Women in cardiology: no progress in the pace of change

Sonya V Babu-Narayan,[1] Simon Ray [2]

The paper by Shareen Jaijee and colleagues[1] in this edition of *Heart* puts figures onto what many cardiologists will recognise as an everyday reality of our specialty. It makes unwelcome but not unexpected reading. In the last 15 years, progress with regards to gender representation in UK cardiology practice[2] and leadership appears to have stood still or at best run at a pedestrian pace. Female cardiologists are still in a minority, particularly in interventional specialities, in academic cardiology and as leaders and are substantially more likely to have been on the receiving end of inappropriate behaviour from professional colleagues. Disturbingly, a third of female cardiologists reported sexual harassment.[1] UK women training in cardiology also report[3] experiencing sexism particularly in the latter years of training (15%) when studying in tertiary centres where more interventional cardiology and research training is located and are more likely to change their preferred subspecialty choice away from intervention and electrophysiology.[3] Non-cardiology trainee respondents to a survey mentioned witnessing and experiencing bullying and sexism by cardiologists and cardiology trainees as a reason not to choose a career in cardiology, with sexism more often reported by women.[4] Negative attitudes and behaviours in UK cardiology therefore affect people at every stage and will likely need multiple actions to stamp out.

One positive finding in this paper[1] is that the great majority of cardiologists, both male and female, feel positive about their choice of specialty despite the obstacles and negative factors reported. This is important as, in considering how cardiology needs to change, we also need to remember what makes cardiology attractive in the first place. Cardiology is interesting, intellectually challenging and demanding and has evidence-based treatments that save and improve lives making it among the most competitive medical specialties. As cardiologists, and potential patients, it is in our selfish interest to attract the best and the brightest to be our future colleagues. Objective evidence tells us however that, however positive our views about cardiology as a choice of specialty, we are not tapping the full talent pool available to us and our workforce is not representative of the diversity among the people that it treats. Female graduates make up more than 50% of the output of UK medical schools and have done so for more than 25 years. Yet they only make up around 30% of applicants for specialist training in cardiology and only 13% of the UK cardiology consultant workforce. Women who do apply for cardiology specialist training (resident) are, if anything, more likely to be awarded the post. In academic cardiology, women authors and papers with mixed authorship tended to gain more citations of their work.[5 6] Obviously, competencies relevant to cardiology do not have 'male' or 'female' attributes but a career in cardiology appears to be more often seen as unattractive by women. Cardiology is lagging behind other medical specialties with regards workforce representation.

PERCEIVED AND ACTUAL BARRIERS TO ADDRESS

Perceived and actual barriers to choosing cardiology for women include access to working less-than-fulltime, flexible training and a 'boys club' or 'locker room' culture. Some, although limited, progress was made following previous British Cardiovascular Society recommendations.[2] However, there is a pervasive view within cardiology and within medicine more widely that questions the commitment and contribution of those overwhelmingly female colleagues, who choose to train or work less-than-full-time, and by inference, whether they have the same drive and desire for excellence as their full-time peers. Linked to this there are misplaced perceptions that procedural specialties are incompatible with pregnancy, maternity or adoption leave or that traits that lend themselves to procedural specialties are somehow male or female in nature. Female cardiologists responding to the current survey[1] were less likely to be married or have children compared with their male counterparts.

Both men and women within cardiology will need to be accountable if we want long overdue cultural change. There is no doubt that cardiology requires drive, dedication and commitment, but these should not be conflated with a requirement for excessively long working hours, 'presenteeism' and the exclusion of outside interests and family life either for men or for women. Currently, those who wish to practise in coronary intervention require to commit to taking part in a primary PCI rota as a consultant which will need to be planned around, but assumptions should not be made on behalf of women that they cannot or will not choose to do so. Different ways of working including career breaks for parental leave and part-time working need to be embraced as the norm to the benefit of all, not just as something to be tolerated.

STARTING EARLY

In the UK, work by the British Junior Cardiologists Association, British Cardiovascular Society and the British Cardiovascular Intervention Society is ongoing to encourage and support more women to consider cardiology and provide mentorship to aspiring trainees from medical student stage onwards. We should be seeking equality of opportunity where all medical graduates can make an informed decision whether they want to pursue a career in cardiology or any of its subspecialties secure in the knowledge that they will be judged on the basis of their personal abilities and not on perceptions linked to gender.

RECOGNISING, RETAINING AND REWARDING TALENT EQUALLY

In the UK, as in the USA, women remain underrepresented as leaders in cardiology and cardiovascular science, a gap that is not fully explained by the younger age profile of the female workforce. This does matter. Lack of diversity of the leadership stifles creativity and innovation and gender inequality may help sexism or sexual harassment go unchallenged. Missing out on talent could cost lives.

For those who have already chosen a career in cardiology, female mentors and role models are often seen as helpful. But mentors, champions and sponsors need not be limited to women, which would reduce the pool and limit the diversity of experienced voices available to them. There must be a level playing field for female and male cardiologists aspiring to

[1]Cardiology, Royal Brompton Hospital, London, UK
[2]President of the British Cardiovascular Society, Cardiology, Manchester University Hospitals Foundation Trust, Manchester, UK

Correspondence to Simon Ray, Cardiology, Manchester University Hospitals Foundation Trust, Manchester M23 9LT, UK; simon.ray@nhs.net

Heart: first published as 10.1136/heartjnl-2020-318057 on 19 March 2021. Downloaded from http://heart.bmj.com/ on March 20, 2021 at The University of Manchester Library. Protected by copyright.

be leaders. We need to be alert to 'benevolent paternalism', whereby women more often receive discouraging advice and obstructions to the path ahead. Furthermore, advice that inadvertently perpetuates stereotypes at the expense of finding new ways to progress will not enable change for the better.

The COVID-19 pandemic has amplified existing inequalities by reversing gains in gender parity, including in medicine where there is a large gender pay gap for consultants in spite of working for a single tax-payer funded employer, the NHS.[7 8] Effective strategies proven to mitigate the unwanted effects of gender or other stereotypes on women or men in cardiology are needed. These must address structural barriers to entry, to pay and to career progression in cardiology including in academic cardiology, and may include continued and robust analysis of gender-related and intersectional pay disparity, transparency of metrics for and access to promotion, fair performance evaluation for assessment for additional renumeration, investment in childcare, centralised budgets for parental leave and incentives to existing leaders to address the imbalance. Sexism and sexual harassment by women or men are no more acceptable in cardiology than anywhere else and must no longer be tolerated.

Contributors Both authors contributed equally to the writing of this manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Commissioned; internally peer reviewed.

© Author(s) (or their employer(s)) 2021. No commercial re-use. See rights and permissions. Published by BMJ.

To cite Babu-Narayan SV, Ray S. *Heart* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/heartjnl-2020-318057

► http://dx.doi.org/10.1136/heartjnl-2020-317837

Heart 2021;**0**:1–2.
doi:10.1136/heartjnl-2020-318057

ORCID iD
Simon Ray http://orcid.org/0000-0001-7775-1900

REFERENCES

1 Jaijee SK, Kamau-Mitchell C, Mikhail GW, *et al*. Sexism experienced by consultant cardiologists in the United Kingdom. *Heart* 2021. doi:10.1136/heartjnl-2020-317837. [Epub ahead of print: 15 Mar 2021].
2 Timmis AD, Baker C, Banerjee S, *et al*. Women in UK cardiology: report of a working group of the British Cardiac Society. *Heart* 2005;91:283–9.
3 Sinclair HC, Joshi A, Allen C, *et al*. Women in cardiology: the British Junior Cardiologists' Association identifies challenges. *Eur Heart J* 2019;40:227–31.
4 Kurdi H, Williams C. Women not in cardiology: where are we going wrong? A survey of the perceptions and barriers to training. *Br J Cardiol* 2020;27:119–23.
5 Asghar M, Usman MS, Aibani R, *et al*. Sex differences in authorship of academic cardiology literature over the last 2 decades. *J Am Coll Cardiol* 2018;72:681–5.
6 van Doren S, Brida M, Gatzoulis MA, *et al*. Sex differences in publication volume and quality in congenital heart disease: are women disadvantaged? *Open Heart* 2019;6:e000882.
7 Woodhams C, Dacre J, Parnerkar I, *et al*. Pay gaps in medicine and the impact of COVID-19 on doctors' careers. *Lancet* 2021;397:79–80.
8 Narayana S, Roy B, Merriam S, *et al*. Minding the gap: organizational strategies to promote gender equity in academic medicine during the COVID-19 pandemic. *J Gen Intern Med* 2020;35:3681–4.

Heart: first published as 10.1136/heartjnl-2020-318057 on 19 March 2021. Downloaded from http://heart.bmj.com/ on March 20, 2021 at The University of Manchester Library. Protected by copyright.