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Professionalization without Autonomy: The Italian Case of Building the Nursing Profession

Abstract: The nursing professionalization is still a work in progress, especially because forms of medical dominance and conflicts with other health professions often undermine its professional autonomy. This article contributes to the understanding of the relationship between professionalization and autonomy building in the health professions by presenting the case of Italian nursing, where medical dominance, supported by the legal system, is the main factor preventing nursing from achieving professional autonomy. The work aims particularly to understand how professionalization and professional autonomy can follow two parallel and sometimes opposite paths toward building the nursing profession, and the role of academic knowledge and specialized roles to legitimize and strengthen professional autonomy. The analysis draws on the literature addressing professionalization, professional autonomy, and medical dominance, as well as various sources on Italian nursing. They include national legislation, research literature, and national sociological surveys on Italian nurses.

Keywords: Professionalization, professional autonomy, nursing, medical dominance, legal system

Sociological studies on the nursing profession have become increasingly prevalent in recent years. One of the more debated aspects concerns the field's professionalization, which has been more problematic than in other professions, especially because nursing has historically been subjected to forms of medical dominance and conflicts with other health professions (e.g., Allen, 2007; Ayala, Binfa, Vanderstraeten, & Bracke, 2015; Bourgeault & Grignon, 2013; Etzioni, 1969; Styles, 2005; Varjus, Leino-Kilpi, & Suominen, 2011; Wall, 2010).

The outcome of the professionalization process is the achievement of "professional autonomy." In the sociology of professions, this concept is commonly referred to as the autonomy of an individual practitioner or professional group to define performance standards and ethical codes for its members in accordance with specific training, as well to conduct discretionary work activities in a normative manner (Engel, 1970; Mastekaasa, 2011; Scott, 1998). In many studies, professional autonomy is used more or less synonymously with "work autonomy," defined as the degree (of freedom, independence, and discretion) to which an individual can determine the kind of work he or she does and the procedures with which to do it (Freidson, 1970, 1994; Hackman & Oldham, 1975). In both cases, the "power" of a profession to identify and safeguard the content and practices of its work influences its evolution and status in the system of interdependent professional relations (Abbott, 1988). The link between professionalization and professional autonomy is often taken for granted, and it is still analysed in a fragmented fashion in theoretical and empirical

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investigations (e.g., Finn, 2001; Kangas, 1999; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006; Mastekaasa, 2011; Salani & Coulter, 2009; Thompson, 2012; Zangaro & Soeken, 2007).

This paper contributes to understanding of the complex relationship between professionalization and the achievement of autonomy by presenting the particular process of how the Italian nursing profession has been built. This process is relatively recent and has undergone relevant changes since the end of the 1990s. During that period, nursing went through several stages. Nursing passed from the status of being a simple health occupation lacking a well-defined and homogeneous qualification or specificity, as well having a principally auxiliary role in the health field, to being a “semi-profession,” namely, an occupation whose status is not yet fully institutionalized, endorsed or composed of a body of specialized knowledge (Etzioni, 1969), to being a real profession with specific and technical knowledge, a university training path, specific roles and competences, a formal code of ethics and a set of legal and institutional acknowledgements (Rocco & Stievano, 2011).

However, although Italian nursing today apparently presents all the formal characteristics to be considered a “profession,” it still has weak professional autonomy within the health professions’ division of expert labour, due to various factors. One of these is the medical dominance, which has been a focus of the main discussion on nursing professionalization (Salhani & Coulter, 2009). Even though in the last 20 years medical dominance has partially declined (Bury & Taylor, 2008; Coburn, 2006; Tousijn, 2002, 2006), it continues to be very strong and exists in different forms in the Italian health system. Another issue is the role of the state (the legal system) in promoting professional autonomy. In Italy, it has been contradictory, since on the one hand the state has formalized nursing’s professional autonomy through specific laws, training paths and health services reforms, while on the other hand, it has impeded the full formal recognition and development of career paths and specific roles for nursing, instead maintaining the power of physicians in the system of health professions.

The purpose of this article is to provide a sociological analysis of the evolution of nursing profession in Italy, highlighting how some aspects related to the process of profession building prevent nursing to achieve a full recognition of its professional autonomy.

The particular focus of the work will be on two different but interconnected aspects of the Italian case. The first concerns institutional reforms that have involved health professions over the last twenty years, changing the academic training and the regulatory system of health professions. This is a central point that addresses much of the professionalization of Italian nursing within the health professions in the last twenty years. Freidson (1970, 1974, 2001) considers professional knowledge and expertise to be secondary to the importance of professional autonomy. He maintains that only when autonomy is assured can a profession secure control of its practice and be in a position to determine its standards and educational requirements, as well as to protect that autonomy through a code of ethics. In many countries, educational reforms have been a key tool for the empowerment of health professions (e.g., Davies, 2008; Gerrish, McManus, & Ashworth, 2003), while in Italy, they have produced significant improvements in the knowledge expertise of nurses but rarely been implemented on an institutional and organizational level because of strong medical dominance of the management and control of specialized nursing training (Abbott, 1988).

The second aspect that this paper addresses concerns the emergence of new social-health integration pathways that should strengthen the role of nurses in many health services outside traditional and medical-centred hospital settings. In recent years, in many countries, task-shifting strategies have been implemented whereby specific tasks and responsibilities are being shifted from the medical to the nursing profession through the central role of governance in reorganizing primary care services (Maier, 2015). In Italy, different models of primary and integrated care have

been promoted by the government, but they have been poorly defined from the point of view of the reorganization of the healthcare division of labour and formal and social recognition of the new tasks and roles, perpetuating the subordination of nursing to the medical profession.

These aspects, more than others, seem to be central to understanding the paradox of the professional evolution of nursing, in which professionalization and professional autonomy processes have followed different and sometimes opposing paths.

The article is divided into three main sections. In the first, a theoretical and conceptual framework is presented. In particular, some relevant theoretical aspects from the literature on the sociology of professions related to professionalization, professional autonomy, and medical dominance are analysed.

In the second session, the particular case of the evolution of the nursing profession in Italy is presented in terms of the main legislative reforms and institutional changes that have influenced the professionalization process. The focus is particularly placed on reforms in the nurse training system, which marked a turning point in the building of the nursing profession within the system of health professions.

The third session analyses the development of new integrative pathways of care and changes in health systems, as well as their opportunity to increase the professional autonomy of nurses, highlighting the paradox produced by the contradictory role of Italian health policies in preventing this process.

The study taps into the relevant theoretical literature, especially by using the conceptual framework for professionalization, professional autonomy and medical dominance provided by the sociology of professions. The analysis of the Italian case draws on a variety of sources, including national legislation, research literature and a secondary data analysis of national sociological surveys on Italian nurses produced in the last 20 years. This period is considered the most significant for observing the main changes in the process of building the nursing profession.

Theoretical framework and previous research

Many writings have debated the definitions and characteristics of professions and taken various positions on the process of “professionalization.” Generally, the process that leads an occupation to become a “profession” comprises different social, political and institutional phases, which are sometimes co-present with no precise sequence, ranging from the appearance of a certain type of work considered to be full-time employment with a body of specialized knowledge and techniques, to the establishment and development of specialized training schools, creation of professional associations, recognition by the state as professional activity and, in many cases, development of a formal ethical code (Etzioni, 1969; Evetts, 2002, 2011; Frankford, 1997; Freidson, 2001; Muzio & Kirkpatrick, 2011; Styles, 2005; Wilensky, 1964). However, the attainment of these features by profession is in many cases a necessary but insufficient condition to obtain professional recognition and autonomy (Salhani & Coulter, 2009). More relevant to this purpose is how a profession is able to define its professional boundaries within the “system of professions” based on complex and dynamic networks of professional groups within a specific work sector and constantly struggling in legal, public and workplace arenas characterized by “jurisdictional disputes” (Abbott, 1988). According to Abbott (1988, p. 59), the “diagnosis, treatment, inference and academic work provide the cultural machinery of jurisdiction.” Specialized academic training, which in health professions is a necessary requirement to access the profession itself, is one of the fundamental characteristics that distinguishes a profession from other types of occupations and contributes to the strengthening of its jurisdictional boundaries in relation to other professions (Abbott, 1988; Freidson, 2001; Saks, 2012).

Even if the dominance of one profession over other professional groups is a central factor influencing all levels of professional autonomy in various jurisdictions,

this aspect has been widely studied in health professions specifically in the doctor-nurse relationship. This expression, first formulated by Freidson (1970), means both the high “professional autonomy” of physicians in their work and the “predominant” position of the medical profession in relation to the autonomy of other health occupations and professions and to the power exerted over patients and their care process (Starr, 1982; Tousijn, 2000, 2002; Twaddle & Hessler, 1987).

Tousijn (2000, 2002) distinguishes four main forms of medical dominance that have historically influenced the doctor-nurse relationship in different countries. The first form is the “functional” type. It consists of the exclusive assignment to doctors of central functions within the overall system of care, such as making the diagnosis and choice of therapy. This power has been associated with the hospitalization process for most diseases. In this context, nurses, but also other health occupations, such as midwives or pharmacists, in the face of control by the much more autonomous and independent medical profession, have been forced to accept forms of subordination to it. The second form of medical dominance is the “hierarchical” or “vertical” type in relation to the division of health labour. Even in this case, the organizational development of hospitals is the most important phenomenon, since in hospitals, doctors have been considered the top of the hierarchical scale, with nurses and midwives, followed by many other health professions such as laboratory and radiology technicians and rehabilitation therapists, placed further down. The third form is the “scientific” type. It means that the medical profession itself has the exclusive power to identify fields and methods of medicine as a science. This kind of dominance arises, for example, from critiques and struggles by many doctors against non-conventional medicine, such as homeopathy or pranotherapy, which are more often practiced by other health professions, such as nurses, midwives, and physiotherapists. Finally, there is also a form of “institutional” medical dominance, which is manifested in the almost exclusive presence of doctors on many health occupations’ qualification commissions, academic staffs, and national institutions.

Medical dominance has undergone a process of decline since the early 1990s due to some changes in health systems, including health system reforms, consumerism, the professionalization of non-medical health occupations, as well as the hyper-specialization and division of the medical profession into different roles, which have weakened and fragmented its power to control health and pharmaceutical services (Andri & Kyriakidou, 2014; Bury & Taylor, 2008; Coburn, 1999, 2006; Gordon, 2005; Parse, 1998; Tousijn, 2002, 2006; Tousijn & Giorgino, 2009). Despite these changes, however, in the Italian context, the medical profession still plays a dominant role in all jurisdictions in the system of health professions, having a particular influence through the four types of dominance described by Tousijn. Particularly evident is the influence of doctors on the state since they are well represented in Parliament and control the legislative process of many health reforms (Toth, 2015).

The professionalization process of nursing

The principal theories of professionalism presented above consider specialized and expert knowledge one of the distinctive features of a profession’s autonomy (Freidson, 2001; Abbott, 1988). Despite the growing convergence of educational systems and approaches among different countries promoted by World Health Organization (WHO), at this time there is no uniformity in the way nursing education is globally organized. Some countries continue to consider education programs at the secondary school level to be sufficient, while others require university-level education as the minimum point of entry to the health professions. In Europe, cultural shifts over the last twenty years have been underscored by reforms in the health disciplines and particularly in educational directives on nursing (Lahtinen, Leino-Kilpi, & Salminen, 2014). Most European countries, such as Ireland, Norway, Sweden, Finland, Netherlands, Spain, and the United Kingdom, have moved the education of

first-level nurses to the higher education sector and now offer an academic diploma or a degree. Several German universities are also now offering a first-level professional and academic qualification, and the nursing profession in France is campaigning for nursing to move to the higher education sector. Accordingly, the link between academic and specialized knowledge and the professionalization process is not so clear that it can be uniquely defined in nursing.

In Italy, the nursing education system is one of the more advanced in Europe. Changes in nursing education started about twenty years ago. Nursing courses have been present in university education since the adoption of Law 341/1990, when the hospital-based nursing diploma was abandoned, and a university-based diploma became the nurse training system. Furthermore, since the University Reform of 1999 and the subsequent Decree of 2001 by the Italian Ministry of Education, Universities and Research on “Determination of the degree classes in health professions,” nursing has seen the establishment not only of an academic title for nursing but also the obligation to achieve this qualification to practice the profession and register with the National Regulatory Board (IPASVI), the only official professional nursing association in Italy. By the same decree, the first advanced degrees and masters in health professions with different specializations were established in 2004. Since 2006, the first Ph.D. in nursing research has been implemented, which for the first time provides nurses the opportunity to have an academic career and conduct research (Rocco et al., 2014).

Despite this extensive training, some contradictions in the formal recognition of advanced academic titles must also be highlighted. Besides the first-level masters (following the nursing degree) in “coordination and management functions,” the masters and advanced degrees activated by Italian universities in the field of nursing are poorly recognized by health organizations through clear contracts and career advancement opportunities (Cipolla & Rocco, 2014). This limitation has repercussions not only for the recognition of nursing’s cultural jurisdiction but also on nursing’s appreciation within the workplace arena. In the United Kingdom, for example, nurses with a master’s degree can become nurse practitioner or advanced practice nurse, roles that enable them to perform several functions that until recently were within the exclusive domain of physicians, including the formulation of diagnoses, prescription of drugs and administration of therapies (Royal College of Nursing, 2012). These types of activities are actually forbidden to Italian nurses, despite their long and advanced academic training.

Furthermore, the affirmation of a specific nursing faculty with full-time academic nursing staff is lacking in Italian universities. Currently, academic courses and research doctorates on nursing are managed and controlled by faculties of medicine, where the only structured teaching staff is mostly composed of physicians, while nurses teach principally as external and adjunct staff.

In Freidson’s (2001) theory, specific training, especially university-based education, is a basic element of professional autonomy. Usually, such education is under the control of the professional group itself, which can manage the number of professionals entering the labour market through having rigid admission standards for specialist schools or requiring candidates to pass an examination to obtain a qualifying title (as in the case of the medical profession). In addition, those engaged in specialist training are generally full-time teachers coming from the profession itself and committed to enhancing the wealth of skills and specific knowledge of the profession through academic study and research. This normally leads to knowledge-based control of the teaching staff and a high level of standardization and reliability of the degrees issued by the education system. In addition, a long, specialized training path produces a student socialization process with a distinct culture and professional identity, creating a strong sense of belonging to a professional community (“professional solidarity”) and an awareness of its roles, skills and responsibilities, which continues even after the training period ends and students embark on different career paths. Although an instructional system can provide the ground for professional attacks by

other professions, preserving the exclusivity and specificity of the profession's knowledge expertise, at the same time, in a system of professions, "few dominant professions lose the ability to instruct themselves, although subordinate professions often lose it to dominants, this being an important means of domination" (Abbott, 1988, p. 57).

So, at least from the point of view of its cultural structure, Italian nursing can be considered, for all intents and purposes, a profession with an increasingly high level of specialization and training. Although this is a necessary condition for being considered a profession rather than a technician or craft occupation (Freidson, 2001), academic training is insufficient to guarantee professional autonomy. The presence of both strong "institutional" and "scientific" medical dominance (Tousijn, 2002) on the levels of academic education and research effectively prevent Italian nursing from not only controlling its own knowledge, still encrusted with purely medical methods and approaches, but also strengthening the involvement and identification of students with the nursing profession. It also reverberates in nurses' medical-centred culture, hindering new generations of nurses' construction of a professional identity and autonomy (Wade, 1999). In this sense, the nursing profession in Italy is still strongly dependent on the medical profession in the building of its cultural structure (Abbott, 1988), since most of the stable professors in nursing academic courses are doctors, whereas nurses have still little chance of accessing a university career, which in most cases is controlled by commissions exclusively composed of physicians (Cipolla & Rocco, 2014). This form of institutional dominance (Tousijn, 2002) seems to have been overcome in other countries such as the United States and Canada, where nurses dominate their own cultural jurisdictional machinery, with academic departments, faculties, schools, and centres of research managed by specific, full-time academic nursing staff. Even the professional Italian nursing association, called IPASVI, which represents the nursing profession on a national and local basis, is able to play only a partial role in advocating for the profession, ensuring that the deontological code is respected, endorsing the professional cultural growth of registered nursing and promoting the Continuing Medical Education (ECM) activities required of all health professionals by the Italian National Health System (Rocco et al., 2014).

Professional paths and institutional constraints

An important step for Italian nursing was the enactment of Law 42/1999, called "Disposition concerning health professions," which ratified nursing's professional autonomy from a legal point of view. Nurses officially became autonomous professionals with specific responsibilities and a formal ethical code, even if nowadays the positive effects of this law can hardly be perceived in professional practice (Rocco & Stievano, 2011).

Some Italian sociological surveys (e.g., Cipolla & Artioli, 2003; Tousijn, 2003) point out that twenty years ago nursing had a quite homogeneous identity, even in terms of social perception. The nurse was seen as a figure appointed to perform auxiliary and subordinate patient assistance tasks. Although this corresponded only partially to the real activities performed by nurses, in the eyes of patients and doctors, the nursing role comprised essentially this. Nevertheless, at the beginning of the millennium, a national survey conducted by Cipolla and Artioli (2003) noted the dissatisfaction of Italian nurses towards their level of knowledge, especially in relation to their subjective expectations and the need to have specialist skills. Nurses believed that the formulation achieved by that point was adequate to the organizational context and the necessities of the population; however, it was inadequate for their personal expectations. In other words, the survey highlighted that the desire for higher education mainly came from nurses themselves and not from the organizational health system (Artioli, 2003). In addition, the survey showed that nurses complained

about the limited recognition of their role, their lack of decision-making power, their low regard in public opinion, their residual role with respect to doctors and the insufficient number of nurses compared with patients' care needs.

In the last few years, the doctor-nurse relationship has been influenced by nursing's increasing request to establish itself as a discipline that is separate from the medical one but at the same time equal to it (Allen, 2007; Rafferty, 1996). In the literature, this paradox is often referred to through the dichotomy between "care" and "cure" that historically characterizes the tasks, practices and identities of doctors and nurses (Baumann, Deber, Silverman, & Mallette, 1998; England, 2005; Jecker & Self, 1991; Katz, 1969; Kottow, 2001; Watson & Ray, 1988; Treiber & Jones, 2015). The task of curing the sick derives from the set of medical and scientific knowledge, and it is therefore based on principles of universality, rationality, and emotional neutrality, while the activity of caring comes from much more uncertain and varied knowledge, largely based on interpersonal, relational, psychological, emotional, and aesthetic skills (Cancian & Olikier, 2000; Dowling, 2006; Johnson, 2015). Such duplicity in the nursing profession has meant that it has historically been placed in an intermediate position between the medical profession and the roles of auxiliaries to the medical professions (Sena, 2015; Tousijn, 2000). For this reason, nurses have progressively left the less qualified tasks for occupations with a lower professional profile in performing of specific roles and responsibilities, such as in advanced nursing practice (Bryant-Lukosius, Dicenso, Browne, & Pinelli, 2004; Pulcini, Jelic, Gul, & Loke, 2010; Sheer & Wong, 2008).

At the same time, in recent years there has been a continuous reorganization of the health system and health workforce, aiming to reduce hospitals and to increase alternative services, especially in primary care, with the purpose of offering better follow-up, continuity of care for outpatients with chronic degenerative diseases and integrated care structures for the diagnosis and treatment of different pathologies (Barbazza, Langins, Kluge, & Tello, 2015; WHO, 2016). The delivery of these new health services, which are more functional for the needs of the population and the rationalization of health expenditures, would also seem to suggest a change in nurses' work in terms of greater autonomy and role specialization, strengthening its jurisdictional boundary in the workplace arena (Abbott, 1988; Salhani & Coulter, 2009). This is a global trend in many countries where the doctor-nurse relationship is consistently changing, and it has been identified by WHO (2007) as a strategy to alleviate progressive shortages of physicians, to improve the quality and efficiency of healthcare systems and to reduce the increasing costs of public health. Recent studies (Maier, 2015; Maier & Aiken, 2016; Martínez-González et al., 2014) show that in many Organization for Economic Cooperation and Development (OECD) countries, such as the United States, Australia, Canada, England, Finland, and Netherlands, there is a tendency toward extensive task-shifting from physicians to nurses in the field of primary care, supported by different national regulatory reforms. However, even in this setting, the Italian case shows a delay in professional change, highlighting the strength of the medical profession in maintaining its professional boundaries in all workplace settings (Toth, 2015).

About 80% of Italian nurses today work mainly in hospital settings, although different integrated paths had been formalized by the end of the 1970s and have been considerably promoted in recent years (Sena, 2015). Nevertheless, non-hospital settings present several problems on the implementation level in the Italian health system. For example, the family and community health nurse, who is widespread in many countries and even encouraged by the WHO (2000, 2006), is hard to get formally recognized in Italy, although there have been a specific academic specialization and an official association of family and community nurses (called AIFEC) for several years (Rocco, Marcadelli, Stievano, & Cipolla, 2017). This is due to the fact that family health nurses act with much more autonomy than hospital nurses, overcoming many forms of medical control by general practitioners in primary care and

strengthening interprofessional cooperation in many interdependence areas (Fenster-Thuente, 2008; Martin et al., 2013). However, this role in Italy does not have true organizational legitimacy. Although many experiments in different regions and health organizations have been conducted, at the institutional level, no family or community nurse's path is generally recognized (Rocco et al., 2017). The causes of this delay in Italy, compared with other countries, can be partly explained by the fact that Italy has one of the higher numbers of physicians in the population and, at the same time, one of the lower numbers of nurses. The nurses-to-doctor ratio was 1.5, one of the lowest in the EU-28, where the average is 2.3 (OECD, 2015). Especially in primary care, this ratio is particularly evident. These data confirm the persistence of a doctor-centred healthcare system, even if the trend in recent years supports the idea of a progressive reduction of doctors in the short-to-medium term due to the aging of the Italian medical profession without a rebalancing of tasks and responsibilities among other health professions (Vicarelli & Pavolini, 2015).

A further explanation of nursing's weakness in the workplace arena is the fact that, until the beginning of the 2008 economic crisis, nurses had immediate and stable employment, whereas in the last few years the situation has rapidly changed with a shift from a shortage of nurses in the National Health Service to unemployment problems or an increased use of atypical contracts for those who have recently graduated (Centro Studi Nursind, 2014). This change is principally due to austerity measures introduced by Italian government since 2010, both in terms of expenditure cuts and turnover block (Vicarelli & Pavolini, 2015). The generational replacement block of both doctors and nurses has, indeed, maintained traditional cultural barriers in interprofessional collaboration, effectively strengthening functional and hierarchical forms of medical dominance (Hall, 2005; Tousijn, 2002).

Italian nurses perceive this situation as conflicting with their desire for greater professional autonomy. In the second Italian national survey on the nursing profession (Cipolla & Rocco, 2014), the majority of respondents still felt that they had few tools to manage financial and human resources, despite the management skills received through academic curricula. In addition, nurses continue to be exposed to an excessive workload and a high turnover and have to deal with a lack of instruments with which to influence health policies and the development of the health organizations where they work.

Accordingly, the difficulty of moving the professionalization of nursing toward a parallel achievement of professional autonomy in the Italian context can be explained by the lack of and contradictory support from the state and its regulative reforms in promoting forms of task-shifting from physicians to nurses in the context of primary care and in removing all the above-listed institutional and structural constraints on the empowerment and formal recognition of the nursing profession. Regulatory reforms in primary care, produced at the regional and national level, have actually not changed nursing's status of subordination to the medical profession in the system of health professions. In addition, although there are now several specialized academic training courses for nurses in several topic areas (e.g., family and community nursing, wound care, case management, etc.), these advanced skills are not yet formally recognized in health services in terms of careers paths, responsibilities and interprofessional relations, which are still controlled and undermined by functional and hierarchical forms of medical dominance.

Conclusions

In this work, attention has been paid particularly to two main aspects of the process of professionalization and the achievement of professional autonomy: cultural jurisdiction and the legal system. As outlined above, in these settings, professionalization and professional autonomy do not always follow the same path, although they have

often been considered interrelated and dependent concepts in many theories of professions.

In the last twenty years, the Italian nursing profession has been “built” in a changing institutional, educational and health system, and it now struggles with several constraints of a different nature. The case of Italian nursing shows how a high level of academic and specialized training and institutional reforms to promote new integrated care models in which the role of nursing could be most valued are insufficient to complete the professionalization process and thus to guarantee the achievement of professional autonomy.

The sociological analysis presented here demonstrated that in the last twenty years, Italian nursing has moved from unqualified training to having academic and specialized education like any other profession and more than is required in other countries. However, the numerous reforms to increase this advanced training and the construction of specific areas of practice for nurses have not been followed by a parallel recognition of the profession in terms of its institutional enhancement and autonomy. Medical dominance is still persistent in all four principal forms identified by Tousijn (functional, hierarchical, scientific, and institutional) and, particularly in controls on the educational and organizational levels of health professions. Thus, we can consider the professionalization process to be incomplete because it is not associated with the achievement of professional autonomy. This is confirmed by Italian nurses’ low perception of their own potential as a profession, highlighted by national surveys.

Accordingly, medical dominance continues to be the main factor slowing the complete professionalization of nursing in the Italian system of health professions, despite many studies pointing out that it this dominance is weakening.

The role of the state and regulative changes in the National Health System, especially its reorganization and the rationalization of functions and costs, must be noted. They have often hindered or at least slowed down the turnover of senior health personnel and the introduction of innovation to the health system, such as the development of social-health integration pathways, thus preventing even the possibility of a new generation of nurses’ professional development and empowerment, repeating the dominant position of medical profession in the cultural and workplace arena. The government’s contradictory and ambiguous role in maintaining some structural and institutional constraints on the achievement of nursing’s professional autonomy could be considered the principal cause of the persistence of medical dominance in the Italian healthcare system. In this sense, legal and institutional support must be considered essential for the interconnected development of professionalization and professional autonomy in the system of health professions.

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