Fostering Diversity in Emergency Medicine through Mentorship, Sponsorship, and Coaching

An Information Paper

INTRODUCTION

The diverse population of the United States encompasses a kaleidoscope of races, ethnicities, gender identities, sexual orientations, generational values, religions, socioeconomic backgrounds and experiences. In the medical field and in emergency medicine specifically, our workforce diversity is critical to the delivery of quality healthcare.[1] Emergency medicine strives to mirror the population we serve. Diversity facilitates better rapport and culturally sensitive, empathetic communication with patients and their families. Despite the benefits of diversity, emergency medicine has yet to achieve a workforce and leadership paradigm that comprehensively represents our patients and practitioners.

Recognizing the goal of a diverse workforce in emergency medicine, we sought to identify the best practices for promoting full participation and leadership in emergency medicine by underrepresented minorities (URM). In this concepts paper, we explore the roles that mentorship, sponsorship and coaching play in developing a vibrant community of practitioners and leaders. Additionally, we offer recommendations for institutions and organizations seeking to build a true delivery pipeline for URMs in emergency medicine, from medical education through the highest ranks of leadership.

CURRENT STATE OF DIVERSITY IN MEDICINE AND EMERGENCY MEDICINE

Medical Education

Physician workforce diversity begins with the matriculation of diverse learners into our medical education system. According to the Association of American Medical Colleges (AAMC) 2016 Facts & Figures report on diversity in medical education, the majority of medical school graduates continue to be white. In recent years, significant gains have been made in female enrollment.[2]

- In 2016, enrollment in medical schools was equal for women (49.8%) and men (50.2%).
- Racial and ethnic differences in medical school acceptance rates persist. In 2016, Black or African American applicants had a 34% acceptance rate, compared to Hispanic/Latino and Asian applicants (42%) and White applicants (44%).
- Attrition during medical school did not appear to be significant for black or African American students; the 2011 matriculation rate of 6.1% was similar to the 2015 graduation rate of 5.7%. However, there was a notable loss of Hispanic/Latino students during medical school, with a matriculation rate of 8.5% in 2011 but a graduation rate of only 4.6% in 2015.[2]
- Underrepresented ethnic and racial minorities were more likely to represent a wider distribution of socioeconomic backgrounds, including a greater proportion of those raised in households with annual incomes less than $50,000 as compared to their white counterparts.[2]

Medicine

Ethnic and racial minorities represent 32% of patients in U.S. hospitals, which is comparable to the demographics of the general U.S. population (37% minority representation).[3] Patient data is largely unavailable for underrepresented minority groups defined by religious preference, sexual orientation and other ethnic subpopulations.

Based on 2013 workforce data, U.S. physician diversity remains relatively constant and the gains that have been achieved are not keeping pace with the demographic shifts of the U.S. population, with projected minority majority population by 2050.[4,5] For instance, African-Americans comprise 13% of the nation's population, but only 4% of physicians. [4] Overall, approximately 8.9% of physicians identify as black or African-American, American Indian, Alaskan Native, Hispanic or Latino.[4]

Emergency Medicine

Based on AAMC data for 2007, an analysis of URMs in emergency medicine concluded that racial and ethnic minorities (excluding Asians) were under-represented in emergency medicine residencies compared to other specialties.[6] A survey of 110 emergency medicine residencies in 2013 estimated the median percentage of URMs per program was 9%. Program directors cited the lack of URM applicants as the most significant barrier to recruitment.[7] Women account for approximately 37% of emergency medicine residents.[8]

Leadership Statistics

- **Medical Education:**
  More than three-quarters of full-time faculty in United States medical schools are white (63%) or Asian (15%). Black or African American (3%) and Hispanic/Latino (4%) educators represent only a small contingency of medical school faculty. Women account for approximately 39% of full time medical faculty.[2]

- **Medicine:**
  Few gains have been made in the diversity of hospital leadership teams and governing boards since 2013. One study found that "the percentage of minorities on boards in 2015 was 14% - the same as 2013 and minorities in executive leadership positions was 11% in 2015, a 1 percentage point decrease from 2013." During this same period, hospitals did diversify their first and mid-level management positions, with a 4% increase since 2011 to a 19% minority leadership in 2015.[3]

- **Emergency Medicine:**
  Internal ACEP data suggests significant deficits in national emergency medicine organization involvement and leadership by URMs. "Women represent 26% of ACEP membership, 28% of committee members, 26% of committee chairs, and 27% of council members. In senior leadership, 12.5% are current board members; 10% are state chapter presidents. African Americans represent only 1% of ACEP membership. Hispanic/Latinos represent 1.5% of ACEP membership."[5]

STARTING A DIVERSITY PROGRAM: THEORY AND PRACTICE

Individual programs aimed at increasing diversity in subsets of the medical field have been well described in the medical literature but comprehensive, data driven, proven components of successful programs are limited. Nevertheless, a review of both business and medical literature has highlighted elements believed to be important to successful diversity strategies.

Unsuccessful Strategies

Mandatory diversity training aimed at addressing implicit and explicit bias has been a common strategy employed by both business and healthcare. The 2015 benchmarking study on diversity in U.S. hospitals reported that 79% of hospitals educate all clinical staff on cultural competency, while 40% of hospitals have guidelines for "incorporating cultural /linguistic competence into operations in their strategic plans." [3]

However, these strategies have not improved the diversity of executive leadership in business. One analysis of 30 years of data from 800 U.S. firms and interviews with hundreds of managers concluded that mandatory diversity training falls short because bias cannot be banned and benefits of such training are temporary.[9] Social science research also supports that behavior does not always change with rules and/or reeducation.[9] If diversity training includes negative messaging, mandatory diversity training may reinforce bias and promote negative effects. For instance, one company not only saw no growth, but experienced a decrease in African American women (-9%), Asian men (-4%), and Asian women (-5%) managers after implementing mandatory diversity training.[9] Voluntary diversity training has had greater success.

Successful Strategies

Diversity programs based on certain principles have been successful in business, often mitigating implicit and explicit biases. Key components of successful programs include: [9]

- **Engagement – establish "Diversity Champions":**
  Psychologists have found that people change their beliefs or behaviors to overcome "cognitive dissonance." With time, people's beliefs will match the behaviors they're being asked to practice.

- **Increased contact with diverse groups by establishing a common goal:**
  In World War II, close contact with African Americans in combat duty and the pursuit of a common goal changed perceptions of segregation.

- **Recruitment:**
  College recruitment has shown to increase diversity. Strong mentorship programs have proven to increase college recruitment.

- **Social accountability:**
  For instance, Deloitte wanted to decrease the attrition of female associates. They set up a high-profile task force that focused on transparency to change the culture. The task force asked each office to monitor the career progress and address the needs of its female associates. In eight years, female associate turnover declined; female partners increased from 5% to 14%; and 21% of Deloitte's global partners were women.[10]

Special Challenges in URM professional advancement

In one study that looked at URM advancement in academic medicine, unique challenges were identified:[11]

- Difficulty of cross-cultural relationships
- Isolation and feeling invisible
- Lack of mentoring, role models and social capital
- Disrespect, overt and covert bias/discrimination
- Different performance expectations related to race/ethnicity
- Devaluing of research on community health care and health disparities
- The unfair burden of being identified with affirmative action and responsibility for diversity efforts
- Leadership's role in diversity goals
- Financial hardship

Fostering Recruitment of URMs into Emergency Medicine

As noted earlier, recruitment of diverse trainees is critical to the success of a diversity pipeline. In 2008, the Council of Emergency Medicine Residency Directors (CORD) "developed a set of recruitment strategies

designed to increase the number of under-represented minorities (URMs) in Emergency Medicine (EM) residency," focusing on the racial and ethnic composition of residents in Emergency Medicine.[7]

These strategies include: [7]

- Verbally recognize the diversity present in the residency program when URM applicants arrive to interview.
- Express that the department welcomes and is actively recruiting students from diverse racial and ethnic backgrounds.
- Know the institution's local and community demographics, and address those needs.
- Broaden selection criteria beyond USMLE scores to include intangibles such as leadership, community service, and other life experiences.
- Develop curricula to address topics on diversity, cultural competence and implicit bias.
- Become involved in programs designed to increase the number of URMs entering into the field of medicine.
- Offer URM interview dinners and social events.
- Include diversity in recruitment material and institutional website.

In 2013, a survey was performed to evaluate the efficacy and adoption of the panel recommendations for diversity recruitment. This survey of 110 residencies identified several areas for improvement.[7]

- Only 46% of EM programs employed > 2 recruitment strategies.
- Resident diversity correlated with EM faculty diversity (OR 5.3), prioritization of applicant URM status (OR 4.9), engaging in pipeline activities (OR 4.8) and valuing extracurricular activities (OR 2.6).

PROPOSED FOUNDATIONAL COMPONENTS OF A SUCCESSFUL DIVERSITY PROGRAM

- ***Mentorship*** - a relationship in which a knowledgeable person helps to guide a less experienced person. Mentors can hold any position, but work "behind the scenes" to assist mentees with guidance and support. Goals are largely driven by the mentee.

- ***Sponsorship*** - the public support of a powerful, influential person for the advancement and promotion of an individual who has demonstrated potential.

- ***Coaching*** – the support of a learner in their efforts to achieve a specific personal or professional goal by providing training and guidance.

As Kathy Hannon, National Managing Partner for Diversity and Corporate Responsibility at KPMG, sagely put it, "A coach tells you what to do, a mentor will listen to you and [advise you], but a sponsor will talk about you." [12]

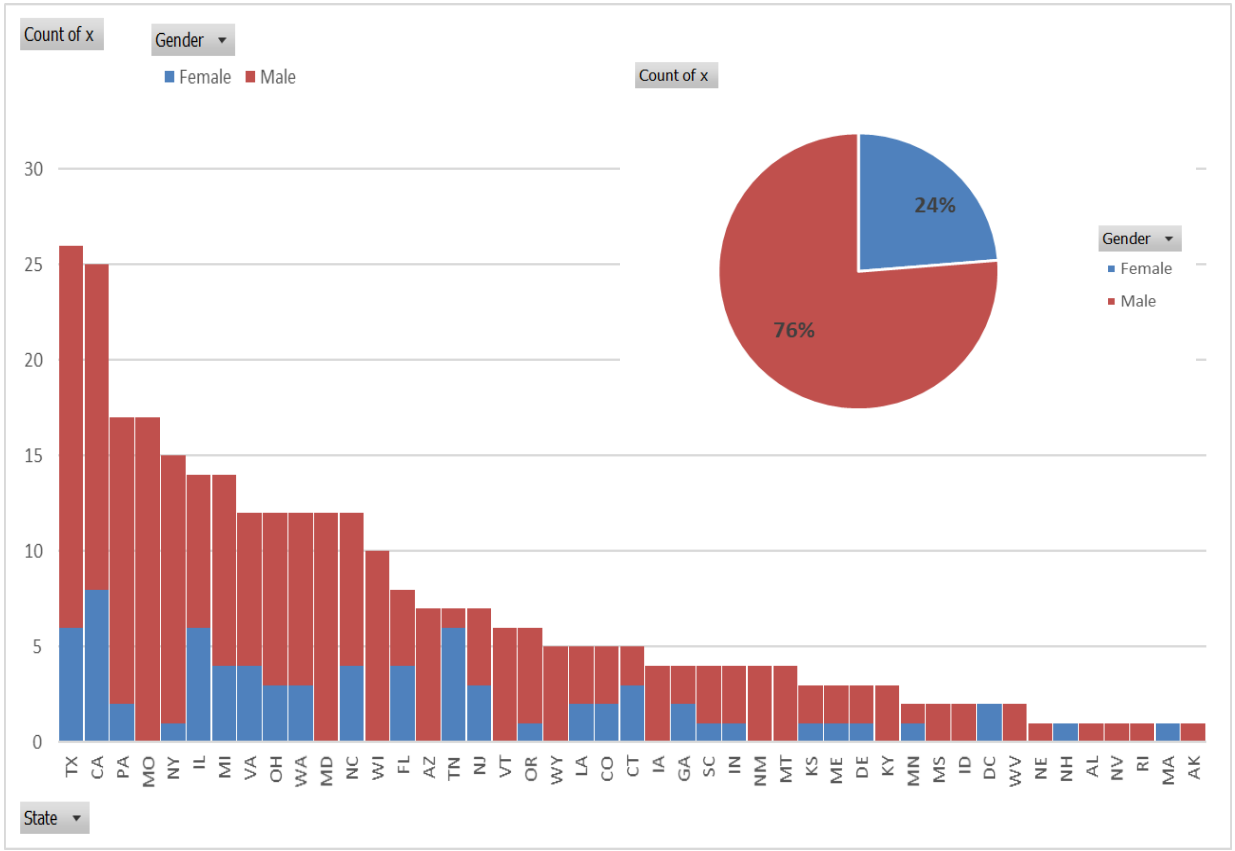
Mentorship – Building Sustainable Healthy Relationships

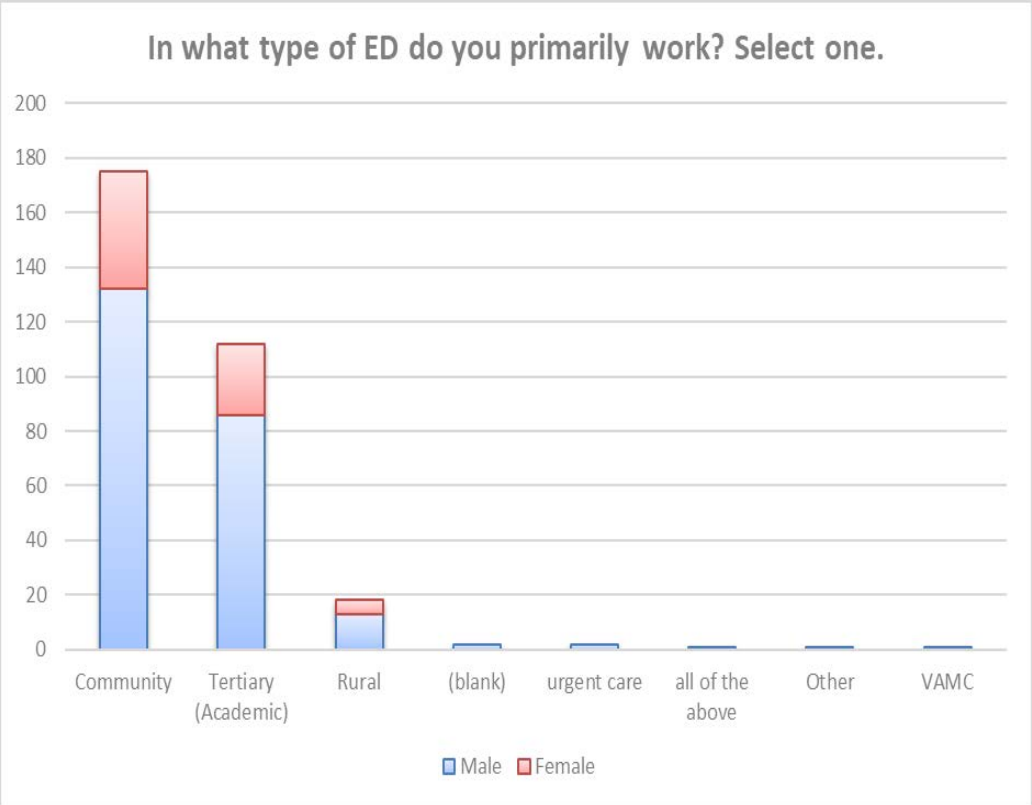
The idea of mentoring in education began in the 1980s as a way to assist the growth of novice educators. Business literature shows that mentorship is highly regarded and believed to influence job performance, career management, and leadership development. In both business and education mentorship, the concepts of "challenge" and "support" emerge. [13] Business mentoring often includes "stretch" assignments, sponsorship, professional exposure, acceptance, protection, and motivation that encourages a mentee's

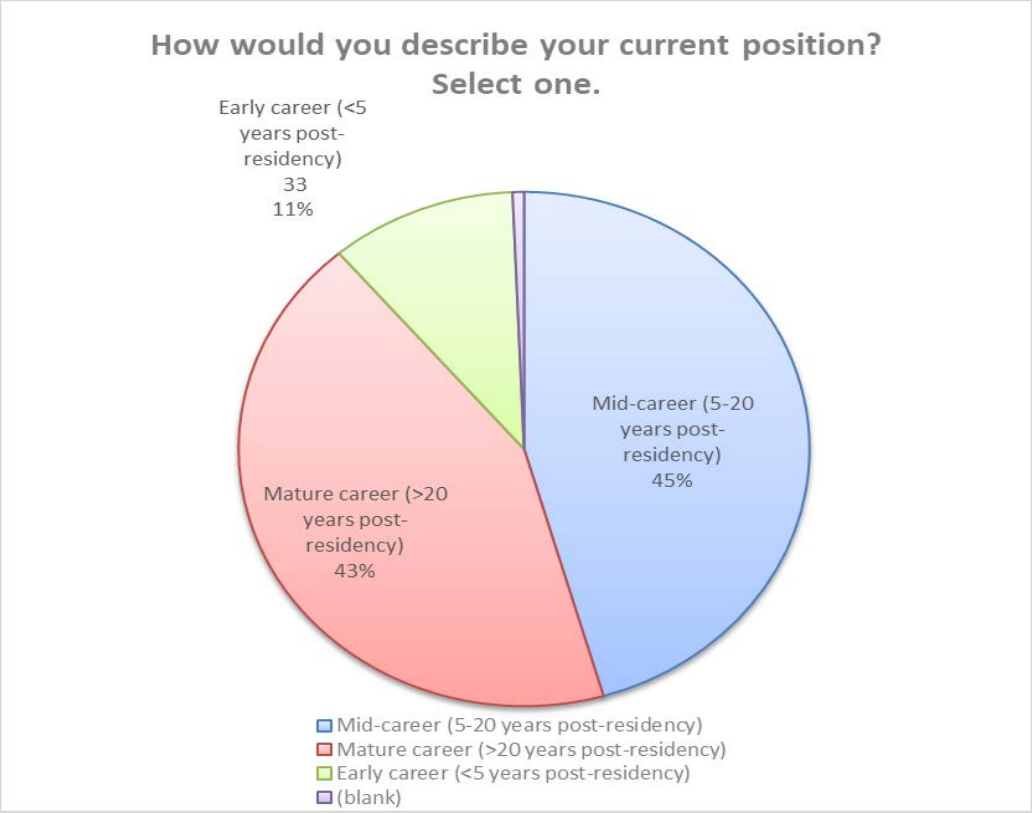
evolution. In comparison, mentorship in education focuses on reflection, assessment, mediating, and teaching to assist with the progression of novice educators. Eby and Allen noted that mentor-mentee relationships also provide interpersonal relationships that give a sense of belonging to participants.[14] This is particularly important for URMs who often report isolation as a barrier to professional development.[11]

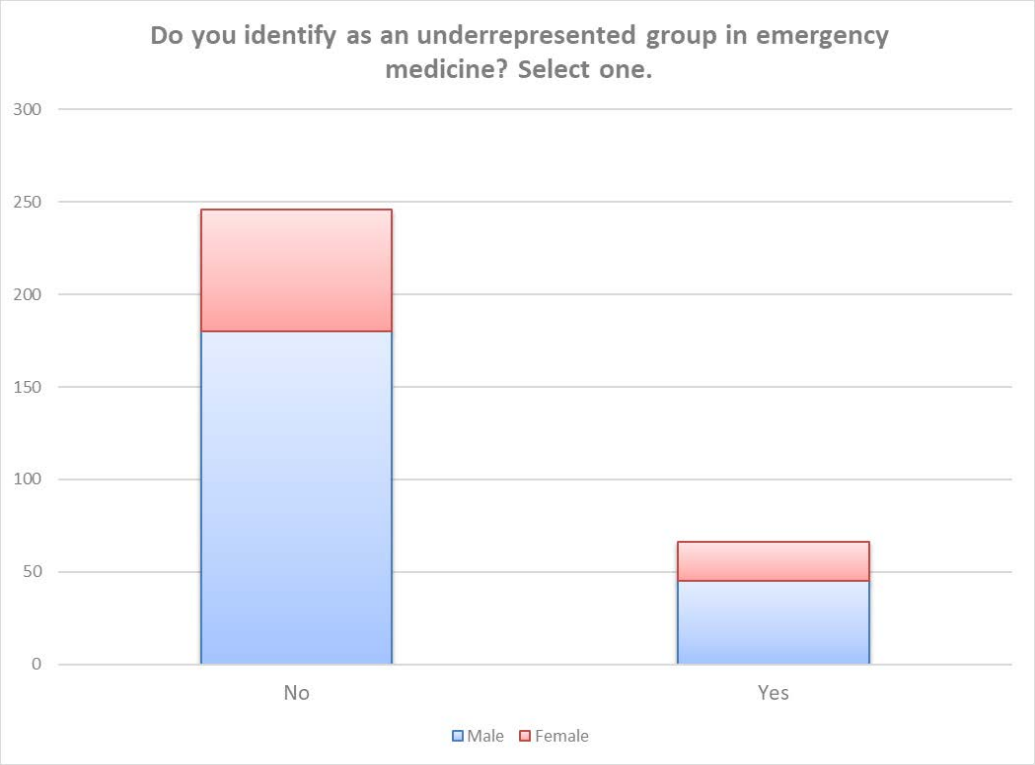
To assess the role that mentorship plays in the career development of emergency medicine practitioners, we sent a survey to 893 participants in ACEP's Emergency Medicine Practice Network (EMPRN) in March 2017. We received 301 responses. Practitioners were asked a series of questions regarding the role of mentorship in career development, their job satisfaction, and valued elements of their mentor-mentee relationships.

The 301 respondents represented a wide range of geographic regions, practice settings and experience. Approximately ¾ of respondents were male. Over half practiced in a community setting (55%) and rural practice represented only a small proportion of respondents (6%). Most physicians classified themselves as being mid-career (5-20 years post training) or having a mature career (>20 years post training). 21% self-identified as an URM on the basis of ethnicity, gender, religious preference, sexual orientation or age.

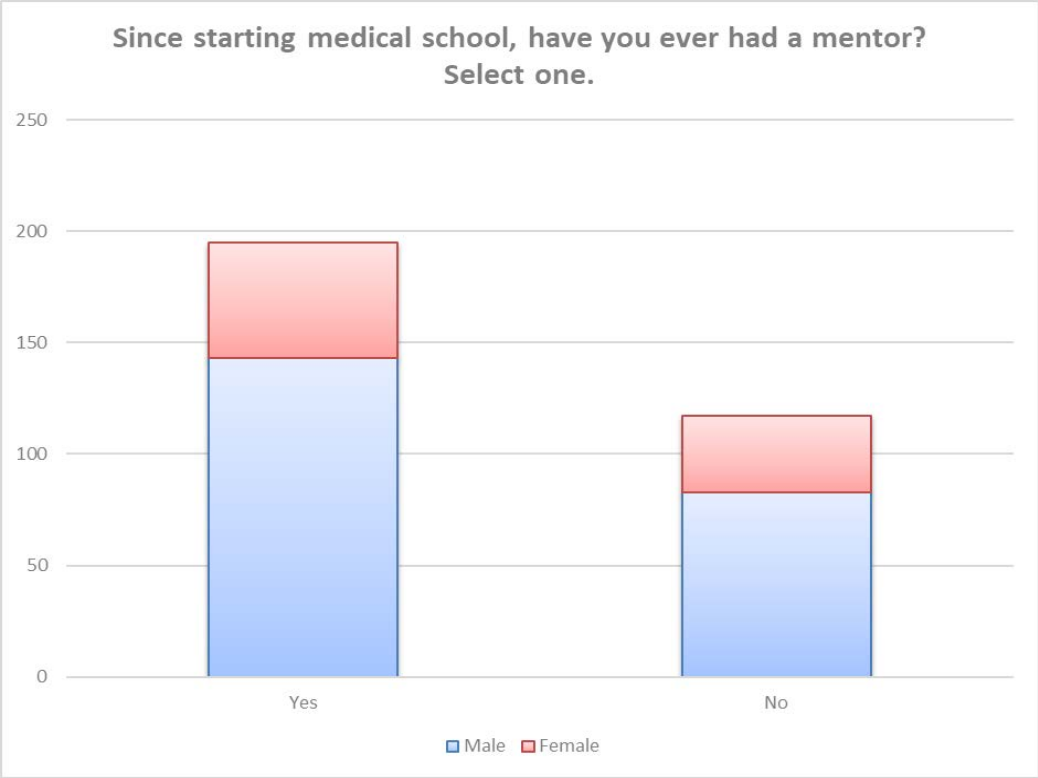


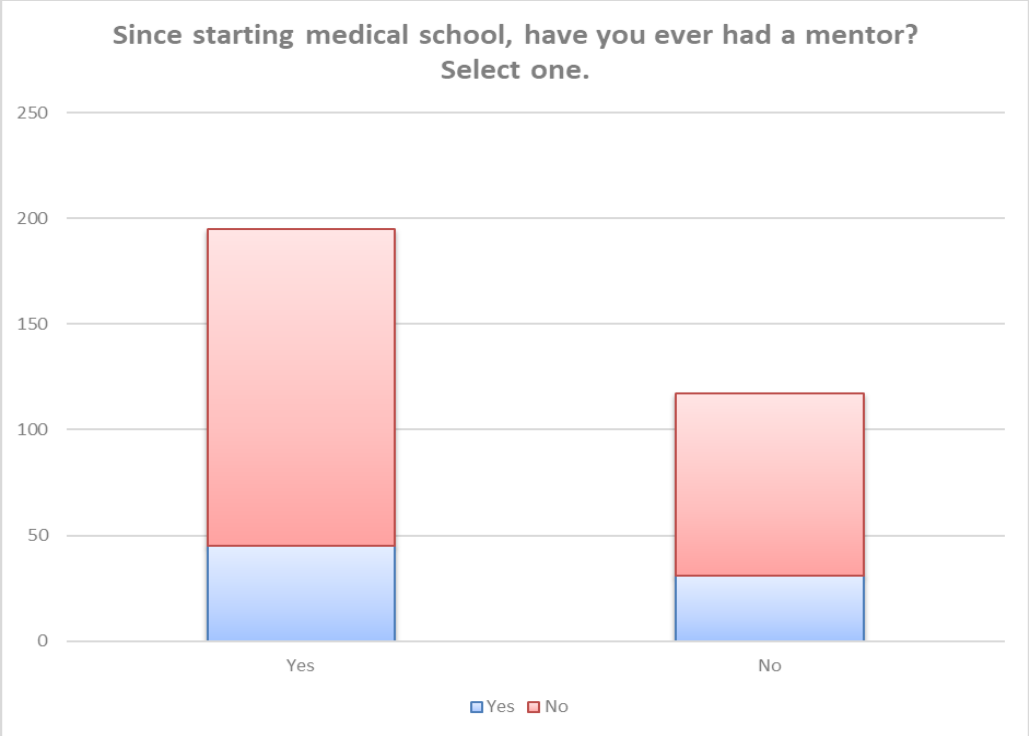

In what type of ED do you primarily work? Select one.
200
180
160
140
120
100
80
60
40
20
0
Community
Tertiary (Academic)
Rural
(blank)
urgent care
all of the above
Other
VAMC
Male
Female


How would you describe your current position? Select one.
Early career (<5 years post-residency) 33 11%
Mid-career (5-20 years post-residency) 45%
Mature career (>20 years post-residency) 43%
Mid-career (5-20 years post-residency)
Mature career (>20 years post-residency)
Early career (<5 years post-residency)
(blank)

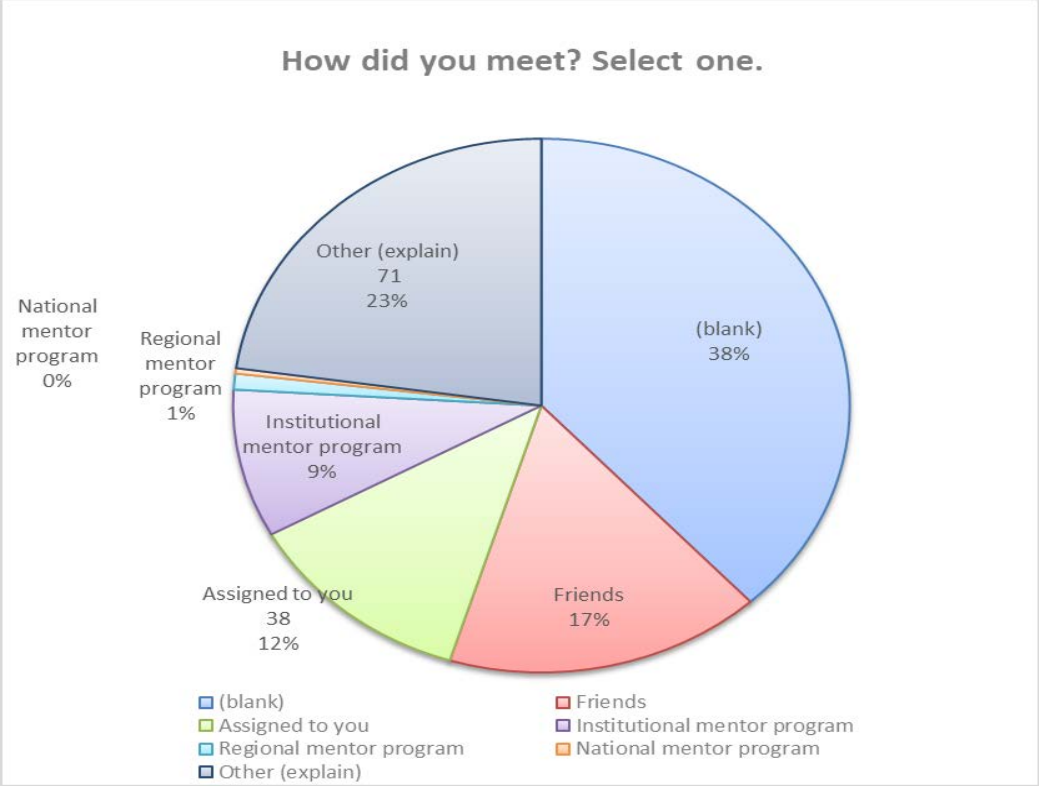


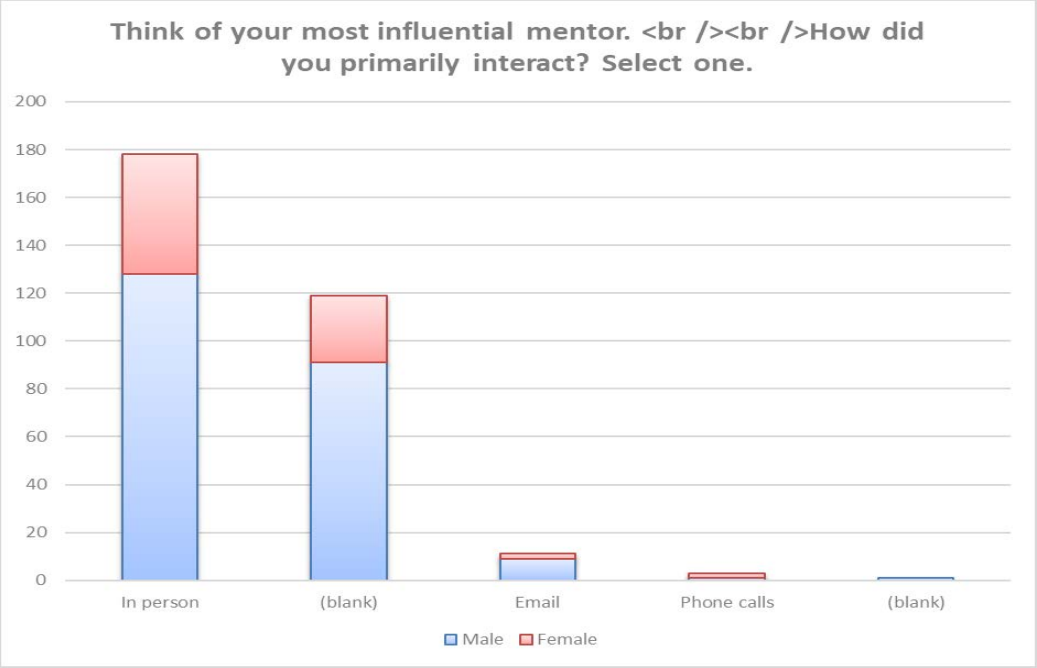
Most physicians sought out mentorship during their career. Women (67%) and those self-identified as URMs (59%) sought out mentorship more frequently than their male counterparts (53%).



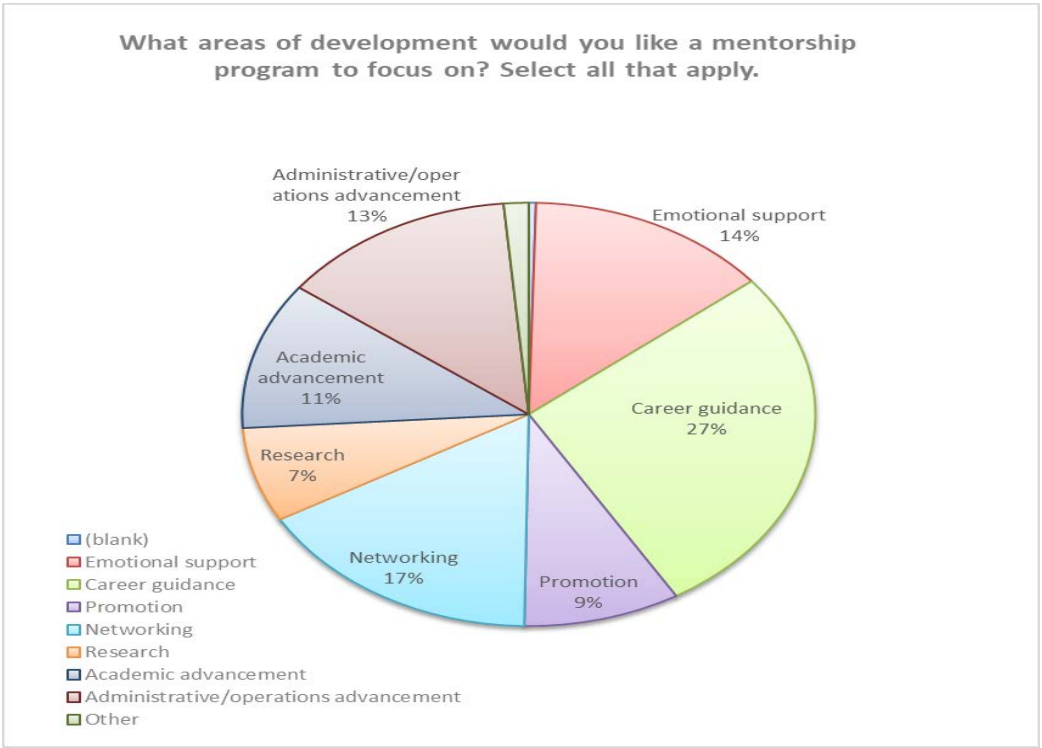


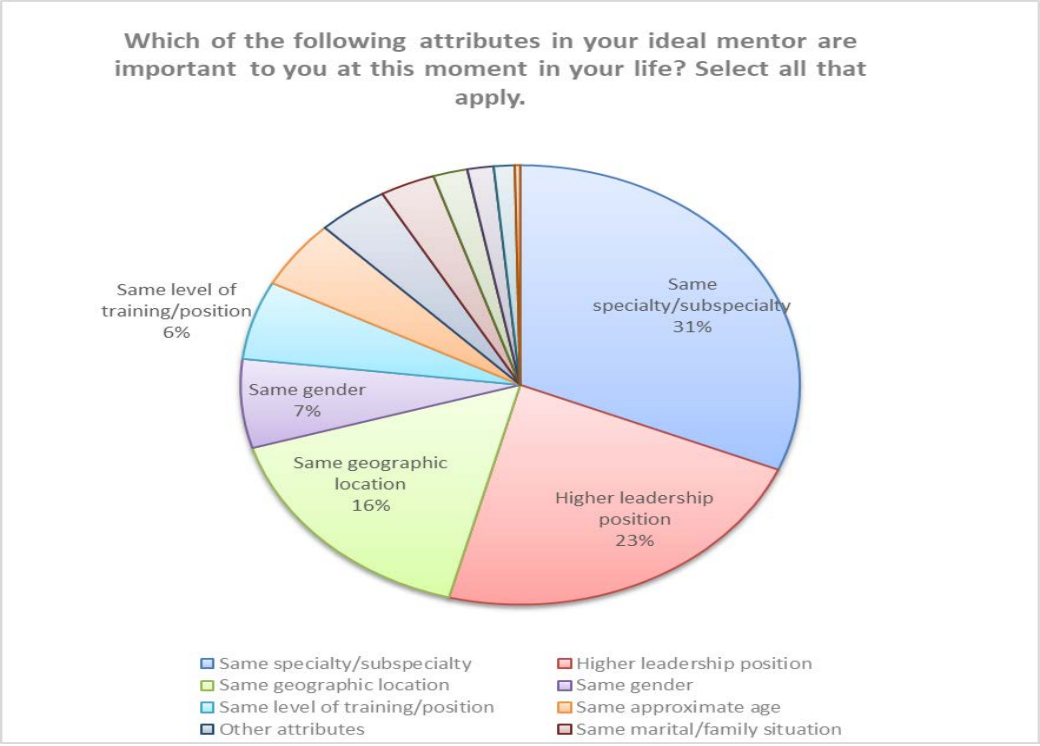
For those who described their introduction to mentorship, their mentor relationships began either through friends, an assigned mentorship, or networking experiences focused on residency/fellowship or common interests such as research. Mentees most commonly interacted with mentors in person.



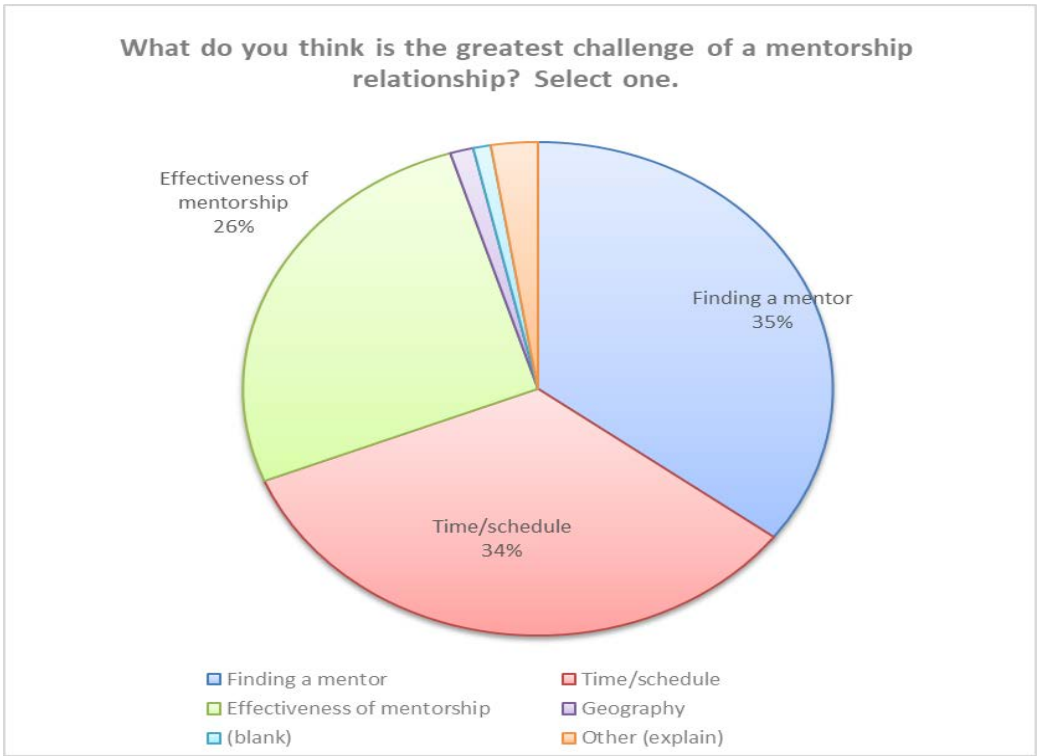


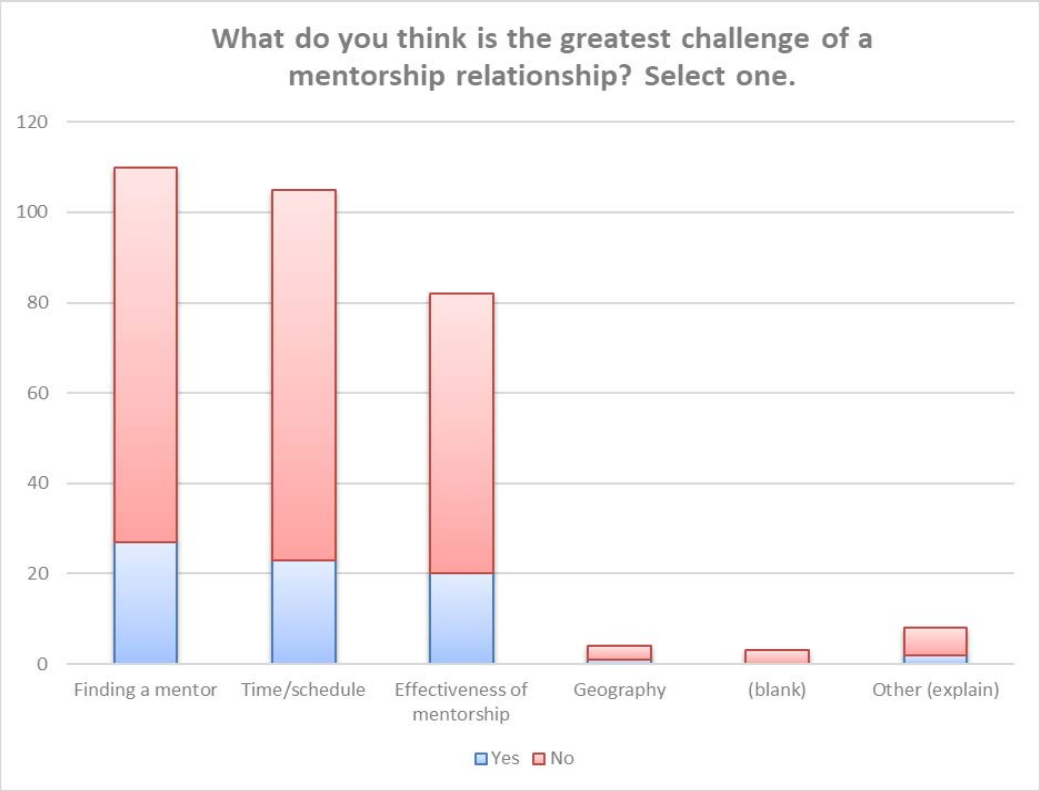
Areas of development that participants thought mentorship should address included career guidance (27%), networking (16%), emotional support (14%), and research (7%). Other needs that were identified and possibly better addressed through a sponsorship program included networking (16%), promotion (9%), academic advancement (12%) and administrative/operations advancement (14%). Respondents also identified several key mentor traits; these included a shared specialty (21%), higher leadership position (23%), same geographic location (16%), and same gender (7%).

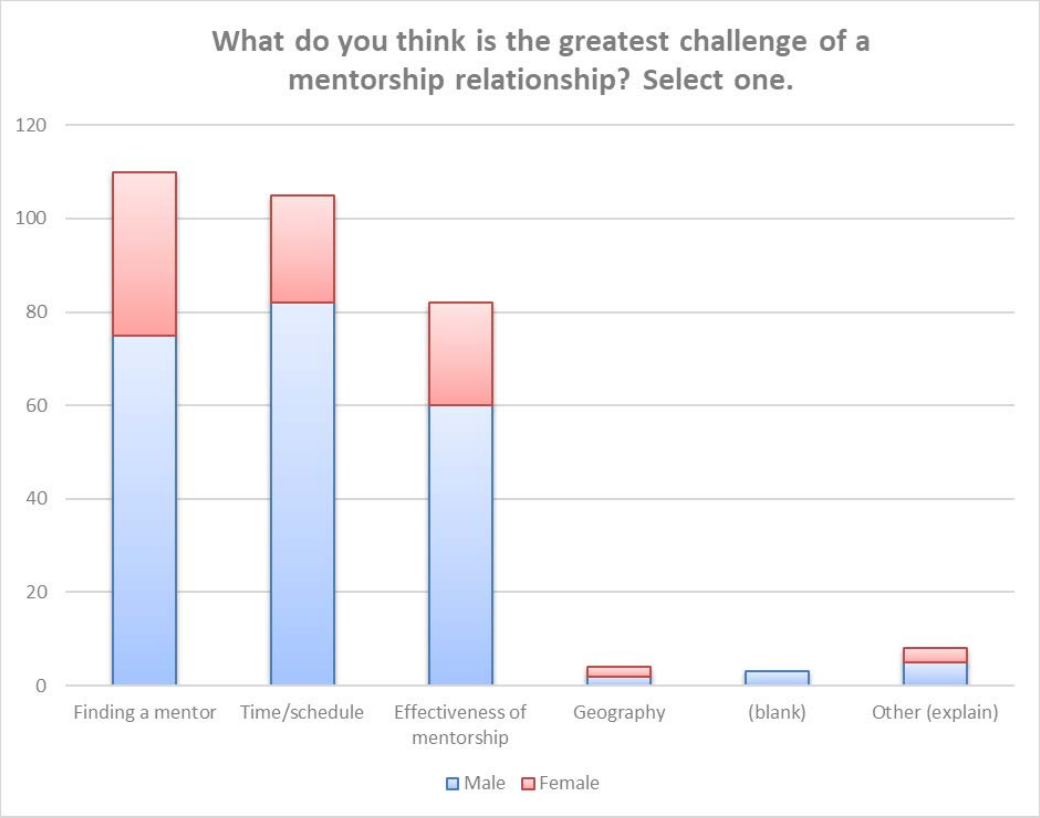




Finally, respondents pointed out friction points when establishing and maintaining mentor relationships. Other studies have also demonstrated that the most significant barriers to mentorship are time (both for mentors and mentees), lack of recognition for mentors, and lack of a formal process for selecting mentees/mentors.[22]




What do you think is the greatest challenge of a mentorship relationship? Select one.
120
100
80
60
40
20
0
Finding a mentor
Time/schedule
Effectiveness of mentorship
Geography
(blank)
Other (explain)
Yes
No


What do you think is the greatest challenge of a mentorship relationship? Select one.
120
100
80
60
40
20
0
Finding a mentor
Time/schedule
Effectiveness of mentorship
Geography
(blank)
Other (explain)
Male
Female

Components of Starting and Maintaining a Mentorship Program

Because there is no clear definition of what constitutes a successful mentoring program, it is difficult to study. Many mentor programs lack concrete structure or formal evaluation processes. This makes it difficult to form an objective statement on program efficacy. Furthermore, while mentoring is important for URMs who face unique challenges, relatively few publications exist for these specific populations.[15]

- **Goals and Objectives:**
  A successful program has clear and simple strategic planning. In some cases, programs fail because they focus on detailed tactics without understanding or agreeing on the overarching, "big picture" goal. The key is to define the goal and develop a strategic plan that supports it.

- **Administrative Support:**
  Often times, the person or group that develops a mentorship program does not have the time or resources to maintain it. Mentorship programs should have a clear organizer, succession plan for institutional memory, and administrative support to ensure their survival.

- **Defined Roles and Responsibilities:**
  A mentorship program requires basic structure and outlined roles and responsibilities. The program should provide resources (both organizational framework and ideally mentorship) for mentors to assist with unfamiliar questions and provide instruction regarding key topics. Although flexibility is often needed, basic expectations should be spelled out for both mentors and mentees.

- **Adequate Supply and Support of Mentors:**
  In general, fewer mentors exist than demand from mentees. Successful programs focus on outreach, marketing, and promotion to ensure a steady pipeline of mentors. Additionally, mentors need training and support to become effective partners in the mentor-mentee relationship.

- **Technology:**
  Manual input of demographic data and background characteristics to match mentors and mentees by hand is incredibly time-consuming and burdensome. Errors occur with misinterpretation of handwriting and data transfer. Improved technology allows mentors and mentees to sign up online and automates data collection and matching.

- **Feedback and Accountability:**
  Mentorship programs need to be evaluated on a regular basis to determine if they are achieving objectives and meeting the needs of mentees and mentors. Critical analysis and feedback identify ways to update and improve mentorship programs.

Mentee and Mentor Characteristics

Students tend to select mentors based on personal qualities in addition to academic accomplishments. Mentors' non-academic interests and mentor/mentee "chemistry" are as important as the accomplishments on a curriculum vitae when establishing a fruitful mentor-mentee relationship.[16,17] In a study of telephone interviews, same gender and race were not felt to be essential in mentorship pairings[17], but other studies have suggested that female mentors offer viewpoints that are valuable to female mentees.[18,19] Mentors can hold any position but because goals are largely set by the mentee, mentors should have life or professional experiences to guide mentees in those areas of interest. Outstanding mentors exhibit enthusiasm and compassion, tailor support to each mentee, honor commitments with regular meetings, and act as role models

for future mentors.[20] Specific actions of effective mentors include offering career guidance, providing emotional support, and promoting life/work balance.[21]

In turn, effective mentees are active listeners, who are open to feedback, and respectful of their mentors' time.[22] A successful relationship boasts reciprocity, mutual respect, clear expectations, a personal connection, and shared values.[22] Forced relationships, lack of commitment, personality differences, stealing credit for work, competition, and lack of mentor experience are qualities present in difficult or failed mentor-mentee relationships.[21,22]

Mentor - Mentee Ratios

The number of mentees an individual mentor can advise has not been well studied, but surveys suggest it is often more than 1:1. In one German program, the median ratio of mentor to mentee was 5.9 to 1. On average, these mentor/mentee pairs met 7 times per year.[23] Another survey of 111 mentors in internal medicine demonstrated a median of 5 mentees per mentor. Mentors were willing to supervise a maximum of 6 at once; those with mentorship funding had more mentees on average - 8.3 versus 5.1. Likewise, full professors tended to carry more mentees than associate professors (8.0 vs. 5.9). The maximum number of mentees was determined by the mentor's availability, position, and work load.[24]

It is also reasonable for mentees to have more than one mentor.[16] Most mentors with experience co-mentoring thought the mentee received a better experience than if he or she had only a sole mentor. Co-mentoring helped relieve some of the time constraints and responsibilities for individual mentors. To ensure effective co-mentoring, mentors need to have a good relationship, maintain clear expectations, and have complementary expertise with their co-mentors.[16]

Virtual Mentorship

Well-qualified mentors are not always locally accessible but technology has opened up new potential for mentorship networks. In one German study on academic mentorship in medicine, it was determined that geographic distance had no impact on the quality of mentorship. Furthermore, 91% of participants stated that they used email or telephone regularly to communicate with their mentor.[23] In a study by Luckhaupt et al, 67% had experience with mentoring from a distance. Overall, the sentiment was that such relationships were less demanding, but also less fulfilling due to limited opportunities for meetings and direct observation.[24] Chemistry has been cited as important for interpersonal matches,[17] which may be a limitation of long-distance mentorship. Telemedicine may enhance distance mentoring by including a video chat component to personalize the mentorship experience as much as technologically possible.

Examples of virtual mentorship include:

- The Society for Academic Emergency Medicine (SAEM) developed a virtual advising program geared toward students without an EM-affiliated program. Students request an advisor and faculty mentors volunteer to participate. The virtual relationship assists students in selecting a sub-internship and provides guidance on specific interests.[25]

- The Emergency Medicine Residents' Association (EMRA) created a Resident–Student Mentorship program in 2006. Although no formal training is required, residents are able to provide a unique perspective and mentorship to students interested in emergency medicine. Each resident is assigned 1-3 students. Mentees are assigned to mentors based on backgrounds and interest, with specific priority given to military, osteopathic and international applicants based on needs that were determined via survey. Although each mentorship relationship is unique, most people involved in the EMRA program

discuss questions via email and contact each other several times over the course of the academic year. Topics of discussion generally focus on the match and finding a residency program.

Current Mentoring Programs

Mentorship programs are available through national organizations, but the focus on underrepresented groups through these organizations ultimately comes from diversity task forces, such as ACEP's Diversity and Inclusion Taskforce, SAEM's Academy for Diversity & Inclusion in Emergency Medicine and the EMRA Diversity and Inclusion Committee. These taskforces strive to provide resources that foster mentorship, scholarship and foster a sense of community. ACEP, SAEM, and AAEM all have their own resident and medical student committees that host events at their annual meetings, as well as ongoing activities throughout the year. Regional, state and individual programs offer both structured mentorship opportunities through formal and informal methods, as well as opportunities for involvement in each respective organization. Several examples of mentorship opportunities are listed below:

- **EMRA Hangouts:**
  A virtual mentorship program that allows both medical students and residents to engage with emergency medicine faculty in real time and offers the potential to develop longer-lasting mentor relationships.

- **Diversity-Oriented Away Rotations/Scholarship Programs:**
  Local and regional recruitment programs aiming to increase diversity in emergency medicine. These programs are advertised through the EMRA website (https://www.emra.org/students/diversity-oriented-aways/scholarship-programs/)

- **SAEM Speed Mentoring Session:**
  Recently debuted program at SAEM17 to include "chemistry" assessment in the formation of mentor-mentee relationships.

- **Tour4Diversity and Mentoring in Medicine (Pre-medical education mentoring):**
  - T4D motivates, inspires, and cultivates future minority physicians, dentists, and pharmacists along the educational pipeline to health professions school. (tour4diversity.org/)
  - MIM does its work in disadvantaged areas with students in three different phases, from third grade through health professional schools. These phases include: Recruitment—large conferences and symposia that educate pre-high school students and their parents about medicine, nursing, and Allied Healthcare professional career opportunities; High School—after-school and in-school curricula on advanced biology concepts, organ systems, diseases, and an introduction to healthcare concepts and health career pathways; and College/Post-Baccalaureate—mentoring and strategic planning for school admission, including study skills, test preparation, and internships.

- **AAMC Recommended STEM-Based "Coaching" Style Mentor Matches:**
  The National Research Mentoring Network and mentornet.org, both which provide relatively short (4-month duration) virtual mentorship. Mentors and mentees can link demographically by race/ethnicity, scholarly interests, and even criteria such as "first college graduate in family". Associations or companies can work with mentornet.org to create unique mentor-match programs for exclusive use within their specific association or company.

Sponsorship – Amping Up the Advocacy

Thought leaders in business have proposed that closing the diversity gap requires fostering "sponsorship." In "The Sponsor Effect: Breaking Through the Last Glass Ceiling," Hewlett notes that "effective sponsorship builds on effective mentorship."[10] Sponsors advocate for their protégés by suggesting and opening up opportunities they hadn't considered, promoting their strengths, increasing their visibility and "using chips" to advance their career. Reciprocally, sponsored protégés are more likely to take risks than those without sponsorship.[10]

In a recent Patton, et al, study published in JAMA, researchers surveyed National Institutes of Health (NIH) Mentored Career Development grant awardees and found that sponsorship correlated with successful careers for both men (73% vs 58%) and women (59% vs 45%). However, more men reported sponsorship compared to women, as well as specific sponsorship experiences.[26]

In emergency medicine, examples of sponsorship in our career and life are evident. Dark horse candidates for chief resident are awarded their prestigious title based on a single, persuasive advocate at a closed faculty meeting. A pay raise and promotion materialize after an impassioned discussion of an individual's potential for success and impact of loss on the organization during a chair level meeting. These conversations occur "behind the scenes," in the absence of the physician in question but can advance a career to a level that would otherwise not have been attained.

Components of Starting and Maintaining a Sponsorship Program

Very little has been published on successful sponsorship programs in medicine. However, successful programs in the business community demonstrate the following components:[10]

- **Weaving Sponsorship into a Larger Talent Development Program:**
  In isolation, sponsorship may benefit certain individuals but may not yield the systemic changes that are required to broaden diversity in emergency medicine leadership. A cultural change is needed to both recognize the lack of diversity and foster a commitment to creating an environment that allows diversity programs to thrive.

- **Nurturing the Pipeline:**
  Sponsorship hinges on identifying and promoting under-recognized talent and potential. In order for talent to be highlighted, it first has to be fostered. Thus, strong sponsorship programs are often linked to strong mentoring and coaching programs that develop and support protégés along the way. Furthermore, sponsorship relationships can begin at any level — but successful programs recognize that sponsorship is most needed at each career transition point and focus their efforts on those times with the greatest impact.

- **Engaging Leadership and the C-Suite:**
  Engaging leadership and the C-suite early is critical to success. Visible and active support from the most senior leaders determine the difference between good intent and real outcomes.

- **Making Sponsorship Safe:**
  Programs that establish formal, safe and simple platforms to establish new sponsorship relationships help bridge the gap when URMs seek sponsorship.

Sponsor and Protégé Characteristics

Unlike mentorship, sponsorship asks sponsors to advocate for their protégé by leveraging their reputations and own career trajectories based on the performance of their protégés - both their successes and failures. Thus, protégés demonstrate a strong track record or high potential to reliably deliver superior results. Even so, the complex sponsorship relationship goes beyond mere performance.

Sponsors, by definition, hold high leadership positions and have many responsibilities. Increased job satisfaction is the prime reason that sponsors cite for spending their valuable time fostering a network of protégés, but another motivation is to boost their own careers. Protégés provide key information and feedback on the organization that sponsors may not be in touch with as they move up the career ladder.[27] A protégé's strengths can also bolster a sponsor's areas of weakness, creating a symbiotic relationship from which both parties benefit.

Catalyst, a nonprofit organization committed to building inclusive workplaces, stresses that sponsorship relationships are based on trust on both sides, honesty to promote candid feedback, communication, and commitment.[12] Trust and loyalty were identified as the key attributes in a protégé based on one survey of business managers (37% male managers and 36% female managers surveyed).[27]

Current Sponsorship Programs

- **FTSE 100, the FTSE Cross Company Mentoring Programme:**
  Started in 2003, the FTSE 100 Cross-Company Mentoring Programme has worked to increase the number of women on FTSE boards. A chairman nominates a woman from the "marzipan layer," corporate executives directly below the C-suite. Participants are asked three questions: (1) Why do they want to participate? (2) What do they want to get out of it? (3) What are their first thoughts on what to work on with a mentor? To avoid conflict of interest, the protégé is matched with a chairman who was in another FTSE company that was not in the same industry as the mentee. Of 39 women who have gone through the FTSE Programme, 15 have been appointed to the executive committee or main board of their FTSE company. Eight have been appointed to a non-executive director position in a FTSE company. Fifteen have been promoted at their own company or have moved companies for a promotion. Three women have been named as chief executive of a FTSE 250 or other company.[10]

- **American Express – Women in the Pipeline and at the Top:**
  The initiative was developed to encourage sponsorship opportunities for women with senior members within the organization. The company conducted focus groups to identify their needs. Seven central themes emerged; (1) Women had less access to networking opportunities (2) Women wanted more feedback (3) Leadership culture is characterized by male behaviors (4) Work-life balance is difficult for men and women as they advance (5) Limited role modeling for women aspiring to senior positions makes it difficult to know what success looks like (6) Style requirements narrow as they ascend the career ladder and that to succeed they need to fit a specific mold (7) Absence of clear road maps. To address these issues, they established a "gender intelligence" education program for senior leadership and established a "Pathways to Sponsorship" program that offered multiple options to create sponsorship opportunities.[10]

Coaching – Honing the Requisite Skills

Coaching is often short-term and focused on personal skill development through performance analysis and ongoing feedback during performance. Four functions of coaching have been proposed:[28]

- Skill Enhancement
- Increased Performance
- Professional Development
- Strategic Planning

Unlike mentoring, managing or training, optimal use of coaching leads to the increased utilization of a person's current skills and resources without counseling or advising.

Coaching facilitates goal attainment by helping individuals:[29]

- Identify desired outcomes
- Establish specific goals
- Enhance motivation by identifying strengths and building self-efficacy
- Identify resources and formulate specific action plans
- Monitor and evaluate progress toward goals
- Modify action plans based on feedback

Coaching often involves motivational input from the coach to the coachee to assess barriers to performance on a given task, identify strengths and weaknesses, and provide critical evaluation and feedback to promote enhanced performance in future attempts. Coaching facilitates acquisition of specific knowledge and relevant suggestions to improve a coachee's approach to a given task or skillset, which collectively will advance that coachee's expertise in their job functions. Coaching can provide non-judgmental, direct feedback that encourages a participant's self-belief in his or her own ability to manage challenges through brainstorming, teamwork, and resourcefulness.

Components of Starting and Maintaining a Coaching Program

- Goal directed, outcome-based coaching.[29,30]
- Self-reflection or self-assessment incorporated throughout the process.
- Mechanisms included to provide coach feedback on performance.
- Voluntary relationships fostered or accounting for "chemistry" in coach/coachee assignments. As with both mentorship and sponsorship discussions, mutual trust has been identified as imperative to successful coaching relationships.[31,32]
- Cooperative or collaborative Learning without competition. Coaching belongs to the co-operative learning paradigm, which has achieved more success in knowledge acquisition and creativity in problem solving than competitive or individually focused learning.[33] Co-operative learning has also been linked to cognitive growth.[30]
- Focus on participants' strengths and amplification of capacity. [34]

Coach - Coachee Ratios

While the ideal ratio of coach-coachee has not been well studied within medicine, a review of the coaching literature in medicine suggests most programs utilized a 1:1 ratio or dyad coaching relationship. However, the authors noted that the ratios varied greatly from 1:1 up to 1:37 (nursing units).[35] This review concluded that "the ratio of coach to trainee did not seem to impact the success of the coaching, whether it was conducted in a 1:1 ratio or on units where the ratio was 1:6 or even up to an average of 1:37."[35]

Current Coaching Programs

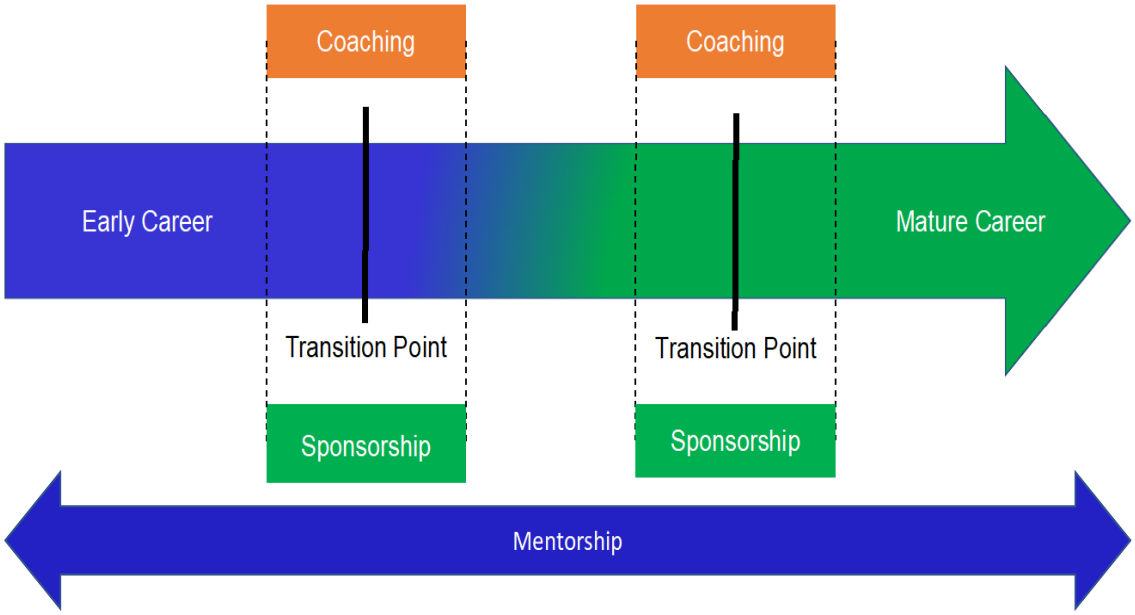
- **Research to Reality (R2R) Mentorship Program:**
  A coaching program endorsed by the CDC – was particularly effective in facilitating knowledge acquisition and competency in a variety of domains pertaining to public health programming and utilization of evidence-based interventions.[36]

- **Clinical Performance of Hospitalists at Massachusetts General Hospital:**
  A pilot clinical coaching program providing hospitalists feedback from senior clinical advisors with greater than five years' experience. Of those who participated, 92% responded that the senior clinical advisor was helpful in reducing subspecialty consultations, increasing clinical confidence (72%), and improving quality of care (76%).[37]

CONCLUSIONS

In medicine, URMs have shown improved representation in 1st tier management as well as mid-level management but have remained stagnant or even experienced slight declines in executive leadership representation at U.S. hospitals.[3] To advance our collective goal of greater diversity and inclusion, emergency medicine will be tasked to build a strong, sustainable pipeline to emergency medicine and within emergency medicine. Mentorship is a proven method of improving diversity and inclusiveness in the workforce. While mentorship will help an individual advance to a certain point, it may not be enough to propel an URM to executive leadership. Sponsorship programs will likely be required to catapult URMs to the highest ranks of leadership; while coaching enhances and builds the skills needed to improve performance and the likelihood of a successful transition.

Our recommendation is a robust network of national, regional and local mentorship, sponsorship and coaching programs aimed to support, foster and promote URMs throughout their careers.



Created by the Academic Affairs Committee - October 2017
Reviewed by the Board of Directors - November 2017

[1]Sullivan Commission. Missing persons: minorities in the health professions. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. Washington, DC: Sullivan Commission; 2007.

[2] American Association of Medical Colleges (Ed.). (2016, December 20). Diversity in Medical Education: Facts and Figures 2016. http://www.aamcdiversityfactsandfigures2016.org/. Retrieved August 2, 2017.

[3] American Hospital Association, Institute for Diversity in Health Management. Diversity and Disparities: A Benchmark Study of U.S. Hospitals. http://www.diversityconnection.org/diversityconnection/leadership-conferences/2016%20Conference%20Docs%20and%20Images/Diverity_Disparities2016_final.pdf. Retrieved May 26, 2017.

[4] American Association of Medical Colleges (Ed.). Diversity in the Physician Workforce: Facts and Figures 2014. http://aamcdiversityfactsandfigures.org/. Retrieved August 2, 2017.

[5] Parker RB, Stack SJ, Schneider SM, et al. Why diversity and inclusion are critical to the American College of Emergency Physicians' future success. *Ann Emerg Med*. 2017 Jun;69(6):714-7.

[6] Landry AM, Stevens J, Kelly SP, et al. Under-represented minorities in emergency medicine. *J Emerg Med*. 2013 Jul;45(1):100-4.

[7] Boatright D, Tunson J, Caruso E, et al. The impact of the 2008 Council of Emergency Residency Directors (CORD) panel on emergency medicine resident diversity. *J Emerg Med*. 2016 Nov;51(5):576-83.

[8] Reiter M, Wen LS, Allen BW. The emergency medicine workforce: profile and projections. *J Emerg Med.* 2016 Apr;50(4):690-3.

[9] Dobbin F, Kalev A. 2016. Why Diversity Programs Fail. *Harvard Business Review*, 94(7).

[10] Hewlett S, Peraino K, Sherbin L, et al. 2010. The Sponsor Effect: Breaking Through the Last Glass Ceiling. *Harvard Business Review.*

[11] Piloli L, Cooper LA, Carr P. Race, disadvantage and faculty experiences in academic medicine. *J Gen Intern Med*. 2010 Dec;25(12):1363-9.

[12] Catalyst. Fostering Sponsorship Success Among High Performers and Leaders. New York, NY: *Catalyst*; 2011 August. http:// http://www.catalyst.org/knowledge/fostering-sponsorship-success-among-high-performers-and-leaders.

[13] Ghosh R. Mentors providing challenge and support: integrating concepts from teacher mentoring in education and organizational mentoring in business. *Human Resource Development Review.* 2012;12(2):144-76.

[14] Allen TD, Eby LT, Lentz E. Mentorship behaviors and mentorship quality associated with formal mentoring programs: closing the gap between research and practice. *J Appl Psychol*. 2006;91(3):567-78.

[15] Beech BM, Calles-Escandon J, Hairston KG, et al. Mentoring programs for underrepresented minority faculty in academic medical centers: a systematic review of the literature. *Acad Med*. 2013 Apr;88(4):541-9.

[16] Garmel GM. Mentoring Medical Students in Academic Emergency Medicine. *Acad Emerg Med*. 2004 Dec;11(12):1351-7.

[17] Jackson VA, Palepu A, Szalacha L, et al. "Having the right chemistry": a qualitative study of mentoring in academic medicine. *Acad Med*. 2003 Mar;78(3):328-34.

[18] Frei E, Stamm M, Buddeberg-Fischer B. Mentoring programs for medical students - a review of the PubMed literature 2000 - 2008. *BMC Med Educ*. 2010 Apr 30;10:32.

[19] Sambunjak D, Straus SE, Marusic A. A systematic review of qualitative research on the meaning and characteristics of mentoring in academic medicine. *J Gen Intern Med*. 2010 Jan;25(1):72-8.

[20] Cho CS, Ramanan RA, Feldman MD. Defining the ideal qualities of mentorship: a qualitative analysis of the characteristics of outstanding mentors. *Am J Med*. 2011 May;124(5):453-8.

[21] Straus SE, Johnson MO, Marquez C, et al. Characteristics of successful and failed mentoring relationships: a qualitative study across two academic health centers. *Acad Med*. 2013 Jan;88(1):82-9.

[22] Straus SE, Chatur F, Taylor M. Issues in the mentor–mentee relationship in academic medicine: a qualitative study. *Acad Med*. 2009 Jan;84(1):135-9.

[23] Meinel FG, Dimitriadis K, von der Borch P, et al. More mentoring needed? A cross-sectional study of mentoring programs for medical students in Germany. *BMC Med Educ*. 2011 Sep 24;11:68.

[24] Luckhaupt SE, Chin MH, Mangione CM, et al. Mentorship in academic general internal medicine. Results of a survey of mentors. *J Gen Intern Med*. 2005 Nov;20(11):1014–8.

[25] Coates WC, Ankel F, Birnbaum A, et al. The virtual advisor program: linking students to mentors via the world wide web. *Acad Emerg Med.* 2004 Mar;11(3):253-5.

[26] Patton EW, Griffith KA, Jones RD, et al. Differences in mentor-mentee sponsorship in male vs female recipients of National Institutes of Health grants. *JAMA Intern Med*. 2017 Apr 1;177(4):580-2.

[27] Hewlett S. 2013. How to Choose the Right Protégé. *Harvard Business Review.*

[28] Witherspoon R, White RP. Executive coaching: a continuum of roles. *Consult Psychol J Pract Res*. 1996 Spr;48(2):124-33.

[29] Kristal Z, 2010. The role of reflection on clients' change in the coaching process, Thesis, Teachers College, Columbia University.

[30] Ladyshewsky RK. Building competency in the novice allied health professional through peer coaching. *J Allied Health.* 2010 Summer;39(2):e77–82

[31] Sabo K, Duff M, Purdy B. Building leadership capacity through peer career coaching: a case study. *Nurs Leadersh*. 2008;21(1) 27-35.

[32] Cox E. Individual and organizational trust in a reciprocal peer-coaching context. *Mentor Tutor Part Learn*. 2012;20(3):427–43.

[33] Ladyshewsky RK. Building cooperation in peer coaching relationships: Understanding the relationships between reward structure, learner preparedness, coaching skill and learner engagement. *Physiotherapy*. 2006 Mar;92(1):4–10.

[34] Grant A, Passmore J, Cavanagh MJ, et al. The state of play in coaching today: A comprehensive review of the field. In: Hodgkinson GP, Ford JK, ed. *International Review of Industrial and Organizational Psychology 2010* Volume 25. New Jersey:Wiley-Blackwell; 2010:125–167.

[35] Schwellnus H, Carnahan H. Peer coaching with health care professionals: what is the current status of the literature and what are the key components necessary in peer coaching? A scoping review. *Med Teach*. 2014 Jan;36(1):38-46.

[36] Sanchez M, Purcell EP, Michie JS, et al. Building cancer control capacity: a mixed-method evaluation of the Research to Reality (R2R) Mentorship Program. *Prev Chronic Dis*. 2014 Feb 29;11:E24.

[37] Iyasere C, Baggett M, Romano J, Jena A, Mills G, and Hunt, D. Beyond continuing medical education: clinical coaching as a tool for ongoing professional development. *Acad Med*. 2016 Dec; 91(12):1647-50.