Reflections

Rumination

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I am 100 years old. It's hard for me to grasp that. I understand it as an actuarial fact, but oddly, I don't feel old. I feel I'm the same me, the same person, but worn and weathered. I'm reminded of a comment I once saw, attributed to Senator Claude Pepper on his 90th birthday: he said he didn't feel like an old man—he felt like a young man who had something the matter with him. I get that. Although mostly intact and functional, I'm a little slower, a little more deliberate, a little wearier. All that, I suppose, is par for the course, but I'm increasingly hampered by two superimposed difficulties that have now become problematic.

One is bilateral leg weakness, due to lumbar spinal stenosis and sarcopenia. I'm unsteady on my feet, and standing and walking have become uncertain and laborious. I've had a few falls, most of them indoors and without major consequences; but I can still get around in the house or walk short distances using a cane and holding my wife's arm for stability. Walking has become a difficult activity, in a sense a chore I have to decide to undertake despite the instability and exertion involved.

The other big issue is deteriorating vision due to macular disease, slowly progressive in recent years and now seriously impairing my ability to read. That's a major concern. I can compensate to some extent by doing my reading on the computer or Kindle using enlarged fonts. I can still pick up a newspaper or journal and skim the headlines or titles, but I can't read the articles except with the help of those electronic prostheses.

Each of these limits me substantially, and the combination has impacted me to a major degree. I am at this point effectively house-confined and increasingly and uncomfortably dependent on others, especially my wife, for managing the details of daily life, such as reading my mail or carrying a book or plate of food across a room. I have no gastrointestinal or cardiopulmonary symptoms despite a minor degree of aortic regurgitation and a 15-pack-per-year smoking history, discontinued some 65 years ago.

Jeremiah A. Barondess, MD. Illustration by Steve Derrick

As far as I can tell, my mentation is intact, but my

memory and recall, especially for names, is patchy. I sleep well. Interestingly, I have no disabilities in my dreams, which are pleasant enough, and sometimes interesting.

Psychosocially I think I'm in reasonable shape, although my physical limitations confine me to an annoying degree, and sometimes make me crotchety. I'm impacted even more, though, by social isolation. My wife and son are dear to me and close, but I've outlived almost everyone else in my family, and most of my friends. That's a major deprivation. I can't see them, hear from them, or call them just to schmooze or to ventilate or exchange perplexities. That induces a particularly profound kind of isolation because it adds loneliness, and it's permanent.

As I've noted, I have no disabilities in my dreams. Occasionally, I'm at work in them, maybe sitting in on a small conference or talking with a student or colleague, but never delivering clinical care. In one, I was giving a lecture in French! There was an amphitheater and an audience; I had a vague sense it was at the Sorbonne—shades of an American friend who earned a degree there—but it was a short vignette because my French wasn't up to the challenge.

I think about death far more than I used to. Not in a religious framework and not so much with apprehension or sense of things not done, but with a kind of irritation and sad resignation rooted in its inexorability and in leaving the people I love and an interesting and pleasant personal world. I can't imagine being dead—not existing—and in the absence of belief in an afterlife I'm not sure how to think about that.

Pragmatic shifts

Retirement has brought big pragmatic shifts—especially the need to organize my days rather than having them structured by externally imposed responsibilities: no patients to see, no students, no office schedule, no program or institution to manage. That's a big gap, but those connections haven't been altogether left behind. I try to stay in touch through former colleagues who come to visit, and by scanning a few online journals and presentations, and by a little writing.

The writing, and the associated reflection, seem in some ways an effort to sum up, to put things together, to see what I've learned—or what I've become, at least in a professional sense. That seems portentous, but it's not a deliberate search for meaning—it's been spontaneous, *sui generis*. There's a sense of hurry, of time pressure, in it.

Medical school during WWII

An associated shift is that I don't plan for the future any more except in the near term. I suppose that means that another big thing, ambition, or at least career ambition, has also slipped away, a pressure I felt from the time I arrived at medical school. I realize I'm describing my education and its impacts as if it all began when I got to medical school. In a sense it did because of the war (World War II) my college education was chopped up and irregular—one year at Hofstra College, where the nascent idea of becoming a pre-med congealed, and one year at Penn State, during which I enlisted in the Army Reserves so I could finish my sophomore year before I was drafted. I was called up in 1943, at age 19, and after basic infantry training was assigned to Wayne State University in Detroit to prepare to be a combat engineer.

While I was at Wayne State it became possible for former pre-meds to take what was termed a medical aptitude test, for potential assignment to a medical school. As a result, I had three abbreviated but productive semesters as a pre-med student at the University of Michigan, and when I finished there in December 1944, the Army assigned me to medical school at Johns Hopkins.

For the intervening months before my class entered, I was attached to the Regional Hospital at Fort Meade in Maryland, a large Army port of embarkation for the European Theater. I was assigned to the venereal disease ward, learned the laboratory diagnosis of gonorrhea and early syphilis, gave a lot of penicillin injections, and did a lot of lumbar punctures.

Abruptly, and unpredictably, shortly before I was to move to Baltimore, I was told that my orders had been changed: I wouldn't be going to Hopkins, I would be going to Okinawa, Japan as a battlefield medic—all due to an error in my medical record. In the ensuing shrek I went to the office of the chief of the medical service, where the assistant chief, a lieutenant colonel who was on the Hopkins pediatrics faculty in civilian life, made things right with a lengthy phone call to Washington. And thereby, he saved my medical career and possibly my life.

The war ended in August 1945, while I was at Fort Meade. The Army sent me on to Baltimore and discharged me early in 1946 after six months of medical school, which I was able to continue with the help of the GI Bill. After I graduated, I had two productive and formative house staff years on the Osler Medical

Service at the Johns Hopkins Hospital. At that point, the U.S. was involved in the Korean War, and I, like many others, was required to go back into service to repay medical school. Some in the same cohort went to the National Institutes of Health, got involved in clinical investigation, and started full time faculty careers. I didn't particularly want laboratory research training and wasn't inclined toward a full-time faculty career, so I went into the Epidemic Intelligence Service (EIS), a branch of the Public Health Service that had just been organized as a biological warfare defense unit for the continental United States. The idea was that a biological warfare event would probably appear as an anomalous disease outbreak—not unlike infectious in nature—that would have to be investigated epidemiologically.

There were 20-25 of us in the new EIS, almost all from academic residency programs. We were given a few months of intensive training in epidemiology and then stationed across the country, mostly in state health departments, as an initial response cadre, on call when needed. I was to be responsive primarily to outbreaks in the Northeastern United States. I was based at the Children's Hospital of Philadelphia, part of the department of pediatrics at the University of Pennsylvania. I was involved in studies of viral hepatitis, a substantial problem for the Army in Korea. I participated in efforts in Werner Henle's laboratory to develop a hepatitis vaccine, investigated two sizable community epidemics of hepatitis and a family outbreak of botulism in rural Georgia. I was assigned to several human volunteer studies related to the vaccine project.

At one point, I was attached to a large study that evaluated the efficacy of gamma globulin in poliomyelitis prophylaxis in an outbreak in Houston. Because of that experience and the hepatitis studies, I attended one or two meetings of the Armed Forces Epidemiological Board, a valuable exposure to population level planning.

At the end of my public health service stint I was invited back to Hopkins to complete my residency training. I was strongly tempted, and agonized over the decision. My two years on the Hopkins house staff had been an exciting time of extraordinary growth for me, but I had a sense I would end up practicing in New York, where I had grown up, had family, and where I was courting a girl. So, I went to New York Hospital/Cornell for the final two years of my training.

As I finished, I was offered a faculty job and a chance to build a liver disease unit there, but that track didn't appeal to me. I told the chief I wanted to be an academic generalist clinician, a model I had seen and admired at Hopkins. He said new appointments were being made only in the subspecialty divisional structure in the department of medicine at Cornell, so instead I went into practice as an internist and was appointed to the voluntary faculty.

Life-long friendships

It proved possible for me to be an academic generalist, more or less, on my own terms. My practice was interesting, clinically challenging, and intellectually rewarding. Over time, I got involved with the major clinical and academic societies in my specialty, which provided friendships with kindred spirits, and a degree of engagement with national issues in medicine. Over the years, I had substantial teaching and administrative responsibilities at Cornell, including an appointment as Associate Chairman of the Department of Medicine, as well as a rewarding, ongoing connection to Hopkins.

Over the years, I've published on a range of clinical and educational topics, and edited several books. I have been invited to ventilate in a variety of academic venues, mostly on trends and values in internal medicine and the forces shaping them.

On a few occasions, I was invited to look at opportunities elsewhere, including a clinical chair at Hopkins, and a foundation presidency. Each time I found that I was content with where I was and with what I was doing, but I ultimately developed a degree of burnout and an urge to be involved in issues beyond individual patient care so, after 35 years at Cornell I accepted an invitation to revivify the 143-year-old New York Academy of Medicine, to widen its activities beyond continuing medical education and to get closer to broad determinants of health, especially at the population level. It proved possible with that general agenda to recruit a talented professional staff—primarily from academic centers—and to develop a grant-supported program in urban health issues, and I came to feel we were useful to both the academic and practicing communities, and increasingly relevant on the national level.

A new career trajectory at 82

I retired from the Academy after 16 years, at age 82, feeling I had reached a career asymptote. A few years later came an invitation to join the Mailman School of Public Health at Columbia University—a bend in career trajectory that built on the clinical years and my brief spin as an epidemiologist. The faculty had a frame

of reference oriented to fundamental determinants of health and of disease risk, many of them behavioral, social, and environmental. It was an agenda strikingly different from the diagnostic and therapeutic priorities of clinical departments and the immediacy of clinical problems, and my own primarily clinical perspective was enriched by the experience.

I came to understand many acute disorders, as episodes in the course of underlying chronic diseases, e.g., myocardial infarction, stroke, and pancreatitis or pyelonephtitis. I got a better sense of the complex causality of disease, and the key role of prevention, or at least risk mitigation.

A COVID retirement

Retirement, after several years at Columbia, was catalyzed by the COVID-19 pandemic. It has isolated me, separated me physically from the ferment of a busy academic community, and left me with mostly electronic connections—a vital link but a diluted experience.

I have few regrets about my checkered career path, which has taken some unanticipated turns, but overall has been right for me. I've advised medical students over the years to be careful in the selection of their ambitions because they're likely to realize them. Perhaps I should also have emphasized the malleability of the medical career, the opportunities that come with new interests, new capabilities and new challenges, and the importance of being open to varying expressions of one's core career vector. It's played out that way for me: it's been possible to be a clinician, a generalist, and an academic, or at least, my version of the combination, and that's made all the difference.

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