STFM Annual Spring conference

In Pursuit of Equity and Diversity in the Family Medicine Workforce and Leadership

Preconference Workshop
May 5, 2018

STFM Annual Spring conference

Presenters

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Associate Residency Director
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Disclosures

We have nothing to disclose.

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Pre Conference Survey

- Respondents 33/38 (84%)
- Respondents were asked to answer
  - Demographics
  - Professional roles/settings
  - Previous Trainings
  - Baseline knowledge assessment
  - Goals and Challenges
- 84% of respondents were physicians
  - trainees, behavioral health, research and administration are represented
- Most have had formal training in Implicit bias (87%)
- Only 38% have had formal training in negotiation and 29% in finance
- Survey Monkey with 3 email invitations over 2 week period

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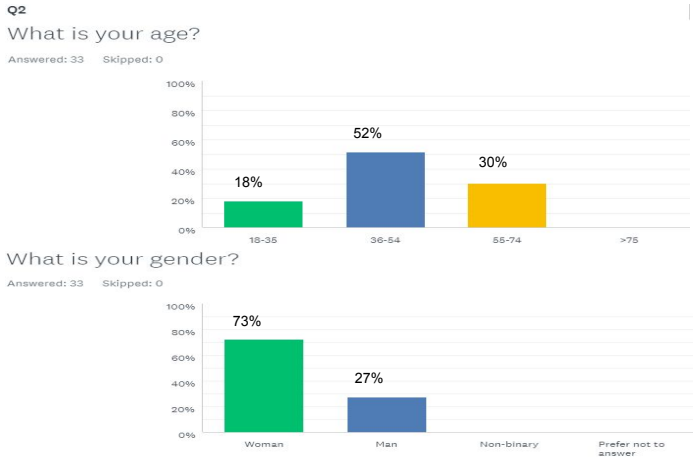
Participants' Age and Gender



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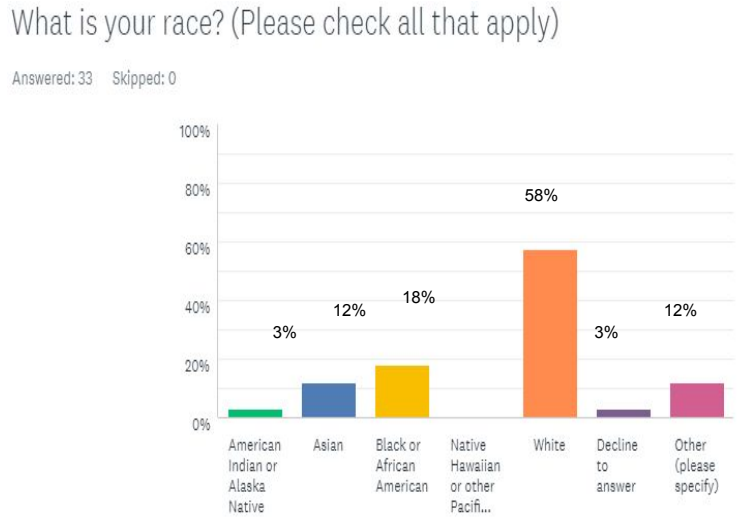

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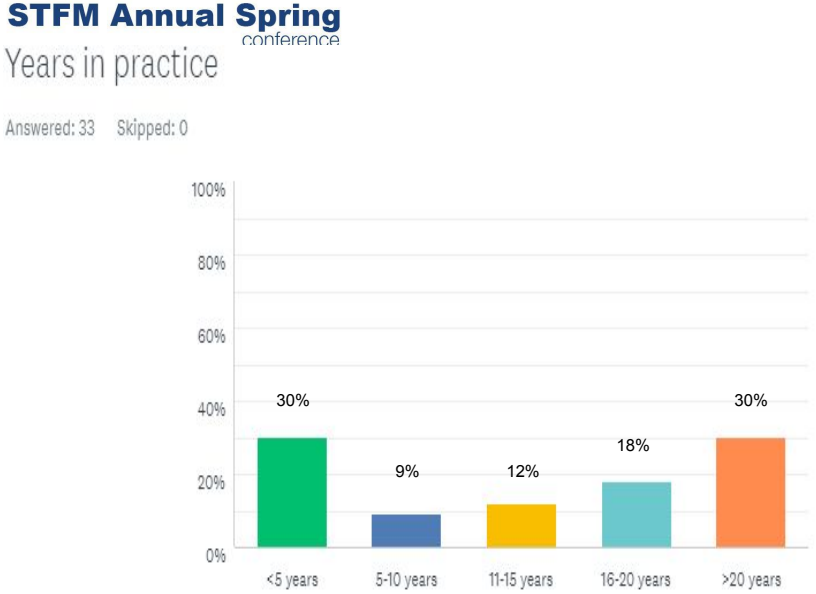

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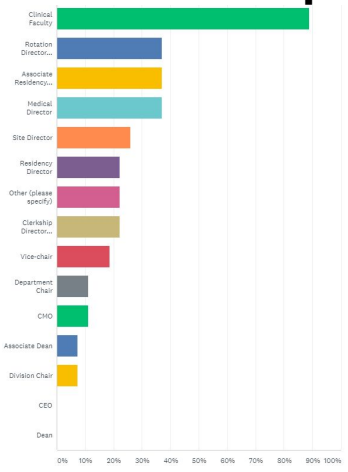
Leadership Positions Held



Highlights:

- Clinical Faculty 89%
- Rotation Director (residents) 37%
- Associate Residency Director 37%
- Medical Director 37%
- Site Director 26%
- Residency Director 22%

- Other: Research, diversity, fellowship, associate roles

**Participants were asked to choose all that apply, so each individual may have multiple previous leadership roles

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Challenges you are facing...

- Finding effective mentors
- Changing departmental culture
- Being cognizant of bias and privilege
- Career planning and next steps
- Succession planning
- Salary negotiation
- Promoting departmental diversity

Our Goals

Inform. Inspire. Ignite.

Our Objectives

1. Understand the structural issues within academic institutions that contribute to inequity in leadership and the workforce.

2. Appreciate the importance of mentoring and sponsorship for academic success. They will develop a personal leadership plan and identify steps for obtaining a sponsor or sponsoring a colleague.

3. Practice and build skills for negotiating an environment/contract/position that builds resilience.

Ground Rules

- Preserve safety
- Recognize we all have bias
- Listen actively
- Ask questions
- Keep an open mind
- Share with each other

- Logistics: Bathrooms, Snacks, Break

The Afternoon

12:05-12:10	Introductions
12:10-12:15	Objectives and Methods
12:15-12:45	Reflection and Goal Setting
12:45-1:00	Structure and History of Academic Institutions
1:00-1:10	Literature Highlights
1:10-2:00	Negotiation
	Expert Panel - Cases - Q and A
2:00-2:10	BREAK
2:10-4:35	Mentorship and Sponsorship
4:35-5:00	Wrap Up and Next Steps

Reflection and Goal Setting

Reflection and Goal Setting

Jennifer Snyder, MD
Harry Strothers, MD
Joedrecka S. Brown Speights, MD

Objectives

- Practice **short term goal setting** using the SMART mnemonic
- Introduce **long term goal setting** using a mentoring contract incorporating SMART goals

Reflection/Mindful Moment

- Take 20 seconds to be mindful!
  - On purpose
  - In the present moment
  - Non-judgemental
- Take 40 seconds to write a free flowing reflection about why you are here today.

Pair & Share

Goal Setting

- Focus
- Motivation
- Productivity

SMART mnemonic

https://www.act-on.com/blog/set-smart-marketing-goals/

SMART or Not? (short term)

1. I'm going to learn how to mentor.
2. By the end of this session, I will be able to describe the components of the SMART mnemonic and practice setting 1 SMART goal.
3. I'm going to make one new connection and call them next week to discuss what we learned today.
4. By the end of this session, I will practice one tool that I can use next month in my peer mentoring circle to enhance accountability in attending regular mentoring meetings.

Write one SMART goal for this workshop.

Pair & Share

Mentoring Contracts

- Facilitate communication
- Facilitate clear expectations
- Invigorate the mentor and mentee and identify synergistic goals
- Allow for productive/efficient meetings
- Factor in accountability and SMART goal setting

Mentors and Mentees

Should I say YES?

How Do I Say NO?

Structure and History of Academic Institutions

Jeannette South-Paul, MD
Carrie Pierce, MD

Flexner Report, 1910

- Established science as the focus and foundation of medical training
- Thought the role of the physician in society was actually broader and encompassed both public health and social service

Muller D, Meah Y, Griffith J, et al. The role of social and community service in medical education: the next 100 years. Acad Med 2010;85:302-309

Flexner Report

The new system fostered a narrowing of medical schools' interests to issues of technical concern. From the beginning, the focus of the modern medical school was on disease organically defined, not on the system of health care or on society's health more generally.

- Kenneth Ludmerer

Betancourt JR, Maina AW. The Institute of Medicine Report "Unequal Treatment": implications for academic health centers. Mt. Sinai J Med2004; 71:314-321.

Public Good from Flexner

- Higher quality of medical school graduates
- Advances in disease treatment as a result of publicly-funded research
- Increased charity care
- Responsiveness to societal needs during times of war and population expansion

Flexner A. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. Bulletin No.4. New York, NY: The Carnegie Foundation for the Advancement of Teaching; 1910.

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Segregated Medical Education the downside of Flexner

- **1868 - 1904: 7 medical schools for blacks established.** Only 2 remain:
  - Meharry Medical College
  - **Howard University Medical School**
- This was a result of the Flexner Report of 1910
- **The report acknowledged that 2 schools would be unable to train enough black physicians to serve the 9.8 million African American living in the US**
- Morehouse School of Medicine founded in 1975

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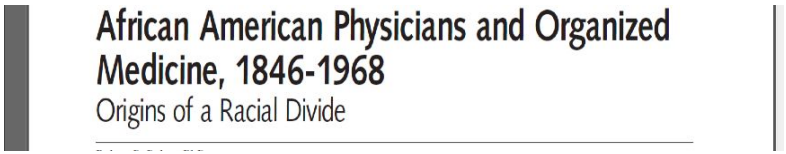

The history of the American Medical Association AMA and the National Medical Association NMA and the influence of racism in the US on professional segregation

Baker, JAMA, 2008

Gratitude to Stephanie Dewar, MD for the next few slides

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Women in Health Professions

1874, Harvard professor Edward Clarke **reported that women who attended medical school would develop:**

•monstrous brains and puny bodies:

•abnormally active cerebration and

•abnormally weak digestion;

•flowing thought and constipated bowels.

Eliza Lo Chin; This Side of Doctoring : reflections from women in medicine 2002

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Academic Health Centers

- Medical School
- Other health science schools – nursing, dentistry, public health, allied health, pharmacy
- Clinical units – hospitals, ambulatory offices and/or clinics, home health, pharmacies
- Governance – unified (Dean/CEO), shared (academic + business), governmental (eg state controlled and directed; federal – military or VA); Board of Governors/Trustees

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Financed By:

- Federal support – CMS, NIH, HRSA
- Clinical revenues – cash, health insurers, employers
- Commercial products
- Tuition revenues
- Grants
- Philanthropy

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Scope of Activities

- Education/Training
- Clinical Care
- Research
- Service
- Community outreach

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Governance of AHCs

- Historical patterns of leadership
- Tenure – based hierarchy – controls committee membership, leadership, and decision-making roles
- Variable structures across AHCs – medical schools +/- health/hospital systems
- Role of pedigree in appointments and promotion – regional, legacy, sponsorship

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Physician Career Development

Extrinsic Forces

- Educational opportunities
- Role models
- Mentorship
- Financial support

Intrinsic Forces

- Intellectual curiosity
- Community service
- Altruism

Ratanawongsa N, Howell EE, Wright SM. What motivates physicians throughout their careers in medicine? Compr Ther. 2006;32:210–217.

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Race-conscious Professionalism – David Wilkins

- A paradigm used to understand the dual obligation encountered by many minority physicians not only to pursue excellence in their field but also to leverage their professional stature to improve the well-being of their communities
- The desire of many minority faculty to have their work focused on the community will be at odds with traditional paths to professional advancement.

Wilkins D. Identities and roles: Race, recognition, and professional responsibility. MD Law Rev. 1998;57:1502–1595.

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Scholarship

- The colonial college took a view of scholarship that focused on the student – on building character and preparing new generations for civic and religious leadership
- America's research institutions today focus on the scholarship of discovery as a necessary requirement for the professional advancement of individual faculty members

Boyer EL. *Scholarship Reconsidered: Priorities of the Professoriate*. Princeton, NJ: The Carnegie Foundation for the Advancement of Teaching; 1990, p.3.

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Teaching Portfolio

<u>Teaching philosophy</u>

- Discuss your personal philosophy of teaching.
  - Your personal theory regarding learning.
  - Your view regarding the role of the teacher.
  - Your view regarding the role of the learner.
  - Personal objectives for teaching.
- How have you tried to accomplish these objectives?
- How have they changed over time?
- How effective are you by these criteria?

Rita Patel, UPMC GME DIO

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Guidelines (www.medfaculty.pitt.edu)

Associate Professor	Professor
Evidence of consistent, significant contributions to the School of Medicine or departmental educational goals and objectives (greater than 5 years; evidenced by letters).	Evidence of continued significant contribution to School of Medicine or departmental educational goals and objectives (10 to 12 years; evidenced by letters).
Contributions to the design, organization, and instruction of course or clinical programs.	Leadership role in educational mission (e.g. Program Director).
Demonstration of ability to evaluate and counsel medical or graduate students.	Leadership role in the design and implementation of educational programs.
Participation in postgraduate courses.	Leadership in program initiatives.
Contributions to chapters and books.	Contributions to books and teaching materials.
Evidence of mentorship and serving in the preceptor role.	Invited lectureships at major universities and lead scientific societies.
	Leadership in the development and presentation of CME
	Invited panelist.
	Teaching award(s).

Academic Pitfalls for Junior Faculty

- Too much service effort
- Diffusion and confusion
- Lack of mentoring and guidance
- Exploitation by other faculty
- Inattention to academic integrity
- Lack of discipline and perseverance

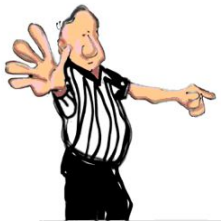
Grigsby RK. Five potential pitfalls for junior faculty at academic health centers. *Academic Physician and Scientist*. May 2004.

Examples of problems

- Busy clinician
  - PBL facilitator
  - Good evals from students and residents
  - A few papers
- Excellent teacher, develop courses, many awards
  - No external exposures or publications
- Good teacher, some responsibility
  - ?not a pure educator by chair's assessment
- Researcher who does no teaching

Challenges for the Committee

- Referees
  - No recognition outside the institution
  - Hard to find "peers"
  - Referees have trouble with metrics
  - "at my institution…"



Summary

- Know and keep your focus.
- Identify a mentor and listen to his/her guidance.
- Know your institution and faculty handbook.
- Work with colleagues whom you can trust and communicate with.
- Meet regularly with your chair/division chief.
- Develop your own executive summary.
- Work tirelessly!

Keystone Species

•Term coined by Robert Paine (1966) after extensive studies examining the interaction strengths of food webs in rocky intertidal ecosystems in the Pacific Northwest.

http://www.nature.com/scitable/knowledge/library/keystone-species-15786127

Keystone Species - Pisaster

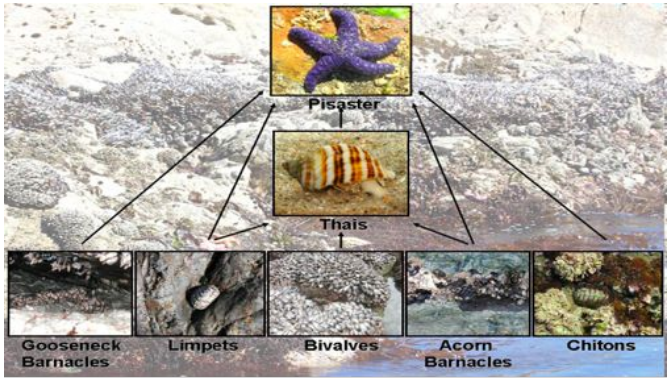


Figure 1: Food web of species present in temperate intertidal ecosystem

Paine's observances of the temperate intertidal ecosystem

- intertidal area where *Pisaster* had been removed changed compared to control area.
- Remaining members of the ecosystem's food web immediately began to compete with each other to occupy limited space and resources.
- Within 3 months of the *Pisaster* removal, the barnacle, *Balanus glandula*, occupied 60 to 80% of the available space within the study area. Nine months later, *Blanus glandula* had been replaced by rapidly growing populations of another barnacle *Mitella* and the mussel *Mytilus*.
- This phenomenon continued until fewer and fewer species occupied the area and it was dominated by *Mytilus* and a few adult *Mitella* species. Eventually the succession of species wiped out populations of benthic algae.

http://www.nature.com/scitable/knowledge/library/keystone-species-15786127

A keystone species exerts top-down influence on lower trophic levels and prevents species at lower trophic levels from monopolizing critical resources, such as competition for space or key producer food sources.

Ecologist Bob Paine

http://www.nature.com/scitable/knowledge/library/keystone-species-15786127

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Are you a Pisaster or a barnacle???

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Literature Review

Jennifer Snyder, MD
Harry Strothers, MD
Joedrecka S. Brown Speights, MD

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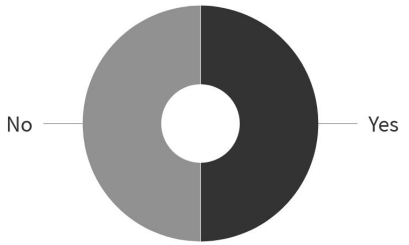
Do the AAFP and STFM support women and minorities?

Yes **A** No **B**



Do the AAFP and STFM support women and minorities?

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Yes

!

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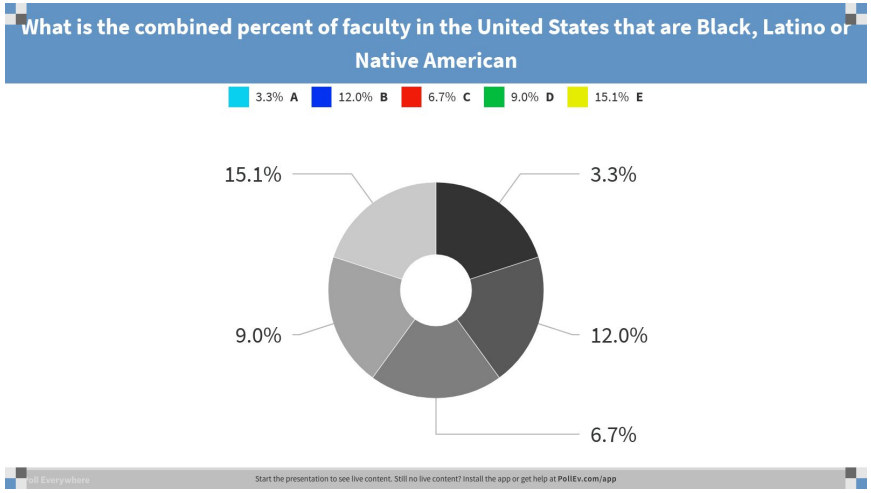

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Poll

What is the combined percent of faculty in the United States that are Black, Latino or Native American?

a. 3.3%
b. 12.0%
c. 6.7%
d. 9.0%
e. 15.1%

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Black or African American, Latino or Hispanic or Spanish origin, or American Indian or Alaska Native, or Native Hawaiian or other Pacific Islander faculty members collectively make up only 9% of academic medical Family Medicine faculties while representing almost 33%* of the national population.

https://www.aamc.org/download/486116/data/17table20.pdf. Accessed 4.28.18.
AAMC Faculty Roster, December 2017
*Black or African American, Latino or Hispanic, Native Hawaiian or other Pacific Islander, and American Indian or Alaska Native, U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/US/PST045216. Accessed 4.29.18.

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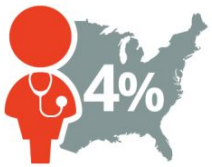
2.44% Black faculty at Medical Schools Nationally (AAMC 2014)



Blacks and African-Americans comprise only 4 percent of the physician workforce.

4.3% Latino faculty at Medical Schools Nationally (AAMC 2014)

Association of American Medical Colleges. Diversity in the Physician Workforce: Facts & Figures 2014
http://aamcdiversityfactsandfigures.org/section-ii-current-status-of-us-physician-workforce/

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Underrepresented in Medicine Minority Faculty

The AAMC definition of underrepresented in medicine is:
"Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."

https://www.aamc.org/initiatives/urm/

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Female Faculty

- 39% of full-time faculty are female
- Only 22% of women are full-time professors
- Only 4% of full-time faculty identify as Black or African American, Latino or Hispanic, Native American or Alaska Native, or Native Hawaiian or Pacific Islander females.
  - At the department chair level, women of color representing only 3% of department chairs in academic medicine.[3]

http://aamcdiversityfactsandfigures2016.org/report-section/section-3/
Diversity in medical education: facts and figures 2012. Washington, DC: AAMC; 2012.
Multiracial in America: proud, diverse, and growing in numbers. Washington, DC: Pew Research Center; 2015. http://www.pewsocialtrends.org/2015/06/11/multiracial-in-america/.
Lautenberger D, Moses A, Castillo-Page LC. An overview of women full-time medical school faculty of color. AAMC Analysis in Brief. 2016;16(4):1-2.

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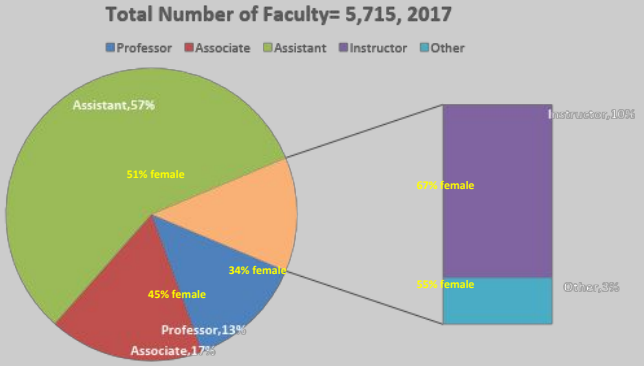
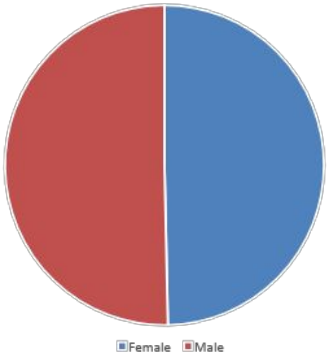
Family Medicine Faculty Rank & Sex



https://www.aamc.org/download/486116/data/17table20.pdf. Accessed 4.28.18.
AAMC Faculty Roster, December 2017

Family Medicine Female/Male



https://www.aamc.org/download/486116/data/17table20.pdf. Accessed 4.28.18.
AAMC Faculty Roster, December 2017

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Unconscious Bias

Can affect faculty recruitment even prior to position advertisement

Unconscious bias of mentors and mentees can challenge the mentoring process

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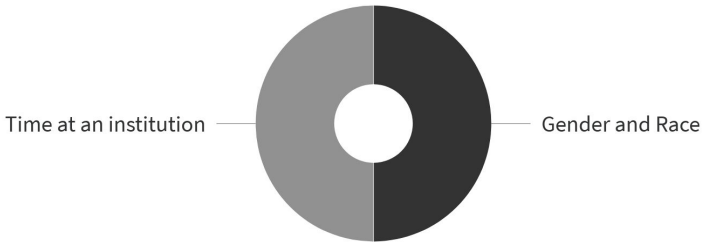
Which most influences advancement/Leadership?

Gender and Race **A** Time at an institution **B**



Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

Which most influences advancement/leadership?

Gender and race or time at institution?

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Time at the Institution

Is the culture of academic medicine consistent with the values of women and minorities?

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Probably Not.

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Faculty Vitality

- **National Faculty Survey Studies**:
  - over 40% of a nationally representative sample of medical school faculty (including 512 URMM faculty) seriously considered leaving their institutions in the prior year due to dissatisfaction
  - over 25% had seriously considered leaving academic medicine entirely
  - No difference between URMM and non-URMM faculty
- **Dimensions of culture associated with these findings:**
  - Lack of relationships
  - Low sense of belonging and trust
  - Non-alignment of personal and institutional values predicted leaving one's institution
  - Higher levels of ethical moral distress and a sense of being adversely changed by working in medical schools was linked to abandoning academic medicine entirely
- **URMM faculty reported**
  - Higher leadership aspirations
  - Lower relational connection and trust
  - Lower alignment between personal and institutional values

Pololi LH, Krupat E, Civian JT, Ash AS, Brennan RT. Why are a quarter of faculty considering leaving academic medicine? A study of their perceptions of institutional culture and intention to leave in 26 representative medical schools. Academic Medicine. 2012;87:859–869

Do faculty development programs and mentoring aid in promotion of women and URM faculty?

Probably…

Experiences of URMM faculty

Race, Disadvantage and Faculty Experiences in Academic Medicine

- 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
- Devaluating of research on community health care and health disparities
- Unfair burden of being identified with affirmative action and responsibility for diversity efforts
- Leadership's role in diversity goals
- Financial hardships

Pololi L, Cooper LA, Carr P. Race, Disadvantage and Faculty Experiences in Academic Medicine. Journal of General Internal Medicine. 2010;25(12):1363-1369. doi:10.1007/s11606-010-1478-7.

Underrepresented in Medicine Minority Faculty

1. Similar levels of engagement and self-efficacy*
2. Lower sense of inclusion, trust, and relationships
3. Higher leadership aspirations
4. URMM faculty at HUFI schools more value alignment**
5. URMM have more positive perception of equity at HUFI schools.

*Engagement: being energized by work. Self-efficacy in career: confidence in ability to advance in career.
**HUFI- high URMM faculty institutions, which are institutions where more than 50% of the faculty are minority group members underrepresented in medicine.

Pololi LH, Evans AT, Gibbs BK, Krupat E, Brennan RT, Civian JT. The experience of minority faculty who are underrepresented in medicine, at 26 representative U.S. medical schools. Academic Medicine. 2013;88:1308–1314

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Conclusion

-More studies are needed to demonstrate efficacy

-Percentages fairly consistent and speak for themselves

-Evidence for mentoring and sponsorship exists

-Importance of combined efforts toward institutional culture change as well as individual change are needed

-Qualitative evidence critical in provoking change

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Negotiation

Expert Panel

Y. Monique Davis-Smith, MD, FAAFP

David Henderson, MD

Jeannette E. South-Paul, MD

Denise V. Rodgers, MD, FAAFP

Facilitators

Stephanie Carter-Henry, MD, MS and Kristen Goodell, MD

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A story about Negotiation

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Y. Monique Davis-Smith, M.D., FAAFP

Associate Professor, Residency Program Director
Department of Family Medicine, Medical Center Navicent Health, Mercer University School of Medicine

1. The negotiation skill does not always determine the outcome
2. Resiliency in negotiating
3. Know your audience

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David Henderson, MD

Assoc. Dean for Student Affairs, Assoc. Dean for Multicultural and Community Affairs
Assoc. Professor, Dept. of Family Medicine, University of Connecticut School of Medicine

1. Strategic vs. tactical approaches
2. Intentionality when negotiating is central
3. Building consensus and being willing to accept shared ownership
   (e.g. sometimes it does take a village)

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Jeannette E. South-Paul, MD

Andrew W. Mathieson UPMC Professor and Chair
Department of Family Medicine, University of Pittsburgh/UPMC

1. Negotiations take time and can span many months.
2. Issues change because of what may seem unrelated but parallel occurrences.
3. It is important to clearly define the principles upon which you stand and want to negotiate and don't be side tracked by personalities.

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Denise V. Rodgers, MD, FAAFP

Vice Chancellor for Interprofessional Programs, RBHS Endowed Professorship in IPE
Professor of Family Medicine
Director, Rutgers Urban Health and Wellness Institute

1. Negotiating for your program/department/ co-workers/learners vs negotiating for yourself
2. Think about which "battles" to choose.
3. The burden of considerations of "isms" in the negotiating process.

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Negotiation Cases

Please works in groups of 2-3 to discuss the cases and the questions that follow them.

We will spend 10 minutes total in discussion and then come back to the large group for Q and A.

Questions
and
Answers

Facilitator Observations

- It's not just about time and money; Consider academic appointment, space, staffing, parking
- Think about what you need to be successful
- Anticipate your audience
- If at first your negotiations do not succeed try something different
- Patience is important and repetition progresses the conversation
- A change in role is an opportunity to advocate for yourself

Enhancing Mentorship

Kerwyn Flowers, DO
Judy Washington, MD, FAAFP

Setting the stage…

- Think of someone that has been a mentor to you.
- Write down the characteristics of that person.
- What made them stand out to you as a leader/mentor ?

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MENTOR –

A kind of guide who, despite having been far enough ahead to know something of what's down the path, comes back to walk with you, and thus leads without leaving you to follow.

Boyd D. Introduction: Lawrence Kohlberg as mentor. Journal of Moral Education 1988;17(3):167-171.

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What made them stand out to you as a mentor/leader?

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Mentoring-

A process by which an experienced, highly regarded, empathetic person (the mentor) guides another individual (the mentee)

- in the development and re-examination of their own ideas
- Learning, personal and professional development

-Royal College of Peadiatric and Child Health (UK)
Melon A., Murdoch-Eaton D. Arch Dis Child 2015;100:873-878

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Differing Roles

- Mentor
- Coach
- Sponsor

***a different approach from Janet Bickel's model in the next slide

Levels of mentoring

- Teach
- Sponsorship *(create opportunities, open doors)*
- Support
- Intervention *(identify & fix a problem)*
- Critique *(tell you the hard stuff)*

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Mentorship vs. Coaching

- Coaching uses processes directed at specific performance development
  - engage with or observe you during your work and provides feedback
- Mentoring has a general developmental focus around interactions between a more experienced individual and a less experienced one in a particular setting
  - Steers away from measuring performance
  - While considering such change to be a desirable outcome of self improvement

Melon A., Murdoch-Eaton D. Arch Dis Child 2015;100:873-878

3 Basic Tasks of the Mentor

- Inspire
  - Inspirer recognizes the mentee's potential and encourages the mentee to realize his/her dream
- Invest
  - Investor pushes the mentee, draws out his/her capabilities and demonstrates trust by putting the mentee in charge
  - Pass along information
- Support
  - Supporter functions to help reduce stress, assist with orientation and provide a sense of belonging

The Mentoring Partnership, Mayo Clinic Proceedings, 2000; 75 (5), 535-537

Mentoring models

- Peer
- Group
- Mosaic (Multiple)
- Micro-mentoring
- Cheerleaders
- Assigned (institutional)
- Instrumental
- Paper

Adapted from Janet Townsend, MD
The Commonwealth Medical College

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Mentoring is important…

- To attract, retain and engage high performers
- To swiftly acculturate new members
- To foster a collaborative environment
- To increase stability and productivity
- To promote diversity of thought and style
- To develop leadership talent
- Being a mentor is the most effective way of extending one's professional contributions

Lakoski JM, Fitch B. CRSP. UPSoM. 2006

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Setting the stage…

- Write down the characteristics of that person.
- What made them stand out to you as a leader/mentor ?
- What are you doing to become that mentor?

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Small Groups

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Mentor Qualifications

- Excellent communication and interpersonal skills
- Perceptiveness and ability to listen
- Flexibility in working with new people
- Initiative and problem-solving skills
- Accessibility
- Persistence, tenacity, and resilience
- Ability to recommend alternatives/options
  - James P, Canton M. Mentoring Circle, 1995

Mentee Qualifications

- Clear goals and objectives
- What do you want/need?
  - Type of mentor/mentee relationship
- Are you open to feedback?
- Do you know how to be an active listener?
- Are you prepared to be respectful of a mentor's input and time?

The mentor's approach to the mentorship relationship

- Mentors investigate mentees before agreeing to mentor
- Mentors value honesty in communications
- Mentors are reluctant to mediate conflicts but are usually willing to be an advocate and advisor
- Mentors should be clear regarding what they can contribute to the relationship

Mentorship Traps (How to avoid them)

(developed from research by the Center for Underrepresented Minorities in Academic Medicine, FSU College of Medicine)

Mentor *(Instrumental Mentoring)*

- Increases inclusion and belonging
- May or not be URMM, but can be helpful
- Individually focused
- Task driven
- Helps develop individual strengths

(Recognize the Monster)

- The illusion of mentorship
- Bully
- Acts in own best interests
- Non-individualized advice
- May have a supervisory role or be an assigned mentor
- Almost never a long distance mentor

Exercise 2

- Discuss a current mentoring relationship
  - Why it is/is not successful?
  - Identify at least 1 concrete area for improvement
- Who can serve as a mentor to you?
  - Within your organization
  - More senior faculty
  - Peer Mentors
  - Interdisciplinary Mentors
  - Why?

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Reports from small groups…

- Report back on successes or challenges on mentoring relationships
- Share plans for improvement

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- How do you think these topics affect the advancement of women and minorities?
- What can we do to prevent some of the challenges faced by these groups?

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A story about Mentorship

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Discussion with Drs. Flowers and Hepworth

Problems in Identifying a Mentor

- Lack of initiative
- Limited scope of search
- Inadequate background check
- Being rebuffed - time and timing, resources, miscommunication
- Politics
  - "When you swim with the sharks, beware of the wounded!" Gavin

Lessons to impart for someone seeking a mentor

- Determine whether you need more than one mentor and the respective goals for each
- Investigate the mentor's reputation
- Look for synergy – personality, goals, breadth of experiences
- Ensure the prospective mentor has the time to meet your needs
- Establish a relationship with your mentor's assistant to facilitate communication

A story about Sponsorship

Sponsorship

Mary Hall, MD

Jeri Hepworth, PhD

Harry S Strothers III, MD, MMM

Judy Washington, MD, FAAFP

Mentors vs. Sponsors

Mentors	Sponsors
Advise	Act
Can be any level	Usually 1 or 2 levels above
Selected for their style	Selected for their clout
Help you define your career	Enable your career
Speak "with" you	Speak "about" you

Sponsor Behaviors

- Give feedback and coaching. Make introductions to key people.
- Identify shadowing opportunities.
- Apprentice sponsoree on a specific skill.
- Advocate for the sponsoree.
- Ask good questions.
- Help sponsoree build business acumen.
- Help sponsoree navigate politics.

Expectations of Sponsors

Involve sponsoree in "real work" to develop key skills. Provide exposure to key people and projects. Give direct feedback to the sponsoree.

Share his/her own experiences, lessons learned, give advice and counsel.

Expectations of Sponsorees

Sponsoree should take the lead in initiating meetings with her sponsor. (Meetings should be in person if possible.)

Sponsoree should plan an agenda/goals for each meeting and let sponsor know ahead of time.

Sponsoree should focus on reciprocity in the relationship. "How can I support/give back to my sponsor?"

Sponsoree should be clear that there are no "promises" (promotion, recognition, etc.) from this process other than developing a meaningful relationship with the sponsor.

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Small Group Conversation

How do we get someone to sponsor us?

Identify at least one concrete opportunity to ask for/offer sponsorship?

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Mentoring and Sponsorship

Wrap Up

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Wrap Up - What Next?

What are you thinking now?

How do we improve diversity and advance this conversation?

What was something you learned today that surprised you?

Think back to your goals from earlier this afternoon- how are you closer to accomplishing that goal?

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Post Conference Survey

There will be a post conference survey in the next few months. Please take your time to complete this.

Thank you!

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Special Thanks

- STFM
- CAFM
- Negotiation Panel
  - *Y. Monique Davis-Smith, MD, FAAFP*
  - *David Henderson, MD*
  - *Jeannette E. South-Paul, MD*
  - *Denise V. Rodgers, MD, FAAFP*
- Ray Rosetta
- Priscilla Nolan
- Our Participants

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