

SPECIAL ARTICLE**John T. (Jack) Boyer, MD: Reflections of an aging geriatrician****Rosemary Browne MD, AGSF^{1,2}  | Mindy Fain MD¹  | Leslie Boyer MD³ **¹Department of Medicine, University of Arizona College of Medicine, Tucson, Arizona, USA²Southern Arizona VA Health Care System, Tucson, Arizona, USA³Department of Pathology, University of Arizona College of Medicine, Tucson, Arizona, USA**Correspondence**

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On October 2, 2021, the Arizona Geriatrics Society (AZGS), state affiliate of the American Geriatrics Society (AGS), presented Dr. John T. (Jack) Boyer with the Lifetime Achievement Award for his contributions to geriatric medicine. Many AGS members already know and admire this 92-year-old physician, one of the early founders of geriatrics in the state of Arizona. Recognized as a leader on local, national, and international levels, he sculpted a career of rigorous scholarship, academic governance, and compassionate clinical care.

The article that follows has been condensed from Jack Boyer's acceptance speech, as delivered to the AZGS. The statement was edited and transcribed by his daughter, Dr. Leslie Boyer. It consists entirely of his own words, either extracted from his unpublished memoir or derived from personal interviews in preparation for acceptance of the award. As will be clear from the opening paragraph, however, Jack's dementia has now reached a point where speaking in public is difficult. For this reason, the statement was read aloud to the group by Leslie, with Jack listening at her side.

“Good afternoon. I appreciate your welcoming me to this program. And what a pleasure to have the most important efforts of my life discussed. It is hard to find something any nicer than that. I'm not sure anybody wants to see me demented, though. And that's what I'll be—demented. In my own thoughts these days, I have enough retention of memory to know what lies behind. Mainly I have good feelings about what I was doing back then. I was joyful, proud of myself, aware. But that doesn't mean I know the details. Giving a speech, myself, would be impossible.

I had an odd career as a subspecialist in medicine. Beginning in Cleveland in 1960, I was a hematologist and a blood banker. Blood Disease was the hottest item among medical subspecialties and was the farthest along in basic science. I looked after transfusion patients—those suffering from anemias of several distinct kinds, leukemias, bleeding problems, and clotting problems. I had a large number of Black patients suffering from sickle cell anemia; in many ways, it was the most interesting practice of all, as I got to know some good people from differing cultures with severe and complex problems. Many were chronically ill and I followed them for prolonged periods of time. The patients with leukemia all died relatively quickly. I greatly enjoyed being their physician even as I failed them. Often, I was the only person they felt comfortable with because I was willing to speak about death, something family members often have trouble doing.

Moving to the University of Arizona turned out to be the wrong thing to do from a hematology standpoint; no one had sickle cell disease in Tucson, and anemias were rare. And most of all—times were changing. Hematology was becoming a small sub-interest of a new specialty, oncology, and blood banking in Tucson was much less demanding than in Cleveland. So I decided to become a rheumatologist. This may not seem an obvious career move, but remember that in 1971 rheumatology was just a budding specialty. Board certification and fellowship training were not yet

common. Tucson was full of arthritics who moved southwest to get the benefit of the warm weather. Rheumatologic expertise was badly needed, but the science was too primitive to attract the academic scientist-physicians (of which I felt I was one). The research about the worst forms of arthritis suggested an immunological cause—and I flattered myself to be a clinical immunologist.

So, I gave up 11 years of hematology experience for rheumatology. My lab work in 'complement and Inflammation,' however, moved easily into my new undertaking. I did several things I was proud of in the 15 years or so I was in the hematology lab—it was an amazing time of discovery and innovation. I loved the lab work, but even more I enjoyed taking care of patients and interacting with colleagues.

Adjusting to the clinical care of the arthritis patients was more difficult and newer for me—these were chronically ill individuals who could never be cured. There was absolutely NO science behind the interventions. This was in contrast to hematology where illness was usually acute, and a great deal of science stood behind the care. Death was more common in hematology and care of the dying patient was something to which I had adjusted. With arthritis patients, they seldom got better, and they never died, and they would seem to come back each time to imply, 'Got any more ideas, Doc?' The trick was for the doctor to get enough experience so that one could be comfortable with the diseases causing the arthritis. Patients were then so relieved to find a physician who was not afraid to take care of them that they welcomed one as if a cure had been found.

By 1984 there was no longer a shortage of rheumatologists in Tucson. Now, instead, there was a need at the medical school for a geriatrician. I went first to Harvard and then to Johns Hopkins to observe the most outstanding geriatricians in America at that time. And I came back and realized that I could enjoy this specialty for the same reasons that I had enjoyed internal medicine from the very beginning.

The switch to geriatrics felt uncomfortable at the beginning. It was—and is—so ill defined. Basically, it is general medicine in old age. But at what age is one old? Other than pediatricians, most docs feel they can take

care of someone at any age. Although there is not nearly as much research yet on disease in the elderly as in youth and middle age, it is something else that sets geriatrics apart. *Mostly, it is valuing older people that makes it unique.* Willingness to spend time with the patient to understand all his diseases and personal problems, while accommodating his slow responses, is a rare quality that good geriatricians have. In contrast, I find few geriatricians interested in the scientific side of the physiology and psychology of aging, which is disappointing. Does familiarity breed contempt? Sometimes I feel that way when I look at the world's excessive medical bills for the elderly or when I walk through the nursing home; I see the majority of residents there vegetating at a level that I can't imagine is worthwhile. Certainly, I don't want to contribute to either problem. But—as I age myself, the more I think efforts just to keep one alive are inappropriate. My values lie in providing a good life for everyone who can appreciate it. Would I have thought about this issue if I had not shifted into geriatrics? Almost certainly, but perhaps not as early in my life.

After retirement in 1993, I still volunteered for an hour or two each week in geriatrics and enjoyed it. I became the example of an older patient more than of a geriatrician. It was a good switch. I could argue with the fellows/residents with the authority of a patient and a physician. It was fun!

Being old is interesting. It is not a feeling of pleasantness or unpleasantness. That doesn't enter into my mind much. Sliding into dementia was a surprise. That I was bright enough to know it was both annoying and depressing. I wish I could remember the details of teaching, relationships, humor, kindness. That is what I would like to have.

I do enjoy visitors. I enjoy it, I feel it. But I feel wistful and guilty also. If I'm trying to entertain you now and I see you getting more and more frustrated, I think 'why am I damaging you to please myself?' On the other hand, I don't get very sad about it. Still, rediscovery of myself is interesting and fun. Suddenly thoughts will come to me that I have not had in ages. Or maybe it isn't ages? Maybe it is only a short time. But when you remind me of a story and I recognize the

truth in it, that is fun. Nothing bothers me very much because I don't have the where-withal to miss it. I'm inclined to think it's a little amusing, that I'm so superficial. I don't fear death. I don't particularly want to die. But I have to admit to myself, as we put this final view together, there isn't much here that I care about losing.

I'm a little disturbed by what Leslie put together for this speech because it seems a little egotistical. As I heard it now, I felt, 'Boy am I puffing myself up.' Saying, 'Aren't I wonderful?' It makes me uncomfortable to hear it; those are words better said for someone who is not in the room. But I did enjoy the memories and felt a sense of forgotten pride, even as I feel awkward about the bragging. Thank you to all for this occasion, and for the great honor of receiving this award. Most particularly, it is a pleasure knowing

that so many young geriatricians are out there taking good care of folks like me."

Jack Boyer, MD 10/2/2021

Since receiving this award, Jack has continued to live with his wife (and former medical school classmate) Dr. Georgiana Boyer at their home in Tucson, Arizona. He takes pleasure in visits with family and in observing the wildlife outside his window. Isolation imposed by the community spread of SARS-CoV-2, combined with declining physical mobility and the relinquishment of his car keys, has meant that he can no longer attend rounds with faculty and trainees at the University of Arizona. He laments the loss of control that comes with the fear that he may stumble and fall, but more so the loss of mentation that has made it difficult to participate fully in conversation. He remains aware and articulate when discussing his own dementia, however, and he unhesitatingly consented to publication of this paper.



Dr. Jack Boyer, then aged 91, watches remotely with Dr. Mindy Fain as he is presented the Arizona Geriatrics Society's Lifetime Achievement Award on October 2, 2021. (Photo credit: Dr. Leslie Boyer)

Communicating about one's own dementia, he says, "is a difficult phenomenon that produces many inconsistencies," but "I don't prefer privacy. I feel that it would be a contribution to society for geriatricians to talk about it more."

AUTHOR CONTRIBUTIONS

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CONFLICT OF INTEREST

There are no conflicts of interest related to this article.

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