Difficult Issues in Mentoring: Recommendations on Making the "Undiscussable" Discussable

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Abstract

Many mentoring relationships do not reach fruition because the individuals fail to bridge a critical difference. When a difference prevents a learning partnership from achieving its potential, the loss is multidimensional for the individuals and the institution—wasting opportunities for the fostering of current and future talent. Insights into when such impasses are likely to arise may help both mentors and mentees address what feels "undiscussable." The authors offer numerous examples of how differences related to ethnicity, language, gender, and generation may interfere with the development of mentoring relationships. Next, the authors offer recommendations on preparing for and handling difficult conversations, including creating safety, noticing assumptions and emotions, and raising sensitive issues. Virtually all faculty can become more effective at communicating across differences and addressing difficulties that prevent mentoring relationships from achieving their potential. The pay-offs for these efforts are indisputable: increased effect in the limited time available for mentoring, an expanded legacy of positive influence, and enhanced communication and leadership skills. The honing of these relational skills enhances the colleagueship and teamwork on which virtually all research, clinical, and educational enterprises depend. Academic health centers that systematically support mentoring enhance institutional stability, talent development, and leadership capacity.

In the competitive world of academic medicine, the present and future success of trainees and faculty depends to a great extent on obtaining career-facilitating mentoring. Yet virtually all studies about mentoring within academic medicine have found that large percentages of faculty and residents are not obtaining the mentoring they seek.[1–3] In response to their expressed need, many institutions have updated mentoring practices and structures (e.g., offering programs that assist pairings and facilitate peer mentoring).[4,5] However, these important improvements do not address the disengagement that occurs when a mentoring relationship reaches an impasse that feels "undiscussable." When such a relational difficulty prevents a learning partnership from achieving its potential, there is a multidimensional loss for the individuals and the institution—not only wasting an opportunity for talent development, collegiality, and interpersonal skill-building but also contributing to each individual's sense of detachment, if not cynicism, about the mentoring relationship. In this article, we give examples, drawn from our experience and the literature, of how differences related to ethnicity, language, gender, and generation may interfere with the development of mentoring relationships, and we offer recommendations on preparing for and handling difficult conversations, including creating safety, noticing assumptions and emotions, and raising sensitive issues.

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Challenges in Finding Common Ground

We adopt an expansive definition of *mentoring* as "a scaffold for sharing expertise in the service of lifelong learning that could otherwise only be attained from direct experience." Despite the restrictiveness of the term *mentor* (traditionally understood as a kind of academic "parent") and the awkwardness of the term *mentee*, no better alternatives present themselves. Our focus is on developmental relationships in which both parties have a stake and good intentions; thus, not included here are "toxic" mentors (e.g., someone who dishonestly takes credit for the work of a mentee).

Sambunjak and colleagues'[6] systematic review of the qualitative literature on mentoring relationships provides a useful starting point for identifying numerous characteristics of mentoring relationships that make it difficult for the participants to find common ground. Following those authors' observations and our own, we concentrate on the following types of common differences that mentors and mentees must often bridge: those related to (1) race, ethnicity, and/or language, (2) gender, and (3) the participants' generations.

An in-depth treatment of each of these highly complex dimensions is beyond the scope of this article; our purpose here is to alert mentees and mentors to challenges they may encounter. Although we focus separately on each of these dimensions, a few commonalities exist. For example, both underrepresented minorities (URMs)[7] and women[8] tend to be allowed a narrower range of assertive behaviors in their work; they may internalize such restrictions and, consequently, underestimate their own abilities and downgrade their ambitions. In addition, both women and URMs sometimes experience the stress of "surplus

visibility" (i.e., extra attention paid to their style and appearance).[9]

A commonality that transcends all categories is that multiple tensions are inherent in the desire for feedback—within the self, between individuals, and in the learning environment, as Mann et al[10] have so usefully and recently described.

Racial, ethnic, and language barriers

The trainees and faculty at most academic health centers (AHCs) are quite ethnically heterogeneous. When this diversity reflects that of the local community and when differences stimulate learning about other cultures, it is a great strength. But, too often, positive potentials get submerged beneath a variety of challenges. Focusing on those challenges that interfere with mentoring, we identify three categories: (1) URMs, (2) other cultural/ethnic differences, and (3) linguistic barriers. The only generalization that holds true across these is that most AHCs lack forums for addressing them.

URMs. By definition, URMs suffer from relative isolation, with few mentors of their own races or backgrounds available. Even well-intentioned majority mentors may be unaware of the disadvantages that URMs continue to experience, such as heightened pressures to serve their community (e.g., the "black tax"), feeling socially unwelcome, being identified by appearance rather than abilities, and being assumed to represent an entire race.[11] Regarding mentoring, URMs tend to encounter extra difficulties in forming and maturing cross-race relationships.[12] When the mentor has trouble identifying with the mentee, he or she is less likely to see beyond the mentee's weaknesses or to give the mentee the benefit of the doubt.[13] For both the URM mentee and the non-URM mentor, whether and how to raise any issue related to racism is fraught with the possibility of being perceived as prejudiced. One URM physician stated, "Whenever I do try to raise racial issues, others steer clear of it."

Here are some examples of issues that may be difficult to raise:

> *Mentee:* I strongly identify with the small community of African Americans here. They've been my best support, but it also feels like I'm carrying this invisible load of care—expected to be a shining role model 24–7 and to do anything asked of me. I don't know how to prioritize and make sure that I also focus on what it takes to be promoted.
>
> *Mentor:* My mentee gets asked to serve on many committees. She needs to be careful not to get distracted from her academic pursuits, but I know she feels a commitment to enhancing diversity. How do I talk to her about making those choices?

Other cultural and ethnic differences. AHCs attract international medical graduates (IMGs) and postdoctoral fellows from around the globe. Most IMGs have moved many miles from home and face multiple cultural and practical difficulties acclimatizing to life in the United States.[14] Cultural differences that contribute to misunderstandings in mentoring relationships take many forms, such as differences in body language and religious and social practices. For instance, Asians and Native Americans from less individualistic cultures tend to experience discomfort drawing attention to themselves, even if that is appropriate. And men from some Middle Eastern and African countries may lack experience relating to women as equals. Of course, generalizations such as these have many exceptions as well.

Here are examples of common, culture-related differences that may interfere with the formation of mentoring relationships:

> *Mentee:* My division chief acts as if he were royalty—especially around women. I need his support but I feel awkward with the way he "commands" me to do something.
>
> *Mentee:* My mentor seems to think that because I am Asian I will stay at the lab all night. But I want to spend time with my family as well.
>
> *Mentor:* I've committed to introducing her around at our next society meeting, but her handshake is so weak and she barely makes eye contact—it's kind of embarrassing.
>
> *Mentor:* Despite her scientific brilliance, she seems reluctant to receive the attention her works deserves.

Linguistic barriers. Most IMGs lack familiarity with U.S. idioms and colloquialisms. Also, grammatical accuracy and the impact of the speaker's first language on the pronunciation of English often interfere with oral communication.[15,16] Because language is a primary way of connecting, these impediments to communication hinder many from attracting and connecting to potential mentors. IMGs may be unaware of how hard others struggle to understand them and how much this interferes with the IMGs' professional development. Individuals who are difficult to understand or whose names are hard to pronounce are usually less approachable—decreasing their opportunities to practice English and creating a negative cycle.

Here are some examples of these linguistic barriers:

> *Mentee:* Sometimes I don't understand my mentor's humor. But I am afraid I will look stupid if I ask for an explanation.
>
> *Mentor:* It feels awkward asking him to repeat himself so often, but I don't know what else to do.

Gender-related barriers

In human beings, a person's gender is the most obvious form of difference. A common finding is that women in academic medicine tend to gain less benefit from mentoring relationships than men do, especially benefits related to career planning and participation in professional activities outside the institution.[17] Also, men tend to have much less experience sponsoring women than sponsoring other men,[18] and, thus, may not be as forthcoming or comfortable with women as with their male mentees. Because it is through relationships that organizational structures become knowable and opportunities accessible, this disadvantage is cumulative.[19]

The increasing numbers of women in academic medicine are not eliminating these disadvantages[20]; a recent study found that women students are less able than their male peers to negotiate uncomfortable situations with attending physicians.[21] Many of these extra challenges stem from the continuing influence of gendered-lenses, that is, the often unconscious expectation that women should behave communally (exhibiting nurturing and socially sensitive attributes) and that men should behave agentically (demonstrating dominance, competitiveness, and achievement orientation).[22,23]

These examples illustrate common "undiscussable" dynamics:

Mentee: My male mentors have emphasized how much they sacrificed and how many hours they worked, presumably while their spouses took care of their households. Can I find someone who can give me reasonable advice on how to keep my professional aspirations while also managing my other responsibilities?

Mentee: The other women and I experience our division chief as consistently marginalizing the women faculty, yet the other day he said to me, "I treat women equally, don't you agree?" What do I say to him?

Mentor: How can I tell this young woman that the form-fitting outfits she's wearing are not professional?

Mentor: As lab director, I've worked hard to coach this graduate student—and I've been as accommodating as I can be, given her family-related needs. But when this got to be unfair to the rest of the group and I had to pull back, she started crying, saying "Why are you so mean?"

Generational differences

This is the first time in history that *four* generations are in the workplace together. Shaped by the eras and countries into which they were born, each generation has a few distinctive characteristics. For instance, in North America, Baby Boomers (most midcareer and senior faculty) have tended to define themselves through their jobs, are comfortable with hierarchy, and expect loyalty. Generation X (most junior faculty, residents, and postdoctoral fellows) came of age with both parents likely to be working outside the home, divorce rates dramatically increasing, and corporate downsizing taking a toll. As a result, Generation Xers are less willing to sacrifice family and have less faith in organizations than their parents did. In contrast to the previous generations' orientation to "work first," high percentages of both men and women Generation Xers and Millennials (now emerging from medical and graduate schools) are explicitly creating and pursuing personal life first—with work blended in.[24] The demand for flexibility in the workplace (previously considered a "women's issue") has now become more generational in character,[25] although a double standard is still detectable, with men more likely than women to get "points" for attending to their children's activities.[26]

Another relevant difference between Millennials and previous generations is that as children they received frequent praise; thus, many members of this "trophies for everyone" generation look for frequent encouragement and may not even recognize critical feedback as mentoring.[27] The extent to which any of the above generalizations apply to young people from other countries would be highly variable.

Here are some examples of prevalent "undiscussable" generational issues:

Mentee: I don't see her as a role model—all she does is work—I even overheard her say, "Ha! Take care of myself? I definitely don't have time for that."

Mentee: Don't established faculty realize how much harder it is now to "make it," to get funded? Plus with our debt levels! And they think *we* act entitled!

Mentee: I don't want to disappoint my mentor, but he believes that unless I'm willing to be just as focused as he was at this age, I'll not succeed.

Mentor: The resident showed up 15 minutes late with a Starbucks cup in hand!

Mentor: Some trainees seem to think a mentor is someone who will rescue them—when they seem uncommitted, why should I bother?

Mentor: Why do I feel like I have to put on kid gloves with students?

Mentor: My mentee is all about work–life balance, but she thinks nothing of giving me something to review with less than 24 hours warning!

Making the "Undiscussable" Discussable

Discussion of problematic behaviors and uncomfortable questions requires a willingness to lean into tensions rather than giving in to the urge to escape them. Also required are patience and careful consideration of goals and strategies for the conversation. Below, we provide recommendations for optimizing communication at the beginning of mentoring relationships and preparing for difficult conversations as they become necessary.

Creating safety

The power difference in most mentoring relationships is such that the younger person often feels vulnerable and unsure about raising the questions that are likely to be the most pressing. It is up to the mentor to try to create a safe exploratory space.

As a start, especially when the relationship bridges many differences, it may be helpful to start with commonalities, e.g., "Let's begin with discovering what we share." The mentor might also ask relevant open-ended questions such as "What relationships outside our institution and discipline do you want to build?" and "What, if anything, is holding you back at this point?" At an appropriate point, the mentor might offer, "Because of our differences there will be times when I do not understand your perspectives or experiences. I'll try to let you know when this is happening so you can tell me more—and I invite you to do the same. Do you feel comfortable with this? Do you have other suggestions to help us bridge our differences?"

Another trust-building activity is for the mentor to disclose some difficulty or uncertainty the mentor experienced to which the mentee might relate. The mentor should invite the mentee to articulate goals and hopes for the relationship, particularly regarding how much contact there will be and how it will be arranged, followed by a discussion of what the mentor can realistically provide. It is helpful to close with the mentee's repeating his or her understanding of the agreement reached.

Communicating positive regard can be especially useful at the beginning and when broaching sensitive subjects. The following examples can be remembered as PEARLs:

Partnership ("I really want to work on this with you"),

Empathy ("It sounds like that was hard for you"),

Acknowledgment ("You put a lot of work into that"),

Respect ("I respect your commitment"),

Legitimization ("This would be hard for anyone"), and

Support ("I want to see you succeed").[28]

It is helpful to remember that positive regard is like oxygen; when people feel they are not getting enough of it, that is all they can think about. *How* we interact and respond to one another often has

more lasting impact than *what* we actually talk about.

Noticing our labels, assumptions, and emotions

To reduce uncertainty and complexity, the human brain tends to "group" and "label"; the resulting unconscious shortcuts are often misleading. For instance, most people seriously overestimate the extent to which others see things the way they do; overcoming this kind of "egotistical anchoring" takes work.[29] How can individuals get better at challenging their own assumptions? Appreciating that the lure of cognitive shortcuts is built into the brain is a start.[30] Simply slowing down and pondering helps individuals anchor more accurately. In this pause, the "stories" one may be telling oneself become apparent; individuals tend to find themselves playing either the victim, the hero, or the martyr. Another way to become more aware of one's own assumptions is to practice "bracketing," that is, actively suspending one's beliefs and judgments for the purpose of understanding another's presuppositions.[31]

Finally to be suggested is an exercise known as *left-hand column*[32]: Recall a frustrating conversation. On the right-hand side of a piece of paper, write what you actually said; in the left-hand column, write what you were *thinking, but not saying*. As you reflect on the results, ask: Why didn't I say what was in my left-hand column? Did I achieve the results I intended in the conversation? How might my comments or omissions have contributed to the difficulties? Next time, could I more skillfully share what's important?

Below are examples of how such mental flexibility looks:

> *Mentee's first impression:* She seems proud of being tired, so I won't even try to discuss my work–life with her.
>
> *Alternatively, the mentee might reason:* She has mentored a lot of men and women, she had preschoolers once, and now has aging parents; maybe I can ask her what she has seen that works and doesn't work.
>
> *Mentee's first impression:* My mentor is supposed to be there for me but she's always swamped; what's the point of this relationship?
>
> *Alternatively the mentee might reason:* I understand she has a lot of responsibilities. I could ask how I could make it easier for her to mentor me or give her permission to back out if that's more practical.
>
> *Mentor's first impression:* The route I followed is the best.
>
> *Alternatively, the mentor might reason:* Everyone defines success differently.

Another component of skilled "inner listening" is noticing when we are overreacting. When challenged, we tend to default in a particular way, such as distancing, automatically judging, or taking control of the conversation. An intelligent use of emotions in relationship necessitates detecting our feelings at subtler levels.[33] So, at the first urge to defend oneself or the first hint of a visceral response such as a quickened pulse, it is helpful to pause and ask, "I wonder what hooked me?" or "Why am I reacting so strongly?"

Also, when feeling rushed or fatigued, we often operate on "automatic," sorting into right/wrong, agree/disagree. In contrast, when we are fully present, we remain curious, asking "What could make that possible?" and "What do you see that I don't?" A mentor who listens in this deep, generative manner is better able to discern the optimal balance of support and challenge for each mentee, optimizing the value of both partners' time.

Even though this process seems time-consuming, gaining insights into others' values and motivations prevents costly (and time-consuming) misunderstandings. It also increases the chance of hearing what people are *not* saying—a key to surfacing difficult-to-raise issues.

Deciding how to raise difficult issues

There are many ways to prepare for a difficult conversation. Experienced clinicians might remind themselves that their finely honed patient communication skills transfer into other settings. Similarly, those skilled at dialogue can aim for this means of evoking insight, reordering knowledge (especially one's assumptions), and learning to inquire together about what matters most.[34]

Questions a mentor might consider asking herself or himself in preparation include

- What would I most like to communicate?
- How do I want the other person to feel after the conversation?
- What strategy (direct or indirect) seems likely to keep them from feeling defensive?
- How emotionally charged is this likely to be? Should I ask permission before broaching?

The following are possible conversation openers for mentors:

> *Mentor:* Because your progress is important to me, I need to raise what might be a difficult issue. [Mentor then raises the issue.] How do you see this?
>
> *Mentor:* I've become uncomfortable with the way you [state the issue]. I'll bet you bring a different perspective to this. Would you be willing to share it?

Here are applications of these openers:

> *Mentor:* Because both your progress and the high functioning of our division are important to me, I need to raise what feels like a difficult issue to discuss. From my perspective, I've tried to accommodate your family-related needs without being unfair to others. I appreciate from your distress during our last interaction that you probably bring a different perspective to this, and I'm eager to hear and understand it.
>
> *Mentor:* I've become uncomfortable with your arriving late but holding a Starbucks cup. Since it makes me wonder about your priorities and raises the possibility that others may as well, I think it's important to mention. How do you see this?

To be sure, not all mentoring relationships are going to bear fruit; some will die a natural death. Even so, how much better if the relationship achieves an appreciative, respectful closure?

Institutional Supports

The above suggestions focus on *individuals*' relational and communication skills. Institutional supports also are necessary to enhance the likelihood that faculty will be the best mentors they can be and to facilitate the development of relationships.

Here are some specific suggestions for institutional actions:

- Create institutional programs and practices (e.g., attention to mentoring in the evaluation of faculty and chairs) that encourage and support the formation and maturation of mentoring relationships.
- Offer faculty and trainees training in relational communication skills.
- Offer coaching to mission-critical mentees who face extra challenges in obtaining effective mentoring, for instance, the first URM faculty member in a department.
- Offer assistance and resources for IMGs aimed at "cultural transition," "English as a second language" or "accent reduction." These could be sponsored by human resources or by a drama or speech department at a local college.
- Address the demand for flexibility and less-than-full-time career options,[35] including opportunities to alternate high-involvement phases of productivity with lower involvement,[36] postservice "catch up" time, and mini-sabbaticals. Although such options may incur some up-front costs, they are less expensive than continuous re-recruiting and reorienting replacements and are likely to build loyalty in individuals who have many decades of professional life ahead of them.[37]

Just as the patient–clinician relationship has evolved from hierarchy to partnership, the above recommendations support attention to relational process and partnership in other mission-critical areas.[38]

The Bridge to Continuing Excellence

Mentoring represents the most tangible bridge to continuing excellence in academic medicine. Young professionals seek authenticity and courage from their mentors. When they find mentors who are "there" for them, they are more likely to aspire to pursue academic careers and to become great mentors themselves. Virtually all faculty can become more effective at communicating across differences and addressing difficulties that prevent mentoring relationships from achieving their potential. The pay-offs for these efforts are indisputable: increased impact in the limited time available for mentoring, an expanded legacy of positive influence, and enhanced communication and leadership skills.

Our treatment in this article of difficult issues that arise in mentoring relationships and how to address them is not exhaustive. For instance, conflicts of interest (e.g., when the mentee or mentor are competing for resources or when mentors are responsible for the bottom line) present other challenges. However, the strategies above apply equally well to those situations.

AHCs that systematically support mentoring enhance institutional stability, talent development, leadership capacity, and the development of relational skills key to the teamwork on which virtually all research, clinical, and educational enterprises depend.

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