# My mentors

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After my third attempt, I could sense the frustration of the nurse who was holding my patient folded in the fetal position. Taking up a bed in the resuscitation bay for a quick lumbar puncture (LP) was barely acceptable, and the tension to finish and get the patient to the intensive care unit (ICU) was mounting by the minute. Sweat began to form on my brow, while the humidity of my breath made my mask soggy. I made one final attempt but received nothing but a faint sputter of blood in my syringe. I flicked my gloves in the garbage, as well as the empty cerebrospinal fluid (CSF) bottles, and prepared myself for the worst part—the confession of failure to my preceptor.

That day, I was not working with just any emergency physician. I was paired with the attending physician who was largely responsible for my success in matching to the residency program. In my fourth year of medical school, she had recognized my enthusiasm and encouraged me to consider the profession. Despite my inexperience at the time (and, in hindsight, almost total lack of useful knowledge or skill), she provided me with letters of support for my applications across the country. For some reason, she had faith in my potential. To many, I had referred to her as my mentor.

By some twist of fate, it took until the third year of my residency to work with her again, and this was one of the first cases we shared. I brought her into the room and explained that I had been unsuccessful. I had no good excuse. In fact, the last 10 LPs I had done had gone quite smoothly, and this patient proposed no particular anatomic challenge. She kindly asked permission to give it a try herself and obtained clear, almost glacial CSF on her first attempt. We looked at the needle marks where I had been aiming, and it was obvious that I had been lateral to the midline—so lateral that I would have been more likely to obtain a bone marrow aspirate from the iliac crest than an LP.

To comfort me, she said the patient was a bit scoliotic. She added that despite being thin, the patient had a bit of meat on her to obscure the landmarks—"skinny-fat" was the adjective she used. Rather than accept the excuses being made for me, I remained silently embarrassed and disheartened. In retrospect, I realize that the main reason for my failure was not technical but instead the immense pressure I had placed on myself to impress my former mentor and justify my presence in the residency program.

It was clear that several drawbacks of having a mentor who was also a direct supervisor existed. Although I felt we had a great working relationship, it existed on a strictly professional level. In the past, I had not felt comfortable speaking about mistakes I had made, my insecurities about becoming an emergency department physician, and the struggles I had experienced when choosing the best institution at which to train. Because this physician was also my evaluator, I was reluctant to engage in critical self-reflection in her presence. Instead, I attempted to portray complete confidence and perfection, and it was not going nearly as planned.

Later that shift, to conclude with decisiveness, I caused a pneumothorax during a thoracentesis. It seemed as if I had encountered more complications that day than I had cumulatively in residency thus far, all in the spotlight of my mentor. On my way home, I called up my chief resident to meet and talk about what happened. It was not uncommon for us to meet

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informally and talk about our successes and failures in medicine and out-of-hospital life. Particularly in times of wavering self-confidence, he was able to share a similar experience that he had survived and provide reassurance that I would as well.

As we talked and sipped hot tea, my mood lifted, and the low tones of our conversation turned to laughter. He reminded me of how far I had come in residency and the relative insignificance of a single bad day. I realized how instrumental my senior colleague had become in my development. He, too, was medically knowledgeable and technically skilled and thus could serve as an academic resource. Because he was not responsible for my evaluation, I knew the time he spent with me was a result of his genuine concern for my growth and development. Although this relationship arose without any formal pursuit or nomination of a "mentor," I realized that this was the most honest, open, and supportive mentoring relationship I could have asked for.

Some have questioned whether senior residents or junior attending physicians are fit to serve as mentors, citing their lack of academic and political experience compared to senior staff. Of much greater importance is the quality of the relationship that is formed between the individuals, with the greatest benefit coming from an environment of mutual respect and emotional safety.[1] Intuitively, this may be more likely to arise when both parties are in closer places in their evolving careers. A young mentor may be able to provide a more cogent sense of empathy and relevance than one who has long since trained.

A few weeks later, I was alone in the ICU. An opportunity for a redemption LP had arisen, but this time, the patient was morbidly obese, and it was 4 in the morning. Alone at the bedside, I reflected on my last performance and remembered the advice of my attending physician: "If you are ever having trouble landmarking again, palpate the *entire* spine, from top down." It proved to be effective, and I exhaled with gratitude when my tubes began to fill. Part of my thanks was for the success of the procedure, but most of it stemmed from how fortunate I felt to have such great mentors. My attending physician had believed in me without fully knowing me. My chief resident had believed in me despite knowing my greatest insecurities and flaws. For both of them, I am forever grateful.

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## REFERENCE

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