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Glass Ceiling Syndrome: A Perspective of Women Working In Health Institutions

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ABSTRACT

Background and Purpose: Although women constitute the majority of the workforce in the healthcare sector, the number of representations in management positions needs to be increased. This study aimed to determine female health workers' glass ceiling syndrome perception levels and examine socio-demographic variables' effect on this level.

Design/methodology/approach: The research sample consists of 708 female healthcare professionals who work in six public hospitals. Perceptions were measured using the 42-item Glass Ceiling Perception scale. Measurements were made on a 5-point Likert scale ranging from 0 to 4.

Findings: It was found that the glass ceiling syndrome perception levels of female healthcare professionals were neutral (1.94). It has been determined that female healthcare professionals with a high level of education, doctors and nurses, those between the ages of 26-35, those who work in medical units, and those with a child have higher perception levels of glass ceiling syndrome.

Keywords: Glass Ceiling Syndrome, Career Barriers, Female Healthcare Professionals, Female Managers.

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INTRODUCTION

Over the course of two decades, there has been a noteworthy rise in the presence of women in the workforce, mirroring the global economic, social, and cultural advancements. Working life for women also includes various obstacles as well as many advantages. "These obstacles manifest themselves both in factors affecting the decision-making processes of women in entering the business life, in the difficulties they face when searching for a job in the labor market and the recruitment process, and in front of their promotion to management positions in institutions" (Gülbay, 2012; Irmak, 2010). Similarly, Maume (1999) stated that there are barriers to gender and race in front of promot ion to a management position.

According to the United Nations Gender Social Norms Index Report, there are prejudices regarding gender worldwide, regardless of the level of human development. One of these prejudices is the belief that men make better business executives and political leaders than women (UNDP, 2023). There are other supporting data that reinforce the findings of the mentioned report. Among 67 nations surveyed in 2019, Iceland exhibited the most noteworthy rate of male labor force engagement among individuals aged 15 and above, reaching 84.9%, whereas Moldova demonstrated the lowest rate at 47%. Iceland boasted the highest rate of female labor force participation at 77.4%, while Jordan had the lowest, with only 13.4% of female participating in the workforce. The female workforce rates in some other countries are as follows; USA 57.4%, Germany 56.6%, China 66.7%, Italy 41.3%, the UK 58.5%, and France 51.3%. The ILO estimated approximately the same year that the proportion of female managers worldwide is 27.9%, 22.4% in low-income countries, and 35% in high-income countries. According to ILO's "Women in Management in 2019" data, the highest rate of middle and senior management were in Iceland at 44.3%, and the lowest was in Jordan at 13.4% (International Labour

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Organisation Statistic (ILOSTAT, 2020). When examining the representation of individuals within managerial roles and the proportion of female in the labor force, both within the context of Turkey and globally, it is evident that in the year 2019, the labor force participation rate stood at 72% for men and 34.4% for women in Turkey (TSI, 2020).

In spite of the increasing participation of women in the labor force, both within Turkey and on a global scale, there persists a necessity to enhance the level of female representation within executive leadership positions to align with the envisaged proportions. According to the research, many reasons prevent women from promoting to managerial positions. One of these rationales pertains to the glass ceiling barrier, a subject of scholarly investigation in recent times (Mizrahi & Aracı, 2010; Stainback et al., 2016).

Substantial strides have been taken in Turkey towards mitigating disparities in women's education and workforce participation. Aycan (2006) asserts that there is a noticeable rise in the presence of women within the Turkish industrial sector; nonetheless, these individuals encounter specific impediments in their path towards attaining executive roles. Moreover, this situation is not unique to Turkey. Numerous scholarly investigations have consistently highlighted the limited presence of women in prominent management positions, exhibiting a pattern of underrepresentation that spans diverse cultures and countries on a global scale (Alobaid et al., 2020; Budhwar et al., 2013; Desvaux et al., 2007). Considering the fundamental principles of human resource management, such as equality, diversity, career, selection, development, and representation in management (Ahammad, 2017; Sharma, 2023), the inability of women to attain executive positions is an unexpected situation in today's world. Particularly, the investigation of this situation in the health care sector, which is predominantly female-oriented, has become a subject of interest (Johns, 2013). This increasing interest, constitutes the fundamental motivation behind the cross-sectional screening study we conducted in hospitals.

LITERATURE REVIEW AND HYPOTHESIS DEVELOPMENT

Glass Ceiling and its Causes

Glass ceiling is employed to typify the impediments that impede the progression of women, irrespective of their accomplishments, and which are both elusive in discernibility yet resistant to resolution. This concept emerged in the USA in the 1970s (Wirth, 2001). Consistent with the provided information, the conceptualization of the "Glass Ceiling" metaphor pertains to imperceptible obstructions that stem from ingrained organizational biases and established paradigms, necessitating adept women to surmount these barriers in their pursuit of ascending to elevated echelons within the professional hierarchy (Buscatto & Marry, 2009; Wirth, 2001).

Glass ceiling is symbolically represented by its transparency akin to glass, affording women a perceptual insight into upper echelon positions attainable within an organizational hierarchy. However, its transparency does not change that the barrier is a ceiling that prevents women from reaching these positions (Morrison & Von Glinow, 1990).

It can be said that even in today's advanced societies, working life is characterized by the ideologies of the powerful ruling class and the constantly ongoing gender barriers (Hoobler et al., 2010). For this reason, many women complain that their qualifications and professional competencies are subject to a double standard in the work environment. Many women experience a sense of frustration in the professional field. This situation is expressed as an invisible obstacle, "a glass ceiling" built by men and society for women (Ailes & Kraushar, 2000). Rarely these glass ceilings are cracking in some sectors, but injustices such as unequal salaries stand out (Commission & Labor, 1995; Kräft, 2022).

In theory, the categorization of barriers pertaining to the glass ceiling varies. From an integrative point of view, glass ceiling barriers combine three primary factors: individual, organizational, and social barriers. Personal obstacles encompass the various roles individuals juggle and the personal inclinations and viewpoints of women. On the other hand, institutional hindrances involve factors like the culture and politics within an organization, the absence of mentorship, and the challenge of engaging in informal communication networks. Social barriers are explained as occupational segregation and stereotyping (Taşkın & Çetin, 2012). Melanie Lockert confirms the existence of the glass ceiling in her article on Business Insider, suggesting that these barriers may stem from social norms, patriarchal culture, women's preferences for flexible jobs, and their tendency to negotiate less in terms of work and salary (Lockert, 2022).

Smith et al. (2012) predicts that the glass ceiling in business life globally will continue for many years.

Cassirer and Reskin (2000) found that women do not care about promotion opportunities as much as men. Hoobler et al. (2010), who conducted a meta-analysis based on 96 studies, concluded that conflicts carried from work to home and from home to work constitute a glass ceiling. It has been concluded that mainly family-work conflict negatively affects work performance. Cech and Blair-Loy (2010) delved into the determinants that underlie the inadequate presence of femail in management positions across the domains of technology and science. The outcomes of their study revealed that the primary factors influencing the presence of the glass ceiling are the organizational culture and managerial dispositions. They also found that different careers and different family situations differentiated the situation. The aforementioned research revealed that women possessing advanced educational qualifications and occupying leadership positions at the highest echelons of an organization are susceptible to heightened levels of gender-based disparities.

Snavely (1993) investigated the reasons for the poor management skills of female managers. In that research, it was concluded that factors such as women not being included in the informal communication network by their male friends within the organization, evaluating their management performances with different criteria, having conflicts between manager and family roles, and defining career and job descriptions suitable for men's values cause women's management skills to be weak. Bagues and Esteve-Volart (2010) investigated whether there was any gender discrimination in recruitment in the interview commissions in Spain between 1987 and 2007. This study has concluded that women's chances are lower when a woman or man candidate applies for the same position.

Interestingly, the same research revealed that most women evaluators in the interview commission resulted to the detriment of women because women often evaluate the qualifications of male candidates at a higher level than they are. In their research conducted in 157 countries, Ferber and Lowry (1977) argued that one of the indicators of gender discrimination is the separation of jobs into "male's" and "female's" jobs." They stated that the business lines in which women work extensively differ from country to country, but this is caused by management style, culture, and religion, not gender. Kee (2006) concluded that the primary determinant of the wage disparity is gender, and a more pronounced glass ceiling phenomenon exists within the puclic sector as opposed to the private in the context of Australia. Women highlighted their family responsibilities and paid more attention to their families' needs than their career goals (Jones & Oppenheim, 2002).

The main aim of this study is to ascertain potential variations in the perception of the glass ceiling phenomenon drawing upon the socio-demographic characteristics of women employees working within secondary and tertiary healthcare institutions situated in Trabzon. The subsequent hypotheses, formulated for the purpose of empirical examination, are delineated as follows.

Many researchers have demonstrated that married women have a high glass ceiling perception due to their responsibilities (Buddhapriya, 2009; Jordan & Zitek, 2012). Research findings indicate that unmarried women are considered more compatible with consulting firms compared to their married counterparts. This inclination is attributed to their perceived dedication to career advancement, adeptness in achieving professional success, limited engagement in social obligations, and greater willingness to invest extended periods of work. The study further asserts that the commitment and occupational efficacy of women tend to decline following recent marriage; conversely, newly married men exhibit an augmentation in commitment levels and job performance (Jordan & Zitek, 2012). Owing to the dedication required for familial obligations which exert a notable impact on their professional trajectories, it has been found that married and widowed or divorced women face difficulties in business life and more barriers in their career development than single women (Buddhapriya, 2009). This current study proposes the following hypothesis:

$H_{1:}$ Glass ceiling syndrome varies according to marital status.

Enid Kiaye and Maniraj Singh (2013) found that women in Durban adopt the idea that they do not have the desired experience and education to take management positions. Sampson and Moore (2008) found that although women have the same education and experience as men, glass ceilings are common in the UK, women take fewer senior positions, and women are paid less. Cech and Blair-Loy (2010) found that women with higher degrees are more exposed to gender inequality. Akyurt (2018) found a difference in glass ceiling syndrome according to education status. However, Kılıç

and Çakıcı (2016) and Uysal and Ak (2020) argued that the glass ceiling syndrome does not change according to education status. This study proposes the following hypothesis:

H_2: Glass ceiling syndrome varies depends on educational status.

The research conducted by Köksal (2016) as well as Akkum and Ulusoy (2019) underscored the significance of occupational distinctions in contributing to the phenomenon of the glass ceiling syndrome. Parallel conclusions were drawn in the investigation carried out by

In the study by Soysal and Baynal (2016), it was established that the glass ceiling syndrome exhibits a more prominent manifestation within the medical doctor profession. Albrecht et al. (2003) shed light on the persistent existence of the glass ceiling across various sectors and occupational categories in Sweden throughout history. This study puts forth the subsequent hypothesis:

H_3: Glass ceiling syndrome varies depending on the profession.

Jones and Oppenheim (2002) found that women did not encounter any obstacles until their forties, but glass ceilings were formed for them after that age. Sever (2016) found that the rate of exposure to glass ceiling syndrome in older people decreased. Uysal and Ak (2020) suggested that glass ceiling syndrome does not differ according to age. This study proposes the following hypothesis:

H_4: Glass ceiling syndrome varies depending on age groups.

Soysal and Baynal (2016) determined that women working in the administrative unit have higher glass ceiling perceptions. This study proposes the following hypothesis:

H_5: Glass ceiling syndrome varies depending on the duty area.

Jackson (2001) states that family life is also an obstacle because women prefer their families over their careers. Sever (2016) identified an inverse relation between the quantity of offspring and the prevalence of the syndrome. He argued that women with more children were exposed to fewer glass ceilings. This study proposes the following hypothesis:

H_6: Glass ceiling syndrome depends on the number of having children.

METHOD

Participants

The research population consists of all female employees (doctors, nurses, managers, administrative staff, and other health technicians) working at six hospitals in Trabzon city center. The research aimed to reach the whole population without using the sampling method. However, the number of volunteering employees has been limited to 708 people because health institutions' service cannot be postponed and is continuous. In 2021, the data were obtained by survey. All female employees in the hospitals where the research was conducted were invited to the study one by one. Everyone who participated voluntarily was included, and no one was excluded. Although the response rate is 20%, it is known that the predictive power of a sample of 708 people at the 95% confidence interval is high.

Data and Analysis

The survey consists of 42 questions, two parts, and nine sub-dimensions. In the first part, there is a "Personal Information Form" to obtain the socio-demographic information of the female employees. In the other part, there is a "5-Likert Scale" to determine glass ceiling syndrome of female employees. The questionnaire form used in the research was developed by Irmak (2010), using scales Karaca (2007) and Sezen (2008) in their master theses. After the changes and additions made by Irmak (2010), a reliability analysis was made, and it was calculated as 0.826. The scale has nine sub-dimensions.

Analysis of Data

The SPSS 25 program was utilized for conducting the analysis. Initially, the program was employed to compute descriptive statistics pertaining to the study participants. Subsequently, the program was utilized to determine the standard deviation (sd) and mean (x) values of the scale and its constituent dimensions. The subsequent step involved the examination of disparities in the means of the variables relating to socio-demographic and occupational factors, as outlined in the initial section of the data collection tool. Given the absence of normal distribution assumptions within the study data, non-parametric methods were employed for the subsequent analysis.

RESULTS

The total number of participants is 708 people. It was determined that 37.3% of the participants (264) were between the ages of 26-35, 36.2% (256) were between the ages of 36-45, 68.5% (485) were married, 47.6% of them (337) had a bachelor's degree, 25.6% (181) had 21 years or more of experience, 59.6% (422) worked in medical units, 38.3% (271) were other staff and 37.1% (263) were nurses.

Table 1. Socio-Demographic Variables of the Participants

Variables		N	%
Age	25 and below	68	9,6
	26-35	264	37,3
	36-45	256	36,2
	46-55	109	15,4
	56 and above	11	1,6
Educational Degree	Primary Education	24	3,4
	High School	106	15,0
	Associate Degree	175	24,7
	Undergraduate	337	47,6
	Postgraduate	66	9,3
Marital status	Married	485	68,5
	Single	200	28,2
	Other	23	3,2
Working Area	Medical Unit	422	59,6
	Administrative Unit	120	16,9
	Other	166	23,4
Profession	Doctor	56	7,9
	Nurse	263	37,1
	Manager	17	2,4
	Administrative Staff	101	14,3
	Other	271	38,3
Number of Children	No	241	34,0
	1	124	17,5
	2	241	34,0
	3	90	12,7
	4 and above	12	1,7
Professional Experience Period (years)	1-5	136	19,2
	6-10	138	19,5
	11-15	142	20,1
	16-20	111	15,7
	21 and above	181	25,6

The glass ceiling syndrome scale characteristics, which consist of 9 sub-dimensions, are given in Table 2. According to the research, the overall mean of the scale was found to be 1.94. In dimension of glass ceiling syndrome with the highest mean was "Mentoring," with 2.46, and the lowest average was "Negative Prejudices against Women," with 1.069.

Distinction" dimension mean scores was found to be significant. On the other hand, it was found that the mean scores of the Negative Prejudices against Women, Family Life, Gender Discrimination, and Obstacles in the Advancement of Women in Career Levels did not show a significant difference at the level of 0.05 according to the education degree.

Table 2. Glass Ceiling Syndrome Sub-Dimensional Characteristics

Scale and Dimensions		**Mean**	**Sd**	**Cr. A.**
Individual	Factors in the Promotion of Women's Career Ladder (FPWCL)	2,32	0,93	0,740
	Family Life (FL)	2,27	0,73	0,573
Organizational	Obstacles Caused by Upper Management (OCUM)	2,01	0,78	0,201
	Organizational Culture and Policies (OCP)	2,04	0,87	0,733
	Informal Communication Networks (ICN)	2,28	0,74	0,351
	Mentoring (M)	2,46	1,21	
Social	Gender Discrimination (GD)	1,66	0,61	0,586
	Negative Prejudices Against Women (NPAW)	1,06	0,69	0,595
	Professional Distinction (PD)	2,32	0,99	0,493
Total		1,94	0,44	0,812

Table 3 shows the standard deviation (sd) and mean values of glass ceiling syndrome perception levels according to various variables such as marital status, education degree, occupation, age, unit of work, and the number of children. In addition, statistical analysis results are included in determining the differences between the means for each variable.

The statistical analysis revealed that there was no statistically significant disparity observed in the glass ceiling syndrome and its associated sub-dimensions based on marital status. As a result of the analysis, the initial hypothesis H1 was refuted, indicating that there existed no discernible divergence in the levels of the syndrome among female healthcare professionals in relation to their marital statuses.

Table 3 shows the test statistics on whether the difference in the perception of glass ceiling syndrome of female healthcare workers according to their education degree is significant. According to the education degree of female health workers, the difference between the "Mentoring", "Barriers Arising from Senior Management", "Organizational Culture and Policies", "Informal Communication Networks", and "Occupational

The mean score of the Barriers Arising from Senior Management sub-dimension of the female healthcare professionals with a postgraduate degree is higher than the others. The mean score of female healthcare professionals with undergraduate degrees is also higher than high school graduates. Organizational Culture and Policies sub-dimension mean score of female healthcare professionals with a postgraduate degree was higher than that of primary and high school graduates.

Furthermore, the study revealed that the average scores of individuals who have completed their undergraduate studies surpass those of high school graduates, while the average scores of high school graduates exceed those of primary school graduates. Moreover, the research findings indicated that within the subgroup of female healthcare professionals holding postgraduate degrees, the mean score pertaining to the Informal Communication Networks sub-dimension was higher compared to those with primary and high school education. Additionally, individuals possessing an undergraduate degree exhibited a higher mean score in this sub-dimension compared to their counterparts with only a high school education. In the sub-dimensions of

Table 3. Means of Glass Ceiling Syndrome Scale and Dimensions in Terms of Various Variables

Variables		N	Individual				Organizational								Social						Total	
			FPWCL		FL		OCUM		OCP		ICN		M		GD		NPAW		PD			
			x̄	s	x̄	s	x̄	s	x̄	s	x̄	s	x̄	s	x̄	s	x̄	s	x̄	s	x̄	s
Marital Status	Single	200	2,40	0,87	2,26	0,75	2,01	0,74	2,06	0,83	2,34	0,69	2,43	1,24	2,66	0,62	1,04	0,74	2,42	0,99	1,95	0,43
	Married	485	2,27	0,95	2,29	0,73	2,02	0,80	2,04	0,88	2,27	0,77	2,48	1,19	1,67	0,62	1,08	0,68	2,28	1,00	1,94	0,45
	Other	23	2,76	0,87	2,05	0,76	1,84	0,70	1,93	1,00	2,15	0,74	2,46	1,44	1,67	0,59	1,13	0,56	2,33	1,14	1,93	0,44
	Sig. (p)		**0,017**		0,291		0,520		0,815		0,611		0,904		0,936		0,384		0,233		0,853	
	Post Hoc		2,3																			
Educational Status	Primary	24	2,62	0,96	2,24	0,81	1,51	0,77	1,54	0,82	1,99	0,57	1,50	1,47	1,68	0,59	1,12	0,78	1,38	1,33	1,75	0,483
	High Sc.	106	2,43	0,96	2,13	0,86	1,75	0,77	1,70	0,79	2,03	0,80	2,36	1,34	1,66	0,69	1,04	0,76	2,13	1,14	1,82	0,49
	College	175	2,29	0,89	2,29	0,75	1,96	0,77	2,02	0,83	2,27	0,75	2,50	1,20	1,64	0,61	1,01	0,72	2,32	0,95	1,92	0,43
	Bachelor's	337	2,27	0,94	2,29	0,70	2,07	0,75	2,14	0,88	2,35	0,73	2,52	1,15	1,68	0,62	1,11	0,68	2,40	0,95	1,98	0,44
	Post Graduate	66	2,44	0,93	2,41	0,57	2,44	0,78	2,33	0,84	2,56	0,65	2,64	1,12	1,67	0,57	1,04	0,56	2,57	0,74	2,09	0,34
	Sig. (p)		0,164		0,257		**0,001**		**0,001**		**0,001**		**0,010**		0,962		0,390		**0,000**		**0,000**	
	Post Hoc						(5-1,2,3,4)		(5-1,2,3,4)		(5-1,2)		(1-2,3,4,5)						(5-1,2,3,4)		(5-1,2)	
Profession	Physician	56	2,63	0,86	2,44	0,55	2,52	0,70	2,25	0,77	2,57	0,68	2,52	1,18	1,59	0,51	0,94	0,49	2,47	0,90	2,07	0,34
	Nurse	263	2,23	0,91	2,38	0,72	2,07	0,73	2,12	0,86	2,33	0,74	2,51	1,14	1,71	0,61	1,17	0,71	2,42	0,96	1,99	0,43
	Manager	17	2,46	0,91	2,29	0,61	2,18	0,61	2,20	0,98	2,29	0,84	2,24	1,30	1,65	0,64	1,11	0,95	2,18	1,25	1,98	0,44
	Adm. Staff	101	2,32	1,00	2,17	0,82	1,95	0,82	2,02	0,91	2,23	0,73	2,41	1,32	1,73	0,64	1,05	0,72	2,23	1,09	1,92	0,47
	Others	271	2,35	0,93	2,18	0,75	1,86	0,80	1,93	0,87	2,21	0,76	2,46	1,25	1,62	0,64	1,00	0,68	2,23	1,00	1,87	0,46
	Sig. (p)		**0,033**		**0,002**		**0,001**		**0,007**		**0,010**		0,949		0,192		**0,033**		0,112		**0,001**	
	Post Hoc		(1-2,4,5)		(2-1,3,4,5)		(1-2,4,5)		(2-1,3,4,5)		(1-2,4,5)						(2-1,3,4,5)				(1,2-3,4,5)	
Age	25-	68	2,51	0,78	2,33	0,75	2,09	0,71	1,95	0,70	2,35	0,55	2,56	1,14	1,75	0,58	1,03	0,76	2,53	0,90	1,99	0,39
	26-35	264	2,34	0,93	2,40	0,71	2,03	0,79	2,04	0,86	2,31	0,74	2,52	1,19	1,66	0,56	1,09	0,65	2,40	0,98	1,97	0,41
	36-45	256	2,21	0,97	2,21	0,74	1,97	0,76	2,02	0,87	2,26	0,73	2,44	1,21	1,67	0,64	1,09	0,72	2,33	1,00	1,91	0,46
	46-55	109	2,43	0,93	2,14	0,74	2,03	0,84	2,17	0,96	2,32	0,85	2,35	1,29	1,64	0,70	1,02	0,70	2,03	1,02	1,92	0,50
	56+	11	2,43	0,78	1,86	0,77	2,06	1,09	1,91	1,10	1,74	1,13	2,46	1,57	1,65	0,91	0,71	0,57	1,86	1,36	1,75	0,57
	Sig. (p)		0,060		**0,001**		0,843		0,494		0,411		0,801		0,627		0,303		**0,006**		0,384	
	Post Hoc				(2-,3,4)														(1,2-4)			
Working Area	Medical	422	2,34	0,91	2,31	0,71	1,07	0,69	2,08	0,86	2,33	1,18	2,47	1,18	1,68	0,6	2,05	0,78	2,38	0,95	1,96	0,43
	Administrative	120	2,25	0,95	2,17	0,73	1,07	0,7	2,08	0,86	2,39	1,25	2,39	1,25	1,66	0,6	2,08	0,76	2,28	1,00	1,92	0,45
	Other	166	2,32	0,96	2,24	0,78	1,06	0,68	1,91	0,81	2,49	1,26	2,49	1,26	1,62	0,65	1,85	0,77	2,19	1,08	1,87	0,46
	Sig. (p)		0,781		0,085		**0,004**		0,076		0,068		0,765		0,481		0,989		0,131		**0,027**	
	Post Hoc						(1,2-3)														(1-3)	
Number of Children	No	241	2,40	0,89	2,22	0,75	2,04	0,74	2,04	0,85	2,34	0,69	2,37	1,23	1,62	0,62	1,01	0,68	2,38	0,97	1,93	0,44
	1	124	2,38	0,88	2,44	0,71	2,08	0,83	2,20	0,91	2,39	0,74	2,66	1,18	1,78	0,59	1,13	0,61	2,61	0,89	2,06	0,43
	2	241	2,29	0,97	2,27	0,74	2,02	0,81	2,03	0,87	2,26	0,81	2,53	1,19	1,67	0,62	1,07	0,73	2,21	1,05	1,93	0,45
	3	90	2,13	1,01	2,25	0,67	1,86	0,73	1,92	0,83	2,13	0,67	2,41	1,21	1,66	0,63	1,20	0,71	2,21	0,96	1,88	0,42
	4 and over	12	2,48	0,86	1,95	0,82	1,81	0,92	1,60	0,95	1,81	0,95	1,67	1,44	1,49	0,53	0,73	0,62	1,29	0,99	1,62	0,48
	Sig. (p)		0,134		**0,047**		0,311		0,088		**0,010**		**0,038**		0,076		**0,040**		**0,001**		**0,002**	
	Post Hoc				(2-1,5)						(2-5)		(2-5)				(3-1)		(1,2-5)		(2-1,3,4,5)	

Mentoring and Professional Distinction, the mean scores of female healthcare professionals with postgraduate, undergraduate, and associate degrees are higher than those with primary education. It was determined that the syndrome levels in female healthcare professionals with a postgraduate degree are higher than in primary and high school graduates.

It was determined that the difference in the glass ceiling syndrome perception levels of female health professionals depending on the education degree was statistically significant at 1%, and the H2 hypothesis was accepted.

Table 3 also shows the test statistics on whether the difference in the perception of glass ceiling syndrome of female healthcare workers according to their profession is significant.

It was found that the difference between the mean scores of Barriers Arising from Senior Management ($p<0,01$), Negative Prejudices against Women ($p<0,05$), Family

Life (p <0,01), Obstacles in the Promotion of Women in Career Steps (p<0,05), Organizational Culture and Policies (p<0,01), Informal Communication Networks (p<0,05) sub-dimensions and Glass Ceiling Syndrome (All) (p<0,01) was statistically significant according to the professions of female health professionals. In addition, it was concluded that there was no significant difference in Gender Discrimination, Mentoring, and Occupational Discrimination sub-dimensions according to the professions variable.

According to their professions, the physicians' mean scores were higher than the nurses, administrative and other female health professionals in the sub-dimensions of "Obstacles Arising from Senior Management", "Obstacles in the Advancement of Women in Career Steps", and "Informal Communication Networks". It was determined that the mean scores of nurses were higher than other female health professionals in the sub-dimensions of "Negative Prejudices against Women", "Family Life", "Organizational Culture and Policies". At the perception levels of glass ceiling syndrome, it was determined that the mean scores of doctors and nurses were higher than other female healthcare professionals.

As a result of the analysis, it was determined that the difference in the glass ceiling syndrome perception levels of female health professionals according to the professions was statistically significant at 1%, and the H3 hypothesis was accepted.

The test statistics on whether the difference in the perception of the glass ceiling syndrome of female healthcare professionals according to their ages is significant or not is presented in Table 3. The table determined that the difference between the mean scores calculated for the determined age ranges of female healthcare professionals only for the Family Life and Occupational Discrimination sub-dimensions was significant at a 1% level.

According to age groups, the Family Life subscale means a score of female healthcare professionals between the ages of 26-35 was determined to be higher than those between the ages of 36-45 and 46-55. When the mean scores of Occupational Distinction were examined, it was determined that female healthcare professionals under 25 and between the ages of 26-35 had a higher mean score than those between 46-55.

It was concluded that the difference between the mean scores calculated for glass ceiling syndrome and sub-dimensions by age groups was not different. Therefore, the H4 hypothesis was rejected.

Significant distinction was observed solely in the mean scores pertaining to "Obstacles Arising from Senior Management" and the cumulative scores of the "Glass Ceiling Syndrome," with respect to the occupational domains of female healthcare practitioners. Conversely, it was deduced that there existed no statistically notable distinction across the remaining sub-dimensions with regard to the domains of responsibility.

According to the results of the Bonferroni post-hoc analysis, which was conducted to determine the sources of differences that occur according to the field of duty of female health professionals, it was determined that the mean scores of the Barriers Arising from the Senior Management sub-dimension of female healthcare professionals in medical and administrative units were higher than other personnel. In addition, the glass ceiling syndrome perception level of female healthcare professionals in medical units was higher than those working in other units.

Based on the analysis conducted, it was established that a statistically significant disparity exists at a significance level of 5% in the perception levels of the glass ceiling syndrome among healthcare workers, contingent upon their respective fields of duty. Consequently, the H5 hypothesis was affirmed.

Test statistics on whether the difference in the perception of glass ceiling syndrome according to the number of children of female healthcare professionals is significant or not is presented in Table 3. According to the test results, the differences between the mean scores of "Negative Prejudices against Women", "Family Life", "Informal Communication Networks", "Mentoring", "Professional Discrimination" sub-dimensions and "Glass Ceiling Syndrome" (total) according to the number of having children of female healthcare professionals was found to be significant. However, it has been determined that there is no difference in the sub-dimensions of "Obstacles Arising from Senior Management", "Barriers to the Advancement of Women in Career Steps", "Organizational Culture and Policies, and Gender Discrimination" according to the number of children.

Mean score of Negative Prejudices against Women of female healthcare professionals who have three children was higher than those without any children. Family Life means the score of female healthcare professionals with one child was higher than those with no children and those with four or more children. The Informal Communication Networks mean score of female healthcare professionals with one child was higher than

those with three children, and their Mentorship mean score was higher than those with four or more children. Mean score of Professional Discrimination of female healthcare professionals with no children and one child was higher than those with four or more children. The glass ceiling syndrome perception levels concluded that those with one child had higher mean scores than those with two, three, four, or more children.

Consequent to the conducted analysis, a statistically significant variation in the levels of the glass ceiling syndrome among female healthcare professionals was ascertained in relation to children they have, reaching a significance level of 1%. Accordingly, the H6 hypothesis was corroborated and accepted.

DISCUSSION AND CONCLUSION

The health sector increasingly continues to be a sector dominated by women. Despite the overwhelming majority of women in preventive healthcare services and hospitals where treatment services are concentrated, the number of women healthcare professionals in management positions is insufficient. In this respect, determining the sub-dimensions that are thought to affect the glass ceiling syndrome the most and socio-demographic characteristics can be an effective guiding tool in solving this problem.

It was determined that the opinions of women working in hospitals in Trabzon regarding glass ceiling syndrome were at a moderate level ($\bar{x} = 1.94 \pm 0.44$). The investigation revealed that the "Mentoring" sub-dimension of the glass ceiling syndrome exhibited the highest mean score, recording a value of 2.46. This situation indicates that women agree with the idea that "there are not enough female managers to be role models for women." On the other hand, it was determined that the lowest average of 1.069 is the "Negative Prejudices Against Women" sub-dimension. This situation indicates that the participants disagree with the thought that there are negative prejudices against women in hospitals in Trabzon. In light of this, there is a prevailing belief that effective mentorship and robust support are essential factors in breaking down the barriers of the glass ceiling. This is also emphasized in McKinsey's report (Desvaux et al., 2007). The report suggests actions such as providing external coaching services for women, offering leadership development programs, initiating initiatives to nurture potential women leaders, and creating networks specifically tailored for women.

Perceived level of glass ceiling syndrome differs depending on the education status, profession, age, duty area, and the number of children of female healthcare workers. The research has unveiled that the glass ceiling phenomenon is more pronounced among female healthcare professionals pursuing postgraduate education, in comparison to those who have completed primary and high school education. Similarly, it was found that attitudes toward female managers differ according to their education degree the study by Akkum and Ulusoy (2019). However, Kılıç and Çakıcı (2016) argued that the perception of the glass ceiling does not change depending on the education degree. At the glass ceiling syndrome perception level, the mean scores of doctors and nurses are higher than other female health professionals. The studies of Köksal (2016) and Akkum and Ulusoy (2019) found that occupational difference is practical at the perception level of glass ceiling syndrome. Similar findings were reached in the study of Soysal and Baynal (2016), and the research revealed that the extent of glass ceiling syndrome perception was more pronounced among physicians compared to their counterparts in the broader healthcare profession. In the study conducted by Cech and Blair-Loy (2010), it was concluded that workers with higher education are exposed to more gender inequality. According to the field of duty, syndrome levels of female healthcare workers in medical units were found to be higher than those working in other units. Contrary to this result, Soysal and Baynal (2016) found that women working in administrative units had a higher perception level of glass ceiling syndrome. According to the number of children, it was concluded that the glass ceiling syndrome level was higher in those with one child than in those with two, three, four, or more children. This finding contradicts the belief that females may experience the syndrome due to challenges in balancing work-family life.

Changes at the perception level of glass ceiling syndrome depending on the individual, organizational and social factors are presented below. It was determined that there is a difference according to socio-demographic characteristics in all sub-dimensions of the glass ceiling except for the "Gender Discrimination" sub-dimension.

Changes in the glass ceiling syndrome perception level depending on individual factors are evaluated according to the sub-dimensions of "Factors in the Promotion of Women's Career Ladder" and "Family

Life" and are presented below. Glass ceiling syndrome differs depending on marital status and occupation according to the "Factors in the Promotion of Women's Career Ladder" sub-dimension. According to the profession, the scores of the doctors were higher than the nurses, administrative, and other female health professionals. According to marital status, the scores of divorced or widowed female health professionals were higher than those of married. Similar to the results of this study, Öztürk and Bilkay (2016) found that the perceived level of glass ceiling syndrome is higher in widowed or divorced women. Married women feel fewer obstacles in becoming managers. This situation could also be an indicator of the continuous support they would receive from their husbands.

On the contrary, Kılıç and Çakıcı (2016) found that married female employees experience a lower perception level of glass ceiling syndrome than single women. It has been determined that the perceived level of glass ceiling syndrome that occurs depending on the "Family Life" sub-dimension differs depending on the profession, age, and number of children. Nurses' family life sub-dimension scores were higher than other female healthcare workers. According to age, the score of female health professionals between the ages of 26-35 was determined to be higher than those between the ages of 36-45 and 46-55. Those with one child had higher scores than those with no children and four or more children. In the investigation conducted by Doğru (2010), it was brought to light that prevailing glass ceiling barriers are primarily attributed to individual factors. Parallel findings were drawn by Sezen (2008), who observed that a substantial proportion of employees encounter glass ceiling obstacles attributable to individual factors. Furthermore, Ünal (2015) asserted that the preeminent determinant giving rise to the glass ceiling phenomenon is indeed individual-oriented factors.

Similar to our findings, in Akyurt (2018), a notable disparity in the perception of the glass ceiling was observed based on the sub-dimension of organizational culture and policies, contingent upon variations in educational attainment. It has been determined that the level of the Informal Communication Networks sub-dimension differs depending on the education degree, profession, and the number of children. According to their educational status, the informal communication networks score of postgraduate female health workers is higher than those of primary and high school graduates; those with a bachelor's degree were higher than those with a high school degree. According to the profession, the doctors' informal communication network score was higher than that of nurses, administrators, and other female health personnel. According to the number of children, the score of those with one child was higher than those with three. Snavely (1993) stated that the problems faced by female employees in the management arena are that they are not included in the informal communication network by their male friends in the organization, and they experience conflicts between family roles.

It has been determined that the perceived level of glass ceiling syndrome, which occurs depending on the mentoring sub-dimension, differs depending on the educational status and the number of children. Mentoring scores of those with one child are higher than those with four or more children. According to educational status, the mentoring score of female health professionals with graduate, undergraduate, and associate degree graduates was higher than those with primary education graduates.

Likewise, Akyurt (2018) identified a notable distinction in the perception of the glass ceiling within the mentoring sub-dimension, contingent upon one's level of education. In the research conducted by Karcıoğlu and Leblebici (2014), elements such as organizational culture, institutional policies, scarcity of mentorship opportunities, and instances of professional discrimination emerged as the pivotal factors attributing to the phenomenon of the glass ceiling.

The study determined that female health workers with graduate, undergraduate, and associate degree graduates were exposed to occupational discrimination more than those with primary education graduates. It has been determined that female health workers under 25 and between the ages of 26-35 are exposed to occupational discrimination more than those between the ages of 46-55. Contrary to this research, Jones and Oppenheim (2002) suggested that women did not encounter any obstacles until their forties, but glass ceilings formed after this age. It has been determined that female health workers with no children and one child are exposed to occupational discrimination more than those with four or more children.

On the other hand, Ferber and Lowry (1977) showed that the occupations in which women work intensively differ from country to country, but this is caused by factors such as management style, culture, and religion, not gender. It has been determined that the level of Negative Prejudices Against Women differs depending on the profession and the number of children. It has been determined that nurses face higher levels of negative prejudice than other female health workers, and those with three children are more likely to face negative prejudice than those with no children. Similarly, Kiser (2015) and Moldovan (2015) showed in their studies that there are prejudices about women being managers. Hoşgör et al. (2016) found that female health workers with a master's degree were more exposed to negative prejudice than those with a high school degree. In their respective studies, Inel et al. (2014), Özyer and Orhan (2012), and Karaca (2007) have all underscored the societal impact on the manifestation of the glass ceiling phenomenon. Similarly, Akdöl's (2009) research has highlighted the role of social factors in the genesis of the glass ceiling. These scholarly inquiries collectively assert that the perpetuation of stereotypes, particularly directed at female employees, substantiates the glass ceiling.

It is essential for top managers in the health sector to support female health workers and adopt a management approach that will help highly motivated, determined, and talented workers overcome the career barriers faced by female health workers. On the other hand, although overcoming the glass ceiling obstacles requires a social and organizational effort, female health workers need to develop their self-confidence and show dedication to reach their goals to cope with this problem. Considering professional effects beyond supporting and training women in managerial positions, addressing the presence of women executives within the medical community at a policy level, and implementing quotas, will make the glass ceiling more fragile.

LIMITATIONS OF THE RESEARCH

The fact that the research was conducted only in 2nd-level, medium capacity and 3rd-level high-capacity education hospitals in the city center of Trabzon, private hospitals and clinics were not included, the research was cross-sectional, and lastly, male employees were not included in the sample are important limitations. In addition, this study does not aim to explore the causes of glass ceiling perception in society in depth. In future qualitative studies for this purpose, the staff's views on the glass ceiling could be examined in more detail. These studies might state different reasons and proposed solutions. Additionally, occupational groups could have distinct dynamics regarding the glass ceiling barriers and being managers. Conducting studies that consider this distinction could enrich the research in the healthcare sector.

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