

Women, healthcare leadership and societal culture: a qualitative study

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Purpose: Women leaders encounter societal and cultural challenges that define and diminish their career potential. This occurs across several professions including healthcare. Scant attention has been drawn to the discursive dynamics among gender, healthcare leadership and societal culture. The aim of this study is to assess empirically gendered barriers to women's leadership in healthcare through the lens of sociocultural characteristics. The comparative study was conducted in Greece and Malta. The interest in these countries stems from their poor performance in the gender employment gap and the rapid sociocultural and economic changes occurring in the European-Mediterranean region.

Subjects and methods: Thirty-six individual in-depth interviews were conducted with healthcare leaders, including both women and men (18 women and 18 men). Directed content analysis was used to identify and analyze themes against the coding scheme of the Barriers Thematic Map to women's leadership. Summative content analysis was applied to quantify the usage of themes, while qualitative meta-summative method was used to interpret and contextualize the findings.

Results: Twenty and twenty-one barriers to women's leadership were identified within the Greek and Maltese healthcare settings, respectively. Prevailing barriers included work/life balance, lack of family (spousal) support, culture, stereotypes, gender bias and lack of social support. Inter-country similarities and differences in prevalence of the identified barriers were observed.

Conclusion: The study appraised empirically the gendered barriers that women encounter in healthcare leadership through the lens of national sociocultural specificities. Findings unveiled underlying interactions among gender, leadership and countries' sociocultural contexts, which may elucidate the varying degrees of strength of norms and barriers embedded in a society's egalitarian practices. Cultural tightness has been found to be experienced by societal dividends as an alibi or barrier against sociocultural transformation. Findings informed a conceptual framework proposed to advance research in the area of women's leadership.

Keywords: gendered barriers, sociocultural contexts, Greece, Malta, directed content analysis

Introduction

Cultures are never static. They are in a constant process of flux and negotiations, adapting and changing over time and space. Helman¹ stated that culture must always be seen in its particular context made up of, among others, socioeconomic factors. Leach² held that the cultural lens which societal divisions, such as profession and gender, develop are imbued with different values, rules and perspectives on life. These often coexist uncomfortably within the same social context. Intersecting identities, namely, "the mutually constitutive relations among social identities" (Shields, 2008, p. 301),³ reflect the individual's social location, beliefs, perceptions and power

relations embedded within.⁴ Along that perspective, Maurice⁵ underlined the importance of interplay between societal and professional settings within countries' cultural boundaries. These were articulated by Foucault⁶ as "regimes of truth", namely, discourses in time and context bearing an "invisible power" under their cultural capacity.⁷ Likewise, the leadership prism exhibits itself differently in each context and culture. This is also true in relation to women leaders and culturally legitimized social power and authority.⁷⁻⁹ Literature has dealt with asymmetries in cultural evaluations of gender within geographic boundaries. Unveiling women's voice is one the most important missing voices in the majority of western accounts of culture.^{9,11}

Delimiting countries' sociocultural contexts

This study focuses on two countries in the European Union (EU)-Mediterranean (Med) region. Greece has been heavily affected by the global financial crisis and the ensuing burden generated various economic, political, social and cultural impacts. Malta, while not having been seriously negatively affected by the financial crisis, has experienced a rapid sociocultural transition in recent years.^{12,13} These economic and social changes are both relevant to gender and power dimensions.¹⁴ The authors focused on Greece and Malta, two EU-Med countries, which have been ranked low-to-middle in the Gender Equality Index¹⁵ and are among the worst performers in terms of gender employment gap.¹⁶⁻¹⁸ The objective lies in understanding similarities and differences in sociocultural and economic contexts with reference to the explored phenomenon by highlighting the "structures and systems that support or inhibit women on the path toward leadership in health".¹⁹

Greece

Greece has been profoundly affected by the devastating economic crisis which generated harsh social and economic implications; it is considered as an "omens of a Greek tragedy", referring among others to the deepening lack of proper healthcare delivery.¹⁸ The healthcare system suffered dramatically²⁰ and had been previously reported as "a major factor" contributing to the country's economic hardship. As such, it came under intense scrutiny.²¹ Dramatic reductions in health sector salaries and changes to working conditions, such as employment under fixed-term contracts, resulted in hasty retirements to ensure better pensions, even substantially reduced, and in understaffing and poor quality of healthcare delivery.²¹ Health indicators deteriorated, including child and

elderly health, due to decline in public spending and household income.^{22,23} The crisis affected predominantly women and single-parent families, especially in the health, education and social care sectors;^{24,25} women who were tertiary education graduates were concentrated in less-rewarding, but economically safer disciplines.²⁶ The ensuing social and economic constraints forced women to make the culturally expected and accepted choice to prioritize family support and care, formal or informal, over pursuit of career advancement according to the power structure of Greek society.²⁷ Being a collectivist culture, Greek society values the family unit, which remains male dominated. The social pattern touches upon patriarchy, expecting women to assume less authority and power than spouses within social and family boundaries and to continue to be responsible for household duties despite a high level of education and contribution to the household income.²⁸ In a nutshell, cultural, economic and political processes embedded in an institutional and societal context had an important effect on labor choices and women's senses of worth within the Greek society.²⁹ The devastating financial crisis in Greece since 2009 has jeopardized any progress gained in gender equality and equal work opportunities, triggering a backlash in employment practices and choices.²⁴

Malta

Malta has been traditionally a patriarchal, deeply religious society, which was further influenced by the impact of British colonialism and the country's relative geographic isolation.³⁰ Historically, Maltese women became professionally active in caring positions in the domestic, education or health sectors.³¹ Emancipation was given a push forward because of conscription during the Second World War which, over a period of time, eventually resulted in their taking on various roles including the directorship of hospitals and full professorship in academy.^{31,32} However, the long-standing, socially constructed, gendered norms and expectations dictated prioritization of household and child-rearing tasks over a career. Thus, women were prevented from achieving their full potential in terms of empowerment and leadership.³³ In 2004, women represented only 32.6% of the Maltese labor market, with many opting for part-time work to reconcile work with family demands, resulting in ongoing situations of economic hardship and dependence.¹⁶ Additionally, sectorial and occupational segregation still abounds with many opting for family-friendly employment, such as education, service workers and assistant professionals.¹⁶ Although the policy agenda has changed and structural measures, including availability of free child care, have been adopted, enabling

great strides forward to be accomplished over a few years, sociocultural resistance remains strong. Discrimination and rigid stereotypes in relation to family roles keep limiting women's participation in the labor market, and in corporate and political roles, despite high educational levels and professional experience.³⁴ Advances among younger couples have not yet superseded the social norm which expects women to shape their life choices to fit in their husbands' interests since "God forbid if a husband would have to adapt his life to suit his wife's lifestyle" (p. 23).²⁴ In essence, the country is still performing poorly in women's leadership and gender equality; the Global Gender Gap Report 2016 states that Malta is one of the three lowest performing countries in Western Europe regarding gender equality.¹⁷

Health care sector and women's leadership

Studying the healthcare sector⁵ may identify and explain the distinctiveness of barriers specifically experienced by women leaders in this setting by exploring the interplay between sector and societal settings within countries' cultural boundaries. The value of analyzing the relationship between the country-specific sectoral framework and dominant sociocultural and economic factors shaping social reality derives from the position that actors cannot be separated from structures and vice versa. Actors intrinsically participate in a way or another in building the social reality in which they are active.³⁵ Comparison and extrapolation of the phenomenon through the lens of social and cultural diversity between countries may establish a basis to better understand the relationship of dominant sociocultural factors and barriers hindering women's leadership advancement.

Previous research confirms that women fall severely behind men in assuming leading roles in healthcare as they are hindered by numerous barriers.^{36–39} Even though their added value in the healthcare sector is acknowledged,^{40,41} women leaders encounter societal and cultural challenges that define and diminish their career potential. This study considers the dynamic dialogue among societal culture, professional leadership and gender as a socially constructed concept⁴⁰ pervading the society in a constant flux and negotiation. These interactions shape mechanisms over time, such that dominant perceptions are enabled and constantly reinforced through country's social, cultural and economic influences.

This paper draws upon qualitative data which are used to understand the social phenomenon of women leaders' underrepresentation in healthcare sector by unveiling the underlying dynamics among women, healthcare leadership and country's specific societal culture.³⁵ Taking into account that the healthcare sector constitutes one of the biggest

employers worldwide and is populated mainly by women,³⁶ researchers sought to explore the dominant factors, such as culturally imbued norms, affecting women in this setting; roles and values assumed by healthcare leaders reflecting external influences such as education, family, community and peers are also considered.⁴³ The aim of this study is to assess empirically the gendered barriers encountered by women leaders in healthcare through country's sociocultural specificity.

Subjects and Methods

The researchers undertook a small exploratory, qualitative study using semi-structured interviews⁴⁴ to "put people in the context of their lives and the lives of those around them".⁴⁵ The research question addressed was "What are the barriers and their importance in shaping women's leadership in Greek and Maltese healthcare settings?" Authors set out to critically evaluate and contextualize the empirical findings to gain in-depth understanding of the relationship between the barriers identified as hindering the advancement of women leaders in healthcare within the country-specific sociocultural and economic contexts.⁴⁶

Ethical approval

Ethical approval was obtained from the ethics committees of the Maastricht University (No. METC 16-4-266; January 19, 2017), the National and Kapodistrian University of Athens (Medical School) (February 3, 2017) and the University of Malta (March 10, 2017).

Study design

The study used a non-experimental, descriptive design. Thirty-six semi-structured interviews were conducted with the healthcare leaders in Greece and Malta. Gender balance was achieved in the purposive sampling of interviewees from the academic, clinical and medical groups to ensure the best possible inclusive insights with regards to the research question posed (Figure 1).

Participant recruitment

Geographically defined urban areas were conveniently selected in Greece for the needs of sample selection: Athens, Thessaloniki, Patra and Heraklion for Greece. National sampling was performed in Malta. A number of eligible organizations/agencies operating in the district were identified, representing the academic, clinical and medical facets (eg, medical schools, hospitals, medical associations) in the healthcare sector. Academic leaders included trained medical practitioners at the level of full professor. Clinical leaders included trained medical practitioners holding the position of chief executive

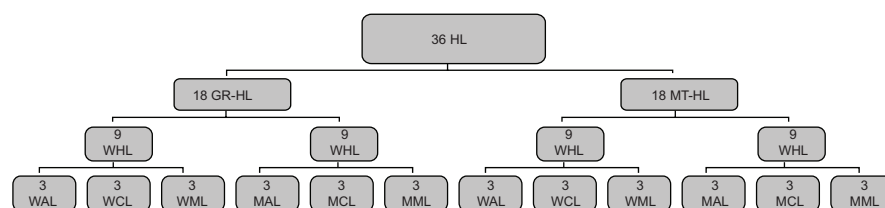


Figure 1 Study design - interviewees.

Abbreviations: GR, Greece; HL, healthcare leaders; MAL, men academic leaders; MCL, men clinical leaders; MML, men medical leaders; MT, Malta; WAL, women academic leaders; WCL, women clinical leaders; WML, women medical leaders.

officer or board member or a clinical directorship in a public or private hospital. Medical leaders included trained medical practitioners presiding over a professional organization and/or holding top leading positions in health ministry, health or medical organizations.⁴⁵ Purposeful and snowball sampling were used to identify participants in the research team members' networks in each country, rippling outward to wider networks of linked colleagues and agencies. Three men and three women were selected per facet and per country, namely, 18 participants per country and 36 participants in total (Figure 1). The purposeful sampling of 18 participants per country provided variation in the facets and participants in this study. The number was sufficient to reach thematic saturation.^{45,47}

Research procedures

Potential interviewees were approached by phone or email; all participants agreed to participate and were interviewed with no subsequent dropouts. Greek leaders were interviewed between March 2017 and October 2017; Maltese leaders were interviewed between June 2017 and August 2017. Interviewees were free to choose between a face-to-face interview, with their office as the interview setting, and a telephone interview. In both cases, both interviewee and researcher confirmed that nobody else was present during interviewing. Interviews were recorded with the interviewee's consent, except for two Greek interviewees who asked researcher SK to take field notes by hand. Interviewees were asked if they wished to confirm transcription output, but they declined due to time constraints. Transcription output was reviewed by two members of the research team (MP and SB). Interviews were conducted in Greek for Greek native interviewees and translated into English by a third party, and in English for Maltese interviewees since English is an official language in Malta. Researchers SK, EP and MP checked the translated Greek texts separately to increase the reliability of the data.⁴⁸

Prior to the interview, participants were informed orally and in writing about the study objectives, methods and data protection, and granted their consent including signing an informed consent form. Two experienced members of the research team (SK and LC) carried out the semi-structured interviews; inter-

views lasted from 20 to 50 minutes. The interview questionnaire focused on the nature of encountered barriers, on reasoning and potential ways to overcome them (Figure 2) and was informed by the output of a previously conducted systematic literature review pertaining to gendered barriers to women's leadership in healthcare⁴⁹ and by dedicated workshops and focus groups.^{50,51}

Analyses

Following each interview, interviewers noted initial thoughts and ideas. Field notes and transcribed interviews were read several times by four researchers to gain close immersion in the data. More specifically, a case description was initially drafted for each of the 36 interviews using all data. Then, the process included data coding into meaningful groups using the coding scheme of the Barriers Thematic Map (BTM).⁴⁹

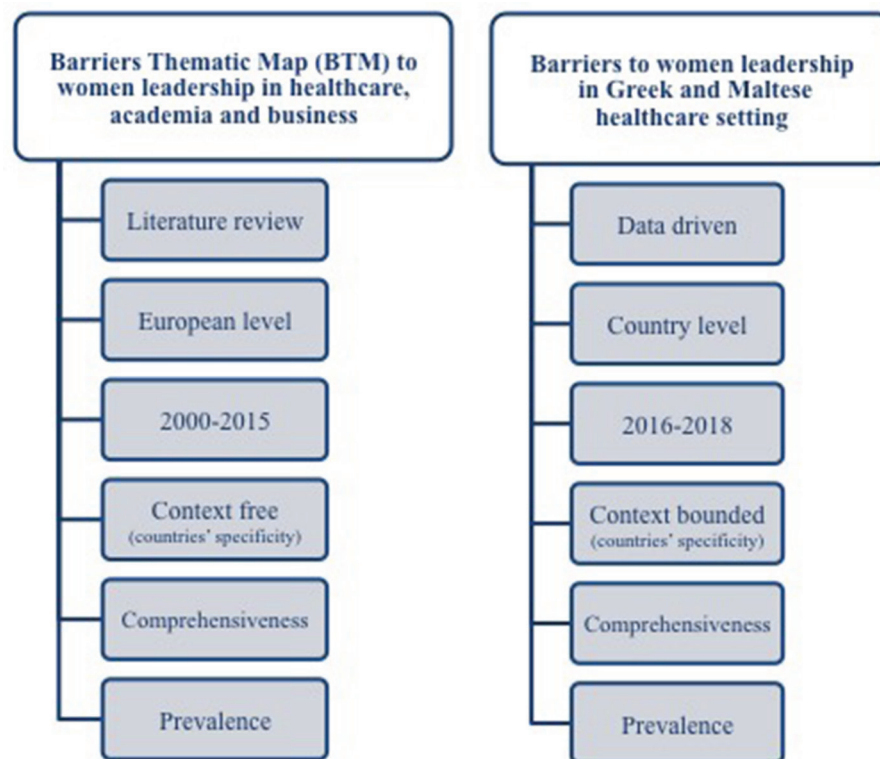
Researchers adopted the BTM coding scheme to contrast the study's findings on the grounds of comprehensiveness and provided prevalence (Figure 3). BTM illustrates a comprehensive list of 26 barriers to women's leadership with varying degrees of prevalence resulting from a systematic literature review with European coverage ranging from 2000 to 2015; the list has also been validated by several experts and focus groups during dedicated workshops.^{50,51} Thereby, the BTM was deemed to offer an educated, context-free (both at country and sector levels), theoretical basis on barriers to women's leadership in healthcare. The prevalence component was considered useful in terms of a comprehensive approach of barriers; it served the objectives of this empirical study by means of providing a comparative tool to explore similarities and differences between researched countries and extrapolate evidence-based conclusions.

Two randomly selected interviews per participant country were piloted for decoding and matching with BTM for the purposes of performing a validity check. The list of different BTM codes was then sorted into potential themes by gendered barriers encountered by healthcare leaders, based on patterns of meaning.⁵² Two experienced qualitative researchers per participant country coded interviews' data independently from the raw data and applied pattern matching technique with BTM (Greece: EP, MP; Malta: NA, LC).

Interview questionnaire for the study:

"Exploring barriers to women's leadership in Greek and Maltese healthcare setting"

1. How did you become a professor in medical school/hospital CEO/president of the health body?
2. What is your education level?
3. Please tell us about your experiences in professorship/top level administration/presidency in terms of gender diversity (eg, easier/tougher as a woman/man, relationship with male/female colleagues, administrators, students, etc)
4. What barriers/difficulties related to your gender if any have you faced during your carrier advancement?
5. Would you please elaborate further on the nature of the barriers you faced? (probe question)
6. What according to you might have been the reasons of the barriers you faced?
7. How did you feel when confronted with the barriers? How did you deal with them? Have you been offered opportunities during your carrier advancement related to your gender? Why? Why not?
8. Have you had any support while advancing in your career? If so from whom?
9. What are your thoughts about gender diversity in your field?
10. What does gender equality mean to you?
11. What is your advice to younger female professionals who want to make career in the healthcare field?
12. What is your advice to younger male professionals who want to make career in the healthcare field?

Figure 2 The interview questionnaire.**Figure 3** Characteristics of BTM study vs current study.**Abbreviation:** BTM, Barriers Thematic Map.

Data were examined using directed content analysis to identify and analyze themes.⁵³ These were further examined to explore the relationship among factors of interest and barriers hindering women leaders' advancement, as well as to gain informed insights on the country-specific interplay and process in shaping social reality. Thus, contextualiza-

tion was addressed as an important component of theory on barriers constraining women leaders' representation in healthcare.⁵⁴ Summative content analysis was then used to quantify the usage of themes (barriers)⁵⁵ and allow deeper understanding of the contextual use of themes. The qualitative meta-summative method was lastly applied to interpret the

content and discover underlying meanings.^{56,57} The analysis strategy applied, strengthened by the different backgrounds of the research team (academics, medical and non-medical, public health specialists), contributed to the study's ecological triangulation⁵⁸ and supported reliability and validity.⁴⁸ The COnsolidated criteria for REporting Qualitative research checklist was considered regarding study's qualitative research criteria and completed to ensure sound approach in data accuracy and analysis (Table S1).

Results

Twenty and twenty-one barriers to women's leadership were identified from the interview data within Greek and Maltese healthcare settings, respectively (Table 1; Figure 4). The barriers were classified into percentage order of the two explored countries to better serve the objectives of data interpretation and elaborate on the research question on countries' specificity in relation to women's underrepresentation in healthcare leadership.

The unfolding processes of cultural reality in relation to the social phenomenon being explored presented both commonalities and variations in the prevalence of the barriers identified in the Greek and Maltese healthcare settings. To avoid an excessive focus on culturalism, the authors applied the "bounded variability" concept⁵⁹ on the grounds that differences between countries have limits and, therefore, explored contexts were delimited by discussed barriers. The social construction of the concept of barriers was deemed conceptually, contextually and functionally equivalent among male and female Greek and Maltese interviewees, providing a suitable grouping of experiences and perceptions.

Striking similarities and differences in identified barriers and their respective prevalence illustrate the complexity of the web of barriers within each country's sociocultural and economic substance and indicate each country's uniqueness in relation to the phenomenon being explored. Work/life balance (17%), lack of family (spousal, namely, husband, wife, partner, mate, significant other) support (12%), gender gap (10%), gender bias (8%) and lack of social support (6%) featured in Greek interviewees' experiences and perceptions across healthcare settings. The top-ranking barriers presented in Malta included work/life balance (13%), culture (12%), lack of family (spousal) support (11%), stereotypes (9%), gender bias and lack of social support both ranked at 6%. The barriers that were perceived less frequently in both countries were the lack of leadership skills, lack of mentoring and networking, lack of confidence, lack of flexible working environment, the gender pay gap, the queen bee syndrome ("the

Table 1 Barriers to women's leadership in Greek and Maltese healthcare setting (arithmetic presentation)

Barriers to women's leadership in healthcare	Greece (%)	Malta (%)
Work/life balance	17	13
Lack of family (spousal) support	12	11
Culture	4	12
Gender gap	10	5
Stereotypes	5	9
Gender bias	8	6
Lack of social support	6	6
Lack of equal career advancement opportunities	5	4
isolation	3	5
Lack of flexible working environment	3	5
Lack of executive sponsor	4	4
Lack of mentoring	1	4
Lack of networking	3	3
Lack of leadership skills	3	2
Gender pay gap	3	1
Sexual harassment	3	0
Lack of confidence	2	3
Lack of role models	0	3
Queen bee syndrome	2	1
Age	2	0
Glass ceiling	0	2
Race discrimination	0	1
Tokenism	1	0
Glass cliff	0	1
Personal health	0	0
Limited succession planning	0	0

reluctance of successful females to support other women", p. 50)⁶⁰ and the lack of equal career opportunities.

Work/life balance

The difficulties in achieving work/life balance and the costs or sacrifices expected from women pursuing a top-level career in the field were explicitly described using negative overtones by Greek and Maltese healthcare leaders:

Work/life balance is very difficult, almost impossible to be achieved. [WA15]

and

Sometimes it does involve making sacrifices and letting go of the work/family balance. [WC8]

or

I prioritize my job; ... I chose not to raise a family. [WC7]

or

stepping out of career leading aspirations due to unforeseen family care tasks

Socially legitimized expectations regarding roles, responsibilities and claims for women, except for the cases of approving husband, were also highlighted:

My husband helped me a lot; he was not envious of my career. [WM2]

or

A woman has to consider whether she wants to raise a family; for a man does not make a big difference. [MM24]

Whereas Greek leaders perceived the systemic influence of culture more flexibly:

In Greece men do not participate significantly in family issues; they participate more than previous years, but still this is not enough. [MA9]

or

It was easier for him (the General Director) to tell off a woman. [WA15]

Stereotypes, gender bias, isolation, gender gap

In both the Greek and Maltese contexts, a high prevalence (5% and 9%, respectively) of stereotypes coupled with gender bias (8% and 6%), isolation (3% and 5%) and gender gap (10% and 5%) depict a rather women-unfriendly working environment that denies equal authority on the grounds of deeply rooted power roles:

At the higher echelons of the medical profession there are few women, even though they are very good, of very high standard. The few women I know in leadership positions in medicine are high performers and must be better than their male counterparts. [MM16]

or

Women have to prove themselves constantly, which is different from men who, once they reach a certain level, are more accepted by fellow men. [WC7]

or

Here it is a male dominated situation in terms of power, [...] even though women are treated as equal to equal in terms of scientific competence. [WA27]

or

Our organization is male dominated; the rules of the game are quite male friendly and women unfriendly. [MM16]

Social and professional exclusion due to stereotypes and bias was articulated explicitly as being one of the major barriers to career advancement:

I avoided joining some lobbies depriving myself of some career opportunities; they were male dominated lobbies, sort of Big Boys' Club; I could not and did not want to cope with their terms. [WC19]

or

Women are in a disadvantaged position. To be honest, we have not yet reached a satisfactory level of women representation. [WM35]

Lack of social support

The strong positioning of traditional cultural values in the Maltese social reality appears to demarcate the boundaries of expected roles, responsibilities and claims for women and induces social consequences when trespassing these boundaries:

Our culture, our society, enforces a lot of guilt on women coming not only from men, but from women as well. [WA2]

or

So being a woman, a doctor and occupying a top position, is strange, you know; there is so much unjustified jealousy and criticism. [WM15]

On the contrary, Greek society seems to be more concerned about gaining power and social status; the achieved and ascribed status is desirable and sought after:

A woman in Greece coming from a middle or lower social class faces often tough criticism from her social environment should she choose to prioritize her career over her family. [MA1]

or

I may work harder than men just to receive the same recognition. [WM11]

Furthermore, a dysfunctional gap between gained professional recognition and the respective culturally legitimized authority was reported:

Medicine is a science, there is no hierarchy, but this is not always given within social system. [WM23]

Age was proposed by interviewees as a biological barrier holding back women during career stages of critical

importance due to its coinciding with pregnancy and childbirth. In fact, both women and men reported that pregnant women or women of reproductive age are considered, even though it should not be allowed, as it is a liability to their organization's performance since

Pregnancy is not a disease and should not be addressed as such. [WM35]

Furthermore, sexual harassment as a means of power exertion to offer or to pursue career advancement (top down to bottom up and vice versa) was reported as a well-known, often unvoiced occurrence limiting opportunities on non-meritocratic grounds.

(Un)conscious biases and stereotypes applied by gatekeepers to prevent women from entering the higher echelons were described as “male-dominated environment” and “Big Boys’ Club” (WA2). These were deemed instrumental in retaining highly qualified women leaders in middle management ranks. On the other hand, complying with social expectations and in the absence of supporting structures and flexible working policies, women often opted for more family-friendly specialties. For example, specialties with programmed working hours (eg, public health, radiology, dermatology) were more likely to be sought by women compared to more time-demanding, unprogrammed and stressful specialties (eg, surgery, oncology). This has the effect of limiting career choice. Interviewees widely held that it was the women's choice to pursue a top career over raising a family. Compromising aspirations for career endeavors have also been approached as a culturally driven type of competition between spouses, affecting both genders in terms of social status.⁶² The paradox of the deficit in women leaders in healthcare despite their added value was acknowledged from all interviewees. “Hard workers” (MM22), “problem solvers” (MC18) and “inclusive leaders” (WC31) were the terms used to describe the competences through which women are believed to contribute significantly to organizational performance in contrast to the typical male aggressive leadership style. However, it was commonly accepted that, even though talented women have typically equal access to career advancement opportunities, career–family dilemmas, deeply socially rooted biases and organizational culture and practices reduce their odds for attaining success.

Research findings reflect interviewees' perceptions on the tripartite interactions between gender, healthcare leadership and sociocultural contexts, shedding light on the relationships between the barriers to women's leadership in the Greek and Maltese healthcare context (Table 2). All

three groups of interviewees (academic, clinical and medical) presented commonalities with respect to barriers to women's leadership and the role of societal and professional culture. However, deeper exploration of the interviews may uncover critical nuances related to each group's professional context. For example, time constraints in clinical leading roles may manifest differently than in academic roles (urgency vs long hours). Similarly, it may be argued that the power interplay in professional hierarchy roles may also be considered an aggravating factor in generating barriers to women's leadership. Barriers to women's leadership related specifically to healthcare groups or to professional power interplay are of critical importance to better understand the context of gendered challenges in healthcare and merit further exploration.

Discussion

This study empirically appraised the “regimes of truth”⁶⁶ with regards to gendered barriers and culturally legitimate societal power and authority in the Greek and Maltese healthcare sector. The similarities and differences explored through a country's sociocultural lens highlighted the need to address a common challenge comprehensively within a contextually bound frame. This would contribute to evidence-based research, facilitating the development of evidence-informed policy in this field.

Previously published research on barriers to women's leadership in healthcare was mainly approached at the sector or practice level. For example, Newman et al^{39,63} discuss several gendered constraints in pre-service and in-service education and employment systems hindering gender equality and diversity in health workforce research, leadership and governance. Similarly, Kuhlmann et al^{64,65} consider challenges in terms of leadership at all levels of management and organizational performance. Bismark et al⁴⁷ identified and interpreted a range of barriers across medical leadership roles through the perceptions of capability, capacity and credibility. Schuh et al⁶⁶ reported sociocultural constraints lowering power motivation to aspiring women leaders and, thus, mediating the link between gender and leadership role imbalances. Toh and Leonardelli⁶⁷ related cultural constraints to women leaders' advancement with the degree of cultural tightness, namely, the strength of norms and social sanctions embedded in society's egalitarian practices.

Building upon the available literature on women's leadership in healthcare and on cultural pressures on women leaders, this study discusses the relationship between the pervasiveness of gendered barriers, leadership in healthcare and

Table 2 Interview excerpts on prevailing barriers to women's leadership in Greek and Maltese healthcare setting

Barriers	Interview excerpts from Greek healthcare leaders	Interview excerpts from Maltese healthcare leaders
Work/life balance	Work/life balance is very difficult, almost impossible to be achieved; the majority of women bear the cost [WA15] It depends on the sacrifices a woman is willing to do; what she wants to prioritize (family or career) and what to leave behind [MM24] I prioritize my job; being at the hospital almost 24/7; I chose not to raise a family [WC7]	If you want to balance your career aspirations as a family person, it's tough; especially for women; they need to get that delicate compromise [MM17] Sometimes it does involve making sacrifices and letting go of the work-family balance [WC8] I had to re-assess my work-life balance, my priorities when my mother got sick [WA1]
Lack of family (spousal) support	My ex-husband was very competitive with me on both a professional and social level; I believe my professional success cost me opportunities in my personal life [WC19] They [women] are good at their science and on the other hand they have to run their household by themselves. I have seen it in my female colleagues and the young female professors. They face significant difficulties [MA9]	My husband helped me a lot; he was not envious of my career [WM2] I told my daughter that she was good enough to become a doctor, but her life was going to suffer moving to a country where no family support was available [MA5] If you do not have spousal support, you can forget it [WA3]
Gender gap	Women are in a disadvantaged position. To be honest, we have not yet reached a satisfactory level of women representation [WM35]	At the higher echelons of the medical profession there are few women, even though they are very good, of very high standard. The few women I know in leadership positions in medicine are high performers and must be better than their male counterparts [MM16]
Gender bias	I may work harder than men just to receive the same recognition [WM11]	Women have to prove themselves constantly, which is different from men who, once they reach a certain level, are more accepted by fellow men [WC7]
Lack of social support	A woman in Greece coming from a middle or lower social class faces often tough criticism from her social environment should she chooses to prioritize her career over her family [MA1] Medicine is a science, there is no hierarchy, but this is not always given within social system [WM23]	Our culture, our society, enforces a lot of guilt on women coming not only from men, but from women as well [WA2] So being a woman, a doctor and occupying a top position, is strange, you know; there is so much unjustified jealousy and criticism [WM15]
Stereotypes	Here it is a male dominated situation in terms of power, even though women are treated as equal to equal in terms of scientific competence [WA27] I avoided joining some lobbies depriving myself of some career opportunities; they were male dominated lobbies, sort of Big Boys' Club; I could not and did not want to cope with their terms [WC19]	Our organization is male dominated; the rules of the game are quite male friendly and women unfriendly [MM16] Our faculty is still a male dominated environment, a Big Boys' Club; if you look at the committees, they do not have a woman member [WA2]
Culture	It was easier for him (the General Director) to tell off a woman [WA3] A woman has to consider whether she want to raise a family; for a man does not make a big difference [MM24] In Greece men do not participate significantly in family issues; they participate more than previous years, but still this is not enough [MA9]	Women have a more important say at home; there is still this mentality; it is a cultural influence and it is more natural for women to keep with this kind of mentality [MC12] In our Mediterranean culture, men have more of a lust for power, they are after power for the sake of power; women are more consensus seekers, cooperative and very logical, unless you make them your enemy [MM16] Mediterranean culture is more chauvinistic and has more difficulties with having women in leading positions [MA6]

Abbreviations: MA, man – academic setting; MC, man – clinical setting; MM, man – medical setting; MW, woman – medical setting; WA, woman – academic setting; WC, woman – clinical setting.

country's sociocultural specificities. The plethora of barriers (20 for Greece and 21 for Malta) with striking differences in the reported frequency corroborates essential sociocultural features of EU-Med countries. Taking into account that the conceptualization and operationalization of barriers were consistent across interviewees and that leadership is largely shaped by dynamic relationships between context, gender and culture,⁶⁸ it may be deduced that gender asymmetries

in terms of power and authority are socially and culturally defined within a country's context.

Cultural expressions include the ability to gain compliance and recognition, the distinction between power and culturally legitimate authority,⁹ as indicated by the

I may work harder than men just to receive the same recognition. [WM11]

comment. Yet, generalization may be dangerous and lead to misunderstandings and prejudices¹ unless subculture context, such as the healthcare profession, is taken into consideration. Paraphrasing Parsons,⁶⁹ it may be argued that anything so general as gender asymmetries may be the result of a canvas of different factors deeply involved in the foundations of society, the qualities of which are sociocultural dependent. In alignment, the Maltese approach that

Men have more of a lust for power, they are after power for the sake of power; women are more consensus seekers, cooperative and very logical. [MM16]

contrasting with the Greek

It was easier for him (the General Director) to tell off a woman. [WA15]

manifests the gradation of cultural effects' strength on gender, power and authority relationship within countries' healthcare sociocultural contexts; the cultural stiffness Maltese society experiences to overcome deeply rooted perceptions is well evidenced also by the yielded prevalence on "culture" (Malta: 12%, Greece: 4%).

Following Durkheim,¹¹ that the structure and quality of social relationships in terms of private life influence modes of thinking and cultural interaction, it may be suggested that gender-ascribed roles and responsibilities have been institutionalized and culturally legitimized in both countries. Work/life balance and lack of family (spousal) support scored high in Greek (17%, 12%) and Maltese (13%, 11%) settings underpinned with particular socioeconomic features; for example, Greek women were observed to opt for lower and less-rewarding but economically safer positions to secure support for their families due to the economic crisis in Greece; in contrast, the Maltese women were found to opt for part-time or lower level jobs aligning with the ascribed sociocultural obligation to prioritize family tasks over career. However, even in Sweden, widely considered to be a socially progressive country which may lend itself to work/life studies standing out in its statutory requirements in the field, culture and cultural differences are considered more important factors than legal measures toward achieving balance between personal and professional life.⁷⁰ Hence, it may be argued that culture's tightness expressed in norms and legitimizations may strengthen deeply established practices, resulting in less power and authority for women, thus leading to women's leadership deficit.⁶⁷ Hence, persisting underrepresentation of women leaders may be approached by addressing the tight control societal culture exerts over its subdivisions and

their constituents. In line with this, Fox et al⁷¹ noted that the hierarchical gender stratification of careers is being seconded by informal gender classifications in the society. This was also reported by an interviewee

Medicine is a science, there is no hierarchy, but this is not always given within social system. [WM23]

Nonetheless, health professions are still held in high regard socially.⁷²

However, even though culture should be considered a mix of constant influences, the boundaries among societies are vague.¹ It may be claimed that in explored sector, societal culture is experienced by some as a resisting barrier to professional advancement and subsequent social change and by others as an alibi for not leaving a personal comfort zone. For example, women's leadership is perceived positively by Maltese male leaders, but still they settle with the family-related constraints imposed to women by local culture. Similarly, Greek male leaders recognize the systemic influence of culture in family-related issues and the small steps made toward change; yet, they acknowledge the long way to go to achieve an acceptable balance in family/work responsibilities. It may be argued that the analogy applies for the men's perceptions of women's leadership; all male interviewees acknowledged the leadership potential of their female counterparts, both at scientific and output levels; they also accepted that the barriers encountered by women in acquiring leading positions are many and complicated and, oftentimes, societal and professional cultures do not provide the required authorization to society members to function differently. The paradox of women's leadership challenges lies on the observation that women perceive the barriers hindering their career advancement the same way as men do. Despite potential underlying professional power struggles, which may happen in any professional interaction and among all genders, all interviewees' perceptions recognized the impact of societal culture on women's leadership. The observed cultural tightness seems to moderate the degree to which egalitarian practices may be receptive by social dividends to accept, implement and sustain such changes. However, healthcare professions being in high social regard, their potential to serve as a catalyst to social and cultural transformation, to challenge established norms and values and offer role models to social settings should not be underestimated. Considering the multiple social identities a person bears and the societal impact that they may generate, it may be argued that healthcare leaders should be reckoned as a critical component in an agenda for positive social change.

The present study illuminated the discursive dynamics among gender, professional leadership and societal culture shaping mechanisms that influence social behavior and women's professional choices. Gendered barriers to healthcare leadership within country's sociocultural contexts may be better addressed by taking into consideration the evidence of the barriers within country's specificity that adversely impact women's leadership opportunities. Further research on the impact of these tripartite interactions across cultures is very much needed.

Implications

People grow and change within the realm of their relationships.⁷³ Acker⁷⁴ described the dynamics produced from interactions of gender, hierarchy and sociocultural setting as "inequality regimes", embodying perceptions on authority, power, leadership and more. Bringing change requires challenging traditional, culturally rooted views and values which are influenced in an untraceable, constant and timeless way. Rather than put forward a single causal proposal to empower change, authors propose a tripartite conceptual framework which links a country's sociocultural contexts with comprehensive data on gendered barriers harvested from the healthcare sector (Figure 5).

Addressing the durability and transferability of gendered barriers within sector and country contexts, a reality check may be provided via barriers' detailed mapping and prevalence through country-specific lenses, such as socioeconomic

and cultural contexts. Policies to equalize career opportunities may suffer from blind spots; for example, policy measures may address a lack of flexible working environments that give flexible work schedules to young parents, leaving though untouched sexual harassment challenges or the needs for leadership, mentoring and inclusion training programs. Thereby, mapping and evaluating the barriers and their prevalence may provide a "snapshot" to gendered challenges in organizations and support meaningful, progressive practices eschewing resources' waste in fragmentary, fashionable interventions. For example, application of an easy-to-use online toolkit providing anonymously data on barriers to women's leadership advancement in healthcare organizations may offer a reliable basis to assess existing gendered policies and practices. Nonetheless, further research is recommended to assess required gendered organizational policy changes and expected benefits for both healthcare organizations and society.

Prior research asserts culture has been the "wooden leg" of policies,⁷⁵ overriding statutory efforts at change. Policymakers may be better informed by a comprehensive, evidenced-based approach responsive to country's sociocultural specificity and may develop policies and practices resonating to actual gendered needs and gaps. In that line, society and its subdivisions may experience a more effective and smooth transition toward desirable social balance and equality within work and social contexts.

Limitations

The authors acknowledge the study's limitations resulting from the constraints posed by the finite time and resources for this research. Convenience and snowballing sampling may be considered a limitation as the lack of random selection does not ensure representativeness. For example, the lack of interviewees residing in rural areas may have missed an important and different perspective. However, the interviewees' diverse origins and accumulated experiences provided a rich source of data on which to base meaningful analysis.

The directed content approach to the analysis also has some inherent limitations in terms of researchers sticking to existing theory and not recognizing potential contextual aspects of the researched phenomena that may limit the applicability of such theory.⁵³ To address these limitations and achieve neutrality or confirmability of trustworthiness, research team members, except SK and KC, examined those theme definitions before the team undertook the study.

The "coding down" approach to theme development introduces a limitation in terms of potential narrowing perceived



Figure 5 Conceptual framework to address gendered barriers to healthcare leadership within country's sociocultural contexts.

notions from interview content. However, published literature offered the researchers the possibility to make inferences from new data.

Regarding language limitations on the translation of the interviews' content, translators' expertise in the subject area may not have been adequate to translate subtle nuances expressed by the interviewees.

The interviewees might have been susceptible toward study's topic since their participation has been related to their work area. The Hawthorne effect and reporting bias⁷⁶ may have occurred in interviewees' responses due to their leading position. Still the study is considered to have made an empirical contribution to the literature on discursive dynamics on barriers to women's professional advancement through the country-specific cultural lens.

Nuances on potential similarities and differences on perceptions about barriers among explored healthcare groups (academic, clinical and medical) have not been discussed in detail as they are not within the scope of this study. Similarly, gendered professional hierarchies and the underlying power interplay, such as doctor–nurse and/or midwife, have not been deeply elaborated. The authors acknowledge the contribution of such findings in the field of women's leadership in healthcare; to this end, the research team proposes to further explore the professional power interplay through the lens of gender in healthcare.

The transferability of the study findings across regional and international contexts may be limited. Expansion of the study to include neighboring countries in the region would add to the trustworthiness of the findings. The study would also benefit from further exploration of additional factors such as employment contract variations in public/private sectors, subsectors' particularities and implications from migratory pressure.

Conclusion

The study explored the gendered barriers to women's leadership in healthcare through a country-specific approach. Findings unveiled underlying interactions among gender, leadership and country's sociocultural contexts, which may elucidate the varying degrees of strength of norms and barriers embedded in society's egalitarian practices. Cultural tightness can act as an alibi or barrier against sociocultural transformation. A conceptual framework is proposed to address evidence-based research in the field and inform policymakers in developing sector- and country-specific policies for advancing women's leadership in healthcare.

Author contributions

SK and KC were involved in the conception and design of the study. SK and LC conducted the interviews. SK and EP checked the translated Greek texts. KC, SB, EP and MP were involved in the extraction of themes and the pattern matching technique. All authors contributed to data analysis, drafting and revising the article, gave final approval of the version to be published, and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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Supplementary material

Table S1 COREQ checklist^a for Kalaïtzi et al (2019) “Women, healthcare leadership and societal culture – a qualitative study”

Topic	Item no.	Guide questions/description	Reported on page no.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	SK/LC (p. 11)
Credentials	2	What were the researcher's credentials? For example, PhD, MD	PhDc/PhD
Occupation	3	What was their occupation at the time of the study?	Doctoral student/researcher
Gender	4	Was the researcher male or female?	Female(s)
Experience and training	5	What experience or training did the researcher have?	Official/field training
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	No
Participant knowledge of the interviewer	7	What did the participants know about the researcher? For example, personal goals, reasons for doing the research	Participants were informed about the reasons of this research (p. 11)
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? For example, bias, assumptions, reasons and interests in the research topic	Interests (research, paper publication) (p. 11)
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and theory	9	What methodological orientation was stated to underpin the study? For example, grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Directed content analysis (p. 13)
<i>Participant selection</i>			
Sampling	10	How were participants selected? For example, purposive, convenience, consecutive, snowball	Purposeful and snowball (p. 10)
Method of approach	11	How were participants approached? For example, face-to-face, telephone, mail, email	Email, telephone (p. 10)
Sample size	12	How many participants were in the study?	36 (p. 10)
Non-participation	13	How many people refused to participate or dropped out? Reasons?	Two due to time constraints
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? For example, home, clinic, workplace	Workplace (p. 11)
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	No (p. 11)
Description of sample	16	What are the important characteristics of the sample? For example, demographic data, date	Highly educated, healthcare professionals (p. 10)
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Questions, prompts; tested with focus groups (p. 11, 13)
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	No
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	Audio (p. 11)
Field notes	20	Were field notes made during and/or after the interview or focus group?	Yes (p. 11)
Duration	21	What was the duration of the interviews or focus group?	20–50 minutes (p. 11)
Data saturation	22	Was data saturation discussed?	Yes (p. 10, 13)
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	Yes, but declined due to time constraints (p. 11)
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	4 (p. 13)
Description of the coding tree	25	Did authors provide a description of the coding tree? Yes (p. 12)	

(Continued)

Table S1 (Continued)

Topic	Item no.	Guide questions/description	Reported on page no.
Derivation of themes	26	Were themes identified in advance or derived from the data?	In advance (p. 12)
Software	27	What software, if applicable, was used to manage the data?	N/A
Participant checking	28	Did participants provide feedback on the findings?	No
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? For example, participant number	Yes (pp. 16–22, 25–27)
Data and findings consistent	30	Was there consistency between the data presented and the findings?	Yes (pp. 14–15)
Clarity of major themes	31	Were major themes clearly presented in the findings?	Yes (pp. 15–21)
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Yes (pp. 21–22)

Note: *Developed from: by permission of Oxford University Press.¹

Abbreviation: COREQ, COnsolidated criteria for REporting Qualitative research.

Reference

1. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357.

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