Inclusive Mentorship and Sponsorship

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KEYWORDS

• Inclusive Mentorship • Sponsorship • Hand Surgery • Diversity • Equity • Inclusion

KEY POINTS

- Barriers to inclusive mentorship center upon the current mindset of prospective mentors and potential obstacles to building a relationship with a mentee of a different background.
- Specific barriers fall into six categories: (1) traditional views of success, (2) lack of validation, (3) focus on rescue, (4) diminished value of achievements, (5) mixed goal agreement, and (6) mixed motivations.
- Solution-based approaches must be accepted by the medical community to bridge gaps within the surgical field and form inclusive mentoring relationships.
- The medical community can look to pioneering organizations that have leaned into the complex work of diversity, equity, and inclusion for additional support, insight, and resources.

THE EVOLUTION OF MENTORSHIP

Mentorship, which is simplistically defined as the process of guidance being passed from one individual with more experience to another with less experience, has been considered a core component across all our medical and surgical specialties. Its roots are often traced to the character of Mentor in the Odyssey (Homer), a text that details Odysseus' perilous journey following the Trojan War. In this narrative, the old friend Mentor appears and provides support and guidance during various trials of the plot. Fast forward centuries later, the art of mentoring—and the critical need for mentorship—continues to exist today as a central aspect of one's own personal and professional success.

One can only imagine the challenges faced by Odysseus and his family are not the same as the workplace or academic needs that warrant intentional mentorship today. That said, the principles are similar. Over the last several decades, we have watched mentorship evolve from an organic connection between two individuals who may share similar goals, vision, interests, or assignments, to a more structured process that was initially assigned in the workplace to help certain groups become aware and accustomed to professional politics. As the concept of mentoring spread to a more universal approach, with medical students, trainees, and faculty all being asked to identify mentors, we have seen the term "mentorship" being used with so much regularity that even Odysseus himself would be shocked. In fact, in academic settings and societies, awards are given to recognize the best mentors and faculty promotion decisions consider how many individuals a candidate for promotion has mentored over his/her tenure. Accordingly, we have seen an increase in individuals desiring mentors across all medical professional designations, as well as a rise in individuals seeking to become mentors to others. As a byproduct, often touted as the next step to mentorship, sponsorship also became popularized as the next phase. The goal of sponsorship has been to take the benefits of mentorship (guidance) into the decision-making environments (advocacy) to promote and publicly support the mentee. One adage is that sponsorship is bringing someone into a room, figuratively, without them having to be there.

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With that amount of attention, there is controversy over whether mentorship is truly organic and intrinsic, or if it should be constructed and manufactured. *Is one born a mentor? Does everyone need a mentor? What makes a "good" mentor?* Many have explored, and postulated, various criteria for effective mentoring, including knowledge in the subject matter, proven success, benevolence, directness, and communication skills (including an ability to listen). Considering the potential impact mentorship and sponsorship can have on personal and professional experiences, it is important to execute them with care so that the results of these touchpoints are positive and productive. However, what has not be readily explored and promoted, is the importance of *inclusive mentoring.* We have asked, *is mentorship available to everyone in the same quantity and the same quality? If not, why not?* In this article, we will dive deeper into the concept of inclusive mentorship and sponsorship, and their inextricable link to areas of diversity, equity, and inclusion in our professions. We will set the stage using Orthopedic Surgery as the example field, given its designation as one of the least diverse medical specialties with extremely low numbers of female and minority resident, fellows, and attendings despite decades of efforts. Inclusive mentorship and sponsorship provide the opportunity to bridge these gaps.

MENTORSHIP AND SPONSORSHIP IN THE TWENTY-FIRST CENTURY

The concept of mentorship has been in existence for centuries and is accepted into the academic zeitgeist as a core principle and offering to learners and faculty. As entry into medical school, residency, fellowship, and the job market become more competitive, applicants look for guidance to enhance their chances to achieve their goals. This has resulted in the establishment of many formal mentoring programs and has increased the popularity of individual one-on-one mentorship. Furthermore, students with less experience or resources in the medical field are theoretically provided an opportunity to reach an even playing field with their counterparts with this guidance from more experienced individuals who have reached a certain stage of achievement.

Guidance and advocacy come in various formats. The advent of the internet and social media has expanded the possibilities, resulting in greater reach and visibility. When students in the high school, college, and medical school phases can see themselves represented by aspirational figures, and can communicate with or follow these individuals virtually, there is a certain provision of confidence and the knowledge their goals can indeed be realized. This visual representation of physicians from underrepresented demographics and the expanded formats have encouraged the call for more diversity in relatively homogenous fields, such as Orthopedic Surgery.

Another method of providing productive guidance to mentees is developing formal peer-support programs. Formal programs not only foster interest by sharing knowledge and teaching mentees about their passions, but it allows them to connect with mentors who have been identified as committed to the process. Mentors are connected directly with mentees. Mentees belonging to formal programs can feel more comfortable reaching out, asking questions, and building a relationship with a more experienced individual. Another nuance of the formal programs is the provision of expectations for both the mentor and the mentee to support the cultivation of a healthy, productive connection. This is different from the more organic approach to mentorship where expectations may not be clearly delineated.

Regardless of format, the most effective mentors bestow guidance toward professional opportunities and are truly invested in the success of the protégé. On the track to residency, professorship, or leadership, mentors should have the capacity to elevate. Sponsorship requires the additional step of advocacy. They carry the responsibility of guiding their pupil, promoting their positive contributions and attributes amongst colleagues, and truly advocating for the path forward at decision-making tables.

In **Fig. 1**, the general phases of mentorship are outlined, highlighting components of mentorship and sponsorship. Importantly, inclusive mentorship is identified and defined as mentoring across differences. Revisiting the question, *is mentorship available to everyone in the same quantity and the same quality*, chances are the responses to our inquiry will be mixed. The idea of inclusion is relatively new and many in positions of power are becoming more aware of the opportunities for creating an environment of belonging in our academic and clinical settings. Although there is rarely intent for disparate guidance and advocacy, those realities do exist and are borne out in the experiences, stories, and concerns of our diverse learners and faculty clinicians. Inclusive mentoring highlights the need of all mentors to be well-versed in the areas of stereotype threat, which is the contextual challenge in which individuals believe they are at risk of conforming to stereotypes about their social or demographic group. In addition, inclusive mentors recognize and circumvent issues

Fig. 1. Phases of mentorship.

of bias and microaggressions. Lastly, inclusivity in this realm will ensure that the mentees have equitable access to the benefits of mentorship.

Indeed, it is human nature to intuitively search for mentors who share similar identity characteristics. However, for those who arguably could benefit the most from mentorship within orthopedic surgery, numbers of similar appearing mentors in academia are scarce. As a result, it is vital for physicians of all identity domains to avail themselves as mentors for members of diverse groups, with intent and inclusivity. Inclusive mentorship can elevate underrepresented populations in medicine and create intercultural relationships that can also benefit the relationships we have with our diversifying patient populations.

DEMOGRAPHICS IN ORTHOPEDIC SURGERY

Although Hand Surgery brings together teams from General Surgery, Orthopedic Surgery, and Plastic Surgery, Orthopedic Surgery is one of the most competitive medical specialties with a rapidly increasing number of applicants annually, yet stagnant progress in the area of diversity.[1] Thus, we will lean on the data from Orthopedic Surgery to show the case for inclusive mentorship. Despite the influx of applicants, Orthopedic Surgery continues to be one of the least diverse surgical specialties regarding sex and ethnicity.[2–4] Underrepresented minorities are defined by the Accreditation Council for Graduate Medical Education (ACGME) as African Americans, Latinos, and Native Americans/Alaskan natives. Within Orthopedic Surgery, Latinos/Hispanic, Black, American Indians, and Native Hawaiian/Pacific Islander physicians represent 2.2%, 1.9%, 0.4%, and 0.2%, respectively.[5] These statistics are drastically disproportionate to the overall US population of 18.7% Latinos/Hispanics, 14.2% African Americans/Black, 2.9% American Indian and 0.4% Pacific Islander[5] according to the 2020 census (**Fig. 2**).

Regarding sex, females currently represent 51% of all medical students. However, females only comprised 15.3% of residents and fellows, and 6.5% of American Academy of Orthopaedic Surgeons (AAOS) membership in 2019.[6,7] In fact, Acuña and colleagues analyzed trends in the annual percentage of women and determined it will take 217 years to obtain an equal proportion of men and women if Orthopedic Surgery continues growing at its current rate.[8–14]

Statisticians believe by 2045 current minorities in the United States will become the majority population, further solidifying the need for more diversity among health care professionals. In order to bridge this gap, inclusive mentorship and sponsorship are vital for the underrepresented demographics of Orthopedic Surgery. Mentors serve as a reminder of the achievable success. Mentors can also provide guidance with preparation and recruitment to residency programs and job placement. Furthermore, mentors can also serve as advocates to ensure their mentees receive appropriate opportunities. Finally, physicians in mentorship roles can assist when mentees experience common feelings of rejection, isolation, and sadness. Promoting inclusive mentorship and sponsorship is the next step to pushing the needle further within Orthopedic Surgery.

ACADEMIC PATHWAY DISPARITIES

To appreciate the necessity of inclusive mentorship, as well as the tools to incorporate it, it is prudent to acknowledge and understand the disparities that exist in an individual's pathway to surgery. From application to entry into a first job or leadership position, there are numerous obstacles and stacked odds that can be overcome by effective mentorship (guidance) and

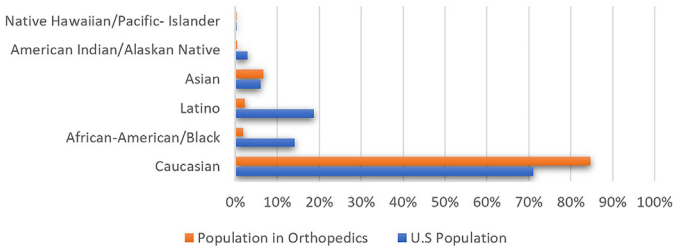

Fig. 2. Race and ethnicity in orthopedic surgery compared with 2020 US population.

sponsorship (advocacy) when done in an intentional manner.

Existing Disparities between Resident Applicants

With a startling match rate of 60% in 2022 (1,470 applicants for 875 positions), applicants strive for optimal preparation before entering the match process.[15] The highest United States Medical Licensing Examination (USMLE) scores and clerkship grades are encouraged. In addition, achieving Alpha Omega Alpha (AOA) status and an outstanding medical student performance evaluation (MSPE) can increase the odds of matching. There is an ongoing struggle to diversify applicants because of existing disparities seen with these residency application requirements.

Eugia and colleagues conducted a study in 2022 identifying commonalities in residents in surgery. They found residents in surgical specialties were less likely to come from disadvantaged backgrounds or have a family median income <$75,000. Students from disadvantaged backgrounds had a 50% decreased chance of entering the surgical field.[16–22] They also saw a family median income >$75,000 was associated with a higher NBME shelf exam score, increasing the ability to match into surgery. As NBME scores are positively correlated to USMLE scores, these findings expose the difficulty of matching into a surgical residency if an applicant stems from a disadvantaged background.[16,23]

High clerkship grades are required for an induction into Alpha Omega Alpha Honor Society. As a result, this inevitably affects the number of underrepresented minorities in AOA. The available literature already highlights the majority of Alpha Omega Alpha Honor medical society members are not Underrepresented Minority (URM) students.[24] The MSPE can also be disadvantageous for the URM student. The MSPE details a student's performance and sums up his/her tenure in one adjective (outstanding, excellent, very good, and good). Low and colleagues[25] showed independent of USMLE step scores, URM students had a lower chance of obtaining a description by the better superlatives.

The last step of the application process is the interview. In 2016, the average Orthopedic Surgery applicant applied to a median of 65 programs (range 21–88) and was offered a median of 15 interviews (range 15–25).[26] In-person interviews presented an additional financial burden on medical students, requiring many to take out additional loans.[26] Beginning in the era of COVID-19, virtual interviews presented new challenges of finding the perfect lighting, camera quality, and background. While removing the financial burden of an in-person interview, virtual interviews may still put some students at a disadvantage if they do not have the proper technology to make a great first impression with a residency program.

In summary, each aspect of the resident application process possesses risk for significant disparities between applicants of various demographics, especially those from a lower socioeconomic status (SES). Although the implementation of a holistic review of resident applicants has improved the number of underrepresented applications and matches, mentorship is one of the key differences between students who go matched and unmatched.[27]

The Impact of Limited Resources and Mentorship

Ulloa and colleagues reported a series of survey responses on the experience of African American and Latino surgeons. They found entry into medicine with a structured plan and appropriate mentorship versus an unstructured experience relying on self-discovery was strongly related to childhood SES.[28] Surgeons from a lower SES were completely unaware of whom or when to ask for assistance. Surgeons from a lower SES also noted unequal academic preparation before beginning medical school. Most importantly, the participants described significant struggles before finding mentorship. Many did not understand the nuance of critical decisions made along their career paths.

The Effects of Bias on a Resident's Psyche

Aryee and colleagues completed a study among 504 residents in multiple specialties examining the relationship between mentorship, feelings of isolation, and withdrawal. The authors found residents with greater access to mentorship displayed significantly decreased feelings of isolation.[29] Minority trainees experienced more challenges when executing orders and female trainees reported more instances of being labeled as staff with a lower training level (physician assistant, nurse, and lab tech) Ulloa and colleagues[28] surveyed African American and Latino surgeons who all described feeling isolated and/or working twice as hard to achieve equal recognition because of the color of their skin. Barnes and colleagues[30] found female surgical trainees experience more frequent, severe and stressful microagressions. These feelings can be difficult to process and can lead toward changing residencies or leaving medicine altogether. This can negatively affect the course of a resident's career, as well as the workflow of the hospital. Mentorship can teach residents how to combat challenges these obstacles.

Elevation into Leadership Positions

Mentorship and sponsorship are also imperative for elevation into positions of influence and power. In 2019, female medical students outnumbered men at 50.5% percent of the student population.[31] However, in that same year, according to an AAOS survey, 6.5% of 29,613 Orthopedic surgeons identified as women. Several residency programs have never hired a female resident.[32] In 2020, only 12.9% of women comprised residency and fellowship positions.[31] A study by Bi and colleagues[32] in 2022 found 27% of women are assistant program directors, 11% are program directors, 9% are division chiefs, 8% are vice chairs and only 3% are chairs among the 161 Orthopedic Surgery programs in the country. Having women and underrepresented minorities in leadership roles is essential to recruiting and retaining a diverse demographic of orthopedic surgeons. In addition, the Orthopaedic Diversity Leadership Consortium (ODLC) has identified the opportunities for empowerment of diversity leaders, including additional support, strategy development, education, and resources for the roles, that increase effectiveness in driving organizational change.

BARRIERS TO INCLUSIVE MENTORSHIP

Given the numerous proven areas of disparate opportunity, why is inclusive mentorship not promoted, discussed, or used? There are several barriers prohibiting inclusive mentorship to be widely accepted. These barriers center upon the current mindset of prospective mentors and potential obstacles to building a relationship with a mentee of a different background. We have separated these barriers into 6 categories: (1) traditional views of success, (2) lack of validation, (3) focus on rescue, (4) diminished value of achievements, (5) mixed goal agreement, and (6) mixed motivations (Fig. 3).

Traditional views of success are commonplace. In fact, as an example, Orthopedic Surgery has a very specific stereotype well known among medical students who announce they are interested in Orthopedic Surgery. These students will often get comments to solidify stereotypes that successful Orthopedic surgeons must have brawn and a certain pedigree. In addition, to be viewed as a successful applicant, many programs focus on number of publications, AOA status, and USMLE scores as surrogate markers. This mindset can deter potential mentors from forming meaningful relationships with mentees who do not meet these benchmarks or stereotypes and are from different backgrounds. This barrier is also encountered by faculty as well. Often, the templates used to guide promotion advancement (publications, society leadership, and awards) are used to determine whether a faculty surgeon is on track to be "successful." Interestingly, it is rare that our mentees or junior faculty are asked to define what success means to them. The medical community needs to expand the definition of success. For example, innovation, entrepreneurship, community service, investment in family and nonacademic personal achievement goals are also experiences that enhance skills as a physician and overall human being.

Lack of validation is another barrier to inclusive mentorship that is unfortunately experienced by many in Surgery, especially women and underrepresented minorities. Making excuses and invalidating one's experiences can be shown with common phrases like "*it's not them… it's you," "oh, that's just the way they are"*, *"that happens to everyone",* or "*perhaps you're too sensitive*." Invalidation of experiences can negatively affect one's confidence and trust in authority figures who could have or currently serve as a mentor. Furthermore, imposter syndrome can be exacerbated when one's own trusted confidants and mentors minimize the magnitude of microaggressions. It is a well-known fact that minority students and physicians often suffer from imposter syndrome which has been correlated with depression

Fig. 3. Barriers to inclusive mentorship in orthopedic surgery.

and anxiety.[33,34] Lack of validation can further contribute to this phenomenon.

Another barrier is a presumptuous **focus on rescue** that many mentors lead with during their interactions. There is an assumption that all diverse mentees need to be pulled up to break through some sort of metaphorical glass ceiling. Although this may certainly be the case, it should not be assumed. There are many individuals who are at a place or position that brings them satisfaction and joy and they seek mentorship to optimize their success. By enforcing that the mentee "aim bigger" and "break barriers," we may apply undue stress on diverse individuals who are more interested in being provided equitable choice and opportunity in their current environment. Mentees generally have the grit, internal drive, and intelligence necessary to excel. They simply require an additional resource, including advisors with expertise and the ability to serve as an advocate.

Diminished value of achievements is a barrier that is often employed unknowingly. This involves pervasive "rising star" mentality and language. Even when an individual has gained several promotions, achieved his/her personal definition of success, and has excelled as a leader, they continue to be viewed as a "rising star," implying that they are still subordinate, or have incompletely arrived. This is a form of infantilizing that many diverse individuals are subject to when being addressed or discussed by majority counterparts. There is no clear consensus on when someone is no longer "potential" or "young" or "rising," but there should be some thoughtfulness when that terminology is used in describing minorities or women in professional settings. In surgical specialties, there is also no consensus based on using this language and it is unclear whether it is the individual's faculty appointment level, choice of social circles, level of society committee involvement, or the personal characteristics or identity that contribute to the infinite subordinate designation. It can be demeaning unintentionally, at which point the mentor or sponsor should be receptive to that feedback. It is the role of sponsors to advocate for their mentees in the form of speaking high and appropriate praises. If the mentee is frequently demoted or demeaned when discussed, it will be hard for colleagues to recognize their value and to treat them as equal peers.

The barriers to **mixed goal agreement** and **mixed motivation** refer to reasons for mentoring outside of altruism and connection. Mentorship roles, especially toward underrepresent populations, are at times sought after for academic promotion or professional/social media prestige instead of an actual invested interest in the individual. It can be damaging for the mentees to partner with mentors who are not truly serving their best interests. Eventually, the lack of true interest comes to light and can skew the view of our profession. Mentors should be equally committed to the mentorship process for learners and faculty of all backgrounds. The goals and expectations for the relationship will be individualized and that should be discussed toward the beginning of the interactions. There are indeed bidirectional benefits of the relationship, but without some substance behind the exchange, authenticity can be challenged.

NOW WHAT? APPROACHES TOWARD INCLUSIVE MENTORSHIP

We have outlined the evolution of mentorship, reviewed disparate experiences along the pathway, and identified real barriers to inclusive mentorship and sponsorship. The good news is that there are ways to mitigate these barriers and provide equitable mentorship experiences for all interested parties.

Embrace Differences

A solid first step is for us as a medical community to become comfortable working in a mentoring capacity with people from different backgrounds and communities. An ideology that has quickly gained traction over the past few decades is incorporating cultural humility and social determinants of health in medical education. After the US Department of Health and Human Services created the first review of ethnic and socioeconomic health care disparities, training on care for patients of various backgrounds began to become incorporated into the curriculum.[35] These curriculums familiarize future physicians with potential patient populations, as well as colleagues from diverse demographics who can serve as future mentors. We do not know what we do not know, so opening oneself to education on different cultures and identities is paramount for effective relationship formation.

Practice Humility

A healthy mentorship relationship is a bidirectional learning experience. Gone are the days when information is just passed from one older person to a younger person as a finite transaction. In fact, mentoring can occur at any chronological age, and position/power level does not always imply who is the provider or recipient of the mentoring. As such, all mentors must practice humility, as many mentees are already leaders and teachers, with amazing experiences to share. Our own intellectual and professional templates should not serve as the absolute benchmarks for success. Further, active listening should be employed with space made for the mentees to have a voice and influence. Mentors must also be able to recognize talent without fear of uplifting a mentee who has a nontraditional skillset. Furthermore, we must listen to the mentees' experience, allow them to feel validated, and create an avenue specific to that experience.

Empower

We described the "rescue" mentality as a barrier to true inclusive mentorship. The key to mitigation of this barrier is moving away from the "mentor as hero" narrative, and rather emphasizing the empowerment of the mentee. There is real value in encouraging mentees to take back control of situations or opportunities. Mentors can tap into their internal confidence and guide individuals through the complex political landscape that often plagues our clinical and academic environments. In addition, mentors can lead by equipping their learners or colleagues with the tools for in-the-moment action when microaggressions occur and, as a next step, can be active sponsors by advocating for increased respect and belonging in the workplace. This requires that mentors become better-versed in the frameworks used to optimize professionalism and navigate crucial conversations. When these tools are recognized and brought into play, we can shift from an escape-approach to a thrive-approach in our mentorship interactions.

Learn About Cognitive Biases

Our brain employs a multitude of cognitive biases that allow us to survive threats, perceived and real. Understanding the fine line between healthy survival use of biases, and the biases that can cause harm and loss of opportunity is critical for mentors and sponsors. For example, *anchoring bias* is the use of preexisting data as a reference point for all subsequent data. This can alter the decisions we make and influence the potential of others. In mentoring, this shows up when we compare individuals to an existing idea of what a surgeon—or leader—should look, sound, and behave. The antiquated prototype is the benchmark, and all other individuals are compared with that. *Confirmation bias*, on the contrary, causes us to seek out information and data that confirm our preexisting ideas to the point that we even ignore contrary information. This is frequently employed for diverse individuals at all levels of the surgical education and academic pathway. If a mentee is considered an "academic risk," or if a faculty peer mentee is labeled as "difficult," then any behavior that supports that narrative will be sought out and emphasized to confirm what was already believed, regardless of any performance, achievements, or skills that suggest the contrary. Of note, being academically risky or difficult are attributes disproportionately applied to diverse individuals. Another bias, known as the *framing bias*, is based on making decisions based on the way the information is presented, rather than based on the facts alone. This can impede effective sponsorship. How a mentee is discussed (what frames are used) impacts their pathway.

There are many more cognitive biases that we put in play, and they have been extensively studied. The more we educate ourselves about our cognitive biases, which we all have, and how they may manifest to the detriment of others, the better mentors will be at validating the experiences of diverse mentees and recognizing when the biases are entering our relationships.

Co-Create the Future

We have discussed the importance of breaking through traditional views of success in our mentorship relations. Another way to navigate through this area is to co-create the future with your mentee. Many surveys, focus groups, analyses, and exit interviews focus on the past, and sometimes the present: *what was, what is, what went well, and what is going wrong.* Rarely do we ask our mentees what an ideal future state would look like to them. By communicating with the mentees about their own views and visions of success, an inclusive future state of our profession can be created as a collaborative endeavor. With this approach, we will avoid some of the "hit and miss" iterations that can occur when majority populations decide what is best for others without any shared decision-making or dialogue in the process, apply the intervention, and then spend extensive time exploring why it did not work out. The co-creation process is not only more effective but confers levels of respect and belonging that

excites both the mentor and mentee, thus strengthening the interaction.

Promote Resources for Mentorship

Many steps have already been taken to improve diversity, decrease biases, and foster mentorship. These resources, whether didactic courses or organizations, should be promoted by mentors and used as instruments to support success in the inclusive mentorship experience. For example, in Orthopedic Surgery, organizational pioneers who focus on these areas include the J. Robert Gladden foundation and the Ruth Jackson Orthopaedic Society. The J. Robert Gladden foundation named after the first African-American certified by the American Board of Orthopedic Surgery in 1949, was created in 1998. With the mission of increasing diversity in Orthopedic Surgery, mentorship is a key focus in JRGOS.[36] The creation of the annual JRGOS networking luncheon at the AAOS meeting, in-person and social media Q&A sessions, and financial aid provided for research and review courses has helped the 600 members.[36] Lastly, JRGOS members have been leaders in diversity, equity, and inclusion literature in Orthopedic Surgery, which continues altered the minds/culture of Orthopedic environments.

The Ruth Jackson Orthopedic Society, created in 1983, is an organization dedicated to uplifting women in Orthopedic Surgery. Ruth Jackson, a physician who experienced discrimination through her medical training and career, often working without pay, became the first female accepted into the American Academy of Orthopedic Surgery (AAOS).[37–39] A key focus of Ruth Jackson Orthopaedic Society (RJOS) is mentorship of a medical student, residents, and midcareer attendings. Mentorship includes mock interviews, grant writing tips, CV and cover letter templates, mock and exams for the American Board of Orthopaedic Surgeons (ABOS) examination.[37] RJOS also provides scholarships and traveling fellowships.[37]

Black Women Orthopaedic Surgeons (BWOS) and American Association of Latino Orthopaedic Surgeons (AALOS) are additional organizations that have blossomed within the last several years. The Perry Initiative and Nth Dimensions are pioneering pipeline programs for premedical and medical students that provide exposure and mentorship for students passionate about Orthopedic Surgery. The presence of these organizations is imperative to provide a voice for groups within Orthopedic Surgery that are small in number.

As we move into the leadership pathways, the ODLC has carved out a critical space for resources and support of diversity, equity, and inclusion leaders across the United States and internationally. Through formal courses, strategy sessions, networking events, and monthly "Transformation Talks," Diversity, Equity, and Inclusion (DEI) leaders, most of whom are also practicing surgeons, come together to share best practices, understand organizational dynamics, and learn strategic frameworks on how to create effective, sustainable change across all dimensions of diversity in a multitude of environments. This organization has been very effective for faculty and learners who serve in diversity-focused leadership roles that are intrinsically challenging yet gratifying. Many mentor-mentee leadership relationships have been established through the power of this network.

SUMMARY

Mentorship and sponsorship are two vital components to professional and personal success and have become a mainstay in many academic and clinical environments. Without a doubt, there are still several barriers prohibiting inclusive mentorship from being widely understood and employed. There is much opportunity in our surgical fields to bridge gaps, subtle and macro in size, and bring respect, belonging, and empathy to our environments. The disparities begin earlier than is recognized and occur through multiple parts of one's journey.

Fortunately, there are solution-based approaches that can be taken to mitigate these obstacles and form healthy, inclusive mentoring relationships. We can engage with the pioneering organizations that have leaned into the complex work of diversity, equity, and inclusion for additional support, insight, and resources. Our mentees deserve the best guidance and advocacy we can provide, which will significantly benefit the patients and communities we are gratefully obligated to serve.

CLINICS CARE POINTS

Pearls

- Surgeons from a lower socioeconomic status benefit from more guidance through mentorship—often unaware of whom or when to ask for assistance and struggling significantly on the premedical track.[28]

- Students from disadvantaged backgrounds had a 50% decreased chance of entering the surgical field. They are more likely to have lower National Board of Medical Examiners (NBME) shelf scores, USMLE scores, and Alpha Omega Alpha status.[15,23]
- Female surgical trainees experience more frequent, severe and stressful microagressions.[30]
- There are several mentorship organizations focusing on inclusive mentorship of medical student, residents, and midcareer attendings through one or one relationships, formal courses, strategy sessions, and networking events.[36,37]

Pitfalls

- Documented barriers to effective mentorship include mismatched expectations between mentor and mentee, lack of available mentors, lack of time/compensation for mentors, and geographic separation between mentor and mentee.[40]
- Many physicians in the workplace do not feel their institution supports mentorship in the workplace.[40]
- Without institutional support, the workplace environment does not demand inclusion and responsibility of promoting this environment falls on individuals, not the workplace.[40]

DISCLOSURE

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