Interview with Lewis P. “Bud” Rowland, MD
American Academy of Neurology
Oral History Project

November 18, 2012
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Interview with Lewis B. “Bud” Rowland, MD
Professor of Neurology, Department of Neurology,
Chairman Emeritus of Neurology & Director of the Neurology Service (1973 - 1998)
The Neurological Institute of New York, Columbia University Medical Center
Attending Neurologist, Columbia-Presbyterian Medical Center,
New York Presbyterian Hospital, and Eleanor and Lou Gehrig MDA/ALS Center
Past President of the American Academy of Neurology

Dr. and Mrs. Rowland’s Home
Riverside Drive, New York, New York
November 18, 2012

Steven Frucht, MD, and
Barbara W. Sommer, Interviewers

Lewis P. “Bud” Rowland: LPR
Esther Rowland: ER
Steven Frucht: SF
Barbara W. Sommer: BWS

(Track 1007)

BWS: We are recording an interview today with Dr. Lewis P. “Bud” Rowland for the American Academy of Neurology Oral History Project. Dr. Rowland is Professor of Neurology at Columbia University and Attending Neurologist at Columbia Presbyterian Medical Center and at the Eleanor and Lou Gehrig MDA/ALS Center, which he founded. From 1973-1998, for twenty-five years, Dr. Rowland was Chair of the Department of Neurology at Columbia University College of Physicians and Surgeons and Director of the Neurological Service at Presbyterian Hospital. He also served as co-director of the H. Houston Merritt Clinical Research Center for Muscular Dystrophy and Related Diseases at Columbia-Presbyterian Medical Center. It is Sunday, November 18 [2012]. We are at Dr. and Mrs. Rowland’s home on Riverside Drive in New York City. Also present is his wife, Esther Rowland. The interviewers are Dr. Steven Frucht, Department of Neurology at Mount Sinai Hospital, and Barbara W. Sommer.

(01:12)
Thank you for having us this afternoon. We appreciate your opening your home to us. We will start by asking you to start at the beginning of your medical career to ask, why medicine? Tell us about why [you chose] medicine and why you chose neurology.

LPR: Those are two different stories. One is a family story. [BWS: OK.] The story is that when I was four or five years old, my mother took me for a walk and we met a friend of hers who said – and I quote, “Oh, what a cute little boy. And what do you want to be when you grow up, young man?” And I said, “A doctor.” And my mother said, “That’s right.” And it has never changed since that moment. [laughter] I was committed before I knew what commitment meant.

BWS: Before you were in school.

LPR: And neurology is a little more complicated. You asked the question about people who influenced my life [referring to list of topics sent to Dr. Rowland in preparation for the interview]. [BWS: Yes.] There are a string of them that we’ll come to. But one was - the early years of medical school were very influential. I didn’t go to medical school to become a neuroscientist or a neurologist. I just went to medical school because I was interested in medicine. But my literary hero was a character named Martin Arrowsmith, who was a feature in a book by Sinclair Lewis, the writer of the [19]’20s. Arrowsmith was a young doctor and his hero was a man named [Max] Gottlieb, who was a research scientist who was modeled after a real person. He – Arrowsmith was not interested in making money; he wanted to do science. It was the story of how he did it.¹ Sinclair Lewis was a very popular writer in the [19]’20s.

(04:01)
So medicine was easy. Neurology came later. It came in my first years at medical school. We had an interesting professor of neuroanatomy whose main attribute was that he could draw the brainstem with two hands. He would make it perfectly symmetrical with his left as well as his normal right hand. He was an odd duck but he got us interested in the nervous system. Then Yale had a requirement that, for graduation, every medical student had to write a dissertation. I could have become a psychiatrist were it not for the requirement about the dissertation. The reason was that I went to an assistant professor. [He was a] young assistant professor of psychiatry who later became famous and the head of departments – one of the most influential psychiatrists of his generation [and] the Dean of the Yale Medical School. His name was Fritz Redler. He was a German refugee; very smart. I had a brilliant idea, I thought. I took

¹ *Arrowsmith* by Sinclair Lewis was published in 1925; Lewis won the Pulitzer Prize for it in 1926 but refused to accept the award. The book, written after medical education reforms resulting from the Flexner Report on medical education in the United States and Canada (1910), has been described as the first to deal with the culture of science.
it to him and I asked him to be my supervisor for the dissertation. He said, “What do you want to write about?” I said, “Well, I’m interested in comparing the hallucinations of schizophrenics with the delusions of mountain folks – snake worshipers and so on.” He didn’t say, “That’s not a good idea” or “Let me help you find another one.” He just said to me – in not quite so many words, “That the stupidest goddamn subject I ever heard.” [laughs] That was it. That was the end of the interview and the end of my career in psychiatry. So I had to get another subject. We had an odd professor of neuroanatomy – odd in many ways but very influential to me. His name was Fred Metler. He was the author of a textbook of neuroanatomy.\(^2\) He had been in Georgia before coming to Columbia and he had contact with all the medical students – the first year medical students – at Columbia and also, indirectly, at every medical school in the country. What happened was – frontal lobotomy was a prevalent and, in retrospect, an interesting procedure that had swept the country, literally. Everybody – it was being done everywhere. It ended up with a bad name because it was adopted by somebody who – I don’t want to be too judgmental of him – but he was a little bit of, I think, a psychopath. He ended up doing what are called orbital lobotomies; he would come into a place and do fifteen or twenty or fifty and then move on to the next place and do them without any recording of adverse effects or anything. [He would do this] without any controls, without any theoretical background for what he was doing. How he got to that was from Yale. In our first year, one of the other influential people was a man named John Farquhar Fulton who had been a Rhodes Scholar and worked with [Sir Charles] Sherrington.\(^3\) He came back and he was interested in seeing what chimpanzees - how their behavior was altered by taking pieces of the frontal lobe out. That much had been known; the frontal lobes had something to do with primate behavior. It was from that that a Portuguese neurologist named [Antonio Caetano de Abreu Freire] Egas Moniz noticed that at an international congress in the [19]’30s somewhere, Fulton recorded the behavioral changes in Becky and Lucy, two chimpanzees. He took little pieces of frontal lobe out, not thinking that he was treating them or anything, but just to see what would happen – and they became very docile. So he mentioned at this international congress that it might be worthwhile doing it on people, but he was not going to do that on people. In the audience that day was this Portuguese neurologist, Egas Moniz [spells name], and he thought he would be interested in trying it on people who were agitated, had agitated depressions. He did it and he reported on five patients. Some of them got better and some of them didn’t get better and one of them got worse. So he had all the bases covered and he ended up doing

\(^2\) *Neuroanatomy* by F.A. Metler (St. Louis: The C.V. Mosby Company, 1942).

more. He got a Nobel Prize, not for that, but for inventing cerebral angiography. He was a really interesting character. He was also very active in Portuguese politics. I don’t think he became president but he had some higher offices in public life. He is another [influence] here

(11:48)
BWS: All this was going on when you were studying?

LPR: It was before.

BWS: Before you were studying.

LPR: It was there when we learned neuroanatomy and neurophysiology. It was there when Fulton talked about it. Then, just to continue that story, because it had a very mixed-up end – at this break point, I would say that it was very important for another reason. After World War II, psychoanalysis became the dominant force in academic psychiatry in the United States. Lobotomy was just the other way of looking at the world – it was more biological psychiatry than analysis was. Analysis had no theory or background except that perhaps developmental changes in the brain would be important, which was an important contribution. It left a legacy of talk therapy which we still have. But it got to be abused by Walter Freeman [Walter Jackson Freeman II] and it ended up moderately discouraged.

The other thing that contributed to biological psychiatry was electric shock therapy, which came from Italy. [Ugo] Cerletti published in the [19]’30s also. Shock therapy is still around now. And even lobotomy is still around now. One of our former residents is a wonderful young woman named Helen Mayberg. She started combining little pieces of surgery with functional MRI and has made a remarkable career herself with that. So after all these years we are still doing a little psycho-surgery.

BWS: You ended up coming into all of that during the World War II era. Is that correct?

LPR: It mostly happened after World War II.

BWS: It happened afterwards. That is when you came into it?

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4 Egas Moniz shared the Nobel Prize in Physiology or Medicine in 1949 with Walter Rudolf Hess. Egas Moniz’s share of the award was for his discovery of the therapeutic value of leucotomy in certain psychoses.
LPR: I was in the class of [19]’48. The war ended in [19]’45. I’ve been in neurology since 1950. That’s the year of the landmark.

BWS: The brain?

(15:41)
LPR: There was a child psychiatrist who talked about mindless psychiatry, which was psychoanalysis, because the ego and the id were not anywhere localized in the brain. Then he talked about brainless psychiatry, which was Pavlov’s psychiatry, which just invented the brain for no good reason and stuck it in. Which is where we are now – trying to understand how the brain is related to thinking and behaving.

SF: When you were training, who were the major people at Columbia?

LPR: [H.] Houston Merritt was there.5

SF: He had come in [19]’46? Is that right?

LPR: [19]’48. He came to Montefiore [Hospital] in [19]’48 and then he came to Neuro [Neurological Institute] a couple of years after that. [SF: I see.] I started in [19]’50. [Tracy Jackson] Putnam came first.6 Putnam – he was such an interesting man. He was so smart and Columbia was so terrible – just terrible – to him. Putnam came in 1939 and he appointed four people. David Nachmanson, who was a German Jew. Harry Grundfest, who was a Russian Jew. There was a third Jewish one and one was not Jewish. Later on he was fired by the hospital, not by the Dean. The Dean made it quite clear he had nothing to do with it. He was fired by the hospital because he was not managing the service well. They never explained that. When I was writing the book about Putnam and Merritt, I tried my best to find the records of the medical board, who the secretary of the medical board was, or somebody who would know the story of why Tracy Putnam was fired. It was so covered up; there was just no way of getting it. It is still a mystery. The person who did it was the President of the Board of Presbyterian Hospital. I don’t see any way of refuting it. Somebody may go over it again and try to sleuth it out. It was beyond my capacity to crack it at all.7

5 H. Houston Merritt was Chair of the Neurological Institute of New York and Dean of the Columbia University College of Physicians and Surgeons.
6 Tracy Jackson Putnam was Chair of the Neurological Institute of New York. With Merritt, he was the discoverer of Dilantin for controlling epilepsy.
BWS: Houston Merritt was there when you were there?

LPR: Houston Merritt was there when I became a resident.

BWS: OK. Who were some of the others who taught you?

LPR: The people who came from Montefiore were Sidney Carter – who was really the father of child neurology in the United States. He was set up – he was appointed by Merritt. There had been a pediatric neurologist before him – a nice, sweet, kindly old giant of a man who could hold an infant in the palm of one hand. His name was Louis Casamajor and among other things, he had a falsetto voice and his famous line would be – he would hold a baby in one hand and look at it and say, “This is a silly baby.” [laughter] He was always right. He could tell by looking and watching a child’s behavior. He was there. And [Melvin] Yahr was there. Yahr later left to become the chairman of neurology at Mount Sinai. Was he there when you were there?

(20:31)
SF: When I went through, I met him when I was interviewing for a fellowship. He was still seeing patients.

LPR: Danny [Daniel] Sciarra came with Merritt from Montefiore. And Arnold Friedman – Arnold Friedman was the man who made headache a neurological specialty in the United States. He ran a headache clinic at Montefiore and then when they came downtown, it was at Columbia Service at Montefiore then. Then he just brought it to Presbyterian. We had one for the next twenty or thirty years until something happened and Dr. [Mark W.] Green took the headache service to Mount Sinai. We haven’t recovered from that since.

BWS: You had some powerful teachers.

LPR: Yeah. I hope I haven’t left out any. I wanted to mention John P. Peters who was a professor of medicine at Yale. He, like many good teachers in my career, even great teachers, was terrible to make rounds with because he was inaudible. I even say that about one of my most-admired professors at

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5 Sidney Carter was a Columbia University neurologist and clinician. He helped define the field of pediatric neurology.
6 Melvin Yahr was an early expert in the use of L-dopa to treat Parkinson’s disease.
Columbia now. He is absolutely brilliant, totally articulate, knows everything about anything including non-neurological things, but he just doesn’t talk up. I want to shake him and make him do it. You have to be a loudmouth like me to communicate.

SF: You’ve written about Merritt.

LPR: Merritt was the laconic – was extremely over –

SF: Right – and there are legendary stories about his ability to make diagnoses in a very intuitive fashion. Sometimes not even to fully communicate why he made the diagnoses.

LPR: No, no, he communicated fully. You would ask him, “Dr. Merritt, how did you come to that conclusion?” He would say, “Well, what else could it be?” [laughter]

SF: I see. But he wouldn’t tell you his thought process.

LPR: No. He was known for that when he was in Boston before he came to Neuro.

SF: Do you think that those styles influenced you directly? Did you take from those styles?

LPR: I did to a certain extent. Let’s say Merritt as a role model. He was absolutely free of pomposity. He was absolutely straight in saying what he thought. He was absolutely sentimental in never offending a patient or a resident. There are some people - [Derek] Denny-Brown was supposed to be terrible with patients and with residents. Houston, he just was too kind for that. He was a good role model. As long as you spoke up, he was okay. The others – Danny Sciarra was a good role model by teaching. Sid Carter was great in both things. Sid Carter had the first training grant in pediatric neurology from NIH – NINDB [National Institute of Neurological Diseases and Blindness] is what it was in those days. The first group, they were all sensational. That set the pattern for everybody. The group was Arnold Gold – there were four of them – Abe [Abraham] Chutorian (who is still around), a guy who translated Bertolt Brecht from the German whose name was Gary Nelhaus; he went to Colorado and started a group there. There was a fourth.

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10 Derek Denny-Brown was British neurologist recruited to the United States to be professor of neurology at Harvard Medical School and director of neurology at Boston City Hospital.
SF: They were the original class of Sid Carter?

LPR: Yeah, and they all became big, important, national influences.

SF: And then you left?

LPR: I went to Penn [University of Pennsylvania].

SF: You went to Penn.

LPR: That was an interesting exercise too. In January 1967, we were told that Milton Shy was coming to be the chairman. I had known Milton because – .

[telephone rings, short break in interview]

(Track 1008)

BWS: Go ahead.

LPR: So Milton Shy was coming. I had known him when I was at NIH [1953-1954] and we had gotten along all right. But we had a mis-step along the way. When he came to NIH, I was already there doing the work of a resident. He asked us to come and speak to him. He was a little bit miffed because the house staff had been picked by somebody else, not by himself. He asked me where I had trained, which I think he really knew because we had our CVs. I said, “The Neurological Institute.” He said, “Oh, that’s interesting.” He said, “When were you in Montreal?” – which was his Neurological Institute. [laughs] We straightened that out. We got to be pretty good friends. We got to be friends of his family and his son. His son is now in charge of neuromuscular disease at the University of Iowa, but before that he had been the neuromuscular person in Detroit. He had been one of our trainees. He is a wonderful young man.

BWS: You spent some time at Penn?

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11 George Milton Shy was the first clinical director of NINDB. He died unexpectedly shortly after becoming the chair of the department of neurology at Columbia.
LPR: Because I got invited to look at the job at Penn [Professor and Chairman, Department of Neurology, University of Pennsylvania School of Medicine, 1967-1973] and we went. The Dean of the school was Sam Gurin – G-U-R-I-N. He would say, “My name is Sam Gurin; it rhymes with urine.” When we went down there and as he showed us around, he became enamored of Esther Rowland. [To ER: He did, he did. He spoke freely about his affection for you.] We went down there one day and we signed the next day, as I recall. [aside comment] So we went and we had a wonderful time. We had a house that belonged to Thomas Wynne who founded Wynnwood, the immediate suburb next to City Line Avenue in Philadelphia. He had a wonderful stone house. We had rapid absorption into the culture of the department, into the culture of Philadelphia. We loved every minute of it. And then, in 1973, they asked me to come as a consultant to the Search Committee because there had been a serious problem at Columbia. The chairman was a Quaker gentleman and Mel Yahr was a tough New Yorker; they were not getting along and they decided to find someone else. The Dean at that time and [one other person], Paul Marx and Donald F. Tapley – both friends of mine, were the heads of the Search Committee. So they invited me as a consultant, but they were really after me. They offered me the job that day [Professor and Chairman, Department of Neurology, Columbia University, College of Physicians and Surgeons; Director, Neurological Service, Presbyterian Hospital], as I recall. I hemmed and hawed about it, but thought that the service was in trouble because of the battle between the two leaders. I was doubly arrogant. That was the first act of arrogance – to think it was worth saving. And secondly, that I was going to be the savior – that was the worst arrogance. So I came and Yahr moved to Sinai before I got there and that took care of the whole fight. It was gone. [Richard] Masland and I were friends; he ended up retiring a couple of years later. That was the transition.

(08:53)
SF: You had met Stan [Stanley] Fahn at Penn or before?

LPR: At Penn.

SF: At Penn.

ER: He came down with us.

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13 Stanley Fahn is the H. Houston Merritt Professor of Neurology and Director of the Center for Parkinson’s Disease and Other Movement Disorders at Columbia University.
LPR: He came down with us. That makes more sense. And Audrey Penn came with us from Columbia to Penn and came back with us. Louis DiMauro came for a two year stint as a fellow to Penn. He came with us. He is still around.

SF: You brought all three back to Columbia at the same time.

LPR: And there was a fourth. A guy named William Bank who went back to be a clinician. Or, he stayed there. Didn’t he stay?

ER: Yes, Bill Bank came from New York to Penn and stayed.

LPR: Right.

ER: Stanley went from New York to Penn and came back. Audrey went and came back.

LPR: And then [she] left to go to NIH.

SF: What was the department like when you started in [19]’73?

LPR: Oh, that’s a good question. When I was growing up in neurology at Columbia I used to say that the department had two classes of – two groups of second-class citizens. There were research people who gave the place its name, but never made a living. [phone rings] The other group were people in private practice who were making a living but who felt powerless because the full-time people controlled appointments and everything else. So neither group was fully happy. Stanley and I decided that we would appoint new people to a full-time position at salaries which they would get for themselves largely in the way of grants. That was the practice of the day. It [finding grants] wasn’t so hard in those days. It has gotten worse since. We would just not re-appoint anybody except in a full-time capacity. We started that; I’ve forgotten, I think we had seven slots to fill. I don’t think there was any ill will that came out of that. It was the right way to do it and the right thing to do even though it has taken a long time.

BWS: What made you decide to do it that way?

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14 Audrey Penn has served as Deputy Director, Acting Director, and Special Advisor to the Director of the National Institutes of Neurological Disorders and Stroke (NINDS).
LPR: We thought it was the right thing to do. The right goal was to have everybody full time and on salary. The question was how to get there without disruption? I wasn’t going to come in and tell people, “Look, you go full time or you’re fired.” They were my friends and my teachers. It worked out all right.

SF: What was the focus in terms of, let’s say, the research that was going on in your lab and in other labs? And in, let’s say, in the ALS center?

LPR: [General comment] If you asked what I did for science, it was only to get good training. I did everything a Ph.D. student would do in the way of taking courses and so on. I worked in David Shemin’s lab for four years. I had a couple of papers out of that, nothing very world-shaking. I wrote a lot. I talk a lot and I write a lot. I like writing. We published a book – Merritt’s *Neurology*, which competes with [Raymond] Adams and [Maurice] Victor. It has now got a couple of other names including Joe Martin and is still the competition.\(^\text{15}\)

SF: How did you end up revising it? Because Merritt did the first four editions – right? All by himself.

LPR: Yes, and then he used help after that. I think I was involved in the seventh to the eleventh and then the eleventh now had three because Tim [Timothy A. Pedley] came along.\(^\text{16}\) Right now we are at a dead end because there are a couple of other people who want to edit the book without me or Tim. We’ll see how that comes out. I proposed that we end up with four editors. I don’t think it matters how many names you have on the cover except for their interrelations. That is what I am pushing for now. We’ll see whether I last.

BWS: How did it come to you?

LPR: I helped Merritt. I was the one. I’ve done a lot of writing over the years. I was the editor of the green journal [*Neurology*], a big journal, for ten years. My good friend, Bob [Robert] Fishman set the


\(^{16}\) Timothy Pedley is chair of the Department of Neurology at Columbia University and neurologist-in-chief at the New York-Presbyterian Hospital and Columbia University Medical Center.
ten-year limit, which most people think is good.\textsuperscript{17} I’m not sure it’s right. If you are doing something and doing it well, it is okay to let it go, but that was the rule that he set. I think most people think it’s a good idea. I was the editor of \textit{Neurology}, the green journal. [BWS: The green journal.] And of \textit{Neurology Today}, which is also green. Green has become the color of Academy publications. We started with \textit{Neurology}, the journal. The \textit{Official Journal of the American Academy of Neurology} is the full title. The writing is part of me. I still do it. The question is – what am I going to do if I retire? Now I think the natural thing is for me to write a book about neurology, which I would do because I think the transition – that was one of your questions. What were the major changes? I think that there are two. One is imaging. The arrival of CT and MRI and functional MRI has just transformed everything that we do. The other thing that has had a similar impact is molecular genetics, which has transformed everything that is familial. And in neurology, there is a lot of familial disorder, so a lot of the advances in molecular genetics have come for neurological diseases.

(14:49)

BWS: You said, in 1991 when you were interviewed for the ANA [American Neurological Association], the diseases you were interested in were “wide open.”

LPR: I was mostly interested in muscular dystrophy in those days, but the way I was going about it wouldn’t have worked if I did it for a hundred years. What you were going to do was go through the muscle proteins one by one and see if they were normal or abnormal by chemical means. The first one we picked was myoglobin and we learned a lot about a condition called myoglobinuria. We didn’t find the disease. It just was not the right way to do it. Molecular genetics was the right way to do it but it hadn’t been invented yet. Then along came the first molecular geneticists who were Louis Kunkel at Harvard and his student, Eric [P.] Hoffman who is now a big shot in Washington at the National Children’s Hospital, I think it is called. I think that they could have won the Nobel Prize. They found the abnormal protein in Duchenne’s Muscular Dystrophy – the most common muscular dystrophy and a heart-wringing one because it affects young boys and is just fatal, ultimately. It’s still in medical newspapers because heart transplants are one of the ways to keep the children alive. Steroids, to my surprise, have helped too.

SF: When did the ALS Center coalesce into a multi-disciplinary center the way we see it now?

\textsuperscript{17} Robert Fishman was chair of the Department of Neurology at the University of California-San Francisco and chief editor of the \textit{Annals of Neurology}. 
LPR: That’s another interesting thing. The sign up there says I founded it. We had had an ALS Center before, an ALS clinic, then somehow we made it a Center with some research labs. And then Tim [Pedley] hired Hiroshi Mitsumoto to become the Director of it. He had been in Cleveland when they had a very active Center. He came and took over. Right now the place is in turmoil again. I don’t know whether you know about it but Richard [Mayeux], the new [department] chairman, has decided to put all patient care activities on the third floor with the movement disorders. [SF: Right.] So Hiroshi is down there now. He’s got his office up on the eleventh floor and his patient care will be delivered on the fourth floor which is okay, I guess. You can go to where your outpatient facilities are. They don’t have to be where you’re permanent office is. But it’s a giant change, so we’ll see how that works out.

SF: How do you think the NI [Neurological Institute] building and the library and its storied historical – how do you think that shaped the training and experience for residents and for faculty?

LPR: You could tell me better than I can tell you. What it was like to go through it and what has happened to you since and how you feel about it? My notion is that its tradition is remarkable. I don’t know whether you know that there was a paper in the Archives of Neurology last year. Do you know about that paper?18 [SF: Right. Yes, I saw it.] Let’s put it on the recording because it is one of the things that makes me very proud. It was [written by] a group of neurologists – I know none of them personally – [who] thought it would be interesting to find out which training programs were responsible for training the faculties of all of the neurology training programs. They developed a list and which one was the most efficient in that? The Neurological Institute. It had to go back; it was 2011, I think, when they published that, but it had to go back through the years. I think it was 2002-2011. That’s when we were in charge, so it was very complimentary.

(21:14)

SF: Let me press you on that point, because this is certainly something I am interested in. Do you think that that was because of the resources that were available in terms of expertise or do you think it’s because of your and the other’s skill in picking the right people to be trained?

LPR: We lucked out because the people who applied to us were so sensational. When you think the people that we couldn’t take – [they] went somewhere else and have become great. I think it was the

18 Medical School and Residency Influence on Choice of an Academic Career and Academic Productivity Among US Neurology Faculty. Peter G. Campbell, MD; Young H. Lee, BA; Rodney D. Bell, MD; Mitchell G. Maltenfort, PhD; Darius M. Moshfeghi, MD; Theodore Leng, MD; Andrew A. Moshfeghi, MD, MBA; John K. Ratliff, MD Arch Neurol. 2011;68(8):999. doi:10.1001/archneurol.2011.67.
tradition of Neuro and then the separate building – nobody else has a separate building for neurology. It was not only sentimental but we never had competition for space. It was our space. The whole building was ours. Not anymore, but it was. We didn’t have to fuss about anybody else. We just had all the space we could use.

SF: Yeah. I bring that up because I was a resident at Cornell which was a much smaller program than the city, but Fred Plum – one of his proudest accomplishments was he trained seventeen department chairmen. I think it was mostly because of his skill in picking people. He had a knack for that, because it certainly wasn’t the overwhelming resources.

LPR: I disagree.

SF: You disagree.

LPR: I think it was the same. I think that Fred Plum – you know, we were competitors.19

SF: I know.

LPR: But we were good friends, really good friends. We ended up buying his dog one night when dinner was delayed at his house. Esther was part of that too. [aside comments]

ER: Talk about Fred Plum. I want to hear the end of that.

SF: You think it was what he had to offer?

(24:42)

LPR: I think that Fred was such a remarkable person that he attracted the best people in going into neurology, just as we did. There were enough to go around, to fill both programs. I think he was a more complicated person than I am. He was domineering, loudmouthed, egotistical, wonderful. A great combination for a great teacher. [SF: Yes.] Smart as hell. I get sentimental about people I like and I like people who may ruffle other people’s feathers, but it wasn’t mine. He never ruffled me. [aside comment] He had a wonderful house, just as we had a wonderful house in Philadelphia. He had a historic house.

19 Fred Plum was Chair of Neurology at Cornell Medical College and editor-in-chief of the *AMA Archives of General Neurology.*
He invited us for dinner one night when I was just beginning my career as chairman. When we got there, there was a fire in the kitchen so dinner was delayed. He had a dog – a poodle, a prize poodle. The poodle had just had a litter [of puppies]. He offered us one of them. We paid $25 as I recall.

SF: I think dogs are the key to existence. I love my dog. I’m going to press you on the topic of picking people because this is a topic that I’m very interested in. I’ve been very curious in thinking about this interview and what your answers to these questions would be. Whether or not you think that there are certain personality characteristics that maybe are necessary or that predispose for someone to be interested in neurology and/or successful as a neurologist?

LPR: Well, if they applied to a competitive program, they’re interested, I think. You can tell, not from the interview so much, but from the letters of recommendation whether they are any good or not. I’m not sure that I can tell from the interview anything more than whether the candidate’s personality is likeable or not. I’m not sure that I can tell more than that. But when you start with the top of the crop you can’t go very far wrong. I’m trying to think of whether there were any terrible errors we made. We must have. Somebody must have screwed up.

SF: Do you, though, that there is – do you think that a neurologist is made or are they born?

LPR: I think they develop.

SF: Do you think it is both?

LPR: Yes. Do you know who the most difficult case we had was the famous case of the guy who was in the Big Brother/Little Brother club. We’re not going to name the person on tape. He was on national TV one night. I’ve forgotten what happened. Something bad happened. They said that one of the residents at the Neurological Institute in New York played a featured role in that.

SF: I guess I’m more thinking of the way people think or their intellectual thought process. Do you think there is a way?

LPR: I’m drawing a blank.

(31:08)
BWS: What is the characteristic of a neurologist? Some characteristics of neurologists that you would say were important? Curiosity? Stick-to-it? Ability, obviously?

LPR: First of all, they’ve got to be compulsive. There is a lot of iterate learning. Re-iterate learning. They’ve got to be tenacious. They’ve got to have the clinical skills of empathy and sentimentality. They do have those things. A frequent comment that was not quite on your list – maybe it was – is “how can you spend your life doing a specialty like ALS where you make the diagnosis and you have to tell them that it is lethal; they are going to die of it, and there is not much you can do about it.” We can do more now than we could before in relieving the symptoms and making death smoother and less painful – painful being less suffering. But we can’t keep them alive. We can keep them alive if we do a tracheostomy which is a different quality of life. The question you have to ask the patient – and I ask them straight out, is – “How are we going to deal with it now? We’ve got a serious diagnosis which is going to be tough for you. It is going to be tough for your family. We are going to have to decide one of these days – do you want us to keep you comfortable or do you want to live as long as possible? They are not the same.” For the family, that is a family decision. One of the crass things that they have to decide, and other people decide, is that it’s expensive to stay alive with all the equipment you need, and the personnel, to stay alive – and that affects your survivors. Such a tough disease on every level. But it is interesting that it is a field of research. I think everybody involved thinks that ALS is one of the diseases that we’re going to crack one of these days. You were asking how people feel about it. I don’t know why people are optimistic about it. It is not even on the horizon or breaking news.

SF: Let me press you on this. You have now a perspective on this that is probably broader than almost anybody around. Having seen the pre-pre molecular biology days and then the molecular biology days and the clinical trial days – if you had to make, let’s just say, a prediction, what do you think therapeutics will be like in five years or ten years or fifteen or twenty in ALS?

(35:05)

LPR: What we need is to start with – I think I’ve got a list of twenty-five mutations that cause familial ALS, familial ALS with dementia or not. With frontal temporal dementia. If we get one, then that will help get to the others, I think, because of this. Every mutation, every one of the twenty-five, causes a recognizable syndrome that we call ALS. But the twenty-five, they are all different. So there must be an intermediary stage between the mutation and the mutated protein. There has got to be some common link. If you could get hold of that, then you might be able to stop the progression of the disease. It’s like what is going on now with the pre-symptomatic identification of Alzheimer’s disease. [SF: Right.] I
think that’s a gigantic step. I never thought that Alzheimer’s would be ahead of ALS; it really [ought to be] the other way around because it’s simpler, but that’s not the way it worked out.

SF: Using that as a starting point, then maybe can I press you on, let’s say, your global take on therapeutics in various subspecialties. Let’s just take movement disorders.

LPR: It is way ahead of everybody else

SF: Epilepsy.

LPR: Way ahead.

SF: Neuromuscular disorders.

LPR: Myasthenia is treatable.

SF: Compared to your original – I remember your “fatalities” paper from the [19]’50s.20

LPR: You are right about that.

SF: In myasthenia. But we don’t think of it as a fatal disease today.

LPR: It is but it isn’t. The mortality rate has gone from 33% when I first started to less than 5% now. Some of the mortality is in people who live long enough to have a heart attack. The treatment of neuromuscular disease – one thing that has made it less lethal is the development of the neuro ICU. It is an indirect advance in neuromuscular disease. The use of steroids is indirect because, as Houston Merritt would say, “Steroids are good for coughs, colds, sore holes, and pimples on the rectum.” “Pimples on the belly,” excuse me.

SF: How did the neuro ICU [Neurology-Neurosurgery Intensive Care Unit] develop at Columbia?

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LPR: It starts when I was invited to go to Penn. At that time, I had tried to get an ICU at Columbia and I was told it was impossible. Then I went down to Penn and they had, I think, four ICUs. They had a pulmonary ICU and a neuromuscular ICU. There was one that was general [and] a fourth. I was just shocked by that. I said, “Here I am, going from the world’s greatest neurology hospital in the world to a – not second-rate or second-class, second-tier – hospital at Penn and they are way ahead of us. So when I came back, they asked me whether there was anything we needed that they could do. I said, “Well, I tried to get an ICU – a neuro ICU – before and I would like to have it now.” So they said, “No problem. We’re with you that we need one. We will do it and make it the first thing on top of the list.” I’ve forgotten whether it took five years or ten years, but we finally got one. In the meantime, we acted as though we had one. So when we had to make do one or two years – we had tank respirators longer than anybody else I think. You’ve probably seen the pictures of the tanks. [SF: They were like iron lungs.] Yeah, they pulled the air into the lungs and then pushed it out again. Then along came the polio epidemic of 1953. If a person stopped breathing, they would get a medical student to push an Ambu bag – a bag that filled up with air and you pushed it out through a valve into the patient. They had medical students rotating to do it day and night. Then they ran out of medical students so they decided – somebody decided – brilliantly to invent a mechanical medical student that would be a pump that would push the air through the bag. Once they did that, they killed an old superstition that you can’t do positive pressure respiration because it would impede venous return to the heart. Once that was gone, it was just a technical thing to develop the beautiful respirators we have now.

(42:50)

SF: Fred Plum used to talk about that. I think that was one of his original inspirations for neuro ICU and for interest in ventilation.

LPR: Absolutely. And he had a young assistant with him. A guy named Jerry [Jerome] Posner who worked on the respirator.

SF: Right. Was Matt [Matthew E.] Fink the first person who headed the ICU at Columbia?

LPR: Yeah, Matt was an ideal candidate to do that. [aside comments] He was skilled in pulmonary care before he came. He was a natural person to put in charge and he did a great service to the institution. I wrote that story somewhere. I wrote a review of a book called Back from the Brink, which
was the story of the ICU and how it was developed in general. I focused on the neurological point. The review was published in *Neurology Today*.²¹

SF: Maybe I can follow that up with another question about training as it was when you were chairman and how it has evolved. Neurology training in terms of the residents’ experience.

LPR: What’s dominated everything – residents, professors, everybody – is money. It is so intrusive now. When you have to pay rent in order to see patients and take care of them, there is something cuckoo about it. It is not just us. I ask whether other people pay rent and they do now. It’s crazy. The economics of this system have gone awry, I think.

SF: I couldn’t agree more. I’m going to follow on that point because this is a sore point for myself. It’s pretty clear how you’ll answer the question of what you think of the current obsession with billing and remuneration, but clearly, at least from my perspective, the way it used to be – or at least I was told that the clinical revenue often helped tide along the research. [LPR: Yes.] But then things did a complete flip, somewhere in the [19]’90s and early 2000s. From your perspective, what do you think – how much, let’s say, with all this focus on remuneration and on timing, what do you think is the adequate amount, let’s say, of time to be spent with a new patient or a follow-up patient in the office?

(46:10)

LPR: I could only say what I did. I would always allow an hour for a new patient and a half-hour for an old patient or a continuing patient. That didn’t matter whether I was in the clinic or a private office. I don’t have private patients anymore because I was losing money. [phone rings]

BWS: You were losing money because you were spending an hour, or the time needed?

LPR: Whatever it was, my account was in deficit. I got fired for that reason.

SF: We all have our own take, but I’m curious what your take on it is in terms of what impact that has on people going into the field and in their training?

LPR: I don’t think what field they go into matters. They’ve got it in every field. The Dean says we’re not going to tolerate deficits anymore. He says it because the Trustees tell him, “You can’t be in deficit.” I was out of the halls of power a long time ago, before Gerry [Gerald D.] Fischbach became the Dean. Gerry Fischbach was a talented neuroscientist and clinical investigator. He came from Washington University in St. Louis. He became Dean and was very popular with the faculty, especially with the basic scientists because he understood their culture and their needs. But he ran a deficit. So he got fired and became a Vice President or something. Then they got Lee Goldman and Goldman’s marching orders were no deficits. So he fired Tim [Pedley], I think. Tim got fired, but he was kept in a place where his talents could still be useful because, I think, Richard didn’t want to have anything to do with the finances of the department. Anyhow, whatever their arrangement is, they worked it out. It is working pretty well now.

SF: Maybe I can ask you more about, let’s say, for resident training. What do you think are – because there has always been a tension between the need for residents to be in the hospital to take care of sick patients, to take care of the ICU, versus now the shift to out-patient neurology.

(50:20)
LPR: We’re doing it right now. Everybody says they’ve got to do more ambulatory neurology. I always thought the old system was okay but that is an antiquated view. The notion was, if a neurologist knew how to take care of really sick patients, you could take care of less sick patients [SF: Right.] without any special training or not. What you can’t do, I think, is to run the ambulatory clinic and make a profit – or at least not lose money. [SF: Right.] That’s the crux of it. And leads me to something that is not on your list of questions. Why don’t we have national health insurance? Why do we have to have profit-making systems?

SF: I think we would need a symposium to answer that question. [laughs] Do you think, though, that residents – wouldn’t you say that they need the training now that so much of neurology has become out-patient? I remember from my own experience feeling ill-equipped to deal with a lot since I was trained to take care of very sick people.

LPR: Yes, they’ll do that. I think they’ll do that. But I want to tell you about the list of people who influenced me. I’d like to go through that list. [SF: Yes, go ahead.] I want to talk to you about John Punnett Peters. He was a professor of medicine at Yale when I was a student. He was one of these hypophonic guys – you couldn’t hear him from an inch away. He mumbled terribly. He was a chemist.
He wrote a textbook of medical chemistry which was a laboratory manual for everything that was done in the Yale diagnostic laboratories. He wrote the method that they would use. He was also literally puritanical. He came from a family with many ministers and he had a divinity school approach to social problems – it was the **responsibility** of physicians to think about what is happening to the patients’ finances when we take care of them and what role that played in their getting sick in the first place or whatever problems would arise from it. He imbued that, I think, in me and people like Frank [Franklin H.] Epstein who became editor of the *New England Journal of Medicine* and [Arnold] “Bud” Relman who became the editor-in-chief of the *New England Journal* and a guy named Charlie [Charles] Nugent, who was one of our friends in Arizona. All of these people, in one way or another, got involved in medical politics, I think all because of Peters. Some of them got into trouble because of their interest in medical politics – like me. You didn’t get to that.

**SF:** When did you get into trouble?

**LPR:** I got thrown out of the NIH. I this is worth putting on record.

**SF:** You got thrown out?

**LPR:** Yes. I just always assumed that everybody knew. When was it, Esther?

**ER:** 1954.

**BWS:** You were there in [1953-1954]. Tell us about it.

(55:10)

**LPR:** The other person besides me who is important in that story was named Joseph McCarthy. [SF: Oh!] And he was in full power then. He scared the bejeebers out of everybody by calling them up and embarrassing them in public or forcing them to take the Fourth Amendment. I had been the president of something called the Association of Interns and Medical Students [AIMS], which had two major goals. One was to get rid of racism in American health care and within the profession of medicine and the other was to have national health insurance. That was sufficient for the AMA to brand AIMS – the

22 The Fourth Amendment to the United States Constitution affirms protection against unreasonable search and seizure.
Association of Interns and Medical Students – a “Red front.”23 That was the nasty name [used by] these mean people if you were [seen as a] hazard. So when I was at NIH, the FBI came after me. I was called down and interrogated; it was like a scene out of Kafka. I was there and they said, “We want to talk to you.” I said, “I don’t want to talk to you.” They said, “But you’ve got to talk to us.” I said, “Can I get a lawyer?” They said, “No.” I said, “Can I talk to my wife?” They said, “I guess that will be all right.” I told Esther that I was being interrogated by the political police and I said I wasn’t going to talk to them. I didn’t talk to them and that became a charge against me later – I had refused to cooperate with the Department of Health and Human Welfare. There was a list of other charges like that. We were living in an apartment house on the campus of NIH – and they said, “Okay, you’re fired. You have to get out of your room.” We had a one-year-old baby (the one who is calling us today). When we got thrown out, I thought I would never work again. There were two heroes that made it possible for me to work again. One was Harry Zimmerman, the neuropathologist at Montefiore who later was the guy who recognized the epidemic of ALS on the island of Guam. He was a captain in the [U.S.] Navy medical corps. He was stationed on Guam and he noticed they were getting a lot of autopsies on patients dying of ALS. They sent other people later and found out that the incidence – the prevalence – was sixty times higher than any other place on earth. You know that that epidemic is gone. [SF: It burnt out.] It is gone. The last patient diagnosed was last year or something. It has got to come back to have a low level, but at the moment it seems to be gone. [SF: The second person was?] Houston Merritt. Houston Merritt got me a fellowship. He helped to get me the job at Montefiore. He wanted to make it easy for them if they didn’t have to pay me, so he got me an MS fellowship. Fishman and I had the first two clinical fellowships from the MS Society. Neither of us were particularly doing MS things. I did a little bit. But I never forgot how much I owed the MS Society. At one time, I became the chair of the Medical Advisory Board of the MS Society in New York. That was my payback, but it was a great pleasure and it was very interesting.

SF: Maybe I can ask you about your activities with the Academy – with the journal and with the institution.

LPR: I was at one time President of the Academy. I was President of the Foundation – the Academy Foundation. I was made the President of the Academy by Steve [Steven P.] Ringel, who was a kingmaker. It was his idea. I enjoyed that and I thought it was important. Some people don’t like that

23 Reference to Senator Joseph McCarthy and his anti-Communist campaign, which became known as McCarthyism. Red was used as a reference to Communists and Communism. Senator McCarthy eventually was censured by the United States Senate for his activities.
kind of bureaucratic assignment but I relished it. The people who get into that are such, themselves, remarkable people. A guy like Fran [Francis I.] Kittredge – a big wheel in the organization. He had a private practice in Portland, Maine; we ended up having a pattern of having a clinician for one term and then an academic for another term. I thought it worked great. We all learned a different field and I don’t think there was ever any friction between the two that “you’re taking my territory” or something like that. I just admired the whole bunch of them.

(01:01:46)
SF: The Academy is certainly – it went through an explosive period of growth in the [19]’70s and in the [19]’80s in terms of the meeting and the size of the meeting, the presentations.

LPR: And the courses. Don’t forget the courses. I’ve been involved in the courses from way back. I developed a course called “The Scientific Basis of Neurology.” I really relished doing it because it was just fun and it was effective as determined by questionnaires and by requests to do it again for another year. I’ve forgotten how many years I did it – at least ten. That kind of thing still goes on. The courses are the main attraction of the annual meeting. And Continuum. I didn’t have much to do with that but that’s another important contribution to lifelong education.

SF: Aaron [E.] Miller [developed Continuum]. Aaron Miller just stepped down after ten years of doing it.

LPR: Right, but I don’t think he was the first. Somebody was there before him. He did very well. They both did – whoever it was before him.

SF: Maybe I can segue way from that. What do you see in the landscape for non-academic neurologists?

LPR: That’s depends on the national health insurance. I think national health insurance would be great for neurologists. We need it. I think we should have another survey of neurologists to find out how they’d feel about national health insurance. I don’t think the Academy is a proponent or a vigorous opponent of national health insurance. It ought to be one or the other.

SF: There is a projected shortfall of neurologists in the next fifteen or twenty years in the United States.
LPR: You know who else said that? He didn’t limit it to neurologists – a very savvy guy. Herb [Herbert] Pardes, the former director of both the Columbia-Presbyterian and New York Hospital. He said we need more doctors. The aging population is one thing. The other things are the changes in finances. That may be right. I don’t know how the Academy feels about that. [aside comments]

(01:06:13)
SF: You’ve mentioned national health insurance. Do you think there is a system now in the world that does this more effectively? Are you looking to the European model?

LPR: I think we’re the only major industrial country in the world that doesn’t have a national health program. I think that’s right. [SF: Yes.] Stephanie Woolhandler and [ER: David Himmelstein.] David Himmelstein – Physicians for a National Health Program. I wish more people would join that. It makes an impression when you say 60,000 doctors are for national health insurance. But it is piddling compared to the 300,000 or the 600,000 in the AMA.

SF: Do you think it is money that drives that opposition?

LPR: No. I think that the AMA is for private practice. That is what they think their people want. It may very well be what their people want. I don’t know how hard it would be to sell national health insurance.

BWS: You asked about other systems. The Canadian system?

LPR: The Canadians have a national health program. What they say is that Canadians come to the United States for specialty care. I’m not sure if that’s right. I’m not sure it’s wrong either.

SF: My own – I’m curious what you would think – if you would support this if we had a national health insurance. But to do that, you would, I think, have to change the way training works – particularly in medical school – and the way that’s paid for. Almost all the societies that have the national health service, medical school does not bankrupt the trainee.

LPR: I think that people should be paid to go to medical school. I was paid to go to medical school. I was in the Navy. They bought us uniforms, books, equipment, guns. [laughter] They took the guns away from us when we started marching around the streets with them.
BWS: Medical school costs now – that comes up a lot [in these interviews].

LPR: There is no reason – if medicine were viewed as a public service, then you send them for training. I think the medical schools would like that – to be assured of tuition income and not have to give so much away in scholarships and financial assistance. They [students] would have no debt. What is the debt of a medical student now?

SF: The average is about $160,000. In some it’s $250,000.

LPR: How do they pay it?

SF: It’s impossible to attract people to primary, non-surgical care.

LPR: Why do we go on like this?

SF: I couldn’t agree more. I think it is a whole other topic.

LPR: You and I would make a great team as the czars of American medicine.

SF: I think I would probably have ended up blacklisted as well, unfortunately. In the Woody Allen movie from the [19]’50s where he is called to testify and he tells them they can go stick it and they take him off to prison in handcuffs. [aside comments]

(01:11:09)

ER: *The Front.* [referring to the name of the movie]

LPR: I wanted to tell you about the people on my list. I told you about Peters. I’ll just read them in this order – it doesn’t matter. David Shemin took me into his lab for four years to let me do whatever Ph.D. students did. And as I said before, I didn’t make any great discoveries but it influenced everything I’ve done since then. Training other people. Supporting research. Writing. Everything. David, at the time we started, it was before molecular biology so the big thing in those days was how do you make large molecules – not proteins – but large molecules, like hemoglobin and cholesterol, out of smaller ones. He was the one who figured out how you end up making hemoglobin from glycine. He was terrific.
Seymour Kety was the one who figured out how you would measure human cerebral blood flow in living patients. He did that when he was at Penn. Then he went down to NIH and was the director of research for both mental health and NINDB. He gave it a start that has sufficed to keep it going for all these years. Walter Freygang is on my list. [William] Landau was a contemporary at Wash. U in St. Louis. He was down there [NIH] at the same time and we became friends. Mutually influential. He is a wonderful maverick; he’s always contrarian. [aside comments] He took me into his lab at the NIH. I went there because he was studying living blood flow and I wanted to do for muscle what Kety had done for the brain – figure out how you could measure muscle blood flow and metabolism. I spent six months in his lab and learned that it was not possible. But that was fulfilling. Merritt is Merritt. Tiffany Lawyer was head of Montefiore. Harry Zimmerman, I mentioned. Chadmonson had a lab when I was learning biochemistry. I worked first in a bigger lab for first-year doctoral students. S-- Bosang was in there. He was a biochemist. I think he retired as a full professor; he was so helpful and so nice. Fishman and I shared offices, labs, and patients for seventeen years before he went to California. He was my big brother in all the time I was growing up – he was a year older than me.

SF: I’ve heard you talk about mentorship. I remember you saying about getting foundation funding – it is always hard to get money and what do you do with it. You would say, “If you have a limited amount of money, the best thing you can do with it is to train someone.” [LPR: That sounds good.] The best investment you can make is to train someone. Clearly your mentors had a big impact on you [LPR: Yes.] and you’ve mentored many, many generations of people. Not everybody is a good mentor. [LPR: Yes.] What do you think are the characteristics of the mentors that you had and that made you an effective mentor?

(01:16:06)

LPR: I think the most important thing is to pick good people and then leave them alone. I’m not even sure that that’s what I did, but I didn’t interfere with people. I would encourage them. I guess it’s the same thing I try to do when I’m an editor. When I’m an editor I try to help people say what they want to say. Say what they mean. I think when I’m involved with somebody’s training, I want to help them do what they want to do. I can’t remember ever wanting to stop somebody from doing what they wanted to do.

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24 Seymour Kety was a neuroscientist who applied basic science to the study of human behavior. He was the first scientific director of the National Institute of Mental Health (NIMH).
SF: Do you think, though, that – because I think you’re being overly modest – it’s not just about picking the right people. It is also helping to guide them or when to guide them or when not to interfere. You clearly take the role of not trying to make hay out of what they are doing – to let them run with their careers – because that is something that struck not only me, but many other people in the department that you built. Each division of that department could have functioned as an entire department of neurology in many institutions around the United States. [LPR: I think that’s true.] Certainly it was true of the movement disorders division when I was there. But it was also true of stroke. It was true of neuromuscular. It was true of memory. That was very unusual. It was unusual for a neurology department.

LPR: But that is the pattern everywhere now. Every department, the top departments, are an amalgam or a cohesion of programs. You can just pick the ones that are at the top of the list in the world, in U.S. hospitals annual report. The group is the same in and out. We’re [Columbia] in the top five always. We’re never number one in that one. We’re two, three, four. It’s the Mayo Clinic – they belong there. It’s UCSF – they belong there. It’s us. It’s Mass General – they belong there. It used to be City Hospital – the Boston City Hospital. I always say that Penn, Columbia, and Harvard all claim to be the cradle of American neurology, but it was the Boston City Hospital. They bounce around within the top five. The Mayo Clinic is – I just find it’s an astounding place. In the middle of nothing for miles around them – Olmstead County is a cornfield – is this great, really great, institution. I remember when I went out there as a visitor. I went out on a site visit team. I take responsibility for making them great. [laughs] They were applying for a training grant and I was on a site visit team. They had it set up so that the muscle guy there – [SF: Engel?] Andy [Andrew G.] Engel and Peter Dick would have an afternoon a week to do research. We wrote a report. I have forgotten who else was on the committee with me; it was a good committee. We rejected the application. We said that it is ridiculous to think you can do research one afternoon a week. That’s just not the way you do research. So we rejected it with the recommendation that they re-submit by just putting these guys on salary and leave them alone. And they did. They got it. And they both have flourished ever since.

(01:22:20)
SF: Maybe I can follow that up by asking about training and the challenges to training of young clinician scientists today, which is a hot topic within academic neurology. What your thoughts on that are?
LPR: We need role models. I’d say do it the way they did it. In a sense we’re doing it. That was Richard Mayeux.

SF: Do you think it is harder now, or was it harder before, to do it?

LPR: We had training grants then. I’ll tell you how the training grants started. It affected me and Fishman. The director of NINDB was Pearce Bailey. He was a friend of Merritt’s. The story went something like this – this is an approximation of what happened sixty years ago. Houston and Pearce Bailey, they knew each other from being on committees together. Merritt probably had something to do with Bailey being picked as the director. Merritt was on the NINDB or DS council three times, the only one in history who was appointed three times. Bailey said to him, “Houston, we’re trying to set up some training programs to train clinical investigators. We think you ought to have one. Don’t you think so?” Houston said, “Of course I ought to have one. We ought to have one.” Then he said, “Do you have any candidates for it?” He said, “Well, I’ve got these two guys here that I call the Gold Dust Twins. Fishman and Rowland.” So Bailey said, “Send down the information about them.” Well, he did and the next thing we knew, Houston said, “What are we going to do now that we have a clinical research grant?” Or maybe he had to put a program up that they could approve it down there. So that is how it started. Both Fishman and I got good training. I went to Shemin’s lab and I went to NINDB. Fishman went to the Armed Forces Institute of Pathology to work with a guy named David [McK.] Rioch. Rioch let Bob do what he wanted to do.

It was Darryl De Vivo. He and I were on a committee, might have been an Academy committee that was advising NIH. It was Darryl’s idea was that what we needed was a fellowship that would be sponsored by the Academy, funded half by the Academy and half by an academic center. We would call it Training in Research Clinical Investigation or Clinical. [SF: Yeah.] That is still going. I think at one time there were thirty of them. That was what we were asking. It still exists. It has been so successful compared to the number of outstanding people who were trained. I think it was all Darryl’s fault, not mine. He is very imaginative when it comes to organization. [SF: Yeah.]

(01:27:05)

SF: Anybody else on your list we want to mention?

LPR: I’ve talked about all of them. I don’t know whether I said something about the professor of neuroanatomy. I’ve got something here that I may have missed. The word is here – I called it bio-
electricity. They guy would measure the electrical retention of people and trees. He had brilliant observation that when a woman ovulated, that he could detect an electrical change. He decided that if he could put that up to a lapel light he would know when a woman was going to have a baby or not.

One of the great lines. You asked about changes and I said no longer “Diagnose and adios.” That was a phrase that was introduced by guy named Labe Scheinberg. Did you ever know that?

SF: That is a phrase I’ve heard Stan use many times. Diagnose and adios.

LPR: That was the nasty description of neurology. We’ve talked about molecular genetics and ICUs. I talked about familial ALS. We talked about the AAN.

SF: Do you think, looking at students today, that the students who are interested in neurology are different in any way from when you were a student?

LPR: Yeah, they get better and better.

SF: Really!

LPR: Don’t you think so?

SF: I think if I were to be a cynic, I would say sometimes I wonder if some of them are hungry enough. You know?

LPR: I’ve said it several times. They’re great. I love them all.

BWS: There is a lot more specialization now?

LPR: We get to know more and more about less and less. But that’s the history of medicine. I think specialization is good, not bad. People say we get too narrow, but I don’t think that has appeared to me.

SF: I would agree. [LPR: Good.]

BWS: You do more because you know more.
LPR: And we still have terrible diseases to deal with. [aside comments]

BWS: Major changes you’ve seen? Anything you see going into the future for neurology?

LPR: I wish I saw something coming for Alzheimer’s and for ALS both. Stroke care has improved immeasurably. The outcome of lethality of stroke is down. The recovery and quality of life is better.

SF: In movement, we pride ourselves on our therapeutics. This is a transformative field compared to when Stan got into the field. He came to Columbia almost forty years ago. The changes. The field looks nothing like it used to be.

LPR: How about stem cell therapy?

SF: Controversial.

LPR: You think there have been any advances?

SF: In neurologic disease?

LPR: In the brain, I’m talking about.

SF: It has been a difficult topic in PV but in inherited metabolic diseases like Steven Goldman’s work and others, I think it is a fascinating area. Is there anything we’ve forgotten to ask?

LPR: I’ve gone through the list again. I think you did very well.

SF: You did very well.

BWS: What advice would you give someone coming into the field now?

LPR: First of all, I would encourage them to come to us for training. [laughs] If they were interested in going to Sinai, that would be okay.
SF: To come to New York?

LPR: That’s another interesting thing. There was a time when people didn’t want to come to New York. It was too dangerous and there were too many drug people around. There was a time when somebody came for an interview and was mugged on the staircase coming up from the subway. Were you around then?

SF: When I interviewed for medical school at Columbia, I had not been to Presbyterian but the cab driver that I tried to get in didn’t want to take me. And on the way out, they said, “You don’t walk down this street and you don’t walk down this street, or this one. This one looks okay but it’s not really okay.” That was the message I got.

LPR: That’s right. This was somebody who actually got mugged. Not hurt, fortunately. [SF: But that’s changed.] New York can be an attraction, which I think it is now, or a distraction. I hate to say it but it became an attraction again when Rudy Giuliani was mayor. [laughs]

SF: But wouldn’t you say though that the fact that the catchment is so great – of people, of patients, of the care – that that drives a lot?

LPR: I’ll tell you – I think one thing is, you could tell me whether this is my saying or whether it is a correct belief. I think it is very hard to go through training at the Neurological Institute without seeing or hearing your peer talk about something that occurs. There are no surprises left. You’ve heard it all at least once. You think that’s it exactly?

SF: I think it is.

LPR: There is so much that comes through. We have such huge numbers of admissions and ambulatory patients now. Huge numbers.

(01:36:16)

SF: My own bias is that it is also a New York phenomenon because of the catchment. A very different feel from when I was in Boston. Very different.

LPR: Is that right?
SF: Yeah, and indispensable to training, wouldn’t you say? That volume?

LPR: Absolutely.

ER: How about the opportunity for jobs for spouses in New York?

SF: That’s true.

LPR: What do you think about that?

ER: I think it’s a lot – there are a lot more. If both of them are medical students and going through residencies, there is more chance of getting one.

LPR: We’ve got married couples.

[general discussion]

ER: Nancy [S. Green] and Richard [Mayeux] and Tim [Pedley] and Barbara [Koppel].

LPR: Nancy and Richard.

ER: And Tim and Barbara. Are you talking about married couples among the faculty?

LPR: We’re talking about – I was thinking first about married couples who are both on the staff. But you are right, there are some that are not on the same staff.

ER: That is the point. In New York, you could be on two different staffs – on many different staffs – and still be in the same city. As opposed to, say. Rochester [Minnesota].

[general discussion]

BWS: Is there anything else we’ve missed?
LPR: If you think of something, send me an email and I’ll answer it.

BWS: A good idea.

[general discussion]

End of Interview

Notes:
The telephone rang several times during the interview. The Rowlands kept the phone ringer turned on because they were expecting a call from a family member.

The interview was recorded on a mild autumn day and the windows in the Rowlands’ apartment were open. Sounds from the street and children playing in the park across the street (along the river) are heard in the background of the recording.
Dr. Rowland is the recipient of many national and international honors and awards:

Distinguished Teacher Award, College of Physicians and Surgeons, 1975
Vice-President, IV International Congress for Neuromuscular Diseases, Montreal, 1978.
Vice-President & Special Lecturer, International Congress of Neurology, Kyoto, Japan 1981.
Vice-President Vth International Congress of Neuromuscular Disease, Marseille, 1982.
Citation Classic, Current Contents 1984 (11/26), p. 22. (Layzer RB, Rowland, LP, Ranney HM. (Arch Neurol 1967; 17: 512-523.)
Srinivasan Visiting Professor (Madras, Bombay, Hyderabad, Trivandrum, New Delhi) 1986.
Honorary Member, American Neurological Association, 1989.
Nicolaus Copernicus Medal, Polish Academy of Science, 1993. 
Certificate of Recognition, Black and Latin Students' Organization, College of Physicians and Surgeons, Columbia University, 1993
Jerry Lewis Research Award Muscular Dystrophy Association, for Lifetime Achievement in Neuromuscular Disease Research, 1993.
Associazione per la Promozione delle Ricerche Neurologiche Prize for Neurological Research and the First Dino Garavoglia Lecturer, Italian Society of Neurology, Florence, 1993
Committee of Honor, Session Chair, Charcot Centenary Celebration, Academie Nationale de Medecine, La Salpetriere, Paris, 1993.
Doctoral Lecture, University of Padua, Italy, 1996
Lewis P. Rowland, MD
Source: www.neurology.org/content/76/9/766/F1.expansion.html
Personal Data
Date of Birth     August 3, 1925
Citizenship       USA

Education
6/45-9/48  M.D. Yale University  School of Medicine       New Haven, CT
9/42-6/45  B.S. Yale University 1942-1945 Class of "1945W" New Haven, CT

Explanation of Gap: I served in the "Doctor-Draft" at the United States Public Health Service via the National Institute of Neurological Diseases and Blindness, National Institutes of Health, as a Clinical Associate, 1953-54.

Post Doctoral Training
1/48-6/48  Research Assistant in Neuroanatomy, Department of Neurology, Columbia University, (six months).
1/48-6/1950 Intern in Medicine, New Haven Hospital; Assistant in Medicine, Yale University School of Medicine (18 months).
1950-1952  Assistant Resident in Neurology, Columbia-Presbyterian Medical Center
1953-1954  Clinical Associate, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Instructor in Neurology, Georgetown University.
1954-1957  Assistant Neurologist, then Adjunct Attending Neurologist, Montefiore Hospital, New York, N.Y.; Instructor then Associate in Neurology, Columbia University.
1956  Visiting Worker, National Institute for Medical Research (Medical Research Council). London, England (six months).
1957-1961  Fellow in Biochemistry, College of Physicians and Surgeons, Columbia University.

Hospital and University Appointments
1957-1963  Assistant Professor of Neurology, Columbia University.
1957-1962  Assistant Attending Neurologist, Columbia-Presbyterian Medical Center.
1961-1967  Co-Director, Neurological Clinical Research Center, Columbia-Presbyterian Medical Center
1962-1967  Associate Attending Neurologist, Neurological Institute, Columbia-Presbyterian Medical Center.
1963-1967  Associate Professor of Neurology, Columbia University.
1967-Present  Professor of Neurology, Columbia University; Attending Neurologist, Columbia-Presbyterian Medical Center.
1967-1973  Professor and Chairman, Department of Neurology, University of Pennsylvania School of Medicine.
1973-1998  Professor and Chairman, Department of Neurology, Columbia University, College of Physicians and Surgeons; Director, Neurological Service, Presbyterian Hospital.
1973-2010  Attending/Consultant, Harlem Hospital.
1974  Co-Director, H. Houston Merritt Clinical Research Center for Muscular Dystrophy and Related Diseases, Columbia-Presbyterian Medical Center.
1989-1999  Founder and Director or Co-Director, Eleanor and Lou Gehrig MDA/ALS Center
1998-Present  Professor of Neurology, Columbia University; Attending Neurologist, Columbia-Presbyterian Medical Center, New York Presbyterian Hospital

1999-Present  Attending Neurologist, Eleanor and Lou Gehrig MDA/ALS Center.


Sometime Visiting Professor or Lecturer:

Universities:

Albert Einstein, Arizona, Baylor, California (Davis, Los Angeles, San Diego, San Francisco), Boston, Case-Western Reserve, Colorado, Univ. Connecticut, Cornell, Downstate Medical Center, Duke, Emory, Florida (Gainesville), Hahnemann Medical College, Jefferson Medical College, Johns Hopkins, Kansas, Manitoba, Maryland, Medical College of Pennsylvania, Massachusetts, Medical College of Georgia, Miami, University of Michigan, New Jersey (Newark), New Jersey (Rutgers), New Mexico, New York Medical College, New York University, Northwestern, Pennsylvania, Rochester, State University of New York (Brooklyn), Southern California, Southern Florida, Temple University, Tennessee, Texas (Southwestern Dallas, Houston), Tufts, Tulane, Vermont, Virginia, Wayne State, Wisconsin, Yale.

Hospitals:

Allegheny (Pittsburgh), Beth Abraham (NY), Beth Israel (Boston), Beth Israel (NY), Brigham & Women's (Boston), Brookdale (Brooklyn), Brooklyn (NY), Chester (PA), Cleveland Clinic (OH), Coney Island, (Brooklyn, NY), Englewood (NJ), Helen Fuld (Trenton, NJ), Lankenau (PA), Lenox Hill (NY), Long Island Jewish (NY), Massachusetts General Hospital (Boston) (~1990; 2006), Mayo Clinic, Rochester (MN), Roosevelt (NY), St. Raphael's (New Haven, CT), Wilkes-Barre (PA).

Institutions Abroad:

Universities of Beijing, Bombay, Cardiff, Copenhagen, Delhi, Genova, Helsinki, Hyderabad, Jinan, Kitasaki, Kumamoto, Kyushu, Lubjiana, Madras, Milano, (University and Instituto C. Besta Modena, Montreal, Montreal Neurological Institute, Nanjing, Oxford, Padova, Siena, Tokyo, Toronto, Trivandum, Warsaw, Winnipeg.

Hospitals & Institutes: Charring Cross Hospital, Instituto C. Besta Modena, Montreal Neurological Institute, National Hospital (Queen Square, London).

Departmental External Review Committees:

University of Utah (1973); Albert Einstein College of Medicine (1976); University of Toronto (1980); Yale University (1980); Tufts University (1983); University of Rochester (1985); University of Washington (1986), University of North Carolina (1991), University of Arizona (1991); Yale University (1992); University of Medicine & Dentistry of New Jersey Robert Wood Johnson Medical School (1992); Montreal Neurological Institute 1993; Cornell (1994); Robert Wood Johnson Medical School (1996), Yale University (1998).

Neurology Societies:

Massachusetts, Pennsylvania, Connecticut, Arkansas

Program Project External Review Committee:

University of Pennsylvania Muscle Center (1975-1979).

P & S Committees:

Medical Faculty Council, 1973-
Dean's Committee on Hospital Appointments, 1973-
Executive Committee, Medical Faculty Council, 1981-85.
Research Development Advisory Committee, 1984-90.
Special Purposes Committee, 1987-90.
Committee on Harlem Hospital Affiliation, Co-Chair, 1991-2.
Special Advisory Committee on Clinical Practice Plans, 1991-
Ad Hoc Conflict of Interest Committee, 1996.

Committee on Appointments and Promotions, Chair, 1998-99, 2001-2, 2002-
Search Committees:
  Psychiatry, 1975 (Chair); 1983.
  Neurosurgery, 1980.
  Medicine, 1982; 1990 (Chair).
Dean and Vice President, 1984-85; 1988.
Dean, School of Public Health, 1984-85 (Coordinator)
Ophthalmology, 1986-87 (Chairman)
Associate Dean for Harlem Hospital Affiliation, 1986-87.
Dean, School of Nursing, 1988 (Chairman)
Clinical Genetics Center, 1988 (Coordinator)
Chief of Medicine, St. Luke's-Roosevelt, 1991-3

Presbyterian Hospital Committees:
  Medical Board (1973-98), Executive Committee of Medical Board (1973-98),
  Vice President (1988-91); President (1991-4); Steering Committee (1994-8).
  Long Range Planning Committee
  Patient Referrals Subcommittee, Chair
  Geriatrics Subcommittee
  Joint Conference Committee of the Board of Trustees (Presbyterian Hospital) (1990-96)

CPMC Joint Committees:
  Dean's Committee on PH Appointments (1973- )
  Comprehensive Cancer Center (1985-1995)
  Residency Committee (1973-83)
  Imaging Research Committee, Chair 1984-88
  HMO Committee, 1985-86
  Clinical Genetics, 1986-1988, Co-Chair
  25 Year Club, 1983 (President 1990-91)
  CPMC Office of Clinical Trials: Research & Development Committee: Chair (1992-6); Advisory Committee
  Managed Care Committee, 1992-3.
  Columbia-Presbyterian Physicians Network Board of Directors (1993-8)
  Columbia-Presbyterian Cancer Center Advisory Committee (1995-2000).

Societies:
  Diplomat, National Board of Medical Examiners, 1950.
  Diplomat, American Board of Psychiatry and Neurology (Neurology), 1955
  Alpha Omega Alpha, 1948
  Sigma Xi, 1949.
  Association of Interns and Medical Students (AIMS) President (1948-50).
  American Neurological Association (1959- ); President-Elect (1978-9);
    President (1980-81); Honorary Member (1989- ).
  American Academy of Neurology (Fellow); President-Elect (1987-9);
    President (1989-90); Board of Directors (1978-1987; 1996-9); Chair AAN Ad Hoc Committee on the
    Physician Work Force in Neurology 1994; Co-Chair, Member, Workforce Task Force (1997-99); Honorary
    Member (1997- ).
  Search Committee for Editor of Continuum, Membership Committee (1996-2006), Publications Committee
    (2000- ); Search Committee for Editor of NEUROLOGY (2006)
Editor-in-Chief, Neurology Today, 2001-
American Academy of Neurology Research and Education Foundation, Board of Trustees (1990- ); President, Chair (1996-1999).
Association for Research in Nervous and Mental Disease, President (1969-70; Trustee 1976- ); Vice President (1979-80); Chairman Board of Trustees (1992-8).
New York Neurological Society, Secretary (1965-67).
Philadelphia Neurological Society, President (1972-73).
American Association for Advancement of Science, Fellow (1999).
Sydenham Coterie, Philadelphia (1970-73)
Sydenham Coterie, Philadelphia (1970-73)
National Vice President (1995-)
Director, Lou & Eleanor Gehrig MDA/ALS Center, Columbia-Presbyterian Medical Center (1988-99).
National Multiple Sclerosis Society:
Medical Advisory Board (1969-1989); Honorary Board 1989-1992);
Research Programs Advisory Committee: (1980-2); (1984-8)
Association of University Professors of Neurology, Member 1967-1998; Secretary-Treasurer (1967-98); Trustee (1973-77); President (1977-78); Chair, Taskforce on Families in Neurology (2002-)
Harvey Society
Society for Neuroscience.
N. Y. Chapter, Multiple Sclerosis Society:
Medical Advisory Committee, Chairman (1977-91);
Professional Advisory Committee, Chairman Emeritus (1992)
Parkinson's Disease Foundation, President (1979- ).
Member, American Society of Human Genetics (1986- ).
Dana Alliance for Brain Initiatives (1993- ).
The European Neurological Society Honorary Member (July 20, 1989)
Vidonian Club
Editorial Positions:

Member Editorial Board:
1. Rowland LP. Some observations of the coronal suture and the problem of variable results in prefrontal lobotomy (Thesis). Library, Yale University School of Medicine, 1948.

2. Mettler FA, Rowland LP. Relation of the trephine opening (Freeman-Watts lobotomy point) to the underlying cerebrum. Trans Am Neurol Assoc 1948; 73:156-158.


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(Abstract) 60th Annual Meeting of the American Academy of Neurology.


Unpublished:


In preparation:


Books:
