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What is This?
Section for Residents and Fellows-in-Training Leaders: Where Are They Now?

Brianne B. Roby, MD¹, Meghan N. Wilson, MD², Nikhila Raol, MD³, John Carter, MD⁴, Kanwar Kelley, MD, JD⁵, Nathan A. Deckard, MD⁶, Estelle S. Yoo, MD⁷, and Jayme R. Dowdall, MD⁸

Abstract
The purpose of this study was to examine the experiences of prior governing council (GC) members of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) Section for Residents and Fellows-in-Training (SRF) and assess the impact of early Academy involvement. A survey was conducted via email on all prior AAO-HNS SRF GC members. The AAO-HNS SRF has elected 52 GC members since its 2003 inception. Each member served an average of 1.5 year-long terms. The mean time since completion of training is 4.1 years. A subspecialty fellowship was pursued in 86%. Fifty-seven percent practice in academic settings, with 3 members advancing to subspecialty division director within their department. More than half (58%) have served on an AAO-HNS committee, and most are frequent attendees of the annual meeting. All prior members felt involvement in the SRF GC was beneficial, enabling them to gain leadership skills and deeper understanding of the specialty.

Keywords
residents, fellows, leadership, American Academy of Otolaryngology, AAO-HNSF

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The Section for Residents and Fellows-in Training (SRF) of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) was established in 2000 to help increase resident involvement in Academy initiatives. By creating this section, residents and fellows were given a representative on the AAO-HNS Board of Directors and Board of Governors. Currently, there are 1559 members in the SRF. In 2003, the SRF began a governing council (GC), which includes chair, vice-chair, member at large, information officer, immediate past chair, Board of Governors (BOG) governor, BOG legislative representative, and BOG Public Relations representative. These positions are elected each year at the AAO-HNSF annual meeting by the members of the SRF who are present. Many current and former leaders of the AAO-HNS have emphasized the importance of getting residents and fellows involved in the Academy at a young age as a way of cultivating future leaders within the Academy. It is often told to residents that getting involved in the SRF will help them to leadership positions within the Academy as their career advances. Literature in the orthopedic specialty has demonstrated that early involvement within their academy translates into long-term involvement,¹,² and studies looking at chief residents in family practice showed that early leadership translated into long-term leadership roles.³ However, there are no data within the field of otolaryngology looking at early leadership and any long-term effects. The purpose of this study is to look at the prior SRF GC members and “where they are now” in terms of practice type and AAO-HNS participation, as well as determine if there was any correlation between early involvement and long-term involvement within the Academy.

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Methods

An institutional review board (IRB) waiver was obtained from Children’s Hospital of Colorado. A survey was developed by the current SRF GC members and distributed to all former AAO-HNS SRF GC members through email to determine current involvement within the Academy. Since there are multiple ways to get involved in the Academy, the survey addressed holding elected positions, serving on committees, teaching instruction courses, or just attending the meetings, as these were all viewed as important ways to be involved in the Academy. Participants were included in the study if they completed the survey. Any GC members currently in training or former GC members who left the specialty were excluded. A control group consisted of residency classmates of the GC members who did not hold elected positions. The control group was selected by surveying recent GC members for residents in their class who did not hold leadership positions. The control group was from multiple residency programs, although did not include members from every residency program with a former GC member. The same survey was given to the control group. The data from the returned emails were entered into a spreadsheet, removing identifiers from the data. The survey is included as Appendix 1 (available at otjournal.org).

The survey was sent out to all former GC members at once, with no pilot data obtained ahead of time. The questions were developed so that responses would be simple 1-word answers and thus be easier to analyze.

Statistical analysis was performed using the Fisher exact test to compare categorical variables between academic and private practice groups.

Results

The AAO-HNS SRF has elected 52 GC members since its 2003 inception. Seven positions are filled each year, but with some members holding multiple offices during their involvement, this has resulted in 52 people holding offices. Five members are currently in training, there was a death of 1 former member, and 2 members changed careers. One changed to a different specialty for health reasons, the other changed to a subspecialty division director. Five members are currently in training, there was a death of 1 former member, and 2 members changed careers. The control group was part of the study, although it in itself may be biased by the number of members in each subspecialty for both groups. Two members no longer practice otolaryngology. A subspecialty fellowship was pursued by 88% compared with 65% in the control group ($P = .046$). Figure 1 shows the number of members in each subspecialty for both groups. Two members no longer practice otolaryngology. Forty-six percent practice in an academic setting ($n = 19$), with 3 members advancing to a subspecialty division director within their department. This compares to 55% of the control group practicing in an academic setting ($n = 11; P = .59$). Medical student or resident instruction is part of the career of 66% ($n = 27$), while in the control group, 80% are involved in resident instruction ($P = .37$). With the exception of the 2 members who no longer practice otolaryngology and the 1 death, all former GC members are members of the AAO-HNS, while in the control group, 10% are not members of the Academy ($n = 2; P = 1.0$). Fifty-four percent ($n = 22$) have served on an AAO-HNS committee, and 10% ($n = 4$) have held elected positions within the AAO-HNS. This compares to only 10% of the control group having served on a committee ($P = .002$) and none being elected to a position ($P = .29$). Most (58%) are frequent attendees of the AAO-HNSF annual meeting compared with only 35% of the control group ($P = .11$), and 29% ($n = 12$) have assisted with an instruction course.

When comparing those members who went into academic vs private practice, there were significantly more members that had held a committee member position (68% vs 31%; $P = .04$), regularly attended the annual Academy meeting (84% vs 36%; $P = .003$), and had helped to put on an instruction course during the meeting (50% vs 13%; $P = .009$). Table 1 shows the results of the survey comparing the GC members with the control group.

Discussion

The purpose of this survey was to determine whether early involvement within the AAO-HNS translated into long-term involvement. This is a difficult if not impossible task as there may be an inherent self-selection bias involved. A control group was part of the study, although it in itself may be biased in those who responded to the survey. Although the study group and control group had similar percentages involved in resident education and academic positions, the difference...
Table 1. Relative Proportions of the SRF Cohort and Control Cohort Members.

<table>
<thead>
<tr>
<th></th>
<th>SRF, %</th>
<th>Control, %</th>
<th>Difference, %</th>
<th>95% CI</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subspecialty fellowship</td>
<td>88</td>
<td>65</td>
<td>23</td>
<td>4.5 to 47.1</td>
<td>.046</td>
</tr>
<tr>
<td>Academic practice</td>
<td>46</td>
<td>55</td>
<td>9</td>
<td>−35.3 to 18.8</td>
<td>.59</td>
</tr>
<tr>
<td>Student/resident instruction</td>
<td>66</td>
<td>80</td>
<td>14</td>
<td>−39.9 to 11.8</td>
<td>.37</td>
</tr>
<tr>
<td>AAO-HNS members</td>
<td>93</td>
<td>90</td>
<td>3</td>
<td>−23.8 to 28.5</td>
<td>.59</td>
</tr>
<tr>
<td>AAO-HNS committee service</td>
<td>54</td>
<td>10</td>
<td>44</td>
<td>18.4 to 66.0</td>
<td>.002</td>
</tr>
<tr>
<td>AAO-HNS elected position</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>−16.6 to 35.4</td>
<td>.29</td>
</tr>
<tr>
<td>Regular AAO-HNS meeting attendee</td>
<td>58</td>
<td>35</td>
<td>23</td>
<td>−3.9 to 48.9</td>
<td>.11</td>
</tr>
</tbody>
</table>

Abbreviations: AAO-HNS, American Academy of Otolaryngology—Head and Neck Surgery; CI, confidence interval; SRF, Section for Residents and Fellows-in-Training.

Results reflect who participated in subspecialty fellowship, academic practice, and student and/or resident instruction; retained AAO-HNS membership; served on an AAO-HNS committee; were elected to an AAO-HNS position; or were regular AAO-HNS annual meeting attendees.

appeared to be in those who held leadership positions and attended the Academy meeting regularly. Residents who elect to run for a position in the SRF GC may already be persons who are motivated to continue an active leadership role in the Academy. Despite this, there is still information that can be gained from looking at the current practice patterns and AAO-HNS participations of the surveyed population.

Prior GC members have developed various careers, including both general otolaryngology as well as various subspecialties in both academic and nonacademic settings. Despite these variations, all have remained Academy members, and many have been appointed or elected to Academy positions. Data in the orthopedic literature, but none in the otolaryngology literature, emphasize that early involvement in a surgical society does translate into long-term involvement.1,2 Also, studies have shown that early leadership in the role of a chief resident in primary care residency programs translates into future leadership roles.3 Multiple articles in the otolaryngology literature emphasize the importance of mentorship for residents4,5; however, there are no data in the extant otolaryngology literature supporting continued involvement after residency. Previous leaders in the AAO-HNS SRF GC responded to the survey listing networking as a valuable aspect of involvement in the section. Networking can often lead to mentor-mentee relationships. This may also have influenced why such a high percentage of the previous SRF GC members matched into fellowships of his or her choice, as they were able to meet leaders from around the country in the different subspecialties and could also influence their decision to continue their involvement within the AAO-HNS in the long term.

More important, previous studies have shown that effective clinical leadership leads to better outcomes for patients.6 As physicians’ outcomes become more scrutinized with recent legislation,7 early leadership skills for residents may translate to improved patient outcomes.

The AAO-HNS has more than 12,000 members, yet only a small percentage of those members are involved in leadership roles. The fact that greater than 50% of the previous GC members have been involved in committees and that 32% have been involved in teaching instruction courses would indicate that early involvement with the SRF does translate into increased long-term involvement. Unfortunately, given the limitations of the survey, it is impossible to determine whether it is the early involvement in the SRF that results in the long-term involvement or whether the individuals who get involved in the SRF naturally seek leadership positions.

Conclusion

This survey of the previous SRF GC members reinforced that becoming involved early can help develop the networking, advocacy, and leadership skills for future involvement in the AAO-HNS. The results presented here indicate that early involvement as resident leaders in the AAO-HNS does translate to longer term involvement and leadership, although this study cannot prove that the early leadership causes the long-term involvement. Encouraging residents to become involved early can help them meet mentors, network, and develop important leadership skills.

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Author Contributions

Brianne B. Roby, design and acquisition of data, drafting article, final approval of paper; Meghan N. Wilson, design and acquisition of data, drafting article, final approval of paper; Nikhila Raol, design and acquisition of data, revising article, final approval of paper; John Carter, design and acquisition of data, revising article, final approval of paper; Kanwar Kelley, design and acquisition of data, revising article, final approval of paper; Estelle S. Yoo, design and acquisition of data, revising article, final approval of paper; Nathan A. Deckard, design and acquisition of data, revising article, final approval of paper; Jayme R. Dowdall, design and acquisition of data, revising article, final approval of paper.

Disclosures

Competing interests: Meghan N. Wilson, SRF Information Officer; Nikhila Raol, SRF Immediate Past Chair; John Carter, SRF Vice Chair; and Kanwar Kelley, SRF Chair.
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Supplemental Material
Additional supporting information may be found at www.otojournal.org/supplemental.

References