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6. THE VALUE AND ROLE OF MENTORING AND ROLE MODELS IN ATTRACTING AND RETAINING JUNIOR WOMEN FACULTY IN ACADEMIC MEDICINE

INTRODUCTION

Women in academic medicine work in complex and challenging environments where they are expected to not only achieve academically in education and\or research and administrative service, but they are also responsible for providing high quality, evidence informed clinical care to patients and their families. In addition, traditional gender roles still exist with the majority of women continuing to assume a larger share of the care of homes and children (Singletary, 2005; Hoover, 2006) even as they embark on an academic career. Women also experience quality-of-life and role strain issues in some specialties, including most of the surgical disciplines (Hoover, 2006). Despite more women entering medical school, women in academic medicine are predominantly at the lowest faculty ranks, with estimates of 70% of women in academic medicine holding the rank of instructor or assistant professor (Hoover, 2006**).** At a senior level, the number of female medical faculty holding the rank of full professor increased by only 2% (10% to 12%) between 1985 and 2006, while male faculty holding full professor rank remained consistent at 30% over the same period (Magrane et al, 2007 in Mayer et al, 2008). Attracting female physicians to careers in academic medicine can be challenging and when women are successfully recruited to an academic career, multiple strategies are needed to retain them. Compounding the recruitment challenge is the underrepresentation of women in academic administrative leadership positions, potentially resulting in gender biased policy decisions and discrete "sexism" (Yedidia MJ and Bickel J, 2001). In addition academic rank and selection for a leadership position such as department chair or deanship are inextricably linked in terms of advanced rank as a prerequisite to apply for these positions (Teach et al,1995).

Mentoring has been identified as an important factor for recruitment (Heid et al, 1999; Reck et al, 2006; Weinert et al, 2006; Steele et al, 2012a) and retention (Heid et al, 1999; Benson et al, 2002; Weinert et al, 2006; Wingard et al, 2008; Steele et al, 2012a) of faculty. In a study of faculty members who left an academic institution one of the most important changes noted by participants that might have induced them to stay was having an effective mentor/role model. Women consistently considered the need for an effective mentor/role model as an important issue (Kevorkian CG

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and Tuel SM, 1994). In a qualitative study of 16 faculty members almost 98% of participants identified lack of mentoring as the first or second most important factor preventing career progress in academic medicine (Jackson et al, 2003).

To understand factors that may be barriers to recruitment and retention of junior faculty, Steele et al, 2012a completed a mixed methods study of department/division chairs/chiefs, junior faculty, senior residents and physician fellows across all clinical departments at the Schulich School of Medicine & Dentistry, The University of Western Ontario, London, Canada. Questionnaire results indicated that having role models increased commitment to an academic career; mentorship experience during residency training was a high incentive to pursue an academic career; and junior faculty did have identifiable mentorship experiences. Focus group results revealed that mentoring as well as the presence of role models a few years ahead of the junior faculty would promote career development. Females preferred similar age role models who spoke the same language (in a metaphorical sense), particularly in the area of promotion. Females identified several challenges and issues including a lack of researcher role models, a range of perceptions regarding the merits of formal versus informal mentoring, and the idea that mentors should provide advice on promotion and grants. Males valued advice on finances while females wanted advice on work-life balance. Role models were viewed as important for retention, and a paucity of mid-career, female researcher role models suggested a gap to be filled in future programmatic efforts (Steele et al, 2012a). A significant majority of junior faculty had experienced a mentor (Steele et al, 2012a) which is in contrast to other studies (Freiman et al. 2005; Palepu et al. 1998; Sambunjak et al. 2006 in Steele et al, 2012a). The study also found that mentorship emerged as an important factor in faculty recruitment consistent with other studies (Benson et al. 2002; Bilbey et al. 1992; Feng & Ruzai-Shapiro 2003; Lynch & Harrell 1974; Rubeck et al. 1995; Sanders et al. 1994 in Steele et al, 2012a). Similarly, mentorship proved important for retention, although there were a number of views on the current adequacy of mentorship in departments. Junior female faculty did not think there was a shortage of female role models, which is in contrast to the literature which indicates a lack of available role models for women faculty (Swenson et al. 1995 in Steele et al, 2012a), with the exception of mid-career researcher female faculty. This contrast may be due to the increase in women entering academics through the years since the 1995 era (Steele et al, 2012a).

A qualitative study of Canadian clinician scientists who were awarded early career support from provincial funding agencies found that female mentees expressed the challenge of finding mentors who could help provide them with guidance around work and life balance, and timing of maternity leave (Straus et al, 2009). In another qualitative study, conducted between 2010 and 2011, of 100 former U.S. National Institutes of Health, mentored career development awardees and 28 of their mentors, female participants acknowledged the importance of having at least one female mentor. These female participants felt that women could provide guidance on specific issues such as workplace communication in a male-dominated environment,

boundary setting, negotiation, and managing the demands of career and family life (DeCastro et al, 2013). DeCastro and colleagues also noted the importance and composition of mentor networks and the need to cultivate more than one mentor; the members of each faculty member's mentoring team or network should reflect the individual's needs and preferences with special attention toward ensuring diversity in terms of areas of expertise, academic rank and gender. Women may benefit more from mentoring relationships that are less hierarchical, more encouraging and collaborative in contrast to a more male-oriented challenging and competitive approach (Robinson and Cannon, 2005). This is rooted in gender differences in socialization that emphasize support and collaboration for females rather than independence and competition (Gilligan,1982). Nevertheless, these stereotypic characteristics may best serve healthy personal and organizational growth where they are combined and tempered with one another so that competitiveness and ambition is delivered with flexibility, nurturing, generous information sharing and collegial mutual support (Fisman, 2013).

MENTORSHIP

A mentor has been defined as someone of advanced rank or experience who guides, teaches, and develops a less experienced person or a novice (Carr et al 2003 in Zerzan et al, 2009). Mentoring is based upon relationships between people. Typically this has been between an instructor and a learner and is affected by what each individual brings to the relationship (Canadian Coalition for Global Health Research, 2007; Baldwin et al, 2011). The mentorship relationship is reciprocal, dynamic, collaborative, sustained, dedicated and requires a genuine personal commitment in order to be successful (Healy & Welchert 1990; Baldwin et al, 2011). Adequate time spent together and active listening and questioning with the development of a psychological climate of trust, are essential ingredients of an engaged mentorship relationship. In return for the dedication, the mentor gains a sense of personal satisfaction and collegial respect (Chesler & Chesler, 2002). Berk et al, 2005 define a mentoring relationship as one

> that may vary along a continuum from informal/short-term to formal/long-term in which faculty with useful experience, knowledge, skills, and/or wisdom offer advice, information, guidance, support, or opportunity to another faculty member or student for that individual's professional development (Note: This is a voluntary relationship initiated by the mentee.)

Mentoring is most traditionally a developmental relationship and while it can serve multiple functions, there are two broad categories of support that mentors provide which include: 1) career related technical support; and 2) psychosocial support (Kram, 1985). The more technical aspects of mentorship support can include specific knowledge based career development issues that apply to intellectual growth in the field, career pathways, work plans and the more hidden "organizational rules"

such as dress code and social norms. Addressing psychosocial needs of the mentee recognizes difficulties with peer or faculty relationships and managing conflict, other organizational issues such as discrimination, and challenges in work life balance (Chesler and Chesler, 2002).

It is increasingly recognized that alternative mentorship models to the all-inclusive single mentor-mentee relationship, can have a better chance of meeting a mentee's diverse needs (Ragins and Cotton, 1999). While faculty time intensive, the advantages of a mentorship committee or team outweigh that of a lone mentor in creating a group with varying strengths that the mentee can tap into. With an emerging younger generation "Y" who have a different mindset and a greater diversity of needs compared with a predominant Generation "X" or "Baby Boomer" culture who are likely to be the current mentors (Lancaster 2004) having multiple mentors would potentially be particularly beneficial to the mentorship process. In a further evolution of both the single and multiple mentoring model referred to as "Collective Mentoring", it is senior colleagues and the department administration that develop the mentorship committee, drawing on the expertise of knowledgeable faculty (including female faculty). There is a clear message about the priority of the mentee's progress and sensitivity to their individual academic and personal needs. Peer mentoring is another alternative that serves to build community and is non-hierarchical. It is best utilized in an adjunctive capacity to more formal mentoring alternatives which complement the lack of experience and expertise that is likely within a group of peer mentors (Chandler, 1996).

The rewards of mentoring have been identified as manifold: benefiting mentees, mentors and the organization. Mentees benefit by learning about networking, negotiation skills, conflict management, academic writing and presentation skills. In addition, the academic identity of the mentee evolves and they are better able to plan and anticipate their career trajectory. Mentors benefit by gaining satisfaction from participation in the mentee's development process as well as sharing experiences and learning with and from junior colleagues. Mentors also become part of a support network of senior doctors. Both mentees and mentors develop personally and feel valued resulting in provision of better patient care. The latter benefits the organization (Taherian et al. 2008). In addition institutional change in the direction of a more positive organizational culture may occur as a result of an improvement in morale (Chesler and Chesler, 2002).

ROLE MODELS

Role model is defined as "a person whose behavior in a particular role is imitated by others" (Merriam-Webster Dictionary 2013). A role model is a person who teaches by example and someone who influences professional identity (Kenny NP et al, 2003). The process of role modeling requires identification with a mentor (Kram, 1985 in Allen et al, 2006) which is facilitated when individuals share things in

common (Ragins, 1997 in Allen et al, 2006); for example, similarity in academic rank (Allen et al, 2006). Role modeling may also occur when that individual holds a position that the faculty member next aspires to (Allen et al, 2006). Mentoring often includes role modeling; however, role modeling is less intentional, more informal and more episodic than mentoring (Kenny et al, 2003). There appears to be a dearth of studies on role models in academic medicine and this may in part be due to a lack of distinction between the terms role model and mentor in existing studies (Steele et al, 2012).

MENTORING PROGRAMS:

Several studies have addressed the role of mentoring in improving women faculty retention by implementing faculty development mentoring programs. In a Department of Medicine, St. John's University School of Medicine, Baltimore, United States where there was attrition of women faculty, interventions including mentorship for junior faculty, resulted in an increase in retention and promotion of women faculty by 550% over 5 years (Fried et al.1996 in Steele et al, 2012a). Creighton University School of Medicine, Omaha, Nebraska, United States implemented a mentoring program for junior women faculty and for underrepresented minorities. The five-year retention rate for the first year of the mentoring program was 58%, as opposed to 20% prior to implementation of the program (Kosoko-Lasaki et al. 2006 in Steele et al, 2012a).

In 1995, the Executive Leadership in Academic Medicine (ELAM) program was developed at Drexel University in Philadelphia, Pennsylvania, United States to assist senior women faculty, who are associate or full professors, to become senior academic medicine leaders. Mentorship is an integral component of the ELAM program as the fellows participate in learning communities of women which act in some ways as peer mentors. There are other activities in which the fellows are mentored by senior women leaders (as in Collective Mentoring). The success of the program has been evidenced by a large number of graduates assuming senior leadership roles (ELAM® Fast Facts, Drexel University College of Medicine, 2011). The University of Pennsylvania, United States developed a women's health research program in 1997. Soon after its institution a mentoring component was added and since its implementation there been an increase in the number of women being promoted to senior ranks (Hoover, 2006).

A pilot mentoring program was developed at the Institute of Psychiatry, King's College, London, England involving female mentees who were matched with a mentor (male or female). Both mentees and mentors were provided with training and the mentoring pairs were advised to meet between four and twelve times per year. Online surveys were completed to compare health-related and attitudinal measures and expectations of mentoring at baseline with outcomes at 6 months and one year. Job-related well-being, self-esteem and self-efficacy all improved significantly and work-family conflict diminished at one year. For mentees, expectations at

baseline were higher than perceived achievements at 6 months or one year follow-up. The authors concluded that mentoring can contribute to women's personal and professional development (Dutta R, et al, 2011).

At the Schulich School of Medicine & Dentistry, The University of Western Ontario (Western), London, Canada a formalized mentorship program was developed at the request of the Clinical Teachers Association (CTA) at Western when a new framework was being implemented for clinical full time academics. This required that they be formally placed into an academic role category (i.e. Clinician Teacher, Clinician Educator, Clinician Researcher, Clinician Scientist, or Clinician Administrator) (Schulich School of Medicine & Dentistry, The University of Western Ontario, 2009). As a result, the Schulich Mentorship Program was developed in 2010 through establishment of an institutional policy that every new faculty member or any faculty member assuming a new academic role category must be offered a mentorship committee. It was the decision of the faculty member whether they chose to participate (Schulich School of Medicine & Dentistry, The University of Western Ontario, 2010). The Schulich Mentorship Program also provided guidelines around developing the mentorship committee. The program does not preclude other types of mentoring such as peer mentoring or individual mentoring.

In order to evaluate the potential benefits of the mentorship program for mentees, mentors and the larger institution, the mentorship program will be evaluated annually for five years. To this end, on-line surveys were sent to the faculty members after one year to obtain mentor and mentee perspectives on how well the program is being implemented and working from their respective perspectives. Despite a small response rate, results indicated that mentees believed the Mentorship Program clarified expectations about professional roles and responsibilities particularly with respect to progression to promotion and tenure and support from an established faculty member. Both mentors and mentees consistently agreed that the mentorship committee was beneficial as it: allowed the mentee to learn about the environment; assisted with networking; fostered academic achievements through research activities and education activities; improved the mentees' administration skills (e.g. meeting management, time management); and enhanced career satisfaction and career development and growth. The predominant challenges that the mentees experienced were difficulties with mentor/mentee relationships particularly the inability to find mentors interested in the mentees' academic work, communication barriers and the availability of mentorship committees for meetings. The results suggest that the institution of a formal mentorship program in a medical\dental school can benefit both mentors and mentees by establishing relationships, building skills, and enhancing professional knowledge (Steele et al, 2012b).

CONCLUSION

Mentorship has emerged as an important strategy for both attracting and retaining young faculty in academic medicine. It is also a potentially valuable tool in the

promotion and career development process. While this is important for both males and females, the added pressure on junior female faculty to manage their careers and families requires a concerted effort with different mentorship strategies than those that may work for their male counterparts.

Mentorship that is ensconced in institutional policy with clear faculty support and direction, and tailored to serve the needs of individual faculty, is more likely to result in an academically successful and personally rewarding career trajectory. This may include clearly prescriptive academic role categories which take into account the particular strengths of individual faculty.

Moreover, an institutional culture that supports an "androgynous approach" to faculty development, blending individual ambition with collective support and collaboration, will be more conducive to the delivery of successful mentorship.

Ultimately, mentorship as we have outlined in this chapter is necessary in academic medicine to prevent both "leakage"and "blockage" of the promotion "pipeline", so that over time the goal of a gender equal professoriate, that is congruent with the overall proportion of females entering a medical career, can be achieved.

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