EDITORIAL

Women in cardiology: a European perspective

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Women may be under-represented in cardiology in the UK, but what about the rest of Europe?

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Variety generates strength. This principle, dear to farmers and geneticists, also befits the medical workforce. The recruitment of new talents from the widest possible catchment pool is another rule of thumb that raises competitiveness and working standards. The dearth of women among UK cardiologists, reported in this issue of *Heart*,[1] highlights at least two important matters: that the above basic precepts in job appointments have been contravened, and/or that women are not up to, or not interested in, cardiology. In the UK, the latter explanation does not seem to fit the facts.[1] What about the rest of Europe: are women under-represented there as well? If so, what are the reasons? These questions are substantial, as the want of such a broad workforce as that provided by the female contingent, and the ensuing reduction in professional diversity, may seriously limit the vitality and progress of cardiology as a whole.

CAN A WOMAN BE MORE LIKE A MAN?

Women, by tradition or innate make-up, are prone to care for the needy (children, elderly parents), to build strong bonds of affection, to educate the young, to perform fine handiwork, and to run family affairs. They are considered careful and hard workers. They do not have the "luxury" of a wife to attend to them. Their potential for repeated pregnancies, childbirths, and breastfeeding suggest considerable physical endurance. They are also capable of great intellectual depth, as exemplified by the first person to receive two Nobel prizes: Polish born chemist and physicist, Marie Curie, at age 44.

This array of characteristics, revealing sensibility, stamina, ability to supervise, and cleverness, probably explains the deep seated trust that has led many societies to consign to women one of the greatest of responsibilities: childrearing—that is, the shaping of future adults. Yet, in western societies, the professional aptitude of women is still marred by notions of emotional, intellectual, and physical inadequacy. In medicine, and particularly in cardiology, women are generally under-represented among heads of units, administrators, and executives.[1–5] For them, positions associated with secretarial assistance (which is often female) are still considered unnecessary or inappropriate, perhaps through the confused concept that women should be secretaries (and wives) unto themselves. But if women can be trusted to raise children, they can handle the challenges of clinical problem solving, procedures, teaching, fundraising, politics, and research, at all levels of responsibility and authority.

EQUAL OPPORTUNITIES?

In many European countries, women were first allowed to attend college only around 1910.[6] In Italy, an exception was Maria Montessori, who achieved a medical degree in 1896, probably through papal intercession (Montessori's methods of education, which included introducing child sized furniture into schools, were so effective that they rapidly spread worldwide and won her three nominations for the Nobel Peace prize).[7] The female quota in Italian medical schools has progressively grown, equalling (in the 1980s) and outnumbering (in the 1990s) that of men.[4] Recent statistics indicate that women compared to men are less inclined to leave college prematurely, achieving a degree somewhat sooner and with better grades.[1 4] The exact proportion of European female graduates who go on to specialised training is not easily available. Data suggest that women, more than men, do not pursue a specialisation,[8] which may explain the generally lower than 50% female presence among specialised staff. In particular, in the USA[9] and UK,[1 10] women appear to shy away from cardiology.

What emerges from all enquiries[1–5 11 12] is the gradual tapering of female representation with advancing career stages. In a single, central Italian medical school, in 2002, women made up approximately 30% of the clinical academic staff (both tenured and untenured), but the proportion fell dramatically as the academic rank increased (from 42% of untenured doctors to 2% of full professors), with no female heads of department.[11] In the whole of Italy, in 2003, roughly a quarter of the tenured academic medical staff was female, ranging from about 30% of those at the lowest level ("researchers") to about 7% of full professors.[12] The female share of academic cardiology appears to be even smaller, forming less than 5% of Italy's full professors.[4] Similarly, only 7% of the European scientific board members of the *Italian Heart Journal* are women,[13] although female scientific productivity (in terms of funded grants and published papers) is similar to that of men.[3]

ATTITUDES IN NEED OF CHANGE

A number of conditions and attitudes may concur to hinder the integration of women in cardiology (table 1) and, consequently, limit the variety and potential growth of this branch of medicine. Passive female submission to—and active male encouragement of—these unbalanced

Table 1 Conditions and attitudes hindering the integration of women among cardiologists

Female	Male
• Lack of role models	Difficulty in recognising female professional autonomy
• Dependence on male figures	Uneasiness with female authority
• Low self esteem	Sense of intellectual, physical and psychological superiority
• Low level of expectations and demands	High level of ambitions and expectations
• Undisputed role as family caretaker (children, parents)	Undisputed role as family bread winner
• Taking on responsibilities in excess of level of authority	Delegating responsibilities but not authority to female colleagues
• Charm used for career advancement	Some degree of sexism tolerated
• Unfounded fear of radiation	Unfounded fear of women?

behaviours (table 1) probably play equally important parts in their perpetuation, such that searching for a gender specific origin of the imbalance may be pointless. It is clear, nonetheless, that, in the currently androcentric cardiological environment, women who wish to achieve professional recognition must struggle against two sets of unbalanced attitudes (both female and male, table 1), while men find themselves ''supported'' by behaviours favouring the status quo. Therefore, the greatest effort to redress the imbalance must come from women rather than men.

STEPS FORWARD

The document produced by the British Cardiac Society Working Group examines the natural history of male and female careers in medicine and cardiology in the UK.[1] With figures at hand, they show that women are well represented and perform somewhat better than men in medical school.[1] Despite an estimated male to female ratio of 5:2 in selecting cardiology as a career aspiration, only about one in five registrars, and less than one in 10 consultants, are female.[1] Factors identified as contributing to the shortfall of women are: (1) the lack of flexible training, of part time posts, of childcare facilities, and of female role models; (2) an unfounded female fear of radiation; and, possibly, (3) sexist attitudes discouraging women from pursuing cardiology and its subspecialties.[1] The group further propose a ''triple A'' strategy, based on **A**wareness and **A**cceptance of the existing gender inequalities, and **A**ction to improve the recruitment and opportunities of female cardiologists. Such actions include: (a) focused censuses, questionnaires (that should be addressed to both males and females), and their divulgation; (b) development of—and access to—flexibility and childcare programmes, part time jobs, and female mentors; and (c) control of possible sexist behaviours.[1]

Continental Europe has tended to lag behind, the first countries paying systematic attention to the gender differences in cardiology being the UK[10] and the USA,[2] followed by Italy.[4] The relative excess of cardiologists within many European countries[14] is no excuse for tolerating gender inequalities in recruitment and career advancement. Therefore, a concerted European ''triple A'' strategy (see above) is dearly needed.

CAN A MAN BE MORE LIKE A WOMAN?

By welcoming female talents, European cardiology is expected to raise its level of diversity, novelty, strength, and competitiveness. Conversely, and by the same token, a greater presence of men (including male cardiologists) in the child rearing process is likely to offer inestimable benefits to innumerable families and their related social networks. Men should perhaps reconsider their truncated share in domestic life, guided by the popular saying that the hand that rocks the cradle (not the hand that runs cardiology departments) is the hand that rules the world.

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