the problem has been solved, and that there is still a long way to go. Minority women do not see much progress. They feel that significant barriers to their advancement still exist.

Education

Education has become an increasingly important factor for advancement in the workplace. An undergraduate degree is now a necessity for executive advancement. Much more, a graduate degree is not only a helpful asset today but also an important credential for advancement and promotion. Compared to their predecessors, the young executives of both sexes and races are better educated today.

With a higher educational attainment, there is a greater possibility for the person to be a labor force participant. Thus, the labor force participation rates of women age 25 years and over by educational attainment are: 32.7% among those with less than a high school diploma; 55.0% for those with a high school diploma; 71.8% for those with some college, no degree- associate degree; and 71.8% for those with some college, no degree and 73.1% for those with a bachelor's degree and higher (U.S. Department of Labor, 2005). The same labor agency pointed out the inverse relationship between greater education and unemployment rate. Thus, the ascending order of women's unemployment rate by education is: those women with a bachelor's degree and higher (2.9%); those with some college but no degree (4.9%); women with a high school diploma (5.2%); and women with less than high school diploma (9.8%).

The female work force is becoming better educated than the male work force. They are earning more of the bachelor's and master's degrees except in science and engineering. This is especially true for those workers under the age of 40 for all ethnic groups. However, it must also be pointed out that women, like minority men, did not begin earning their college and, especially, graduate degrees in any substantial numbers until 1970. Thus, it is simply a matter of time before more women will be found in

executive positions. Others argue further that this emphasis on degrees is just a smoke screen to mask the fact that racism and gender stereotyping by corporate leadership prevent women and minorities from being promoted (Wernick, 1994 as reviewed in the Glass Ceiling Commission Report, 1995).

In relation to this, the human capital theory suggests that individuals are rewarded in their current jobs for their past investment in education and training. The Bureau of Census' annual look at educational achievement in America culled from a survey in March, 2004 has shown that regardless of race or gender, a college graduate on average earned over $51,000 compared with $21,000 for someone with only a high school diploma or an equivalent degree (Armas, 2005). With race and gender factored in, the same study has noted that black and Asian women with bachelor's degrees earn slightly more than similarly educated white women and white men with four-year degrees. A white woman with a bachelor's degree typically earned nearly $37,800 in 2003 compared with nearly $43,700 for a college-educated Asian woman and $41,000 for a college-educated black woman. Hispanic women took home slightly less than $37,600. Some sociologists and economists explain the differences in salary may possibly be due to: the tendency of minority women, especially blacks, to hold more often more than one job or work more than 40 hours a week, and the tendency of black professional women who take time off to have a child to return to the work force sooner than others. On the other hand, the same study has pointed out that a white male with a college diploma earns far more than any similarly educated man or woman in excess of $66,000 a year. Asian males with bachelor's degree earn more than $52,000 annually compared to the $49,000 of the Hispanics and $45,000 of the blacks. All these uphold the earlier findings of

Morrison and Von Glinow (1990) and Wernick on her *Preparedness, Career Advancement, and the Glass Ceiling* paper for the Glass Ceiling Commission (1995) on reviewed studies that show that educational and training investment yield higher returns for white men than women and minorities.

A paper prepared by the National Science Foundation on *Women, Minorities, and Persons With Disabilities in Science and Engineering* (1994) showed that doctoral female scientists and engineers are less well off than men with respect to unemployment, underemployment, median salary, academic rank, and tenure; and that when women and men with similar years of professional experience are compared, differences between the sexes narrow but are not eliminated. Recently, Harvard's President Larry Summers has triggered a national uproar in an academic conference hosted by the National Bureau of Economic Research when he said "that genes and personal choices may help explain why so few women are leaders in science and engineering fields" (2005). He has also further asserted "that although socialization and bias may slow the progress of women, it is the gender variation in test scores that can possibly explain the larger number of men at the top of the professional ladder".

Age

The making of chief executives is a long complicated process whether in business, education, health care or any other fields. Chief executive officers (CEOs) are generally in their 50s or 60s when they assume the top position. At such an age, they would usually have spent 20-25 years "in the pipeline" or in various positions that would help them climb the top. Thus, it can be said that women are working their way up, although the path they tread on appears to be rough.

Marital Status

It is obvious that single women are preferred over the married ones for the simple reason that the married women would have to divide their time among their family, their work and themselves. As the male chief executive officers and corporate presidents from Southern California interviewed by Davies-Netzley (1998) state: "Married women do not perform as well because they can not commit the time that male counterparts can. There is still conflict between work and home for women in senior positions that require 12 to 14 hour work day". The same group of male executives views single women without children as better suited to corporate elite positions than wives and mothers.

What do married women managers say then? They defend themselves by pointing out that they can still do a good job in spite of having to juggle their schedule and energy to cover their responsibilities at work and home although doing so entails lots of creativity, perseverance, and difficulty.

Job and Career Goals

Just like any employee, a typical female worker will always strive to do her job well and aspire for promotions to better positions. These work pattern and aspirations continue until she has attained her job and career goals. Only after she has been on her job for a period of time does she realizes, usually, from observing her department, her institution, and other similar institutions that career attainment, mobility, and salary are influenced by gender, race, education, experience, and sometimes, who you know. Oftentimes, her observations confirm findings of studies which show that white men tend to progress more quickly into middle and upper-management positions than do women in

general despite comparable education and experience (Wernick, 1994 as reviewed in the Glass Ceiling Commission Report, 1995).

Not to be overlooked is the importance and appreciation of the personal choices that women make, which impact their economic progress over the years (Furchgott-Roth and Stolba, 1997). The decisions to enter previously male-dominated college/graduate courses and work; to marry and bear children later in life; to join the work force; and to leave the work force to raise children greatly affect women's achieving total parity with men. This legacy of choice is often ignored in favor of women being portrayed as victims of discrimination. Because of this, the possibility that women do not want to reach the top of the organization is overlooked.

Work Factors

The work factors that may affect the promotion of women to higher management positions include: experience in the core areas of the organization; managerial, executive, and leadership skills; access to information through networking and mentoring; and career planning.

Experience in the Core Areas

Career paths to top positions in an organization differ by industry. Certain functional areas are more likely to lead to the top. These "right" areas are usually the line functions such as marketing or production or a critical control function like accounting or finance. Most women tend to be in supporting staff function areas like personnel/human resources, communications, public relations, affirmative action, and customer relations. Movement between these positions and line positions is rare in most major organizations.

Moreover, career ladders in staff functions are generally shorter than those in line functions. Thus, staff positions offer fewer opportunities to gain varied experience needed for advancement.

The best opportunity for advancement for women into management and decision-making positions appear to be in three types of industries: those which are fast-growing (as in business, health and management services); those like telecommunications where change such as deregulation or restructuring have occurred; and those with primarily a female work force like in banking and insurance.

Managerial, Executive and Leadership Skills

No studies have been found to compare the managerial, executive and leadership skills of food service directors and hospital administrators. In a survey of the membership of the American Management Association, Schmidt and Posner, as reviewed by J.S. Borman (1993), found significant differences between genders on a number of managerial values. Women have been found to place greater importance than men on organizational stability, organizational leadership, and organizational growth. Also, women have been found to value flexibility more than men.

An ex post facto research design was used to survey 1,089 hospital chief executive officers and chief nursing executives regarding their managerial, executive and leadership skills (Borman, 1993). With a response rate of 61.2%, the data were analyzed using weighted regression with position and gender as independent dummy variables and multivariate analyses of covariance with highest educational attainments as covariates. Results showed that there were no differences in executive characteristics by position. Gender differences were noted in terms of flexibility and connection to others. These

characteristics were found to be significantly higher in women than men in both positions. Also, the same study showed that nursing executives significantly scored differently from the chief executive officers in terms of the following executive skills: human management knowledge, negotiation/compromise, and political savvy. The chief executive officers viewed their ability to facilitate positive board relations significantly more important for their position than the nursing executives.

Powell (1990), in his extensive review of research on sex differences in management, found no difference between male and female managers in terms of task- and people-oriented behavior. Task-oriented behavior is directed to subordinates' performance and includes initiating work, organizing it, and setting deadlines and standards. People-oriented behavior is directed toward subordinates' welfare. It includes: seeking to build the self-confidence of subordinates, making them feel at ease, and soliciting their input about what affects them

Female managers in business (Bass, 1991) and nursing (McDaniel and Wolf, 1992; Dunham and Klofehn, 1990) have been found to use transformational leadership. This may be so because women are more comfortable empowering others and encouraging group decision making while men are socialized to compete as individuals and use direct control measures. Rosener (1990), a Management professor from the University of California describes this leadership style of women as interactive or participatory.

Networking, Mentoring, and Career Planning

In order to advance themselves, women managers need networking, mentoring and to plan their careers. They need to network among themselves and also with the male executives not only to decode the corporate communication style, both across the gender

line and between cultures (Henderson, 1994) as reported in the Glass Ceiling Commission Report (1995), but also to exchange information on "what and how what works". As Davies-Netzley (1998) gathered from her interview of female chief executives, women need to develop similarities with male peers to be successful. This may include altering appearance to fit the proper business attire, changing speech and behaviors to conform to situations with other elites, talk sports and politics, etc.

Mentoring helps individuals develop and advance to management and executive positions. Mentors provide coaching, sponsorship, greater exposure and visibility for the protégés to learn the ropes and adapt to organizational expectations (Morrison, White, and Van Velsor, 1987; Brown and Nkomo, 1992 as reported in the U.S. Department of Labor's Glass Ceiling Commission Report, 1995). Women managers still encounter difficulties securing both male and female mentors.

There is still the prevailing notion that male mentors prefer male mentees. Also there may possibly be fewer female executives for the number of female mentees available in an organization.

It is rare that women think of any "career strategy" at the beginning of their career after graduating from college. The focused group interviews of thirteen female health care administrators in New York and the St. Louis metropolitan areas revealed that career strategy has evolved as their career progresses and that this process is seldom at a standstill (Haddock and Aries, 1989). The same group of administrators claims that their aspirations, ambitions, and goals, as well as the path that seem to lead toward them, change as their careers progress.

Family Factors

There are many family factors that can deter the advancement of female managers to top-level positions in organizations. Among those to be discussed here are women's role and responsibilities in the family, age of children, availability of outside child care help, etc.

Women in top managerial positions are much more likely to be single (either never married or divorced). Fifty-two per cent of successful women are either divorced or unmarried compared to 5% of men at the same level (Bennett, 1986)

Most women managers' efforts to combine family and career do not result from systematic decision-making. The blending of work and family is problematic for women because of their greater family responsibilities. Wiggins (1995) points out that women's work and family demands are simultaneous and men's are typically sequential. A good example of this is a mother is likely to be called at work or is expected to remain at home to tend to a sick child (simultaneously); whereas a father usually fulfills his parenting role after work hours or on week-ends (sequential). Additionally, women in our society bear the burden of child rearing, care giving, and household responsibilities, whether they work full-time, part-time, or in the home.

Since the most time-consuming household labor is caring for children, some women managers make a conscious decision not to have them. Others are just lucky to have their children as adult themselves when these women attained their elite positions. For the younger executives with one to three school-age children in Davies-Netzley's study (1998), they acknowledge that work and family have conflicted at some

points in their careers. One mother states that: "It's had a lot of inconveniences but it's never impossible because my husband and I have always been able to work it out"

Other female executives suggest the following to reconcile work and family: use of day care facilities, modifying schedules with spouses to accommodate child care, and paying for live-in help if affordable (Haddock and Aries, 1989; Davies-Netzley, 1998)

Many of the successful women agree, though, that the most significant sacrifice that has resulted from the pressure to balance work and family obligations is their loss of personal time.

CHAPTER III

METHODOLOGY

This study used a cross-sectional survey design. In this chapter, a description of how data were collected to answer the study questions is included. The sample participants are also described as well as the instruments used for data collection, the procedures employed, and the methods for data analysis. Furthermore, it also shows how the survey instrument was modified from its original design, validated, and assessed for its reliability.

Study Participants

Data for this study was collected between May and August, 2002. The participants in this study were hospital administrators and food service directors from the tri-state area: Connecticut, New Jersey, and New York. 767 hospital administrators and food service directors from various health care facilities were solicited to join the study. Table 1 shows that questionnaires were sent to 639 participants whose names and addresses were obtained from the Directory of Health Care Professionals, 2000. An additional 128 participants were taken from the membership roster of the American College of Health Care Executives (2002) and the American Society of Healthcare Food Service Administrators (2002). As much as possible, a questionnaire each was sent to the

Table 1
Number of Questionnaire Sets Mailed

	Food Service Director		Hospital Administrator		Total	
	N	(%)	N	(%)	N	(%)
1 Names from Directory of Health Care Professionals, 2000	326	(81.7)	313	(85.1)	639	(83.3)
2 Names from cross-checking membership of the American Hospital Association - American College of Healthcare Executives (2002) & the American Society of Healthcare Food Service Administrators (2002) for the Tri State Area	73	(18.3)	55	(14.9)	128	(16.7)
Total Number of Questionnairs Mailed:	399	(100)	368	(100)	767	(100)

hospital administrator and food service director of the institution. For hospitals grouped into a health care system or network, it was highly possible to have only one hospital administrator and/or food service director for the different sites or have one hospital administrator and different food service director (site manager) for the various merged hospitals. Thus, there were a total of 399 food service directors and 368 hospital administrators that made up the 767 study participants.

The names and addresses of the subjects were obtained from the Directory of Health Care Professionals, 2000 (2000), a book that lists all hospitals by state and the names of those in top management positions from the hospital administrator to the head/chief of the various departments. This list was crosschecked against the membership list of the American Hospital Association-American College of Health Care Executives and the American Society for Healthcare Food Service Administrators for 2002 for the tri-state area for those who currently hold the position of Hospital Administrator or Chief Executive Officer and Food Service Director or Chief of Nutrition and Food Service respectively.

Table 2 shows the distribution of the prospective study participants. More subjects were listed for New York (484), followed by New Jersey (220). The fewest number of participants were from Connecticut (63).

Instruments

A 105 item questionnaire used in a related study of nursing executives developed by J.S. Borman (1993) was adapted for this research, with the author's permission. Borman's original questionnaire consisted of 105 items that were grouped into four parts:

Table 2
Distribution of Questionnaire by State & Position

	Connecticut		New Jersey		New York		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Food Service Director								
—from Directory of Health Care Professionals	27	(43)	100	(45)	199	(41)	326	(43)
—from membership roster	4	(6)	11	(5)	58	(12)	73	(19)
Total	31	(49)	111	(50)	257	(53)	399	(52)
Hospital Administrator								
—from Directory of Health Care Professionals	30	(48)	106	(49)	177	(37)	313	(41)
—from membership roster	2	(3)	3	(1)	50	(10)	55	(7)
Total	32	(51)	109	(50)	227	(47)	368	(48)
Grand Total	63	(100)	220	(100)	484	(100)	767	(100)

(1) Leadership skills; (2) Importance of organizational goals, stakeholders, personal traits (characteristics of executives), and executive skills; (3) Balancing work and non-work-related activities; and (4) Demographics.

Development of Questionnaire: Beliefs Regarding the Importance of Organizational Goals, Stakeholders, Characteristics of Executives, and Executive Skills

To adapt the original questionnaire to the needs of the study, the sequence of its four parts were rearranged; and two new parts were added. The modified questionnaire consisted of: (1) Beliefs regarding the importance of organizational goals, stakeholders, characteristics of executives, & executive skills; (2) Leadership skills; (3) Considerations when hiring top administrators; (4) Balancing work and non-work-related activities; (5) Desire for career advancement; and (6) Demographics. Sections modified from the original questionnaire were (3) and (5). Thus, the final questionnaire used had about 120 items.

This section (QA) determined the hospital executive's personal beliefs and values about the importance of organizational goals (QA1a-j), stakeholders (QA2a-l), executive characteristics (QA3a-n), and executive skills (QA4a-j). The ten organizational goals and ten executive skills in Borman's questionnaire were maintained. The organizational goals ranged from "high productivity" to "organization's value to society" while the executive skills varied from "General management knowledge" to "Having a total organizational view".

To suit the needs of the study and to avoid redundancy, the number of stakeholders was reduced from 14 to 12. The panel of nutrition experts and consulting statistician,

during the pre-pre-testing of the revised questionnaire, recommended that "My co-workers" be retained while "My colleagues" be excluded since they were believed to be referring to the same groups of stakeholders. Also, "Employees" and "Technical employees" were combined into "Professional employees" as differentiated from two other groups of employees in the list: "white collar employees" who referred to the administrative or office employees; and the "craftsmen" who referred to the different workers from Facilities Management or Engineering.

On the other hand, the characteristics of executives rated were increased from twelve to fourteen. It was believed that "Willing to mentor" and "Academic credentials" were additional characteristics that a top hospital executive should possess in today's hospital organizations.

All the questions for this section on beliefs regarding the importance of each of the organizational goals and stakeholders and the characteristics of executives, and executive skills were rated on a scale of one to five, according to the personal beliefs of the respondent rather than what was required of him to express publicly because of his position. An answer of one indicated "Not at all important" while five would mean "Very important". The higher the score on an item, the more importance or value placed on that item.

Examples of questions on beliefs and values about the importance of organizational goals and stakeholders and the characteristics of executives and executive skills are listed on Table 3. They are all scored on five-point Likert-type scales with response options ranging from "Not at all important" to "Very important" in the questionnaire. All

Table 3

Examples of Questions on Beliefs & Values About the Importance of Organizational Goals and Stakeholders, and the Executive Characteristics & Skills Needed to Perform a Manager's Job

	Examples of Questions
Beliefs & Values: Importance of	
Organizational Goals	• How important is "high productivity" to you personally?
	• How important is "high employee morale" to you personnally?
Stakeholders	• How important are "Patients" to you personally?
	• How important are "Departmental Managers" to you personally?
Characteristics of Executives	• As an executive at your level, how important to you personally is "High Ability"?
	• As an executive at your level, how important to you personally is "Ambitious"?
Executive Skills	• How important to you personally in your own job is "General Management Knowledge"?
	• How important to you personally in your own job is "Fiscal Management Skills"?

questions categorized under each of the four categories of beliefs and values are listed in Appendix A and B.

Leadership Skills

The "Multi-factored Leadership" questions (QB1-21) were designed to capture how the employees reporting directly to hospital executives perceive their leadership style. After several thorough reviews, the panel of nutrition experts and more so, the consulting statistician strongly suggested that the original 26 questions be trimmed to 21. Aside from redundancy for some questions, those that were obviously negative were reworded to make them a bit less obvious. They were also distributed among the more positive ones. Of the final twenty-one questions, five addressed "Charismatic leadership skills" (questions 1 to 5); five illustrated "Individual consideration"; (questions 6 to 10); four implied "Contingent reward" (questions 11 to14); two typified "Intellectual stimulation" (questions 15 to 16); and the last five reflected "Management by exception" (questions 17 to 21).

Charismatic leadership, individual consideration, and intellectual stimulation are said to characterize transformational leadership. On the other hand, transactional leadership is said to consist of contingent reward and management by exception.

Like the previous questions on the importance of organizational goals, stakeholders, characteristics of executives, and the executive skills, the multi-factored leadership questions were scaled from one to five, with one indicating that the respondent "Almost never" showed that leadership behavior while five showed that the participant exhibited

Table 4
Examples of Questions on Leadership Styles

Leadership Styles		Examples of Questions
Transformational:		
	Charismatic	• You make everyone around you enthusiastic about assignments • You are a model for them to follow
	Individual Consideration	• You give personal attention when they feel neglected • You find out what they want & help them get it
	Intellectual Stimulation	• Your ideas challenge them to rethink some of their own ideas • You provide them with new ways of looking at things
Transactional:		
	Contingent Reward	• You are open to negotiations about working conditions • You assure them they can get what they want in exchange for their efforts
	Management by Exception	• You allow them to suggest new ways at looking at things • You tell them only what they have to know to do their job

"Almost always" that leadership skill. Thus, the higher the mean score on a subscale or overall scale, the higher the use of that type of leadership skill. Examples of questions for the different leadership styles are listed on Table 4. All the questions for leadership skills are listed in Appendix A and B.

Considerations When Hiring Top Administrators

In this section (QC1-5), both hospital administrators and food service directors were asked about qualifications they think were important in hiring an assistant /associate hospital administrator.

In QC1, the hospital executives were asked to choose four characteristics of executives from Section QA3 and four executive skills from Section QA4 that they would consider when hiring an assistant/associate hospital director. Both the characteristics of an executive and the executive skills were ranked from one to four, with "1" being the "Most important" characteristic and skill while "4" denoting the "Least important" characteristic and skill.

The participants of the study were also asked in QC2 whether they would choose the candidate from their "age group, gender group, outside or within the hospital they worked". Responses were scaled from one to five, with one denoting a "Not at all likely" choice while five pointing to a "Very likely" selection.

Moreover, the respondents were also queried in QC3 as to what educational preparation and specific major field of study would they look for from the candidates for assistant/associate hospital administrator. Choices of responses for the education degree included: "Associate," "Bachelors," "Master," and "Doctorate," with the participants

putting a check mark on either "Yes" or "No" for the chosen degree and writing in the specific field of study.

Furthermore, it was determined in QC4 how many years of work experience at a department head or similar management level would be considered essential for one to be considered for an assistant/associate hospital administrator's position. The study participants checked the box corresponding to "0-2 years," "3-4 years," or "More than 4 years."

Finally, certain departments/services in the hospital would offer its head/chief the necessary experiences & knowledge that would qualify him for promotion to higher administrative positions in the hospital. The departments/services commonly available in any hospital were enumerated. The respondents were asked in QC5 to choose four departments from the list where the head/chief can possibly be mentored to apply for assistant/associate hospital administrator. They were asked to rank the departments from one to four, with "1" denoting the department that would most likely; and "4" as the department that would least likely offer the best knowledge and experiences for consideration for promotion to higher administrative positions in the hospital organization such as the assistant/associate hospital administrator.

Balancing Work- and Non-Work-Related Activities

Section QD1a-j asked the respondents about the frequency as to how they are affected by issues related to balancing work and non-work-related responsibilities on a five-point scale. The answer chosen ranged from "1" which meant "Almost never" to "4" meant "Almost always."

Those without children were asked to skip to Section QE, "Desire for Career Advancement." Those with children were further asked how many children they had and the children's ages (Section QD2a). They were also queried on their age when their first child was born (Section QD2b). All this information is believed to impact the participant's ability to balance work and non-work-related activities and more so, his ability to balance work and child-rearing responsibilities. These portions (QD2a-b) were not in the original questionnaire.

Those with children were also requested to rate how strongly they felt about issues related to working and childrearing responsibilities (Section QD2c) as presented to them in six statements. The scale and the ratings used here is exactly the same as those in balancing work- and non-work-related activities (Section QD1a-j).

Examples of questions on issues related to balancing work and non-work-related activities and balancing work and child-rearing responsibilities are listed in Table 5. The complete set of questions on these are listed in Appendix A and B.

Furthermore, the participant's responses to the questions in Section QD may affect his desire for career advancement, especially in today's intense climate in the healthcare industry.

Desire for Career Advancement

For this section (QE), questions on career development were phrased differently for the two groups of hospital executives: the hospital administrators and the food service directors. The hospital administrators were asked how important it was for them to seek this position within the hospital organization QE1a). Responses were from a five-point

Table 5
Examples of Questions on Balancing Work & Non-Work Related Activities and Balancing Work & Childrearing Responsibilities

Issues Related to	Examples of Questions
Balancing Work & Non-Work Related Responsibilities	• My job keeps me from doing the things I want to do • I have more to do than I can handle
Balancing Work & Childrearing Responsibilities	• I worry whether I should work less & spend more time with my children • I find enough time for my children

scale. "One" meant that it was "Not at all important" while "Five" showed that it was "Very important". Also, the hospital directors were asked for three reasons as to why they accepted their present position (QE1b); and to rank-order them, with "1" as the "Most important reason" and "3" as the "Least important reason".

On the other hand, the food service directors were asked whether they wanted to be hospital administrators (QE1a). Their answer was keyed on a five-point scale, with "One" as "Definitely no" and "Five" as "Definitely yes". They were also asked whether they would accept an offer of a higher position in the hospital organization now and five years from now (QE1b). To both questions, their answer was a check mark on either the "Yes" or "No" box. Finally, they were asked to give three reasons as to why they would accept an offer of a higher position in the hospital organization (QE1c), which was to be ranked as "1" being the "Most important reason" and "3"being the "Least important reason".

Since the questions on this section, QE-Desire for career advancement, were slightly different for each position, a separate questionnaire was given to the food service directors and hospital administrators.

Demographics

Section QF of the questionnaire asked for demographic data: position title (QF1), years as hospital administrator or food service director at current place of employment QF2), years as hospital administrator or food service director in other place/s (QF3), hospital type (QF4), licensed number of in-patient beds (QF5), gender (QF6), ethnic group (QF7), age range (QF8), education (QF9), current marital status (QF10), annual salary

range (QF11), employment status of spouse/partner that the respondent lives with (QF12), and membership in a religious order (QF13).

Pilot-testing of Questionnaire

The content validity of the original questionnaire was established by J. Borman (1993) when she used this instrument on her target population of nursing executives and hospital administrators. All the questions on "Importance of organizational goals, stakeholders, characteristics of executives and executive skills" and "Multi-factored leadership skills" were found to have sound psychometric properties in earlier studies by Feldman (1981) and Rosener (1990). However, since some modifications were done on certain questions in terms of reduction of number of and combination of similar stakeholders and leadership skills; increase in the number of characteristics of executives; and rewording of some of the leadership skills, reliability coefficients were recalculated for each of the scales based on the sample data.

All the scales for the importance of organizational goals, stakeholders, characteristics of executives, and executive skills had alpha reliability coefficients ranging from .78 to .84. These are shown on Table 6. The leadership scale also had a highly acceptable alpha coefficient of .81 as shown on Table 7. Table 7 points out that the alpha coefficient for the scale on issues related to balancing work and non-work-related activities is .73. If taken together, the issues related to balancing work and child-rearing responsibilities had an overall alpha of .29 as shown on Table 8. This may be due to a mixture of 2 positively worded-out statements on having enough time for childcare and being comfortable about childcare arrangements and four negatively worded-out statements about worries on

Table 6
Cronbach's Alpha Reliability Coefficients for Scales Measuring Importance of Organizational Goals, Stakeholders, Characteristics of Executives, and Executive Skills

Scale	Number of Items	Alpha
Organizational Goals	10	0.82
Stakeholders	12	0.84
Characteristics of Executives	14	0.83
Executive Skills	10	0.78

Table 7

Cronbach's Alpha Reliability Coefficients for Scales Measuring Leadership Skills

Scale	Number of Items	Alpha
Charismatic Leadership Skills	5	0.73
Individual Consideration	5	0.77
Intellectual Stimulation	2	0.77
Contingent Reward	4	0.70
Management by Exception	5	0.72
Overall Leadership Skills	**21**	**0.81**

Table 8
Cronbach's Alpha Reliability Coefficients for Scales Measuring Issues Related to Balancing Work & Non-Work Related Activities

Scale	Number of Items	Alpha
Issues related to balancing work & non-work related activitie	10	0.73
Issues relating to balancing work & child-rearing responsibilities:		
positively worded-out statements	4	0.73
negatively worded-out statements	2	0.54
Combined	6	0.29

childcare. Separately, the reliability of the four negatively worded-out statements was .73 and .55 for the two positively worded-out statements.

Face validity was established for the test population for this study by an expert panel in health research and nutrition and a consulting statistician. This panel consisted of a nutrition research behavioral researcher and about fourteen doctoral and master students in nutrition education. The panel reviewed the instrument thoroughly for its clarity, choice of words, and its ability to draw out the information needed to answer the study questions. The statistician thoroughly critiqued the format, the importance of each set of questions in relation to the study's objectives, and ease of analyzing the data that would be collected. Thus, the questionnaire was modified several times.

Finally, the questionnaire was pilot-tested in the spring of 1999. Those who validated and assessed its reliability consisted of three hospital executives from New York and two from New Jersey. Those from New York included a male hospital administrator, a female hospital food service director and a female chief dietitian from a hospital-based nursing home. They were contacted by phone; and were mailed the questionnaire. Those from New Jersey consisted of a female chief of nutrition and food service and a clinical nutrition manager from the same federal government hospital. They were contacted in person and handed the questionnaire.

A cover letter accompanied the questionnaire, explaining the purpose of the study; and requested the participant to provide feedback about the format, clarity, and meaning of each item in the instrument.

Generally, the participants understood the questionnaire and were able to answer the questions without many problems. Much of the feedback centered on clarifying the

wording of certain statements and terms and the redundancy of certain questions/statements, especially regarding the stakeholders and leadership skills. Three of the respondents suggested that the choice of personal traits and executive skills (Section QC1) that a future associate hospital administrator should have and the number of departments that would best provide the experiences and training relevant to becoming an administrator (Section QC5) be limited to four only. Four out of five mentioned that while it was not mandatory to offer the $500 raffle, it was a good incentive for responding. The average time it took to complete the questionnaire was about 40 minutes.

The pilot-tested questionnaire was given a final review by the nutrition behavior researcher and statistician. It was modified further for clarity of question format and ease of coding.

Data Collection

Salant and Dillman's (1994) method for conducting mailed surveys was basically followed for collecting data in this study. After preparing the labels for each name of the seven hundred sixty-seven potential participants, sets of questionnaires were coded and mailed. A set consisted of a letter of introduction from the Coordinator of the Program in Nutrition Education (Appendix C), a cover letter (Appendix D), a coded questionnaire for the hospital administrator/director (Appendix A) or for the food service director (Appendix B), and a self-addressed stamped return envelope. The letter from the Program Coordinator in Nutrition Education introduced the study and the questionnaire. The cover letter was intended to briefly describe the nature of the study, the importance of

completing the questionnaire, and to motivate the hospital administrators and food service directors to respond by introducing the $500 raffle.

Questionnaire sets were mailed first to Connecticut on May 6, 2002. Those for New Jersey was mailed on May 17, 2002. Finally, the first half of those for New York were mailed on June 5, 2002; and the final half on June 17, 2002.

Ten days after the initial mailing for each batch, the non-respondents were sent a postcard (Appendix E), to thank those who might have just returned the questionnaire and to remind those who had not to do so. Another questionnaire set was mailed to those who had not responded to the postcard three weeks after the initial mailing. Follow-up calls were also made at this time to those with valid listed phone numbers with area code " 973" in New Jersey. Around four weeks later, another follow-up post card was mailed to remind those who still have not responded. The time intervals between each mailing were modified to be longer than what Salant and Dillman suggested. This was to allow the participants more time to answer the questionnaire and to make them not feel that they were being hurried.

Unopened questionnaire sets returned by the Post Office back to the office of the secretary of the Coordinator of the Program in Nutrition Education were followed up by calling the hospital for the names of the current hospital administrator and food service director. Whenever possible, another set of the questionnaire was mailed. The follow-up process of sending postcard reminders and questionnaire replacement was also initiated.

Returned questionnaires were also examined for completeness. Sections of the questionnaires that were left unanswered, perhaps due to oversight, were copied and sent back to the respondent with a cover letter requesting completion (Appendix F) and a self-

addressed stamped envelope. By the end of August, 2002, no more questionnaires were received except for only one in December 3, 2002. The $500 cash raffle was conducted on December 14, 2002 at the researcher's office in the Veterans Administration Medical Center in East Orange, New Jersey.

Many of the suggestions of Salant and Dillman for a higher response rate were followed. All letters were personalized and signed by the researcher. To make the mail look more important and get through the postal system faster, first class postage was used. The stationary and envelopes used the letterhead of the department, college and university to increase credibility. In lieu of a prepaid financial incentive and an additional telephone call or two-day priority mail contact for achieving highest response rate, inclusion in a $500 raffle and an additional second post card reminder were used to increase the response rate.

Methods of Data Analysis

Data from the questionnaire were coded and analyzed via computer- aided analysis. Version 10 of the statistical software application called Statistical Package for the Social Sciences (SPSS) was used. All the questionnaire items were analyzed using descriptive statistics, frequency distribution, cross tabulation or statistical inferences. Each scale or construct representing the participant's beliefs and values about his organization and his role in it (the importance of organizational goals and stakeholders, characteristics of executives, and executive skills, leadership skills, and his ability to balance work and non-work-related activities were analyzed for Cronbach's internal

consistency reliability coefficients. Mean scores and variance for the same factors per questionnaire item were also calculated.

Frequency distributions were used to describe the considerations for hiring the associate or assistant hospital administrator; the number of; the age when the first child was borne; questions on desire for career advancement; and some of the demographic data. The general linear model was used to study the data on importance of organizational goals and stake holders and characteristics and skills of executives, leadership skills, and balancing work non-work related activities and child-rearing responsibilities data.

The general linear model –multivariate procedure consists of tests (Pillai's Trace, Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root) which examine whether there are differences among the dependent variables simultaneously. Multivariate Analysis of Variance (MANOVA) is designed to test for main effects and interaction. For the purpose of this study, the general linear model results are reported using Wilks' Lambda

Cross tabulations were used on the rest of the data. Chi-square was utilized to determine any significant difference between groups by position or gender whenever appropriate.

CHAPTER IV

RESULTS

The study reported here was designed to examine the possible barriers to the promotion of food service directors to higher administrative positions in hospital organizations as perceived by the food service directors themselves and the hospital administrators. A self-administered questionnaire on executive leadership was mailed to food service directors and hospital administrators in the tri-state area: Connecticut, New Jersey and New York. The results of the study are presented in this chapter in six sections as follows:

1. Description of the flow chart showing the mailing and return of questionnaires, post card reminders, replacement questionnaires, undeliverable questionnaires, response rates, and invalid questionnaires.
2. Descriptive statistics for the "self" factors: Cross tabulations and frequency analyses were performed to determine the distribution of study participants on each of the demographic variables related to 'self" factors and position. Where cross tabulations were done, chi-square analysis was also determined whenever appropriate.
3. Descriptive statistics for the "work" factors: These showed how the male and

female food service directors and hospital administrators value the importance of organizational goals, importance of stakeholders, characteristics of managers, executive skills and leadership skills. Means and standard deviations were calculated for each scale of the five variables.

Relationships between each of the five variables: importance of organizational goals, importance of stakeholders, characteristics of managers, executive skills, and leadership skills and position (food service directors and hospital administrators), gender (male and female food service directors and male and female hospital administrators), and/or the interaction of gender and position. The general linear model was used where multivariate tests determined any significant relationship between any of the five main groups of variables and the position, gender, and interaction of position and gender. Where the multivariate tests were significant, between subjects effect test was done to determine the specific variable within the five main groups would be causing the significant interaction.

4. Descriptive statistics for "family" factors: These showed how the male and female food service directors and hospital administrators compare when balancing work and non-work related activities, balancing work and child-rearing responsibilities, and with regard their number of children, ages of children, and spouse's or partner's employment status and work location.

Relationships between each of the variables on balancing work and non-work related activities and balancing work and child-rearing responsibilities and positions, gender, and the interaction of position and gender were also determined using the general linear model described earlier.

5. Descriptive statistics for considerations when hiring top hospital administrators: Cross tabulations and chi-square analysis of qualifying managerial characteristics and executive skills were done to determine the level of importance of each managerial characteristic and executive skill to the positions and gender of the study participants. Frequency analyses were performed to determine the educational preparation, major fields, years of work experience as a department head or similar management level and the four departments that would offer the best experiences for promotion to assistant/associate hospital administrator. The general linear analysis was also used to analyze the data on whether the study participants considered choosing associate/assistant hospital administrator candidates from their age and gender groups, and whether they would recruit from within or outside their organization.
6. Descriptive statistics for desire for career advancement: Frequency distributions and cross tabulations were done on the food service directors' desire to be a hospital administrator; acceptance of this position if offered now or 5 years from now; and their reasons for accepting the position. Likewise, frequency analyses were also done on how important the hospital administrators feel about accepting their present position and the reasons for their acceptance.

Questionnaires Mailed and Returned

Figure 1 shows how the questionnaire distribution method of Salant and Dillman was applied in this study. There were a total of 767 questionnaires that were mailed out to the food service directors and hospital administrators in Connecticut, New

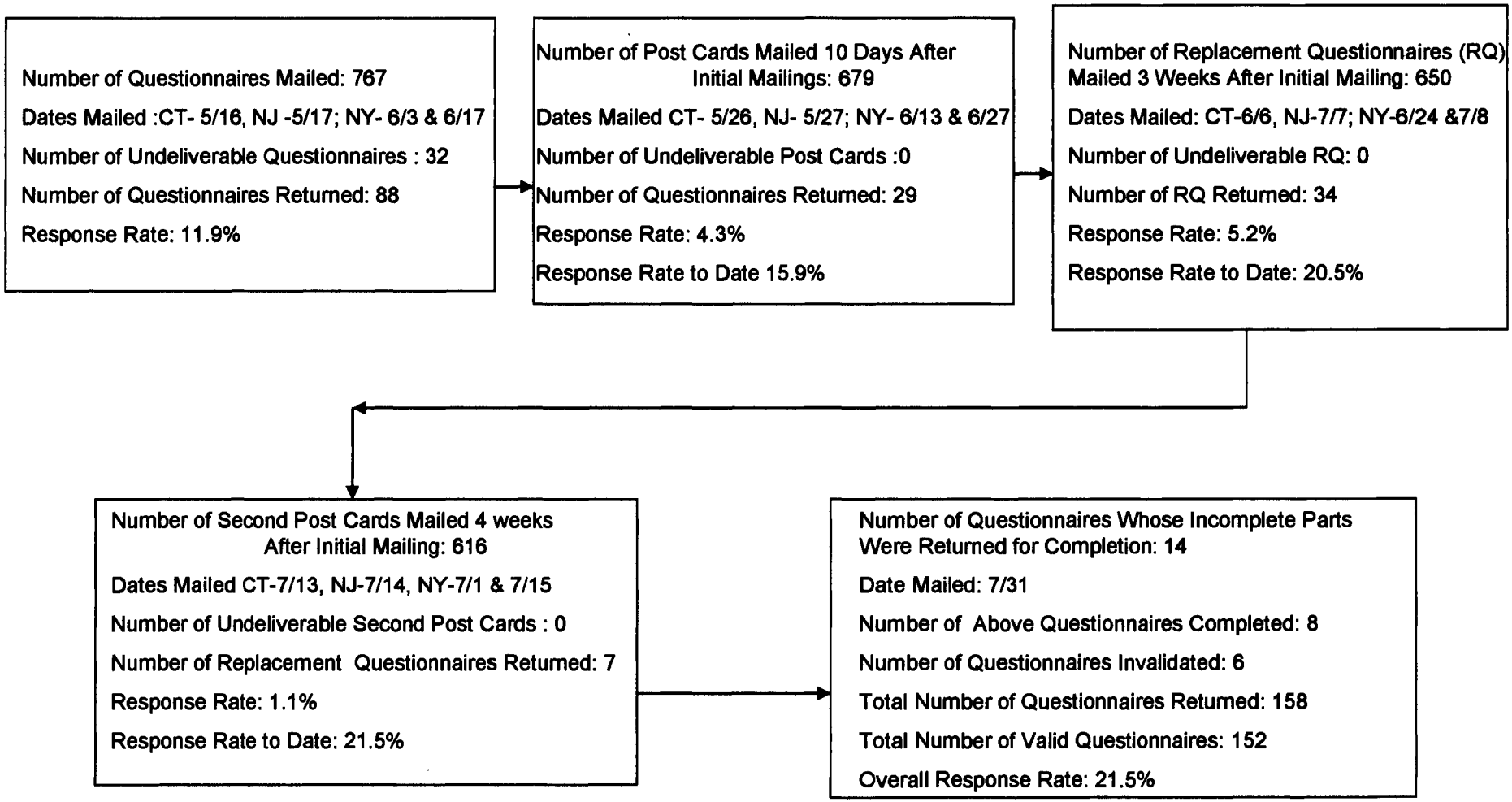


Figure 1 . Flow Chart of Mailings & Return of Questionnaires

Jersey, and New York in batches at different dates from May 17, 2002 to June 17, 2002. Post card reminders were mailed after the initial mailing of questionnaires and after the mailing of the replacement questionnaires. Response rate was biggest after the initial mailing of the questionnaires; and lowest after the mailing of the second post card reminder. Returned questionnaires were checked off against the list of study participants. There were 32 questionnaires which the Post Office labeled "undeliverable" and returned to sender. There were also 14 questionnaires with uncompleted parts that were copied and mailed back to the respondents for completion. Of these, 8 were completed and returned.

As shown on Table 9, there were 158 questionnaires that were returned, of which 152 were valid. Six questionnaires were deemed invalid. The overall response rate was 21.49%. The per cent of valid responses was 95.6%.

"Self" Factors

Of the 152 study participants, 105 were food service directors and 47 hospital administrators (Table 10). 53 percent (81) of them were females while 47 percent (71) were males. Most of the study participants were from New York (63%) while the smallest group was from Connecticut (15%).

Cross tabulations and frequency analyses were performed to determine the distributions of study participants on each of the demographic variables related to "self" factors. Where cross tabulations were done, chi-square analysis was also determined whenever appropriate. The grouped frequency distribution of the "self" factors-related demographic variables is shown in Table 11.

Table 9
Questionnaire Response Rate & Percent of Valid Responses

	Food Service Director	Hospital Administrator	Total
	N	N	N
Number of Questionnaires Mailed	399	368	767
Number of Questionnaires Undelivered by Post Office	17	15	32
Number of Questionnaires	108	50	158
Response Valid	105	47	152
Response Invalid [a]	3	3	6
Questionnaire Response Rate [b]	28.27%	14.16%	21.49%
Per Cent of Valid Responses [c]	97.2%	94.0%	95.6%

a Responses were categorized as invalid when more than 1/3 of questions were missed.
b Questionnaire response rate = (number of questionnaires returned) / (number of questionnaires mailed - number of questionnaires undeliverable)
c Percent of valid responses = (number of responses valid) / (number of questionnaires returned)

Table 10
Distribution of Subjects by State, Position and Gender

Gender	Connecticut		New Jersey		New York		Total	
	FSD*	HA**	FSD	HA	FSD	HA	FSD	HA
Male	43% (6)	63% (5)	40% (8)	50% (7)	39% (28)	68% (17)	40% (42)	62% (29)
Female	57% (8)	37% (3)	60% (12)	50% (7)	61% (43)	32% (8)	60% (63)	38% (18)
Total	100% (14)	100% (8)	100% (20)	100% (14)	100% (71)	100% (25)	100% (105)	100% (47)

* FSD = Food Service Director
** HA = Hospital Administrator

Table 11
Grouped Frequency Distribution for Demographic Variables

Variables	Food Service Directors (105) N	%	Hospital Administrators (47) N	%	Whole Sample (152) N	%	X^2	(df)	p value
Years at current place of employment:							129.656	(25)	0.000***
0 - 5 years	49	48.5%	22	51.2%	71	49.3%			
6 - 10 years	18	17.8%	9	20.9%	27	18.8%			
11 - 15 years	19	18.8%	5	11.6%	24	16.7%			
16 - 20 years	6	5.9%	3	7.0%	9	6.2%			
21 - 25 years	4	4.0%	1	2.3%	5	3.5%			
26 - 30 years	4	4.0%	3	7.0%	7	4.8%			
31 & > years	1	1.0%	0	0.0%	1	0.7%			
Type of Hospital:							11.853	(4)	0.018*
Community Hospital	38	37.3%	30	65.2%	68	45.9%			
Medical Center	30	29.4%	7	15.2%	37	25.0%			
Speciality Hospital	15	14.7%	6	13.0%	21	14.2%			
Osteopathic Hospital	0	0.0%	0	0.0%	0	0.0%			
Religious Hospital	6	5.9%	3	6.5%	6	4.1%			
Others	13	12.7%	3	6.5%	16	10.8%			

* $p < .05$
** $p < .01$
*** $p < .001$

Table 11 Continued
Grouped Frequency Distribution for Demographic Variables

	Food Service Directors (105)		Hospital Administrators (47)		Whole Sample (152)		X^2	(df)	p value
Variables	N	%	N	%	N	%			
Licensed Number of In-patient beds							110.645	(101)	0.240
0 -100 beds	17	17.3%	6	15.4%	23	16.8%			
101 - 200 beds	27	27.6%	6	15.4%	33	24.1%			
201 - 300 beds	22	22.4%	12	30.7%	34	24.8%			
301 - 400 beds	14	14.3%	8	20.5%	22	16.1%			
401 - 500 beds	4	4.1%	3	7.7%	7	5.1%			
501 - 600 beds	5	5.1%	1	2.6%	6	4.4%			
601 - 700 beds	4	4.1%	2	5.1%	6	4.4%			
701 - 800 beds	2	2.0%	0	0.0%	2	1.4%			
801 - 900 beds	3	3.1%	1	2.6%	4	2.9%			
Gender:							6.143	(1)	0.013*
Male	41	40.6%	29	63.0%	70	47.6%			
Female	60	59.4%	17	37.0%	77	52.4%			
Ethnicity:							1.796	(5)	0.877
African-American	6	5.9%	1	2.2%	7	4.8%			
Asian	1	1.0%	1	2.2%	2	1.4%			
Hispanic	3	2.9%	1	2.2%	4	2.7%			
Native American	2	2.0%	1	2.2%	3	2.0%			
White	89	87.2%	41	91.2%	130	88.4%			
Others	1	1.0%	0	0.0%	1	0.7%			
Age:							6.188	(4)	0.186
30 years & below	7	6.9%	1	2.2%	8	7.5%			
31 - 40 years	13	12.9%	3	6.5%	16	10.9%			
41 - 50 years	55	54.5%	25	54.3%	80	54.4%			
51 - 60 years	23	22.8%	17	37.0%	40	27.2%			
61 years & older	3	2.9%	0	0.0%	3	1.4%			

* $p < .05$

Table 11 Continued

Grouped Frequency Distribution for Demographic Variables

Variables	Food Service Directors (105) N	%	Hospital Administrators (47) N	%	Whole Sample (152) N	%	X^2	(df)	p value
Education:							0.650	(3)	0.885
Associate Degree	36	34.2%	10	21.3%	46	30.3%			
Bachelors Degree	82	78.1%	32	68.1%	114	75.0%			
Masters Degree	40	38.1%	38	80.8%	78	51.3%			
Doctoral Degree	3	2.9%	2	4.3%	5	3.3%			
Others	11	10.5%	7	14.9%	18	11.8%			
Marital Status:							2.853	(4)	0.583
Never Married	14	13.7%	5	10.9%	19	12.8%			
Married	67	65.7%	30	65.2%	97	65.5%			
Remarried	15	14.7%	6	13.0%	21	14.2%			
Divorced	6	5.9%	4	8.7%	10	6.8%			
Separated	0	0.0%	1	2.2%	1	0.7%			
Widowed	0	0.0%	0	0.0%	0	0.0%			
Annual Salary:							48.065	(5)	.000***
Less than $75,000	64	63.4%	16	35.5%	80	54.7%			
$76 - 100,000	29	28.7%	4	8.9%	33	22.6%			
$101 - 125,000	7	6.9%	8	17.8%	15	10.3%			
$126 - 150,000	1	1.0%	5	11.1%	6	4.1%			
$151 - 175,000	0	0.0%	3	6.7%	3	2.1%			
$176 - 200,000	0	0.0%	9	20.0%	9	6.2%			
Over $201,000	0	0.0%	0	0.0%	0	0.0%			
Spouse's/ Partner's Employment Status							13.503	(2)	0.001**
Full time, outside home	63	77.8%	18	50.0%	81	69.2%			
Part time, outside home	11	13.6%	5	13.9%	16	13.7%			
Inside home, only	7	8.6%	13	36.1%	20	17.1%			
Membership in a religious order							0.062	(1)	0.803
Yes	3	2.9%	1	2.2%	4	2.7%			
No	101	97.1%	45	97.8%	146	97.3%			

* $p < .05$; **$p<.01$; ***$p<.001$

Gender

There were more female respondents (52.4%) than males (47.6%) as mentioned earlier. By position, there were more female food service directors (59.4%) and male hospital administrators (63.0%). A significant association between position and gender ($p<.05$) was determined by chi-square analysis.

Ethnicity

As a group, 88.4% of the hospital executives in this study are whites. The food service directors are primarily whites (87.2%), too. Only 5.9% of them are blacks, followed by Asians (2.7%). The smallest minority group consists of the "Others" (.7%) who is a Caribbean Black,

Among the hospital administrators, there is no question about the majority being whites (91.2%) and the rest of the group is equally (2.2%) represented by each of the minority ethnic groups.

Age

Slightly over half (54.4%) of the hospital executives in this research are in the 41 to 50 year old age group. This is also true when looking at the food service directors (54.5%) separately from the hospital administrators (54.3%). The second biggest number of hospital executives is in the 51 to 60 years age group, with 22.8% of the food service directors and 37.0% of the hospital administrators belong to this age group. Only 6.9% of the food service directors and 7.5% of the hospital administrators are in the 30 year old or younger age bracket.

Education

Most (75%) of the hospital executives finished their bachelor degree: 78.1% of the food service directors and 75% of the hospital administrators. Compared to 38.1% of the food service directors, 80.8% of the hospital administrators are masters-prepared. This accounts for the mean of 51.3% of both positions having a master degree. Only 3.3% of both groups combined have a doctorate degree.

Marital Status

About 65 % of each group are married and busy juggling their work and family responsibilities. Only 12.8% never married, with more of the food service directors (13.7%) compared to the hospital administrators (10.9%). There are more divorced (8.7%) and separated (2.2%) hospital administrators compared to divorced (5.9%) and no separated food service directors.

"Work" Factors

This study examined "work" factors that include work-related demographics (years at current place of employment, type of hospital, licensed number of in-patient beds, annual salary, and membership in a religious order), importance of organizational goals and stakeholders, executive characteristics, executive skills, and leadership skills.

Years at Current Place of Employment

Table 11 shows most of the food service directors (48.5%) and hospital administrators (51.2%) have been in their current place of employment between 0-5 years; followed by food service directors who have been with the same place of

employment for 11 to 15 years and hospital administrators who have been in the same place of employment for 6 to 10 years. Four percent of the food service directors and 3 % of the hospital administrators have been in their present place of employment for 26 to 30 years. Chi-square analysis showed a highly significant association between positions and years at current place of employment ($p<.001$).

Type of Hospital

Community hospitals are the health care facilities where most of the study participants are connected with: food service directors (37.3%) and hospital administrators (65.2%). This is followed by 29.4% of the food service directors and 15.2% of the hospital administrators being employed in medical centers. None of the participants came from osteopathic hospitals. Those (12.7%) who claimed to be working in "other" hospitals are referring to long term care and/or psychiatric facilities. There is a significant association between the participants' position and the type of hospital where they work ($p<.05$), meaning that more hospital administrators and food service directors work in community hospitals.

Licensed Number of In-patient Beds

The mean number of in-patient beds is 271. Overall, 24.8% of the study participants work in places where the licensed number of in-patients ranged from 201 to 300. However, majority of the food service directors are in facilities with about 101 to 200 beds. A few of them (3.1%) and 2.6% of the hospital administrators are in hospitals which have 801 to 900 in-patient beds. The result of the chi-square analysis between licensed number of in-patient beds and positions is also shown on Table 11.

Salary

In this study, 35.5% of the hospital administrators earn less than $75, 000 annually followed by 20% with an annual income between $176, 000 to $200,000. Mean time, about 63.4% of the food service directors earn less than $75, 000 annually, followed by 28.7% of them earning from $76,000 to $100, 000 per year. The highest annual income surveyed for the food service directors is between $126, 0000 to $150, 000 (1%) while that of hospital administrators is between $176-200,000 (20%)

Chi-square analysis results show a highly significant association between salary and position ($p<.001$).

Membership in a Religious Order

Only 2.7% of the study participants are members of a religious order: 2.9% of the food service directors and 2.2% of the hospital administrators.

Importance of Organizational Goals

The list of possible goals (QA1a-j) for the hospital organization varies from "high productivity" to "organization value to society". Their mean scores by position and gender are shown on Table 12. Both groups, by gender and position, rated most of the organizational goals between "Important" (4) and "Very Important" (5). "Profit Maximization" is the only organizational goal that was rated between "Somewhat Important" (3) and "Important" (4).

"High employee morale" is valued most by the food service directors (4.72) and hospital administrators alike (4.75). Additionally, the hospital administrators equally

Table 12
Importance of Organizational Goals

Organizational Goals	Food Service Director						Hospital Administrator					
	Male (42)		Female (62)		Total (104)		Male (29)		Female (18)		Total (47)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
High Productivity	4.45	0.59	4.60	0.61	4.54	0.61	4.56	0.57	4.50	0.62	4.53	0.58
High Employee Morale	4.69	0.47	4.74	0.48	4.72	1.47	4.72	0.53	4.78	0.43	4.75	0.49
Efficiency	4.55	0.59	4.61	0.55	4.59	0.57	4.66	0.48	4.33	0.84	4.53	0.65
Effectiveness	4.58	0.54	4.73	0.49	4.67	0.57	4.72	0.46	4.67	0.49	4.70	0.46
Industry Leadership	3.93	0.99	4.16	0.83	4.07	0.91	3.97	0.82	3.94	0.87	3.96	0.83
Organizational Growth	4.07	0.89	4.24	0.74	4.17	0.81	4.17	0.76	4.22	1.81	4.19	0.77
Profit Maximization	3.88	1.15	3.79	1.13	3.83	1.14	3.97	1.21	4.17	0.79	4.04	1.06
Organizational Stability	4.62	0.54	4.45	0.67	4.52	0.62	4.49	0.63	4.33	0.84	4.49	0.72
Organization's Reputation	4.67	0.53	4.69	0.59	4.68	0.56	4.69	0.54	4.83	0.38	4.75	0.49
Organization Value to Society	4.43	0.70	4.50	0.67	4.47	0.68	4.55	0.63	4.56	0.71	4.55	0.65
Average of above Mean Score of Importance of Ten Organizational Goals	4.39	0.70	4.45	0.68	4.43	0.79	4.45	0.65	4.43	0.71	4.45	0.67

Note. Importance of Organizational Goals were scored on five point Likert-type scales with response options ranging from 1 ("Not at all Important") to 5 ("Very Important").

valued most "Organization's reputation" (4.75). "High employee morale" is also the most valued goal by both males and females regardless of position.

The multivariate test results of the general linear model show no significant difference in how male and female food service directors and hospital administrators value the importance of any of the ten organizational goals.

Importance of Various Stakeholders

Stakeholders are those groups of people who may influence or have a vested interest in an organization or institution. In a healthcare facility, the stakeholders may include not only the patients and different groups of employees (departmental managers, co-workers, professional employees, white collar employees, craftsmen, etc.) but also the general public, elected public officials and regulatory agencies.

Table 13 shows the means and standard deviations of scores illustrating the importance of stakeholders (QA2a-l) in a hospital organization as perceived by the male and female food service directors and hospital administrators. The ratings varied from "Somewhat important" (3) to "Very important" (5). Both positions (4.94) and genders (4.94) agreed that the patients are the most important stakeholders since they are the customers. The hospital administrators gave the same rating (4.94) to the departmental managers since the success of the hospital is highly dependent on the performance of each manager and his/her department. On the other hand, the elected public officials were chosen to be the least important stakeholders by both positions (3.38) and genders (3.40) as they do not directly impact the funding or revenues earned by the healthcare facility.

Table 13
Importance of Stakeholders

Stakeholders	Food Service Director						Hospital Administrator					
	Male (39)		Female (56)		Total (95)		Male (28)		Female (17)		Total (45)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Patients	4.92	0.27	4.88	0.47	4.90	0.40	5.00	0.00	4.94	0.24	4.98	0.15
Departmental Managers	4.08	0.74	4.23	0.60	**4.17****	0.66	4.61	0.50	4.94	0.62	**4.56****	0.55
My Co-Workers	4.69	0.52	4.64	0.55	4.66	0.54	4.61	0.50	4.47	0.51	4.58	0.50
Professional Employees	4.13	0.70	4.25	0.48	**4.20***	0.63	4.46	0.58	4.53	0.71	**4.44****	0.62
White Collar Employees	3.77	0.87	4.16	0.68	**4.00***	0.79	4.39	0.63	4.41	0.73	**4.31***	0.67
Craftsmen	3.97	0.67	4.11	0.71	4.05	0.69	4.14	0.93	4.18	0.83	4.11	0.89
My Supervisors	4.23	0.87	4.30	0.76	4.27	0.81	4.43	0.57	4.06	0.80	4.44	0.66
My Subordinates	4.74	0.44	4.75	0.44	4.75	0.44	4.75	0.44	4.16	0.56	4.75	0.48
Myself	4.51	0.60	4.46	0.74	4.48	0.68	4.43	0.74	4.47	0.51	4.44	0.66
Elected Public Officials	3.13	1.13	3.20	0.92	**3.17****	1.01	3.40	1.83	3.88	0.86	**3.58****	0.87
Regulatory Agency Bureaucrats	3.49	1.23	3.59	1.09	3.55	1.15	3.54	0.69	4.00	0.94	3.71	0.82
The General Public	4.28	0.76	4.00	0.93	4.12	0.87	4.39	0.83	4.41	0.80	4.40	0.81
Average of above Mean Scores of Importance of Twelve Stakeholders	4.16	0.73	4.21	0.70	4.19	0.74	4.35	0.69	4.37	0.68	4.36	0.64

Note. Importance of Stakeholders were scored on five point Likert-type scales with response options ranging from 1 ("Not at all Important") to 5 ("Very Important").
*p<.05; **p<.01

Hospital administrators usually deal with all the stakeholders being studied here more than the food service directors. It is then expected that the mean score hospital administrators have for all the stakeholders is higher (4.36) than that of the food service directors (4.19). The females (4.29) for both positions generally rated the importance of stakeholders higher than the males (4.26) for both positions.

In spite of all the stakeholders being considered important by the food service directors and hospital administrators, results of the multivariate analysis of the general linear model show that the overall aggregate effect of position was significant, Wilks' Lambda (Λ)=.84, F=2.04 (1,139), ($p<.05$), with hospital administrators rating stakeholders higher. There was no effect of gender, Λ=.95, F=.59 (1,139), p=.84. The test for an interaction between position and gender was also not significant (p=.23).

A further test of between subjects effect of position on importance of stakeholders determined that food service directors and hospital administrators vary significantly in their judgment of the importance of four stakeholders: department managers [F=10.85 (1,139), p=.001], professional employees [F=4.5 (1,139), p=.035], white collar employees [F=5.4 (1,139), p=.021], and elected public officials [F=7.086 (1,139), p=.009].

The significant difference in the effect of position on the importance of the above 4 stakeholders is also reflected on Table 13, where the mean scores for each position and for these stakeholders are in bold print and italics. This is also illustrated in Figure 2.

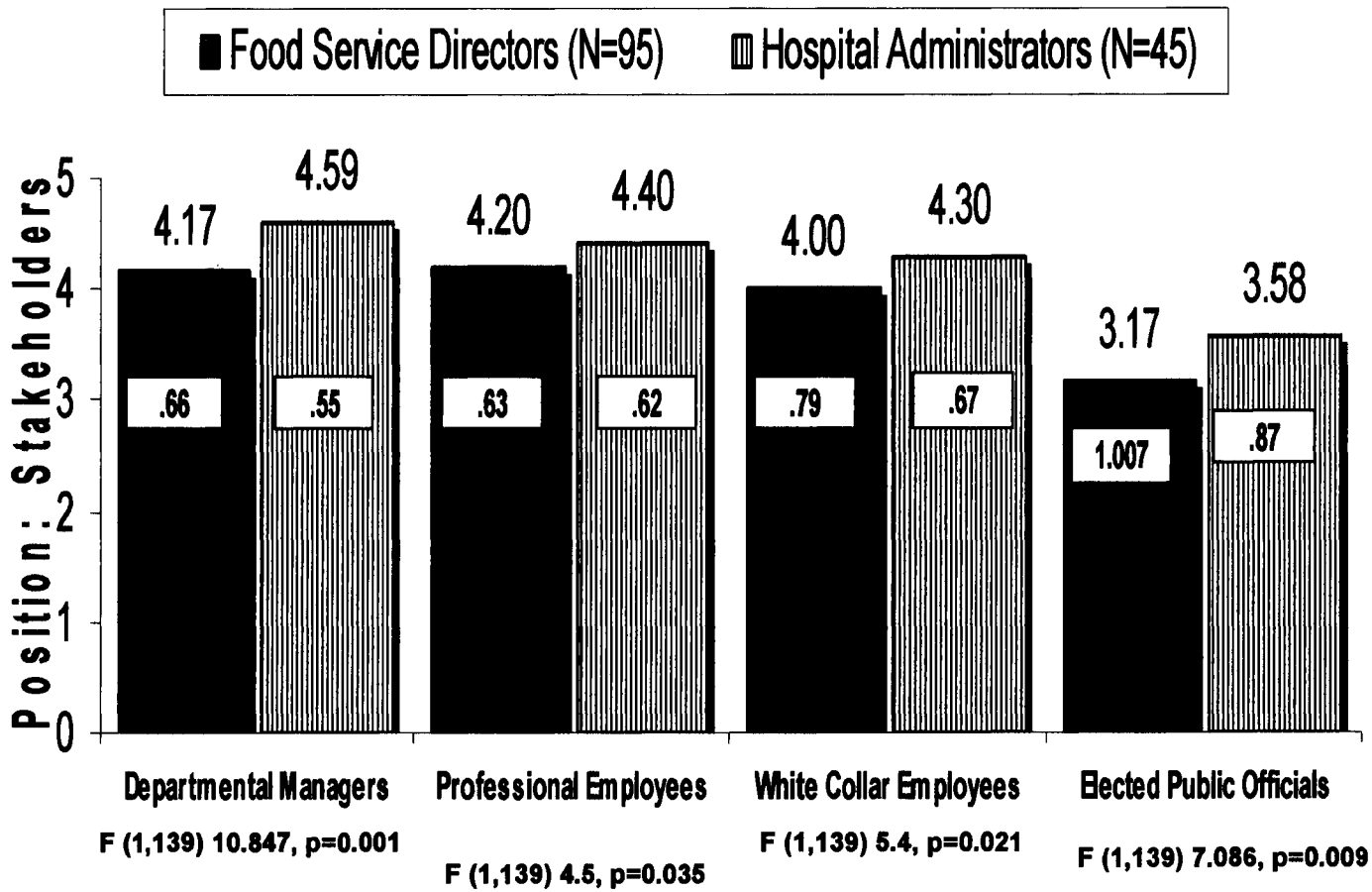


Figure 2. Effect of Position on Importance of Stakeholders

Characteristics of Executives

There are fourteen characteristics (QA3a-n) that are potentially important for executives. Some of them are: high ability, ambitious, flexible, connected to others, and creative. Table 14 shows the mean scores of the importance of these characteristics to both female and male food service directors and hospital administrators. The average of the mean scores for the importance of the 14 characteristics is 4.35 for both positions and genders. Food service directors rated being "cooperative" highest (4.73) while hospital administrators ranked highest (4.72) the characteristic "connected to others". The scores given ranged from "Important" (4) to "Very important (5). Those characteristics that have been rated lowest by both positions and genders include "competitive" and "academic credentials", which were rated between "Somewhat important" (3) and "Important" (4).

The results of the multivariate test results of the general linear model show that gender had a significant overall effect on the importance of executive characteristics, Wilks' Lambda, (Λ) = .84, F= 1.80 (1, 150), ($p<.05$). This means that male and female food service directors and hospital administrators vary significantly ($p<.05$) in their regard of the importance of executive characteristics. Position had no effect on the importance of stakeholders, Λ = .89, F= 1.16 (1,150), p=.311. There was also no interaction effect of position and gender (p=.066).

Results of tests of between subjects effect of gender on the importance of executive characteristics show significance for academic credentials [F=5.176 (1,150), p=.024 and marginal significance for willing to mentor [F (1,150) = 3.869, p=.051]. This means that female food service directors and hospital administrators consider these two executive

Table 14
Importance of Executive Characteristics

Executive Characteristics	Food Service Director						Hospital Administrator					
	Male (42)		Female (62)		Total (104)		Male (29)		Female (18)		Total (47)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
High Ability	4.55	0.59	4.55	0.53	4.55	0.56	4.66	0.48	4.56	0.62	4.62	0.53
Ambitious	4.24	0.79	4.00	0.79	4.10	0.80	4.03	0.78	4.33	0.59	4.15	0.72
Skillful	4.45	0.55	4.48	0.57	4.47	0.56	4.52	0.51	4.33	0.59	4.45	0.54
Cooperative	4.69	0.47	4.76	0.47	4.73	0.47	4.52	0.51	4.56	0.62	4.53	0.55
Achievement oriented	4.55	0.63	4.48	0.59	4.51	0.61	4.59	0.50	4.39	0.61	4.51	0.55
Satisfied with the job	4.24	0.69	4.36	0.60	4.31	0.64	4.14	0.69	4.28	0.83	4.19	0.74
Creative	4.38	0.58	4.34	0.60	4.36	0.59	4.52	0.51	4.56	0.78	4.53	0.62
Successful	4.21	0.78	4.18	0.69	4.19	0.73	4.28	0.59	4.00	0.69	4.17	0.64
Flexible	4.52	0.63	4.73	0.49	4.64	0.56	4.66	0.48	4.72	0.46	4.68	0.47
Competitive	3.88	0.92	3.57	0.92	3.69	0.93	3.79	0.73	3.89	0.83	3.83	0.76
Caring	4.71	0.46	4.57	0.59	4.63	0.54	4.66	0.55	4.67	0.49	4.67	0.52
Connected to others	4.55	0.55	4.77	0.42	4.68	0.49	4.76	0.44	4.67	0.49	4.72	0.45
Willing to mentor	**4.29***	0.71	**4.36***	0.68	4.33	0.69	**4.07***	0.75	**4.50***	0.71	4.23	0.76
Academic credentials	**3.50***	0.99	**3.94***	0.96	3.76	0.99	**3.48***	0.74	**3.78***	0.55	3.59	0.68
Average of above Mean Scores of Importance of Fourteen Executive Characteristics	4.34	0.67	4.36	0.64	4.35	0.65	4.33	0.59	4.38	0.59	4.35	0.61

Note. Importance of Executive Characteristics were scored on five point Likert-type scales with response options ranging from 1 ("Not at all Important") to 5 ("Very Important"). *p<.05

characteristics to be necessary and very important more so than their male counterparts, as shown italicized and in bold print with the corresponding mean scores for each gender group on Table 14. These findings are also noted on Figure 3.

Executive Skills

In managing the entire hospital organization, the hospital administrators make use of the ten executive skills (QA4a-j) studied here more frequently in a bigger scale. The food service directors may utilize these same skills as they apply to their nutrition and food service department. Some of the skills that they make limited use of include: facilitating positive medical staff relations unless this relate to the functions of the clinical dietitians (For example, having the clinical dietitian join medical ward rounds and service audits or case presentations with emphasis on the nutritional management of patients.); facilitating positive board relations; and having a total organizational view. All these may explain that as a group, the hospital administrators' average of the mean scores for the executive skills is higher (4.55) than that of the food service directors' (4.39), as shown on Table 15. Interestingly, the females (4.51) for both positions valued these executive skills more than the males (4.43) for both positions.

Both food service directors (4.73, 3.80)) and hospital administrators (4.85, 4.35) have rated "Leadership" highest in importance and "Facilitating positive board relations" lowest in importance respectively. "Human management skills" were most important to male food service directors (4.83) and female hospital administrators (4.89) while "Having a total organizational view" was most important to male hospital administrators (4.75) and "leadership to female food service directors "(4.75). The males of both

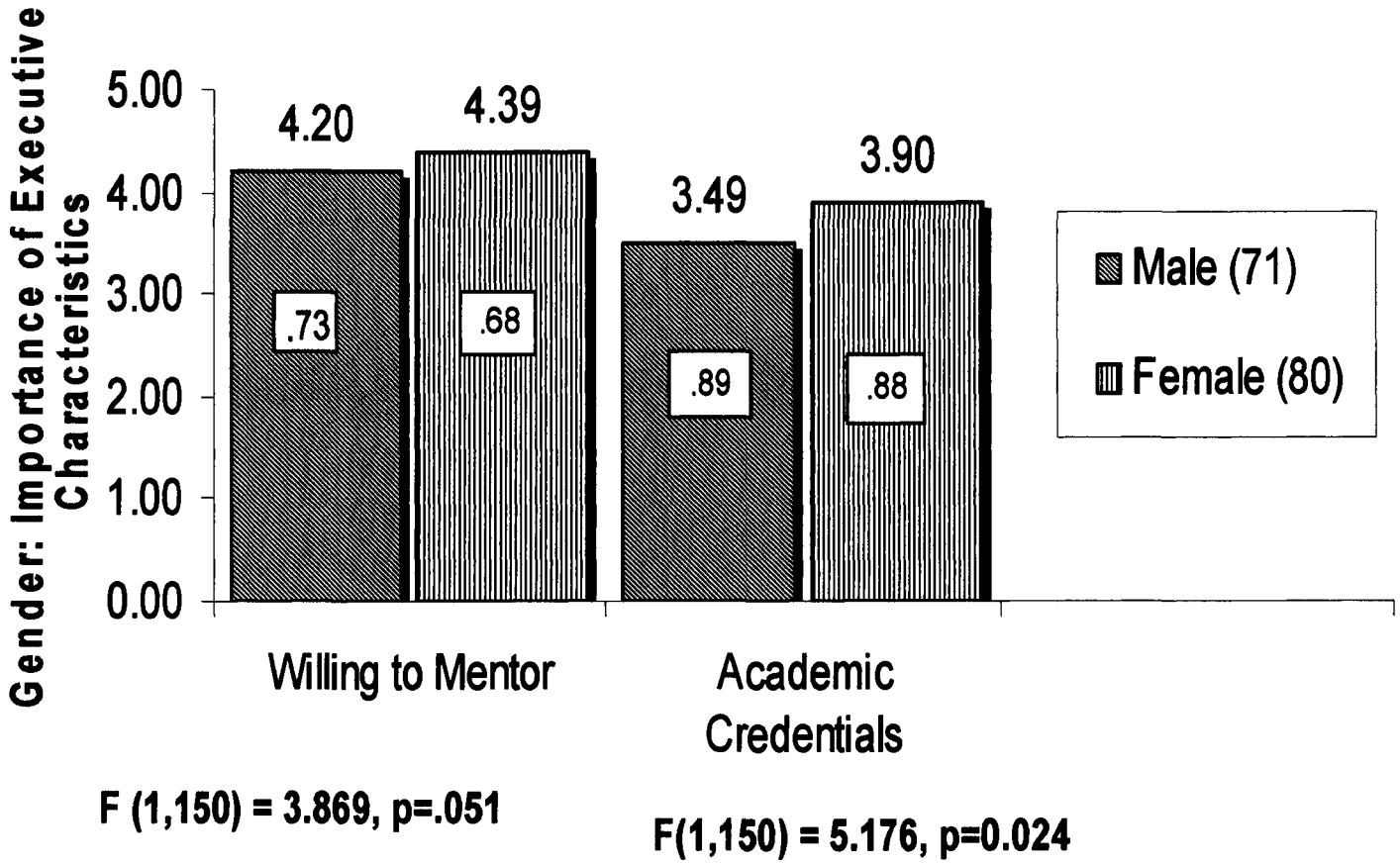


Figure 3. Effect of Gender on Importance of Executive Characteristics

Table 15
Importance of Executive Skills

Executive Skills	Food Service Director						Hospital Administrator					
	Male (42)		Female (61)		Total (103)		Male (28)		Female (18)		Total (46)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
General Management Knowledge	4.60	0.50	4.59	0.56	4.59	0.53	4.57	0.57	4.5	0.51	4.54	0.55
Fiscal Management Skills	4.48	0.59	4.54	0.57	4.52	0.58	4.50	0.58	4.56	0.62	4.52	0.59
Human Management Skills	4.83	0.38	4.93	0.25	4.89	0.31	4.68	0.48	4.89	0.32	4.76	0.43
Negotiation/ Compromise/ Conflict Resolution	4.62	0.49	4.72	0.49	**4.68***	0.49	4.46	0.51	4.50	0.62	**4.48***	0.55
Facilitating Positive Medical Staff Relations	4.02	0.87	4.07	0.93	**4.05****	0.90	4.32	0.72	4.61	0.50	**4.44****	0.66
Faciliating Positive Board Relations	3.81	0.97	3.79	0.97	**3.80****	0.96	4.36	0.73	4.38	0.59	**4.35****	0.67
Leadership	4.69	0.52	4.75	0.47	4.73	0.49	4.86	0.36	4.83	0.38	4.85	0.36
Political Savvy	3.76	0.88	3.85	0.93	**3.82****	0.91	4.25	0.70	4.50	0.62	**4.35****	0.67
Strategic Planning	4.17	0.73	4.36	0.73	4.28	0.73	4.36	0.78	4.50	0.62	4.41	0.72
Having a Total Organizational View	4.38	0.62	4.59	0.56	**4.51****	0.59	4.75	0.44	4.78	0.43	**4.76****	0.43
Average of above Mean Scores of Importance of Ten Executive Skills	4.34	0.66	4.42	0.65	4.39	0.65	4.51	0.59	4.60	0.52	4.55	0.56

Note. Importance of Executive Skills were scored on five point Likert-type scales with response options ranging from 1 ("Not at all Important") to 5 ("Very Important").
*p< .05; **p< .01; ***p< .001

positions rated "political savvy" lowest in importance (food service directors - 3.76, hospital administrators - 4.25). Females of both positions rated "Facilitating positive board relations" as the least important executive skill (food service director – 3.79, hospital administrators – 4.38).

There is also a very significant difference ($p<.001$) as to how important are executive skills to food service directors and hospital administrators. The multivariate analysis of the general linear model points out the highly significant effect of position on the importance of executive skills, Wilks' Lambda, (Λ) = .97, F= 3.99 (1, 144), ($p<.001$). No effect was shown for gender, Λ = .91, F= 1.34 (1,144), p= .21. There was also no interaction effect of position and gender on the importance of executive skills (p=.942).

Results of tests of between subjects effect of position on importance of executive skills and Figure 4 show that the two positions significantly vary when determining the importance of five executive skills: negotiations/compromise/conflict resolution [F=4.145 (1,144), p=.044), facilitating positive medical staff relations [F=7.755 (1,144), p=.006], facilitating positive board relations [F=11.466 (1,144), p=.001], political savvy [F=13.804, (1,144), p=.000], and having a total organizational view [F=7.944 (1,144), p=.005]. Table 15 shows these findings with the mean score of each position for the 5 executive skills in bold print and italics.

Leadership Skills

Twenty-one leadership skill statements (QB1-21) were designed to capture how those reporting directly to the food service directors and hospital administrators perceive

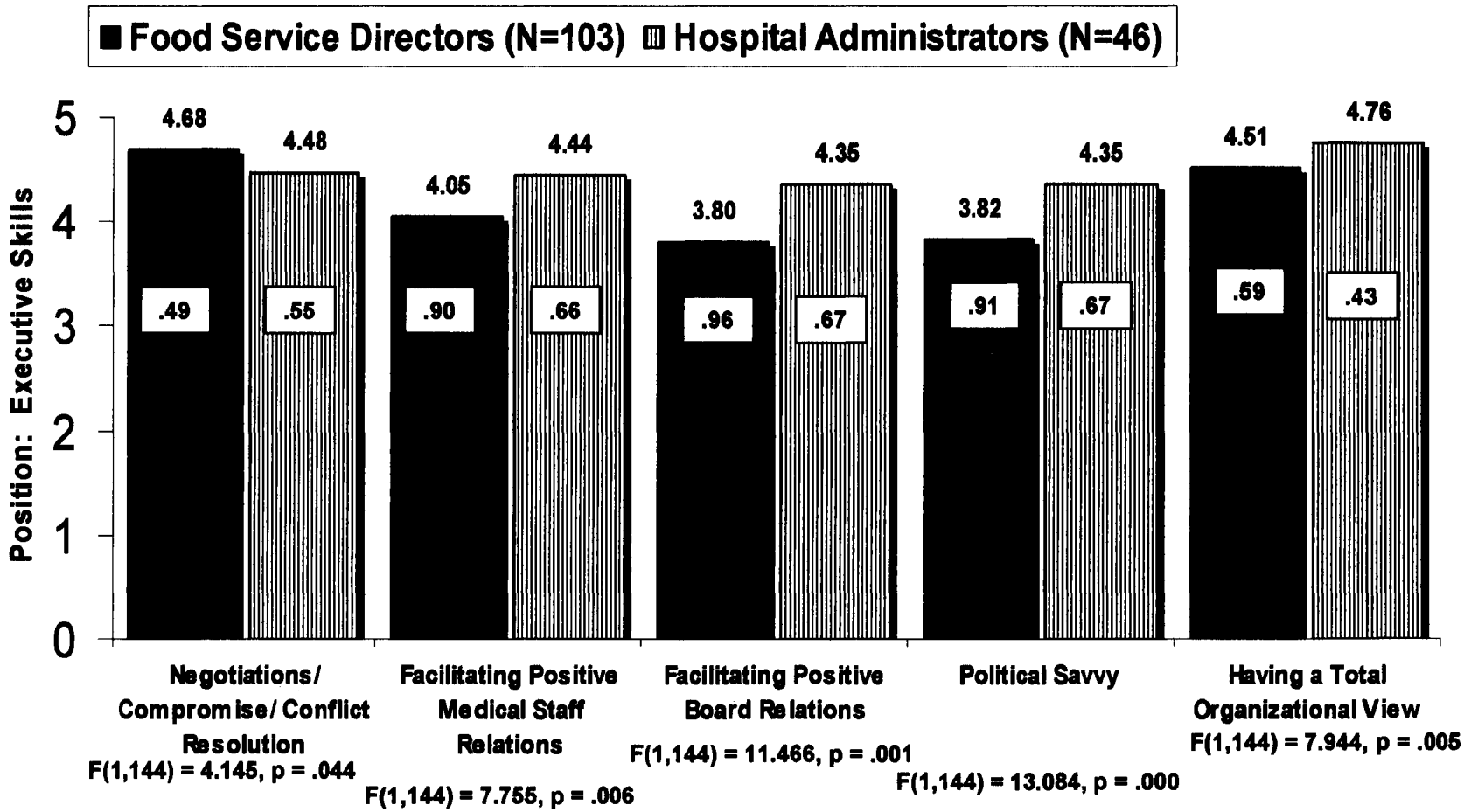


Figure 4. Effects of Position on Importance of Executive Skills

their leadership style: transformational or transactional. Charismatic leadership skills (QB1-5), individual consideration (QB6-10), and intellectual consideration (QB15-16) make up the transformational leadership style. Contingent reward (QB11-14) and management by exception (QB17-21) constitute the transactional leadership style.

The average of the mean scores of the 21 leadership skills, as shown on Table 16, indicates that food service directors and hospital administrators "show these skills "sometimes" to "often" (3.89). Female hospital administrators have practiced these leadership skills "often" to "almost always" more so than the female food service directors (4.02 vs. 3.84); while both male food service directors (3.94) and male hospital administrators (3.81) were noted to exhibit these skills "often" only.

It is very interesting to point out that both positions and gender "almost never" to "seldom" tell their employees only what they have to know to do their job (1.87-2.54). This implies that employees are told and trained more than what they have to know to do their job. For example, telling employees how their job relates to other jobs within and outside the department and the achievement of the goals of the department or hospital organization may motivate the employees to work better.

Hospital administrators (4.63), whether males (4.54) or females (4.8) "often" to "almost always" transmit the sense of mission to the employees. Food service directors (4.57) in general and the females (4.6) in this group usually express appreciation to employees for a job well done "often" to "almost always". Male food service directors (4.59) as a group tend to treat each of the employees as individuals "often" to "almost always".

Table 16
Leadership Skills

Leadership Skills	Food Service Director						Hospital Administrator					
	Male (41)		Female (57)		Total (98)		Male (28)		Female (15)		Total (43)	
Subordinates think -	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
You make everyone around you enthusiastic about assignments	3.80	0.56	3.88	0.73	3.85	0.66	3.82	0.67	4.13	0.52	3.93	0.63
You are a model for them to follow	4.17	0.67	4.35	0.55	4.28	0.61	4.29	0.71	4.73	0.46	4.44	0.67
You inspire loyality to the organization	4.41	0.67	4.30	0.65	4.35	0.66	4.50	0.64	4.60	0.51	4.53	0.59
You have a sense of mission that you transmit to them	4.54	0.64	4.30	0.65	4.40	0.65	4.54	0.64	4.80	0.41	4.63	0.58
You excite them with your visions of what can be accomplished working together	4.15	0.88	4.07	0.75	4.10	0.81	4.11	0.74	4.73	0.46	4.33	0.71
You give personal attention when they feel neglected	4.32	0.79	4.28	0.75	4.30	0.76	4.00	0.77	4.60	0.63	4.21	0.77
You find out what they want & help them get it	4.17	0.63	4.11	0.70	4.13	0.67	3.89	0.74	4.27	0.59	4.02	0.71
You express your appreciation when they do a good job	4.54	0.64	4.60	0.56	4.57	0.59	4.32	0.77	4.67	0.62	4.44	0.73
You treat each one of them as individuals	4.59	0.50	4.54	0.60	4.56	0.56	4.43	0.69	4.73	0.59	4.53	0.67

Table 16 (Continued)
Leadership Skills

Leadership Skills	Food Service Director						Hospital Administrator					
	Male (41)		Female (57)		Total (98)		Male (28)		Female (15)		Total (43)	
Subordinates think -	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
You make sure they receive fair benefits from their work.	4.39	0.63	4.40	0.68	4.40	0.65	4.25	0.65	4.33	0.62	4.28	0.63
You give them what they want in exchange for showing their support to you	3.63	0.94	3.40	1.07	3.50	1.02	3.29	1.01	3.60	1.24	3.40	1.09
You are open to negotiations about working conditions	4.20	0.75	4.16	0.75	4.17	0.75	4.11	0.74	4.33	0.62	4.19	0.70
You assure them they can get what they want in exchange for their efforts	3.41	1.00	3.25	1.04	3.32	1.02	3.18	0.98	3.47	1.19	3.28	1.05
You show them how to get what they decide they want	3.56	0.81	3.65	0.79	3.61	0.79	3.32	0.90	4.07	1.10	3.58	1.03
Your ideas challenge them to rethink some of their own ideas	4.17	0.63	3.91	0.71	4.02	0.69	4.04	0.64	4.47	0.52	4.19	0.63
You provide them with new ways of looking at things	4.20	0.71	4.07	0.70	4.12	0.71	4.14	0.71	4.33	0.49	4.21	0.64
You are satisfied with the existing procedures as long as they work	3.20	0.87	3.21	0.80	3.20	0.82	3.29	0.94	2.87	0.74	3.14	0.89
You allow them to suggest new ways at looking at things	4.41	0.67	4.51	0.63	4.47	0.65	4.54	0.64	4.53	0.64	4.53	0.63

Table 16 (Continued)
Leadership Skills

Leadership Skills	Food Service Director						Hospital Administrator					
	Male (41)		Female (57)		Total (98)		Male (28)		Female (15)		Total (43)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Subordinates think - You ask of them only what is absolutely essential	2.73	1.05	2.35	1.06	2.51	1.07	2.71	0.90	2.40	1.24	2.60	1.03
You will allow them to take the initiative but you do not require them to do so	3.56	1.18	3.37	1.14	3.45	1.16	3.00	1.22	3.00	1.13	3.00	1.18
You tell them only what they have to know to do their job	2.54	1.27	1.98	1.03	2.21	1.16	2.14	1.24	1.87	1.06	2.05	1.17
Average of above Mean Scores of Twenty-one Leadership Skills	3.94	0.79	3.84	0.78	3.89	0.78	3.81	0.81	4.02	0.75	3.88	0.80

Note. Leadership Skills were scored on five point Likert-type scales with response options ranging from 1 ("Not at all Important") to 5 ("Very Important").

Both positions appear to use more of the transformational leadership style "often" to "almost always" (food service directors – 4.22, hospital administrators - 4.29), compared to practicing the transactional leadership style "sometimes" to "often" only (food service directors – 3.30, hospital administrators – 3.34), as shown on Tables 17 to 19. Table 18 shows that the most commonly used transformational leadership skill by both male and female hospital administrators is charismatic leadership while that of the male and female food service directors is individual consideration. Table 19 shows the frequent use of contingent reward transactional skill by both positions and genders.

When multivariate analysis of the general linear model was done on each of the 21 leadership skills, no significant difference was found among position, gender, and the interaction of position and gender. The same multivariate analysis test was done on these skills grouped as transformational and transactional leadership styles. Results showed a significant interaction effect of position and gender on leadership styles, Wilks' Lambda, (Λ)= .95, F= 3.83 (1,140), (p=.024); but no separate effect for either position (p=.158) or gender (p=.178). The tests of between subject effect of position and gender was found to be highly significant when transformational leadership style is being practiced as shown italicized and in bold print on Table 17 and Figure 5.

Moreover, when the same multivariate analysis test was also done on the leadership skills (charismatic leadership skills, individual consideration, and intellectual stimulation) that make up the transformational leadership style, there was a significant relationship found between position and these skills, Wilks' Lambda, (Λ)=.94, F= 2.99 (1,146), (p=.033). There was no effect found for gender, Λ=.96, F= 1.74 (1,146), p=.161. There was also no interaction effect of position and gender (p=.234).

Table 17
Transformational & Transactional Leadership Styles

	Food Service Director						Hospital Administrator					
	Male (41)		Female (57)		Total (98)		Male (28)		Female (15)		Total (43)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Transformational Leadership Styles	4.27	0.40	4.19	0.41	4.22	0.40	4.17	0.40	4.51	0.30	4.29	0.40
Transactional Leadership Styles	3.49	0.57	3.35	0.50	3.30	0.60	3.40	0.63	3.41	0.53	3.34	0.61

Note. Transformational and Transactional Leadership Styles were scored on five point Likert-type scales with response options ranging from 1 ("Almost Never") to 5 ("Almost Always").

Table 18
Transformational Leadership Skills

Leadership Skills	Food Service Director						Hospital Administrator					
	Male (42)		Female (61)		Total (103)		Male (28)		Female (16)		Total (44)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Transformational Leadership												
Charismatic Leadership	4.21	0.46	4.21	0.48	4.21	0.47	4.25	0.47	4.55	0.34	4.36	0.45
Individual Consideration	4.38	0.47	4.40	0.48	4.39	0.48	4.18	0.51	4.45	0.47	4.28	0.51
Intellectual Stimulation	4.18	0.58	3.99	0.62	4.07	0.61	4.09	0.61	4.28	0.66	4.16	0.63
Average of the Above Scores of Three Transformational Leadership Skills	4.26	0.50	4.20	0.53	4.22	0.52	4.17	0.53	4.43	0.49	4.27	0.53

Note. Transformational Leadership Skills were scored on five point Likert-type scales with response options ranging from 1 ("Almost Never") to 5 ("Almost Always").

Table 19
Transactional Leadership Skills

Leadership Skills	Food Service Director						Hospital Administrator					
	Male (42)		Female (61)		Total (103)		Male (28)		Female (16)		Total (44)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Transactional Leadership												
Contingent Reward	3.70	0.66	3.62	0.63	3.65	0.64	3.48	0.68	3.86	0.83	3.62	0.75
Management by Exception	3.29	0.70	3.07	0.58	3.16	0.64	3.15	0.68	2.99	0.67	3.09	0.67
Average of the Mean Scores of Two Transactional Leadership Skills	3.50	0.68	3.35	0.61	3.41	0.64	3.32	0.68	3.77	0.75	3.36	0.71

Note. Transactional Leadership Skills were scored on five point Likert-type scales with response options ranging from 1 ("Almost Never") to 5 ("Almost Always").

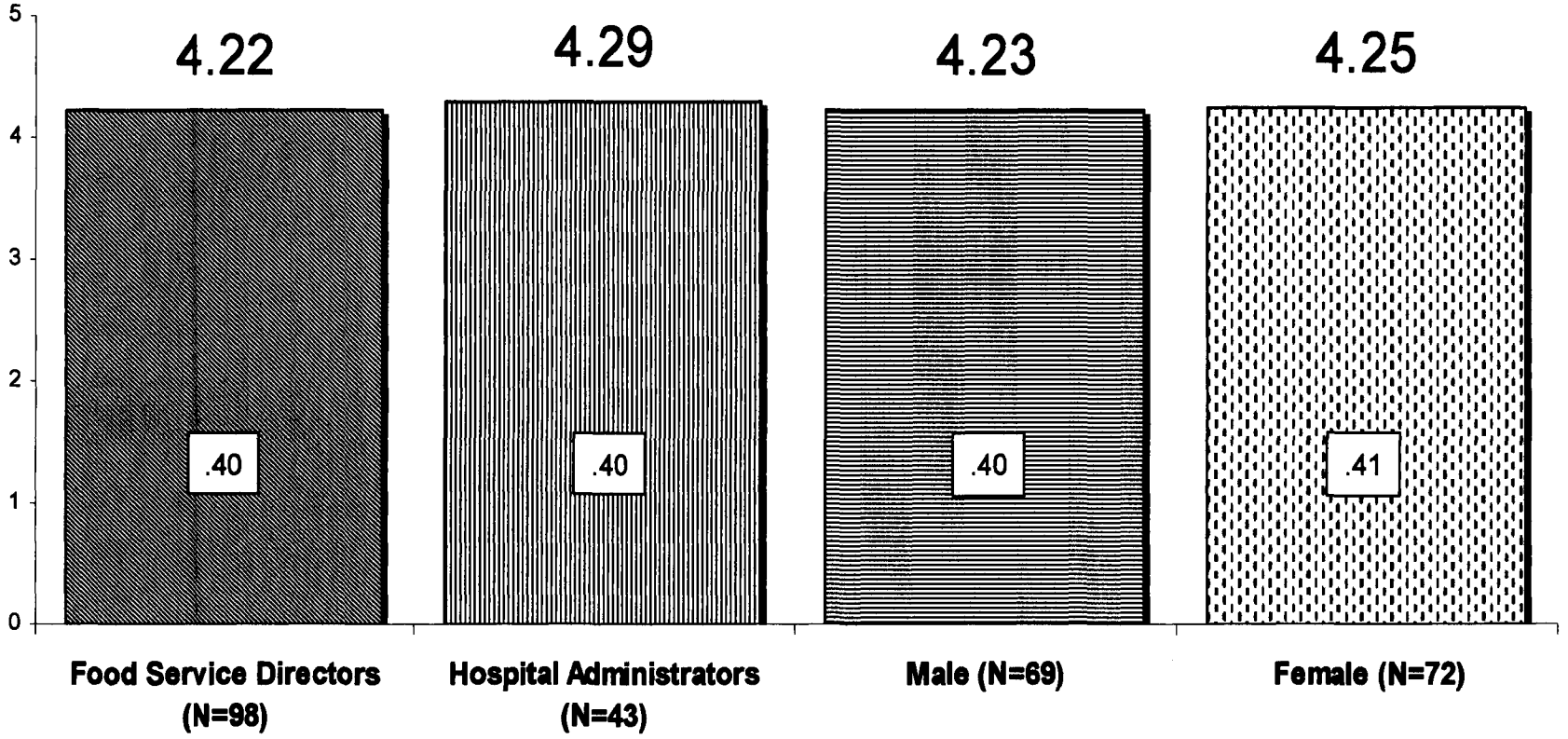


Figure 5. Effects of Interaction of Position & Gender on Transformational Leadership Style

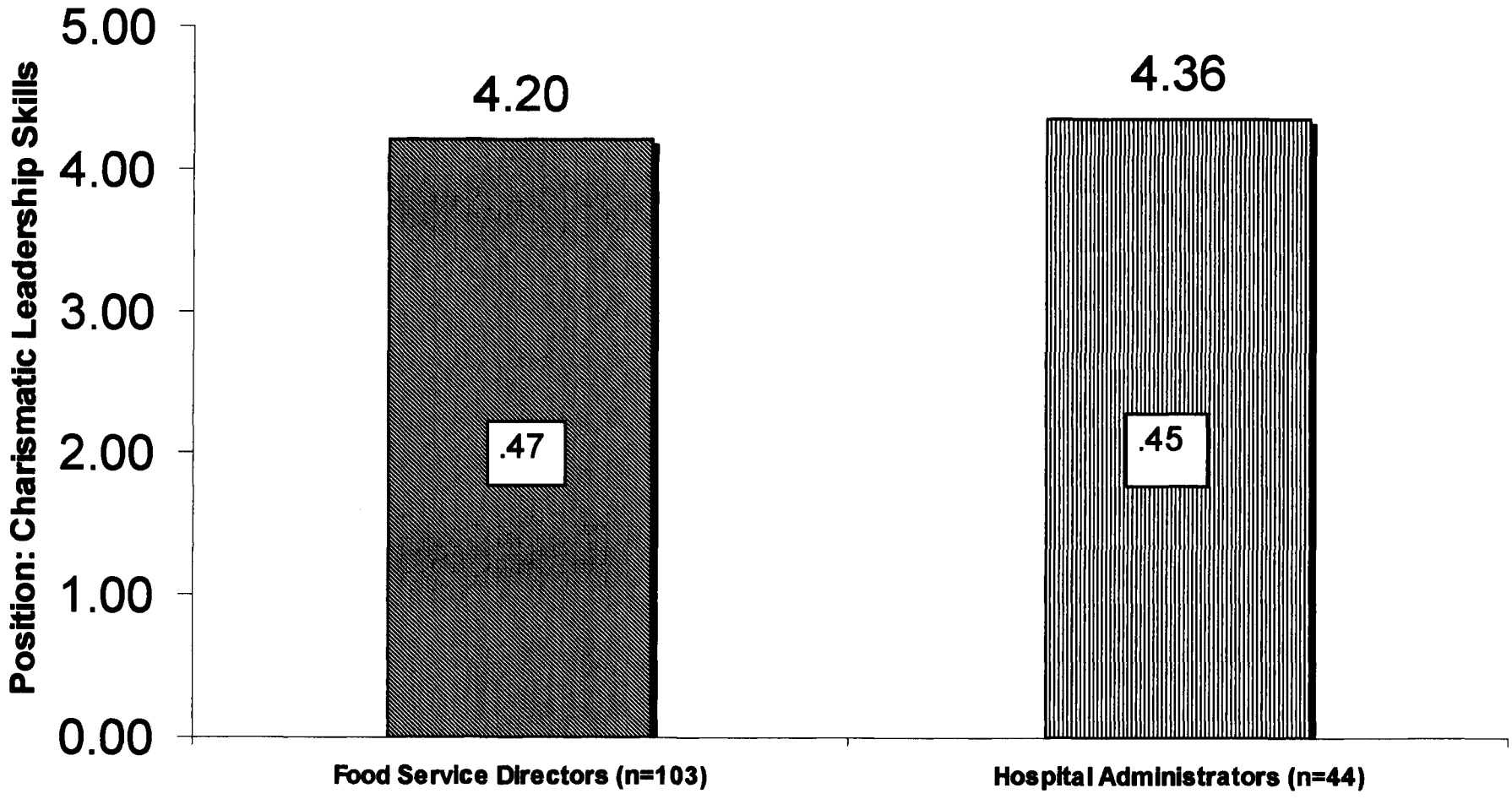
The results of tests of between subjects effect and Figure 6 show the significant effect of position on the use of transformational leadership skills. Table 18 points out that food service directors and hospital administrators significantly differ in their use of the charismatic leadership skills ($p<.05$) by having the means scores for each position on this set of skills in bold print and italics.

"Family" Factors

"Family" factors will include the study participants' ability to balance work and non-work related activities and the employment status of the spouse's/partner's. For those with children, information about their ability to balance work and child-rearing responsibilities, the number of children they have, and the age when the participant had the first child will also be noted.

Balancing Work and Non-Work Related Responsibilities

Both positions (2.89-2.94) and sexes (2.86-2.96) feel that the issues related to balancing work and non-work related activities "seldom" to "sometimes" affect them only (Table 20). All male and female food service directors and hospital administrators also "almost never" to "seldom" worry that people at work think that their personal responsibilities interfere with their job (1.38-1.68). What bother hospital administrators as a group and the females for both positions the most is wishing to have more time to do thing with others (3.17-3.44). The food service directors as a group and the males of both positions are bothered most by trying to have a good balance between work and personal time (3.31-3.50).



F (1,146) = 5.116, p=0.025

Figure 6. Effect of Position on Charismatic Leadership Skills

Table 20
Issues Related to Balancing Work & Non-Work Related Activities

Issues	Food Service Director						Hospital Administrator					
	Male (42)		Female (63)		Total (105)		Male (29)		Female (18)		Total (47)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
My job keeps me from doing the things I want to do	3.00	0.80	2.94	0.84	2.96	0.82	2.86	0.88	2.83	1.15	2.85	0.98
I have more to do than I can handle comfortably	3.21	0.95	2.95	0.91	3.06	0.93	3.10	1.08	3.22	1.00	3.15	1.04
I have a good balance between work and personal time	3.40	0.83	3.56	0.89	3.50	0.87	3.31	0.97	3.39	0.98	3.31	0.96
I wish I had more time to do things with others	3.29	0.83	3.17	0.79	3.22	0.81	3.28	0.84	3.44	0.98	3.34	0.89
I feel physically drained after work	3.07	0.89	2.83	0.87	2.92	0.88	2.90	0.86	3.17	0.71	3.00	0.81
I feel emotionally drained after work	3.14	0.95	2.87	0.89	2.98	0.92	2.93	0.96	3.17	0.71	3.02	0.87
I have to rush to ge t everything done each day	3.05	0.79	2.95	0.92	2.99	0.87	3.21	0.94	2.83	0.99	3.06	0.96
My free time does not match my family's/ friend's schedule well	2.88	0.80	2.49	1.05	2.65	0.97	2.83	1.04	2.61	0.98	2.75	1.01
I do not have enough time for myself	3.00	0.94	3.05	1.05	3.03	1.00	3.28	1.10	3.39	1.09	3.32	1.09
I worry that people at work think my personal responsibilities interfere with my job	1.38	0.62	1.68	1.01	1.56	0.89	1.66	0.77	1.56	0.71	1.62	0.74
Average of above Mean Scores of Issues related to balancing work & non-work related responsibilities	2.94	0.84	2.85	0.92	2.89	0.90	2.94	0.94	2.96	0.93	2.94	0.94

Note. Issues related to balancing work & non-work related activities were scored on five point Likert-type scales with response options ranging from 1 ("Almost Never") to 5 ("Almost Always").

The multivariate test results of the general linear model did not find any significant relationship between any of the issues related to work and non-work related activities and position, gender, or the interaction of position and gender.

Spouse's/Partner's Employment Status

Table 11 shows that slightly more than half (54%) of the spouses/partners for both positions work full time outside their homes. About 11% of them for both positions work part-time outside the home. 28.9% of the spouses/partners of hospital administrators do not work & just stay at home (28.9%) compared to 6.7% of the stay at home spouses/partners of the food service directors. Moreover, there is a significant association between position and spouse's/partner's employment status ($p<.01$), as shown by the chi-square analysis.

Balancing Work and Childrearing Responsibilities

Issues related to balancing work and childrearing responsibilities as shown on Table 21 "seldom" to "sometimes" affect food service directors and hospital administrators of both sexes (2.76-2.96). All of them are very comfortable with the arrangements for their children while they are working (4.00-4.38). Also, none of these positions or gender groups is strongly bothered with how other people feel that they should spend more time with their children (1.57-1.82).

The general linear model did not also determine any significant relationship between any of the issues on balancing work and family responsibilities, position, gender, or the interaction of position and gender.

Table 21
Issues Related to Balancing Work & Childrearing Responsibilities

Issues	Food Service Director						Hospital Administrator					
	Male (37)		Female (35)		Total (72)		Male (21)		Female (11)		Total (32)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
I worry whether I should work less and spend more time with children	2.54	1.14	2.71	1.10	2.63	1.12	2.67	1.02	2.91	1.14	2.75	1.05
I find enough time for my children	3.51	0.87	3.91	0.74	3.71	0.83	3.57	1.03	4.00	0.77	3.72	0.96
I worry about how my kids are doing while I am working	2.62	0.95	2.63	0.97	2.62	0.96	2.52	0.87	2.27	1.10	2.44	0.95
I am comfortable with the arrangements for my children while I am working	4.00	1.20	4.38	0.74	4.18	1.02	4.24	1.14	4.18	1.25	4.22	1.16
I exert a lot of effort while I am working making arrangements for my children	2.16	1.21	2.27	1.21	2.21	1.20	1.86	0.91	2.55	1.29	2.09	1.09
I worry that other people feel I should spend more time with my children	1.78	1.18	1.57	0.81	1.68	1.02	1.71	0.85	1.82	0.87	1.75	0.84
Average of above Mean Scores of issues related to balancing work & childrearing responsibilities	2.77	1.09	2.91	0.93	2.84	1.03	2.76	0.97	2.96	1.07	2.82	1.01

Note. Issues related to balancing work & childrearing responsibilities were scored on five point Likert-type scales with response options ranging from 1 ("Almost Never") to 5 ("Almost Always").

Information About Children

Table 22 shows that both hospital administrators and food service directors have at least an average of three or more children. The male hospital administrators have the most number (3 or more) while the female food service directors have the least number (1-2) of children. Moreover, all the hospital executives by position and gender have had their first child between the ages of 25 to 34 years.

Considerations When Hiring Top Hospital Administrators

Qualifying Characteristics

Both male and female food service directors and hospital administrators rated "high ability" as the most important qualifying executive characteristic that applicants for assistant/associate hospital director position should have (Table 23). They also decided that "academic credentials" were least important to consider when choosing the applicants. Food service directors as a group and females from both positions selected "connected to others" also as an important executive characteristic while the hospital administrators as a group and the males from both positions picked "creative" as the important characteristic for the same applicants.

Qualifying Skills

In terms of qualifying executive skills, both positions and genders picked "leadership" as the most important and "political savvy" as the least important skills respectively (Table 24). Food service directors as a group and female hospital

Table 22
Information about Children

	Food Service Director						Hospital Administrator							
	Male (39)		Female (37)		Total (76)		Male (24)		Female (11)		Total (35)			
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	X2	(df) *p* value
Number of Children	2.05	0.92	1.97	0.93	2.01	0.92	2.33	0.64	2.18	0.60	2.29	0.62	9.56	(5) 0.089
Age when first child was born (1 = Under 25 years) (2 = 25 to 29 years) (3 = 30 to 34 years)	2.36	1.06	2.49	0.98	2.42	1.02	2.08	0.83	2.18	0.98	2.11	0.87	2.66	(4) 0.617

Table 23

Qualifying Executive Characteristics Considered by Position and Gender When Hiring Top Hospital Administrators

Level of Importance	Position						Gender					
	Food Service Director (92)			Hospital Administrator (40)			Male (66)			Female (74)		
	Executive Characteristic	%	N	Executive Characteristic	%	N	Executive Characteristic	%	N	Executive Characteristic	%	N
Most Important	High Ability	33%	30	High Ability	45%	18	High Ability	41%	27	High Ability	35%	26
Important	Connected to others	37%	34	Creative	33%	13	Creative	27%	18	Connected to others	43%	32
Least Important	Academic credentials	30%	28	Academic credentials	22%	9	Academic credentials	36%	21	Academic credentials	22%	16

Table 24
Qualifying Executive Skills Considered by Position and Gender When Hiring Top Hospital Administrators

Level of Importance	Position						Gender					
	Food Service Director (110)			Hospital Administrator (42)			Male (56)			Female (106)		
	Executive Skill	%	N	Executive Skill	%	N	Executive Skill	%	N	Executive Skill	%	N
Most Important	Leadership	32%	35	Leadership	43%	18	Leadership	48%	27	Leadership	25%	26
Important	Leadership	36%	40	Conflict Resolution	33%	14	Fiscal Management	34%	19	Leadership	30%	32
Least Important	Political Savvy	32%	35	Political Savvy	24%	10	Political Savvy	18%	10	Political Savvy	20%	22

administrators considered "leadership" as an important qualifying executive skill compared to the choices of "conflict resolution" by hospital administrators as a group and "fiscal management" by male hospital administrators.

Sources of Candidates

The descriptive statistics for sources of candidates for associate/assistant hospital administrator on Table 25 show that by position, the subjects will "not very likely" to "somewhat likely" choose their candidates from their age or gender groups; but will "somewhat likely" to "likely" choose them from outside or within the hospital they work. The bigger range of mean scores of the subjects by gender point out that they will choose their candidates "not at all like" to "somewhat likely" from their age and gender groups; but will "not very likely" to "likely" choose the candidates from outside or within the hospital they work.

Ideal Educational Preparation of Candidates

Majority of the hospital administrators (53.2%) and the food service directors (64.8%) think that the candidates for associate/assistant hospital administrator should have finished their bachelor degree (Table 26). In addition to this, 89% of the hospital administrators and 80% of the food service directors believe that said candidates should be Master degree holders, too. Neither position thinks that the candidates should have a doctoral degree. Furthermore, there was no significant association between the choice of educational preparation and position when Chi-square analysis was done.

Table 25
Sources of Candidates for Associate / Assistant Hospital Administrator

Sources	Food Service Director						Hospital Administrator					
	Male (41)		Female (61)		Total (102)		Male (27)		Female (16)		Total (43)	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
You would try to choose the Candidates:												
From Your Age Group	2.59	0.92	2.67	1.02	2.64	0.98	2.19	0.68	1.69	0.70	2.00	0.72
From Your Gender Group	2.54	1.05	2.38	0.84	2.44	0.93	2.37	0.84	2.25	0.78	2.33	0.81
From Outside the Hospital You Work	3.63	0.97	3.44	0.89	3.52	0.92	2.96	0.94	3.38	1.20	3.12	1.05
From Within the Hospital You Work	3.09	1.16	2.95	0.94	3.01	1.03	3.15	0.82	3.06	1.12	3.12	0.93

Note. Sources of candidates for Associate / Assistant Hospital Administrator were scored on five point Likert-type scales with response options ranging from 1 ("Not at all Likely") to 5 ("Very Likely").

Table 26
Ideal Educational Preparation of Candidates for Associate Hospital Administrator as Perceived by Food Service Directors and Hospital Administrators

	Food Service Director (102)		Hospital Administrator (46)				
Educational Degree	N	%	N	%	X2	(df)	*p* value
Associate Degree	1	0.98	0	0.00	13.774	(19)	0.797
Bachelors Degree	19	18.68	3	6.52	41.768	(49)	0.359
Masters Degree	75	73.53	41	89.13	66.612	(61)	0.290
Doctorate Degree	7	6.86	2	4.35	3.181	(9)	0.923
Total:	102	100.00	46	100.00			

Candidate's Major Field of Study

Majority of the study participants prefer that the candidate for associate hospital administrator/director has a master's degree either in Health Care Administration (48.25%) or Business (48.25%), as shown on Table 27. If the candidate only has a bachelor's degree, both food service directors and hospital administrators would like one who has a business major (60.87%). Although both positions do not require the candidate to have a doctoral degree, they would also like the doctoral degree prepared candidate to have majored in health care administration (40%) or business (40%).

Years of Work Experience

For both positions and gender, the subjects were unanimous in deciding that the candidates for associate/assistant hospital administrator should have at least more than four years of experience as a department head or similar management level (Table 28).

Ranking of Hospital Departments that Offer Qualifying Experience for Promotion to Associate Hospital Administrator

Nursing was ranked to be the department which offers the best (23.7%) qualifying experience for promotion to associate hospital administrator as shown on Table 29, followed by Fiscal (21.1%). Medical Administration and Information Resource Management tied for third (11.2% each). Amazingly, Environmental Management Services was fourth (13.2%).

Table 27
Candidate's Major Field of Study

	Associate Degree		Bachelor Degree		Master Degree		Doctoral Degree	
Major Field	N	%	N	%	N	%	N	%
Health Care Administration	0	0.00	2	8.70	55	48.25	2	40.00
Business	1	100.00	14	60.87	55	48.25	2	40.00
Food & Nutrition	0	0.00	7	30.43	3	2.63	0	0.00
Nursing	0	0.00	0	0.00	1	0.87	0	0.00
Medicine or Ph D	0	0.00	0	0.00	0	0.00	1	20.00
Total:	1	100.00	23	100.00	114	100.00	5	100.00

Table 28

Number of Years of Work Experience as Department Head/ Similar Management Level Considered Essential to be an Assistant / Associate Hospital Administrator

Years of Work Experience	Food Service Director						Hospital Administrator					
	Male (42)		Female (63)		Total (105)		Male (29)		Female (18)		Total (47)	
	N	%	N	%	N	%	N	%	N	%	N	%
1 = 0 - 2 Years	1	2.4%	4	6.3%	5	4.8%	0	0.0%	0	0.0%	0	0.0%
2 = 3 - 4 Years	8	19.0%	15	23.9%	23	21.9%	11	37.9%	4	22.2%	15	31.9%
3 = More than 4 Years	33	78.6%	44	69.8%	77	73.3%	18	62.1%	13	72.2%	31	66.0%
No Response	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.6%	1	2.1%

Table 29

Ranking of Hospital Departments that Offer Qualifying Experience for Promotion to Associate Hospital Administrator

Rank	Department	Frequency	Percent
1	Nursing	36	23.7
2	Fiscal	32	21.1
3	Medical Administration Service	17	11.2
	Information Resource Management	17	11.2
4	Environmental Management Services	20	13.2

Desire For Career Advancement

Hospital Administrators

Wanting to be a hospital administrator. The hospital administrators were asked as to how important was it for them to seek this position. Table 30 shows how strongly they felt about having their current position: 40.9% felt that it is important and another 40.9% felt that it is very important.

Reasons for accepting their position. Frequency results of the reasons of the hospital administrators for accepting their current position were ranked as primary, secondary, and tertiary. For each level the highest 3 reasons were included. Thus, the "challenge" of the job came out to be the main reason for each level, as shown on Table 31.

Food Service Directors

Wanting to be a hospital administrator. When asked whether they want to be hospital administrators, 45.6% of them gave a "possibly yes" response followed by 20.4% who said "definitely yes" (Table 32). It is interesting to note that there were more females (21.7%) than males (18.6%) who definitely want to be hospital administrators. Also, there were more males (25.6%) than females (13.3%) who definitely did not want to be hospital administrators.

When they will accept offer to be hospital administrators. Whether offered now or 5 years from now, the food service directors, whether male or female, will accept the offer (Table 33). There were more females who responded more positively than the males if the position was offered now (67.7% vs. 58.1%) or 5 years from now (69.4% vs. 62.8%).

Table 33
Frequency Table of Importance of Wanting to be a Hospital Administrator

Scale / Rating	Frequency	Percent
1 = Not At All Important	0	0.0%
2 = Not Very Important	3	6.8%
3 = Somewhat Important	5	11.4%
4 = Important	18	40.9%
5 = Very Important	18	40.9%
Total	44	100.0%

Table 31
Reasons of Hospital Administrator for Accepting Their Position

			Reasons	
Ranking			N (43)	Percent
Primary	1	Challenge	13	30.2%
	2	Career Advancement	8	18.6%
	3	Qualifications	5	11.6%
Secondary	1	Challenge	10	23.2%
	2	Career Advancement	9	20.9%
	3	Qualifications	8	18.6%
Tertiary	1	Challenge	10	23.3%
	2	Better Pay	7	16.3%
	3	Career Advancement	6	13.9%

Table 32
Desire of Food Service Directors to be a Hospital Administrator

	Male (43)		Female (60)		Total (103)	
Response	N	%	N	%	N	%
1 = Definitely No	11	25.6%	8	13.3%	19	18.5%
2 = Possibly No	6	14.0%	7	11.7%	13	12.6%
3 = No Opinion	1	2.3%	2	3.3%	3	2.9%
4 = Possibly Yes	17	39.5%	30	50.0%	47	45.6%
5 = Definitely Yes	8	18.6%	13	21.7%	21	20.4%

Table 33
Food Service Director's Acceptance of Offer of a Higher Position (Assistant / Associate Hospital Administrator or Hospital Administrator

Question		Male (43) N	Male (43) %	Female (62) N	Female (62) %	Total (105) N	Total (105) %
If it were offered now:	1 = Yes	25	58.1%	42	67.7%	67	63.8%
	2 = No	18	41.9%	20	32.3%	38	36.2%
If it were offered 5 years from now:	1 = Yes	27	62.8%	43	69.4%	70	66.7%
	2 = No	16	37.2%	19	30.6%	35	33.3%

Reasons for accepting position. Frequencies done on the reasons given for accepting the offer for hospital administrator position were grouped into primary, secondary, and tertiary reasons. For each grouping, the three highest reasons were given. "Qualified for the job" was the lead reason in the primary and tertiary groups (Table 34). "Challenge" of the job was the lead reason for the secondary group.

Table 34

Reasons of Food Service Directors for Wanting to Accept The Position of Associate / Assistant Hospital Administrators

Ranking		Reasons	N (108)	Percent
Primary	1	Qualified for the Job	29	26.9%
	2	Career Advancement	13	12.0%
		Challenge	13	12.0%
	3	Better Pay	11	10.2%
Secondary	1	Challenge	25	23.2%
	2	Qualified for the Job	24	22.2%
	3	Better Pay	10	9.3%
		Career Advancement	10	9.3%
Tertiary	1	Qualified for the Job	18	16.7%
	2	Career Advancement	17	15.7%
		Challenge	17	15.7%
	3	Better Pay	12	11.1%

Chapter V

DISCUSSION

This study was conducted to understand why food service directors may not be promoted to higher administrative positions in hospital organizations. Since there was no way of asking this question directly to hospital administrators or their assistant for operation or patient care service, to whom food service directors are directly responsible to, this study sought to find out whether the food service directors and hospital administrators differed in some key parameters essential for the top hospital position.

The results will be discussed with references to these key parameters: "self," "work," and "family" factors, hiring considerations, and desire for advancement. How various factors affected the response rate will also be discussed as well as limitations of the study and recommendations for future research and practice.

"Self" Factors

The gender profile of each position simulates that of the key organizations which were referenced to earlier: the American Society of Healthcare Food Service Administrators for the food service directors and the American Hospital Association-American Society of Healthcare Executives for the hospital administrators. There are more female food service directors than males. This just reaffirms the fact that food

service management, especially in health care, is one of those female fields. However, having more male hospital administrators than females is expected since men have held the top positions in most hospitals and other healthcare organizations since 1950.

With more female graduates of healthcare administration, there are now more of them in the pipeline (Plant, 1985), as the growing female membership (40.2%) of the American College of Healthcare Executives indicates (American College of Healthcare Executives, 2005). More importantly, the primary key finding of Catalyst (2004) in the study on "Connecting Corporate Performance and Gender Diversity" showed that the group of companies, including health care, with highest representation of women on their top management teams experienced better financial performance than the group of companies with the lowest women's representation. The financial measures used consisted of return of equity (ROE), which is 35.1% higher and Total Return to Shareholders (TRS), which is 34.1% higher. This confirmed an earlier finding by Adler (2001) of the Glass Ceiling Research Center.

The ethnic distribution of the two groups of hospital executives follows that of the American labor force, where whites predominate. However, with minorities getting more educated and a growing number of them pursuing graduate degrees, there is the great possibility that their number in hospitals' top management will also grow; and modify earlier findings by Morrison and Von Glinow (1990) and Wernick (1995) about educational and training investments yielding higher returns for white men than women and minorities. The beginnings of this is seen in the study cited by Armas (2005) where he noted that black and Asian women with a bachelor's degree earn slightly more than similarly educated white women and white men with four year degrees. Furthermore, it is

noteworthy to mention that the current president of the American Hospital Association is a young black man, Kevin Lofton (Grayson, 2005).

It is common knowledge that an employee has to work for many years and learn more about the job and organization to prove himself and earn the top position in the department; and much more to get the top position of an organization. With years of work experience also means maturing, age-wise. This is why most department heads and executives are usually middle-aged (41 to 50 years old) and older (51 to 60+ years old). It is rare that one sees a 30 year old or younger heading the nutrition and food service department; and much more, the hospital organization as the administrator.

It appears that education highly correlates with job position. A large percentage of hospital administrators have a master degree. This asserts the importance of this degree to being in that position. In today's highly competitive job market, having a graduate degree is always considered a great plus. Additionally, being married is no longer associated to not achieving career success. A great majority of the food service directors and hospital administrators prove this so.

Overall, there were no major differences between the food service directors with regard "self" factors.

"Work" Factors

Work-Related Demographics

Most of the food service directors and hospital administrators have been in their current place of work from 0 to 5 years. Many more for both positions have been with their employer from 6 to 15 years. This is the best way of building up one's seniority and

correspondingly, one's value to the employer. The longer one stays with the same employer, the more he learns about the job, the work force there, and the organization. All these usually lead to better chances of job promotions, more satisfactory work conditions, and ultimately, better salaries.

The salary of the hospital executive is usually determined by the job description, the responsibilities that come with the job, the number and job positions of people being directly supervised, the size of the hospital in terms of number of in-patient beds, the amount of same day surgery done, and the scope of ambulatory care. Therefore, it is an accepted fact that the salary of the hospital administrator is usually higher than that of the food service director as he is in charge of the whole hospital while the food service director is only in charge of his department.

Importance of Organizational Goals

Organizational goals provide direction to the hospital administrators and his department heads. However there seemed to be no major differences as to how male and female food service directors and hospital administrators value their importance. Both hospital executives rated them an average of from important (4) to very important (5).

Why food service directors rated "profit maximization" lowest (3.83) may be due to the fact that they realize that their department is a support service and not really a revenue-generating one compared to Radiology or Pharmacy. Generally, most nutrition and food services, especially the cafeteria, are subsidized by the hospital. However the food service director is highly rewarded if his department consistently controls costs and generates profit through its coffee shop and/or convenience store or gift shop.

Hospital administrators rated "industry leadership" lowest (3.96). Although they strive for this all the time, their immediate concern is the attainment of the other goals which directly impact their individual hospital. They believe that if their employees are highly productive, have high morale; efficient, etc, they will easily be highly competitive in the hospital industry.

Both hospital executives rated "high employee morale" as a very important organizational goal (food service directors - 4.72, hospital administrators – 4.75). When employees' morale is high, employees are happy and are usually more productive. There are fewer problems for the hospital executives to deal with; and it is a lot easier to achieve their set goals. As a result, the organization grows; attains stability; and eventually improve its reputation and value to society.

Importance of Stakeholders

When it comes to importance of the different stakeholders, both positions consider all of them important to very important, as shown by the average of their mean scores of the importance of the 12 stakeholders. Needless to say, each position values them slightly differently, according to how each affect their job performance. There is no doubt that the patients are the primary stakeholders in a healthcare facility. As the top official of the hospital, hospital administrators need to deal with all stakeholders while the food service directors may just have to collaborate with those who directly impact their department. In this regard, the findings that the mean scores on the importance of the stakeholders show that the hospital administrators significantly consider four out of twelve of them: department managers, professional employees, white collar employees, and elected public officials more important than do the food service directors.

The higher rating given by hospital administrators on the importance of department managers implies that they rely on the productivity and performance of all department managers in order for the hospital operation to be up to par with the standards of regulatory agencies such as the Joint Commission for the Accreditation of Hospital Organizations. On the other hand, food service directors may just need to coordinate with certain department managers whose services they always have a demand for. Examples of these departments include: Facilities Management for maintenance and repair of kitchen equipment, utilities, and physical layout and Environmental Management Service for pest control, removal of solid kitchen wastes, and special heavy cleaning of ducts and vents.

Professional employees are deemed significantly important by the hospital administrators. They include the doctors, nurses, dietitians, speech pathologists, various kinds of therapists (respiratory, occupational, etc), social workers, financial analysts, information technology specialists, accountants, engineers, environmentalists, etc. This is the group of employees that runs the hospital. Most of them are considered "high influence, high interest" stakeholders (Boutelle, 2004). Their viewpoints need to be understood.

Patronage of the hospital by patients is highly dependent on the quality of doctors affiliated with hospital, kind of nursing care available, and the high quality of allied services that they can avail of. These may include timely food service & good food just like those from Mom's kitchen, "smelling and looking good" rooms made possible by Environmental Management Service, and other amenities and appropriate services like short or no waiting time in the clinics or doctors' offices. It is a fact that highly qualified

and renowned doctors bring patients to the hospital in bigger numbers. The same is true with high level of tender loving care provided by the nursing staff and members of the allied professions.

Hospital administrators significantly recognize the importance of white collar employees than food service directors. They know the great roles of such white collar employees like the administrative assistants who manage the day to day operations of certain offices/clinics; executive secretaries who programs their bosses' (whether this be a department manager or doctor) daily schedule; and program specialists who do distinct activities or projects for the section or department.

Elected public officials may impact the job of the hospital administrators more than that of the food service directors. This may have something to do with possible solicitation of public funding for the hospital, especially if the hospital is government-owned or sponsorship or lending some publicity to certain hospital projects such as the annual fund raising activities. For this reason, the hospital administrators significantly consider the elected public officials more important.

Importance of Executive Characteristics

Just like the organizational goals and stakeholders, the average of the mean scores given by both positions and genders for all 14 executive characteristics was 4.35, meaning that they consider all theses characteristics "important" to "very important", too. "Being connected to others" was rated the most important executive characteristic by both positions. This just shows how necessary it is for both positions to be attuned to what's going on and what their people are doing. This also accounts for the many regular meetings that each one must preside over and attend, especially for the hospital

administrators. As the hospital administrator relies on his key staff to constantly update him on what he needs to know, the food service director turns to his front line supervisors for feedback and updates.

"Willing to mentor" and "academic credentials" were the 2 executive characteristics out of 14 that were rated significantly more important by female food service directors and hospital administrators compared to their male counterparts. This finding implies that the female hospital executives consider it very helpful for an older and more experienced member (mentor) of the hospital organization to take a junior colleague (mentee) "under his/her wing", helping him/her get socialized into the organization and meet the key people in the hospital. The mentor usually provides the mentee information, advice and emotional support in a relationship lasting over an extended period of time and marked by an emotional commitment by both parties. This could be a part of a formal mentoring program/s in conjunction with the organization's succession planning that is available in the hospital to develop qualified staff or managers. Female hospital executives more than their male counterparts, support mentoring as a process to further the career of the mentees or protégés.

Most of the literature in mentoring show women seeing wisdom in the mentoring process as a catalyst for advancement, whether this is in the healthcare industry or education (Wilson and Elman, 1990; Hubbard and Robinson, 1998; Walsh and Borkowski, 1999; Wessel, 2003). This can be due to the fact women are still new in the executive positions in organizations; and therefore, they need more guidance getting to this point. This is where the mentors come in.

It is also highly possible that many of the female executives in this study were mentored either during their internship or in the early part of their careers and found it to be very beneficial in terms of performing great in their current job and building their self-esteem and self-confidence. Therefore, they tend to confirm the findings of Walsh and Borkowski (1999) that exposing female executives to mentoring at an early stage of their career encourages them to initiate mentoring relationships in the future. They further explained that male managers do not involve themselves in a lot of mentoring relationships because they focus in more lateral or "network" relationships through professional or social organizations, where they develop multiple relationships with executives in said organizations. As Barbara Brown, editor of Nursing Administration Quarterly (1995) said, "there is the challenge to mentor and prepare future leaders, whether male or female, to meet the chaos in the healthcare industry head-on with every fortification of knowledge and skills needed to preserve the caring of America".

Female food service directors and hospital administrators valued academic credentials differently from their male counterparts. The finding that the females rated academic credentials higher than the males may possibly be due to the fact that females by nature are more serious about studying and obtaining the necessary college and graduate degrees than their male counterparts. However, what is surprising is that later on, when asked to select the least important qualifying characteristic to be considered when hiring top hospital administrators, the same female executives together with the males for both positions also chose academic credentials to be the least important executive characteristic. This may imply that said executives realize later on that it is not just academic credentials that matter but more so, the work experience, characteristics

and other skills that they bring to the job that they may have acquired or developed during the early part of their career in addition to networking with a dash of being politically savvy. Furthermore, majority of both positions cited having a master degree to be the ideal educational preparation of candidates for associate/assistant hospital administrator position in addition to a bachelor's degree.

The importance of academic credentials, especially having a minimum of a college degree, is further collaborated by Armas (2005) when he pointed out that a college graduate on average earned over $51,000 compared with $21,000 for someone with only a high school diploma or an equivalent degree.

Importance of Executive Skills

Hospital executives also consider executive skills highly important, as evident in the 4.39 to 4.55 range of the average of the mean scores of the 10 skills for the two positions. Food service directors consider human management skills very important, while hospital administrators selected leadership. Hospital administrators head the hospital organization and all the staff and employees. They direct and at the same time, coordinate the whole hospital operation. Generally, they directly deal with their key staff and department heads. For all these, the hospital administrators must provide the required leadership. On the other hand, food service directors must deal with their front line supervisors and rank and file employees, where good human management skills are necessary for success.

The finding of a significant difference as to how the two positions rated five out of ten executive skills can be explained by the different work demands and constituencies of the two groups of study participants. The hospital administrators rated the following executive skills: facilitating positive medical staff relations, facilitating positive board

relations, political savvy, and having a total organizational view significantly higher than the food service directors suggests they deem them more important in their position than the food service directors.

The nature of the job of the hospital administrators is such that they run the whole hospital through their key people. They are directly answerable to the hospital board. Thus, it is imperative that the administrators keep the board informed about the going-ons in the organization. This is reiterated by Irma E. Goertzen, president and chief executive officer of Magee-Women's Hospital in Pittsburgh, Pennsylvania (Brown, 1995) when she said that the " role of the hospital administrator is to keep the board informed about the activities of the hospital as well as what's happening with external activities, such as health care reform." Another hospital executive, Barbara A. Donahue, president and chief executive officer of St. Anthony's Hospital in St. Petersburg, Florida (Brown, 1995) also pointed out that "you have to make sure that the board act appropriately by educating them." For her it is a "new kind of relationship to manage a board which in essence has the authority over you- they have the hire/fire authority over you."

Facilitating positive medical relations is a very important skill that all hospital administrators need to develop as the patronage of the facility is largely determined by the kind of medical staff that it has. With increased patronage of the hospital comes the needed revenue to keep it highly competitive. Dr. Robert Heyssel, president of the John Hopkins Hospital in Baltimore, Maryland (Hospitals, 1990) concurred with this when he said that "the hospital has changed from a place where physicians practice to a true partnership between physicians and the hospital." Lately, having doctors move their practice group into the hospital rather than employing them is getting to be a popular

arrangement in many hospitals. The practice group just pays rent to the hospital and/or share a certain percentage of their gross profit, which is clean and pure revenue for the facility. The hospital does not have to be bothered with recruiting reliable and renowned physicians.

Although it would be beneficial for the food service directors to have political savvy and have a total organizational view, it is mandatory for the hospital administrators to have these skills since they head their organizations. Their positions are highly visible not only in the hospitals but also in the community where their hospitals are located. An article in Hospitals (1990) calls for hospital administrators who are good at public image building and addressing the concerns of diverse groups, while maintaining the hospitals' interests.

While hospital administrators also engage in negotiations/compromise/conflict resolutions, they do this in a bigger scale compared to the food service directors. With their human resources manager and chief financial officer, the hospital administrators usually deal with the unions in terms of negotiating the contracts that are renewed periodically. With the hospital's legal officer, the hospital administrators compromise or litigate any suits filed for or against the hospital. Any negotiations they do with any employees would be those cases that have not been resolved on the departmental level; and has been referred to them for final settlement. On the other hand, the higher rating given by food service directors for this negotiating skill may imply that they use this more often in their daily work life. Since they deal with mostly rank and file employees (food service workers and cooks), there is more activities that entail conflict resolution and compromising at their level.

Leadership Skills

Among the employees they directly supervise, hospital administrators and food service directors perceive themselves to be practicing the various 21 leadership skills on from "sometimes" (3) to "almost always" (4) and no differently from each other. It is not unusual that hospital administrators believe that their "Subordinates think that you have a sense of mission that you transmit to them" "often" to "almost always". As leaders, they are really expected to see to it that every employee in the hospital knows its mission Aside from have postings of the hospital's mission and visions in strategic areas in most federal hospitals, the employees' identification card has them printed at the back.

Because of the kind of employees that Nutrition and Food Service has and the nature of their jobs, the food service directors believe that it is important for their subordinates to think "often" to "almost always" that they express their appreciation whenever they do a good job. Expressions of appropriate recognition and appreciation to food service workers are great morale boosters. They ranged from a simple "thank you" for a job well done to special contribution awards of time off or money. For example, certain hospitals give employees who come to work during blizzards or heavy snowstorms $100 and 4 hours off as incentives to come to work during these difficult times.

When both positions and gender are taken together, the study participants significantly use more of the transformational leadership style, which includes the leadership subscales: charismatic leadership scales, individual consideration, and intellectual stimulation. Of these transformational leadership subscales, charismatic leadership skills were most significantly practiced.

The overall similarity of the findings for leadership among the male and female food service directors and hospital administrators leads to the conclusion that the groups had become relatively homogenous in their perceived leadership styles as a result of prior socialization. Both perceive that they significantly use more of the transformational leadership. This is similar to the findings of Borman (1993) on an earlier similar study between hospital administrators and chief nursing executives.

A survey of chief executive officers of hospitals (Hospitals, 1990) supports the finding about transformational leadership style as the most effective in the coming years. Transformational-charismatic leadership involves leaders as visionary, gaining the respect, trust and confidence of others and transmitting a strong sense of mission to them. A former hospital administrator (Hospitals, 1990) describes this leadership skill in the following:

> Vision is probably the most important word that can be used to describe the role of a chief executive officer (CEO). Vision can sometimes be a lonely position – but the example set by a visionary CEO can move down the ranks. You have to be authentically visionary and a catalyst of a realistic vision, and you have to be a person who can determine what must be done.

As both female and male hospital administrators and food service directors practice transformational leadership style which also entails team management, there is a bigger assurance that their organizations will succeed.

"Family" Factors

Family-Related Demographics

The finding that 79.7% of the study participants are married and remarried suggests that the food service directors and hospital administrators appear to cope with the rigors

of marriage in addition to those of their work life. However, there are still the 12.8% who never ventured into marriage or those 7.5% who either are divorced or separated. The burden of their work might have influenced their current status so that they prefer to live life by themselves. Others may also consider marriage and family life as a stumbling block to their career growth.

Most spouses of the study participants work full-time jobs outside their homes, especially those of the food service directors. It is important to note that the majority of the food service directors are females; and therefore account for their husbands, the major breadwinners, to be working full time outside the homes. In the same light, there were more spouses of the hospital administrators more than those of the food service directors, who just stay home. This may be due to the fact that the majority of the hospital administrators are males; and that they have bigger incomes than the food service directors to afford their spouses to stay home.

Issues Related to Balancing Work and Non-Work Related Activities

Most of the issues on balancing work and non-work related activities deal with time management at work and at home; and being physically and emotionally fit to deal with everyday life whether one is single and married. It becomes quite complicated for the married since one has to take care of the family in addition to oneself, especially when younger children are involved. One learns how to blend work and family life, practicing and developing skills in organizing and prioritizing. One also gets to accept the fact that there is always the feeling of not having enough time for oneself, family, and friends.

Furthermore, one needs to respect his mind and body. This means that when one feels physically exhausted and emotionally drained, it is about time to have a break or diversion to regenerate oneself.

Generally, the results of the study show that the study participants are "seldom" to "sometimes" affected by these issues in spite of the fact that 79.7% of them are married or remarried. This suggests that they are able to cope with the rigors of their family and work life. In addition to this, a great majority of the hospital executives are in the 41 to 60 years age group. This implies further that they are old and mature enough to better manage their time at home and at work now compared to when they were younger. Also, at such an age, they would have had established their patterns in running their households; have eventually develop systems of doing their jobs; and have refined their skills in coordinating their family and work lives. At this point of their career, both hospital executives should not have much difficulty seeking permission from their immediate supervisor (the associate director for patient care service or operation for the food service director and the board of directors for the hospital administrator) to take appropriate time off.

Issues Related to Balancing Work and Childrearing Responsibilities

It is a natural feeling for parents to be concerned about having enough time and making appropriate arrangements for the care of their children. Much of the burdens of these, though, fall on the mothers in spite of the growing trend of fathers to be house-husbands, full or part time. Thus, the earlier findings by Davies-Netzley (1998) about male chief executive officers and corporate presidents from Southern California believing

that married women do not perform well and can not commit the time that their male counterparts can may still be partially true.

Both food service directors and hospital administrators seem to "seldom" (3) to "sometimes" (4) have any problem balancing work and childrearing responsibilities. Again, this can be explained by the majority of the study participants being in the 40 to 60 age group. Most of them are at the age where they can manage their work and family life better. Those who might be having more concerns about the arrangements for the care of their children would be the parents younger than 40 years old where 18.4% of the hospital executives fall under; and those with school children or younger and may be older than 40 years. The period when the hospital executives are 34 years old and younger may be considered critical as 54.4% of them have their first child born at that time. Working mothers today are better off with the increasing number of employers providing on-site day-care and after school facilities, not to mention the increasing availability of safe and affordable child care outside the workplace, as noted by Haddock and Aries (1989).

The number of children obviously complicates family and work life. Obviously, the bigger the family, the process of coordinating family and work life becomes more complex. The average number of children the study participants has ranged from 1 to 3.

With majority of the children of both food service directors' (39.1%) and hospital administrators' (44.7%) children between 16 to 25 years old, the hospital executives do not have to be bothered with "baby-sitting" issues. Rather, they now have to deal with issues like who are they with or how are they doing in school to name a few.

More so, there is also the growing trend of temporary or permanent reversed role: husbands staying at home to be househusbands and married women working as the main breadwinner and are called Alpha Earners, especially in cases where the women's career have bigger earning potential (Tyre and McGinn, 2003). All these began in 2001 when male-dominated businesses like manufacturing and information technology declined and corporate downsizing was everywhere compared to traditionally female industries like healthcare and education. In 30.7% of married households, the working wife's earnings exceeded that of the husband's.

Considerations for Hiring Top Hospital Administrators

The study participants were unified in their choice of qualifying characteristics, skills, years of work experience in a management capacity, educational preparation, whether to select the candidate from their age and gender groups and to choose applicants from within or outside their facility for the hospital top position. Several departments in the hospitals were selected to offer the qualifying experience for promotion to associate hospital administrator from Nursing to Environmental Management Service. This signals the fact that there may be no one route to the top. There are the hospital administrators who may come from the traditional path: with a Masters in Health Care Administration or Business Administration majoring in Health Care; worked their way up through occupational ranks; and are mostly males. The other breed comes from the non-traditional path. They include physicians, chief financial officers, nurses, ambulatory care administrators, Health Management Executives, etc who have broad visions, strong perspectives on operations and cost effectiveness, and are more sensitive to the patients

and community (Hospitals, 1990). The choice of what kind of hospital administrator is best is based on the need of the hospital organization. This is where the food service directors can come in. Possessing the right mix of executive characteristics, executive skills, education, work experience, mentoring and networking, the food service directors can aim for the position of associate hospital administrator for now and eventually, for the top position of hospital administrator later on.

Food Service Directors' Pathway to Higher Positions in Hospital Organization

Those food service directors who are aiming for higher positions in their organization can undertake several things to align themselves on the right track. They need to make their department and themselves visible. They can invest in programs or projects that will conserve revenues such as controlling the use of unscheduled or overtime. They can also generate revenues for the hospital such as selling "food-to-go" or "food-to-bring-home" at affordable prices to employees who do not have much time to prepare food at home. Furthermore, they can also engage in intensive catering in and outside the hospital. Food service directors can also have their clinical dietitians worked closely with the medical staff in various clinics such as those for Diabetes, Renal and Hemodialysis, and Wellness for reimbursements for medical nutrition therapy.

The food service directors can also volunteer themselves to join active hospital committees such as the Performance Improvement Council, Infection Control & Sanitation Inspection Committee, Fund-raising or Development Committee, etc. Membership in said committees will not only give the food service directors a chance to

share their knowledge and experience but enable them to network with key people of the hospital and learn the nature of their jobs.

As mentioned earlier, the food service directors can also explore any leadership and mentoring programs available in their organization. They should not be complacent in their present position. Rather, they should develop themselves further through continuous attendance of in-house and outside trainings and conferences where they can network further with colleagues in or outside the profession. One never knows when one can get an offer of a higher positioned-job by those people one meets in conferences and training sessions.

The food service directors may also want to consider taking a certificate program in health care administration or a Master's degree in this or business administration with a major in health care administration to learn the ins and outs of health care operation. This would solidify whatever experience they may have from their job.

Furthermore, healthy alliances with the union representatives and officers without compromising their position will prove to be an enriching experience for food service directors. This will prepare them for bigger cases to negotiate with the union and enable them to make better decisions.

Response Rate

The response rate of 21.49 % could have been affected by several factors. A major factor was the occurrence of the anthrax scare of 2000, with several incidents in New Jersey and New York, where infected white powder was being mailed. Although the questionnaires were mailed about 3 months after the initial anthrax incident, most people

were very wary about opening mail from unfamiliar senders. At the time of the first anthrax incident, the questionnaire sets were already being packed and labeled. Prolonging postponement of their mailing was impractical.

The nature of the job of the hospital administrators and food service directors is such that they are usually busy most of the time. They may not be able to spare the time to fill out the questionnaire. Directly related to this is the fact the questionnaire is quite lengthy. It takes an average of 40 minutes to complete it in spite the fact that most of the responses can just be checked. Also, the incentive of inclusion into a $500.00 raffle may not be attractive to certain people who consider such remuneration as not immediate or "uncertain" because one may never be picked and there can only be one winner. Furthermore, some potential respondents may feel uncomfortable participating as they fear they will not remain completely anonymous even with the assurance that all names will be coded.

Moreover, getting the names and addresses of the prospective study participants from a published directory may not be that practical. It has been discovered and realized later on that it takes a while before the information needed for the directory is updated and completed. It also takes time before the directory is published. Once the directory is published, the information in it may not be that accurate anymore. The people in certain positions may have changed jobs, place of work, etc. It is also highly possible that some health care facilities may have closed down or merged into a system hospital or converted into an ambulatory care service. It was also found out later on that even checking an earlier version of the publication with a later one does not help much at all in getting the latest names and addresses unless the authors and publisher are highly reliable. Getting

the names and addresses from professional organizations may be more functional since they update their membership roster annually every time the members pay their dues. However, this service entails payment of quite a fee for processing and their printing of name and address labels.

In spite of the low response rate, the profile of hospital administrators in the study appear to be similar to those of the 2005 membership of the American Hospital Association-American College of Healthcare Executives (ACHE) when comparing certain demographics such as having more male than female hospital administrators; whites as the dominant race; the 40 to 59 years age group as the most common age group for the majority of the hospital administrators; masters prepared with Health Care Administration or Business as the major field of study. Likewise the profile of the food service directors in the study for certain demographics are highly comparable to those of the 2005 membership of the American Society of Healthcare Food Service Administrators ASHFSA). These include: predominance of female members compared to males; the common age group to which most members belong to is the 41 to 60 years age group; more whites than all minority groups combined; and mostly working in facilities with 100 to 199 licensed in-patient beds. The study participants differed from the ASHFSA members when it comes to education. While majority of the food service directors in the study just finished a bachelor's degree, those in ASHFSA are mostly master's prepared. Other demographic comparisons are not feasible as the two professional organizations are unable to provide the data presently.

The greatest implication of the study's low response rate is that their findings can not be generalized. It leads to a hypotheses generating study, not one that draws conclusions.

Additionally, a greater response rate than the present may affect the results for certain parts of the study, especially those of the hospital administrators whose response rate was only 14.16%. With the non-responders appearing to be similar to the study participants in terms of the more common demographics such as gender, age, type of hospital employed with, possible education, etc, there is still a possibility that their inputs may just magnify the present results.

To summarize the findings of this study, there were no major difference between the food service directors and the hospital administrators in terms of "self," "work," and "study" factors. Both hospital executives were similar in their choices of qualifying executive characteristics and skills, years of work experience in management, etc that they would seek among applicants for associate hospital administrator except that hospital administrators prefer that the candidates have a master's degree either in Health Care or Business Administration. Finally, the food service directors are interested to be promoted to higher administrative positions in hospital organizations such as the associate or assistant hospital administrator's position.

Limitations of the Study

There are several limitations of the study when analyzing the conclusions drawn earlier. The major limitations are the cross –sectional design of the study and the small (21.49%) response rate. Because of these, the study can only generate hypotheses but not draw conclusions. Although some of the statistical tests uses resulted in certain significant differences in the key factors being examined between the 2 groups of study participants, the differences may not be real but due to chance, because of the small

response rate. This may also cause a bias in data due to unknown differences between those who chose to respond and those who did not. Secondly, the questionnaire was self-administered and all of the data were self-reported. Some of the information given may have been influenced by social desirability. Thirdly, the responses given are supposedly as perceived by the subjects; and therefore, not actually measured.

Recommendations for Research

A similar future research should make sure that the sampling is more systematic. It would be more effective if sampling is made in terms of hospital type and size. Since the study is indirectly focused in improving the lot of dietitians, the choice of hospitals should also be limited to where the food service directors are registered dietitians. Doing so would also give us a better picture as to how hospital administrators regard dietitians for higher administrative positions in hospital organizations. The study of family issues can be expanded and made more thorough perhaps by developing a better assessment instrument for this purpose.

For future research, it is recommended that the graduate degree program in nutrition be evaluated to determine the need to include courses in health care administration and leadership skills. This way, students are better prepared for higher administrative positions in health care. This make the program broader to keep the students.

Recommendations for Practice

This study has shown that the food service directors have many attributes in common with hospital administrators. However, if food service directors are to be promoted to

higher administrative positions in hospital organizations, they need to develop their leadership skills and those executive characteristics and skills needed to operate an organization larger than their department. They also need to be exposed to the hospital's stakeholders and organizational goals to develop a broader perspective of the hospital's operation. If they still do not have a graduate degree, they might think of taking one either in business or health care administration. If doing a graduate program is not a possible option for now, they might want to consider related short courses such as those offered by the American Management Association, American Hospital Association, and American Society for Health Care Executives, etc, whether sponsored by their hospital or from their own pocket. Aside from marketing their department to administration, food service directors need to make themselves visible to hospital officials through active committee works, controlling costs in their department, generating revenues, networking with other department managers, collaborative and amicable settlement of union issues.

On the other hand, the hospital administrators should also be able to recognize the potentials of food service directors' serving at higher positions in the hospital organization by encouraging their participation in committee works, community out-reach programs, executive leadership training, succession planning, and mentoring programs for higher level staff members.

Even if the study showed that academic credentials is the least qualifying characteristic considered when hiring a hospital executive over high ability, connected to others and being creative, it is strongly believed that having the right ones still enable the candidate to have an edge over one who does not have it in addition to their years of related work experience and executive skills such as leadership, fiscal management, and

conflict resolution. It must be noted that a large majority of the hospital administrators have their graduate degree. Additionally, any further education or training is an investment to one's development and better self-esteem.

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Appendix A

Survey Questionnaire-Food Service Director

SURVEY OF EXECUTIVE LEADERSHIP IN HOSPITALS (FOR FOOD SERVICE DIRECTORS)

Please complete and return this survey to

Leonor U. Maro
P.O. Box 1426
Seaford, New York 11783-0255

A. BELIEFS THAT YOU HOLD.

As a high ranking manager or executive in the field of healthcare, you have certain beliefs and values about your organization, your role in it and the characteristics and skills needed to perform your job. Below are sets of questions about such beliefs. When answering these questions please state your own personal beliefs rather than those you may be required to express publicly because of your position

1. Organizational Goals. The following is a list of possible goals for your hospital organization. Next to each, circle the number that best describes how important that goal is to you personally. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. High productivity	1	2	3	4	5
b. High employee morale	1	2	3	4	5
c. Efficiency	1	2	3	4	5
d. Effectiveness	1	2	3	4	5
e. Industry leadership	1	2	3	4	5
f. Organizational growth	1	2	3	4	5
g. Profit maximization	1	2	3	4	5
h. Organizational stability	1	2	3	4	5
i. Organization's reputation	1	2	3	4	5
j. Organization's value to society	1	2	3	4	5

2. Stakeholders. There are many stakeholders in any hospital organization. Next to each group, circle the number that best describes how important that group is to you personally. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. Patients	1	2	3	4	5
b. Departmental Managers	1	2	3	4	5
c. My co-workers (Other employees in your dept/office)	1	2	3	4	5
d. Professional employees	1	2	3	4	5
e. White collar employees (Admin or office employees)	1	2	3	4	5
f. Craftsmen	1	2	3	4	5
g. My superiors	1	2	3	4	5
h. My subordinates (Employees directly under you)	1	2	3	4	5
i. Myself	1	2	3	4	5
j. Elected public officials	1	2	3	4	5
k. Regulatory agencies' bureaucrats	1	2	3	4	5
l. The general public	1	2	3	4	5

3. Characteristics of Executives. The following is a list of characteristics that are potentially important for executives. Next to each characteristic, circle the number that best describes how important to you personally that characteristic is as an executive at your level. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. High ability	1	2	3	4	5
b. Ambitious	1	2	3	4	5
c. Skillful	1	2	3	4	5
d. Cooperative	1	2	3	4	5
e. Achievement-oriented	1	2	3	4	5
f. Satisfied with the job	1	2	3	4	5
g. Creative	1	2	3	4	5
h. Successful	1	2	3	4	5
i. Flexible	1	2	3	4	5
j. Competitive	1	2	3	4	5
k. Caring	1	2	3	4	5
l. Connected to others (Team player)	1	2	3	4	5
m. Willing to mentor	1	2	3	4	5
n. Academic credentials	1	2	3	4	5

4. Executive Skills. The following is a list of skills that are potentially important for executives. Next to each skill, circle the number that best describes how important that skill is to you personally in your own job.. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. General management knowledge	1	2	3	4	5
b. Fiscal management skills	1	2	3	4	5
c. Human management skills	1	2	3	4	5
d. Negotiations/compromise/conflict resolution	1	2	3	4	5
e. Facilitating positive medical staff relations	1	2	3	4	5
f. Facilitating positive board relations	1	2	3	4	5
g. Leadership	1	2	3	4	5
h. Political savvy	1	2	3	4	5
i. Strategic planning	1	2	3	4	5
j. Having a total organizational view	1	2	3	4	5

B YOUR ROLE AS LEADER

In this section, we would like to learn more about managerial role behavior and leadership skills. The questions are designed to capture how those reporting directly to you perceive your leadership style. Circle the number next to each behavior that best describes how often you believe subordinates would think you display that behavior.

Subordinates think:	Almost Never	Seldom	Sometimes	Often	Almost Always
1. You make everyone around you enthusiastic about assignments.	1	2	3	4	5
2. You are a model for them to follow.	1	2	3	4	5
3. You inspire loyalty to the organization.	1	2	3	4	5
4. You have a sense of mission that you transmit to them.	1	2	3	4	5
5 You excite them with your visions of what can be accomplished working together.	1	2	3	4	5
6. You give personal attention when they feel neglected.	1	2	3	4	5
7. You find out what they want and help them get it.	1	2	3	4	5
8 You express your appreciation when they do a good job.	1	2	3	4	5
9 You treat each one of them as an individual.	1	2	3	4	5
10.You make sure they receive fair benefits from their work.	1	2	3	4	5
11.You give them what they want in exchange for showing their support to you.	1	2	3	4	5
12.You are open to negotiations about working conditions.	1	2	3	4	5
13.You assure them they can get what they want in exchange for their efforts.	1	2	3	4	5
14.You show them how to get what they decide they want.	1	2	3	4	5
15.Your ideas challenge them to rethink some of their own ideas	1	2	3	4	5
16 You provide them with new ways of looking at things.	1	2	3	4	5
17.You are satisfied with the existing procedures, as long as they work.	1	2	3	4	5
18.You allow them to suggest news ways at looking at things.	1	2	3	4	5
19.You ask of them only what is absolutely essential.	1	2	3	4	5
20.You will allow them to take the initiative but you do not require them to do so.	1	2	3	4	5
21.You tell them only what they have to know to do their job.	1	2	3	4	5

C. CONSIDERATIONS WHEN HIRING TOP ADMINISTRATORS.

As a food service director, you have the opportunity to hire people. In this section, we would like to learn about qualifications you think will be important in hiring an assistant/ associate hospital administrator.

1. If you were asked to hire an assistant/associate hospital administrator director, what qualifying characteristics and skills would you look for in the candidate? Choose four (4) characteristics and four (4) skills from A3 and A4 on page 2 and rank order them from "1" as the most important qualifying characteristic and skill to "4" being the least important qualifying characteristic and skill:

Assistant/ Associate Hospital Administrator

Rank	Characteristic	Skill
1. Most Important		
2.Important		
3.Somewhat Important		
4.Least Important		

2. In choosing the candidate, you would try to choose from your:	(Circle your answer) Not at all Likely	Not very Likely	Somewhat Likely	Likely	Very Likely
a. age group	1	2	3	4	5
b. gender group	1	2	3	4	5
c. outside the hospital you work	1	2	3	4	5
d. within the hospital you work	1	2	3	4	5

3. Circle the educational preparation and specify the major field you believe the candidate should have

Educational Degree	No	Yes	Major Field
Associate Degree			
Bachelors Degree			
Master Degree			
Doctorate Degree			

4 How many years of experience as a department head or similar management level is essential for the candidate to have in order that he/she can considered for an assistant/ associate hospital administrator's position: Check the box corresponding to your answer:

☐ 0 - 2 Years ☐ 3 - 4 Years ☐ More than 4 Years

5. If you could mentor your future successor, list at least four (4) departments where in your opinion he/she would gain the kinds of experiences to qualify him/her for promotion to assistant / associate hospital administrator. These departments/ services may include, Acquisition and Material Management (Mgt.), Environmental (Housekeeping) Mgt., Engineering, Fiscal, Information and Resource Mgt., Medical Administration, Laboratory, Nursing, Nutrition and Food Service, Pharmacy, Radiology, etc. Rank order them from "1", being the department providing the most qualifying experience to "4", being the department providing the least qualifying experience.

	Department	Rank
a.		
b.		
c.		
d.		

D. BALANCING WORK AND NON-WORK-RELATED ACTIVITIES.

In today's intense climate in the healthcare industry, managers and executives often have to balance work and non-work-related activities.

1. The following statements describe some issues related to balancing work and non-work-related responsibilities. Next to each statement, circle the number that best describes how often you feel each way. Use the following key:

	Almost Never	Seldom	Sometimes	Often	Almost Always
a. My job keeps me from doing the things I want to do	1	2	3	4	5
b. I have more to do My than I can handle comfortably	1	2	3	4	5
c. I have a good balance between work and personal time	1	2	3	4	5
d. I wish I had more time to do things with others	1	2	3	4	5
e. I feel physically drained after work	1	2	3	4	5
f. I feel emotionally drained after work	1	2	3	4	5
g. I have to rush to get everything done each day	1	2	3	4	5
h. My free time does not match my family's/ friend's schedule well	1	2	3	4	5
i. I do not have enough time for myself	1	2	3	4	5
j. I worry that people at work think my personal responsibilities interfere with my job	1	2	3	4	5

If you have no children, please skip to Section E

2a. How many children do you have? (Circle your answer)

	State the age of your children
One	
Two	
Three or more	

2b. How old were you when your first child was born? (Circle your answer)

Under 25 Years	1	35 to 39 Years	4
25 to 29 Years	2	40 Years or more	5
30 to 34 Years	3		

2c.. The following statements describe issues related to balancing work and childrearing responsibilities. Next to each statement, circle the number that best describes how often you feel that way. Use the following key.

	Almost Never	Seldom	Sometimes	Often	Almost Always
a. I worry whether I should work less and spend more time with my children	1	2	3	4	5
b. I find enough time for my children	1	2	3	4	5
c. I worry about how my kids are doing while I am working	1	2	3	4	5
d. I am comfortable with the arrangements for my children while I am working	1	2	3	4	5
e. Making arrangements for my children while I work involves a lot of effort	1	2	3	4	5
f. I worry that other people feel I should spend more time with my children	1	2	3	4	5

E. DESIRE FOR CAREER ADVANCEMENT.

The following questions seek to determine your desire to advance your career based on your present position.

1. a. Would you think you would want to be a hospital administrator ? Circle your answer and use the following key:

Definitely No	Possibly No	No Opinion	Possibly Yes	Definitely Yes
1	2	3	4	5

b Would you accept an offer of a higher position in your hospital's organization (e.g. assistant/ associate hospital administrator or hospital administrator)?

1. If it were offered to you now?
YES ☐ NO ☐

2. If it were offered to you five years from now?
YES ☐ NO ☐

c. Whatever your answer to (b), give three (3) reasons why you accepted the position. Rank order them from "1", being the most important reason to "3", being the least important reason.

	Reason	Rank
(a)		
(b)		
(c)		

F. ABOUT YOU.

Finally, we would like to ask you some questions about yourself to help interpret the results this questionnaire.

1. Are you the food service director who is responsible for the Nutrition and Food Service Department? Check the box corresponding to your answer.

YES ☐ NO ☐

WRITE YOUR TITLE HERE_____

2. How many years have you been a food service director at current place of employment: _____YEARS

3. How many years have you been a food service director some place else (i.e. before your current job)? _____YEARS

4. Your hospital's type? (Circle all that apply.)

MEDICAL CENTER	1	OSTEOPATHIC HOSPITAL	4
COMMUNITY HOSPITAL	2	RELIGIOUS HOSPITAL	5
SPECIALITY HOSPITAL	3	OTHER	6

IF OTHER, STATE TYPE HERE:_____

5. Write your hospital's licensed number of inpatient beds (exclude newborn bassinets and long-term care beds):_____BEDS

6 What is your gender.? (Circle your answer.)

MALE 1 FEMALE 2

7. What is your ethnic group? ? (Circle your answer.)

African American	1	Native American	4
Asian	2	White	5
Hispanic	3	Other (Specify)	

_____

8. How old are you ? (Circle your answer.)

30 years old & below	1	51 – 60 years old	4
31 - 40 years old	2	61 years old	5
41- 50 years old	3		

9. Please describe your education (Circle one and specify your major field)

	NO	YES	MAJOR FIELD
ASSOCIATE DEGREE			
BACHELORS DEGREE			
MASTERS DEGREE			
DOCTORAL DEGREE			
OTHERS			

10. What is your current marital status? (Circle your answer.)

NEVER MARRIED	1	DIVORCED	4
MARRIED	2	SEPARATED	5
REMARRIED	3	WIDOWED	6

11. Your annual salary? (Circle your answer.)

Less Than $100,000	1	$151 -$175,000	4
$101 - $125,000	2	$176 -$200,000	5
$126 - $150,000	3	Over $201,000	6

12. What is the employment status of the spouse/ partner you now live with? (Circle your answer.)

FULL TIME, OUTSIDE HOME	1	INSIDE HOME ONLY	3
PART TIME, OUTSIDE HOME	2	NOT APPLICABLE	4

13. Are you a member of a religious order (e.g., a nun, or priest)? Check the box corresponding to your answer

YES ☐ NO ☐

YOU ARE DONE! THANK YOU AGAIN FOR YOUR PARTICIPATION. PLACE A CHECK MARK IN THE BOX BELOW IF YOU WOULD LIKE TO RECEIVE A SUMMARY OF THE RESULTS.

YES, please send a summary ☐

Appendix B

Survey Questionnaire-Hospital Director

SURVEY OF EXECUTIVE LEADERSHIP IN HOSPITALS (FOR HOSPITAL DIRECTORS)

Please complete and return this survey to

Leonor U. Maro
P.O. Box 1426
Seaford, New York 11783-0255

A. BELIEFS THAT YOU HOLD.

As a high ranking manager or executive in the field of healthcare, you have certain beliefs and values about your organization, your role in it and the characteristics and skills needed to perform your job. Below are sets of questions about such beliefs. When answering these questions please state your own personal beliefs rather than those you may be required to express publicly because of your position

1. Organizational Goals. The following is a list of possible goals for your hospital organization. Next to each, circle the number that best describes how important that goal is to you personally . Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. High productivity	1	2	3	4	5
b. High employee morale	1	2	3	4	5
c. Efficiency	1	2	3	4	5
d. Effectiveness	1	2	3	4	5
e. Industry leadership	1	2	3	4	5
f. Organizational growth	1	2	3	4	5
g. Profit maximization	1	2	3	4	5
h. Organizational stability	1	2	3	4	5
i. Organization's reputation	1	2	3	4	5
j. Organization's value to society	1	2	3	4	5

2. Stakeholders. There are many stakeholders in any hospital organization. Next to each group, circle the number that best describes how important that group is to you personally. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. Patients	1	2	3	4	5
b. Departmental Managers	1	2	3	4	5
c. My co-workers (Other employees in your dept/office)	1	2	3	4	5
d. Professional employees	1	2	3	4	5
e. White collar employees (Admin or office employees)	1	2	3	4	5
f. Craftsmen	1	2	3	4	5
g. My superiors	1	2	3	4	5
h. My subordinates (Employees directly under you)	1	2	3	4	5
i. Myself	1	2	3	4	5
j. Elected public officials	1	2	3	4	5
k. Regulatory agencies' bureaucrats	1	2	3	4	5
l. The general public	1	2	3	4	5

3. Characteristics of Executives. The following is a list of characteristics that are potentially important for executives. Next to each characteristic, circle the number that best describes how important to you personally that characteristic is as an executive at your level. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. High ability	1	2	3	4	5
b. Ambitious	1	2	3	4	5
c. Skillful	1	2	3	4	5
d. Cooperative	1	2	3	4	5
e. Achievement-oriented	1	2	3	4	5
f. Satisfied with the job	1	2	3	4	5
g. Creative	1	2	3	4	5
h. Successful	1	2	3	4	5
i. Flexible	1	2	3	4	5
j. Competitive	1	2	3	4	5
k. Caring	1	2	3	4	5
l. Connected to others (Team player)	1	2	3	4	5
m. Willing to mentor	1	2	3	4	5
n. Academic credentials	1	2	3	4	5

4. Executive Skills. The following is a list of skills that are potentially important for executives. Next to each skill, circle the number that best describes how important that skill is to you personally in your own job.. Use the following key:

	Not at all Important	Not very Important	Somewhat Important	Important	Very Important
a. General management knowledge	1	2	3	4	5
b. Fiscal management skills	1	2	3	4	5
c. Human management skills	1	2	3	4	5
d. Negotiations/compromise/conflict resolution	1	2	3	4	5
e. Facilitating positive medical staff relations	1	2	3	4	5
f. Facilitating positive board relations	1	2	3	4	5
g. Leadership	1	2	3	4	5
h. Political savvy	1	2	3	4	5
i. Strategic planning	1	2	3	4	5
j. Having a total organizational view	1	2	3	4	5

B YOUR ROLE AS LEADER

In this section, we would like to learn more about managerial role behavior and leadership skills. The questions are designed to capture how those reporting directly to you perceive your leadership style. Circle the number next to each behavior that best describes how often you believe subordinates would think you display that behavior.

Subordinates think:	Almost Never	Seldom	Sometimes	Often	Almost Always
1. You make everyone around you enthusiastic about assignments.	1	2	3	4	5
2. You are a model for them to follow.	1	2	3	4	5
3. You inspire loyalty to the organization.	1	2	3	4	5
4. You have a sense of mission that you transmit to them.	1	2	3	4	5
5 You excite them with your visions of what can be accomplished working together.	1	2	3	4	5
6. You give personal attention when they feel neglected.	1	2	3	4	5
7. You find out what they want and help them get it.	1	2	3	4	5
8. You express your appreciation when they do a good job.	1	2	3	4	5
9. You treat each one of them as an individual.	1	2	3	4	5
10.You make sure they receive fair benefits from their work.	1	2	3	4	5
11.You give them what they want in exchange for showing their support to you.	1	2	3	4	5
12.You are open to negotiations about working conditions.	1	2	3	4	5
13.You assure them they can get what they want in exchange for their efforts.	1	2	3	4	5
14.You show them how to get what they decide they want.	1	2	3	4	5
15.Your ideas challenge them to rethink some of their own ideas	1	2	3	4	5
16.You provide them with new ways of looking at things.	1	2	3	4	5
17.You are satisfied with the existing procedures, as long as they work.	1	2	3	4	5
18.You allow them to suggest news ways at looking at things.	1	2	3	4	5
19.You ask of them only what is absolutely essential.	1	2	3	4	5
20.You will allow them to take the initiative but you do not require them to do so.	1	2	3	4	5
21.You tell them only what they have to know to do their job.	1	2	3	4	5

C. CONSIDERATIONS WHEN HIRING TOP ADMINISTRATORS.

As a hospital administrator, you have the opportunity to hire people. In this section, we would like to learn about qualifications you think will be important in hiring an assistant/ associate hospital administrator.

1. If you were asked to hire an assistant/associate hospital administrator, what qualifying characteristics and skills would you look for in the candidate? Choose four (4) characteristics and four (4) skills from A3 and A4 on page 2 and rank order them from "1" as the most important qualifying characteristic and skill to "4" being the least important qualifying characteristic and skill:

Assistant/ Associate Hospital Administrator

Rank	Characteristic	Skill
1. Most Important		
2.Important		
3.Somewhat Important		
4.Least Important		

2. In choosing the candidate, you would try to choose from your:	(Circle your answer) Not at all Likely	Not very Likely	Somewhat Likely	Likely	Very Likely
a. age group	1	2	3	4	5
b. gender group	1	2	3	4	5
c. outside the hospital you work	1	2	3	4	5
d. within the hospital you work	1	2	3	4	5

3. Circle the educational preparation and specify the major field you believe the candidate should have

Educational Degree	No	Yes	Major Field
Associate Degree			
Bachelors Degree			
Master Degree			
Doctorate Degree			

4 How many years of experience as a department head or similar management level is essential for the candidate to have in order that he/she can considered for an assistant/ associate hospital administrator's position: Check the box corresponding to your answer:

☐ 0 - 2 Years ☐ 3 - 4 Years ☐ More than 4 Years

5. If you could mentor your future successor, list at least four (4) departments where in your opinion he/she would gain the kinds of experiences to qualify him/her for promotion to assistant / associate hospital administrator. These departments/ services may include, Acquisition and Material Management (Mgt.), Environmental (Housekeeping) Mgt., Engineering, Fiscal, I nformation and Resource Mgt., Medical Administration, Laboratory, Nursing, Nutrition and Food Service, Pharmacy, Radiology, etc. Rank order them from "1", being the department providing the most qualifying experience to "4", being the department providing the least qualifying experience.

Department	Rank
a.	
b.	
c.	
d.	

D. BALANCING WORK AND NON-WORK-RELATED ACTIVITIES.

In today's intense climate in the healthcare industry, managers and executives often have to balance work and non-work-related activities.

1. The following statements describe some issues related to balancing work and non-work-related responsibilities. Next to each statement, circle the number that best describes how often you feel each way. Use the following key:

	Almost Never	Seldom	Sometimes	Often	Almost Always
a. My job keeps me from doing the things I want to do	1	2	3	4	5
b. I have more to do My than I can handle comfortably	1	2	3	4	5
c. I have a good balance between work and personal time	1	2	3	4	5
d. I wish I had more time to do things with others	1	2	3	4	5
e. I feel physically drained after work	1	2	3	4	5
f. I feel emotionally drained after work	1	2	3	4	5
g. I have to rush to get everything done each day	1	2	3	4	5
h. My free time does not match my family's/ friend's schedule well	1	2	3	4	5
i. I do not have enough time for myself	1	2	3	4	5
j. I worry that people at work think my personal responsibilities interfere with my job	1	2	3	4	5

If you have no children, please skip to Section E

2a. How many children do you have? (Circle your answer)

	State the age of your children
One	
Two	
Three or more	

2b. How old were you when your first child was born? (Circle your answer)

Under 25 Years	1	35 to 39 Years	4
25 to 29 Years	2	40 Years or more	5
30 to 34 Years	3		

2c.. The following statements describe issues related to balancing work and childrearing responsibilities. Next to each statement, circle the number that best describes how often you feel that way. Use the following key.

	Almost Never	Seldom	Sometimes	Often	Almost Always
a. I worry whether I should work less and spend more time with my children	1	2	3	4	5
b. I find enough time for my children	1	2	3	4	5
c. I worry about how my kids are doing while I am working	1	2	3	4	5
d. I am comfortable with the arrangements for my children while I am working	1	2	3	4	5
e. Making arrangements for my children while I work involves a lot of effort	1	2	3	4	5
f. I worry that other people feel I should spend more time with my children	1	2	3	4	5

E. DESIRE FOR CAREER ADVANCEMENT.

The following questions seek to determine your desire to advance your career based on your present position.

1. a. Already a hospital administrator, how important was it for you to seek this level of position within the organization?: Circle your answer and use the following key:

Not At All Important	Not Very Important	Somewhat Important	Important	Very Important
1	2	3	4	5

b. Give three (3) reasons why you accepted the position. Rank order them from "1", being the most important reason to "3", being the least important reason.

	Reason	Rank
(a)		
(b)		
(c)		

F. ABOUT YOU.

Finally, we would like to ask you some questions about yourself to help interpret the results of this questionnaire.

1. Are you the hospital administrator to whom the governing authority has been delegated the continuous responsibility for the operation of the hospital in accordance with established policy? Check the box corresponding to your answer.

YES ☐ NO ☐

WRITE YOUR TITLE HERE _____

2. How many years have you been a hospital administrator at current place of employment: _____YEARS

3. How many years have you been a hospital administrator some place else (i.e. before your current job)? _____YEARS

4. Your hospital's type? (Circle all that apply.)

MEDICAL CENTER	1	OSTEOPATHIC HOSPITAL	4
COMMUNITY HOSPITAL	2	RELIGIOUS HOSPITAL	5
SPECIALITY HOSPITAL	3	OTHER	6

IF OTHER, STATE TYPE HERE: _____

5. Write your hospital's licensed number of inpatient beds (exclude newborn bassinets and long-term care beds): _____BEDS

6 What is your gender.? (Circle your answer.)

MALE 1 FEMALE 2

7. What is your ethnic group? ? (Circle your answer.)

African American	1	Native American	4
Asian	2	White	5
Hispanic	3	Other (Specify)	

_____

8. How old are you ? (Circle your answer.)

30 years old & below	1	51 – 60 years old	4
31 - 40 years old	2	61 years old	5
41- 50 years old	3		

9. Please describe your education (Circle one and specify your major field)

	NO	YES	MAJOR FIELD
ASSOCIATE DEGREE			
BACHELORS DEGREE			
MASTERS DEGREE			
DOCTORAL DEGREE			
OTHERS			

10. What is your current marital status? (Circle your answer.)

NEVER MARRIED	1	DIVORCED	4
MARRIED	2	SEPARATED	5
REMARRIED	3	WIDOWED	6

11. Your annual salary? (Circle your answer.)

Less Than $100,000	1	$151 -$175,000	4
$101 - $125,000	2	$176 -$200,000	5
$126 - $150,000	3	Over $201,000	6

12. What is the employment status of the spouse/ partner you now live with? (Circle your answer.)

FULL TIME, OUTSIDE HOME	1	INSIDE HOME ONLY	3
PART TIME, OUTSIDE HOME	2	NOT APPLICABLE	4

13. Are you a member of a religious order (e.g., a nun, or priest)? Check the box corresponding to your answer

YES ☐ NO ☐

YOU ARE DONE! THANK YOU AGAIN FOR YOUR PARTICIPATION. PLACE A CHECK MARK IN THE BOX BELOW IF YOU WOULD LIKE TO RECEIVE A SUMMARY OF THE RESULTS.

YES, please send a summary ☐

Appendix C

Letter of Introduction From Program Coordinator

TEACHERS COLLEGE

COLUMBIA UNIVERSITY

DEPARTMENT OF HEALTH AND BEHAVIOR STUDIES

PROGRAM IN NUTRITION

Dear Hospital Administrator/Food Service Administrator:

I am sure you are aware of the great need for but lack of available quality hospital executives. In connection with this, Leonor Maro, a doctoral student in Nutrition Education at Teachers College, Columbia University, will be conducting a survey to determine the "Perceived Barriers to the Promotion of Food Service Directors to Higher Administrative Positions in Hospital Organizations".

The results of this survey will be shared so that hospital executives can learn of each other's desires, considerations, and perceived barriers for career advancement; and hopefully, look into these when considering applicants for higher hospital administrative positions. The study results will also be used to modify existing health management programs for nutritionists-dietitians and other health care professionals.

Please find enclosed Mrs. Maro's survey questionnaire. Also, kindly take a few moments to complete and return it in the postage-paid envelope that is also enclosed.

Thank you in advance for your assistance. Your participation in this survey will be very much appreciated!

Sincerely,

Isobel P. Contento, PhD
Professor and Coordinator
Program in Nutrition Education

BOX 137, 525 WEST 120TH STREET, NEW YORK, NY 10027-6696 (212) 678-3950 http://www.tc.columbia.edu/-academic/nutri/www/

Appendix D

Cover Letter

TEACHERS COLLEGE

COLUMBIA UNIVERSITY

DEPARTMENT OF HEALTH AND BEHAVIOR STUDIES

PROGRAM IN NUTRITION

Dear Hospital Administrator/Food Service Administrator:

Recruitment of highly qualified executives has always been a big concern. In connection with this and as part of my doctoral research at Teachers College, Columbia University, this survey questionnaire is being distributed to hospital administrators and food service directors to determine their desires, considerations, and perceived barriers for career advancement. At the same time, the study seeks to compare their management and leadership skills.

You have been especially selected to receive this questionnaire. Thus, your responses are extremely important. Your voluntary completion of the survey will provide insights and experiences that are extremely valuable in helping the department to modify the existing health management programs for nutritionists/dietitians and other health care professionals. At the same time, appropriate continuing education programs for said health care professionals can be planned and implemented.

On the other hand, you might hesitate to share your insights, and feeling about the topic. Please be assured that your name, institution, and responses will be kept strictly confidential. Each name will be assigned a code number, which will be used solely for follow-up mailing. Your consent to participate in this study is implied by your completing and returning the questionnaire.

If you have any questions about this research or your participation, kindly write or call me at: P.O. Box 1426, Seaford, New York 11783, Phone Number: 973-676-1000 extension 1497.

Any questions about your rights as a study participant or in case of dissatisfaction at any time with any aspect of the questionnaire may be directed, anonymously if you wish, to: The Institutional Review Board at Teachers College, Columbia University, 525 West 120th Street, New York , New York 10027, Box 151 or 212-678-4105.

After you have completed the survey, please mail it in the enclosed self-addressed, stamped envelope. Your time and effort are greatly appreciated!

With sincere thanks,

Leonor U. Maro, M.A, M.S, RD

P.S. Upon receipt of your completed questionnaire, your given code will be included in the $500 cash raffle. Thanks again!

Appendix E

Follow-up Postcard

Dear Hospital Administrator/Food Service Director:

Last week, we sent you a questionnaire on *Executive Leadership in Hospitals.* Your input is important in determining not only the management & leadership skills of hospital executives like you; but also your perceived desires, considerations and barriers to career advancement. The results will also be used to modify existing health management programs for nutritionist-dietitians and other health care professionals.

If you have already completed and returned the questionnaire, please accept our sincere thanks. If not, please do so today. Including your input in this study will benefit a lot of career health care professionals.

If by chance you did not receive the questionnaire or it got misplaced, please call (516 826-3768 or 973 676-1000, ext 1497) or e-mail (MARO.LEONOR_U@EAST-ORANGE.MED.VA.GOV) and will send you another one immediately.

Sincerely,

Leonor U. Maro, R.D.
Health Care Management Research Project

Appendix F

Cover Letter Requesting Completion

TEACHERS COLLEGE

COLUMBIA UNIVERSITY

DEPARTMENT OF HEALTH AND BEHAVIOR STUDIES

PROGRAM IN NUTRITION

Dear Hospital Administrator/Food Service Director:

Thank you for participating in our survey. However, we need you to complete the parts that you overlooked so that your questionnaire can fully be considered and your code included in the cash raffle. We also noted any comment that you have made regarding the questionnaire which we will consider in the study's limitations. Upon completion of said sections, kindly return them in the enclosed self-addressed, stamped envelope.

If you have any question, please contact me at: (973)676-1000x1497(AM) and at (516)826-3768 or MARO,LEONOR_U@EAST ORANGE.MED.VA.GOV. Once again, thanks!

Sincerely,

Leonor U. Maro, R.D.

BOX 137, 525 WEST 120TH STREET, NEW YORK, NY 10027-6696 (212) 678-3950 http://www.tc.columbia.edu/-academic/nutri/www/