Dr. Ashley Nassiri:

Hello. Welcome to ENT in a Nutshell. My name is Ashley Nassiri, and today we are here with Dr. David Haynes to discuss mentorship in otolaryngology. Dr. Haynes, thank you so much for being here.

Dr. David Haynes:

Thank you for having me.

Dr. Ashley Nassiri:

Well, today we're discussing a topic that doesn't follow our usual recipe for patient workup and treatment. But this topic is arguably one of the most important factors in career development for all medical professionals. We're going to define mentorship and its style variations, go over what to look for in a mentor and how to be a receptive mentee.

Before we begin, I'd like to introduce our guest speaker. Dr. Haynes is the Senior Professor of otolaryngology at a busy tertiary medical center here in the United States. He is the Director of skull base surgery and cochlear implant programs at his institution. And he serves as the Vice Chair of academics and the Director of Relationship Development for the Department of Otolaryngology. He has been a fellowship director for over 15 years, and he has trained countless residents.

Despite this impressive pedigree, he consistently points to his mentorship relationships as his most important accomplishments. His trainees and mentees have an impressive track record and today we're going to shine some light on developing productive mentorship relationships. So, let's jump right in. Dr. Haynes, you have always demonstrated the importance of history and development and understanding a topic. If we follow your formula, can you start by telling us a little bit about the derivation of the term mentor?

Dr. David Haynes:

Yes, Ashley. Mentor was actually a person. In Homer's the Odyssey, mentor was the person that Odysseus entrusted his son's development with while he went off to fight the Trojan war, if you recall, he was gone a long time decades much like a surgical residency length. But it's interesting that the word mentor is actually a person's name.

Dr. Ashley Nassiri:

That is really interesting. Can you tell us a little bit about the history and the role of mentorship model in medicine?

Dr. David Haynes:

If you look at the Hippocratic Oath, which we've all read, but I encourage you to read it again and just look it up in Wikipedia. The entire first paragraph of the Hippocratic Oath is dedicated to teaching phrases like, "I will teach the art." "I will willingly teach you, ever wants to learn."

It appears multiple times in that first paragraph before the second paragraph until you see the phrase to help the sick. The mentorship model in surgery is critical. You often heard a self-taught guitarist or a self-taught golf swing. But there are no self-taught surgeons. We have 17 year curriculums that are dedicated to teaching. I think the length of time is standard, but the difference is in the quality of the teaching, is what we're trying to achieve at my institution.

Dr. Ashley Nassiri:

So, there can certainly be some parallels drawn between athletic coaching and medical training. In your mind, how do you compare these two?

Dr. David Haynes:

I read a lot of books written by coaches, and I really enjoyed that. If you think of the parallels to make a college team, you've had to train for long periods of time. There's been a selection and cutting of players. And then all of a sudden, a coach has a group of highly performing people that he has to, or she has to win championships with.

One of the best books I've ever read is by Pat Summit, former coach of the Tennessee women's teams. She's got a great book called Reach for the Summit. It was written years ago. But if you think that... They take this highly functional group of people, she has to teach them the basic skills, but she has to teach them also how to be leaders on the court, off the court to make their grades. They're judged though. If you look at a coach, they're judged every time they play. The score, how many championships did you win?

Our feedback is less specific. We're not judged. We don't have a score to look at. We don't have a winning record or a losing record. It's difficult to know how well you're doing until you look at the people that you've trained and you look at how they're doing in their careers. But it's very hard. It takes a while to know what you're doing right. What you're doing wrong, as opposed to a coach. A coach doesn't win they're done. So they have to be looking at the strategy where they're looking at all of these things in order to succeed.

Dr. Ashley Nassiri:

So, we've talked a little bit about the definition of a mentor, but let's dive into some of the details. Can you describe the difference between active and passive mentorship and how this plays a role in training?

Dr. David Haynes:

Yes, I've studied that. In my training, a lot of the training was passive much like watching a surgeon in the clinic, observing, watching in the OR. There's a role for that, certainly. Especially when you're young and you just want to watch everything and know the protocol. There was very little though active teaching, an active mentorship model in the old school. It was much more passive. I think, as we move forward, concept of actively teaching and actively mentoring is much more common now.

I'm known to talk all the time. I say I have seven years to train someone specifically, two years to train a fellow and I'm always talking. And when I'm making coffee, I'm telling people about, "Let's talk about this patient and here's the four options we can do. This is why we would do this." Let me tell you about a case where I was an expert witness on where somebody did the opposite and how that could have been prevented. I mean, I'm talking... But I really think there's a role for that. And I think that's sort of what a fellowship is all about. It's more than just learning how to do the surgery. It's learning all the aspects of the field and professionalism and development.

Dr. Ashley Nassiri:

So I think you summed it up quite well, as far as your teaching method and how important it is to have constant communication. What are some of the other qualities that mentees shall look for in a great mentor?

Dr. David Haynes:

I think we all have a certain style. And think one thing that I always do is, the first case when I'm working with someone is I'll say, "Let me do this." That's part of that observational mentorship. And I'm going to explain everything I do. And as you know, I have a method for how to put your gown on, how to put your gloves on, how to drape the patient. You've heard me always talk about that one resident who put the drapes on wrong and caused a cochlear implant infection and how important that is.

And you know that every detail is important. But I don't expect the residents and fellows to be mind readers. Without at least showing them one time, how you do everything and why you do it, I think that's one reason I'm talking a lot is, because there's a method to the madness and why I do something and I'll explain exactly why we do something. And I think that communication is quite critical.

I've studied the qualities of how to teach and some of the books I'll share with you, Grit by Angela Duckworth. I'm really a big fan of Anders Erickson's work. Both Duckworth and Erickson have books, but his book is called Peak and has several academic papers that you can search. The 10,000-Hour Rule is from Anders Erickson, and it's often misunderstood. You've heard that phrase, "If you do something for 10,000 hours, you'll be an expert." And it's actually not true. Erickson brings that out. Erickson, he studies mastery, he studies expertise and he's an expert on expertise.

And if you study his work, it's not doing something for 10,000 hours, it's doing something for 10,000 hours where there's intense focus and coaching. What he terms, deliberate practice. I'll give you an example, we all know there's something in golf where these guys get together twice a week and they play. And at the end of 20 years, they've played golf for 10,000 hours. And I would argue that they're better than average at most at the end of 10,000 hours of playing golf.

Yet if one breaks off and he's gone for a month and comes back and he's better. They'll say, "How come you're better? Did you go take some lessons?" So, it's not just doing something over and over again. The concept that there are super skilled people, super skilled residents or surgeons, you really don't see that. And I'll give you an example for that too. Let's say you take some gifted athletes, basketball players. They are gifted and you take 100 and say, "You're going to play golf. You guys are gifted athletes and you play golf for 10,000 hours."

But you take one of those out and you say, "Over here, we're going to take you, and we're going to teach you the game. We're going to work on every aspect of the game." There's no doubt in anyone's mind who will be the better golfer. It's the one who's coached and taught, and then there's better ways to teach and better ways to coach. You could take 10,000 athletes and you won't find that gifted athlete that has such a gift or innate skill that could just teach himself how and better than the one who's being coached. And so we've taken those concepts to medicine and clearly have tried to improve the way we train people.

Dr. Ashley Nassiri:

So when we try to unpack what makes a good mentor, can you provide some tips for those of us looking to improve our mentorship skills?

Dr. David Haynes:

Yeah, sure. I was on a panel with [Darryl Bragman 00:10:08] and [Harry van Laverne 00:10:10] and [Florian Rosser 00:10:10] at the Mayo Clinic, Vestibular Neuroma Conference. Hats off to Matt Carlson, who was organizing the bulk of that meeting. Instead of the typical panels, he had a panel on mentoring and teaching. I think we need more of that. But I'm sitting there taking notes down and learning.

And Harry van Laverne went over his 10 rules for training and mentoring. We wrote a paper about this, it'll be an otology neurotology coming out soon I hope. But his rule number one, which I agree with is, to become a master surgeon. I think this is an overarching goal. I can't emphasize that enough. I think we've all seen surgeons come into a medical center, where they're not a master surgeon, where their training was a subpar.

After seeing that early in my career I made a vow to myself that none of our trainees would ever be in that position. And that's an unenviable position to be in. We see people coming in who can't write a grant, or maybe can't publish a paper or can't write, and you can develop those skills later. But when you arrive at a medical center, you have a patient, you have an operating room, you have residents watching you, and it's unfair to all of those players for you to be unskilled. And that faults not from the person necessarily, some of the fault lies in the places in which they trained and the teaching that they received.

So being a master surgeon, I can't emphasize enough. You have to be a master in order to teach those skillsets to the people you're training. If you look at the cost of doing a fellow that you give up, you gave up the salary of attending or a private practitioner. You're moving, you're living in an apartment. You're sometimes separated from your spouse, and for us to not pay the ultimate attention towards maximizing that time for your work training, the future leaders of the field and you've given a lot to us just to be here as a trainee, and we want to give everything back to you, and we want you come to my institution and train with us. We want you to live, if nothing else as a master surgeon.

There are several ways to do that. I know one of his rules I like is the rule number of five, the white tile. I think some of us do that more than others. I probably could do it a little more. The white tile is where you leave someone, you leave them alone. You may go to the bathroom, you may go to the clinic to see a patient. You might be even possibly helping another surgeon in another room. And that's a real reality check. I mean, that's a forced assessment of what your skillset is. If you think about surgery, we've all been in that moment where, "I wish I'd paid more attention."

I kind of go through the motions. I'm a bit of a daydreamer myself. I will listen to a book, on an audible, be daydreaming about something else and not paying attention. But that is a forced assessment. Those need to be distributed throughout someone's training so that you know. One of the best residents I've ever worked with, we have multiple training sites, some with more autonomy than others.

He went to one facility after working with me and came back and he said, "Hey, listen, I don't want to even scrub on this case. I've got this notebook. I want to see how you do this because when I tried to do this meatoplasty or this mastoidectomy, I thought I knew how to do it, but I didn't." He goes, "I want to just watch you do this." He was one of the best people we've ever trained. He had that insight to know. And sometimes it's forced on you. You think, you know how to do this case until you're there, you think you know how to solve this problem until you actually start to solve it.

Another important part of mentorship is his rule, which I like, is to use accelerators. We've built a lab, a multi million dollar facility outfitted for our trainees to practice. It's skull base surgery allows the ability to practice, unlike some other procedures. There's no excuse for not practicing. If someone comes up to me and says, "I want to play and win the masters one day. I want to win the masters golf tournament. I want to play in Wimbledon." Those people are practicing night and day.

Night and day, they get up in the morning and they are playing golf or tennis all day long. When someone says, "I want to be the best skull base surgeon in the country." Like, "Okay, let's meet in a couple of weeks and talk about it." And I'll say, "Were you in the lab since we met last time?" "No, no, I've just been busy doing things." Could you imagine the person who just stated that they want to play in the masters that went two weeks without playing golf?

I think this concept of practicing in the lab and in a facility, it was built specifically for you to practice in. I can't emphasize that enough that this is your opportunity. You don't learn in the operating room. You don't practice in the operating room. These are people. That's like saying you're going to go into the NFL and practice when you make the team for the New Orleans Saints. You're not going to practice then and learn then. You're going to learn long before you ever get there.

And if you go in as a trainee, knowing and practicing and knowing what you're doing, you'll get to do more. We have this phrase, "Let me take a look at that. Let me look under that microscope." Meaning, you're pretty much being moved out. And sometimes it's because... "I can't really tell what's going on. There's somethings weird." You'll be able to sit in the chair longer if you practice outside of the operating room and you'll do more and you'll end up being a better surgeon.

Dr. Ashley Nassiri:

I think you've brought up some incredibly important points for those of us who are transitioning into senior resident or fellow positions, where we're starting to teach some of the younger residents, how to operate and how to navigate the academic medicine. When you have identified a mentor that you want to work with, what are some of the building blocks of a good mentorship relationship that we should work on?

Dr. David Haynes:

Well, I think understanding who you're working with. If you read that Pat Summit book, you could tell that not everyone is mentored and pushed in the same way. Some people can get pushed where they break down. Some people can get pushed where it doesn't phase them. And I think every good coach, if you think of Nick Saban, Pat Summit, they know how to individually read people and to push them to maximize their greatness, if you will.

I think we don't do that. We kind of have this recipe where everyone's going to get the same level of mentorship or the same style, but as we move forward into a more, instead of passive mentorship model, but a more active mentorship model, I think knowing how to push someone's buttons without breaking them down is the key.

Dr. Ashley Nassiri:

So, we've touched upon active and passive mentorship. What are some of your thoughts on structured versus unstructured mentorship programs?

Dr. David Haynes:

I think as we try to structure our mentorship program here, it's been a bit of a challenge. There's been some... Doctors don't like anything forced upon them. It's always funny to me when someone studying for their boards, for example, and here you are, you're going to hang out your shingle one day and say, "I'm a world's expert in otolaryngology." For example. And it's like, "I don't want to be studying for these boards." You're wanting to be an expert.

If you were an expert on the Battle of Gettysburg, you wouldn't be saying, "I don't want to be reading about this Battle of Gettysburg." But it's something about being forced to do something that as physicians we don't like. And so, quite happens a lot. You get assigned a resident to mentor and they may be a plastic surgeon and you're like, "Well, I can't help you much in this. Let me pass you off to so and so."

So, a lot of this is kind of wandering around in most programs looking for the person that you connect with that's in your field. And it's different from other fields. I was in a fraternity in college. We had these young pledges, and the first time a pledge messed up, there're many ways that a college freshmen can mess up. The question, "Who's their big brother? They're not doing a very good job." You had this mentor in college, but when a resident or a fellow doesn't really have that formal relationship, we blame the resident fellow for messing up, not their "big brother or big sister" in a sorority.

Dr. Ashley Nassiri:

Do you think that a structured model does a better job of ensuring time together? Is it effective in that manner or does it create more roadblocks?

Dr. David Haynes:

As I look at bigger programs, you have to have a structured model, that someone could just really fall through the cracks. ENT, otolaryngology, certainly our fellowship is much smaller and no one's going to fall through the cracks. So we may be a little less structured for that, but a big program, say medicine or cardiology, without that, somebody could really fall through the cracks and slip through and not receive the training that they should have received and deserve to receive.

Dr. Ashley Nassiri:

So, that kind of brings us to our next point of discussing how culture plays a role in mentorship. You've mentioned bigger programs. And I think across programs, even within the same specialty, we have different cultures. What role do you feel that culture plays in the efficacy of a mentorship program?

Dr. David Haynes:

I'm always talking about strategy. Strategy, literally means, it's Greek again, for, think as a general would think. Take care of all the small aspects, not just the fighting and not just the surgery, but the entire program. I've been interested in this most of my life. I had surgery when I was a young kid in Louisville, Kentucky at this place called the Kleinert Hand Center. This was the mecca.

But it was in Louisville, Kentucky. And later in my life, I come to Nashville, Tennessee, one of the meccas to train was the [Mike Glasscock's 00:21:07] otology group across the street in Nashville. Other places to train were in Zurich, Switzerland in Los Angeles. And I was thinking, "How did these meccas is exist in Zurich, Louisville, Nashville, Mike Glasscock?" So, original office where people flocked to train and people came from other countries to have surgery looked somewhat like a mobile home.

I took a picture of it. I hang it on my wall and walked by it every day and I look, and you think of what happened here that it created this greatness where you have these ivory towers and fountains. A lot of that I think is a mastery. You have to have that surgical mastery for people to want to come to train and patients to want to come to have that surgery there. A lot of is one person decided at all those institutions.

I mentioned that we're going to be great. We're going to be great at everything. We're going to create a strategy and look at every aspect of everything we do, and we're going to be a great institution. And how I teach our fellows that, "You can build this Mecca like mentality if you pay attention to the small details, anywhere you want to, anywhere." Because it's been done. It's not like never been done to have these meccas in relatively small unassuming places.

Dr. Ashley Nassiri:

You know when we kind of summarize the qualities that we look in a mentor, a lot of it comes down to communication, leadership and insight into what the future should look like. And I think when you summarize the goals of the culture, as you just did, I think that really emphasizes the role that the mentor plays in leading a field.

When we have mentors around us that are in positions high up in leadership, or who have made great contributions to the field that they're working in, sometimes they can be difficult to work with because they're so busy with their different academic positions. So, what advice do you have for trainees and selecting mentors, as far as availability goes and how you find somebody that's going to be working well with you?

Dr. David Haynes:

Well, I have a funny story for that. I think I'm known to tell stories. I think I was elected most likely to tell a story in my MBA class, which kind of hit home, but we were taking one of our best fellows out to dinner, I don't know why. I think all of our wives were out of town. And it was George Wanna, who's now the chair at New York Eye and Ear Institute. One of our best fellows we've ever had. George was a young faculty member at that point. I was obviously the senior and we took this fellow out beginning of second year to tell him what to work on and what to pay attention to this year and the responsibilities of teaching the upcoming fellow.

I was the program director. George was really interested in mentorship. And so he was the associate program director. Here we are a program that takes one person a year, but we had two people that had to run it. It's kind of funny if you think about it. But we're sitting there with this fellow and somehow the word mentorship came up and the question you just asked, how do you select one.

I said, "Well, you look for someone, it doesn't have to be here at this program. Even someone in another program on the campus or another specialty, or even in another medical center." He goes, "Well, I don't have to look very far for a mentor. They're sitting right here at this table." And I said, "No, please stop. You're embarrassing me you know." He goes, "He has the best mentor in the world. I'm looking at him right now, George Wanna." And I'm like, "Oh, okay. I thought you're talking about me."

George was only a few years out of his training at that point and young faculty member. I was so proud because, you know what? You don't really need to be a senior person to be a good mentor. You just had to be attentive and guiding. George was a good mentor. And I think as a group, we all mentor the fellows. We all have our strengths and weaknesses and things we're good at. We try to give leadership positions in certain areas.

Even within our small field of neurotology, we have quality and safety director, an endoscopic ear director, radiation oncology director. So everyone has a chance for leadership and mentorship. And part of the culture that we talked about comes from the top, where the leader has to establish that culture of mentorship, and then make sure that all of the faculty are competent at that, to a point where the fellows pick the junior faculty as their mentors, not always the senior faculty.

Dr. Ashley Nassiri:

You bring up a great point that you don't have to have just one mentor. And in fact, most of us have different mentors for different reasons, and we can tailor that to the strengths of the mentor and their relative accessibility for that specific task or a skill you're looking to develop. So, once you've selected your mentor as a mentee, what advice do you have for trainees in developing mentorship relationships and what should do to get the most out of that relationship?

Dr. David Haynes:

It's a good question. There is another author that I have looked at their work. Carol Dweck, and she writes a lot about a growth mindset. That concept is that you have to be willing to be taught. You have to be willing to learn, and you have to be willing to take criticism. We've all seen. As a resident, Ashley, you've taught other residents and medical students.

And you see a vast difference between those and the ones who don't learn... Imagine, I'll use the golf analogy again. Okay? If I say, "I'm terrible at golf," which I am, "I'm going to go pay someone $100 an hour," which is probably more than what I make, "To teach me to do better." And if they come in and say, "You're gripping this wrong." I can't say, "Well, no, that's just the way I like to hold it."

And they said, "Well, your stance is wrong." Or, "Your swing is terrible." And I go, "No, I like doing it this way. This is the way I feels good to me." Then they should say, "Okay, then just keep being terrible at what you do." I have to go in there... And most of the time we are. We've made that decision that I need to do better. And when you get an MBA, you've said, "I don't know anything about this. I really want to know about it." Some accounting professor will say, "You're terrible at the spreadsheet. You need to do better. Here's your grade." So we're in a growth mindset saying, "I want to learn this better. Yeah, tell me what I'm doing wrong."

"Yeah, okay, thanks. Thanks. Okay. I'm going to practice this and we'll come back again. And then you'll grade me on how much better I am." That's a growth mindset. That means, "I am willing to admit that I'm not good." Have you ever worked with a resident... "Don't be holding the drill like that." "Well, this is why I like. I'm holding like this because..." I'm like, "Well... [inaudible 00:28:39]"

Those people don't get better. And you have to pull them aside and say, "Listen, I'm going to really tell you everything you're doing wrong. And you have to be really ready to accept that. You're here. You're here for two years. If you do something new, that means that's something new you're going to be bad at. And there's going to be a person better than you and that person, if they give you feedback, that means they actually care for you."

That golf coach. For example, let's say I go out there and I'm just terrible missing the ball, slicing the ball. And he just sits there or she sits there and, "Oh, that's good. You're doing a great job, David. Yeah. Okay." The end of that hour would be a wasted hour for me, a wasted time and I may have liked them for not criticizing me, but they would have been a terrible coaching job and a waste of everyone's time and ineffective. Anders Ericsson talks about that, that the key for a teacher is to give immediate feedback. And the key for the mentee is to be willing to accept that feedback and change.

What does Nick Saban and those guys, why do those coaches have a whistle? They blow that whistle, "Stop. You did that wrong." Immediate and effective feedback. They don't say, "You know, last month in practice, you did something wrong." You have to be intentional. You have to give that feedback immediately.

These performance evaluations are kind of funny. Like once a year, where we're going to get together, we're going to tell you what you did wrong. Why wait six months. I'm going to tell you what you did wrong every day and what you did right. And what you did a good job at. That's how great coach is. And that's how great players get better and great surgeons get better.

Dr. Ashley Nassiri:

Dr. Haynes, you bring up a really important topic for residents. And that is feedback. I know that from personal experience that I frequently get feedback from all of the otologist in our department, but certainly when we get busy or when we have to rush off to prepare for the next case, sometimes there isn't time, or it slips one's mind to give residents feedback. Do you have any recommendations for trainees to politely elicit that feedback?

Dr. David Haynes:

You're right. We are very busy. Isn't it ironic that we're too busy to teach, even though we're a teaching institution? You've often heard me say, "All right, you ask me that after clinic." Or, "When we're walking to our car, you ask me that question will answer it then." "I want to tell you something about this case tomorrow." Or, "Want to tell you something about the case we just did today, come find me later, or call me, or call me tonight at home."

Those are opportunities to give feedback that aren't in the middle of acoustic tumor removal. We have to have the training. You're very good at this, Ashley, you look for feedback. That's what good trainees do. They want for you, you're here for that. But some, you have to say, "Okay, I'm going to give you feedback on this rotation." The feedback will, most of the time be bad. I did an MBA late in life. I was 55.

Those professors gave me all kinds of feedback about how bad I was at Excel or something. Sometimes in the form of grades and sometimes verbally, but you were ready for that. I'll have to say you have to be ready for you to get better. I mean, imagine the tennis coach saying, "Okay, I'm going to give you this lesson. But when I tell you to change your grip, don't get mad at me." Because we all want to be liked. We want to have relationships with our residents, but you're doing the training, a disservice to watch them do something poorly and then go out into the world and continue to do something poorly.

We talked at the beginning that that was my vow to never have anybody that trained under me, be put in that very terrible, awkward situation. When you come into it, an academic medical center somewhere where you underperformed surgically, that's not fair to the patient, if nothing else. And certainly not fair to the people that they're going to train and to the medical center. The need to give that feedback before your training. You're not supposed to be good. "You're you're not supposed to come in. We want you to be in the lab to be ready to learn, but you're learning." And then, "We have a finite amount of time to train you. We've tried to optimize that time, but that time is optimized by giving you hard feedback on what you need to work on."

Dr. Ashley Nassiri:

So you bring up the point of asking for feedback. And I think you, as a resident, just from my personal experience, asking for that feedback shows that you're interested. And most of our attendings have always looked upon that very positively. And they know that you're willing to learn, which I think is a huge part of that relationship is when the mentor and the mentee are both on the same page and both are aiming towards the same goals. When we talk about working with a mentee and their level of enthusiasm, how much does that impact how you go about that relationship and how important is that in building that relationship?

Dr. David Haynes:

Like I said, we want to be liked. But, as Nick Saban liked by the person he's yelling at, or Pat Summit, you think of a hard coach. What people don't realize is, we're not yelling, but if we're telling you something that could make you better then that person cares more for you than someone who just turns and walks away. It may take you much of your life to realize that. But if you look back at the people who taught you the most, they gave you the most perhaps negative feedback, not negative, but the most constructive advice. And sometimes it's not in the OR it's regarding professionalism or how to manage something in the clinic, how to manage coworkers, professional advice.

And I think the fellowship offers that. I think when you look at why is the fellowship so important, you're really hanging out and learning all these things an hour. We're always talking, [Reeve

00:35:26] is a talker, I'm a talker. George Wanda was a talker. [Matt O'Malley 00:35:31] is a... We're talking, talking, talking. Always trying to impart some form of wisdom to someone who has to listen to... because they can't just walk away from us. You understand? We enjoy that. I think we enjoy the concept that at the end of your training, you've imparted with, not just surgical wisdom but all kinds of wisdom on how to manage the world of neurotology.

Dr. Ashley Nassiri:

So we've talked a lot about surgical mastery, a little bit about research and how the mentor plays a role in those two skill sets, but from personal experience, I know that a lot of what we learned from our mentors is about leadership and how to develop your career. Can you speak a little bit to that and what kinds of wisdom you impart and how you do that?

Dr. David Haynes:

I think that one of the reasons there's a relative lack of papers in our journals and lectures at our meetings on mentorship and leadership is, it's sort of, and a bit embarrassing to do that just because you're proclaiming some sort of expertise in those areas. When you asked me to do this, I was like, "Let me go study this." There's, I don't want to say arrogance, but when you give a talk on leadership, to me, it always seemed like there was some arrogance to that. Like, "I know all about this. Let me talk about." Unlike. "I do know about how to do ear surgery because I do that all day." And I'm learning both of those things, burnt learning leadership and newer techniques and in surgery as we go.

But some of what we've developed in otology in our neurotology fellowship is leadership training and many aspects of that. If we look at why some people's careers aren't where they want to be. It's usually because they're not smart. Everyone here in our residency is super smart. That's the basketball team where you get... you would have been cut a long time ago, if you weren't smart.

If you look at why they didn't achieve their goals, even some that were terminated it was not because they weren't smart. And the concept of someone being great at everything but surgery, where they just don't have the hands for that. That's pretty rare too. That's usually if someone's not a good surgeon. They're also not good at a whole host of other things. And so, while I said that by far and away surgical mastery is what's where you start.

You're going to go to your job wherever that is, knowing how to do the surgery. That is key. But all these other things help you succeed. A lot of it, we teach on the fly. We have a little coffee room here where I think my mouse's moving than my hands, while we make coffee and we're going to talk about things. Usually things that aren't about how to take an acoustic neuroma out, that will make you a success. Some of the things I learned in my MBA... When I did my MBA, there were lectures on leadership and leading teams and conflict resolution and alike. I was 50 something and I looked across the room and there was some 21 year old kid there.

I'm like, "My resident right now is leading a team. They're in the ICU leading a team, rounding on our patients. Yet we don't have formal training in that. Why is this 21 year old kid who hadn't run a lemonade stand, getting these lectures? Why don't we get those lectures?" And so we're trying to formalize that process and take these topics. We have lectures in the morning. Some of our lectures are not on facial nerve reanimation, but they're on leadership and topics related to that. Like I said these programs that exist in smaller places, it's because someone decided they're going to make that place great.

One of my favorite things to ask someone who wants to go into a different field or wants to do a sinus fellowship somewhere, wants to do a voice fellowship somewhere, like "Why do you want to go there? What's the top program. Why is it the top program?" And I'm taking notes too, because if they

say something we're not doing, then we're going to start doing it because we want to be the top program. We want to be changing and learning from other people.

And this is done granted, these leadership talks aren't done in the middle of the day. They're done before we start, after the clinic's over, while we're walking to the OR, while we're making coffee. Just sometimes there are little stories, little anecdotes, how do you even treat your referring base? My referring doctors, we have a very strong relationship with them.

These guys are often smarter than me, better board scores than me, better grades than me, went to better schools than me. And they're out there seeing these patients. And we treat our referring docs with a lot of respect, and I teach our guys to do that as well. And they're practicing how to build a practice and the leadership piece of what you do if you want to build a great program is critical.

Dr. Ashley Nassiri:

So I think you've brought up some incredible points throughout this discussion. I think that you don't want to call yourself an expert in mentorship, but having gone through your program, I think that's an appropriate title. And it's been an honor to interview you today.

I'll go ahead and jump into a summary of our discussion as we usually do. First off, the mentorship model has played a critical role in teaching since the beginning of surgical training, even being mentioned in the Hippocratic Oath. Mentorship programs should strive to be active with constant teaching, interactions and exchange of ideas. Great mentors can be difficult to define, but they commonly exhibit resilience and grit. They have developed a mastery of surgery and continue to grow and improve through deliberate practice.

Both structured and unstructured mentorship models are practiced, and each has benefits and drawbacks. Structured models provide a framework for learning through formal didactics and ensure face to face time, but at times they can feel a little bit artificial. Unstructured models may not provide formal teaching, but they can be effective when both the mentor and the mentee are dedicated, work together frequently and communicate effectively.

A combination of the two is most commonly practiced. Mentees should think both short and longterm about career and personal goals and should seek mentors that reflect these aspirations. A hardworking and enthusiastic attitude towards training and reception of criticism for a mentorship relationship is the most critical aspect.

Dr. Haynes, it's been an absolute honor interviewing you about mentorship in otolaryngology today. I would just like to wrap it up, but if you have any final comments, we'd be happy to hear from you.

Dr. David Haynes:

No, Ashley, thanks for addressing this topic. I think it's an under addressed topic and what you and Matt Carlson are doing with this venue and this unique learning opportunity, I'm proud to be part of it.

Dr. Ashley Nassiri:

Thank you so much.