Fostering Interest without Intimidation in Otolaryngology

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I am currently a fellow in otolaryngology, and I have never reviewed Electronic Residency Application Service applications. However, I hope for an academic career, so I am likewise concerned with the recent trends in otolaryngology applications.1 I am writing to suggest a potential avenue for increasing future otolaryngology residency applications.

My path to otolaryngology started with something simple: an interest. As an early medical student, I was not thinking about board scores and publications. I simply enjoyed surgery and the anatomy of the head and neck. As a student, I did not have any publications or presentations on my curriculum vitae. I let my interest guide me. Fortunately, my interest superseded my lack of publications, and those who helped foster my interest became my mentors.

As a resident, I reciprocated this mentorship by creating an otolaryngology interest group (IG) for medical students at my institution. The IG scheduled events and demonstrations (eg, laryngoscopy, otomicroscopy) for students to learn about otolaryngology. The IG was designed to provide what Dr Chang refers to1: it was organized by residents and students, offered to all students, and not elitist; it removed barriers by avoiding in-depth discussions of “necessary” qualifications for applicants. It offered an unintimidating environment for students to learn about the specialty without the pressures an authority. Students came to meetings because they were interested, not because they had a certain board score. We surveyed residency programs around the country to see how active the concept of an IG was and found that, unfortunately, IG played only an minor role in influencing residents’ interest in the specialty.2

It is difficult to quantify interest on an application. However, fostering interest in lieu of intimidation through otolaryngology IGs might reverse the recent trends in otolaryngology residency applications.

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Mindful Mentoring

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I thank Dr Naples for his letter and insight.

Everyone has a story about how she or he got interested in otolaryngology. The details vary from person to person, but they all usually have one common denominator: mentorship. During my surgery rotation as a third-year student, I chose to rotate through orthopedic surgery. My first day involved holding the leg stationary in a certain position for the duration of the case. Later that day, I happened to meet Joe Edmonds, MD, then a fifth-year otolaryngology resident, who basically said to me, “If you jump ship to come and check out ENT, I’ll be able to show you the ropes.” That was the start of it all.

Mentorship happens in many ways. Mentorship can come from faculty and resident physicians. Mentorship can come from medical students. Mentorship can come from family and friends.

Otolaryngology interest groups in medical schools are one way to mentor those interested in the specialty. These groups enable medical students to experience and grow as part of a community of like-minded students. However, for this group to truly be successful, it requires not only a cadre of motivated and interested students but perpetual investment and enthusiasm from department faculty.

Insinuating otolaryngology more formally into the medical school curriculum would be beneficial. However, connecting...
to medical students through lecture sessions has become a less fruitful endeavor in this day, as many students prefer to watch the recorded lectures (played back at 2× speed) than attend them live. Personal contact now occurs chiefly through hands-on workshops (suture laboratory, physical examination sessions, problem-based learning sessions) or ambulatory clinical experiences. In addition, many medical schools have a mission to graduate physicians with a primary care focus, which competes for the attention of medical students.

Physician mentorship will continue to remain an important component of recruiting and advising residency applicants. How this mentorship is conducted has larger implications in not only increasing the quantity of applicants but also shaping the composition of that pipeline. If we prioritize equality and opportunity, this mentorship needs to be encouraging and welcoming, not discouraging and exclusive. For otolaryngology to remain vibrant and healthy, there needs to be continued mentoring that is mindful of our biases, yearns for what is good, looks beyond traditional metrics of meritocracy, and strives to achieve the very best of ourselves.

It is easy to talk the talk; we need the strength and boldness to walk the walk.

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Response to the Letter to the Editor: “Comparison of Medical Therapy Alone to Medical Therapy with Surgical Treatment of Peritonsillar Abscess”
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We thank Dr Ribeiro and his colleagues for their thoughtful letter to the editor.1

The medical therapy (MT) protocol was designed with the reality in mind that patients with peritonsillar abscess (PTA) are almost uniformly diagnosed clinically in the Southern California Permanente Medical Group (SCPMG) emergency department (ED) without the aid of a computed tomography (CT) scan or an ultrasound. Controls were placed in the protocol to protect patients and minimize risk, the most important control being that patients must have uncomplicated PTAs and the next most important being that patients follow up with an otolaryngologist the next morning. Not all PTA patients are treated with MT. If there is any evidence of airway compromise, evidence of extension of the infection to the para- or retropharyngeal spaces, or evidence of bacteremia or sepsis, or if patients are not significantly improved within hours of starting MT, patients are surgically drained.

We also point out the weaknesses of the case series, which includes the fact that the MT group may have had less severe disease. However, to control for severity of the disease, we examined the subgroup of PTA patients with trismus given they were more likely to have an actual abscess. As with the overall group of PTA patients, we found that the trismus patients had no difference in complication or failure rates regardless of whether they were given MT or surgical therapy (ST). Instead, we found the trismus patients who were treated with ST required significantly more opioids.

Since the institution of the MT protocol in 2008, thousands of patients clinically diagnosed with PTA have been treated successfully with MT without a resulting mortality. Our latest data indicate that between 2015 and 2016, 89% of 1979 patients with PTA presenting to SCPMG EDs were treated with MT. While it is possible that most of these PTA patients did not have an actual abscess, it is very unlikely.2 Rather, our data indicate that the average patient clinically diagnosed with an uncomplicated PTA in the ED can be safely and successfully treated with MT, regardless of whether a CT or ultrasound is performed.

Given the advantages of MT compared with ST outlined in our article and the success we have had with MT over the past 10 years, we encourage other head and neck surgery groups to adopt the MT protocol at least on a trial basis. If any questions arise, we are here to help and provide guidance at any time.

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Reference