FREE*

*FACULTY RESOURCES FOR EDUCATIONAL EXCELLENCE

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Faculty Mentorship

Mentorship is a critical necessity for faculty personal and professional development. While it can be formal or informal in nature, mentorship has been shown to enhance faculty career satisfaction, productivity, and social connection.[1] Additionally, mentorship relationships have been shown to improve teaching, enhance clinical practice, promote communication, and foster reflection.[2] Maintaining a positive faculty mentorship experience requires the development of meaningful relationships through regular correspondence, both electronic and in-person in nature.[1]

Building faculty mentorship relationships provides a meaningful mechanism to support and promote our faculty in their complex roles. Additionally, faculty mentorship relationships foster collaboration, the development of best practices, and expand research endeavors. While the faculty mentorship experience can be positive for both the mentor and mentee, there are many challenges when it comes to finding the best mentor/mentee match. Lack of mentoring can result in obstacles related to growth and development for faculty within academic medicine such as opportunities for promotion, skills acquisition, and enhanced enthusiasm for continuing in their role.[3]

Mentorship opportunities play an important role in ensuring faculty have the necessary support to achieve academic success and excellence throughout their careers. There is no standard model for faculty mentorship and no one-size-fits-all mentorship pathway, so it is important to look for tailored faculty mentorship opportunities to support the various important roles faculty play throughout the academic system. Faculty mentorship can include a myriad of areas that contribute to their roles such as work-life integration, promotion/career advice, diversity and inclusion, research, teaching, and clinical needs.

UC Berkley outlines some principles and best practices for faculty mentoring that are intended to help faculty meet high standards of rigor, depth and innovation in scholarship, and to realize their full potential as scholars, teachers, and members of the academic community.[4] Below are some of their best practices that may be helpful as you engage in a faculty mentorship relationship.

Best Practices for Faculty Mentoring:

1. Develop a mentoring plan with your Chair or Dean that includes participation by several members of the department and external faculty. This should serve as a helpful exercise to outline mentorship needs related to teaching, clinical responsibilities, research, and more.
2. Foster a "climate of mentoring" within your Department by engaging in collegial conversations and informal mentoring.
3. Create opportunities to engage with faculty from different levels of expertise and experience to build community.
4. Recognize collaborative and interdisciplinary work as a unique form of mentorship.
5. Identify opportunities to connect regularly with your Chair or Dean to review goals and progress.
6. Identify resources (both internal and external)to help support formal and informal faculty mentoring needs that are inclusive to all.
7. Mentor by example through role-modeling in all settings.
8. Expand and share knowledge about mentorship.

Faculty mentorship supports the relevant needs, resources, recognition, and relationships that are critical to the success of faculty. In an effort to foster faculty mentorship across the organization and increase access to mentoring support, an electronic survey will be distributed in the coming weeks to all faculty aimed at gauging current faculty mentorship opportunities, responsibilities, and needs across the organization. **Please take a few minutes to complete this survey to help support the development of faculty mentorship resources and opportunities.**

- Mariah Rudd, BS (Director, Office of Continuing Professional Development)

References:

1. Haggins, A., Sandhu, G., & Ross, P.T. (2018). Value of near-peer mentorship from protégé and mentor perspectives: a strategy to increase physician workforce diversity. Journal of the National Medical Association, 110(4), 399-406.
2. Bell, A. E., Meyer, H. S., & Maggio, L. A. (2020). Getting better together: a website review of peer coaching initiatives for medical educators. Teaching and learning in medicine, 32(1), 53-60.
3. Files, J. A., Blair, J. E., Mayer, A. P., & Ko, M. G. (2008). Facilitated peer mentorship: a pilot program for academic advancement of female medical faculty. Journal of women's health, 17(6), 1009-1015.
4. Adapted from the University of Michigan College of Literature, Science and the Arts (LS&A)*Junior Faculty Mentoring and Third-Year Reviews: Principles and Best Practices: A report to chairs, directors, and faculty* from Dean Shirley Neuman, June 18, 2001

"If you cannot see where you are going, ask someone who has been there before." - J. Loren Norris

Dean's Corner

Last year, the Dean's Corner focused on the principles of Health Systems Science. The focus for the remainder of this year will be Diversity, Equity, and Inclusion and will be authored by Azziza 'Kemi' Bankole, MBBS, Carilion Clinic psychiatrist and VTCSOM associate professor of psychiatry and behavioral medicine and chief diversity officer. Dr. Bankole devotes this month to the effects of discrimination.

What Makes Us Better?

It is often thought that discrimination only hurts the target of the discrimination. The fact is, discrimination hurts everyone. It is apparent that it does not affect everyone equally, and the target (or targeted community) will experience the worst outcome of such discrimination. This is not an abstract concept. Discrimination has had and continues to have real life consequences that have been felt far beyond the initial targeted community.

The subprime mortgage crises is such an example. It contributed significantly to the "Great Recession" of 2007-2008, and its worldwide impact foreshadowed the impact of the current COVID-19 pandemic. Subprime mortgages became a hot commodity for financial institutions in the 1990s. Rugh and Massey posit that "*residential segregation created a unique niche of minority clients who were differentially marketed risky subprime loans that were in great demand for use in mortgage-backed securities that could be sold on secondary markets*".[1]

Redlining and other forms of institutional discrimination made it easier to carve out the neighborhoods that these mortgages were marketed to and had significant negative impact on the borrowers from when they obtained the loans to foreclosure. A critical look at subprime mortgages should have sent out warning signs that they were a bad, if not terrible, product. However, because they could be sold as mortgage-backed securities in other markets they were deemed profitable and so were able to expand beyond the initial targeted population.

In the wake of the Great Recession one of my patients made a statement that has stayed with me since. He said "I've lost everything. If I was 40 years old, I could start again. What can I do now?" Here was an 80 something year old upper middle-class Caucasian man living in leafy suburban Long Island in the midst of his first major depressive episode asking a profound question. Discrimination hurts everyone. It has been shown that lenders who sold more subprime mortgages to Black and Hispanic borrowers were more likely to have gone bankrupt than those who did not.[2] Rugh and Massey conclude "*Ultimately, the racialization of America's foreclosure crisis occurred because of a systematic failure to enforce basic civil rights laws in the United States.*" [1]

This non-clinical example illustrates how discrimination affects the whole of society but there are numerous examples that we encounter routinely in medicine including gender and racial disparities in ADHD diagnosis and treatment, racial and ethnic disparities in transplant services, and of course with COVID-19. As clinicians our prime directive is *primum non nocere*. First, do no harm. The fact is, discrimination based on race or ethnicity, age, gender and gender identity, sexual orientation, disability, socioeconomic status, geographical location and other factors hurts everyone.

Understanding the impact of discrimination on others should be enough for us to work towards ending such practices. Diversity is our strength. It makes us better. Diversity is clearly manifested in one aspect of medicine that we see every day. Just imagine a world in which all doctors were geriatric psychiatrists! That sounds frightening even to me, a geriatric psychiatrist. Increasing diversity in medicine improves patient experiences and outcomes; it improves innovation and even financial returns.[3] In short, diversity makes us better.

- Azziza 'Kemi' Bankole, M.B.B.S. (Chief Diversity Officer)

References:

1. Rugh JS, Massey DS. Racial Segregation and the American Foreclosure Crisis. American Sociological Review. 2010;75(5):629-651. doi:10.1177/0003122410380868
2. Avery R, Bhutta N, Brevoort K, Canner G, Gibbs C. The 2008 HMDA Data: The Mortgage Market During a Turbulent Year (April 28, 2010). Federal Reserve Bulletin. Available at SSRN: https://ssrn.com/abstract=1480830
3. Gomez LE, Bernet P. Diversity improves performance and outcomes. J Natl Med Assoc. 2019;111:383–392.DOI: 10.1016/j.jnma.2019.01.006.

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