

Reflections on the mentoring of a young surgeon

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In a 2004 decision, the College of Physicians and Surgeons of Manitoba found no evidence of professional misconduct by any physician involved in the 12 deaths investigated by Associate Chief Judge Murray Sinclair's inquiry into the Pediatric Cardiac Surgery Program at Winnipeg Children's Hospital.¹ The College's decision reiterated Sinclair's findings, namely, that the errors that occurred could not easily be pinned on one individual and pointed to a series of systemic deficiencies not unique to Winnipeg Children's Hospital. The decision resulted in considerable controversy in the Winnipeg media and angered at least one of the parents of the children who died.² In addition to writing eloquently on the nature of error and the intrinsic fallibility of humans, Sinclair's report questioned the culture that allows newly trained surgeons to operate without adequate supervision. If we have learned anything from these tragic events, it is that none of us can or should function or feel alone, especially at the start of practice. The mentoring process that often occurs during surgical training must continue throughout our careers if we are to develop to our full potential.

In 1994, after completing a residency in cardiothoracic surgery at McGill University, Montréal, and

fellowship training in pediatric cardiac surgery at Boston Children's Hospital, Dr. Jonah Odum began practice as the only pediatric cardiac surgeon in Manitoba. A little over a year later, Odum left Winnipeg after the pediatric cardiac surgery program at Winnipeg Children's Hospital was shut down and an inquiry called into the circumstances underlying the deaths of 12 children who underwent cardiac surgery. Among many insightful observations in Sinclair's report was the lack of a clear mentoring process, whereby a young surgeon, new to practice and in a new environment, found himself "alone."

I have never met Jonah Odum, the surgeon at the centre of the controversy, but I feel we are somewhat kindred spirits. In July 2002, fresh from 8 years of residency training and a fellowship in pediatric neurosurgery at Toronto's Hospital for Sick Children, I began practice as the only pediatric neurosurgeon at Winnipeg Children's Hospital. Odum and those 12 children were never far from my mind and weighed heavily on my decision to come to Winnipeg. I knew that as a young surgeon, new to practice, and a solo practice at that, I would be under tremendous scrutiny. I feared that bad outcomes early on, unfortunately an inherent part of neurosurgery, would quickly result in a

second inquiry, with my picture on the front page of the *Winnipeg Free Press* and the headline "Here we go again!"

Fortunately, 4 years after starting practice, the similarities between Odum's career and my own seem to have ended. How did 2 surgeons, on the surface quite similar, have such different experiences in the early stages of their practice? Although I would like to think it is solely related to surgical skill, I know that just as it takes a village to raise a child, it takes an entire hospital to raise a surgeon.

Before starting, I knew that, although I would be the only pediatric neurosurgeon at the University of Manitoba, I would not be alone. A mentoring process was put in place, both formal and informal, whereby I could discuss cases with my colleagues in adult neurosurgery. I knew that for difficult and complex cases, I would not be left by myself in the operating room but would be joined by one of the "adult" neurosurgeons as an assistant. This mentor/assistant in the operating room was not optional and was presented as a way to protect me (and my patients) as I eased into practice. I was encouraged to discuss cases with my pediatric neurosurgical colleagues across the country and, if need be, arrangements could be made for another pediatric neurosurgeon to come to Winnipeg to assist me. At no

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time did I feel pressured to accept cases beyond my expertise. I did not see these conditions as an insult to my training or surgical skill, nor as a threat to my surgical “manhood,” but rather as a way to introduce me to a new hospital and medical culture. It was actually quite a relief to have the assistance of more senior colleagues during a difficult case.

The concept of mentoring in surgery is not novel but for too long has largely been confined to the mentoring of trainees, either as medical students or residents.^{3,4} To assume that the need for mentoring stops at the end of residency training does a disservice both to our patients and to us as physicians. Whereas most surgeons can point to at least one informal mentor during their training, the mentoring process can and perhaps should be a lifelong one.

As those who are mentors know,

the learning process from mentor to “mentee” is not unidirectional. New faculty bring new ideas and techniques to their institutions and help keep a department in a continual state of renewal. The father of modern mentoring, Sir William Osler, knew that we are all lifelong students and saw the mentor as a “senior student anxious to help his juniors. When a simple earnest spirit animates a college, there is no appreciable interval between the teacher and the taught — both are in the same class, the one a little more advanced than the others.” Although Osler’s words were meant for medical students, they easily apply to us all.

I have often heard senior colleagues say they learned more in their first years of practice than in their entire residency, and I know the learning process is continual for me. It is time to recognize and for-

malize the mentoring process that all new surgeons and all physicians should benefit from. It would be one more step in ensuring that the tragic events at Winnipeg Children’s Hospital in 1994 are never repeated.

Competing interests: None declared.

References

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Essential reading

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