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RESEARCH ARTICLE

Finding and Being a Mentor through a Lifetime

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ABSTRACT

Mentor has roots in Greek mythology. Its current practitioners have lent their own interpretation and meaning by their actions. We offer the case studies and lived experience of a select group who have never met all the others. Each asked the same questions, they tell the story of how each found their mentor(s), try to be mentors themselves, and what they try to impart to their mentees through the vicissitudes of their professional responsibilities and personal lives over a career.

Introduction

In Greek mythology, Odysseus asked his friend Mentor to take care of his son, Telemachus, when he left for the Trojan War. Because of Mentor's relationship with Telemachus, Mentor has become a description of someone who imparts wisdom to and shares knowledge with a less experienced colleague.

Coming of age in medicine in the late 70s one rarely heard the word mentor. Mentoring in rheumatology was the subject of the 1986 American College of Rheumatology Presidential address by the late Ed Harris.¹ He noted that being a mentor "is not a role for everyone" and that "the best mentors are not necessarily ...the best of scientists, teachers, or clinicians. . .The spark that lights the roaring fire may itself be insignificant."

Sometime in the last generation, mentoring became advice for how to advance in one's career, get promoted or recognized, and the peculiarities and culture of a particular field or organization.²

At NIH, competitive career development awards were required to designate a mentor and to outline a mentoring scheme. Some medical schools and hospital training programs assigned mentors; and awarded excellence in mentoring. The absence of mentoring is seen by young faculty as a major barrier for the aspiring academic.³

Many believe that one should pick or find or ask for a mentor who is not their boss or supervisor and someone probably over 50 who has already arrived and not trying to get the best out of you nor competing for the same limelight. Everybody needs mentors, as many as possible, and possibly different ones over one's lifetime and for special circumstances such as parenting young children. When the opportunity presents itself, mentees should also be mentors; promotion committees ask for evidence of mentoring. Atul Gawande, an endocrine surgeon, suggests that those who perform procedures should have a coach to help them do it better just as professional athletes, singers and musicians.⁴

Mentoring has also become the coaching of inexperienced grant applicants and the teaching of grantsmanship. In the 80s allied health professionals (nurses, physical therapists, and occupational therapists) applying for Arthritis Foundation grants were mentored during their first application.^{5,6} The National Institutes of Health and the Arthritis

Foundation first sponsored a 2.5-day Master's Class at Woods Hole, Massachusetts in 1998. The participants had not yet secured their first grant. Young faculty chosen and sponsored from programs all over the country attended the retreat signed up for "office hours" with 4 senior clinician-scientists, workshops for methodologic issues, grant making assistance and career development advice. The syllabus and venue were shared with the Young Investigator Initiative of the United States Bone and Joint Initiative, an international collaborative for musculoskeletal conditions. The program began in 2005 and continues to this day. It provides mentoring until a novice has achieved their first extramural grant.

On the other hand, Hal Holman, the first Chief of Medicine at Stanford and involved in building a new academic medical center starting with eight faculty, felt that much of what passed for mentoring is really a pernicious way to "play the game," and to maintain conformity. He believed that what is really needed are role models.⁷

An attendee at a mentoring workshop of a professional society meeting 22 years ago suggested to one of the authors that the frank conversations that day should be disseminated, particularly how novices found their mentor(s), their secrets on how mentors stayed at the top of their game, stay engaged and changed over a lifetime, and how they managed all the expectations and duties expected of them (time management).

That attendee became editor of a monograph series and made his idea a serious request. He left his post before we could get him a draft but colleagues had already been approached. They were busy full-time clinicians, teachers, and researchers in academia, private practices, and Veterans Healthcare. All juggled their to-do list constantly through the day prioritizing their attention with patients first, balancing life events, illness, disability, and family along with professional demands.

The same questions were asked individually to get them started. The following are the things they chose to talk about from oldest to youngest. Six women were also contacted, all professors or senior clinicians with academic lives, to participate. Three had become well-known as well as raised children; two never replied. One accepted. The ones we did not get we imagined had learned to say, "No, thank you." – perhaps one of the most enduring suggestions of successful busy people.

How did you find your mentor(s)?

Gratwick born 1943

Geoff Gratwick is the quintessential Renaissance Man and literatus. He practiced adult and pediatric rheumatology along with ACR Master Sid Block in Bangor, Maine, a town of 33,000. He was one of only three rheumatologist/arthritis specialists in Northern and Eastern Maine and from 1979-2015 ran rural rheumatology clinics for catchment area of 250,000 people.

At age seven, after Geoff had gone through his family's library, he worried that there would be no more good books to read. After that epiphany, he went to Harvard College, Cambridge University, and then Columbia and Cornell for his medical training. Following this, he taught at a medical school in Iran and sailed for a year with his wife before moving to Bangor.

At the time I approached him about this project, he had a rich life outside of patient care. He had sat on the Bangor City Council. He was a major figure in the Maine Humanities Council that runs programs such as Literature and Medicine, an award-winning reading and discussion program for health care professionals that, as one participant wrote, "renews the heart and soul of health care". The Council's annual Winter Weekend explores a single great work of literature each year from many perspectives. Weekends have been devoted to such works as Tolstoy's *Anna Karenina*, Cervantes's *Don Quixote*, Thomas Mann's *The Magic Mountain*, and *Beowulf*. As a speaker, Geoff had variously addressed the audience in a toga and a suit of chainmail.

Geoff won national and European rowing championships while in college, has rowed the *Head of the Charles* in Boston every year and won a gold medal at the 2016 European championships.

When I first asked him about writing his thoughts, he wrote back..." I suspect my perspective is somewhat different in than yours in that I still deal with ghosts/mentors inside my head but I am happy to expose them to the light of day. My life has taken something of a curve recently in that I am running for the Maine State Senate..." That year, 2012, he won a hotly contested race, beating the incumbent Republican to become Bangor's State Senator; he was termed out in 2020. While in the Legislature chaired several committees including the Health and Human Services Committee. In 2017, he formed the Health Care Task Force which was charged with ensuring that health care in Maine would be universal, affordable, accessible and of high quality. In his retirement he has continued this passionate quest as a board member of

Maine AllCare. He and his wife, Lucy, a clinical psychologist, have two adopted children, six grandchildren, various chickens, sheep, geese, goats on their small farm, and he is a sometime health contributor to the *Bangor Daily News*.

Geoff wrote, "I have had remarkable teachers who became classical mentors over time. They believed in me, took chances with me, pushed me. My Chief of Medicine at P&S, Gerald Thomson, sat back in his chair and with a twinkle in his eye bade me to think deeper. Charles Reagan looked me up and down as I stood in his office and finally said, slowly, that I could become a fine rheumatologist if I put my mind to it. Charles Christian at HSS rocked back gently on his heels, standing ever so erect and magnificent, and told me that in research "you get the results you get" and bade me follow where the trail led.

But my most influential mentor was the less conventional Deedee Schwartz with her attendant instructors - William Carlos Williams, Tolstoy, Anne Fadiman, Euripides, Tim O'Brian, et al. Deedee was an artist, a print maker, who on a whim became head of the Maine Humanities Council, the state arm of the National Endowment for the Humanities. She was an early convert to Literature and Medicine, that now well-established program bringing together those who work in medicine - doctors, nurses, administrators, support staff - to talk about medical care through the lens of literature. I was one of Deedee's board members, her devotee. She helped me establish the Literature and Medicine program at Eastern Maine Medical Center in Bangor.

I have now read, and taught, and been taught for twenty-five years by writers great and small. From them I have learned about my patients as people. King Lear taught me about madness, loss and growing old, Ann Fadiman's *The Spirit Catches You and You Fall Down*.⁸ It's about cultural differences separating us and the Hmong that render my logical scientific approach totally illogical, and Siddhartha Mukherjee in his extraordinary *The Emperor of all Maladies* about the sweep of cancer.⁸ I have learned from short poems and from *War and Peace*. Our group talked for two hours about Robert Murphy, an anthropology professor at Columbia who charted his progressive quadriplegia from an inoperable spinal cord tumor in *The Body Silent*.⁹ This was as intense as any bedside interaction I have ever had. Murphy spared us nothing with his brutal honesty about how we, as medical professionals, had treated him. As he lay dying, fifteen of us read his deepest thoughts in our

two-hour discussion. We listened to him. We paid attention.

As I approach my 80s, I am both an emeritus legislator and an emeritus physician. I am a mentor to new legislators, helping them to navigate the tangled paths our health care system. And I myself am still being mentored. The thinkers and writers who opened windows to the world for me in the past are pushing me yet again to new perspectives. To appreciate the infinite variety of human experience writers and readers alike need to be healthy, that is to have health care. Universal health care, health care for us all, is now my mission.”

Liang born 1944

[Liang's father, Ping Yee, graduated in 1936 in China's first western-style medical school, the Peking Union Medical College a class of 15, 9 women and 6 men, from all over China and post-doctoral studies at Johns Hopkins where he met his future wife. They returned to Nanking the regional capital during the war and then to Guangzhou. In 1949, the family fled their home and went to Baltimore. Ping Yee's sayings were his sons' guideposts: "Good, better best. Never rest, until good becomes better and better becomes best;" "Never tie your shoes in a melon patch." Ping Yee read every issue of the Journal of the American Medical Association even after his practice wound down because he wanted "to do the best for his patients." His wife, a nurse, had Parkinson's and was bed-to-chair from the time Matthew was in high school; Ping Yee took care of her between seeing patients at 2 offices. As an eye, ear, nose and throat surgeon, he stopped his malpractice insurance and told his patients that it would just increase his office fee about \$10 in 60s dollars.

His two sons, both physicians, were never more than one of three Asians through public school, college until they had completed medical training. Arthur became a career public health teacher at the Communicable Disease Center and led the Food Safety Program. Matthew, was aiming to be a primary care doctor in New England but ended up in academia and never left Boston. After an emergent 6-vessel CABG for unstable angina at age 56, a strept millerei lung abscess and empyema from a dental cleaning 3 years later, the end of his 23 year marriage, pronouncing his closest colleague in his home, refunding his research group, an admission for disseminated Herpes zoster and trying to find the poetry of his youth by working at the Veterans Healthcare system parttime and rebuilding a small Boston University-Harvard section of rheumatology for the region. At age 65 he closed his practice in part because EPIC the electronic medical record that

was sweeping US teaching hospitals came online; he was not alone. Now his doctoring is limited to occasional supervision of fellows in the VA and Consultative Medicine something heralded as a new specialty but, for his generation, what was taught as being a real physician.⁸ Now, his mentoring is not for the best and brightest on an elite career path but people with roots in foreign cultures with highly unusual demons, post-traumatic stress disorder, sons and daughters of minority, disadvantaged, illegal immigrants or with no prior exposure to being a health provider. The cycle continues.]

I don't remember ever discussing mentoring; we thought more about people we admired— Charles Barlow, Dan Federman, Alexander Nadas, Sam Thier, Michael Stewart, Joe Murray, Howard Burchell, Charlie Davidson, Roger Mark, Hal Holman, Dick Nesson, Brian Hoffman to style ourselves, more honestly, copy as a physician and as a person.

At my first and only real job at the Brigham, in the new general internal medicine and primary care teaching practice and up Mission Hill in rheumatology at the old Robert Breck Brigham. I found help, understanding and friendly fire amongst my cohort in the Scholars program, Bob Meenan, Bob Pantell, John Wasson, who were navigating similar waters in other institutions. Lawren Daltroy came from a national search as a condition of funding for a new educational component of a program grant that I started. He was recommended by Larry Green who was on sabbatical. I had no idea of what a public health educator was when I started the search. But after a recruitment dinner in the New England cold, we talked short-hand about our ideas for hours.⁹

In 2003, I went to the Veterans Administration part-time to the VA Cooperative Studies Program and found myself responsible for rheumatologic care at 5 sites in Massachusetts after the former head, Gerry Greene, had retired. The Brigham had an agreement with the VA for orthopedics and rheumatology services negotiated by an administrator who was subsequently arrested at the hospital for stealing more than \$288,000 from the orthopedic practice. He had signed an agreement that had no backup in the event of illness or vacation. Kristine Phillips and then Sheetal Chhaya, wonderful physicians joined the existing nascent section of 3 part-time individuals; but each followed their physician husbands to other opportunities in Ann Arbor and Phoenix respectively. Our section chief was Samar Gupta and by the time he was recruitment away, the department realized the

importance of rheumatology. The Chief at that time and a mentor since, Brian Hoffman, convinced the leadership to secure another full-time position and to find someone through a formal search. That search brought in a number of candidates but the fit was not completely right for either party and the search suspended. Eventually, someone we had reached out to at the beginning of the search called to see if the job was still open. That was Paul Monach an unanimous choice; his mentoring and wise council has made a tremendous difference to our morale and quality.

I first met Brian when he was on rheumatology rotation at Stanford. He became my boss. Unlike any boss before he proactively watched out for me and our section. When he stepped down, we continued our conversations about life and medicine whenever I could catch him usually with his armfuls of mail going past my office. He was a wonderful mentor and protected me from myself as the worst enemy. He has retired and in the new virtual digital world continues 3000 miles apart and careers away. When I have a medical predicament or life issue is still one of 4 people I would talk to.

Shoor born 1948

[Stanford Shoor has never been far from Stanford. The son of a Stanford trained surgeon, he was a Stanford undergraduate, a successful, charismatic rock concert organizer, a Stanford medical student, a Stanford fellow in rheumatology and immunology and Robert Wood Johnson Clinical Scholar. He and his medical school side kick, Harold Goldberg, worked on novel ways to empower patients in chronic disease and were there at the start of the self-help movement in chronic diseases, a field that Kate Lorig and Hal Holman made their own. They and others founded the Mid-Peninsula Health Service, a community health care system organized as a true collaboration between the clients and the providers. It became a laboratory for patient education in an aging arthritis patient population.]

Shoor is back in his second career after 27 years with the Kaiser Permanente, the mother of all Health Maintenance Organizations. Within the shadows of his alma mater, he is a clinician teacher and received the Samuel Sherman Award for Innovation and Contribution to Continuing Medical Education from the California Medical Association Institute of Medical Quality, Associate Director of the Internal Medicine Residency program, Chief of Continuing Medical Education and founded and chaired the Chiefs of Rheumatology.]

I found Hal Holman as a Stanford medical student and Woody Emlen by chance rotating through his service during my University of Washington residency.

Lansdale born 1954

[A 3rd generation miller's son from Olney, Maryland, even casual acquaintances would call him "doctor." He looked like, sounded like, walked like, behaved like a physician. Being a physician was who he was. He was the doctor's doctor.]

As a cum laude American history and literature major at Harvard, he sang for years in 8:45-9 morning church service with the Krokodiloes, Harvard's oldest A cappella group. He came to medicine late and almost not at all. In fact, his advisor discouraged him from applying to medical school. He was rejected by 18 medical schools. Thankfully, George Thorn, who became Chief of Medicine at the Peter Bent Brigham Hospital encouraged him to persist. To increase his chances of acceptance, he took Physics for Poets and Vacuoles, both "guts" and got above 3.0, worked at the Mass General Hospital Radiation Research Lab which he hated, and dropped his day-job at the College delivering linens and bartending.

He got into Case Western Medical School two years later and was an academic star and elected to Alpha Omega Alpha. Tom did his medical residency at University of Pennsylvania where he joined the faculty. In 1987 he was recruited to the Brigham to the Division of General Internal Medicine and Primary Care. Over 3000 physicians are employed at the Brigham. Tom was the go-to general internist and few saw him leave the hospital before 7 pm.

In 1996, Tom returned to Maryland and chaired the Department of Medicine at Greater Baltimore Medical Center 1996 to 2005 and also was the Medical Director of HealthCare for the Homeless with more than 30-year history in Baltimore. He understood that students learn best from people they love. He transformed the medical residency training program and their trainees' pass rate on the American Board of Internal Medicine Certifying Examination went from zero to 100%. Leaders such as Katrina Armstrong, Chief of Medicine at Mass General, and Redonda Miller President of Johns Hopkins Hospital were among his mentees.

Because of ill-health, he "slowed down" in an independent, solo internal medicine practice whose ethos was that healing and pursuing a healthy life required on-going collaboration between patient and their doctor. He decried what his beloved profession had become.¹⁰ At one point in his clinical practice,

Tom participated in no insurance plans, not even Medicare and the only patient charge was an annual fee which covered everything and for as long as it took.

He worked and played joyfully; fished, golfed, kept bees. The latter made the honey for his Carpe Beeum, which he gifted to patients and friends, in addition to bread and soup he made when they needed special treatment. He could grill a chicken on a beer can, loved Mozart, Sondheim, and Sweeney Todd and singing.

For more than 2 decades, he had recurrent atrial fibrillation which befuddled cardiologists in Boston, Durham, Baltimore and Philadelphia, cardioversions, coronary care unit admissions in the 4 cities where he ruled in a couple times, anti-arrhythmia drugs that sickened him, and more than 9 ablations. After the latter, he smelled burned tissue and felt awful.

*Because of his heart ailment, he closed his medical practice. His marriage also ended. At one point, he could not walk 20 feet without being short of breath. He then took all his know-how to minister to dying patients, mostly minority, poor, uneducated, with broken families or homeless as an on-call hospice physician. He discovered and recommended two books to everyone he met as they changed his life forever; *God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine* by Victoria Sweet and *The Body Keeps the Score: Brain, Mind; and the Body in the Healing of Trauma* by Bessel van der Kolk; and for himself the power of acoustic neuromodulation for emotional trauma, and sang a coveted solo at the annual Kroks concert in Falmouth, MA, "I Got Rhythm," celebrating his normal sinus rhythm, at last.*

In 2018, he was in the best shape of his life - out of heart failure, jogging and bench pressing his weight. Then he learned that he had advanced prostate cancer. He followed all the advice "getting ready for battle" and surgery. His worst fear was that stopping his anticoagulation for atrial fibrillation during surgery might put him at risk for a stroke. Hours after his surgery he saw double, had trouble walking but didn't tell anybody thinking it surely was a small stroke that he had feared. Post-op he could not sit without pain, annoyed by his lack of energy, "damn" diapers, and incontinent. He never felt well during the six months after learning of his prostate cancer and a primary brain tumor ultimately diagnosed post op and before passing away surrounded by family and daughter.]

"In medical school, I had the great fortune of meeting a retired Case Western Reserve School of Medicine faculty member who was leading an intensive curriculum review by shadowing students and interviewing them during their third-year rotations. Ed Chester was a superb internist, had won many teaching awards, and was among the first clinical researchers to observe and describe causality links between systemic diseases and retinal pathology. He published a classic textbook on the subject, giving me a copy as a graduation present. I spent many afternoons with him at his home on the west side of Cleveland for the better part of my senior year under the guise of some sort of "elective." We discussed cardiac pathophysiology, but our conversations inevitably broadened to talking about all sorts of things, especially what it means to be a good clinician. He was the finest example of the archetypal "clinician-educator," a term I had never heard before, but I knew I wanted to be like Ed when I grew up in medicine. I stayed in touch with him for many years after I left Cleveland and was crushed when he died. I miss him like I miss my father.

I identified mentors during residency training at Penn by observing who the smartest of my fellow residents respected the most. There was Paul Lanken, the consummate pulmonology attending, who was not only a master diagnostician and teacher, but who became one of the earliest intensive care specialists to highlight the terribly difficult ethical issues involved in providing expert end-of-life care. Mark Kelley, the residency director, had forgotten more clinical wisdom than most clinicians ever learned; I soaked up his pedagogy because it was both brilliant and laced with easy-to-remember good humor. Then there was Larry Beck, an incredibly gifted nephrologist and chief of medicine at the VA, who taught me about triple acid-base disorders like a master chef teaching a culinary novice how to understand complex recipes.

At the Brigham, I was awash in great mentors at every turn. It was easy to identify them – they were the "go-to" clinician-educators everyone looked up to and who helped you when no one else had a clue: Chris Fanta, pulmonology; Marshall Wolf, internal medicine; Marty Samuels, neurology, just to name a few.

As I have gotten older, and the arc of my career has long passed its apogee, I have increasingly realized that some of my best mentors have been patients. They may not have helped narrow a differential diagnosis or brought to my attention an

unusual presentation of a common disorder, but they have taught me more important things: what to say; what not to say; when to say it; how to give bad news gently; how to soldier on when a favorite patient dies.”

Flower born 1965

[Dr. Cindy Flower is a senior associate Lecturer at the University of the West Indies, Cave Hill campus, and a Consultant at the main Hospital in Barbados. She is an international fellow of the American College of Rheumatology and a fellow of the American College of Physicians. Encouraged by her mother, a single parent, to go into medicine, she eventually traveled to the US to take advanced training in rheumatology with Ron Messner. At the time, lupus patients with nephritis on the island were cared for in the renal clinic of the hospital. When she returned from the University of Minnesota she started the first public and private rheumatology clinics for SLE. There were misconceptions, she reminisces, to quash of a colleague “No, a rheumatologist doesn’t just prescribe Voltaren!” and from a healthy male patient “No, a rheumatologist is not a masseuse who pays special attention to joint areas.”

She is the only fully trained rheumatologists in the island nation of 281,200 people. She started the first rheumatology clinic on the island in 1997 and established a registry of rheumatic disease for the island. She conducted the first study of the epidemiology of rheumatic disease with special emphasis on systemic lupus erythematosus .11 Trained in rheumatology at the University of Minnesota, she is known internationally for her work in managing difficult systemic rheumatic illnesses in a resource-constrained environment where immunochemical diagnostics and the latest therapy in lupus like belimumab are unavailable and only recently mycophenolate and rituximab (the latter at the hospital for lymphoma which she "borrowed") has come on formulary.12 She was a founding member of the Caribbean Association of Rheumatology, and on the medical advisory committee of the Hope Foundation of Barbados, a non-governmental organization to increase public awareness and advocacy for persons with lupus and other lesser-known chronic diseases. Her recent monograph for the lay is acclaimed.13

“Accepted Faculty Medicine stop”. That was the first line of the telegram brought to my mother in 1983 by the motorcycled messenger servicing our village in northern Trinidad. My Catholic school teachers had suggested, but my mother had insisted that I apply to Medical School in Mona, Jamaica. I wanted to be a nutritionist not a doctor, but I had

always been taught the sanctification of obedience. It was not until seven years later, on completion of internship that I realized I wanted to be a doctor.

This June coming will be my last month at the hospital. I have resigned after 28 years. I can no longer carry that burden...I have been classed as a "temporary" "12-hour" a week employee. I started off for most years as a "8-hour" a week employee. I have no staff assigned to me, so I have worked as a nurse, house officer and consultant all in one. I have spent long hours at the hospital - most people think I am a full-time employee. My initial monthly salary was a “pittance” as one of my former head of department characterized.

I have always made my living from my private practice. I was content with this as I was privileged to see the complicated cases I do and interact with trainees at the hospital. My mentee...an excellent resident has decided to apply for a fellowship in Canada. I wrote letters of recommendation for her 2 years ago.

During the height of the Pandemic, I was required to shift to being a full-time Internal Medicine Consultant running a team and on- call 1 in 4. It was exhausting and inspiring all at once. On on-call days I would usually return to the hospital around 7 pm to round with the junior staff on the admissions thus far. On the drive in I would notice prostitutes on the roadway who now had to come out earlier as we had a 9pm curfew. In the hospital emergency room, I was able to see likely Covid patients who were “comfortably hypoxic” while awaiting PCR test results and transfer to the Covid Hospital. My drive back home was typically at 9:30 pm, and the junior staff continued call. I would usually not see any other cars on the road. I felt like I was in one of those apocalypse movies...like something happened and I was the last survivor.

In the last few years there have seen numerous circumstances leaving me feeling morally injured, demotivated and disrespected and my every attempt to improve circumstances in the hospital for Medicine in general and rheumatology specifically was ignored. Imagine it took 20 years to finally get an area designated as a medical day unit to facilitate infusions and serve other general medicine functions! As more members of staff have become disengaged- it has become terribly difficult to function. I was left so depleted, had no peace of mind and stopped sleeping.

I asked hospital authorities to recruit another rheumatologist...that was ignored in part I think

because they haven't decided what offer to make to facilitate a credible attempt at recruitment.

I am saddened to leave the rheumatology clinic that I began but I am at peace with the decision and will make other arrangements to continue caring for patients in the public system.

I live a contented life. One remembers the old saying: Life is a test, life is a trust, life is a temporary assignment. Some of my patients live with such hardships and abuse I hope to make some small difference in their lives.

My mentors have always been role models and people who have been instructive in my life and helped shape the way I think. Some of them have never spoken directly to me while others likely do not even know of my existence.

I remember a brilliant dermatologist in Mona Jamaica- Lois La Grenade- from whom I observed the creative art of clinical diagnosis- this moved my interest along the lines of Internal Medicine. As a young resident at the hospital my love for internal medicine was further cultivated by a cardiologist Trevor Hassell. Each of his rounds was an event-compelling and daunting. He was a compassionate humanitarian and insisted on the same high standards for all patients independent of their station in life.

The mentor who had the greatest impact on my choice of subspecialty was George Nicholson, a nephrologist. He had been fascinated with lupus having developed tremendous expertise in diagnosing and managing the disease- he suggested that I study rheumatology. I would come to find out years after his death that he helped facilitate my fellowship opportunity in the US.

But after 10 years, having collected a wealth of clinical data including an informal image library, I turned to a colleague mentor Anselm Hennis in the Barbados, who was an internationally recognized researcher and now Director of Noncommunicable Diseases and Mental Health for the Pan American Health Organization and World Health Organization, to guide me through the study. Through Nicholson and Hennis, I met others trying to deliver contemporary care in resource-limited settings. Using those "experiments of necessity (M. Liang)" in persons with rheumatic disease living in the least developed countries of the world who share some of the same problems as economically disadvantaged persons living in developed countries to gain knowledge for what works. It's

been a meaningful and rich journey and I am proud that what we do has value and currency."

Gupta born 1966

[Born in Hisar, India, Samar Gupta has come the longest distance of this group having done his medical training at Medical College in Rohtak, his medicine at Rush-Presbyterian St. Luke's, Detroit Medical Center, and rheumatology at the University of Michigan. Samar has been in Veterans' health care since 2001. The VA is the largest healthcare system in the US and every study comparing the processes and outcomes of this system has shown its superiority. He took a huge pay cut to leave a large home in Wyoming on 5 acres to come to Boston at age 39; his late father an academic geologist, persuaded him that it was a great opportunity. As the only full-time person in rheumatology, he carried the heaviest clinical responsibility on the broadest shoulders for inpatient & outpatient rheumatology consultation, medical staff, and house officer teaching, health systems improvement, and practice standards at the local and national levels. At UCSF, I met a young physician who said she went into rheumatology because of a rotation with him. Boston is the referral center of last resort in the VA regional system. His "do" list has been endless as he and his wife have two Yale students (a Yale Law graduate student and a Sophomore) and a third 12-year-old daughter who is a State level swimmer and diver. In 2014, he was recruited back to Michigan to be Chief of Rheumatology Clinical Services and Training.]

I met Dennis Lower by a pure stroke of luck. I was searching for a job in 2000 when my resume crossed his desk. His son was completing his MPH from the University of Michigan where I was finishing my Rheumatology Fellowship. He is still there for me in professional and personal dilemmas.

Brian Hoffman is the person who hired me in Boston and helped me stay by empowering me and helping me see the "big picture". He is a "Statesman" in my professional life. A true friend and a great Boss.

Currently, he is a senior faculty member at the University of Michigan Medical School. He is a co-investigator in an NIH-funded trial studying Psoriatic Arthritis. He is a Fellow of the American College of Rheumatology, and a member of the Veterans Affairs Rheumatology Consortium, GRAPPA, and the National Psoriasis Foundation. He has been a leader in developing standards of care and criteria including disability ratings in the VA, the 2013 DXA guidelines for the International Society of Clinical Densitometry [ISCD],

Performance Pay Measures, and Lyme Disease. Dr. Gupta was a member of the team that first described Nephrogenic Systemic Fibrosis and Scleroderma-like skin disorders. He has been a site investigator for controlled therapeutic studies of rheumatoid arthritis, Gout, dermatomyositis, and psoriatic arthritis.

Gupta

I have mentored senior medical residents, rheumatology fellows, and final-year medical students. I show them the model of the game of Tennis - you learn and work towards the whole game, not just serve or forehand. That way, I help them think not in pieces but in the whole puzzle. Second, I show them how I work and act in daily life, so they can imagine themselves in the role if they wish. Also, I teach them that hard work will beat talent when talent doesn't work hard. Finally, writing patient progress notes is an acquired skill - a good note, besides being absolutely free of spelling mistakes (my pet peeve!) - has to deliver additional medical knowledge to the reader, satisfy the billing/coding folks, and keep the attorneys who will read your notes, happy.

Gupta

Spending as much time and energy as required without any limits - to get the patient's problems resolved to my satisfaction and best expertise. It may involve calling the senior physicians, looking up medical resources or just digging into their past records. Then I can turn around and go. I try to keep notes of relevant clinical tips when attending medical seminars, which may help me with difficult patients or just better their care. I try to be up to date and learn the cutting-edge science in my field so that I can help non-rheumatology providers understand the problems & solutions clearly. I subscribe to the electronic table of contents of most of the high-level Internal Medicine, Rheumatology, Dermatology, and Orthopedics journal. I then choose and access full-text articles of interest, and share them with others.

Gupta

It is just impossible if I want to do all the jobs (home and work) the best. One time management seminar teacher gave me two tips which I am, a bit grudgingly, adopting: the 80/20 rule. Twenty percent of the projects take 80 percent of the time. And most of those 20 percent projects don't have to be gleamingly finished - complete the project and get off as soon as it is done satisfactorily. Second, regarding the longer tasks, like writing a big paper or signing a pile of progress notes, the teacher advises a piecemeal approach. Just gnaw at a

small part at a time and don't try to finish the whole thing in one sitting: I really feel that by the end of the day, I finish more stuff than I used to! I now use an Outlook-focused inbox to triage my email and use online shopping whenever I can.

Gupta

Lately, the various lists of Pay 4 Performance Measures (US and International) have come in handy. I choose a few relevant measures carefully to improve the outcomes of my patients. They tend to be more clinical and individual rather than affecting the whole group of patients. Practicing evidence-based medicine than eminence-based medicine has helped me a lot, medically and medicolegally.

Who have you mentored and what worked best?

Gratwick

"What distinguishes a mentor from a wise parent or a wonderful teacher? It is their interest in you and your development, the intensity of the feedback loop between you and them, and the depth of their commitment to seeing you grow and flourish. A good teacher wants you to learn, molds the material in ways that make sense to you, writes detailed and thoughtful notes on your papers - but a mentor does more. A mentor sees further into your soul, finds what is special and untapped and takes you in hand to a new plateau. A parent introduces you to the world and a mentor helps you establish your place in it."

Liang

"I mentor mostly clinician scientists in training over 20 years. They were generalists, surgeons, and individuals interested in care of the elderly, rehabilitation, musculoskeletal and rheumatic diseases or public health, over 50 individuals in their formative years from 7 countries. Each had their strengths and demons to overcome but all grew and I grew and learned with them.

When I began at the VA, I didn't want to compete with my protégés at the Brigham for prospective fellows and have only taken on people who have approached me only for mentoring. These individuals found me by accident, were sons or daughters of colleagues in the US or abroad or from marginalized populations with no academic background.

In the process, I realized that this is where I really feel alive. I meet with each for hours a week preferably over food, share readings, go over documents line by line thinking out loud in front of

the computer screen, to see how I can stretch them and help them find their "bliss."

Shoor

"I mentored Ariella Kelman, Elaine Lambert, Linda Lee, Neelakshi Patel - all clinicians.

My approach:

MODELING

1. Teaching "in the moment" or "on the spot"--have them be present when you talk to colleagues, patients and consultants about their patient and have them model off of your behavior.

For each patient that you see with them in clinic or on the consult service ask: " Before we go into the room....what question(s) do you have about the H & P? What do you want me to ask and/or examine. " What do you think the most important issue(s) are and what question(s) do you have about them? "What do you want to learn from this case?"

2. Critical thinking: When they face uncertainty or a conundrum, guide them through an analytical approach using some of the following questions:

a. What would the effect be of your anticipated plan of action? How will you assess the result? When would you assess the result?

b. If ordering a diagnostic test: what is the accuracy (sensitivity/specificity/predictive value positive and negative) of the test? Will the result change your management?

c. What are the risks of any diagnostic or therapeutic plan? What are the patients' wishes, preferences, questions about the dx and management?

3. Reveal their short and long term goals--both professionally and personally

4. Praise, reward performance; identify inadequate performance ASAP and set specific, concrete behaviors/actions for amelioration and a time frame for progress and reassessment.

5. If you have a vision for them and see special talents or strengths in them, tell them."

Lansdale

"... at various stages of my career, in different settings...,I have mentored students and residents at three teaching hospitals, in the clinic, on the wards, in the ICU's, and in one-on-one meetings in the privacy of my office.

Mentoring is easy and incredibly enjoyable if the trainee is talented, curious, and a pleasure to teach. Mentoring is very hard otherwise. My most intense period of mentoring was from 1993 through 2005, when I was Program Director and Chairman of Medicine at a teaching community hospital in Baltimore. When I was recruited from Boston to help shore up a weak residency program at Greater Baltimore Medical Center, I had no idea how hard that task would be. The academic rigor in the residency when I arrived was nil; the housestaff were unreliable and had little work ethic; worst of all, the pass rate on the ABIM certifying exam was zero! I wondered if I had made a dreadful mistake leaving Harvard and the Athens of the Brigham for the backwaters of GBMC.

By nature, I am a nice fellow, look for the good in people, try to lead by example and not by edict, and I strongly dislike conflict. I would describe my style with the GBMC residents in those early days as being quite different from what would come to me naturally. I was ruthless with new rule setting ("be at Morning Report promptly at 7:30 or you will find the conference room door locked and you will be doing extra call.") I was brutally honest in oral and written feedback, much of which was hardly complimentary ("this admission note is not only inaccurate and poorly written, it is unacceptable as a medical-legal document.") I insisted on professionalism in every aspect, from haberdashery to the quality of relationships with patients, staff and peers. I spent half an hour teaching a Pakistani intern the proper way to look patients in the eye and how to shake their hand in greeting. I overheard a resident bungle his way in a phone conversation during which he told a patient he had AIDS. I kept him after clinic for an hour while I role modeled a much different way of delivering that devastating news. I was more demanding of myself than of my residents, working evenings, weekends and holidays. I recruited expert young faculty members from nearby medical centers to help. In three years, I got a call from the deputy executive at the ABIM asking how my program Board pass rate had gone from zero to one hundred percent in just three years. "Elbow grease," I told him.

I mentored a first-year student at Hopkins who spent one afternoon a week with me in my office seeing my private patients. This is the most fun I have had as a mentor. The student was bright, intuitive, smart beyond her few months of training, and a lovely person. I taught her clinical pearls that are ancient to me but startling to her. The quality of her questions and her written notes improved exponentially in a short time. But the best part of

the experience was showing her how I care for and about my patients, and then observing her displaying the same interpersonal traits and skills that I have just taught her. What a joy.”

Flower

“I have mentored the Internal Medicine residents who displayed an early interest in rheumatology. Some have gone on to complete rheumatology fellowships while others who pursued other subspecialties still tease that rheumatology was a close second choice. I also hope that I have encouraged all trainees with whom I have interacted to see Medicine in general and rheumatology specifically as the fascinating fields they are. Rheumatologists are often considered the “detectives” of Medicine because many diseases have multisystem manifestations and require strong engagement of clinical reasoning skills as well as tenacious pursuit of the truth while navigating a field of possibilities. Clinical reasoning skills and the art of diagnosis are refined in rheumatology making it complimentary to the other clinical subspecialties.

The characteristics that make a good mentor are the same as the characteristics of a good leader. A good mentor, like a good leader, is wise. Wisdom is not just a trait that a few people have, it is also a skill that we all can develop. Informed by work done at the Wisdom and Culture lab at the University of Waterloo in Canada, I aim to impart the best of my knowledge and ripened experience to the trainees. I aim to display open-mindedness and intellectual humility- not being afraid to discuss instructive failures and show authentic benevolence and compassion. I also believe a good mentor sacrifices self-interest and is proud to let the mentee shine.”

Gupta

“I have mentored ...senior medical residents and ...final year medical students. I show them the model of game of Tennis – you learn and work towards the whole game, not just serve or forehand. That way, I help them think not in pieces but the whole puzzle. Second, I show them around how I work and act in day-to-day life, so if they wish – they can imagine themselves in the role.”

How do you stay on top of your profession?

Liang

“Keep a journal or dictate phrases and notes into your iPhone
Keeping a journal trumps time at meetings

File reprints yourself

Dr Google is always informative

Look up any word you do not know, any diagnosis before you finish”

Shoor

- “1. Spend at least 50% of my time in patient care, both inpatient and outpatient. This serves as the “broth” or “medium” in which I’d
2. Spend time in leadership of peers
3. Spend time working with peers nationally and internationally in group or team projects
4. Spend time sharing cases with colleagues
5. Teaching Fellows, residents and med students
6. Exercising daily
7. Telling and hearing jokes regularly
8. RETREAT and REFLECT at least monthly”

Lansdale

“The most important thing for me is that my practice, which is deliberately small and not dependent on the health insurance industry, allows me much more time with patients than I would otherwise have in a traditional high-volume internal medicine practice. Some advantages of this model are obvious: less pressure to see too many patients in too short a time; more time to listen and focus; more opportunity to explore aspects of healthy living that cannot be addressed in a rushed, problem-oriented visit. Less obvious advantages are equally if not more important: I do not suffer burnout at all. I have the luxury of remaining curious to learn more and expand my expertise and enrich my clinical acumen. I have time to read about clinical issues while they are on my mind so that I can apply new knowledge or better insight to my care of patients in a timely fashion. My relationships with my patients can grow richer and more nuanced because of the lack of time pressure – this in turn allows me to know them better, and sense more accurately when something is really amiss.”

Flower

“Staying on top of my profession involves staying curious. This then inspires all the academic work that needs to be done, some of which is tedious. I also never underestimate how much instruction comes from patient interaction. In my youth I was obsessed about having a profound breadth and depth of knowledge – and this level of perfection proved exhausting. Then I read a quote advising leaders/mentors not to be preoccupied with being the smartest person in the room but instead focus on helping all the smart people in the room have more impact. That made sense and felt right.”

Gupta

“Spending as much time and energy as required without any limits - to get the patient problems resolved to my satisfaction and best expertise. It may involve calling the senior physicians, looking up in medical resources or just digging into the records of their past. Then I can turn around and go. I try to keep notes of relevant clinical tips when attending the medical seminars, which may help me in difficult patients or just better their care. I try to be up to date and learn the cutting-edge science in my field, so that I can help non-rheumatology providers understand the problems & solutions clearly.”

How do you save time?

Liang

- “When tired, puzzled, undecided, angry, upset, infatuated, sleep.
- Open snail mail over a wastebasket no more than weekly
- Never open email without a subject, from an unknown, or more than once a day
- Never REPLY to ALL
- Schedule all calls
- The best advice falls like snow
- Ignore slights, catastrophizing, negativity, flattery, noise”

Shoor

- “1. Review and Prioritize
 Short term--daily and weekly
 Medium term- monthly
 Long term - every 3-4 months
 Really long term - 1-4 years
 "The future" - 5 plus years
 2. Put it on my calendar as soon as possible”

Lansdale

“My retainer-fee practice allows me to limit my office hours. Although I am on call for my practice 24/7, I have regularly scheduled office hours only four days a week.

Because I am in solo practice and have only one employee, my office expenses are relatively small. I realize I may be a Luddite and dinosaur, but I still dictate my notes and my office manager transcribes files and faxes them. My records are thorough, descriptive, and informative. I have refused to spend thousands of dollars on an electronic medical record (EMR) because 1) I am not forced to (yet) by the hospital or state or federal legislation (I have opted out of Medicare) and 2) I have yet to see a clinical record in any EMR that impresses me. What

is emphasized in EMR are demographic, coding and billing data. What has been completely lost is the most crucial aspect – the narrative, the story of the illness. I have no idea what the doctor is thinking when I read EMR faxes from colleagues who see my patients. I think the quality of clinical information in electronic records being circulated among clinicians, offices and hospitals is terrible, and compromises the quality of patient care.”

Flower

“I save time in a way that would not be suitable for most individuals. I live-work. My private practice and my home are on the same compound, eliminating the need to commute many days of the week. I am a minimalist and having only a few possessions limits time that would otherwise be needed to manage “stuff”. I am decisive with emails and other forms of communication- my tendency is to action what is important and delete what is not. One useful personal motto is to “ let my focus be resolute and do not procrastinate”. I believe most meetings are unnecessary or certainly are an inefficient use of time.”

Gupta

“It is just impossible if I want to do all the jobs (home and work) the best. One ...time management seminar teacher gave me two tips which I am, a bit grudgingly, adopting: 80/20 rule. Twenty percent of the projects take 80 percent of time. And most of those 20 percent project don't have to be gleamingly finished - complete the project and get off as soon as it is done satisfactory. Second, re: the longer tasks, like writing a big paper or signing a pile of progress-notes, the teacher advises a piecemeal approach. Just gnaw at a small part at a time and don't try to finish the whole thing in one sitting: I really feel that by the end of the day I finish more stuff than I used to!”

Things to improve outcomes of patients

Gratwick

- “I have few secrets other than
1. I like to listen more than talk.
 2. I write everything down longhand for my patients so that there can be no misunderstanding. There still is but at least I have tried... Patients often bring me my prior notes so we can see if we have made progress.
 3. I ask patients with complex diagnoses to keep an updated three-ring notebook with all their records, lab, consults, etc to facilitate communication between their providers.
 4. I try to think of analogies appropriate to the patient's occupation or outlook to explain medical

complexities. With firemen I talk of fire and inflammation, with boat builders of porous nephrons and leaky garboard strakes, with woodsmen of rounded over wooden tent pegs and arthritic spurs, with cooks with lupus the idea that a sunburn changes their skin in the same way that cooked hamburger changes from pink to brown. Sometimes I have to reach pretty far – my patients sometimes look at me quizzically - but the exercise keeps me on my toes.”

Liang

“Pearls from mistakes, near misses, and/or from wiser people.

- Keep it simple; Think out loud; Be Kind (Dan Federman).
- Take no calls, use no devices while you are with a patient.
- Wait 6 seconds after person finishes before you speak (Lawren Daltroy).
- Note personal item to seed and continue the next meeting.
- Write or dictate ASAP immediately after visit.
- Write down and give patient a summary of your recommendations (Lawren Daltroy).
- Before you end a visit, ask...
 - “What is your understanding of [last provider, consultant]?”
 - “What do you think is going on?”
 - “What are you worried or concerned about?”
 - “Did what I say make sense to you?”
 - “What might keep you from doing the treatment?”
- Reconcile medications every visit.
- Pare medications every opportunity; but never stop medications the first time you meet the patient.
- Never begin a medication unless you can define and measure its objective; and the patient agrees.
- For hospitalized person, ensure an advocate to ask “why?”
- Book office visit immediately after hospital discharge; something is always missed in the transition.
- Assume no pass offs or communications have been done accurately.
- Forget the teaching of not getting too close to patients. It’s not the proverbial moth near

a flame getting burned. It’s a chance to have empathy, mindful interaction, and connection with someone.

- Your best - moments, insights, ideas, and lines – are as fleeting as the breeze. Keep a post-it and a pencil nearby. Write all the time.
- “... the secret of the care of the patient is in caring for the patient” (Francis Weld Peabody, 1927).

It turned out that Dr. Peabody didn’t mean caring about a patient but caring for a patient, which he explained, meant doing the little things, the little personal things that nurses usually do—adjusting a patient’s bedclothes or giving him sips of water. That took time, Dr. Peabody admitted, and wasn’t, perhaps, the most efficient way for doctors to spend their time. But I was worth it, he told his [Harvard Medical] students, because that kind of time-costly caring was what created the personal relationship between patient and doctor. And that relationship was the secret of healing (Victoria Sweet).

Shoor

- “Present difficult cases to colleagues.
- “Express” reference the literature--10 min review of a specific question in a specific case.
- Elicit and reveal their preferences, tendencies and beliefs.
- Have them set goals.
- Give them options.
- Answer their questions.
- Get them to laugh.
- Communicate with them by phone or email in between visits.
- Have nurse communicate with them between visits”

Lansdale

“A while ago, I wanted to do a “quality-assurance” or “performance improvement” project in my practice. I looked at my charts and thought that my attention to the adult vaccine status of my patients was sketchy at best. Over the years I had generally recommended annual flu vaccines, a pneumovax here and there, but in truth I had to give myself a poor grade when it came to ensuring that I had at

least recommended all appropriate vaccinations to all my patients and documented in the chart that I had done so.

I downloaded vaccine charts from various websites, devised a tailor-made version for my practice, and set to work. My patients came in for follow-ups, urgent visits, or annual exams, but I took every opportunity to discuss vaccine status with each one, and I convinced many patients to receive routine vaccines such as influenza, pneumovax, Tdap, zostavax and other less common ones according to the situation (international travel, e.g.).

One day I gave a woman pneumovax, Tdap and zostavax all in one visit. Two weeks later she came back complaining of high fever, chills, and a rapidly progressive, diffuse, erythematous, maculo-papular rash. She was diabetic, I was reluctant to treat her with steroids, and pleaded with a busy dermatology colleague to see her right away. The dermatologist favored a viral infection with exanthema such as parvovirus or Coxsackie. The patient was quite ill, and I was worried she might be developing a Stevens-Johnson reaction to one of the vaccines. The viral titers came back negative; she slowly improved over the course of three weeks.

I am still completing my quality assurance project, but my enthusiasm has been tempered a bit. *Primum non nocere.*"

Flower

"Improving outcomes for patients is a monumental task. It requires:-

- Setting up health systems and education of both the public and medical professionals to facilitate early diagnosis of disease.
- These health systems must then be resourced with all that is needed for effective management and monitoring of disease.
- Social and economic assistance must be available for those who need it.
- Psychological support is critical for many patients with chronic disease.

- Finally, society needs to carefully cultivate the minds of children to maximize the possibility of their growth into resilient, prudent, self-reliant, grateful adults who are best equipped to navigate adversity, including ill-health."

Gupta

"Lately, the various lists of Pay 4 Performance Measures (US and International) have come in handy. I choose a few relevant measures carefully to improve outcome of my patients. They tend to be more clinical and individual rather than affecting the whole group of patients."

Conclusion

Setting out to gain insights about finding and being a mentor, we pretend no authority other than our lived experiences. Not surprisingly, there is no one meaning or application. In the moments of one's life with the greatest uncertainty, anxiety, despair, confusion, there are no right answers. One uses what they have and know. "What would mentor X say or do?", we ask. One looks for a sounding board, a validation of our perceptions, that we have not missed something, over-reacted, misinterpreted something. It was not just a wise mentor but a reading, a book, our children, a former student, from overhearing others' converse, as "voyeurs" caring for others with similar dilemmas. We may not have gotten an answer but our mentors were accepting and nonjudgmental; they made us feel safe. They reassured us that it too would pass or chided us to try harder. They were people we admired and mimicked. They stood with us when we suffered from physical, emotional, and moral injury; helped us with "post-traumatic growth."¹³ They held a mirror up to us in telling how we looked to others, re-stated what we said to help find our voice. Being a physician is a lifelong search to imbue it with meaning. For those winding down, modern medicine seems alien. Each of us have dealt with it in our own way to preserve its soul and to pass it on.

References

1. Harris Jr ED Wanted: Catalysts for Growth. *Arthritis & Rheum.* 1986; 29:1297–1300.
2. Liang MH, Roberts WN. The rules of American academic medicine for the would-be-clinical investigator. *Rheumatol Review* 1994; 3:87-90.
3. Ogdie A, Shah AA, Makris UE, Jiang Y, Nelson AE, Kim AHJ, Angeles-Han ST, Castelino FV, Golding A, Muscal E, Kahlenberg JM, Barg FK. Barriers and facilitators of a career as a physician scientist among rheumatologists in the United States. *Arthritis Care & Research.* 2015; 67 (9): 1191-1201. DOI: 10.1002/acr.22569.
4. Gawande A. Top athletes and singers have coaches. Should you? *New Yorker*, October 3, 2011.
5. Vliet Vlieland TPM, van den Ende CH, Alliot-Launois F, et al. Educational needs of health professionals working in rheumatology in Europe. *RMD Open* 2016;2:e00033. doi: 10.1136/rmdopen-2016-000337
6. Henry-Noel N , Maria Bishop M , Clement K Gwede CK , Ekaterina Petkova E, Ewa Szumacher E. Mentorship in Medicine and Other Health Professions. *J Cancer Educ.* 2019; 34(4):629-637. doi: 10.1007/s13187-018-1360-6. PMID: 29691796.
7. Liang MH, Lew E. Halsted R. Holman and the Struggle for the Soul of Medicine. Cambridge Scholars Publishing, Lady Stephenson Library, Newcastle upon Tyne, United Kingdom, 2022.
8. Geng LN, Verghese A, Tilburt JC. Consultative Medicine — An Emerging Specialty for Patients with Perplexing Conditions.2021. *N Engl J Med.* 2021; 385:2478-2484. DOI: 10.1056/NEJMms2111017
9. Liang MH. In Memoriam – Lawren H. Daltroy (December 23, 1948 – September 22, 2003, *Health Ed & Behavior.* 2007; 34: 543-545.
10. Lansdale III, TF. A Medical Center is not a Hospital. *Cleveland Clinic Journal of Medicine.* 2008; 75: 618-619.
11. Flower C, Hennis AJM, Hambleton Ir, Nicholson GD, Liang MH and The Barbados National Lupus Registry Group. Systemic Lupus Erythematosus In An African Caribbean Population: Incidence, Clinical Manifestations and Survival In The Barbados National Lupus Registry. *Arthritis Care & Research.*2012; 64 (8): 1151–1158. Doi 10.1002/Acr.21656
12. Flower CH, Hennis AJ, Liang MH. Report of an international symposium on narrowing the Gap in the treatment and study of SLE worldwide: minimum best practices in the management and monitoring of moderate to severe SLE and improving outcomes in constrained environments. *Current Reviews in Musculoskeletal Medicine.* 2011; 4(3):105-112. DOI: 10.1007/s12178-011-9080-0 PMID: 21505771 PMID: PMC3261257
13. Flower C, Weir S. Lupus Essentials by the Hope Foundation. 2022.
14. Plews-Ogan M, Owens JE, May N. Choosing Wisdom. Templeton Press, Pennsylvania, 2012.