

The girls in the boys' club: Reflections from Canadian women in cardiology

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With impending human resource needs in the field of cardiology, attention has turned to recruitment of female medical trainees. The authors explore the issues around balancing career and family. Possible solutions are considered, and all require a satisfactory work-life balance that will be able to attract young, talented physicians.

Key Words: *Balance; Cardiovascular; Physicians; Sex; Workforce*

For those of you who don't know us, we represent two different generations (a decade apart) of Canadian female cardiologists. In fact, both of us are interventional cardiologists. One may therefore ask, "Where is the problem?" Perhaps Canada is immune to the international concern about how to attract more women into the cardiovascular disciplines.

The American College of Cardiology (1) and the British Cardiac Society (2) have recently reported working group summaries on this issue, which generated numerous editorials from the United States, the United Kingdom and Europe (3-5). All have made suggestions to improve the recruitment and retention of women in cardiovascular disciplines.

Should Canadian cardiovascular specialists be concerned, along with their American and European counterparts, that over one-half of each graduating class is female? To examine this question, we look back over our personal experiences, which together span the years from the late 1980s to the present.

In 1984, it was so rare to have a woman choose a cardiology residency that no one really had any advice to give. So, I (CMK) blindly started my training with little to no idea how difficult it would be to balance a career in cardiology with a family life as a wife and mother. With few exceptions, my role models and mentors were men. I am indebted to several wise male cardiologists who encouraged me to pursue my dream of interventional cardiology despite the obstacles. The obstacles came in strange places and sometimes from unexpected sources. Nurses, patients, friends, family and colleagues would occasionally make comments like, "Women should not be in the cath lab" or, "When you have children, you will give up all this nonsense". My particular favourite was, "You marry a wife; you call a doctor".

There were many serious issues at that time, including a lack of maternity plans, lack of special call arrangements for

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Étant donné la pénurie imminente d'effectifs en cardiologie, on s'intéresse au recrutement de stagiaires en médecine de sexe féminin. Les auteures explorent les problèmes entourant la conciliation entre la carrière et la famille. Des solutions possibles sont envisagées, et toutes exigent une conciliation travail-famille satisfaisante qui permettra d'attirer de jeunes médecins talentueuses.

pregnancy, unequal pay, obstacles to promotion, lack of flexibility in group practices for part-time work and a feeling of isolation with few other women in similar circumstances.

However, those of us who chose cardiology as a career often thrived on the challenges to succeed, and there was a sweet reward at the end when you earned the respect of your colleagues. My most treasured compliment was from a male interventional colleague who said, "She's not a woman, she's an interventionalist".

By the late 1990s, a decade later, we had made much progress, but my coauthor's experiences unfortunately highlight the ongoing issues.

As a medical student, I (MMG) was inspired by a (male) cardiologist to think about cardiology as a career, but it wasn't so easy. When I was an internal medicine resident, most of the attendings told me, "Don't do it, you won't have a job". To make matters worse, many of my friends said, "Don't do it, you'll never meet anyone, get married, have a family, have a life ...". Fortunately, another (male) cardiologist told me to ignore everyone and stick to my plan. But I still got the feeling that female cardiologists were unusual and that this specialty really was a 'boys' club'. By 1996, I was still the only female in my cardiology residency program. Not the first, and certainly not the last, but the only one in the three years I was there (and interested in interventional cardiology, no less!). One of the male interventionalists told me that "women don't belong in the cath lab". I am grateful for the men who inspired and trained me, and for my current colleagues, who make me feel like I am just "one of the gang" (even when I was pregnant). However, I think that things would have been much harder for me had I not had the unique mentorship of my program director (CMK) to show me that women can have both a successful career in cardiology and a family – but not without pain and effort.

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The recent National Physician Survey (6) reported that cardiologists face long workweeks and significant on-call duties, and many (both male and female) are dissatisfied with the balance between work and family responsibilities. The number of cardiovascular specialists is declining, and sufficient numbers of new specialists may not be able to be recruited because new, particularly female, graduates tend to consider workload flexibility and predictability when choosing a specialty area (6). This problem is not unique to Canada. Indeed, in 2005, only 14% of cardiology residents in the United States are female (7). In Canada, it is better, with 18.6% female cardiology residents in the year 2004/2005 (Canadian Post MD Education Registry, personal communication). Very few of these women will choose interventional cardiology or electrophysiology as their specialty.

It seems that the Canadian cardiology community may indeed have a problem; the question is why? Are women under-represented in the cardiovascular specialties because men are better suited, as stated by some? Or are there women who are interested but discouraged by others or who are afraid of the lifestyle that they see cardiologists such as ourselves undertaking? Do they see discrimination in this male-dominated field?

The workload issue is real, particularly the call duties, most notably for interventional cardiology. Unfortunately, there remains a perception that women have to work twice as hard to get half as much recognition. Whether true or not, our specialty does not attract many young female students.

Many of the issues around balancing career demands with family life surround children. Despite the new generation of involved fathers, it is obviously women who bare the burden of pregnancy and carry a significant proportion of child care duties. Organizing a cardiovascular practice or training program around pregnancy remains a difficult matter. Many women do extra clinical service before delivery. Maternity leave is often considerably shorter than for women in other professions, and there is inconsistency in maternity plans across the country; many women receive little or no pay while on leave. In contrast, if a colleague breaks a leg in an accident, it is commonplace to have a group short-term disability plan. Pregnancy is a particular issue for those who work in interventional cardiology or interventional electrophysiology, in which many females have chosen to remove themselves from the laboratory during pregnancy due to the physical issues of wearing lead and radiation exposure. This leads to potential bitterness among some colleagues when increased workloads in the interventional arena fall to male colleagues.

The President of the American College of Cardiology, Dr Pam Douglas, recently suggested that to attract women to cardiovascular training programs, there needs to be at least one woman in the division (7). We couldn't agree more.

However, the issues around balancing career and family are not unique to female cardiologists. The current survey shows that the new generation of male cardiologists also places more importance on a well-balanced life. Paternity leaves are now the norm. More young physicians are dissatisfied with the workload status quo. There is a generalized push from young physicians to consider lifestyle in career choices and in organizing group activities. All cardiovascular specialists, women in particular, need a more flexible work environment with a new attitude, where 7 am and 6 pm meetings are not the norm.

A well-balanced life for every doctor should be the goal. Chiefs and residency training program directors need to incorporate this ideal into their thinking. The new concepts of income structure, alternative funding plans, job descriptions, maternity and paternity plans, job-sharing opportunities and part-time employment opportunities are all part of the new environment that cardiovascular specialists need to embrace if they want to recruit and retain young cardiovascular specialists, particularly women.

Cardiac disciplines must remember that like other corporations and professional societies, we will all face new challenges as work opportunities begin to outnumber the applicants for positions. It will only be those centres that can provide satisfactory work-life balance that will be able to attract young, talented physicians. Most importantly, we will have to provide our potential recruits with excellent role models. It is well known that the best recruitment policy is the retention policy. Physician leaders need to be seen as supportive of their staff and actively promoting young faculty members. We need to show medical students and residents that we indeed work hard, but that we enjoy good, well-balanced lives. The best mentors in the world cannot inspire someone to study cardiovascular medicine if they cannot demonstrate that they are happy themselves.

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