
Mentoring Junior Healthcare Administrators: A Description of Mentoring Practices in 127 U.S. Hospitals

Frances R. Finley, DHA, FACHE, administrator, Aurora Medical Center of Oshkosh, Oshkosh, Wisconsin; Lana V. Ivanitskaya, Ph.D., associate professor, Central Michigan University, Mount Pleasant, Michigan; and Michael H. Kennedy, Ph.D., FACHE, associate professor, East Carolina University, Greenville, North Carolina

EXECUTIVE SUMMARY

A survey instrument about mentoring junior healthcare administrators was mailed to 485 senior-level executives—chief executive officers, hospital administrators, and presidents. Completed surveys were returned by 127 senior executives (26 percent response rate). On average, the respondents were 53 years old, had nine years of organizational tenure in their current position, and had 16.5 years of career tenure as a senior healthcare executive. The mean age of when the respondents first had a mentor was 28 years old. The average length of the respondents' relationship with their mentor was 3.56 years. Although healthcare executives believed mentoring benefits the healthcare industry as a whole, they reported that the benefits were even greater for the hospital where mentoring was done. Personal satisfaction was cited as the primary reason for serving as a mentor. In the 127 organizations represented by the respondents, informal mentoring programs were more prevalent than formal mentoring programs.

Our findings suggest that healthcare executives in formal mentoring programs may be more likely to support mentoring than individuals who entered informal mentoring relationships. Those who reported being mentors or engaging in mentoring-supportive activities had a longer job tenure and career tenure than did individuals who had not served as mentors. The study suggests that mentoring—in particular, informal mentoring—is a popular activity in U.S. hospitals and is carried out by experienced healthcare executives whose primary motivation is personal satisfaction.

For more information on the concepts in this article, please contact Dr. Ivanitskaya at ivani1sv@cmich.edu. The authors thank Dr. Gerald Ledlow and Dr. Carl Lee for their valuable input in designing this study.

Today's senior healthcare executives are faced with the challenge of preparing the next generation of leaders. While individual organizations determine the best method to approach this process, the age-old concept of mentoring can be adapted to today's environment. The term "mentor" originates from Homer's *The Odyssey*, where the character Mentor coaches, counsels, and advises Telemachus, Odysseus's son, as Telemachus prepares to assume the family responsibilities in his father's absence. This term evolved to represent a wise and trusted counselor, friend, and teacher (Lacey 2001) and has been used to describe a relationship that has the fundamental purpose of sharing knowledge and information that can be unique to the organization or industry.

According to Fagenson (1989), most researchers agree that mentoring represents a developmental process or relationship designed to enhance personal growth and provide advancement opportunities. Mentoring is recognized as a process beneficial to both the mentor and the mentee (Allen, Poteet, and Burroughs 1997). The mentee, or protégé, benefits through opportunities for advancement, higher salary, and greater job satisfaction (Burke and McKeen 1995; Fagenson-Eland, Marks, and Amendola 1997).

Mentoring is important to mentors and protégés for a variety of reasons. Mentors benefit from the relationship by gaining internal satisfaction (Kram 1988). Fagenson (1989, 315) finds that "individuals who had mentors rated themselves as having significantly more career mobility/opportunity,

recognition, satisfaction and promotion than individuals who did not have mentors." Although mentoring requires an additional time commitment over and above any formal job requirement, the decision to mentor is driven by a desire to see protégés succeed as well as by the belief that it is an obligation to help the next generation succeed (Allen, Poteet, and Burroughs 1997). Perrone (2003) finds mentoring to be beneficial in providing ongoing career development and accelerating leadership development. May (2003) believes mentoring is one of the most important steps a healthcare leader can take to ensure the future viability of his or her organization. A researcher who studied New Zealand mentors reported that 60 percent of mentors and 70 percent of protégés believed that their mentor significantly affected their careers (Chamove 2002). According to Fagenson (1989), more organizations are now formalizing mentorship roles. Chao, Walz, and Gardner (1992) compare the effect of formal versus informal mentorships and conclude that protégés in informal mentorships benefit more from career support than protégés in formal mentorships. Chao and colleagues also note that organizations recognize the value of mentoring and the benefit of formalizing a program, as opposed to relying solely on spontaneous relationships.

The purpose of this study is to examine the practices of senior-level hospital executives who mentor junior hospital administrators. The study was guided by the following research questions:

- Do healthcare executives see mentoring as an activity that benefits their organization and/or the healthcare industry as a whole?
- Do most healthcare executives serve as mentors because of personal satisfaction, and to what extent are they motivated by extrinsic rewards, such as money or promotion?
- Do senior executives who participate in formal mentoring programs demonstrate greater support for mentoring than those who enter informal mentoring relationships?
- Are senior healthcare administrators with longer tenure more likely to support mentoring than those with shorter tenure?
- Do senior healthcare administrators who mentor others have greater job and industry experience than those who do not mentor?

METHODS

A survey was distributed to hospital executives identified through a mailing list purchased from SK&A Information Services, Inc., in Irvine, California. Twice a year, SK&A's Research Center telephone-verifies data for more than 7,100 hospitals with more than 250,000 decision makers. The database includes acute care hospitals, long-term acute-care hospitals, rehabilitation hospitals, acute psychiatric hospitals, and mental health centers. Of 7,866 hospital executives in the mailing list, 6,798 records were selected based on a job title of chief executive officer (CEO), hospital administrator, or president. The purpose of this judgment sampling was to narrow the list to senior hospital executives. A random-numbers

table was used to further select 485 study participants who received mailed surveys, including a cover letter and a prepaid reply envelope. To maximize the number of surveys returned, we coded each survey so that we could identify nonrespondents and send them reminder cards. The participants were offered an incentive—an executive summary of the study findings—in exchange for their effort and time taken to complete the survey. Because surveys were not anonymous, a cover letter explained steps taken to protect the confidentiality of responses.

The survey included items that measured whether the respondent had ever served as a mentor to a junior healthcare administrator and assessed his or her current support for mentoring, as indicated by mentoring-related activities in which the executive had engaged in the past 12 months. The respondents specified the type of mentoring program in their organization (formal, informal, no mentoring program, or other) and rated how various monetary and nonmonetary rewards influenced their decision to mentor. In addition, they were asked to indicate how their organization and the healthcare industry benefit from mentoring. Space was provided for written comments about senior administrators' mentoring experiences. Healthcare executives reported the number of mentors they had had during their professional career, the age when they first had a mentor, and the average length of their relationship with their mentor. Demographic questions measured respondents' age, gender, ethnicity, position in the organization, level of educational attainment, total number

of years in the current position, and total number of years as a senior-level executive. The instrument was pilot-tested to obtain feedback regarding the sequence and clarity of questions, ease of completing the survey, and survey completion time.

Data were analyzed using descriptive statistics, Pearson's correlations, independent-samples *t* tests to examine the difference in means, and paired-samples *t* tests to examine the means difference between scores for two variables. A *p* value of .05 was used to determine statistical significance. Cronbach's alpha was used to estimate how consistently a set of items measured a single construct, an important consideration for variables developed from a score summated or averaged across multiple items. A reliability coefficient of .70 was considered to be minimally acceptable.

RESULTS

Respondents

A total of 127 usable surveys were returned by mail, which corresponds to a 26 percent response rate. We made every effort to achieve at least a 30 percent response rate, but that rate was hard to obtain because the participants (a) were senior-level executives and (b) did not have a special relationship with the first author of the study (Frances Finley) or the organization with which she is affiliated. All but two of the 127 respondents had served as mentors to one or more junior healthcare administrators. Of the respondents, 84 percent were men, 95 percent self-identified as Caucasian, and 82 percent had earned a master's degree.

Other respondents' characteristics are presented in Table 1.

Most respondents (77 percent) reported that they had been mentored by a senior healthcare executive during their career. Of these, 27 percent had one mentor during their career, 30.3 percent had two mentors, and 24.2 percent had three mentors. About 41 percent of respondents (39 of 95 who responded to this question) were mentored early in their careers, when they were aged 25 years or younger. As shown in Table 1, on average, respondents were 28 years old when they were first mentored, and their relationship with a mentor lasted 3.56 years.

Characteristics of respondents in this study were compared with the characteristics of CEOs who participated in two American College of Healthcare Executives studies by Garman and Tyler (2004) and Khaliq and colleagues (2006). These studies had 46 percent and 38 percent response rates, respectively. Compared with Garman and Tyler's respondents, our study participants were about the same age (median age of 55 years and 53 years, respectively); were predominantly male (86.5 percent and 84 percent, respectively); and were predominantly Caucasian (97.5 percent and 95 percent, respectively). A bachelor's degree was the highest degree earned for about 19 percent of Garman and Tyler's respondents and for fewer than 10 percent of our study participants. Khaliq and colleagues (2006) reported that the median job tenure of their respondents was 3.6 years. Our

TABLE 1
Characteristics of Respondents

Variables	No. of Respondents	Mean	Standard Deviation
Age (years)	121	52.65	7.55
Job tenure in current organization (years)	120	8.66	7.17
Career tenure as senior executive (years)	122	16.45	9.06
Number of mentors during respondent's career (n)	99	2.39	1.48
Age at first having a mentor (years)	95	28.51	5.89
Length of the relationship with a mentor (years)	92	3.56	4.47

respondents' job tenure was identical to those who participated in Garman and Tyler's study (a median of six years).

Do Healthcare Executives See Mentoring as an Activity that Benefits Their Organization and/or the Healthcare Industry as a Whole?

Two scales were used for this question: perceived benefits of mentoring for one's organization and perceived benefits of mentoring for the industry. Each scale consisted of 11 items, representing potential benefits of mentoring a junior healthcare administrator, such as strengthened organizational culture(s); increased technical competence (defined as mastery of functional areas of management such as finance or strategic planning) of those who were mentored; and improved job performance of those who were mentored. Respondents were asked to indicate whether their organization was likely to benefit and whether the industry was likely to benefit. A five-point scale was used, where 1 was "not likely at all" and 5 was "very likely." Two composite

scores were obtained by calculating mean ratings across 11 items, separately for "likelihood my organization will benefit" and "likelihood the healthcare industry will benefit," which resulted in a single score for perceived benefits of mentoring for one's organization and for perceived benefits of mentoring for the industry for each respondent. The possible composite scores ranged from 1 to 5. Cronbach's alpha reliability coefficients were estimated for the perceived benefits of mentoring for one's organization scale ($\alpha = .87$) and perceived benefits of mentoring for the industry scale ($\alpha = .88$).

Overall, the respondents reported that mentoring benefits both their organization and the healthcare industry as a whole. A paired-samples t test was used to test the difference in the mean of perceived benefits of mentoring for one's organization ($M = 3.98, s.d. = .59$) and the mean of perceived benefits of mentoring for the industry ($M = 3.8, s.d. = .62$). As indicated by a paired-samples t test, this difference was significant at the .05 level, $t = 3.51, \text{degrees of freedom } (df) = 108,$

TABLE 2
Rewards and Their Influence on Senior Healthcare Administrators' Decisions to Mentor

Rewards	Respondent Reports	
	"Reward Influences My Decision to Mentor" n (%)	"Reward Is Available to Me in My Organization" n (%)
Personal satisfaction	104 (96.3%)	94 (87.0%)
Professional recognition	33 (30.6%)	56 (51.9%)
Advancement opportunities	25 (23.1%)	23 (21.3%)
Prestige	19 (17.6%)	44 (40.7%)
Bonus opportunities	19 (17.6%)	14 (12.9%)
Increased pay	17 (15.7%)	11 (10.2%)
Stock options	14 (13.0%)	3 (2.78%)

$p < .01$. Therefore, respondents saw more benefits of mentoring for their organizations than for the industry as a whole.

Do Most Healthcare Executives Serve as Mentors Because of Personal Satisfaction, and to What Extent Are They Motivated by Extrinsic Rewards, Such as Money or Promotion?

As described in Table 2, respondents were presented with a list of rewards that may have influenced their motivation to become a mentor and were asked to check the rewards formally available to them (e.g., advancement opportunities) through their organization. It is possible that the number of respondents reporting "reward influences my decision to mentor" would be greater than the number of respondents reporting "reward is available to me" based on whether the respondent's decision to mentor was formally recognized or rewarded by his or her organization or whether

the decision to mentor was internally motivated. Responses were coded as 0 for "not available" or "not influenced motivation" or 1 for "available" or "influenced motivation." As can be seen in Table 2, senior healthcare executives chose personal satisfaction as the primary reason for serving as mentors to junior healthcare administrators.

Do Senior Executives Who Participate in Formal Mentoring Programs Demonstrate Greater Support for Mentoring than Those Who Enter Informal Mentoring Relationships?

To measure current support for mentoring, a list of six mentoring/supporting activities was provided, such as helped to initiate a mentoring program, served as a mentor, and served on a committee related to mentoring. Respondents were asked to check activities in which they had participated during the 12 months preceding the survey administration. For each activity, respondents

TABLE 3
Mentoring Program Types in Respondents' Current Organizations

Type of Mentoring Program	N	% of Total
Informal	78	63.4
Formal	18	14.6
None	17	13.8
Other	10	8.2
Total	123	100

indicated whether their participation was in their organization, outside the organization, or both. Respondents were given one point for participating in each activity, plus a point for each person they had mentored during the preceding 12 months to create a single composite score for current support for mentoring. Respondents also indicated the type of mentoring program in their organization—formal, informal, no mentoring program, or other. Informal mentoring was defined as “a senior and junior health administrator self-select each other, based on shared goals and values,” and formal mentoring was defined as “mentors are assigned by the organization, such as when a pool of potential protégés submit resumes for review by a match-making committee.” Table 3 shows the distribution of mentoring program types across respondents’ organizations.

The mean score for current support for mentoring was significantly lower for the group reporting informal mentoring in their organization ($M = 3.26, s.d. = 2.60$) than for the group reporting formal mentoring ($M = 6.00, s.d. = 4.17$), and this difference was significant at the .01 level, as indicated

by an independent samples t test ($t = -3.56, df = 94, p < .01$). Overall, the data suggest that healthcare executives in formal mentoring programs may be more likely to support mentoring, as evidenced by their actions over the preceding 12 months, than individuals who enter informal mentoring relationships.

Are Senior Healthcare Administrators with Longer Tenure More Likely to Support Mentoring than Those with Shorter Tenure?

Respondents were asked how long they had served as a senior healthcare executive in their current organization (organizational tenure) and how long they had served as a senior healthcare executive for all healthcare organizations where they worked (career tenure). Responses were recorded in years. Organizational tenure and career tenure were then correlated with the current score for support for mentoring. Results of a correlational analysis showed weak but significant positive relationships between support for mentoring and the two tenure variables—namely, organizational tenure ($r = .17, df =$

TABLE 4
Organizational and Career Tenure Comparison

	Served as Mentor		Did Not Serve as Mentor	
	M	S.D.	M	S.D.
Organizational tenure (years)	9.13	7.48	6.04	5.08
Career tenure (years)	17.61	8.94	11.31	8.11

120, $p < 0.05$) and career tenure ($r = .27$, $df = 122$, $p < .01$).

Do Senior Healthcare Administrators Who Mentor Others Have Greater Job and Industry Experience than Those Who Do Not Mentor?

Table 4 shows organizational and career tenure for two groups of respondents—those who had served as mentors and those who had not. Those who had served as mentors had significantly greater organizational tenure ($t = -2.36$, $df = 116$, $p < .02$) and career tenure ($t = -3.090$, $df = 188$, $p < .001$) than those who had not served as mentors.

DISCUSSION

An important responsibility of senior healthcare executives is preparing future leaders who can meet the challenges of a complex and ever-changing healthcare industry. Mentoring is one such method used to prepare future senior-level executives (Rollins 2003). Five research questions were posed to explore mentoring practices in U.S. hospitals:

- Do healthcare executives see mentoring as an activity that benefits their organization and/or the healthcare industry as a whole?

- Do most healthcare executives serve as mentors because of personal satisfaction, and to what extent are they motivated by extrinsic rewards, such as money or promotion?
- Do senior executives who participate in formal mentoring programs demonstrate greater support for mentoring than those who enter informal mentoring relationships?
- Are senior healthcare administrators with longer tenure more likely to support mentoring than those with shorter tenure?
- Do senior healthcare administrators who mentor others have greater job and industry experience than those who do not mentor?

Ninety-eight percent of study participants who served as mentors to junior healthcare administrators saw more benefits of mentoring for their own organizations than for the healthcare industry as a whole. The majority of healthcare executives served as mentors out of a desire for personal satisfaction, as opposed to a desire for monetary rewards or a promotion. Written comments provided by respondents further illustrate the power of nonmonetary rewards. One respondent commented, "The personal satisfaction

of giving someone a good start is the reason I chose to serve as a mentor." Another executive wrote, "I believe in the value mentoring provided to me and wanted to give back to others in the same way." These findings are consistent with an earlier study by Allen, Poteet, and Burroughs (1997); they found that the decision to mentor is driven by the mentor's desire to see protégés succeed and a belief that there is an obligation to assist the next generation of professionals. The data show that the availability of rewards did not necessarily affect the motivation to serve as a mentor. As one respondent commented, mentoring is "not the key to advancement"; rather, it "complements core competencies."

Protégés in informal mentorships have been shown to benefit in the form of additional career support compared with protégés in formal programs of mentoring (Chao, Walz, and Gardner 1992). Healthcare executives who had served as mentors were more likely to describe mentoring in their current organization as informal (63 percent) than formal (15 percent). The data obtained in this study suggest that mentors in formal mentoring programs are more likely to support mentoring than individuals in informal mentoring relationships. It is important to note, however, that the number of respondents who mentored in formal mentoring programs was small ($n = 18$).

The finding that executives with longer organizational tenure and career tenure are more likely to serve as mentors and engage in mentoring-supportive activities supports the idea that mentoring is done by those who have the most experience, knowl-

edge of health administration, and organization-specific expertise.

CONCLUSIONS AND LIMITATIONS

This study explored mentoring practices in 127 U.S. hospitals where senior healthcare executives engage in mentoring relationships with junior administrators. The findings of this descriptive study may be useful to senior healthcare executives who are thinking of establishing a new mentoring program in their organization or improving an existing program. This study contributes information on (a) what motivates mentors to engage in and support mentoring, (b) characteristics of individuals who are most likely to support mentoring, and (c) the prevalence of different types of mentoring programs. The unique advantages and disadvantages of each program type (formal or informal) should be further explored before determining what type of program may work best for a particular organization. Given the challenge of developing competent healthcare executives, a mentoring program that results in a sharing of knowledge that could otherwise be obtained only through many years of personal experience is an opportunity that should be considered by the leaders of most healthcare organizations.

Some of the limitations of the present study are nonresponse bias and social desirability bias. A relatively small response rate in our study and a tendency to report socially desirable behaviors may account, at least in part, for the large number of respondents who reported having served as mentors. Individuals who had served as mentors

were probably more likely to respond to the mentoring survey than those who had not served as mentors. We anticipated this problem and expanded our measurement beyond a single binary variable (served versus did not serve as a mentor). A behavioral checklist of mentoring behaviors (a current support for mentoring scale) allowed for a more precise estimate of the degree to which a respondent is involved in mentoring. Overall, our participants' demographics are remarkably similar to the demographics of CEOs who took part in a recent large-scale study with a 46 percent response rate (Khaliq et al. 2006). One notable exception is education—this sample is more educated than the participants in the study by Khaliq and colleagues.

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PRACTITIONER APPLICATION

Paul B. Hofmann, Dr. P.H., FACHE, president, Hofmann Healthcare Group, Moraga, California

Although this study did not produce any surprising findings, it did confirm a number of significant intuitive impressions about mentoring. Consequently,

the findings merit further discussion and suggest specific actions that should be taken.

The authors noted that more than 95 percent of the respondents were Caucasian and 84 percent were men. Given the success enjoyed by executives who serve as mentors, it is apparent that the field needs more mentoring by and for minorities and women. Although the growing number of minorities and women in healthcare management graduate programs can and should be mentored irrespective of their mentors' race and gender, they will benefit by having more role models who have overcome the discriminatory barriers that, while less prevalent now than in the past, still affect hiring and promotion decisions.

It is reasonable to speculate about the survey's nonrespondents. Because most mentors are proud of their activity, enthusiastic about their experience, and more likely to want to participate in this type of study, the vast majority of nonrespondents were probably not mentors. However, if these individuals realized the high personal-satisfaction rating of mentors, we might expect a much-needed increase in executives who are willing to take on this responsibility. More time and effort should be devoted to reaching those executives who do not realize the enjoyment they are missing.

Having prompt and convenient access to candid advice and feedback from a highly experienced executive certainly benefits the protégé. Conversely, the provocative questions raised by a protégé can stimulate a mentor to engage in a mutually worthwhile dialog on critical issues (Hofmann and Noblin 2002).

One could argue that a 26 percent response rate, in which 125 of 127 respondents reported a mentoring role, is an encouraging result. Although it would certainly be desirable to have a much higher proportion of executives serve as mentors, if one of four executives now perform this function, there is clearly a solid foundation on which to build. Just more than 40 percent of mentoring respondents indicated they were mentored early in their careers. This finding has positive implications for the future because almost 60 percent who were not mentored still recognized the value of becoming a mentor. As the percentage of young careerists who are mentored rises, it can be logically assumed that they, in turn, will reciprocate as their careers advance.

ACHE should develop a formal set of goals, along with specific strategies to meet or exceed these goals, to raise the percentage of chief operating officers and chief executive officers who are mentors. It is difficult to imagine a more appropriate priority for ACHE. Data from this timely study could help design the strategies if they have not yet been formulated.

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