For 50 years, American cardiology has been a fertile field in terms of innovation, invention, and impact on illness (1). But one thing is still in short supply in our specialty—women. Despite a dramatic increase in the number of female medical school graduates in the U.S. during the last generation (13.4% in 1975 to 42.4% in 2000), very few women choose to become cardiologists. Today, when about 39% of internal medicine residents are female, only 10% of cardiology trainees are female, and just 6% of American College of Cardiology (ACC) Fellows are women (2). We need to do more to attract female medical graduates to our specialty because they represent almost one-half of the new doctors trained in this country. Cardiology needs to take full advantage of this large talent pool.

This essay focuses on recruiting women to cardiology, but it also raises the larger and provocative question about the competitiveness of our field in general. If recent trends continue, a majority of America’s new cardiologists will be international medical graduates in the future (3). Although this cultural diversity enriches our specialty and our nation, we must ask ourselves why cardiology does not attract more American medical graduates and, especially, why it does not appeal to women. Two things stand out: cardiology has too few female mentors, and it has an image problem when it comes to balancing career and home-life.

MENTORS AND ROLE MODELS

When asked what led them to choose a particular specialty, physicians often cite the influence of a mentor. This puts cardiology at a disadvantage compared to several other specialties when it comes to recruiting women. The fields with the highest percentage of female residents are obstetrics and gynecology (67%) and pediatrics (65%) (4). In part, these career choices reflect historical traditions where women gravitated toward disciplines that focus on diseases of women and children (5). One important result of this persistent pattern is that female medical students rotating through pediatrics or obstetrics and gynecology often come into contact with women mentors and role models—but both are in short supply in cardiology.

If we hope to narrow cardiology’s gender gap, America’s medical schools and teaching hospitals must appoint and promote more women to positions of responsibility and leadership (6). Of course, for this to happen, more female cardiologists must choose to stay in academic medicine rather than enter private practice (7,8). Once a critical mass of female academic cardiologists is achieved, there will be more role models and potential mentors. This will take years; in the meantime, we can’t depend on female academics to be the main mentors of women students and residents. Whenever they have the opportunity, academic and practitioner cardiologists of both sexes must actively mentor young women if we hope to draw greater numbers of them to our field.

CARDIOLOGY’S MACHO IMAGE

Mentoring is only one part of the equation. The public and professional perception of cardiology and cardiologists is another significant factor. Although many of us celebrate cardiology’s macho image, this stereotype is problematic when it comes to attracting female medical graduates. We live in an era when many young women and men challenge traditional notions of success. New physicians often frame their careers quite differently than their predecessors. Although the aphorism “service above self” and the old phrase “medicine is a jealous mistress” were meant to affirm altruism, today they sound alarms, as the balance between career and family life continues to shift.

If cardiology hopes to compete for American medical graduates—especially women—we must respect this new social reality rather than resent it. Boasting about how demanding training used to be does not resonate with young physicians today. We need to respond to the contemporary cultural context by offering creative career choices. For example, rather than penalizing part-time physicians, we should import innovations (such as job sharing and creative scheduling) from other professions that have been more successful in inventing environments that attract and retain women.

Cardiology’s image as an exciting, dynamic, and demanding discipline is understandable, but it may be part of the problem we have recruiting women and male U.S. medical graduates to our specialty. Some trainees are undoubtedly attracted by cardiology’s fast pace, by our swat-team approach to “sudden cardiac death” and our battle cry “time is myocardium.” On the other hand, I worry that many medical students and residents—especially women—think most cardiologists are so busy that they have little time for...
themselves or their families. We need to reflect on our image and work together to correct this biased and distorted view.

The reality is that cardiology can be both professionally rewarding and family friendly. Publicizing this fact will help our specialty to compete more effectively for young women and men seeking to strike a balance between career and children. Based on the results of a recent survey of ACC members’ satisfaction with their career decisions, the College’s committee on women in cardiology concluded, “Enhancing the day to day professional experience of the cardiovascular specialist by making cardiology practice ‘easier’ and safer will help to achieve the long-term goal of promoting entry into the profession of the ‘best and the brightest’” (9). If we hope to recruit and retain colleagues who are both competent and content, then we must adapt to this new reality.

We must also showcase the broad spectrum of clinical and research opportunities that exist in our field—from primary prevention to percutaneous intervention. Medical students and residents tend to see cardiology as a frenetic procedure-oriented specialty. This reflects the fact that they are exposed almost exclusively to inpatient cardiology practices, where the focus is on invasive diagnostic or therapeutic procedures performed on acutely ill patients. Most students and residents do not see the more typical outpatient, office-based cardiology practice that emphasizes elective consultations, noninvasive tests, and follow-up of patients with stable heart disease. This aspect of cardiology practice can be very rewarding, and the more predictable hours will appeal to many of the physicians of the future.

Things that contribute to making a cardiology practice satisfying both professionally and personally include content, context, and colleagues. The ACC survey revealed that female cardiologists are more likely to be involved in noninvasive activities, such as echocardiography, heart failure, and transplantation, than invasive or interventional cardiology. In part, this reflects the perception that the on-call responsibilities in invasive cardiology are especially onerous and unpredictable, given our current aggressive approach to treating patients with acute coronary syndromes. Another factor is that invasive cardiology entails more occupational radiation exposure than noninvasive cardiologists. Although female cardiologists who are pregnant or who plan to have children are understandably concerned about radiation exposure, they should be reassured by current protection procedures (10).

PHYSICIAN FRIENDLY, FLEXIBLE WORK ENVIRONMENTS

Few physicians—regardless of their specialty—look forward to “taking call” because it adds unsettling uncertainty to what, for most, is already a busy and complicated life. The frequency and intensity of cardiology call often have more implications for female than male physicians. Childrearing is a very important and time-consuming responsibility. Despite significant societal shifts in the past generation, women are not equal partners in parenting—they still do the majority of it in most families. If we hope to recruit more females into cardiology, we must be willing to acknowledge and act on these realities of contemporary culture. Moreover, we cannot tolerate sex discrimination, gender stereotyping, and unprofessional comments or behaviors that will discourage women from choosing cardiology as a specialty. Unfortunately, these destructive attitudes and behaviors still exist, and they definitely affect career choices (9).

Certain practice styles offer greater flexibility when it comes to coverage. For a generation, practitioner cardiologists have gravitated toward single-specialty groups because they provide some real and perceived benefits. One important feature of this group practice model is its critical mass of colleagues with whom to share clinical responsibilities, especially night and weekend call. Medical students and residents rarely see this model in operation, or if they do, they tend to see only the partners who—at one point in time—are covering the hospital services or performing inpatient procedures. If we hope to alter this perception, we need to develop outpatient preceptorships and other opportunities for students and internal medical residents. These potential cardiologists must meet and interact with practitioners in contexts outside of the coronary care unit or the catheterization laboratory.

In the twenty-first century, most male and female medical graduates are seeking better balance between their professional and personal lives. They sense that other specialties will be more compatible with achieving this goal. The sooner we accept this fact and reinvent our cardiology practices to reflect it, the sooner we will be able to attract more candidates to our specialty. We have to be proactive at several levels. All cardiologists—male and female, academics and practitioners—must cooperate in this mission. Our efforts must be concerted and consistent, our arguments must be compelling, and our actions must be credible. Only then will we be able to attract the best and the brightest—of both sexes—to our profession.

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