Supporting intersectional mentoring of women in medicine

Increasing efforts to provide mentorship to female medical students and doctors aim to support career progression, increase representation of women in medical leadership, increase job opportunities, and provide psychosocial support and recognition. Mentorship arrangements are actively encouraged, strongly desired and beneficial for personal and professional success. However, the needs of women from diverse cultural, ethnic, religious, and linguistic backgrounds, and lived experiences are commonly failed by Western-centric male-dominant mentoring models. Acknowledging and addressing systemic barriers that impede women from minority backgrounds reaping the benefits and opportunities intended by these mentoring efforts may help improve program outcomes and success for all women in medicine.

Today's demographics

The Australian medical workforce is becoming increasingly more diverse; 35% are international medical graduates, 44% are women, and the average age of medical practitioners is 46 years.[1] Even outside of medicine, health care in general is increasingly composed of workers from under-represented groups.[2] Health care professionals, specifically of Aboriginal and Torres Strait Islander background, are few but grew over 30% in number from 2016 to 2021 (80% of whom are women).[2] However, as with many high achieving professions and STEM disciplines (science, technology, engineering and mathematics), Australian medical leadership demography does not reflect the above-described medical workforce. Women represent only one-third of Australia's medical deans and about 12% of hospital chief executive officers.[3]

Gender differences in medical leadership are well reported internationally; female physicians hold significantly fewer leadership positions than men ($P < 0.001$).[4] This glass ceiling is further exaggerated in the communities of minority women.[5,6] In American academic surgery, for instance, black women make up only 0.7% of full professors, Asian women 2.6%, Hispanic/Latino women 0.6%, and white men 65.4%.[7] Some efforts to break this well known glass ceiling include mentoring programs that are specifically designed to support women in medicine[8] and improve leadership achievement within universities, academic institutions, specialty colleges, and hospital organisations.[9] Lack of mentoring was identified as one of the two most important factors limiting academic medicine career progression in a study of academic faculty members.[10]

Current mentoring landscape

Through both formal and informal mentor relationships, medical students and doctors across all career stages can access personalised guidance, career support, professional opportunities, industry networks and more.[8,11,12] Mentors can provide experienced role modelling and leadership to help an emerging professional achieve personal and professional goals.[8] In contrast to supervisors, bosses, unit heads or other hierarchal figures, mentors ideally operate without financial responsibility or legal oversight of their mentees.[11] This can often enable the emergence of a peer support relationship, potentially lifelong, between mentor and mentee.[12] Mentorship relationships can also consider succession planning and involve preparing a mentee to take over a role held by the mentor, including senior medical leadership positions, academic roles, board roles and more.[8,13] Under-representation of women in medical leadership roles may therefore also impede advancement opportunities for emerging female leaders,[14] unlike comparable male leadership where younger men are "tapped on the shoulder" for promotion by male mentors.

Decades of traditional male mentoring (from which women are both intentionally and unintentionally excluded) have highlighted the power of professional networking for rapid career progression, job opportunities, professional courtesies, and recognition.[14] Active efforts to replicate this for female medical students, junior doctors and senior doctors are both evident and desired;[15] women in surgery are significantly more likely to be "mentored by the opposite sex though wish to be mentored by the same sex" ($P < 0.001$).[16] In another study, significantly more female gastroenterologists than male gastroenterologists had difficulty finding a mentor and were notably more likely to cite gender as a contributing factor as to why,[17] reinforcing that medicine is not gender neutral.

Intersectional mentoring of women

Intentional same-gender mentorship of women in heavily male-dominated specialties, such as neurosurgery or orthopaedics, may also:

- attract more women to these specialties;
- support mentees through a shared experience in a specific career trajectory; and
- help provide meaningful role modelling and emotional support, especially around sensitive topics such as sexism or sexual harassment.[15]

In a six-month mentorship program of female pre-medical students, there was a statistically significant increase in the mentee's interest in surgical career pathways due to the impacts of deliberate gender-concordant mentorship ($P = 0.001$).[18] Even at a higher career level, fundamental differences in attitudes towards gender are seen; female surgeons encouraged male surgeons to "acknowledge gender bias and admit their potential role", whereas male surgeons

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encouraged other male and female surgeons to "treat everyone the same".[19] This further highlights the need for insightful and open mentoring of women with a clear understanding of specific gender needs.

Even within gender-concordant mentoring relationships, widely differing identity or demographic characteristics may still impede mentoring success. Many women in medicine come from culturally, linguistically, socio-economically, ethnically, and religiously diverse backgrounds, with unique lived experiences of disability, language, psychological and physical trauma, differing housing and family models of childhood and adulthood and more.[6,8] These differing paths in life affect literacy, education, financial security, and subsequent personal and professional opportunity, within and outside medicine. Homogenous westernised or male-dominant approaches to mentoring that do not acknowledge the true implications of diversity fail minority women. Studies focused on the challenges and bridges between mentors and mentees have found that differences in race, ethnicity and age were common causes of mentorship failure, in addition to gender.[6] Junior doctors from minority backgrounds are significantly less likely to have a successful mentoring relationship[20] and therefore fail to reap the benefits of mentorship. Interventions aiming to improve mentoring and reduce inequities experienced by women in medicine must acknowledge and address gender-specific social identities, the complexities of interactions of multiple social and gender roles, and the resulting impact of this in the workplace.[5,6,8,11]

"Intersectionality" refers to how different aspects of a person's identity can place them at risk of discrimination and marginalisation, including but not limited to race, sexual orientation, religion, ability, socio-economic status, and language, in addition to gender.[21] As a result of these social factors, there is a risk of isolation, othering, sexism, racism, stigmatisation and discrimination.[21] Intersectional mentoring of women considers such factors and recognises that women from differing backgrounds are likely to have unique enablers and barriers to personal and professional success, possibly with more sensitive needs in mentoring relationships.[6,22] Intersectional approaches might therefore more effectively support women and foster a greater sense of belonging within the medical community.[23] Intersectional approaches to mentorship appropriately consider wider societal constructs and systemic exclusion of minority women due to socio-political, cultural and economic contributors. Additionally, unique personal factors such as cultural expectations around marriage, fertility, gender roles in domestic work and parenting, financial independence and housing may have greater impact in professional growth or leadership of culturally diverse women.[23] Interestingly, unlike gender, homogeneity of race is not an essential factor in successful mentorship;[10] race is only highlighted as a factor of difference that could result in "undiscussable" impasses.[6] Therefore, increasing knowledge and promotion of intersectionality across the entire medical workforce, and prioritising intersectional approaches to women mentoring is critically important to improving women's professional success in medicine.[6,23]

Recommendations

Ignorantly promoting mentorship opportunities for women, without intentional and respectful invitation to women from minority backgrounds fails all women.[23] To improve leadership opportunities for women in medicine and professional outcomes, better approaches are needed to capture, retain and benefit women with minority backgrounds through intersectional mentoring programs.

First, increased awareness of complex systemic causes of exclusion of minority women needs to be taught as expected knowledge for medical students, doctors and medical leaders. Social determinants are equally relevant in health as well as for womens' success professionally, academically and in leadership. This awareness must be further used by incorporating specific personal and professional factors to best provide individualised mentoring and not lose minority women in the process due to perceived lack of understanding or "undiscussable" impasses. Examples of such factors include holding mentoring meetings in culturally appropriate contexts if relevant (eg, alcohol-free settings, confirming accessibility in physical spaces, providing dietary options), or ensuring mentoring events are not scheduled for times during which mentees may have cultural or religious conflicts.

Second, more events and opportunities need to showcase and introduce women to potential mentors, especially where they are also of minority backgrounds. This could occur through keynote speeches, career talks, hospital orientations, webinars, and dedicated meet-and-greet or mentoring networking events. This could also lead to formalised mentor arrangements.

Third, doctors of all backgrounds need to acknowledge and challenge the disparity in support and mentoring of differing groups of women in medicine. Traditional approaches do not meet the needs of all women and specific Western-centric male-dominant mentoring efforts will fail to support women.[23] Strong role modelling by mentors who practise and advocate for intersectional mentoring will help challenge outdated cultures in medicine, and help highlight that even in 2024, there are many women being left behind. As an example, mentors need to acknowledge and validate mentees' experiences with microaggressions, bullying and other intolerable behaviour that perhaps the mentees have not previously suffered.

And last, adding to the emotional and time burden of women will defeat the intent of such efforts and only contribute to the existing "cost" that exists for women and minorities within medicine. Therefore, involvement and incentivisation of mentoring efforts should occur through financial reimbursement, continuing professional development points, protected mentoring time in salaried positions or training credits.

After all, a rising tide lifts all boats.

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