Lean In,¹ the book by Facebook’s chief operating officer, Sheryl Sandberg, has sparked a debate on the issue of women in the workplace that has spread like wildfire throughout the country. In the book, she highlights the large discrepancy between the number of men and women in positions of power and leadership. She suggests that in addition to external barriers, internal barriers, such as lack of self-confidence and anticipation of future family obligations, are hindering women from being successful. Through this book, she is petitioning for women to close the gender gap by leaning in to their careers, sitting at the main table, and being part of the discussion to promote change. Although her experiences and thoughts are predominantly about the business sector, the discussion is applicable to every field, including our own. Her book should prompt introspection to understand why even in the 21st century there is such an under-representation of women in cardiology, particularly within leadership positions, and what can be done to change this.

According to the American College of Cardiology (ACC) Survey: Addressing the Cardiology Workforce Crisis, which was published in 2009, women comprise a small fraction of all cardiologists (Figure 1).² Only ≈12% of general cardiologists and ≈10% of interventionalists and electrophysiologists are women,² even though women make up 50% of most medical school classes. What is more surprising is that the ACC membership profile data as of June 2012, >5 years later, suggests that only 10% of Full Physician Members from the United States are women. The data are more promising for fellows-in-training because women currently make up 22% of all ACC fellows-in-training members from the United States and 27% internationally (ACC membership profile data, unpublished data, 2013). However, this proportion is still strikingly low, especially considering that 30% of pediatric cardiologists are women³ and 49% of trainees in pediatric cardiology were women in 1998.³

In addition, among cardiologists, women are less likely to excel academically and earn less than their male counterparts as highlighted by a recent report by the Association of American Medical Colleges on the current status of women in academic medicine⁴ and a recent Medscape Cardiologist Compensation Report that published cardiologists’ salaries by sex.⁵ The Association of American Medical Colleges survey reported that there is an attrition of women at higher ranks in the academic leadership ladder creating a large discrepancy between the number of female and male full professors (Table). The Medscape survey pointed out that the discrepancy in salaries between men and women (Table) is partially explained by the under-representation of women in higher paying procedural subspecialties. The question arises, is this because of internal barriers and lack of ambition, or is it because of realities and perceptions within the field that make it more difficult for women to balance work and home life?

In an interview with Katie Couric regarding her book, Sandberg advised that “women should go for the big job and deal with family later” (twitter.com/katiecouric, March 11, 2013), with the intent of early career acceleration. I believe this statement articulates an unspoken reality about success that many do not think about or want to admit. Within my own network in cardiology, I find deferral of personal and family priorities to be the rule rather than the exception. For example, among the 26 fellows in my training program, 7 are women. Of the female fellows, 3 are living apart from their husbands to pursue their career ambitions, 3 are still looking for their life partner, and only 1 is married, living with her husband, and has a child. In contrast, of the 19 men in the program, 13 are married, all live with their spouses, and 9 have children. This anecdotal experience provides an excellent example of how many women in this field are working toward the big job and, in a sense, dealing with family later. Are men given similar advice to defer family obligations? Some women wait to have children because of the demanding/competitive nature of the field and then come up against nature’s deadline when trying to have children. It is true that balancing career and personal responsibilities is a difficult issue that affects both men and women, but in my opinion, it disproportionately impacts women. The ACC Professional Life Survey conducted to learn how career decisions of men and women in cardiology influenced their professional and personal lives, which was published in 1998, supports these observations from my training. The survey found that more men than women were married (90% versus 71%), more men than women had children (88% versus 63%), and females were slightly older at the time of their first child (32 versus

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Academic appointments†‡

Cardiologist compensation*

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<tr>
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<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td>Average annual salary</td>
<td>$310,000</td>
<td>$362,000</td>
</tr>
<tr>
<td>Academic appointments†‡</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructor</td>
<td>6%</td>
<td>5%</td>
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<tr>
<td>Assistant professor</td>
<td>18%</td>
<td>24%</td>
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<tr>
<td>Associate professor</td>
<td>7%</td>
<td>14%</td>
</tr>
<tr>
<td>Full professor</td>
<td>5%</td>
<td>19%</td>
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*Data extracted from the 2013 Medscape Cardiologist Compensation Report.†‡Academic appointments (all specialties) are reported as percentages of full-time faculty at US full accredited medical schools.‡Data extracted from the Women in U.S. Academic Medicine and Science: Statistics and Benchmarking Report 2011–2012.
faculty can proactively address concerns and build a mentorship community. In addition, women faculty should reach out to trainees at all levels of training because women often relate better to women and are more likely to have female mentors.

Last, I think cardiology divisions should consider having longer tenure tracks for women who have young children and need time to focus on their families. Flexibility here may allow women to have it all but just not all at the same time.

However, the onus is not only on the cardiovascular community. It is also important for women to understand the internal and external barriers that prevent them from setting the highest expectation for themselves and work on overcoming them. Many women in cardiology have set a precedence demonstrating that both (career and family) can be balanced and balanced well. Meeting these women is inspiring and motivating. Based on their experiences, it seems that balancing both responsibilities requires collaboration from life partners, delegation of nonessential work, efficient time management, and setting appropriate expectations.

I personally love what I do and want other women who enjoy the field of cardiology not to be deterred. Prior surveys of cardiologists have shown high job satisfaction in the field, almost 90% among men and women. Despite my zeal, I have personal apprehension about the future when I have children and how it may affect my career trajectory. As I discuss this topic with other women in the field, I find this concern is common among women early in their career. Because of biological differences, women will always face greater conflict when trying to balance family and career. We need to embrace the differences between men and women in the cardiology workplace, work to better understand them, recruit more women into cardiology, and create avenues that allow women to flourish and lead in our specialty.

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None.

### References

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Monika Sanghavi

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