

ACC NEWS

President's Page: Women in Cardiology: Leading Our Present, Guiding Our Future

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Cardiology became a viable option for me as an intern when my chief of cardiology approached me in the parking garage one day, assuring me cardiology was a female-friendly specialty and I should strongly consider it as a career. While I did not really buy his contention that cardiology was woman-friendly (a single female fellow in a large training program hardly added up to "friendly" in my mind), I was flattered by the compliment and began to seriously consider the possibility.

A division chief recruiting a talented resident for a cardiology fellowship is utterly unremarkable—except this was the early 1980s and the resident in question was female. Unfortunately, not much has changed. In 2005, when women account for more than 50% of medical school graduates and more than 40% of internal medicine residents, only 14% of cardiology fellows are women and only 6% of American College of Cardiology (ACC) fellows are women. Where does all the female medical talent go? And, more importantly, why do we continue to let it slip away?

This is not a new problem. The ACC Professional Life Survey, conducted in 1996 and published in 1998 (1), noted remarkable differences between male and female ACC fellows. Women were more likely to be single (19% vs. 4%) or childless (37% vs. 12%), and had a greater dependence on hired caregivers (66% vs. 23%) and on-call childcare (44% vs. 11%). Whereas the majority of men perceived advancement and/or salaries to be higher than their peers, only one-quarter of women had the same perception (52% vs. 26%). Instead, a significant number of women felt they were behind their peers, while men generally felt there was parity (39% vs. 3%). Women were much more likely to report perceived discrimination (71% vs. 21%), and a full 61% felt such discrimination interfered with their ability to conduct professional activities. These are not numbers with which most of us feel comfortable, yet have we done enough to change them?

The British Medical Journal recently published a report from the British Cardiac Society decrying the state of women in cardiology in the United Kingdom (2). The Working Group concluded that our profession needs to acknowledge that there is a significant problem, and they proposed solutions such as establishing mentor programs and fostering role models, encouraging flexible training and consultant positions, removing biases against women in

interventional positions, and refusing to tolerate sexism. The report generated a flurry of editorials discussing the scope of the problem in the United Kingdom, Europe, and the U.S. (3–5).

So why consider this topic now, after it recently received such international attention?

We are at a remarkable crossroads in North American cardiology with a historic number of female leaders. In addition to myself as President of the ACC, Dr. Alice Jacobs serves as the President of the American Heart Association, Dr. Linda Gillam is President of American Society of Echocardiography, Dr. Ann Curtis is President of the Heart Rhythm Society, cardiologist Dr. Betsy Nabel was just appointed Director of the National Heart, Lung, and Blood Institute of the National Institutes of Health, and Dr. Ruth Collins-Nakai has been President of the Interamerican Society of Cardiology and will become President of the Canadian Medical Society later this year. There are also women serving as national society leaders in Sweden, Italy, India, and Romania this year.

While women in cardiology are extraordinarily visible in 2005, this collection of talent only serves to underscore what the profession is missing by not welcoming female residents. How many potential future presidents of the ACC are instead choosing careers in infectious disease or endocrinology because the "macho" environment of the interventional laboratory has discouraged them from pursuing their first love? Simply put, the field of cardiology must attract the best and the brightest women in medicine, and we must attract them in similar numbers as men. And once we have gained their interest, we must retain them and ensure that they have successful, fulfilling careers.

There are many ways to increase the applicant pool. I challenge every program director and chief to seek out the two or three best female residents in their internal medicine program, personally invite them to become cardiologists, and to offer them your own unstinting support. Develop a flexible training or attending schedule and make it known such an option is freely available without silent repercussions. Educate all trainees and faculty about the negligible risks of radiation for pregnant women and how to further minimize these risks (6).

Perhaps one of the best ways to attract trainees is to have successful and happy women as colleagues. If you do not

currently have at least one woman in your training program your group, or on your faculty, hire one! Your odds of attracting more female trainees or cardiologists will skyrocket overnight. If your group includes a woman, be supportive of her, since as your colleague, her success dovetails with yours, and the "trickle-down effect" may encourage more bright and talented young people of both sexes to join you. Make sure your administrator or managing partner fairly reviews her productivity and performance against her peers, and confirm that she is receiving an appropriate share of resources, support, and compensation. If there is any doubt, ask her and other women to help conduct a blinded review. Regardless of the results, make them known—either there is a laudable record of nondiscrimination or there is nothing to be ashamed of in acknowledging and fixing a problem.

Encourage your female colleagues to seek professional social opportunities. When I was the sole female faculty member at my first job, I joined women's business groups as a way to meet other professional women. As soon as there were enough of us practicing—or interested in—cardiology, I hosted pot-luck dinners in my home for female faculty, fellows, and residents. Isolation is not a recipe for career success.

Earlier this year, Lawrence Summer, Harvard's president, asserted there may be "issues of intrinsic aptitude" contributing to women's under-representation in the sciences and engineering, in addition to "what are in fact lesser factors involving socialization and continued discrimination" (7). While such pockets of shockingly overt sexism still exist, discrimination in the 21st century has surreptitiously changed its stripes. Unfortunately, it is no less pervasive and no less damaging. Sins of commission, thankfully, are less frequent, and it is unusual to witness blatant bias and openly verbalized policies of exclusion. But their place has been taken by sins of omission. Now, women are not recommended as highly, not supported or acknowledged as frequently, and not offered similar introductions, collaborations, or opportunities (8). Each of us has an obligation to our profession, our colleagues, our students, and our daughters to eliminate these barriers to success in cardiology.

As a professional society, the ACC recently reaffirmed the importance of women to the profession and the need for specific efforts to recruit and retain female cardiologists. At the 35th Bethesda Conference: Cardiology's Workforce Crisis: A Pragmatic Approach expressed concern "that too few women choose cardiology as a career." The conference devoted an entire working group to this topic, producing a report entitled "How to Encourage More Women to Choose a Career in Cardiology," which includes "a number of concepts we must embrace actively and actions we must take immediately if we hope to compete with other specialties for this growing pool of potential cardiologists" (9).

In recognition of the critical need for mentoring and networking to advance these goals, female ACC fellows are piloting a Women in Cardiology section. Already more than 500 have joined, about 25% of the female ACC fellows. Its mission is "1) to advance the interests of practicing female cardiologists to ensure that their practice remains rewarding through the creation of professional development, mentoring, and networking programs; 2) to enhance the appeal of a practice in cardiovascular disease for women in medicine by recommending changes in training programs, and by promoting effective, efficient, and diverse practice opportunities; and 3) to develop programs to encourage young women in high school, college, and medical school to pursue a career in cardiovascular medicine through the creation of mentoring programs and preceptorships" (10). This work is too important to leave to the Section alone; it must be a part of the College's core activities.

If we value our profession and advocate for quality of care, we must support a field that is "welcoming, multifaceted, exciting, and offers opportunities to contribute" (5) to all ACC fellows. We cannot afford to alienate one-half of our applicant pool, nor can we allow the majority of our female colleagues to feel that they are lagging behind their peers. Let us use this year, in which so many cardiology leaders are women, to proactively and successfully address this problem, once and for all.

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