Extreme mentoring in cardiothoracic surgery

Michael K. Pasque, MD

The age-old topic of mentoring has been the subject of much discourse in recent subspecialty meetings and publications. Being a good mentor is clearly considered a desirable attribute. Interestingly, I have never met anyone in our subspecialty who did not consider themselves a good mentor. That being said, most of us would readily admit to being notoriously generous in any attempts at self-appraisal. Now might be a good time for a fresh look at the subject. We must begin with a discussion of the metrics on which such self-appraisal would find a sure-footed foundation.

Before I start, I must admit I have personally found this self-appraisal to be a particularly humbling journey. In those rare moments of honest introspection, I find myself woefully lacking in most of the mentoring attributes described here. Despite the fact that I sincerely desire to excel at mentoring, I am still—at best—a work-in-progress.

Anyone can commit to a superficial mentoring relationship characterized by occasional meetings for encouragement and inconsequential question-and-answer sessions. On the other hand, if we are committing to a mentoring relationship of true value to mentees, the decision to proceed carries with it considerable responsibility. Extreme mentoring comes only at a price—it is going to cost us. Before we move forward, we must first fully appreciate the consequences and responsibilities associated with this decision. We owe this to ourselves—and to our potential mentees. Our first job as a mentor, therefore, must be to fully acknowledge that, if it is done correctly, mentoring cannot be taken lightly.

REFOCUSING OUR ATTENTION

When we agree to mentor, we agree to enter into a unique relationship with our mentees. From that moment on, our relationship with those individuals has changed. It can no longer be self-centered. It must be focused on our mentees.

The refocusing of this relationship is more difficult than most of us would like to admit. As cardiothoracic surgeons, we are used to having the attention focused on us, reinforced by all the different environments in which we work every day. In each, we have both authority and responsibility. When

Michael K. Pasque, MD

questions are asked, we are expected to supply the answers. The focus is always on the individual who supplies answers—and in the settings we frequent, we are that individual. The mentoring relationship is different. Even though everything else in our academic life may be about us, that attitude cannot prevail in a mentoring relationship. If we desire to excel as a mentor, we must adopt a new set of priorities that focus the energy of our relationship on the mentee(s).

ASSESSING POTENTIAL MENTEES

Before entering into a mentoring relationship, we must honestly assess our prospective mentees. We must realistically gauge their potential in regard to cardiothoracic surgical skill, research acumen, teaching proficiency, service to the subspecialty (on both a local and national basis), and all the other attributes that go into making a successful academic cardiothoracic surgeon. The magnitude of the commitment we are making demands that we be compulsive in performing this due diligence. As discussed later, if we are to throw our support wholeheartedly behind our mentees, we must genuinely believe in them. This objective assessment of their potential will fuel one of the most important decisions of both their careers and ours. This assessment will be the primary determinant of whether we enter into an extreme mentoring relationship with true conviction and the appropriate mindset.

SETTING GOALS

Following our initial objective appraisal of our mentees, which may take many face-to-face meetings, our next step is to set the goals of this extraordinary relationship. My formula is to honestly estimate the surgical, research, teaching, and academic life goals that are both desired by, and within reach of, each individual mentee—and then double them. We must set very aggressive goals for our mentees. If we

From the Division of Cardiothoracic Surgery, Department of Surgery, Washington University School of Medicine, St Louis, Mo.

Disclosures: Author has nothing to disclose with regard to commercial support.

Received for publication March 3, 2015; revisions received March 13, 2015; accepted for publication April 17, 2015; available ahead of print May 30, 2015.

Address for reprints: Michael K. Pasque, MD, Washington University School of Medicine, 660 South Euclid Ave, Campus Box 8234, St Louis, MO 63110 (E-mail: pasquem@wustl.edu).

J Thorac Cardiovasc Surg 2015;150:785-9

0022-5223/\$36.00

Copyright © 2015 by The American Association for Thoracic Surgery

<http://dx.doi.org/10.1016/j.jtcvs.2015.04.056>

don't, who will? Most mentees will not do this for themselves, because they lack the necessary knowledge, focus, and confidence. They need and deserve nothing less than very aggressive goals, and it is a mentor's responsibility to ensure that these goals are identified, codified, and specifically targeted.

Once we have assisted our mentees in establishing their career goals, we must then help them visualize this potential as a reality. From day 1, we need to assure our mentees that they have the "right stuff" to fully become the academic cardiothoracic surgeon they aspire to be. If we honestly believe they can be president of the American Association for Thoracic Surgery or the Society of Thoracic Surgeons, then we should begin to treat them as if they are destined to be precisely that. We must direct them to an academic pathway that leads in that direction. Good intentions do not determine outcomes; pathways do. Our mentees may have the very best of intentions, but never actually step onto the pathway that leads to the outcome they desire. Identifying that pathway can be very difficult. Unlike our mentees, we have been on that pathway and know what it looks like—our experienced eyes are needed.

Once our mentees are on the pathway, keeping them there mandates our diligent surveillance of their progress. Obstacles that are capable of knocking them off the pathway will appear. When their progress through these barriers is discussed—and that should be often—then ours should be the voice that reminds them that despite the momentary setbacks, the goals we have set are going to happen.

MEETING WITH OUR MENTEES

Being an effective mentor is impossible if we do not actually meet with our mentees. These meetings must be frequent and substantive. They must be regularly scheduled—once a month being the minimum—and occupy an unassailable place on our calendar. We must encourage our mentees to ask tough questions. But even if they take initiative in doing so, we must be the driving force behind these meetings. For the most part, our mentees will not even be aware of what topics need attention. For instance, helping them identify and understand their areas of academic cardiothoracic surgical proficiency is vital to the optimal use of their unique capabilities. Most have only a superficial appreciation of their skillset, and an in-depth review by an objective mentor is pure gold to most young surgical faculty members. They need our assistance in identifying, nurturing, and capitalizing on their surgical, teaching, research, and national service skills.

In similar fashion, we must additionally help them identify areas that need further development. How can they take the necessary steps for remediation of deficits unless we help identify these and outline an effective course of action? Mentor feedback on progress in eliminating shortfalls is fundamental and a vital component of any effort at quality improvement.

ESTABLISHING MILESTONE TIMELINES

As the mentoring relationship progresses, subsequent meetings should be guided by an established academic milestone timeline. Both mentor and mentee should be on the same page in regard to academic promotion timetables, because both have an important part to play. Further, a continually updated timeline will reinforce a mentee's need to look aggressively forward to the timing of applications for membership in vital subspecialty organizations.

The mentees' establishment of an independent research effort should be guided by a similar timeline of essential milestones. This timeline should include such targeted goals as literature vetting of research hypotheses, early procurement of startup funding, acquisition of preliminary data, and formal grant submission. If mentees have no background or interest in basic science translational investigation, for example, then we can guide their efforts toward clinical outcomes research. Even if basic science research is their passion, we should still encourage them to identify ≥ 1 area of cardiothoracic surgery in which they have interest and aptitude, and to focus on targeted clinical excellence and outcomes publication.

Efficiency in this process is critical. A mentor's efforts should be focused on assisting in avoiding pitfalls that slow research progress. Stagnation in research effort is especially dangerous when a young faculty member is facing the pressure of establishing a clinical presence. The mentee frustration and disinterest that accompany a floundering research effort are well-recognized adversaries.

TAKING ACTION

We must back our meeting recommendations with action. Some of our activities on their behalf will be obvious to our mentees, including assisting at surgery, introducing them to influential friends at meetings, and openly sponsoring them for membership in subspecialty organizations. Other activities are more covert—efforts undertaken on our mentees' behalf of which they may never be made aware. These clandestine operations can have a profound impact on our mentees' success in reaching their goals. These activities should be centered on a continually updated list of the top-10 individuals who have the most to offer our mentees—especially in areas in which we have limited or no influence. This list may include other senior faculty members in our local academic setting, as well as national figures who have the ability to promote our mentees where we cannot. For example, these individuals might facilitate mentee placement into positions on journal editorial boards, as postgraduate course faculty, or on national subspecialty service committees.

Habitual follow-up with the individuals on this influential list is important. If they are local, we may drop in for an impromptu closed-door meeting to promote our mentee. The ease of placing a call or sending a quick e-mail leaves

us no excuse for not contacting even the long-distance members of the top-10 list at least once every 6 months. Ultimately, the cumulative impact of these little reminders can palpably influence the successful achievement of our mentees' goals.

Along this same line, whenever possible, we must make sure that our mentees are allowed to attend the local, national, and international meetings that are appropriate at this stage of academic development. Although their attendance at such meetings may seem to be of minor significance at first, we cannot take it for granted. Many young faculty members do not grasp the importance of either plenary session or postgraduate course attendance. Further, our mentees may be expected to stay and be on call while senior partners fulfill national meeting obligations. Most mentees have little ability to fend for themselves against senior faculty members. In these cases, we may occasionally need to pick a fight for our mentees—and then step in to fight it for them.

We must ensure that our mentees get the opportunities they need. If they do not attend these national meetings early in their career, their development in regard to committee service, peer-group identity, and advanced surgical education can be severely stunted. We must be the senior voice that speaks up for them. They need to attend these meetings, even if we are the ones who must stay behind in their place.

COMMITTED MENTORING IN A UNIQUE ENVIRONMENT

Volumes have been written about mentoring in a broad spectrum of relational and career environments—and yet, ours is truly unique. Being a cardiothoracic surgical mentor is like no other mentoring commitment. A mentoring relationship based only on advice and counseling simply will not suffice. After all, we are cardiothoracic *surgeons*. We are not isolated academicians, teachers, or cardiothoracic researchers. Those roles are all important, but first and foremost, we are surgeons—and our mentoring relationship must reflect this fact.

What does this mean to a mentoring relationship? It means that we cannot give just lip service to mentoring our young faculty partners through the travails of establishing their clinical practice. It means that when they find themselves knee-deep in their first post-infarct ventricular septal defect, or extrapleural pneumonectomy, we should be there. When they are drowning in endocarditis, having just resected the aortic and mitral valves—and everything in between—we should be standing across the table from them.

We cannot just tell our mentees “what we would do” and send them off with a pat on the back, while we head into our own operating room to knock out a couple of elective cases. Instead, we must ensure that our mentees know we are not just here for the advice and counseling, but we are in it for the whole deal. On this point, surgical mentors differ from all others. To be surgical mentors, we have to back our words with action—we have to be willing to actually join

our mentees in the operating room. Keeping commitments such as these is the foundation of any mentoring relationship, but especially of the surgical mentoring relationship.

Further, our commitment to our mentees does not manifest itself from just 8:00 AM to 5:00 PM, Monday through Friday. Our mentees need to know that they can call us anytime. We must be prepared to answer their tough questions in the middle of the night, or even head to the hospital and scrub our hands. We have to be willing to do the late-night heavy lifting with them, or we are never going to be effective mentors. How can we teach them to turn toward the fight if we ourselves refuse to model this behavior? They need us there, dead center in the middle of the fray—and, as their mentors, that is precisely where we must be.

Obviously, most mentees will never make that late-night appeal if we have not made it clear that their calls are welcome at any time, day or night. The moment they sense less than a full commitment—that we balk at their distress call—we have ceased to model the very work ethic that is the foundation of all we value. It is in our response to their midnight call that our mentees learn their true value to us. Our response has the power to make or break our mentoring relationship.

Many would argue that assisting our surgical mentees in such a manner deprives them of a much-needed learning opportunity. They argue that our mentees must learn to fend for themselves. I hear this excuse all the time—mostly by part-time mentors who use it to justify their avoidance of the real work of mentoring. No one would argue that our mentees, like our children, must become independent of us. This is, after all, the ultimate goal of mentoring. But letting patients suffer—or even die—while we hide behind this lame defense of our negligence is inexcusable. Our abandonment of our responsibility in these circumstances breaks the primary guiding principle of cardiothoracic surgery—and medicine in general—that our first priority is always the patients' well-being.

In my experience, the “independence issue” has never been a problem. Most young cardiothoracic surgeons are more than willing to let you know when you are no longer needed in the operating room. They will quite forcefully cut those strings soon enough. But let there be no doubt, it is precisely when our mentees are in the middle of an operative fight—for which they are not fully equipped—that an extreme mentoring relationship shows its stuff. Both mentor and mentee walk out of that operating room knowing that something very special happened that day.

And, best of all, not only does some unknowing patient go home to his or her family because the two of us worked together that day but also countless future patients of our mentee—who will never know our names—will have profoundly benefitted because we helped a young cardiothoracic surgeon become not just good, but *superb*, at that particularly difficult operation. When an extreme mentoring relationship is thriving, young cardiothoracic surgeons learn

to turn toward the gunfire and tackle complex and difficult cases with no fear of learning-curve mortality. Committed mentoring in our environment is all about intense engagement and exceptional investment. It is about engaging our mentee's career as if it were our own.

EXTREME ENCOURAGEMENT

If we have never “gone extreme” in our encouragement, this must change when we shoulder the responsibility of mentorship. Extreme encouragement is fundamental in a surgical mentoring relationship and vital to mentee progress. It is not optional. From the very beginning, we must speak to our mentees as if the future were already here. From day 1, we need to tell them that they are already that which we have told them they will become. Although this approach applies broadly to the many facets of an academic career, it is especially applicable in the operating room. In our conversations with our mentees, we must refer to them as nothing less than *superb* surgeons. No method is more efficient to get them there than to tell them they are there already. If we have been diligent in vetting our mentees, this attitude will be both truthful and easy.

There is something magical about being told you are a good surgeon: You become one. Referring to our mentees in this manner has an amazing effect upon their attitude toward the hard work required to acquire surgical knowledge and skill. They will work zealously to become precisely that which we call them. If we persist, before long, they will look upon the lofty goals that we set at the beginning as realistic and attainable. Once they begin to see these goals as within their reach, we will not be able to hold them back. There is no higher motivational force than being told you are a good surgeon.

The mentee evolution fueled by such encouragement is not toward the arrogance that leads to sloppy mistakes. Instead, our affirmation is aimed at instilling confidence to be bold when their patient's well-being demands boldness. Our mentees move confidently through the challenges that confront them when they know that we believe in them—and that we have their backs.

If we encourage our mentee often and sincerely, it won't be long before we will be telling not only our mentee, but also everyone else, that our mentee is the best surgeon in the hospital. We may even find ourselves telling our favorite referring physicians how good our mentee has become. For most of us, this last step can be threatening. Nonetheless, it signals—like nothing else—that we are selflessly willing to put our mentee's needs above our own. If we truly feel this way, we cannot be threatened by our mentee's success. This feeling is the heart of extreme mentoring.

When our mentees demonstrate that they are in fact becoming exactly what we have been telling them they are, we must reinforce this by celebrating the hard work that led to their achievements. When they do a great job

on a surgical case, or get an abstract accepted for a national meeting, we need to let them know we noticed. We can mention it in discussions with other faculty members. Simple things—like leaving a note on their computer screen telling them they had a very good day in the operating room—can have a profound impact.

We cannot worry that our praise will be cheapened by its frequency. The environment that surrounds our young faculty members is guaranteed to provide an abundant supply of negative commentary. Our young mentees must navigate hostile territory during their early years, and they need at least one person in the cardiothoracic surgical arena who tells them they are special every single day. We will never regret a single bit of the praise we give them. The environment around them will continually tell them that the goals they have set are unrealistic. We must be the voice that assures them otherwise.

TEACHING LEADERSHIP

A mentoring relationship must focus on teaching leadership. If we are not teaching our mentees to lead, then by definition, we are not teaching them to be academic cardiothoracic surgeons. Unfortunately—and despite all of the best intentions and efforts of our subspecialty—leadership is not taught in a 2-day didactic course. It is taught by observation—by mentors modeling leadership.

Further, we cannot teach future leaders to lead without showing them that leading is—first and foremost—about serving. The best leaders are always those who place the needs of others above their own. We must therefore model precisely this in our relationship with our mentees. Once again, the focus must be on them. We cannot teach them to put the needs of others above their own without putting their needs above ours.

FINAL THOUGHTS

As mentors, our greatest desire must be that our mentees exceed our level of accomplishment. Assisting them in this quest—to exceed what we have accomplished in surgery, research, teaching, career advancement, and national recognition—should be our top priority. Further, our deepest desire must be not only that our mentees far exceed us in every metric, but also that they ultimately *replace* us. This thought terrifies most cardiothoracic surgeons. We all think of ourselves as unique, irreplaceable. I have never met a cardiothoracic surgeon who was looking forward to being replaced. Nonetheless, we will never be assured of success in putting the “extreme” in mentoring until the day someone walks into our office and announces that our mentee is a better academic cardiothoracic surgeon than we are.

In fact, truly extreme mentoring requires us to look forward to the day when our mentees are so utterly outstanding that they make everyone *forget* about us. Once again, the very thought of being forgotten is anathema to most normal

human beings, let alone the power-egos that populate our subspecialty. To be forgotten is essentially to have never existed in the first place. The idea that our career, our passion, had no impact is hard for any of us to embrace. As is so often the case, however, the truth lies in the exact opposite direction of our fears. The older we get, the more obvious it will become that our selfless investment in our junior faculty is in fact the crowning achievement of our career and precisely that which makes us most unforgettable.

CARDIOTHORACIC SURGICAL MENTORING SELF-APPRAISAL CHECKLIST

GENERAL

1. Am I willing to be honest in my appraisal of my performance as a mentor?
2. Do I take my performance as a mentor seriously?
3. Am I willing to focus the energy of the mentoring relationship entirely upon the mentee?
4. Am I willing to pay the high price of mentoring?

GOALS, PATHWAYS, AND MEETINGS

1. Have I been diligent in the vetting of my prospective mentee's career potential?
2. Have I assisted my mentee in setting appropriately aggressive career goals?
3. Have these goals been written down and distributed to both parties?
4. Are the expectations of the mentoring relationship clearly understood by both parties?
5. Has my mentee identified career goals and stepped onto a pathway that will lead to those goals?
6. Have I prioritized diligent surveillance of my mentee's progress on the pathway to achieving these goals?
7. Do I have a regularly scheduled mentee meeting on my calendar (at least once a month)?
8. Do our meetings focus on managing obstacles on the pathway to goal achievement?
9. Have I frequently—and recently—told my mentee that the goals will be achieved?
10. Have we discussed surgical and academic proficiencies with emphasis on capitalizing upon the mentee's unique skills?
11. Have we discussed mentee deficiencies and potential corrective pathways?

MILESTONE TIMELINES AND TAKING ACTION

1. Have we established a timeline for achieving university and national academic milestones?
2. Have we established a timeline for developing a successful research effort?

3. Have written copies of all milestone timelines been distributed to both parties?
4. Have we identified ≥ 1 area in clinical cardiothoracic surgery in which to develop *focused* surgical excellence and outcomes publication?
5. Have I made a top-10 list of the individuals who have the greatest potential to assist my mentee in goal achievement—especially in areas where I may have limited experience or influence?
6. Am I regularly contacting everyone on the top-10 list at least once every 6 months?
7. Have I sought the opportunity at national meetings to formally introduce my mentee to everyone on the top-10 list?
8. Have I prioritized my mentee's regular attendance at national subspecialty meetings?
9. Have I made sure that my mentee attends ≥ 1 subspecialty postgraduate course each year?
10. Have I promoted my mentee as a possible speaker to organizers of postgraduate courses?
11. Have I promoted my mentee for division, department, and university academic service positions that capitalize on mentee aptitudes and will move the mentee closer to goal achievement?
12. Have I promoted my mentee for committee and board service in national subspecialty organizations?

CLINICAL ASSISTANCE

1. Have I made myself readily available to preoperatively review challenging surgical cases?
2. Have I made myself readily available to scrub in and assist my mentee when needed?
3. Have I been faithful in keeping my promises to actually show up and assist my mentee in the operating room?
4. Does my mentee know that I will gladly welcome calls for assistance anytime, day or night?
5. Have I spoken positively about my mentee's surgical capabilities to my partners, staff, and referring physicians?
6. Have I told my mentee that he or she is a great surgeon?
7. Do I encourage my mentee every time we have contact?
8. Have I celebrated the hard work of my mentee at the achievement of surgical and academic milestones—and bragged about the mentee to my fellow faculty members?
9. Am I modeling leadership by placing the needs of my mentee above my own?
10. Am I truly looking forward to the day when my mentee exceeds me, replaces me, and makes everyone forget about me?

The author acknowledges the substantive/structural/editorial contributions of Christina C. Pasque, MD, as well as the influence of my many extraordinary mentors and mentees.