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**Author:** Murphy Marie PhD; Record Helena; Callander Jacquelyn K. MD; Dohan Daniel PhD; Grandis Jennifer R. MD

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Mentoring Relationships and Gender Inequities in Academic Medicine: Findings From a Multi-Institutional Qualitative Study

Marie Murphy, PhD, Helena Record, Jacquelyn K. Callander, MD, Daniel Dohan, PhD, and Jennifer R. Grandis, MD

M. Murphy is analyst IV, Department of Otolaryngology-Head and Neck Surgery, University of California, San Francisco, School of Medicine, San Francisco, California.

H. Record is a fourth-year medical student, University of California, San Francisco, School of Medicine, San Francisco, California.

J.K. Callander is a resident, Department of Otolaryngology-Head and Neck Surgery, University of California, San Francisco, School of Medicine, San Francisco, California.

D. Dohan is professor, Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, School of Medicine, San Francisco, California.

J.R. Grandis is distinguished professor, Department of Otolaryngology-Head and Neck Surgery, University of California, San Francisco, School of Medicine, San Francisco, California.

Correspondence should be addressed to Jennifer R. Grandis, Department of Otolaryngology-Head and Neck Surgery, University of California, San Francisco, School of Medicine, 1450 Third St., Room 268, Box 3111, San Francisco, CA 94143; email: Jennifer.grandis@ucsf.edu.

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Abstract

Purpose
This study examined how mentoring relationships may reinforce or mitigate gender inequities in academic medicine.

Method
In-depth, semistructured interviews with 52 women and 52 men who are medical school faculty members were conducted at 16 institutions across the United States in 2019. Institutions were recruited using a purposive sampling strategy to seek diversity in geography, ownership (private or public), and prestige. Within institutions, purposive sampling was used to recruit equal numbers of women and men and to seek diversity in degree type (MD, PhD), age, and career stage. A coding scheme was developed through iterative analysis of the interview transcripts. All interview transcripts were then coded with the goal of identifying intersections between mentorship and experiences of and responses to gender inequities.

Results
Four key themes at the intersection of mentoring relationships and gender inequities were identified. (1) Both women and men became aware of gender inequities in academic medicine through relationships with women mentors and mentees. (2) Both women and men mentors recognized the challenges their female mentees faced and made deliberate efforts to help them navigate an inequitable environment. (3) Both women and men mentors modeled work-family balance and created family-friendly environments for their mentees. (4) Some women, but no men, reported being sexually harassed by mentors.
Conclusions

This study shows that mentoring relationships may be a context in which gender inequities are acknowledged and mitigated. It also shows that mentoring relationships may be a context in which gender inequities, such as sexual harassment, may occur. Sexual harassment in academic medicine has been widely documented, and gender inequity in academic medicine has proved persistent. While mentoring relationships may have the potential to identify and mitigate gender inequities, this study suggests that this potential remains largely unrealized.
There is broad agreement that mentoring relationships are key facilitators of professional success and satisfaction in academic medicine.\textsuperscript{1-3} There is also ample research documenting the presence in academic medicine of ongoing gender inequalities and inequities, which have persisted despite awareness of these disparities and the development of interventions to address some of their manifestations.\textsuperscript{4-7} Nonetheless, there is a paucity of research investigating the intersections between mentoring relationships and gender inequities.

A number of studies have identified the potential for mentoring relationships to support mentees’ professional productivity, career advancement, and career satisfaction in academic medicine.\textsuperscript{3,8-11} There has also been recognition of the possibility for problems to occur within mentor-mentee relationships: although a more experienced mentor provides important benefits to a junior mentee, the inherent power differential in the relationship also leaves the mentee vulnerable to a mentor’s poor behavior, whether it be deliberate or unintentional.\textsuperscript{10,11}

Mentoring relationships are highly interpersonal, largely private, and subject to limited institutional oversight.\textsuperscript{9,12-14} If a mentoring relationship is unhelpful or problematic, the mentee may have little formal or informal recourse.\textsuperscript{3,12,15} Mentoring relationships may form early in mentees’ careers when mentees are relatively powerless, and this power dynamic may persist for the duration of the mentoring relationship—which has no set time limit.\textsuperscript{11} Mentors may be continually called upon to evaluate the mentee’s qualifications (e.g., in letters of recommendation) throughout the mentee’s career.\textsuperscript{8} Ending, or managing, a difficult mentoring relationship may be a major professional challenge for a mentee.\textsuperscript{9}

Previous studies have recognized that experiences of mentoring may vary by gender, to women’s disadvantage,\textsuperscript{2,14,16} and speculated that sexual harassment within a mentoring relationship could be particularly problematic and difficult to address.\textsuperscript{1,12} However, a thorough empirical
examination of the intersections between mentoring and gender inequities is missing from the literature. In this study, we sought to understand how women and men in academic medicine experience, perceive, and attempt to address gender inequities within and outside of mentoring relationships.

**Method**

**Study design and data collection**

The data reported in this article are drawn from a larger qualitative study on women’s and men’s experiences and perceptions of gender inequities in academic medicine. Although gender is best understood as a continuum, previous research on gender inequities in academic medicine has relied on a binary conceptualization of gender and used the categories of women and men. To better understand the experiences behind the patterns reported in previous research, this study focused on participants in academic medicine who identified as women and men.

The study team was led by a surgeon with extensive lived experience in academic medicine (J.R.G.), and 2 qualitative sociologists (D.D., M.M.). One resident (J.K.C.) and one medical student (H.R.) provided assistance with the data management and literature review. Our complementary perspectives converged around the shared objective of developing an in-depth understanding of how participants in academic medicine make sense of the intersections between gender and their work lives. This approach draws from social constructionist or constructivist traditions, which consider the examination of participants’ understandings of their own experiences an important element of studying social phenomena. We employ a social constructionist view of gender, which holds that differences between women and men are the product of social interactions, rather than innate, biological differences.
The senior author conducted in-depth, semistructured interviews with 52 women and 52 men who are academic medicine faculty members at 16 institutions across the United States. We recruited institutions using a purposive sampling strategy to seek diversity in geography, ownership (private or public), and prestige. Within institutions, we used purposive and snowball sampling to recruit equal numbers of women and men with diversity in degree type (MD, PhD), age, and career stage. Participation in this research was voluntary, and interviewees were not compensated for their participation. We assured all participants of confidentiality with respect to both their identity and that of their institution. This study was approved by a University of California, San Francisco, institutional review board (IRB), and all interviewees provided oral informed consent as required by the IRB protocol. Interviews explored themes identified as relevant in social science and academic medicine literature pertaining to gender inequities and included questions about participants’ experiences being a mentor or being mentored. The interviewer’s extensive experience as a participant in academic medicine helped guide the conversations and elicit nuanced details of interviewees’ experiences. Interviews were conducted in 2019. Three pilot interviews were conducted to inform the development of the interview guide (see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B180) and ensure that the questions were sufficiently open-ended and reflective of participants’ experiences, rather than the study team’s assumptions. Interviews were conducted in a conversational, open-ended manner, as is standard practice for in-depth, semistructured interviews.
Two interviews were conducted via Zoom, and the rest were conducted in person. Interviews lasted approximately 60 minutes and were digitally recorded and professionally transcribed verbatim.

**Analysis**

The interview transcripts were loaded into ATLAS.ti version 8 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) for storage and qualitative data analysis. We (M.M., J.R.G., D.D.) developed a mixture of deductively and inductively generated codes based on the senior author’s lived experiences in academic medicine, our familiarity with the relevant literature, and reading and discussion of salient themes within the first 10 interview transcripts. We reflected upon how our individual training and expertise informed our interpretations of the interviews and critically examined the extent to which our assumptions about gender and academic medicine were borne out in the data.²²

After the initial set of codes was developed, 10 additional interviews were reviewed and coded individually, followed by comparison of our individual applications of codes as a group. We addressed differences in our interpretation of data and application of codes, then refined the codes’ inclusion and exclusion criteria accordingly. We then coded another 10 interviews using the refined codebook, and upon comparison of our individual efforts, found that intercoder agreement as defined by Campbell et al had been achieved.²⁵ Subsequently, 2 members of the study team (M.M., J.R.G.) each applied a subset of the codes to all 104 interviews, keeping reflective memos and regularly discussing the application of codes throughout the coding effort, as is standard practice in qualitative data analysis.²⁶
This paper is based on an analysis of transcript segments that included a co-occurrence of the codes “experiences/observations of gender inequities” and “experiences of mentorship.” We coded participants’ experiences and observations of difficulties and inequities in academic medicine that they believed were gender-related as experiences/observations of gender inequities. We coded participants’ experiences of providing or receiving help, support, assistance, guidance, or supervision as experiences of mentoring or being mentored, respectively. We did not attempt to classify individual participants as exclusively mentors or exclusively mentees because some in academic medicine identify a mentor according to that colleague’s actions, rather than an officially designated role, or according to the nature of the relationship they have with that colleague. In addition, it is possible for one to function as both a mentor and a mentee at the same time, and our interview questions covered both types of experiences. All 104 interviews contained discussion of mentoring experiences and gender inequities.

**Results**

The 104 participants included 52 women and 52 men from across academic ranks and from 16 U.S. medical schools, including both private and public universities across the country. Table 1 presents the number of women and men assistant professors, associate professors, and full professors interviewed and their demographic details. Men were more likely to have MD or MD and PhD degrees, and women were more likely to have PhDs. Men more frequently held leadership positions (such as dean, chair, center director) and endowed chair positions. Data with co-occurring gender inequity and mentoring codes included discussion of participants’ relationships with mentors at all stages of their careers as well as their experiences as mentors because interviewees ranged in age and career status. Via interpretative analysis, we identified 4 key themes at the intersection of mentoring and gender inequities: (1) learning about gender
inequities through mentoring relationships; (2) intentionally helping women mentees navigate an inequitable environment; (3) balancing work and family responsibilities; and (4) experiencing sexual harassment. Below, we discuss each theme and provide illustrative quotes.

**Learning about gender inequities from women mentors and mentees**

Both women and men in our study described learning about the presence or extent of gender inequities through interactions with women mentees and mentors. For instance, one man (Participant 4) noted that one of his woman mentees routinely received “inappropriate text messages and emails from prior mentors.” Another man (Participant 69), who identified as gay, said that women often sought him out for mentoring because they knew that as a gay man, he wouldn’t be “a creepy, harassing, piece of crap,” as other men in his department reputedly were. Other men learned about the gender-related difficulties their women mentors had experienced throughout their careers. One man (Participant 69) had a mentor who told him about how dismissive her postdoctoral mentor had been, even though she had 2 papers published in *Nature* by the time she worked with him. Another man (Participant 47) learned of his department’s reputation for chauvinism through his woman mentor’s descriptions of her experiences with their colleagues. One man (Participant 21) recognized that women like his mentor had to be extraordinary to achieve the success that she did—and that as a man, he was not subject to the same expectations. “I didn’t have to worry about being that exceptional, because I’m a guy,” he said. “Men don’t have to worry about being held to that standard.”

Unlike men in our study, the women we interviewed sometimes became aware of gender inequities in academic medicine through their own experiences. However, women too learned about—or more about—the prevalence and extent of gender inequities from women mentors. One woman (Participant 88) saw her woman mentor go through a series of incidents in which
she didn’t feel respected or taken seriously, such as a time when [the mentor] wasn’t considered for an open chair position while her junior men colleagues were identified as candidates.

Another woman remarked,

[My mentor] definitely struggled as a woman, as a new PI [principal investigator]. She was one of the only females in our department. A lot of the men there were very successful and had been around the block and had collaborated, so I think there was definitely an old-boys PI network. [My mentor] wasn’t asked to collaborate, and I don’t think she knew how to deal with that. (Participant 73)

The close, ongoing nature of mentoring relationships enabled mentors and mentees alike to gain insights about their colleagues’ lived experiences of gender inequities in a manner and to a degree that other professional relationships did not. One woman (Participant 73) told us that although she’d noticed an absence of women in her department and in leadership positions in her field, she thought little of it until she heard her woman mentor’s stories of being discriminated against.

**Intentionally helping women mentees navigate an inequitable environment**

Some of the women and men in our study recognized that women face unique challenges in academic medicine and made deliberate efforts to help their women mentees navigate these inequities. Well-intentioned and caring, the effectiveness of these efforts was limited by mentors’ understanding of the nature and extent of gender inequities in their professional world. One man put it like this:

I tell my female trainees pointblank: “You are going to be held to a different standard.” It’s especially true for the foreign-born trainees these days. There’s so much animosity towards the “other.” That’s why I push so hard for [my trainees]
to learn how to present themselves and their work as favorably as possible.

(Participant 4)

Although this mentor seemed deeply committed to ensuring his mentees’ success, his emphasis lay in helping them navigate an inequitable environment—rather than in attempting to create a more level playing field.

Another man we interviewed told his women mentees,

“Look, there are a bunch of old white dudes that are in charge, and you are going to hit some roadblocks when you encounter some of these men. But I am going to make you the best scientist you can be, so your science leads the way.” I also talk to them about having a strong network and let them know that I’m always here if they need to talk about discrimination or any other hurdles they might face.

(Participant 46)

Similarly, the acknowledgment of difficulties women may face when they encounter roadblocks in the form of “old white dudes in charge” may provide a valuable dose of recognition and solidarity to mentees—but does little to disrupt the dominance of the “old white dudes in charge.”

A woman mentor talked about creating systems for ensuring that women get the support they need to succeed professionally:

After I became chair, I had a big aha moment. I realized that [women] would get their first R01 [grant], and we’d basically say, “Good luck. See you when you come up for tenure.” Now we have someone who meets with junior faculty every 6 months to a year and looks through their CVs [curricula vitae] to identify strengths and weaknesses. Things like, “You’re doing great on getting grants, but
you’re not publishing enough.” Or “You’re doing great on those things, but you’re not going to enough meetings—who is going to write your letters?” And that’s the thing that affects women the most.” (Participant 30)

As these examples highlight, mentors in our study often helped women mentees by sharing their awareness of gender inequity in academic medicine and encouraging mentees to inoculate themselves from the negative impact of inequity by developing an unassailable record of scientific achievement.

**Balancing work and family responsibilities**

Women in our study experienced more challenges balancing work and family demands than men did, although some men in our study were primary caregivers for their families and reported difficulties juggling work and family responsibilities. Mentoring relationships were sometimes a context in which women’s disproportionate burden of meeting the demands of work and family was recognized and addressed.

**Role modeling work-family balance.** In our interviews, we found that both women and men modeled work-family balance in ways their women mentees recognized and appreciated. One woman told us,

[My mentor] had kids, and he was part of everything at home. He would say, “I’m leaving to go to my kid’s game,” or “I can’t do this, we have a family vacation then.” We used to have an annual retreat for [cancer biology], and he didn’t go to a single one. It always conflicted with his kid’s birthday, and he never missed that. (Participant 44)
Women participants’ role modeling of work-family balance looked different from the ways in which men participants modeled work-family balance. The very existence of women with children in leadership positions served an important role-modeling function for junior women. Women were acutely aware that many senior women did not have partners or families. Thus the sheer presence of any who did provided proof that being a woman in academic medicine with a family was in fact possible.

Some of the support women mentors gave their women mentees took the form of explicit acknowledgment of the difficulties women with children in academic medicine face. “This is going to be really hard,” one woman (Participant 8) told her mentee prior to the birth of her first child. “Do not waver.” Another woman (Participant 30) received an unsolicited, single-spaced, 2-page letter from her woman mentor, detailing the demands of juggling career and family, along with advice and coping strategies. This type of support illustrated both the promises and the limits of role modeling work-family balance. On the one hand, these women showed other women that “balancing” career and family could be done, without minimizing the likely difficulties. On the other hand, support of this variety did not challenge the conditions that make juggling family and work responsibilities particularly difficult for women.

**Supporting women’s pregnancies and childcare responsibilities and creating family-friendly workplaces.** Both women and men mentors in our study supported women’s pregnancies and parental leave and took deliberate steps to create family-friendly working conditions. One man told us,

> One of my grad students had a child last year, and I paid for her entire leave, even when the university said I couldn’t. Life is life. She’s a productive person, and I want her to be happy. (Participant 46)
Women also remarked upon the support they had received from men mentors in matters related to family. One woman remembered,

I walked into my [first] postdoc 6 months pregnant and told my mentor, “I was advised not to say anything, but yes, I am pregnant.” What could I do? He said, “It’s okay, we’ll figure this out,” and he was very supportive. After I had the baby, I felt like I couldn’t juggle it all. I wasn’t doing a good job at home or at work, and something had to give. So I took some time off, and my mentor was supportive of that, and then he paid me a per diem to help him write grants from home. (Participant 88)

This participant also described the support a woman mentor had given her during a previous pregnancy, and other women we interviewed spoke of the efforts they made to create family-friendly environments when they held the role of mentor. One described her approach like this:

I try to take an interest in what people are doing outside of work and respect the fact that people have families and encourage them to take care of their personal health and their mental well-being. I ask about people’s families, and some bring their kids to the lab. We have pictures of all these kids. One of the best compliments I’ve received was from a graduating student, who said that I’d had 5 [mentees have] babies in my lab in 5 years and been supportive of that. For me, that was huge. (Participant 33)

These kinds of efforts on the part of mentors, and mentees’ responses to these efforts, underscore the power individual mentors have to create working conditions that have significant implications for the careers and lives of junior members of academic medicine. Ensuring adequate parental leave and finding ways to pay mentees to work from home while caring for
young children are examples of concrete, material support for work-family balance that mentors may be uniquely well-positioned to provide.

**Experiencing sexual harassment**

Some of the women in our study who reported experiencing sexual harassment in academic medicine were harassed by mentors. None of the men we interviewed reported being sexually harassed by a mentor. The women in our study who were harassed by mentors mostly reported that they had few effective ways to stop their mentor’s inappropriate behavior or otherwise hold their mentor accountable.

One woman described ongoing sexual harassment from her postdoctoral mentor:

> For example, at one point, he sat down at the desk next to me while we were talking and put his leg up, and he wasn’t wearing any underwear. I could see his full penis, and that could only have been his intention. He also had pornographic pictures up in the office. I just ignored him, but the problem was that he had affairs with other young women in the center where we worked, so when I came along—as a good-looking twentysomething—a lot of people in the center assumed I was having an affair with him too. (Participant 91)

This woman recalled that it “never crossed her mind” to talk to someone about her mentor’s behavior. She’d dealt with sexual harassment in other contexts, accepted it as “part of life,” and chose to focus on moving forward in her career rather than on the harassment.

Another woman experienced ongoing, escalating sexual harassment from her second postdoctoral mentor:
My postdoc mentor made sexual advances towards me. He and I had a good relationship, and he started coming to talk to me in the lab when I was the only one there. He would sit at my desk every afternoon for hours and want to talk when I was trying to get my work done. It progressed from there to him acting inappropriately when we went to a conference together. He didn’t want to leave me alone at the meeting, and then after dinner he invited me to his room, then pressed a hug and a kiss on me when I said no. Later during the conference I agreed to have dinner with him, and he asked me all kinds of questions about the boyfriends I must have had when I was younger. (Participant 88)

This woman summoned the time, energy, and fortitude to take her complaint to her university’s Title IX office, only to be told that her complaint did not meet the criteria of sexual harassment because there was no quid pro quo involved. Geographically constrained by family obligations, she faced the choice between remaining in the lab of the man who harassed her or leaving academic medicine. She stayed.

This woman deemed it prudent to make the best of the relationship until she could find another mentor, and she never reported her mentor’s behavior to anyone because she did not think it would make a difference in terms of “setting anything right.” In addition, she did not want this experience to be part of her professional reputation. This sentiment was expressed by other women in our study. “Nobody wants damaged goods, right?” one woman (Participant 71) remarked of her reluctance to report her mentor’s behavior, an acknowledgment that she, rather than her mentor, would likely suffer if she reported the harassment.
Discussion

This study is the first we know of to examine the ways in which gender inequities are produced, recognized, and mitigated in mentoring relationships in academic medicine. Our study includes the experiences and perspectives of 52 women and 52 men who are diverse in age, degree type, and career stage, from 16 institutions that are diverse in geography, public or private ownership status, and prestige. We found that the unique, defining features of mentoring relationships—their longevity, status discordance, highly interpersonal nature, and lack of institutional oversight—created the conditions in which gender inequities could occur and were difficult to address when they did. Yet we also found that mentoring relationships were a context in which members of the academic medicine community developed new awareness of gender inequities and took actions to address them. Supporting work-family balance was a key example of such an effort.

The starkest examples of gender inequities occurring within mentoring relationships that participants described were instances of sexual harassment. Although previous commentaries have noted the potential for sexual harassment in mentoring relationships, ours documents and describes women’s experiences of mentor harassment and their responses to that harassment.\textsuperscript{1,12} All of the participants in our study who reported being harassed by a mentor were women; their harassers were all men. Most of the women in our study who reported being harassed did not report it when it occurred, citing the desire to keep their focus on their career and a concern that reporting the harassment would negatively affect their professional reputation. These concerns are not unwarranted: empirical research shows that women are sometimes discriminated against in the workplace for reporting their experiences of sexual harassment.\textsuperscript{28}
We found that mentoring relationships, in addition to being a context in which gender inequities could occur, also sometimes provided a setting in which members of the academic medicine community learned about the existence of gender inequities in a meaningful way. Previous research has identified a lack of specific attention to the problems faced by women in academic medicine.\textsuperscript{4,29} An absence of awareness of gender inequities can be a barrier to addressing them, and conversely, awareness of inequities can increase the likelihood of challenging them.\textsuperscript{5,30,31} Professional arenas such as academic medicine are characterized by both faith in meritocratic ideals and enduring inequalities for women. Understanding how participants in these arenas come to recognize the existence and significance of gender inequities is essential to effecting change.

Both women and men in our study reported learning more about the presence and prevalence of gender inequities in academic medicine through relationships with their women mentors and mentees. Although it seems reasonable to imagine that women would automatically be more aware of gender inequities than men are, by virtue of being more likely to experience them, women may not necessarily consider their individual experiences of gender-related inequities to be part of broad patterns of systemic disadvantage. Individuals are often disinclined to interpret their personal experiences as related to or resulting from unequal social processes because such an interpretation undermines their sense of agency and ability to control their professional trajectory.\textsuperscript{32,33} Thus, it is important to understand how all participants in academic medicine come to recognize the presence and importance of gender inequities, rather than, for instance, assuming that women are automatically inclined to be aware of and responsive to them in a particular way that men are not.
Mentoring relationships were also a context in which mentors in our study attempted to mitigate the impacts of gender inequities on their mentees. Both women and men took action to help their women mentees contend with various manifestations of gender inequities in academic medicine, such as by explicitly acknowledging unfair treatment women might experience and helping women take important steps toward professional advancement. But while these efforts provided valuable support to individuals, they may not have done much to make the broader professional environment more equitable. For instance, helping women mentees make their science good enough to stand up to the unduly high standards they might be held to may help individual women succeed but does little to address the possibility that women may be judged by criteria that have nothing to do with their scientific output—no matter how excellent that output might be.

Previous discussions of the relationship between work-family balance and mentoring relationships have emphasized the need for mentors to role model the successful negotiation of family responsibilities and professional achievement. Our findings affirm that mentors can indeed do this, and that they may also serve other, perhaps more consequential, functions.

Mentors may effectively create institutional cultures and make policy decisions within the microcosm of their lab or their department. Both women and men mentors in our study created family-friendly work environments and provided material support for parents (e.g., pay for parental leave). But the very conditions that made these interventions possible and perhaps uniquely potent in their impact also made them limited in their reach. The ongoing, unsupervised, private nature of mentoring relationships may allow a principal investigator to give a mentee extra paid time off for parental leave, if the mentor sees fit, and this may have a tremendous impact on that mentee’s life and career. But in the absence of robust, universal
policies, the extent to which mentees are able to use parental leave or achieve work-life balance may be dependent on the idiosyncratic understandings and priorities of their mentors.

There are several limitations to this study. We did not employ a closed-ended survey, so our study does not quantitatively assess the frequency or intensity of themes across individuals, and we cannot report the frequency of the themes across individuals, time periods, age, or career stage. We focused on participants’ experiences of mentoring and being mentored and did not categorize participants as either mentors or mentees or focus on particular types of mentoring relationships. Although we interviewed an equal number of women and men, our study is not inclusive of a broader continuum of gender diversities. Finally, the study does not attend to the significance of additional dimensions of diversity such as sexual orientation, race or ethnicity, age, and disability, which may have important implications for gender inequities in academic medicine.

This study indicates the importance of additional research on gender inequities within mentoring relationships. Our findings demonstrate that the essential features of mentoring relationships that make them a context in which gender inequities may occur and remain unchecked also make them a place in which mentors may address gender inequities in a variety of impactful ways. Insights from research in this vein could inform the development of interventions to make mentoring relationships more equitable and efficacious and drivers of gender equity within academic medicine as a whole.
References


Table 1
Characteristics by Gender of Interviewees in a Study to Examine How Mentoring Relationships May Reinforce or Mitigate Gender Inequities in Academic Medicine, 2019

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Women, no. (%)</th>
<th>Men, no. (%)</th>
<th>Total, no. (%)</th>
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<tbody>
<tr>
<td>Gender</td>
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<td>52 (50)</td>
<td>52 (50)</td>
<td>104 (100)</td>
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<tr>
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<td>57.0, 32-73</td>
<td>55.5, 32-82</td>
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<td>Degree</td>
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<td>26 (50.0)</td>
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<td>10 (19.2)</td>
<td>14 (13.5)</td>
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<td>16 (30.8)</td>
<td>46 (44.2)</td>
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<td>21 (20.2)</td>
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<td>8 (15.4)</td>
<td>16 (15.4)</td>
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<td>45 (43.2)</td>
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</tbody>
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*Medical school faculty members from 16 institutions across the United States participated in semistructured interviews.