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[Are Young Female Doctors Breaking Through the Glass Ceiling in Italy?]

Abstract: In the second half of the twentieth century, the feminization of medicine increased in large part of Western Europe. Due both to cultural and social models and to welfare policies, there was a very limited increase in the female medical profession throughout the first half of the 1900s in Italy, and a relatively larger one in the second half. Currently, the female incidence is 39.8%, placing Italy among the last positions in Europe. The results of a pilot project research, carried out on a sample of 131 young physicians enrolled with the order of doctors of Ancona, seem to confirm that some changes are currently taking place. Internalizing managerial outlook, showing high degree of self-confidence, balancing work and private life as well as creating good relational and social networks, the women doctors' behaviour allows us to imagine that the future scenario could be very different, although gender discrimination still persists.

Keywords: Women Doctors, Gender Barriers, Generation, Leadership Positions.

Introduction

In the second half of the twentieth century, the feminization of the medical profession increased substantially in large part of Western Europe (De Koninck, Bergeron, Bourbonnais 1997; Riska 2001a, 2001b; Riska, Novelskaite 2008; Kilminster *et alii* 2007; Levitt *et alii* 2008; Elston 2009). In 2012, the highest percentages of feminization are recorded in Finland (56.9%) but also in Portugal (52.1%) and Spain (50.3%) which suggests that parity has been achieved, or will be achieved in the near future. In France (42.1%), Germany (43.7%) and the UK (45.7%), the incidence of women doctors also stands at a very high level, in that it closely approaches 40% of the total. Italy is still somewhat distant from gender equality in the medical profession with a feminization rate of 39.3% (OECD 2012).

These figures raise two main issues: the first concerns the processes of feminization of the medical profession during the twentieth century; the second regards the effects of this trend both on professional practice and on the current leadership position of women.

With regard to the first issue, research on the professionalization of medicine (Parsons 1964; Wilensky 1964; Freidson 1971a, 1971b; Sarfatti Larson 1977; Abbott 1988) is at the basis of long-period studies which seek to reconstruct the genesis and structuring of the medical profession in various countries with more detailed study on gender differences (Burrage, Torstendahl 1990; Malatesta 1996, 2006). Recently, Kilminster *et alii* (2007) claim that further qualitative and longitudinal studies should be carried out as well as research that takes into account the choices and behaviour of the new generation of male and female physicians. However, as Elias (2000) claims, it is necessary to take into consideration that gender relations are not fixed but are maintained by the

This article is the result of the joint work of the authors. However, Giovanna Vicarelli wrote "Introduction" and "The process of feminization in Italy: a long term perspective", while Elena Spina wrote "Hypotheses and Methods" and "Is there a new generation of female physicians in Italy". The "Conclusions" have been written by the two authors.

interaction of various processes at different levels. The cultures and practices of medicine are interrelated with the social contexts in which health care is delivered. The models of healthcare are of the same importance. In fact, they define the conditions of access and of work, that vary over time, of male and female physicians and their interactions with patients.

In regard to the second of the above issues, the existence of a close relation between the number of women present in an organization and work performances has been proposed by a large body of literature since the pioneering work by Moss Kanter (1977) (Gustafson 2008; McDonald *et alii* 2004). As concerns the current position of women in the medical profession, some studies have focused on vertical segregation and deal with the female difficulty to break the *glass ceiling*, and therefore to take on leadership roles (Riska 2003; McGoldrick 1994; Tesch *et alii* 1995; McManus, Sproston 2000). Gender studies offer several suggestions and tools which can be used to interpret gender differences in medical workplaces (McManus, Sproston 2000; Riska 2001a, 2001b; Riska, Wegar 1993). A report entitled *Releasing Potential:Women Doctors and Clinical Leadership* (Newman 2011) was recently published, presenting a theoretical model useful to understand and analyse barriers to women's careers in medicine. The obstacles in achieving leadership roles are divided into two macro-fields. The first is related to mindset and distinguishes between individual and organizational mindset; the second concerns structural barriers and role conflict.

Hypotheses and methods

Given the above, a research was conducted to reconstruct, as Kilminster *et alii* (2007) claim, the development of feminization of the medical profession in Italy and its current configuration in order to analyse possible continuities or discontinuities regarding the two kinds of barriers, suggested by Newman (2011), which can be distinguished between mindset, on one hand, and structural barriers and role conflict on the other.

Therefore, two research questions can be formulated as follows.

1. Through what phases and with what characteristics did the process of feminization of the medical profession take place in Italy?
2. Is a new generation of female doctors emerging, with different values and behaviours from those of previous generations, which is able to remove the traditional barriers to career progression?

In order to answer these questions, the research was carried out through the use of primary and secondary sources.

A first line of inquiry, in fact, adopted a historical perspective to reconstruct the path of feminization of the medical profession in Italy and its current configuration by using institutional and sectoral statistics.

A second line of inquiry focused on the values and behaviours of a sample of young physicians in the Province of Ancona. The provincial order of Ancona comprises 2,902 members, representing 0.8% of the national total, which amounts to 345,323. However, the age and gender composition of the provincial order of Ancona reflects the national average. The sampling was carried out using the list of members enrolled for the first time with the Order in the decade 2001-2011. Units belonging to each year of interest were extracted from the list until reaching 20%, in order to reproduce in our sample the structure of the population by age and gender. The survey was conducted through a self-administered, semi-structured questionnaire, which comprised 95 questions and was divided into four sections: a) education, training experiences and reasons for choosing medicine; b) current job; c) work and family; d) relationship with professional associations. Of the 136 selected doctors, 5 did not respond (4 men and 1 woman): therefore, completed questionnaires were received from 131 doctors (47 men and 84 women), with a response rate of 96%. The first significant data that emerges confirms the trend towards a gradual feminization of medicine: 64.1% of the young doctors surveyed were women. The average age is 33.7 years, with no difference between men and women.

The following sections set out the results obtained by the two lines of inquiry described above.

The process of feminization in Italy: a long term perspective

Several studies (Vicarelli 2008, Vicarelli, Bronzini 2008; Bronzini, Spina 2008; Malatesta 2006; Tousijn 2000) show that the first phase of the feminization of the medical profession corresponded, in Italy, with a residual welfare and health insurance system. For almost one hundred years from 1880 to 1978, in fact, welfare provision was of a benevolent/charitable nature, to which insurance-based social security schemes were increasingly added, although these had clientelistic and particularistic forms inherited from the fascist period. The second phase of the process (1978-2015), instead, coincided with the creation and implementation of the Italian national health service – that is, with a universalist and institutional form of health protection guaranteed to all citizens through direct (financial and managerial) commitment by the state and regional administrations.

The first phase can be divided into three different periods.

In the first period (1880-1922), the number of female medical students never exceeded 2% of the total: a much lower proportion than those recorded in the same period in Scandinavian countries and Great Britain. In Italy, as in Germany and France, numerous female pioneers originated from the countries of Eastern Europe (Russia, Poland etc.), and they were of Jewish or Waldensian origin (Vicarelli 2008; Rennes 2007). Italy pursued the path of non-gender separation in the educational and professional domains (Malatesta 1996, 2006). It thus demonstrated, at least in normative terms, an egalitarian intent which was thwarted by custom and practice. When the order of doctors was founded in 1910, no obstacles were raised against enrolment by female medicine graduates and their entry into the profession. But in practice enrolment was denied to even the most prominent female representatives of science and culture (for instance, Maria Montessori) or of politics (for instance, Kuliscioff, a leading exponent of the Milanese socialist party). Consequently, the only areas of employment available to the women pioneers were charitable and mutual-aid organizations, both of which were very limited in scope and also territorially circumscribed.

In the second period, which coincides with the twenty years of fascism (1923-1943), the professional growth of women was obstructed by the regime's restrictive policy on female work: a policy largely similar to those of France and Germany. Once again, the percentage of women enrolled at faculties of medicine (5% of enrolments at medical faculties in the early 1940s) was very distant from the rates recorded in the same years in Finland (21.3%) or France (20%), demonstrating the country's continuing laggardness (Riska, Wegar 1993; Riska 2003; Finnish Medical Association 2003; Hardy-Dubernet 2005; Vilain 1995; Lapeyre, Lefeuvre 2005). The creation of the National Institute for the Protection of Maternity and Infancy (ONMI) introduced a new social-healthcare system which ramified through the country. However, it was instituted in a manner that created few employment opportunities for women doctors. Nor did mutualism develop to such an extent that it attracted female medicine graduates into a free-professional sector with scarce guarantees and public tutelage. In Italy, moreover, women doctors did not perform the central role in the eugenic policy that characterized their German counterparts (Kopetsch 2004; Kuhlmann 2003; De Grazia 1993).

The decades after the Second World War, the third period (1944-1978), were years in which Bismarckian welfare was much promoted. During the 1950s and 1960s, women doctors had to accept and adjust to the model of male dominance and, therefore, to separate the familial and professional spheres. Employed more than men in hospitals and in local public medical services, they did not compete against males in the sector of contracted free professionalism proper to republican mutualism. In fact, most female medicine graduates decided to specialize in paediatrics: indeed, fully 46.5% of them chose this speciality in 1955-56, with the addition of the 9.9% who chose anaesthesia. Nor had the situation changed substantially in 1962-63 – apart from the 10.6% of women graduates who specialized in "psychiatry and psychology". In both periods, still very few Italian female graduates chose to specialize in obstetrics and gynaecology (4.4% in 1955-56 and 3.5% in 1962-63, for a total of 21 women). Overall, five specialities (paediatrics, anaesthesia, psychiatry, hygiene, and odontostomatology) were chosen by 72.9% of female medicine graduates in 1955-56, and by 65.5% in 1962-63 – figures which suggest that these women doctors worked mainly in hospitals. These were often all-encompassing choices, in the sense that women devoted all their resources to them, forgoing marriage or children. Becoming a doctor and practising the profession was therefore a goal in itself to be pursued and cultivated over time.

The second phase of the process of feminization in the medical profession begins at the end of the 1970s when Italy changed from a meritocratic and occupational health system to a universalist and publicly-regulated one

(Ascoli 2011; Pavolini 2012; Vicarelli 1997, 2010). The institution of the Italian health service – which formally ratified the predominance of general medicine over hospital care – created employment opportunities for women doctors; nevertheless, they continued to prefer the hospital sector. The differences between health-service general practice and public hospital medicine, in fact, were such that women found the latter more closely regulated in terms of working hours and protection (maternity leave) and more attractive than the former. Despite being more profitable, general practice still had the features of a free-professional, semi-entrepreneurial activity. Acceptance of the "dual presence" model by the women belonging to this generation responded to their need to obtain "well-being" from mediation between different (familial and professional) interests (Saraceno, Balbo 1981; Saraceno, Naldini 2013). For instance, women found it difficult to give priority to either work or the family. They tenaciously defended a "non-choice" and sought to maintain a balance, however difficult, between the two domains.

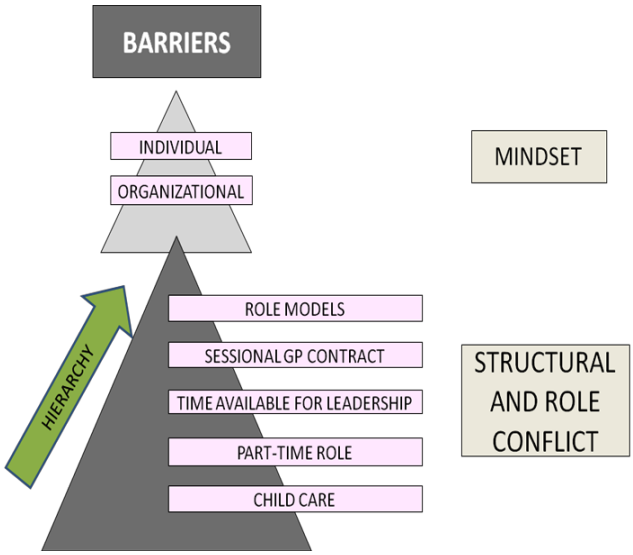
Still marked, however, were power asymmetries, and the direct or indirect exclusion of women from the professional networks in which organizational decisions crucial for their careers were taken. If one considers, for example, the proportions of women in university academic staff from 1997 to 2011, one finds that they constantly increased, but the values were still very low in the most senior posts: female full professors of medicine rose from 8% to 15,5% (+7.5), associate professors from 19% to 27.4% (+8.4), and researchers from 32% to 43% (+11); only two women are deans of faculty. If one looks at the structure of the national council of the FNOMCeO (Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri), which comprises all the presidents of the provincial orders of doctors, one discovers that, for the period 2015-2017, five (4.7%) of the council's 106 members are women. Furthermore, regarding the managerial roles played in the INHS, the presence of women still remains very low: for the period 2009-2010, just 9.1% of them were General Directors, 16.1% Health Directors and 19.5% Administrative Directors. In 2013 just 14.7% of them were Head of Department in hospitals and 30.2% were Directors of Health care Units (Ragioneria Generale dello Stato 2013). As often confirmed by interviews conducted in those years (Vicarelli 2008), exclusion from these networks was put forward by women doctors as a self-restriction of which they could be proud. It was, in fact, indicative of a moral integrity and a professional purity at odds with the behaviour of the medical profession as a whole. From this point of view, as gender identity was being sought, even unconsciously, it pushed towards self-improvement which tended not to contest the substantial restraints imposed by the organization and the dominant power hierarchies. In other words, the "iron maiden" trap seemingly operated for those women who, in the difficult endeavour of reconciling their careers and their families, saw the creation of the National Health Service as promising a new kind of medicine: a medicine which would emphasise the community, prevention, and the central importance of the patient and his/her entire course of treatment.

However, despite the increase in female physicians in recent decades and the creation of the INHS, the glass ceiling has not yet been broken and it is for this reason that it becomes of interest to investigate whether the new generation of women will have the propensity to take on leadership positions in the future.

Is there a new generation of female physicians in Italy?

In order to answer the second research question, a pilot project research was conducted on a representative sample of physicians of the Order of Ancona. To analyse the data from the second phase of our research, the model proposed by Newman (2011) can be used (see Figure 1) as it offers the advantage of summarizing the major issues which are traditionally considered as barriers to women's career progression.

Figure 1 - Barriers to career progression



Source: Newman (2011: 21).

This model outlines some of the obstacles identified in achieving a leadership role. These obstacles have been well documented: they include role conflict and structural barriers, and individual and organisational mindset.

As regards mindset, it is «a set of assumptions, methods or notations held by one or more people or groups of people which is so established that it creates a powerful incentive within these people or groups to continue to adopt, or accept, prior behaviours and choices» (Newman 2011: 22). Mindset can be divided into individual and organizational and it includes low personal aspiration, the perception of a traditionally male cultural environment, a "boys club" and a lack of networking opportunities.

In particular, individual mindset is the lack of self-confidence, namely the lack of confidence in their personal abilities, as well as low career aspirations; all of these are considered as a barrier for the acquisition of leadership roles in the British report (Newman 2011). In order to continue to have fulfilling contact with patients as well as to achieve a work-life balance, female doctors seem to reduce their threshold of expectations and appear to be content achieving less than they aspire to.

Organizational mindset identifies a cultural dimension, namely the prevalence of organizational models which have a traditionally male connotation and do not offer women the same opportunities as men (Newman 2011). The Releasing Potential report highlights the different perception of men and women as regards the existence of a discriminatory mechanism: men, though recognizing the limitations associated with women's greater family responsibilities, do not believe that these mechanisms exist or that they are gradually decreasing; women, on the contrary, «identify barriers related to organizational culture or exclusion from networks» (Newman 2011: 22).

Role conflict and "structural" barriers include the triple burden of domestic, clinical and leadership responsibilities, part-time work, the sessional GP contract, lack of role models and time dedicated to management roles - the latter is also experienced by male colleagues.

As regards role models, the study reports that their lack «can affect career choices» and that «visible and powerful role models would help women aspire to leadership roles» (Newman 2011: 27). Role models include women in leadership positions (vertical dimension) and women doing the same job/speciality (horizontal dimension) who are particularly inspirational during training, however, few are visible later in the careers of the younger generation of physicians.

The British report claims that women physicians are over-represented in the sessional GP contract due to the advantages it offers in terms of part-time work options and freedom from administrative responsibility (Newman

2011). However, given the isolation and the inability to acquire additional roles, the female inclination to choose this sector could be linked with their low inclination to leadership. Therefore, the GP sector is recognized by literature as a low prestige field compared to other medical fields (Riska, Wegar 1993), as well as being characterized by relative isolation, by difficult access to information and, above all, by a lower possibility of acquiring leadership positions.

The British report considers part-time work as a limitation to the acquisition of leadership positions as it can produce isolation and a lack of ability to develop additional roles.

A further critical aspect concerns the segregation generated by the dual role played by women in society: that of mothers and wives and that of workers (Sinden *et alii* 2003; Walsh 2013). This aspect is recognized as a significant barrier to women's career progression as many British women physicians are experiencing a role conflict that may lead them to relinquish leadership positions (Kvaerner 1999; Newman 2011). This could be one of the reasons why many women doctors give up parenting or limit the number of children, often postponing the age of conception of their first child.

Given the above, as this model includes many of the main traditional barriers to women's career progression, it can be used as a framework to interpret our research data.

Individual mindset

Looking at the perception that women physicians have of themselves as professionals, a high degree of self-confidence comes to light: women perceive themselves as adequately prepared to carry out both the clinical part of their job and the managerial tasks; they feel they are adequately trained in the communication process with patients and they are satisfied with the relationship with the latter, thus confirming the female aptitude both towards social relatedness and empathy (see Table 1).

Table 1 - Individual mindset (%)

	W	M
I am required to perform clinical tasks for which I do feel adequately trained	59.5	56.5
I am required to perform managerial tasks for which I do feel adequately trained	58.4	57.8
I feel adequately trained to communicate with patients	66.3	66.7
I am satisfied with my relationship with patients	93.8	87.0
I feel satisfied with my current post	6.2	6.1
(average value on a scale 1-10)	33.1	31.8
I graduated in six years (on time)	16.0	34.0
I have obtained other higher professional or academic qualifications	77.1	66.7
I think that the professional growth of non medical staff will be positive for the quality of care	33.0	30.4

Source: own data.

These data seem to be supported by the level of satisfaction with current job positions shown by the female doctors interviewed who have probably met the expectations they had for themselves when enrolling in medical school.

The successes they achieved during their training period may have increased their self-awareness: at a national level, in fact, more women than men graduated in six years and, of the total members enrolled, women are almost twice as likely as men to register with the professional register before they are 29 years old (5,154 women and 2,932 men, data provided by FNOMCeO in 2012).

Women's perception concerning the role played by other health occupations can also be considered as an indicator of both their aptitude for leadership and their level of self-confidence. As concerns this, our survey shows that the professional growth of these occupational profiles does not threat women's professional autonomy nor reduce the sense of security they have acquired: they favourably view the improvement of the status of these occupations for the quality of care and feel sure that this will not lead to an increase of tensions between different professions (see Table 1) .

Given this framework, it can be argued that women's perception about their skills and abilities is not a limit to their career progression in our sample; they believe in their own skills and competencies and this could support their rise to leadership positions (Kvaerner *et alii* 1999; Eagly, Carli 2007; Carnes *et alii* 2008; Khan 2012).

Organizational mindset

Looking at macro level relationships, over 50% of female respondents (versus 30% of men) state that they are very or fairly satisfied with the relationship with the hospital where they work. However, fewer of them (23.4%) claim to receive good support from the health care organization, where a lack of women still persists in the top posts. The male percentage, however, is not very high (28.9%) which may mean that the ability of healthcare organizations to provide support is not connected to the gender of those who are in leadership positions (see Table 2) .

Table 2 - Organizational mindset (%)

	W	M
I am satisfied with the relationships with the hospital	52.6	30.4
I receive good support from hospital management	23.4	28.9
I receive good support from senior doctors	69.6	61.4
I am satisfied with the relationships with GPs	63.0	58.7
I am satisfied with the relationships with doctors from other specialist branches	71.6	60.9
My workplace presents good equal opportunities for female doctors	39.8	82.2
I think that my professional autonomy could be reduced by the following:		
- mass media	87.7	67.4
- health managers	83.8	76.1
- national legislation	78.8	63.0
- politicians	77.2	60.9

Source: own data.

Moving on to micro-social relationships, the survey reveals that women do not consider the professional environment where they work as a hostile place. Almost 70% of them feel they receive good support from their senior colleagues (versus 61.4% of men). The gender gap can be explained by using the findings of a previous survey carried out in 2004 on a sample of physicians enrolled in the provincial order of Ancona, Turin and Cosenza (Speranza, Tousijn, Vicarelli 2009). Research showed that the relationships between male doctors are imbued with greater competition than those established between women, which are instead based on cooperation. This interpretation is supported by our data, in particular those data focusing on the level of satisfaction with relationships with colleagues. Overall, a high level of satisfaction seems to emerge; however, women registered higher values than men once again, proving that they tend to have a less conflictual perception about the medical environment as well as a greater aptitude for teamwork.

By contrast, the findings of our research concerning the existence of gender discrimination within workplaces seem to reduce the importance of the changes revealed. Only 39.8% of female respondents feel they have the same opportunities as their male colleagues, against 82.2% of the latter. Data concerning professional autonomy seem to confirm the thesis that a male organizational culture tends to prevail. The survey shows that women, far more than their male colleagues, are worried about the possibility that health managers, politicians, national legislation as well as the media might reduce their professional autonomy (see Table 2). As all of these areas are characterized by a dominant male presence, we can assume that women feel most threatened because of their exclusion from these sectors; therefore, they may notice the existence of a different way of thinking.

Role models

Focusing on the vertical dimension of the role models, more than one-third of women have had the support of a significant person during training but the percentage decreases looking at women who had received similar support during their career (see Table 3). Usually the mentor was a doctor (met during training periods or at a later stage) even though the number of respondents who indicate a relative is particularly significant.

Table 3 - Role models (%)

	W	M
I have had a mentor during my training period	36.6	36.2
I have a mentor in my professional career	26.5	29.8
There are doctors among my relatives	38.6	23.9
One of my parents is a physician	8.3	25.5
I am married to a doctor	19.7	43.5
I come from an upper/middle class household	83.3	89.4
I have chosen to enrol in speciality training	75.0	78.5
My area of specialisation is:		
- medical area	50.0	24.3
- surgical area	21.0	27.0
- diagnostic area	24.2	35.2
- public health area	4.8	13.5
Sub-total	*100.0*	*100.0*

Source: own data.

This leads to question the effects that kinship networks can have on the careers of young doctors. We therefore investigated parental status in order to observe how family networks as well as original social capital have affected their career. The first indicator we used was the self-recruitment rate which was useful not only to assess if a hereditary mechanism still exists in the medical profession, but also to assess the professional support they have. One-third of total respondents acknowledge the presence of other physicians among their family members, thus confirming the «existence of a dense and extensive professional network surrounding doctors» as Vicarelli (2008) claimed. Focusing on direct transmission alone, the survey shows that only 8.3% of women doctors (versus 25.5% of men) have chosen the same career as at least one of their parents and a lower proportion of female than male doctors (20% versus 43.5%) are married to doctors.

Subsequently, the socio-economic status of the family of origin was used as it may be useful to evaluate the amount of social capital on which young doctors can rely. Our data seem consistent with the results from other Italian (Speranza, Tousijn, Vicarelli 2009) as well as international studies (Freidson 2001; Adams 1953) that consider upper-middle classes as the major source of origin of professionals. Indeed, the majority of women come

from families with a medium-high socio-economic status: if social class is linked to the amount of social capital, as literature claims, the female sample would seem to rely on significant relational resources, which could affect their chances of career progress.

Focusing on the horizontal dimension and hence looking at the post-graduate choices of young female doctors, an encouraging trend seems afoot, which allows us to imagine a progressive reduction in gender segregation (see Table 3). Women continue to favour some traditional areas of speciality, such as paediatrics and obstetrics and gynaecology, whereas men continue to choose hygiene and preventive medicine, occupational medicine and nutritional science. However, a greater female propensity to undertake more unusual careers than in the past can be observed: a decrease in recruitment in medical and public health areas as well as a sharp increase in the surgical and diagnostic field, which traditionally recruited male doctors, can be observed. This change would seem to support the argument that the gender casting mechanism (Lambert, Holmboe 2005; Morrison 2006), which may tend to exclude women from certain medical fields, especially those of diseases, and reserve them to other clinical sectors such as those focusing on women's and children's wellbeing (Riska 2003), could be partially overcome.

Sessional GP Contracts

Due to its entrepreneurial nature, the GP sector has traditionally recruited a higher proportion of men than women for many years in Italy. The lack of women in GP careers is probably due to the managerial traits of this medical sector as well as to the observed low female aptitude towards managerial tasks. The access to this field can be considered as a further cause of the lack of women in the GP sector. Those who choose GP training after foundation training have to wait for concessions from the INHS and therefore «may be in a weaker position compared to their colleagues who achieved a speciality in another field. Therefore, the path is longer and more uncertain [...]. This can be an obstacle to women who want to plan a family» (Bronzini 2006: 122).

However, signs of change seem to emerge from our research that document an increase in feminization: a slightly higher percentage of women (20.7%) than men (17.4%) embark on this career path and are overtaking the male population in this medical sector, at least in the province of Ancona.

It is not easy to trace the causes of the reversal of this trend: it can be ruled out that women are attracted to this career path due to the greater flexibility and reduced workload that it grants, considering that the GP interviewees state they dedicate to their work the same amount of time and the same resources as their specialist colleagues. One of the reasons may lie in the progressive implementation of associative medicine that seems to offer a number of advantages: from an organizational point of view it allows greater flexibility in terms of working hours, ensuring the possibility of being replaced by colleagues; from an economic point of view this formula allows them to take advantage of a number of incentives and to share costs.

Part-time roles and time available for leadership

While the British report considers part-time work as a limitation to the acquisition of leadership positions, this does not represent a problem in Italy given the low use of part-time contracts in the medical sector. Furthermore none of the interviewed professionals has a part-time work contract. In addition, the survey shows that women physicians' workload is remarkable, both in terms of hours worked and of patients visited. It appears, in fact, that the clinical part of medical work engages women greatly: they see a higher number of patients per week than men (respectively 61 and 40), spending the same number of hours working (average value 39) (see Table 4).

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Table 4 - Part-time role and time available for leadership (%)

	W	M
I have a part-time contract	0.0	0.0
Average number of patients seen per week	61.0	40.0
Average number of hours worked per week	38.7	39.4
Average number of weekends worked in the last three months	4.6	5.0
Average number of night-shifts in the last three months	6.0	10.0
I feel emotionally drained from my work	52.4	47.8
I feel used up at the end of the workday	61.0	52.2
I feel tired when I get up in the morning and have to face another day on the job	62.2	45.7
I have not lost my sensitivity towards others since I started my job	63.8	58.7

Source: own data.

The considerable amount of work carried out by women results in a high level of stress: they feel emotionally drained from their work, used and tired; nevertheless women seem to retain a degree of empathy stating not to have lost their sensitivity towards people since they started work. Everyday clinical tasks make it difficult to find extra time as well as further resources to engage in other activities such as leadership roles. This can represent a limit to women's career progression, reducing their opportunities for professional growth.

Child care

In regard to this issue, our data are considerably different from those reported in *Releasing Potential*, allowing us to imagine a positive sign of change in the near future. Thus, in contrast to a relatively recent past, when women who chose a medical career were often discouraged from getting married as well as from having children (Vicarelli 1989, 2003), our interviews showed that they get married more than men, having children in a percentage that is twice that of their male colleagues (30% versus 17.8%) (see Table 5).

Table 5 - Child care

	W	M
Average age (%)	33.9	33.6
I am married/cohabiting (%)	72.6	51.1
I have children (%)	30.0	17.8
I find it relatively easy to maintain a balance between my professional and personal life (%)	59.0	64.4
I am satisfied with the amount of time that work leaves me for family, social and recreational activities (average value on a scale of 1 to 10)	5.64	4.97
My family life has not affected my professional career in terms of sacrifices and delays (%)	57.8	69.5
My professional career has not affected my personal life, slowing or preventing family stability (%)	61.0	61.7

Source: own data.

This result appears to be particularly significant as the men and women in our sample are of almost the same age with few differences in terms of contractual strength and work environment. Indeed, they work mainly in the public sector (67.4 % of men, 74.7% of women) and have a very similar long-term contract (34.2% of men, 32.7% of women) and a slightly different fixed-term contract (50% of men, 43.6% of women). In actual fact, the latter type of contract is mostly a training contract due to the fact that 42% of the interviewed physicians (39.7% of women, 45.9% of men) attend a specialization school. The data may be explained partially by the tutelage of maternity granted by the 2007 Decree, which provides for new contractual rules for resident physicians. All the provisions foreseen by Decree No. 151/2001 are applied to the latter, such as parental leave, days off and leave for children's sickness. From this point of view, it is evident how this training period coincides with the reproductive

choices of young women doctor. On the other hand, recent national ISTAT data** reveal that the average age at the birth of their first child is 31.3 for women and 35.1 for men and this would explain why the men in our sample, with an average age of 33.6, have fewer children compared to their female colleagues.

Female respondents claim, moreover, relative ease balancing work and private life (59%) saying that their family life has not affected (or excessively affected) their career, in terms of sacrifice and referrals. However, their career choices seem to have affected their personal ones, slowing down or preventing family stability. Finally, it is important to highlight that the level of satisfaction expressed by women in relation to the amount of time that their job allows them to devote to family, social and recreational activities is rather low (see Table 5).

Conclusions

As regards the feminization of the medical profession, Italy's position is the result of a very limited increase in the female medical profession throughout the first half of the 1900s, and a relatively larger one in the second half of the century. The process of feminization, in fact, was slow and difficult until 1970s as the residual and categorical health system did not allow the development of the medical profession for women. Throughout this period, in fact, the percentage of female doctors of the total remained quite limited: from 2% in the first years of the twentieth century to 1970s. Since 1978, with the establishment of the INHS, the number of women who enrolled and graduated in medicine grew to reach the peak in 2003 (60% of the total). However, despite the increase in female physicians in recent decades and the creation of the INHS, the glass ceiling has not yet been broken.

Being a pilot project research, our survey was carried out in a defined area and its findings, based on a limited sample, cannot be generalized. Therefore, further investigation is necessary in this field. Nevertheless, the results of our research seem to confirm that the changes currently taking place are significant and that, although gender discrimination still persists, the future scenario could be very different. First of all, the younger generation of women doctors registered with the provincial order of Ancona seems to have internalized a managerial outlook. The skills they have proven to possess in carrying out managerial tasks as well as the high degree of self-confidence they show, can positively affect their chances of achieving leadership roles. Secondly, without sacrificing marriage and children, they display the ability to balance work and private life, breaking down several traditional barriers to women's career progression. Thirdly, they create good relational as well as social networks at micro and at macro levels; they are experimenting different role models than in the past, both vertically and horizontally; they are choosing unusual career paths, in terms of speciality training, thus reducing the existing gender gap. Finally, despite their heavy workload combined with high levels of stress, women still retain their sensitivity.

Finally, it is appropriate to refer to the international debate on emerging models of professionalism and therefore imagine that the young generation of doctors, particularly female doctors, fall within the *lifestyle* model (Hafferty, Castellani 2010). It is a model in which autonomy, especially in organizational terms, is considered to be very important, work-life balance is essential, while dominance, considered in traditional terms, is completely irrelevant. The use of this approach obviously requires caution, considering the wide differences between the American context, for which this paradigm was created, and the Italian one. In Italy, in fact, not only is there a national health care system but the latter seems to offer more career opportunities for women today while losing its traditional appeal for men, even more in the current economic crisis whose negative effects on public health systems are already very evident.

Is it possible to imagine that the future of Italian women doctors will be different from the past? Will Italy be able to align quickly with European countries, where the processes of overcoming gender differences in medicine have been pursued more rapidly and with greater conviction? The recent election of a woman (previously president of a provincial order) as president of the National Order of Doctors allows us to envisage a change of direction in gender policy. The future is open.

** ISTAT statistics available at the website *http://demo.istat.it/altridati/IscrittiNascita/index.html* (Accessed: 2 June 2015).

References

Abbott A. (1988), *The System of Professions: An Essay on the Division of Expert Labor,* Chicago: University of Chicago Press.

Adams S. (1953), *Trends in Occupational Origins of Physicians*, in «American Sociological Review», 18(4): 404-409.

Ascoli U. (2011, ed.), *Il welfare in Italia,* Bologna: Il Mulino.

Bronzini M. (2006), *I Medici di medicina generale: differenze di genere e di generazione*, in C. Cipolla, C. Corposanto, W. Tousijn (eds), *I medici di medicina generale in Italia*, Milano: Angeli.

Bronzini M., Spina E. (2008), *Le professioniste nel duemila,* in Vicarelli G., *Donne di medicina,* Bologna: Il Mulino.

Burrage M., Torstendahl R. (1990, eds), *Professions in Theory and History: Rethinking the Study of the Professions*, London: Sage.

Carnes M., Morrissey C., Geller S.E. (2008), *Women's Health and Women's Leadership in Academic Medicine: Hitting the Same Glass Ceiling?,* in «Journal of Women's Health», 17(9): 1453-1462.

De Grazia V. (1993), *Le donne nel regime fascista,* Venezia: Marsilio.

De Koninck M., Bergeron P., Bourbonnais R. (1997), *Women Physicians in Quebec*, in «Social Science and Medicine», 44(12): 1825-1832.

Eagly A., Carli L. (2007), *Women and the Labyrinth of Leadership*, in «Harvard Business Review», September.

Elias N. (2000), *Les transformations de la balance de pouvoir entre les sexes*, in «Politix», 51: 15-53.

Elston MA. (2009), *Women and Medicine: The Future,* London: Royal College of Physicians.

Finnish Medical Association (2003), *Health Care and the Medical Profession in Finland*.

Freidson E. (1971a), *Profession of Medicine. A Study of the Sociology of Applied Knowledge*, New York: Dodd, Mead & Company.

Freidson E. (1971b), *Professional Dominance*, New York: Atherton Press.

Freidson E. (2001), *Professionalism, the Third Logic. On the Practice of Knowledge*, Chicago: University of Chicago Press.

Gustafson J.L. (2008), *Tokenism in Policing: An Empirical Test of Kanter's Hypothesis*, in «Journal of Criminal Justice», 36(1): 1-10.

Hafferty F.W., Castellani B. (2010), *The Increasing Complexities of Professionalism*, in «Academic Medicine», 85(2): 288-301.

Hardy-Dubernet A.C. (2005), *Femmes en médecine : vers un nouveau partage des professions ?,* in «Revue Française des Affaires Sociales», 1: 35-58.

Khan M. (2012), *Medicine - A Woman's World?,* in «British Medical Journal Careers», 5 January (Available at: *http://careers.bmj.com/careers/advice/view-article.html?id=20006082*).

Kilminster S., Downes J., Gough B., Murdoch-Eaton D., Roberts T. (2007), *Women in Medicine – Is There a Problem? A Literature Review of the Changing Gender Composition, Structures and Occupational Cultures in Medicine*, in «Medical Education», 41(1): 39-49.

Kopetsch T.H. (2004), *The Medical Profession in Germany: Past Trends, Current State and Future Prospects*, in «Cahiers de Sociologie et de Démographie Médicales», 44(1): 43-70.

Konrad A.M., Yang Y., Cannings K. (2012), *Pay Dispersion and Earnings for Women and Men: A Study of Swedish Doctors*, in «Gender in Management: An International Journal», 27(4): 249-270.

Kuhlmann E. (2003), *Gender Differences, Gender Hierarchies and Professions: An Embedded Approach to the German Dental Profession*, in «International Journal of Sociology and Social Policy», 23(4/5): 80-96.

Kvaerner K.J., Aasland O.G., Botten G.S. (1999), *Female Medical Leadership: Cross Sectional Study*, in «British Medical Journal», 318: 91-94.

Lambert E.M., Holmboe E.S. (2005), *The Relationship Between Specialty Choice and Gender of U.S. Medical Students, 1990-2003*, in «Academic Medicine», 80(9): 797-802.

Lapeyre N., Lefeuvre N. (2005), *Féminisation du corps médical et dynamique professionnelles dans le champ de la santé*, in «Revue Française des Affaires Sociales», 1: 59-81.

Levitt C., Candib L., Lent B., Howard M. (2008), *Women Physicians and Family Medicine. Monograph / Literature Review 2008*, Orlando: WONCA.

Malatesta M. (1996, ed.), *Storia d'Italia. Annali vol. 10: I professionisti,* Torino: Einaudi.

Malatesta M. (2006), *Medici e Stato*, in M. Malatesta, *Professionisti e gentiluomini. Storia delle professioni nell'Europa contemporanea,* Torino: Einaudi.

McDonald T.W., Toussaint L.L., Schweiger J.A. (2004), *The Influence of Social Status on Token Women Leaders' Expectations About Leading Male-Dominated Groups*, in «Sex Roles», 50(5/6): 401-409.

McGoldrick K.E. (1994), *Shattering Medicine's Glass Ceiling*, in «Journal of American Medical Women Association», 49(1): 3.

McManus I.C., Sproston K.A. (2000), *Women in Hospital Medicine in the United Kingdom: Glass Ceiling, Preference, Prejudice or Cohort Effect?*, in «Journal of Epidemiology and Community Health», 54(1): 10-6.

Morrison J. (2006), *Career Preferences in Medicine for the 21st century*, in «Medical Education», 40(6): 530-538.

Moss Kanter R. (1977), *Some Effects of Proportions on Group Life: Skewed Sex Ratios and Responses to Token Women*, in «The American Journal of Sociology», 82(5): 965-990.

Newman P. (2011), *Releasing Potential:Women Doctors and Clinical Leadership*, Cambridge: NHS Midlands and East and NHS Leadership Academy (Available at: *http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-WomenDoctorsAug12.pdf*).

OECD (2012), *Health at a Glance: Europe 2012,* Paris.

Parsons T. (1964), *The Professions and Social Structure*, in Id., *Essays in Sociological Theory* (rev. ed.), New York: Free Press.

Pavolini E. (2012, ed.), *Il cambiamento possibile. La sanità in Sicilia fra Nord e Sud,* Roma: Fondazione RES-Donzelli.

Ragioneria Generale dello Stato (2015), *Conto annuale 2013,* Roma: Ministero dell'Economia e delle Finanze.

Rennes J. (2007), *Le mérite et la nature. Une controverse* républicaine: l'accès des femmes aux professions de prestige 1880-1940, Paris: Fayard.

Riska E. (2001a), *Towards Gender Balance: But Will Women Physicians Have an Impact on Medicine?,* in «Social Science & Medicine», 52(2): 179-187.

Riska, E. (2001b), *Medical Careers and Feminist Agendas: American, Scandinavian and Russian Women Physicians*, New York: Aldine de Gruyter.

Riska E. (2003), *The Career and Work of Pathologists: A Gender Perspective*, in «International Journal of Sociology and Social Policy», 23(4/5): 59-79.

Riska E., Wegar K. (1993), *Women Physicians: A New Force in Medicine?,* in Idd. (eds.), *Gender, Work and Medicine*, London: Sage.

Riska E., Novelskaite A. (2008), *Gendered Careers in Post-Soviet Society:Views on Professional Qualifications in Surgery and Pediatrics*, in «Gender Issues», 25(4): 229-245.

Saraceno C., Balbo L. (1981), *La doppia presenza,* Milano: Feltrinelli.

Saraceno C., Naldini M. (2013), *Sociologia della famiglia,* Bologna: Il Mulino.

Sarfatti Larson M. (1977), *The Rise of Professionalism: A Sociological Analysis,* Berkeley: University of California Press.

Sinden N.J., Sherriff J.M., Westmore S.E.L., Greenfield S.M., Allan T.F. (2003), *Patterns of Child-Bearing Behaviour Amongst Female Hospital Doctors and GPs*, in «Family Practice», 20 (4): 486-488.

Speranza L., Tousijn W., Vicarelli G. (2009), *I medici in Italia: motivazioni, autonomia, appartenenza,* Bologna: Il Mulino.

Tesch B.J., Wood H.M., Helwig A.L., Nattinger A.B. (1995), *Promotion of Women Physicians in Academic Medicine.*

Glass Ceiling or Sticky Floor?, in «JAMA», 273(13): 1022-1025.

Tousijn W. (2000), *Il sistema delle occupazioni sanitarie*, Bologna: Il Mulino.

Vicarelli G. (1989), *Il medico al femminile. le donne nello sviluppo della professione medica in Italia,* in «Polis», 3(2): 225-248.

Vicarelli G. (1997), *Alle radici della politica sanitaria in Italia. Società e salute da Crispi al fascismo*, Bologna: Il Mulino.

Vicarelli G. (2003), *Identità e percorsi professionali delle donne medico in Italia*, in «Polis», 17(1): 93-124.

Vicarelli G. (2008), *Donne di medicina. Il percorso professionale delle donne medico in Italia,* Bologna: Il Mulino.

Vicarelli G. (2010), *Gli eredi di Esculapio,* Roma: Carocci.

Vicarelli G., Bronzini M. (2008), *Il ruolo delle donne nella medicina generale*, in «Economia & Lavoro», 2: 15-30.

Vilain A. (1995), *La féminisation du corps médical*, in «Solidarité santé», 1 : 23-34.

Walsh J.(2013), *Gender, the Work-Life Interface and Wellbeing: A Study of Hospital Doctors*, in «Gender, Work and Organization», 20(4): 439-453.

Wilensky H.L. (1964), The Professionalization of Everyone, in «American Journal of Sociology», 70(2): 137-158.

Zimmerman M.K., La Pierre T.A. (2012), *Career Advancement and Gender Equity in Healthcare Management*, in «Gender in Management: An International Journal», 27(2): 100-118.