



A Collection of Leadership Stories for Chest Clinicians

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Introduction

Can you recall a leader or mentor you encountered in your career who stood out as someone special? Most of us can think of several. We probably would have trouble, however, describing what it was about the person that made him or her an exceptional leader or mentor. We can also think of several who were not very good leaders or mentors. We know a good leader when we interact with one, but it is hard to know the essence of what makes that person so effective. As a result, it can be difficult to develop the skills of being a good leader, mentor, or coach in your own career.

With this in mind, the ACCP, under the leadership of Dr. Suhail Raoof, has assembled the following collection of vignettes, submitted by members, that exemplifies special acts of leadership and mentoring they have encountered in their careers. The stories are remarkable for the wide variety of approaches that these great leaders and teachers used to tailor their message for the needs of the mentee. Each author of the vignettes that follow is a leader in his or her own right, a testament to the effectiveness of the leadership stories captured by these brief essays. The editors have provided “Leadership Points” to focus the reader’s attention on discrete actions that are worthy of emulation in order to develop one’s own style of leadership.

We hope that you enjoy these stories as much as we have and that they encourage you to reflect on what it is to be a good leader and mentor.

Dr. Bernie Roth

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Posthumous Mentoring

I would like to share an unusual story of a special mentor in my life. After completing my training in pulmonary and critical care medicine, including a sub-fellowship in interventional pulmonary, I joined the faculty at Memorial Sloan-Kettering Cancer Center in 2010. As the most junior faculty member, I ended up filling the unexpected void of a prominent pulmonologist, Dr. Dorothy White. She unfortunately passed away a few months after I started. I had an opportunity to present the following letter at her Memorial Service:

Dear Dr. White,

I have never met you nor have I heard you speak. I don't even know the sound of your voice. If I had sat next to you on the subway or bus, I would not have known who you were. However, *even in your absence*, you have strongly influenced my life and my career, and I would like to take this opportunity to express my gratitude.

Shortly after your departure, my career began here at Memorial. I took over most of your patients, your office space, and even the same chair and computer in clinic. Just as you had before, I sit next to your nurse, Alice, and we work diligently together.

We have been extremely busy, but in the midst of the busyness, one of the interesting aspects in my day to day work, has been discovering more about who you were. You left your mark and essence in every corner, especially with your patients. Every single one of them speaks so highly of you, and they have some high expectations from me, as well! I think you may have set the standard a little too high. They describe you as kind and caring. Many say you were an extraordinary physician and it was only after seeing you that their cough, shortness of breath, or other issues were finally resolved. Your patients describe the attributes of the kind of physician that I strive to be.

Many of your patients seem to have had a complicated and challenging clinical course when they saw you initially. It is through your detailed notes that I can see your flow of logic, and the incredible clinical insight you had. I am learning much more than I had anticipated through this process. I recently evaluated a new patient with everolimus related lung toxicity. It was actually my very first time encountering this, but I knew exactly what to do. I already had the benefit of learning from your other patients with the same pathology. From reading your notes, and caring for your patients, I receive the incredible transference of your vast knowledge and experience. Speaking of notes, you had a unique, almost artistic talent of summarizing the most complicated patient history into a concise paragraph. Needless to say, my patient recovered completely from the drug toxicity.

Your colleagues tell me how brilliant of a clinician you were. They say you were the "go to person" for any complicated pulmonary problems. That explains why I am learning so much from your patients. I sometimes feel as if you are present with me, teaching me and molding my thought process, like a mentor.

One day during rounds, as we were discussing an unusual case, I asked the fellows, WWDWD? To many puzzled faces I said, "I mean, What Would Dr. White Do?" It was a joke, of course, but it attests to the level of respect I have developed for you even only after a short time here at Memorial. As a matter of fact, I frequently find myself asking, how you would have approached some of the complicated issues I have to deal with.

Thank you, Dr. White, for leaving me the privilege of your continued teaching, even after your departure. Thank you for setting the standard of excellence that I strive to attain. If anyone ever asks me, who has influenced and shaped my career, I would undoubtedly include you, Dr. White, without hesitation, for you are my mentor, whom I never knew face to face.

Robert P. Lee, MD
Memorial Sloan-Kettering Cancer Center

Mentor: Dr. Dorothy White

Leadership Point

What an amazing tribute and what a tremendous gift Dr. White has posthumously given to her unseen mentee. So what made Dr. White's influence so strong that it persisted even in her absence? She was an expert clinician and a nice doctor. Many are one or the other, but the combination is what made her special. Her patients extolled her virtues because she was good to them, was caring, AND solved their problems. She also appears to have been an expert communicator. Her medical records were not only an accurate summary of patient visits but also a compendium of knowledge and an enduring teaching instrument for her successor. Many of us struggle to complete our charting with words that often seem to just please third-party billing rather than explain our thoughts. This seems to have only gotten worse with the electronic record. Reading how "summarizing the most complicated patient history into a concise paragraph" not only helped the next clinician to care for the same patient but also for other similar patients as well should inspire us all to approach the medical record in a different light. We can only hope to have even close to such a lasting impact when we leave this earth.

A Few Well-Placed Words

In 1990, a 2-year-long national search to replace Alfred P. Fishman, MD, FCCP(Hon), as the Chief of the Cardiovascular-Pulmonary Division (now known as the Pulmonary, Allergy, and Critical Care Division) at the University of Pennsylvania failed to identify any conventionally qualified candidate who was willing to accept the position. Larry Earley, MD, then Chair of the Department of Medicine at Penn, asked me to serve as interim Chief.

Over the next week, I talked to more than 10 senior members of our department about my unanticipated opportunity. Most advised me not to take the position, or at least not to expect anything other than a long, frustrating custodial role that would lead me straight back to where I came from. At that time, first-year Associate Professors on the non-tenure Clinician Educator faculty track categorically did not rise to academic leadership at Penn. One prominent division chief told me bluntly that our small, troubled division was beyond resuscitation and that I should seek an opportunity at a nearby suburban community hospital where I might be happy.

I told Dr. Earley about the advice of my colleagues. He came out from behind his desk, pulled a chair up directly in front of me, leaned forward, planted his elbows on his knees, and said simply, "Prove them wrong." During that meeting and two others scheduled in quick succession, he told me that times were changing fast and that new kinds of leaders would be needed to build balanced, three-mission academic divisions. He blended encouragement with focused advice in rapid-fire conversation, as if there was great urgency to our deliberations. In the third meeting, I asked him naively for a 7-figure investment fund to renovate our space and stabilize our faculty. The next morning, I received a 4-page letter from Larry granting all that I requested.

Two days after I agreed to serve, Larry Earley stepped down as Department Chair. I became an acting chief under an acting chair under an acting dean at an institution that was struggling through a threatening financial exigency.

Larry left Penn shortly afterwards, and I lost contact with him. The path forward for me proved difficult. At times, our division did indeed seem beyond resuscitation. I struggled to overcome my lack of academic stature and leverage and our perpetually low prioritization among clinical specialties at Penn. Through the toughest setbacks and disappointments, I leaned repeatedly on Larry's words of confidence and encouragement, and I carried on.

I next met Larry Earley in 2010. Minus the "interim" qualification, I still occupied the same position that he had persuaded me to take 20 years earlier. We sat this time, roles reversed, in an examination room of the Penn Lung Center to discuss a newly discovered, fist-sized mass in his right lung. My answers to his questions brought tears to his eyes. Then he brought tears to mine by saying how proud he was that I had "proven them wrong" many times over.

Sometimes, entire careers hinge on short, intense exchanges between an aspiring and an established leader. A few well-aimed sparks of confidence can ignite a fire that propels a

person for years to come. Larry Earley propelled me. I most deeply regret that we could not contain the cancer that took his life in 2012.

John Hansen-Flaschen, MD, FCCP
University of Pennsylvania

Mentor: Larry Earley, MD (Deceased)

Leadership Point

A few well-placed words by a trusted leader can change a life, with the resultant effect on many other lives. Why did Dr. Hansen-Flaschen take Dr. Earley's advice when so many other senior mentors had recommended the opposite? Although humility is clearly a good attribute to have in the medical profession, at times we may underestimate our own abilities. The mark of a good leader is being able to see leadership qualities in others and to help them move forward to realize their potential. Dr. Hansen-Flaschen did not feel able to take on the difficult job of leading a division in trouble. The inspiration, support, and confidence that Dr. Earley gave him in a very short time have stood as a motivational foundation for his entire leadership career. We can see the power of a wise leader who is willing to take a risk and support a new path when the old one is losing its usefulness.

A Tireless Champion

Effective leadership in health care is exemplified by Dr. Richard S. Irwin's highly successful efforts to redesign the delivery of critical care at the UMass Memorial Medical Center in Worcester, Massachusetts. Under his leadership, the institution identified weaknesses and opportunities for improvement in critical care and then designed and implemented a comprehensive, interdisciplinary, and collaborative plan for fundamental and far-reaching change.

A decade ago, our institution had multiple adult critical care units that functioned independently, mainly along narrow departmental boundaries and their attendant parochial perspectives. Dr. Irwin's vision was to achieve the highest possible quality by standardizing patient care across these diverse units. The key ingredient for implementing this vision was Dr. Irwin's tireless commitment to and belief in interdisciplinary, collaborative care. Dr. Irwin designed an infrastructure as we moved forward that revolved around deriving consensus, enacting policy, measuring quality, and providing regular feedback to the group and individuals. With this approach, care has been standardized across eight critical care units on two separate campuses. With buy-in from critical care stakeholders and hospital administration, Dr. Irwin created a "virtual" department of critical care medicine, the Critical Care Operations Committee, which was designated as its own hospital financial service line, making it fully accountable for the costs and savings of its programs. The committee meets biweekly to review policies, design supporting programs, and develop clinical practice guidelines based on the best available evidence.

The results of this extensive, interdisciplinary collaboration have been significant. Dr. Irwin's leadership has changed the culture for all the health-care workers in the units, and there is now a sense of strong teamwork, mutual respect, personal accountability, and dedication to quality. Physicians feel engaged, and cross-departmental interactions among faculty and staff have never been better. Clinical practice guideline adherence for deep venous thrombosis prevention, stress ulcers, cardiovascular protection, ventilator-associated pneumonia, and catheter-related bloodstream infections have all improved. Hospital length-of-stay and hospital mortality rates have both decreased. In spite of the costly initial investment in telemedicine, it proved vital in monitoring both the quality of ICU services and compliance with guidelines. All of these improvements have resulted in net cost savings for our hospital, with one estimate showing the average cost per case decreasing by close to 20%. On a large volume of cases, year after year, these enormous savings have contributed to the stability of our entire hospital system, demonstrating that this well-led, interdisciplinary collaboration for quality has resulted in benefits far beyond our intensive care units.

The leadership style that Dr. Irwin has successfully used and has tried to imbue in all of our managers can be described by the 7 Cs: consensus building; effective communication; interdisciplinary collaboration; holding people accountable; celebrate all advances or improvements; and consistency in all. Finally, Dr. Irwin has been instrumental in reminding us all that when it comes to quality and patient-focused care, "you can never rest on your laurels." These efforts will always be a work in progress.

J. Mark Madison, MD, FCCP
UMass Medical School

Mentor: Richard S. Irwin, MD, Master FCCP

Leadership Point

This is a nice illustration of transformational leadership. Transformational leadership starts with a vision—a view of the future that will excite and convert potential followers. It is dependent on a leader who has self-confidence and a true belief in what is to be accomplished. Then, the leader must constantly sell the vision, which takes energy and commitment. This means examining personal values, setting the example by aligning actions with values, harnessing the talent and enthusiasm of followers, seeking innovative ways to change, and fostering collaboration. Personal integrity and an environment of trust are essential. Finally, the leader must enable others to act. Transformation is change on a grand scale, and change is hard. The benefits this institution now enjoys did not happen by accident; they required a leader who is not only a champion but also a tireless coworker.

Another Bleeder

The year was 1978, and I was about halfway through my internship year. Before ACGME work-hour limits, ICU call in our hospital was every other night, there were no limits on continuous hours of duty, and there was no requirement for protected time at all. I was tired and angry almost all the time. In those dark days (before proton pump inhibitors), GI bleeders were a prevalent, labor-intensive, and dreaded admission. The treatment was iced saline lavage. Done by the intern. Standing by the bedside, for as long as it took. Which was sometimes all night. Infuse cold clear saline down the nasogastric tube with a 60-mL syringe; aspirate warm bloody gastric lavage back up the nasogastric tube, until clear.

About halfway through a night of every other on call, I got several of these admissions in a row, culminating with a particularly malodorous and belligerent fellow. Exhausted, irritated, and desperate for some sleep and time to myself, I was slamming that cold saline down and aspirating it back up as hard as I could, over and over again. Bright red blood continued to come back up the tube, and imprecations continued to come out the patient's mouth. At about 3:30 in the morning, my soft-spoken, self-effacing resident strolled up to the bedside and said, "This is a skill, like any other. You are good at it, and probably have had lots of practice. But let me show you how to do it better." Murmuring softly to the patient, who appeared to settle down and listen carefully to him, he began to gently and slowly infuse and withdraw the saline—which cleared, almost immediately. He said, "You were pushing saline down there so hard that you never allowed a clot to form over whatever was bleeding. And sick people pick up on your attitude and sense when you are angry. Sometimes, gentler is better. Now get some rest." I learned about several aspects of compassion that night.

Barbara Phillips, MD, FCCP
University of Kentucky

Mentor: Anonymous

Leadership Point

Perhaps one of the worst aspects of the pre-work-hour-limit era in medicine was the dehumanizing effect that unlimited hours of work would have on a trainee, with the resultant disdain that could be developed for some of the patients we were tasked to "care for." Through such descriptors as "malodorous," "belligerent," and "imprecations," we get a picture of what this physician thought about her patient. Despite work-hour limits, this scenario still occurs more frequently than we want to admit. However, the soft-spoken resident leader showed her how to have compassion for a patient she may not have particularly liked. He showed her how this compassion could translate into a therapeutic benefit. Finally, he also showed her compassion by understanding her anger and not holding it against her. Patience and kindness are not only therapeutic for patients but also for those we lead.

Helping Subordinates Turn Ideas Into Lasting Change

As a member of a nonprofit group, I was once told that an important lesson learned from the 1960s was that the leader cannot be the sole face, the only force, the only actor in an organization. In addition to the job of supervisor, a good leader is also a mentor who grooms those in lower positions to advance. I experienced the power of this approach to mentorship firsthand several years later.

As a resident in internal medicine, I cared for many patients for whom English was not their native language. Often the communication was conducted through an interpreter. However, I felt awkward with this approach and often sensed that there was a failure to elicit nuances about key points in the history or accurately convey details about a complex treatment plan. This led me to recommend to my Program Director that residents needed training in how to best interact with patients through interpreters. I anticipated a response like “do the best you can” or “yes, this is a problem, but there are no good solutions.” Instead, Dr. Schultz listened and reflected. He sought feedback from other residents and decided this problem deserved attention (1 - listen). He said to me, “Write up a proposal, and I will bring it forward” (2 - see potential). I developed a plan with his feedback and critique. We submitted the proposal to the hospital and received approval and funding (3 - capitalize on an individual’s potential). Then, I was off to the races. Dr. Schultz linked me with a faculty mentor to help implement the curriculum. The educational model we developed was successful, benefiting both resident training and patient care (5 - contribute to the mission). The curriculum endures to this day, surviving my tenure as a resident and Henry Schultz’s tenure as Program Director (4 - enduring and self-sustaining advance).

Dr. Schultz’s leadership gave me the confidence to speak up and take action. His mentorship helped me to develop not only as a resident but also as a budding leader, allowing me to experience the extreme gratification that not only accompanies successful treatment of an individual patient but that also occurs when creating a change in process that helps many patients. Dr. Schultz is a great model of a leader who listens, cares, empowers, and takes action.

Cassie Kennedy, MD, FCCP
Mayo Clinic

Mentor: Henry Schultz, MD

Leadership Point

Successful leaders know both how to recognize good ideas in their subordinates and how to assist them to nurture and develop those ideas. This is a skill set with multiple components that can importantly build character and confidence. The effective leader must:

- 1) listen and be receptive;*
- 2) see potential in the subordinate; and*
- 3) capitalize on that potential by developing, empowering, and educating the subordinate to successfully advance his/her idea in an*

- 4) *enduring and self-sustaining manner,*
- 5) *that contributes to the mission of the organization.*

Dr. Schultz adeptly accomplished each of these goals, which resulted in his resident's academic project creating value and lasting benefit to the patient-care mission of the department. This is a case of teaching by emersion, which is an exciting, empowering, and highly effective tool for professional growth.

It's How You Ask the Question

I trained in Winnipeg, Canada, during the late 1970s, before the buzzword “translational” was routinely attached to every research study, however esoteric or divorced from practical application. Dr. Larry Wood was an outstanding physiologist working in Winnipeg at that time and was at the vanguard of training residents to make research a part of everyday clinical care. Every patient admitted to the ICU provided an opportunity to develop a new research question, and every completed research innovation was moved to clinical practice often before the ink had dried on the manuscript submission. A patient with a lung contusion would lead to an animal model of contusion and subsequently novel approaches to treating the next admitted patient with lung contusion.

Larry promoted the attitude that research was a living and breathing entity that drives patient care. Research was in symbiosis with clinical care to extend the lives of patients. He stated that, in the ICU, all patients could be effectively treated by a meticulous dissection of the basic principals underlying their disease pathophysiology. His leadership in the field created a brand of intensive care that was disseminated by his trainees to their patient-care laboratories in other institutions. To Larry, literally no question from a trainee was ever a stupid or worthless question. Every question offered the opportunity to explore the knowledge gaps of the questioner. We were all empowered to ask questions and to learn how to eventually discover our own answers.

All of the trainees who worked near Larry were enriched by his approaches. When I hear that “evidence-based medicine” is a recent innovation in patient care, I think back to a process of continuously creating the evidence that informs clinical decision-making in a virtuous cycle from bed to bench and back again. Larry did not invent that approach, but he did perfect it. He made us all believe that it was the only way a serious physician should practice the science of medicine. Leaders are followed for a series of reasons that often include intangibles. Larry brought us along in his wake; we were compelled to follow. He proved to us that the acquisition of new knowledge for the sake of improved patient care is the most exciting and gratifying way to practice medicine.

Irvin Mayers, MD, FCCP
University of Alberta

Mentor: Larry Wood, MD

Leadership Point

In recent years, “translational medicine” has become a popular phrase with a variety of meanings, mostly related to the advancement of a basic science discovery to the realm of clinical care. It usually requires a collaborative venture among disparate partners from basic laboratories and clinics. However, this vignette highlights an important way in which all clinicians can contribute to fundamental translational science in their daily care of patients. In doing so, their patients benefit from more personalized treatment, and the practitioner benefits from elevating a case example to an evidence-based approach. This is in essence a

complete “translational cycle,” where problems at the bedside are dissected to reveal their physiological, biochemical, and cell biological underpinnings. These deliberations then allow the clinician to reveal causes of disease that inform decisions about therapy or to identify critical gaps in knowledge that require more research. Unfortunately, we are increasingly distracted from this clinical approach to medicine by the limited time we have to interact with patients and the increasing administrative bureaucracy associated with care delivery.

Dr. Larry Wood mentored by example, showing his trainees how translational research should be promoted in the field of medicine. The simple concept of “clinical practice through inquiry” drives personalized medicine, reveals the need for new translational research programs, creates the impetus for patient-focused care, and ultimately forms the basis of evidence-based medicine. Although Dr. Wood never considered a question to be stupid, he taught his trainees how to ask better questions to improve patient care and medical science in general.

Seeking the Best in People

My earliest memory of Professor Surinder K. Jindal is of an energetic and compassionate young physician attending to a school kid with acute asthma (myself!) in the mid-1970s. He would earnestly explain to me the use of inhalers and the importance of taking preventive medicine, which, nearly 15 years later (having pursued medicine and pulmonary medicine), I realized was an approach much ahead of its time in India. That's what Professor Jindal has been and is—a visionary.

In the early 1980s, he envisioned the need for the specialty of respiratory medicine (formerly known as tuberculosis and chest diseases) to be upgraded from a postgraduate diploma to a full-fledged fellowship in the specialty, on par with other specialties like cardiology. His dream was partially fulfilled in 1989, when our institution started the first fellowship program in pulmonary and critical care medicine. Now, 23 year later, 6 universities in India have started fellowship programs, and many more are slated to follow. This will truly complete Professor Jindal's vision.

Professor Jindal's role as a mentor and guide has redefined the lives of so many of his students like me. Soon after I finished my fellowship in 1991, like all of the youngsters in my generation, I was confused about my future. I accepted an assignment in Saudi Arabia. Professor Jindal asked me the purpose of my going to Saudi. I said, "I want to earn money, which will help me in setting up my practice on returning to India, and while in Saudi, I will have the opportunity to take the ECFMG and MRCP examinations, which will qualify me to go to either the USA or the UK." He retorted, "Do you want to come back and settle in India or go to the USA or the UK"? I said, "My wife and I have decided that we will settle in India." His sage advice: "Then focus on your first aim!" He has always emphasized to all of us to be very clear in defining our goals in life and to go after them with singular sincerity and honesty. This singular aspect of his vast wisdom helped a young, wandering mind to define goals, settle down, work hard, and achieve greater heights.

Soon after, I had the privilege of a faculty position in 1993 with Professor Jindal. I was assigned the job of setting up a new respiratory intensive care unit. I was beaming with confidence, and with the utmost energy I would work day and night. I would demand the same quality and commitment from people around me (senior and junior colleagues, residents, paramedical staff, etc.). In the process of pushing the bubbling enthusiasm of my young body and mind, I did not realize that I had ruffled many a feather. Professor Jindal again stepped in with his golden advice: "You cannot judge everyone's performance based on your own caliber and intellect. As a leader, your quality lies in bringing out the best in a person based on his or her own caliber and intellect!"

It is difficult to find a more perfect team leader or role model to juniors, contemporaries, and seniors alike than Professor Jindal. His energy, dedication, clock-like punctuality, and, above all, humility are infectious. His preference for a participative model of governance in our department rather than the prevalent authoritative and hierarchical model is most laudable. His efforts have led our department to reach the status of undisputed leader in pulmonary sciences in India.

Dheeraj Gupta, MD
Postgraduate Institute of Medical Education and Research

Mentor: Surinder K. Jindal, MD, FCCP

Leadership Point

Among the several qualities sought after by younger clinicians in their mentors include the ability to effectively coach juniors, create in them a sense of purpose and well-defined goals in career and life, demonstrate the importance of patient education as part of clinical practice, and teach them to develop the skill to identify the strengths of their own peers and junior colleagues (become leaders themselves). In this essay, Dr. Gupta identifies all of these qualities in his mentor, Professor Surinder Jindal, as well as his mentor's energy, dedication, and humility. Those on the rise to higher positions in their careers will do well to remember Professor Jindal's model of leading by example and the benefit of a democratic approach to administering a department.

The Difficulty of Doing Nothing

There is no deficit of excellent physicians. Through years of training in medicine, most of us are lucky enough to encounter many astonishing clinicians and teachers. Some come with accolades of academia, and others are nestled in the pits of hospitals and clinics, working daily to improve the lives of individual patients.

Sometimes in training or in life, there is a moment that leaves a lasting impression, a mark. Oftentimes we don't realize the moment when it is happening, but rather we recognize it later when the issue comes up again and again to remind us of that particular event.

Dr. Philip Kaplan helped train me to become the clinician that I am today. In fact, he has trained hundreds of physicians and has impacted them possibly as much as he has impacted me. Dr. Kaplan is compassionate and caring. He is a doctor's doctor and a patient's ally. In his life and practice, he sees the person and the circumstances. He is astute in recognizing disease states and ways to improve health.

"Michelle," he said, "sometimes the hardest thing to do in medicine is nothing." He paused, and then walked. We had just finished speaking with a young adult's family about treatment options as he was losing the battle with multisystem organ failure. During the hours leading up to the discussion, the patient had multiple intravenous monitoring devices placed, surgery on necrotic bowel, and anticipated replacement of another access to continue renal replacement therapy. The conversation that we had with the family was a discussion of no further aggressive medical interventions. We were offering the option of comfort care rather than continued procedures and therapy, with little hope of accomplishing the goal of returning their loved one to health. Dr. Kaplan was giving the family time to come to grips with their inevitable loss and allow the patient to progress naturally. To me, a burgeoning intensivist, this felt like defeat. Only after years of practicing the art of medicine is one able to accept that what Dr. Kaplan meant by doing nothing was not nothing. In some cases, it means everything.

Michelle Zetoony, DO, FCCP
Michigan State University

Mentor: Philip Kaplan, MD, FCCP

Leadership Point

The tremendous improvements in critical care have created a cornucopia of interventions that can keep our patients alive while they heal and get well. At some point, however, those therapies cease to be beneficial and only serve to prolong the dying process. Knowing when we have reached that point is perhaps one of the hardest things that an intensivist needs to learn. The timing of these critical decisions is made even more difficult, as in this case, when the patient is a young adult. There are a lot of interventions in critical care that we can do, yet the critical question is, should we do them? Many times it is very difficult to make this differentiation, but make it we must.

For most of us, it takes a lot of experience as well as knowledge to learn to recognize this, as the author of this vignette has learned. A mentor like Dr. Kaplan can help others learn to recognize that there are limits to what we can achieve and reverse. Families are often much more thankful for a death that occurs while we are doing everything to make the patient comfortable rather than everything to keep the patient alive. We can do well to learn from Dr. Kaplan's simple, cryptic message that belies the difficulty in making this decision. However, as we train the new generation of physicians, we should get out of the habit of making the following statement: "There is nothing more we can do." Patients and families feel abandoned when we say this. As the author points out, recognizing the near futility of further aggressive interventions, coaching the patient and family to recognize the benefit of comfort care, and being there for them—if for nothing else than to hold their hand—can be "everything."

With a Wink and a Smile

Dr. Orhan Muren was my medical ICU attending physician on the first day of my fellowship in the Division of Pulmonary and Critical Care Medicine at the Medical College of Virginia (MCV). He was a man of enormous intellect and unceasing energy, with an insatiable thirst for knowledge and a love of teaching beyond comparison. A graduate of the University of Istanbul, School of Medicine, he immigrated to the United States, whereupon he completed residency training in internal medicine and anesthesiology and fellowships in cardiology and in pulmonary disease and tuberculosis. He was one of the nation's first intensivists, helping to establish the ICU at MCV Hospital in 1967. He was famous for reading Harrison's textbook of medicine cover-to-cover and frequently would instruct the learner—many times, me—to review the section on some obscure topic, citing the exact page on which to find it. When we first met, he had won at least a dozen consecutive outstanding professor awards from successive classes of graduating medical students. In short, he was a living legend.

I had a great July in the ICU with Dr. Muren that year and the very good fortune to work with him frequently as a fellow and subsequently as his junior colleague on the MCV faculty (now Virginia Commonwealth University Health System) until his retirement. For a decade after his retirement, he freely dispensed pearls of wisdom with a wink and a smile at the weekly chest clinic. Over his 40-year career as an academic physician, he demonstrated to me and to literally thousands of students, residents, fellows, and colleagues the true value of mentorship. Not only was he a wonderful teacher and consummate doctor, but he was also a great role model, a trusted advisor, a caring friend, and an inspiration for lifelong learning. Dr. Muren died in 2011 but left many gifts, including an entire division of dedicated and award-winning educators and clinicians. As an extension of the lifelong learner, Dr. Muren embodied the concept of the lifelong mentor, instilling in subsequent generations that insatiable thirst for knowledge and lasting need to teach and mentor.

Curtis N. Sessler, MD, FCCP
Orhan Muren Distinguished Professor of Medicine
Virginia Commonwealth University Health System

Mentor: Orhan Muren, MD (Deceased)

Leadership Point

Mentors come in all shapes and sizes. Some show us a new perspective in patient care; some engage us with their enthusiasm, innovation, or interpersonal skills. Most have an "angle," or a unique approach that sets them apart as a leader and mentor. This vignette describes someone different. Dr. Muren is an example of an all-around master mentor who used a classic mentoring style by practicing what he taught. Dr. Muren coupled an unusual breadth of knowledge and experience with the ability to captivate trainees and colleagues by successfully integrating teaching and patient care—probably the most difficult but most effective means of teaching young residents, fellows, and faculty. Every division needs a Dr. Muren, the pinnacle in role models. It is only fitting that recognition of Dr. Sessler's career success through his endowed chair also acknowledges the mentor who facilitated that success.

A Little Respect Can Go a Long Way

It was my second day on the job as the only nurse in a new and growing pediatric pulmonary practice. Although I had 2 years of in-patient pediatric experience and was in graduate school to become a pediatric nurse practitioner, I had absolutely no experience with sick children who were NOT in the hospital. One of my responsibilities was telephone triage. One of my first calls was from a vigilant mother of a two-year-old girl with interstitial lung disease (ILD). The mother wanted to know if I thought her little girl should wear a coat when she went outside on that December day. Looking back, it was a very simple question that could have been answered very simply by advising the mother to dress her daughter as she herself would want to be dressed in this weather.

However, I was new to the world of sick children being cared for at home. I decided that if this mother felt like it was a question worthy of calling the specialist's office, then there must be more to the situation than I was aware of. So, when I checked in with the pulmonologist, I found myself asking if a toddler with ILD should wear a coat on a cold winter day. Rather than scoff, snicker, or dismiss my question, my supervising physician gave a thoughtful, respectful answer and went on to add other pointers about handling calls from mothers who might just need some encouragement. He ended our discussion by giving me permission to handle calls that I felt comfortable with on my own and expressed his certainty that my confidence would increase every day.

This simple exchange taught me a lot about the importance of respecting a new employee's willingness to ask questions and responding in a way that added to the newcomer's knowledge base without belittling them and discouraging further conversations. I did not learn when a little girl should bundle up to go outside—I already knew that!

Renee Bomar, CPNP
Georgia Pediatric Pulmonology Associates

Mentor: Anonymous

Leadership Point

This is a simple but admirable example of a professional demonstrating the much-desired virtue of respect and appropriate response to novices in the trade who seek expert advice. Such personal attributes can only enhance the quality of service to our patients, increase mutual respect, foster educationally productive dialogue among colleagues, and promote a healthy professional work environment. While not intended by the author, the vignette reveals the author's own commendable action of seeking expert opinion on behalf of the concerned mother, even though the author herself knew the correct response. This simple action influenced the supervising physician to trust the author with increased responsibility.

Unconditional Guidance

“We had a great month with you here in the ICU. You should really think about being a pulmonologist.”

Comments like this are not uncommon for learners to receive at the end of clinical rotations. Frequently they represent little more than platitudes, a reward for four weeks of hard work by a motivated resident with a fund of knowledge that catches an attending’s notice.

Yet these two sentences, spoken to me at the end of my MICU rotation in August of my intern year, were the start of my career in pulmonary and critical care medicine. Dr. Lisa Moores, the individual who spoke them, is my steadfast mentor of 17 years. Our relationship has survived and flourished even despite our geographic separation of over a decade.

The difference between platitude and lifelong mentorship in this situation was simple. My mentor was—and remains—a clinician and role model whose exceptional abilities distinguished her within the department in which I trained. Such individuals draw residents to them like moths to the flame, looking for insight, clarity, and future direction. The difference in this situation was that my mentor chose to take a personal interest in me and dedicated herself to providing me with unconditional support and guidance.

Describing a mentor relationship as “unconditional” requires a moment of explanation. Successful physicians are busy people, torn by clinical, personal, and career interests that frequently limit their time and ability to develop strong bonds with young trainees. Learners recognize this and are frequently willing to go to significant lengths to benefit from these individuals’ skill and experience. Education is given in exchange for assistance with patient care; research opportunities are provided with the promise of significant work on the part of the trainee.

I have never experienced this “quid pro quo” from Dr. Moores. As a second-year medicine resident, I was selected to present a small project at a national pulmonary/critical care society meeting. The faculty member who had co-authored the abstract was unable to attend, and the day before my presentation I came to three horrible realizations. My session room appeared to have the capacity to hold 100 people; the other session speakers had all authored the references I had cited; and all my division faculty were leaving before my talk.

I have asked Lisa why she chose to change her plane ticket and stay to support me instead of returning home to her family. She shrugged her shoulders and said, “It was the right thing to do.” This same attitude prompted her to seek me out as a resident, to show me her great cases, and to always have time to answer my clinical questions. Her enthusiasm for the field was infectious, and I applied and was accepted to fellowship. She has since provided me with publication opportunities, introduced me to the ACCP and its NetWork structure, and has supported me in my efforts as a junior leader in that organization. Her

answers to my requests for time and advice are always the same, even as her responsibilities have grown: “Sure, let’s set a time. Always happy to talk.” She knows me, which gives her both an uncanny ability to provide me with opportunities best suited to further my skills and professional goals as well as the intuition to sense and address issues with which I am struggling.

LTC(P) Alexander Niven, MC, USA, FCCP
Madigan Army Medical Center

Mentor: COL Lisa Moores, MC, USA, FCCP

Leadership Point

The everyday pressures that a busy physician faces make it easy to forget the importance of personal connections. A rich mentor relationship requires time, personal interest, and an unwavering commitment by both individuals involved—especially during times of need. These relationships can last a lifetime and can be the most fulfilling part of a professional career. The personal rewards that a leader can experience, watching individuals grow as a result of their efforts, are immeasurable. Even for selfish reasons, this sort of effort is always “the right thing to do.”

A Gentle Touch

A physician that I grew to immensely respect was Dr. Robert Luchi, the Chief of Medicine at the VA. While I was awed by his knowledge of cardiology, it was a rainy Saturday morning that he taught me the importance of understanding and empathizing with patients. There was a patient with dementia admitted with community-acquired pneumonia who was terrorized by the rain and lightning. As each nurse walked by, the patient screamed that his son was out in the rain and “sitting on the telephone pole.” Each person told this patient that he was clearly mistaken, that there was no one outside his window, and that his son was not in danger. The patient, however, became more and more concerned and agitated. A short time later, I saw Dr. Luchi sit on the side of the bed, place his hand on the patient’s shoulder and gently calm the patient. In the end, he told the patient that he would make sure the son understood his father’s concern and get the son out of the rain. Clearly, our patient’s reality can be quite different than our own. Over that month’s rotation, I came to understand how important it was to always sit on the side of the bed when talking to patients and the impact of physical contact when communicating with patients or their families. This form of nonverbal communication has been especially important in the ICU setting, where the surroundings often seem cold and sterile to patients and their families.

Jay Peters, MD, FCCP
University of Texas Health Science Center

Mentor: Robert Luchi, MD

Leadership Point

This vignette exemplifies the importance of a reassuring hand of the physician, nurse, or other health-care provider caring for the patient. We clinicians often forget that most patients come to us with fears of the unknown, anxiety, and a sense of isolation from the familiar world they are accustomed to. Clinicians also fail to remember that patients feel much better after a few soothing and reassuring words rather than the administration of many pharmaceuticals and procedures. An appropriately timed, gentle physical approach, such as a reassuring hand on the patient's forearm, combined with a few simple and reassuring words has a great capacity to allay a patient's concerns and fears. An equally valuable asset for any clinician is to learn the ability to “hear” the patient and try to “get into the mind of the patient” and then take appropriate action, as Dr. Luchi did. As leaders, we must remember the power of the example we set in how we care for our patients.

Step Up to the Plate

I have been blessed with several mentors who have helped me to progress in my leadership skills and career. My most impactful mentor is the administrator of my medical practice.

Kim French joined our organization 17 years ago. We were a traditional small pulmonary practice with the common issues of independent physician personalities and a staff that was directed by our “family” culture. Kim was initially met with opposition as she initiated changes. One day she said to me, “This practice has no effective leadership. If you want it to be something great, you must step up to the task.” With Kim’s guidance, I worked to overcome my lack of skill in dealing with conflict. I initiated difficult conversations. We engaged an industrial psychologist who took the entire organization off site as she facilitated the process by which we established our shared vision, mission, and values. This was the foundation from which we all came together to grow our practice. Today we have 100 employees, including 35 providers. We have developed outstanding services in areas including interventional pulmonary, 24/7 critical/neurocritical care, sleep, allergy, diagnostic testing, and outpatient and inpatient pulmonary rehabilitation. I have watched Kim build a team of excited and competent clinical and administrative staff. Her approach includes fairness, transparency, empathy, and adherence to corporate values. I have learned from her data-driven style as we produce frequent comprehensive reports from which management decisions are made. She has taught me to maintain a calm and positive demeanor, regardless of the circumstance. The leader’s responsibility is to guide the organization through challenging times and to seek opportunity that may emerge. She edits many of my important e-mails to ensure that my communications are positive and effective.

Kim guided me to my ACCP leadership position. My involvement began shortly after her arrival, when the Practice Management Department asked to visit our lab to help them formulate their presentations through the CPT and RUC processes. They recruited me to become involved. The work was extremely tedious, detailed, and time consuming. It was Kim who did the work that supported my presentations at the meetings. The next CHEST annual meeting was in Chicago. She forced me to step outside my comfort zone by attending meetings and receptions and to meet the leadership. She became involved with the Practice Administration NetWork, as I did the same with the Private Practice NetWork. As we ascended to chair those NetWorks, we worked together on projects and presentations. One of her ideas was our “speed pass” model for the PG courses, in which one tuition allows you to attend lectures and receive handouts for all of the courses given on the same day. She seeks opportunities for all members of our practice to grow their professional and leadership skills.

What have I learned from Kim? “Spin it positive.” Approach others with empathy and respect. Appreciate your blessings, as we all have disappointments and burdens. Define yourself and your personal success not by your station in life, but by the real value that you bring to others and by those whom you have helped along the way.

Ed Diamond, MD, MBA, FCCP
Suburban Lung Associates

Mentor: Kim French, MHSA, CAPP

Leadership Point

One is reminded that no organization, large or small, can be successful without a leader and good leadership. In this case, Dr. Diamond was identified by his practice manager as possessing the qualities to lead his growing organization. In so doing, he had to "step up to the plate," as leadership does not always come easy and is not always pleasant. As Dr. Diamond describes, he often had to initiate tough conversations with those he was responsible for leading. Ms. French helped him to learn to deal with conflict. Note that mentorship does not always come from above. We often think of a mentor as a superior whether in age, rank, or hierarchy, but one cannot discount the role of experience in a mentor. Dr. Diamond (the physician leader) recounts the impact Ms. French (the practice manager) has made on him, as they now lead one of the largest private practice groups in the Chicago area. It's also nice to see a place for both of them in the ACCP.

To Boldly Question

Mentorship may come from the most unlikely of sources. It was 1995 at the University of Iowa Hospitals and Clinics where, just finishing a residency in internal medicine, I had planned to pursue a fellowship in pulmonary medicine after being accepted into the occupational medicine residency program in Iowa City. The plan was to combine specialties and find an academic medical center where occupational lung disease was a niche that needed filling. My last internal medicine clinical rotation was in the medical ICU, where I learned about central venous catheters and the relatively new method at that time of central line insertion—the peripherally inserted central catheter (PICC). The attending on the unit was Dr. Joel Weinstock, Chairman, Division of Gastroenterology, at the time. I asked the question that apparently no one else had bothered to consider: Was there any advantage to using PICC lines? It seemed like there were considerable issues with line infections and phlebitis, and it was unclear—to me, at least—if there were any cost savings to using the PICC. Little did I know that Dr. Weinstock was a prolific researcher, a member of a National Institutes of Health (NIH) study section, and a natural mentor.

He challenged me to answer the question I had posed. How would one start to answer the question? What type of study would one consider? How would I know how many patients to study? Suddenly, my statistics courses became more meaningful and urgent. Now I had a reason to use what I had learned. The newness of designing my own project fueled more energy to continue. Each week, long after my rotation ended, I would spend time visiting with Dr. Weinstock in his office. He had a natural way of tossing a proverbial “bone” to his trainees, and it never really occurred to me that it made a difference that he was in a specialty that I had no real interest in pursuing. It didn’t matter.

After publishing an abstract involving a small case series of patients and being prepped by Dr. Weinstock on how to present data effectively at regional scientific meetings, he challenged me to consider applying for an NIH grant. I balked. How could a resident apply for a high-level grant? It didn’t matter, Dr. Weinstock insisted. The subject matter was important enough to warrant a proposal. Dr. Weinstock had a natural gift of being a mentor. He knew when to be firm, when to challenge your thinking, and how to teach you to think with the self-critique of a grant reviewer. I slowly realized that with each visit to his office, there was a bond that had formed: mentor and student.

Over the next year, thanks to Dr. Weinstock’s guidance, I designed a randomized clinical trial that compared PICC lines to standard subclavian vein catheters, followed by a cost analysis for each. The study was funded, in part, with an NIH grant awarded on my first submission. When the trial was accepted for publication, Dr. Weinstock and I celebrated. It was not only a celebration of hard work and the addition of important clinical data to the medical literature, but also a celebration of the culmination of the powerful forces of what mentorship can do for the career of individuals willing to spend the time and nurture the relationship.

Clayton T. Cowl, MD, FCCP
Mayo Clinic

Mentor: Joel Weinstock, MD

Leadership Point

As with a number of the mentoring experiences described in this series, for Dr. Cowl, mentorship was found in a place he least expected—an attending from a service different than his area of interest. The lesson is that there is no uniform prescription for selecting a mentor (or a mentee). Guiding a trainee through the process of developing a good research question is a skill that transcends any particular discipline. As a trainee, you must be alert and open to receiving mentorship from unexpected sources. As a leader, you should be open to mentoring anyone who appears to have a promising skill. A second lesson is to speak up and ask questions. Many preceding residents had the same experience as Dr. Cowl in dealing with the complications of PICC lines. But Dr. Cowl had the audacity to ask the question that everyone else only contemplated silently. Not every question leads to a grant, a publication, or an improvement in patient care. However, every grant, publication, and clinical advance starts with a bold question. The process of generating a question stimulates careful and thoughtful attention to the problem, enhances your understanding of the issue, and adds to a basic framework for approaching medicine that will serve you well throughout your career. Having learned these two lessons, Dr. Cowl, with Dr. Weinstock's support, was able to take the first step of his journey, which has led to a highly successful academic career.

Praise and Improve

I trained under this exceptional figure, who not only sparked my initial interest in pursuing a career in pulmonary and critical care medicine but taught me to continue to strive to learn more. He demonstrated what hard work, dedication, and determination would accomplish.

There are several lessons that he has taught me, a few of which I would like to share:

1) Learn to work with people of different strengths and weaknesses. He brought out the best in everyone. He demonstrated a talent of being able to praise one as he eloquently critiqued the work of that individual, allowing for improvement. He was able to turn weaknesses into strengths by recognizing the effort put into work and suggesting options for further improvement. I have used this advice in my day-to-day practice while working with nurses, therapists, peers, and even family and friends and have improved my ability to work in unity.

2) Think outside the box! He taught us to think broadly in every case with which we were presented. After we had exhausted the potential etiologies during our case presentations, he would add additional possibilities to the list, teaching us to think even further just when we thought there was no more.

3) Be involved in the College—be a part of it. He constantly encouraged and motivated us to participate in the various ACCP events throughout our training. I was fortunate to have had the opportunity to present interesting cases during the popular case puzzler sessions at the annual conferences and participate in the CHEST Challenge tournaments.

I am proud to have been a fellow in training under the 2011–2012 President of the American College of Chest Physicians, Dr. Suhail Raouf. His impact will be generational.

Rubal Patel, MD, FCCP
Tift Regional Medical Center

Mentor: Suhail Raouf, MD, FCCP

Leadership Point

Dr. Patel tells us that Dr. Suhail Raouf is gifted by being able to compliment and offer criticism to a person in the same conversation. How can this be done? The author points out that Dr. Raouf recognized the good in people he worked with, which likely went a long way toward them feeling good about themselves. With our egos intact, we are better able to deal with criticism, respond to it, and improve. It is an art and a gift to provide both at the same time. Also, in the classic sense, it is always a good thing to maintain a broad differential diagnosis to challenge the learner/mentee to think about his or her patient. Thinking is part of the fun in medicine, and we tend to lose sight of that. It takes a good leader to remind us to stop and think.

The Power of Being Available

Part I: It was the early 1990s, and I had a complex case involving significant issues with recurrent deep venous thrombosis and significant cardiopulmonary disease. I got this idea that Dr. Moser at UC San Diego was the only person who could solve my problems. I called his office only to be told that he was busy, but if I would leave my number he would return my call. I had expected this response and knew that a man as prominent as Dr. Moser would never be able to get back to me. Less than one hour later, my nurse informed me that I had a phone call from California. After a few deep breaths I answered the call, expecting to be embarrassed for having bothered him with such a trivial matter. Needless to say, that wasn't the case. He was the kindest and most patient man I have had the pleasure of knowing. Not only did he help me with my case, but over the next few years, he was a constant source of knowledge and guidance in the care of my patients. He taught me that, regardless of how much we have personally achieved scientifically and professionally, we must always be willing to share that knowledge and take the time to foster the growth of those who follow. Kenneth Moser was a truly kind and brilliant man who made me want to be the best that I could be. He is missed.

Robert De Marco, MD, FCCP
Private practice, Windermere, FL

Part 2: It was during morning report, internship year at Georgetown, that I first heard Dr. Ken Moser's name. We had admitted a patient with what we believed was acute pulmonary embolism, but the diagnosis was a challenging one to make with our existing technology. Feeling way out of my league in the discussion, I nervously blurted out some far-fetched ideas about other strategies with which to diagnose pulmonary emboli. Instead of the dismissive chuckle that I expected from my attending, I got something much more terrifying: orders to run the idea by the reigning expert on PE diagnosis, the Division Chief at the University of California, San Diego, Dr. Ken Moser. My attending promised to ask me the next morning about the results of my discussion with him.

I made the call across the country to his office. "Dr. Moser," his secretary said, "is busy now." (Thank goodness!) "Would you please leave me a detailed message?" Cringing the entire time, I told Dr. Moser's secretary that I had some ideas about pulmonary embolism and had called to discuss them with Dr. Moser. Before I could hang up with the true story of my "regretfully" unsuccessful call, she asked me for my office number, so he could call me back. In my state of panic at this possibility, the first number that came to mind was my home phone.

Saturday morning, my home phone rang. "Tim? This is Ken Moser. What'cha got?" Thus started the most attentive and supportive phone call of my career, from a giant in medicine, 3,000 miles away. He spoke with me as if we were equals, drawing on his immense fund of knowledge in a casual, even chatty, manner. Most surprisingly, he seemed interested in my

opinion about it all. He ended with, “Hey, if you’re ever near San Diego, come down and visit us, okay?”

This morning, more than 20 years after that conversation, I walked by his old office. Of course, I did end up “visiting” Dr. Moser. I entered his fellowship, joined his faculty, and eventually became a professor in the division he created. My career is the result of countless hours of inspiration and support from him and from those he trained before me. I spend my time caring for patients in the hospital in which they taught me. The research ideas about a new diagnostic agent for pulmonary embolus that I spoke to him about so long ago progressed through my (!) laboratory and then into multicenter clinical trials. It all has been the ride of a lifetime.

I often reflect on that Saturday morning conversation. I wonder how much of my life’s direction was changed by those few minutes that Dr. Moser took to speak to me as a gentlemen and a colleague. I think of it most of all on busy days, when some young student or house officer wants a little of my time and consideration. During those times, I hope I do justice to the man who did so much for me.

Timothy A. Morris, MD, FCCP
University of California, San Diego

Mentor: Kenneth Moser , MD (Deceased)

Leadership Point

Academic medicine lends itself to certain individuals who develop reputations as “the expert” for various disease entities. At least within our medical community, they become “famous.” Dr. Moser was one of those individuals in regards to thromboembolic disease. It is interesting that a phone call with this individual stands out as one of the most important leadership lessons for the two authors above. They both understandably thought that this man would be too busy for their seemingly trivial patient problems. However, he made the time for both of them, made them feel important, and taught them a valuable life lesson. He clearly did this for more than just these two budding academics. Being available requires effort. Showing kindness, concern, and consideration can be difficult when you are busy. The pay off can be huge, however, when we influence others to carry on in a tradition of sharing information for the betterment of our patients.

Inclusiveness

We believe that Richard Matthay is especially deserving of recognition as a superb mentor. He served in this role for all three of us—and for a large number of other trainees—during our fellowship training and in our early faculty years.

As fellows, we were very impressed with the way that Richard mentored our academic development, from giving us the opportunity to discuss complex cases at the statewide chest conference, to soliciting us to assist in the writing of review articles, to guiding us in selecting our initial faculty positions. Early in our career, he educated us on how to become involved in national organizations and meetings and provided introductions to important mentors and collaborators. He gave us tremendous opportunities to become involved in medical editing as well as in writing. He served as a role model in every possible way. Through his own example, he showed us how to blend a love for clinical medicine with a productive career in writing, education, and clinical research. This was particularly illustrated in the masterful way that he led scholarly and enthusiastic discussions at the weekly statewide chest conferences, respectfully incorporating input from academic faculty and clinicians from around the state.

Years later as a visiting professor at Yale, participating in the same statewide chest conference, I [Dr. Niederman] was again reminded of Richard's mentorship when a fellow presented a complex pneumonia case that Richard had helped him organize. As the conference leader, Richard called on a number of participants from the audience, which included both academicians and local practitioners, in a nonthreatening manner. He asked for their opinions and about their own personal experience in similar clinical situations. This made a big impression on me then, as it had as a fellow, because I gained a renewed respect for the knowledge of practitioners as well as academicians. I saw the respect that Richard had for both and the opportunity for all to work together, which Richard conveyed to all present, including the fellows, on a daily basis.

David Ingbar, MD, FCCP
University of Minnesota

Herbert Wiedemann, MD, FCCP
Cleveland Clinic Foundation

Michael S. Niederman, MD, FCCP
Winthrop University Hospital

Mentor: Richard Matthay, MD, FCCP

Leadership Point

The practice of medicine is done with many types of people, from the academic and practice leaders to the clinicians (physicians, nurses, therapists, etc.) who participate in hands-on daily patient care. Everyone has a role to play and brings experience and insight to the team. Respecting every member of the team and his or her unique role is the job of a good leader.

Everyone wins when the wise leader includes all parties and respectfully listens to all perspectives. By modeling respect and inclusiveness for everyone, Dr. Matthay mentored his young trainees as they progressed in their careers, teaching them by example to demonstrate respect for the important contributions of all, regardless of training level or practice background.

Leaving the Train Station

From an academic perspective, I remember two sayings given to me by my now late division chief that guided my approach to research and mentoring. The first was “. . . you need to love your data more than you love your ideas.” In other words, your experiments may lead you to truth that is different from your hypothesis, so follow it. The second was that mentoring is like a train station. You put your trainees on a train, and the tracks lead away from you. You may control the train they get on and the car they ride on, but their destination is determined by the tracks and how far they decide to ride the train. You must be willing to let your trainees take off on their own. Although they start in your lab, they may take your ideas and go in a different direction. Mentoring is like parenting: you have to be willing to let go and trust that you have raised them properly.

Douglas Arenberg, MD, FCCP
University of Michigan

Mentor: Anonymous

Leadership Point

Clearly, a leadership issue to model and insist on is academic integrity in research if we are truly to advance the care of our patients—just one of the many ethics we hope to instill in our mentees before we pack them away on the train. A good mentor should desire to have the mentee grow to a point that he or she eventually surpasses the mentor, regardless of the path eventually taken. Great mentors are able to help their mentees evaluate opportunities that will get them closer to their personal goals. They are also able to teach their mentees how to say no when an offer, no matter how appealing, may simply derail them from the tracks. On occasion, this may mean a re-evaluation of goals in order to remain on the tracks. Like a parent, the mentor finds ultimate fulfillment when the mentee finds his or her own way to a final destination that is better than either of them dreamed.