GM: This is Gordon Margolin again about to interview Dr. Jesse Roth. Today is March 24, 2021, and we'll hear more of the happenings in 1966 in Bethesda and in the USA's southern states. Dr. Roth was one of the members of the NIH faculty that volunteered to go South to investigate some of the activities within the health system in place there at that time. Dr. Roth's current title is Investigator and Head of the Laboratory of Diabetes, Obesity, and other Metabolic Disorders at the Feinstein Institutes for Medical Research at Northwell Health. Thank you for joining me today, Dr. Roth. I really appreciate it. My first question is to tell us a little about your early life, where you were raised, your early schooling and how you decided to go into medicine.

JR: I was born and raised in Brooklyn, New York. That's a highly desirable place nowadays. In those days when we were growing up, we wanted to leave Brooklyn. Now, as the young people grow up, they hope to move to Brooklyn.

I went to a Jewish day school for the first eight years of my schooling. It was terrific. The classes were small, the teachers were energetic, and the other students were smart. At the end of grade school, I moved to New Utrecht High School, a superior local public high school. I was there for three and a half years. Then I was lucky and got a N.Y. State Scholarship to go to a college in New York. I chose Columbia where I spent four years doing pre-med science and also studying art history. Then I applied to go to medical school.

Like now, getting into medical school was quite tough, especially for those of us who were Jewish. There was still a strongly negative atmosphere for Jewish applicants. My grades were good but not good enough to guarantee that I would get into a medical school in the United States. My hopes centered on SUNY Downstate and a couple of others, but I wasn't going to make it into the big time. At that time Albert Einstein College of Medicine was just beginning. That was one of the schools that I applied to. I was awarded a New York State Scholarship for medical school, which I did by sitting down and taking a competitive exam. The medical schools then wanted to recruit me, because having a state scholarship winner in their student body was a plus. I wasn't sure that I'd go to Einstein because it was new, but my family was from an old stock Jewish family and my parents said to me, "You know, Jesse, if the orthodox Jewish community is sponsoring a new medical school, if you're not going to go, who's going to go?" So, I signed onto Einstein, and it turned out to be a great break in my favor.

I was in Einstein's first class. We had about 50 students. The energy, enthusiasm, and talent of the faculty was extraordinary. We were treated like the Pharaoh's children: We were tutored from beginning to end. We gained an enormous amount of enthusiasm for medicine, not only for medicine as a scientific pursuit, but also for social medicine. They brought in a whole bunch of visiting faculty who taught us about the social aspects of medicine as well. They emphasized poverty and inequality of distribution of healthcare. We became keenly aware that people of color or people who are new to the United States all suffered a much lower quality of care and attention.

So, by chance I wound up going to a brand-new medical school. I and other people who attended a first-year class of a medical school all look back on that experience as career molding because of the energy and enthusiasm of a new faculty. It was a big plus for us. More recently, I had the privilege of seeing Northwell's first class of medical students who attended our new Zucker School of Medicine. It brought back rich memories of lifelong friendships. It's special to be among the first class somewhere, and I saw that in the Zucker students as well.

GM: Were a lot of issues related to social medicine at that time that they particularly emphasized?

JR: Quality of care and access to care for the indigent was given some attention. Many other issues were ignored. For example, in my graduating class from medical school, women and minorities were highly underrepresented. I think that they emphasized, obviously, poverty and inequality of distribution of healthcare. The fact that people of color or people who are new to the United States all suffered a lesser quality of care and attention.

GM: It makes me wonder if that contributed somewhat to your later adventures which we'll be talking about. In which hospitals did you do your postgraduate studies in?

JR: When I graduated from Einstein in 1959, it was time to find a hospital to do my post-graduate work. Our faculty was very good at helping us find good places. In those days, academic medicine was heavily concentrated in the upper outer quadrant of the United States, so that was north of Johns Hopkins and east of Chicago and St. Louis. That quadrant had many hot spots for academic teaching. We were encouraged very much by the faculty to go for highly rated places. Having been raised in New York, we might have just gone to local New York schools, but the faculty encouraged us to try elsewhere. My roommate from medical school wound up going to Yale. I wound up going to Washington University in St. Louis, where I spent two years.

GM: Washington University has always been a very good medical school. How did you get to NIH after that?

JR: When I was at Washington University in St. Louis, the endocrinology program excited me greatly and led me to apply to another strong program, the metabolism program at Yale. My roommate from medical school was going to go there. The leadership at Yale was encouraging but weren't willing to sign me on until later in the autumn and then they filled up with one of their own people.

At that time Irving London, my professor from medical school, came to St. Louis to give a major talk. I attended. At the break he said, "Well, Jesse, where are you going to be next year?" I said that I didn't know. He said, "It's late! It's November." I explained that I wanted to do endocrinology and metabolism. He said, "Well, meet me for a drink after the talk." We went to the hotel Chase that was near there. I'd never been in such a fancy hotel. I never saw somebody sit down in the bar and order a drink and sign the check and all kinds of other fancy accoutrements of growing up. When he heard I wanted endocrinology, he recommended I go to the Bronx Veterans Hospital, which wasn't a famous place yet,

but it had two endocrinologists there who would become very famous: Sol Berson and Roz [Rosalyn] Yalow. You'll probably recognize Roz Yalow's name because she got a Nobel Prize for the work they were doing at that time. They gave her the Nobel Prize in 1977. Sadly he [Berson] died several years before that prize was awarded.

Based on London's recommendation, I wrote to Berson and Yalow asking if I could come. They gave me a hem and haw. Before I had a chance to answer all their questions, I got back another note that said, "Jesse, we spoke to Dr. London. Definitely, you should come," and they arranged for me to come to the Bronx VA. We were there in the vanguard. The first radioimmunoassay was developed just before we came there. My partner at the VA was a brilliant young endocrinologist, Seymour (Shimon) Glick. We couldn't have done better. We were tutored from early morning to late evening. The other interesting thing about it was they wanted to make sure we got a very rich background. We didn't suffer from coming to a small place. We really couldn't have been tutored any better than by Berson and Yalow.

GM: Then what possessed you to go to NIH after that?

JR: Well, my next academic decision was heavily influenced by American involvement in the increasingly unpopular and rapidly growing war in Vietnam. Doctors were being drafted right as soon as they finished their training. So, the race was to try to get a job with the federal government because that would exempt you from going to battle in Southeast Asia. The first year I went to NIH to interview, I didn't match with any NIH faculty. My friends from St. Louis said, "Jesse, be careful. If you go to NIH, there are good jobs and there are bad jobs. Don't take a bad job." So, I had the courage on my first visit to NIH, even though the war was drafting people like crazy, to turn down the second line jobs. The next year I went back for an interview for a job. Berson and Yalow called their friends at NIH with a very exaggerated recommendation about this very special, very accomplished young investigator. On the basis of this exaggerated recommendation, I matched with an excellent group at NIH, the clinical endocrinology branch in NIDDK.

When I came there in 1963, they treated me like royalty, like I was a young prince. Even though I was new to the group, they provided me with a technician and my own lab space. The other thing that was interesting was the boss; he really encouraged me. In those days, if you had a hit in research, you stayed with that for the rest of your life. I was lucky when I was at the Bronx VA with Berson and Yalow. My partner, Seymour Glick, and I were able to put together first-rate assays to measure growth hormone. Growth hormone was a very much unknown hormone at that time and so the likelihood would have been that I would have continued in growth hormone for the rest of my career. But fortunately, the new NIH boss said, "You know, Jesse, you could stick with growth hormone for the rest of your career, but you know this is a special place. This is a special time. Why don't you try for the most exciting science you can do?"

My new lab neighbor at NIH, Dr. Ira Pastan, joined me in taking up the boss's challenge – to find new exciting science to pursue. We soon devoted ourselves to a new area, receptors for hormones, especially cell surface receptors, which was a brand-new area. We were in the vanguard on receptors. In those days, there were hormones, but almost no one was thinking about receptors for the hormones. If you search textbooks, asked people, everything was the hormone. The hormone receptors were not mentioned in the textbooks or in lectures. Given the freedom and encouragement from our boss to pick the best thing we could work on, we decided to work on hormone receptors, especially those on the

surface of cells. That turned out to be a brand-new burgeoning field. After months of exploration and pushing on one another, we settled on this question: how does a target cell know that the hormone is there?

GM: You were in the right place at the right time, obviously. Tell me what year did you graduate medical school and what year did you start in NIH?

JR: I graduated medical school in ‘59, then did two years in St. Louis at Washington University, two years at the Bronx VA, and started NIH in 1963.

GM: Were you then a member of the Public Health Service and the Medical Committee for Human Rights?

JR: All of us who came to NIH—almost all of us who came to the NIH during the war in southeast Asia—were in the U.S. Public Health Service. It was amazing because we as interns and residents lived on a pittance – we were really poor – so when we got to the Public Health Service, even as a low-level medical officer, we felt like millionaires—we finally had a few dollars in our pockets!

The Medical Committee for Human Rights was starting to grow in membership and in the number of projects. The pioneer group inspired me and others; they were a group of politically sensitive and oriented healthcare professionals. I eventually became the co-chair of the Washington DC Chapter of the Medical Committee for Human Rights in the late 1960s. In 1963, though, there were already people from NIH and the Public Health Service who were going South to try to promote voting rights and extending voting to a large fraction of the populations in the South who were being prevented from voting. Those were tough days. They had limited places to house us, so for the first two years during the summer of ’63 and ’64, they didn't take me. However, every Saturday, we would go to a very nice housing complex that was in Maryland that was legally not allowed to be segregated, but it manipulated its rentals, so it was very heavily white. So, we would go and picket. Those of us who went were largely white professionals, but we were picketing for desegregation. What’s more, when minimum wage laws went into place, hospitals were shockingly exempt and paid under minimum wage. And again, that was an area that we would picket against. These were part of the roots of desegregation and the promotion of equality that groups of us in the medical and health professions tried to help Americans achieve.

In July 1965, President Lyndon B. Johnson signed into law the Medicare bill. Politically sensitive federal employees knew that the best way to desegregate hospitals in the south was through using Medicare as an incentive and threat: either you desegregate and get federal dollars, or you stay segregated and get no federal dollars. In 1966, several of my NIH colleagues volunteered to join the hundred or so public health officers who had been assigned the job of desegregating the hospitals.

GM: It was strictly a volunteer opportunity, is that right?

JR: For those of us who were who were at the NIH, participating in the Civil Rights Movement was strictly a voluntary activity. For a large number of the other people, who were career public health personnel, they were assigned.

Because so much violence erupted when public schools were desegregated, the feds were rightly concerned that the same would happen with the desegregation of hospitals. We had to be prepared for that. Those of us who volunteered included me, Paul Plotz, Norman Robbins, and Bob Perlman. We were excited about the opportunity and on edge because of the past history of violence linked to desegregation. All of us gathered in Baltimore at one of the Public Health Service facilities there. The leaders of the three-day training program were very impressive. The training program was remarkably well organized.

GM: What was the charge they gave in terms of going to the South? What were you told to look for or do?

JR: The Public Health Service picked one hospital for each pair of public health service examiners. Our job was to help the hospital to desegregate all its facilities: clinics, hospital beds, outpatient clinics, and facilities for employees. We were going with partners. I had a partner from the Public Health Service who was a career Public Health Service officer and the two of us went together. During the training program, we went through mock interviews with make believe hospital officials to give us a good example of what we might expect.

GM: Were you taught to also interview the public at large outside of [hospital] customers?

JR: The Public Health Service had silently recruited hospital employees and neighbors of the hospital to help us get a full idea of what the segregation was all about in that particular hospital. We needed to get a fuller idea of what the real facts were so that when we got through with our visit and demanded of them improvements, we would have a very clear idea what they were doing and therefore be able to negotiate with them details of some of these changes.

GM: Were you told not to tell them that you were from the government or give that kind of information?

JR: My impression was that we came with government credentials, and they knew we were coming. We didn't give long notice; we gave them short notice, but they knew we were coming.

GM: So where were you actually assigned?

JR: My partner and I were assigned to a large hospital in West Virginia. It was the largest medical center in the area. The people at the Public Health Service headquarters had done their homework. They had

spoken in great detail to employees of the hospital and other people associated with the hospital. On the first day when we were in the area, we didn't go to the hospital, we went to visit these scouts. The scouts were employees of the hospital we were going to. They sat down with us and told us everything we would need to know about how the hospital was run, what was segregated, what wasn't segregated, how patients would be handled, how employees were handled. They were courageous people because they if their employers knew what they were doing, they could have been fired. Others at the hospital in the early 60s may have considered them traitors. For us, it was a little bit scary because the school desegregation was really associated with violence. We were nervous but we were determined to make it. We were a little anxious for the same reason the feds were anxious. Those courageous scouts shared information with us about what to expect at each hospital.

GM: What was the status of the areas where the African Americans were allowed to be? Were they up-to-date or were they out-of-date? What was the status?

JR: The hospital I went to had one dining room that was racially mixed, but a very large fraction of the African American employees ate in a separate dining room in the basement of the hospital. When we were given a tour of the hospital, they showed us the mixed dining room. I said, “Yeah but how about the cafeteria in the basement?” Oh, they didn't know we would know about it. A similar thing took place with hospital beds. Some wards were integrated but other wards were segregated – but because we had been touted so well in advance, we were able to point out facilities that were not meeting standards. We could demand of them that they would need to change. We began to negotiate the desegregation of the beds, the cafeteria, the parking lot, the emergency room, outpatient clinics, whatever facility it was. The care for African American patients had to be in same location and the same level of care as whites. The Civil Rights Act outlawed separate but equal, and the hospitals had to outline the plan to make their hospitals equal.

GM: Were there many Black employees who were serving the patients?

JR: The Black employees were interspersed with the White employees but if it was an all-Black facility, it was clear the ratio of Black to White employees was much higher.

GM: So, did the hospital change? Are you aware that they did respond and desegregate?

JR: My partner and I were lucky. We went to this one large medical center where the chief of the hospital understood that the federal government meant business. He was extremely alert to everything. He quickly launched everything we requested. He was also keenly aware of the political situation in Washington. He was all eyes and all ears and taking notes, and once we said, “Yes, but how about—" he jumped right in. He didn't try to deny anything. He seemed to recognize that things were going to have to change. So, we worked with the hospital going over all the details of how they were going to desegregate each offending unit.

The leaders of the hospital were very responsive to our demands. They seemed to recognize that times had changed. The hospital would need to change too. Some of the other Public Health officers weren't so lucky and met much more resistance at their hospital facilities.

GM: Yes, in my reading I found that that the federal government took a very strong stance and followed through on this whole thing because the earlier attempts of desegregation had not been successful.

JR: I agree with you, but I think that it was not just desegregation. In almost every area where the federal government started to institute change, the clients out in the provinces had to make up their minds whether the government really meant business. How much energy, effort, and money, the hospitals should spend to meet the federal government's demands.

GM: But you didn't go back to the hospital to evaluate changes.

JR: My job was interesting. For whatever reason, I was not sent back multiple times to my hospital, but others of the team were. You have to remember, the number I had in mind was a little under 100 Public Health officers who went South. You had a larger number—but a lot of them did go back and a lot of them really spent time negotiating because some hospitals were more resistant. I was lucky. The medical center that I was sent to was respectful of what was expected and took desegregation seriously.

GM: Was West Virginia less rigid in their Jim Crow stance and was their activity against Blacks less severe than in the deep South?

JR: I think that West Virginia, being in the northern tip of the South, was more prepared to change. Also, we have to remember how West Virginia evolved. West Virginia broke away from Virginia over issues of slavery, so I think that we were in an area that I and my partner felt was more open to progress than, for example, some of the others who went to Vicksburg or other places deep in the South, more heavily entrenched in segregation.

GM: So that doesn't surprise us. But I was wondering if you could see the difference in your activity versus that of some of the others. Apparently, you could. How long did you stay in the office in the Public Health Service, and did you go to more hospitals after that?

JR: About six weeks.

GM: And then you went back to NIH? So, your total role there lasted only about two months.

JR: Correct. Our lab members were pioneers and innovators in this area. I believe that our young colleagues were also awarded recognition for these achievements.

GM: And then what did you do in NIH after that?

JR: I also had modest clinical responsibilities that were linked to our research on cell surface receptors for insulin and other hormones. Overall, we worked very long hours in the lab and in the clinic, studying cell surface receptors – especially receptors for insulin. By then, we had shown that most receptors for most hormones and other intercellular messengers were on the surface of the target cells.

GM: And writing papers, I'm sure.

JR: Oh yeah, we were, and in fact some of the papers in those first couple years became citation classics where they were cited so often in the medical literature that they were given special recognition.

GM: I'm not surprised. You were right at the beginning and had the opportunity to truly develop the whole area. That was good. How long then did you stay at NIH?

JR: A little over twenty-seven- or twenty-eight-years total, starting in 1963 and closing in 1991.

GM: That's all? What caused you to leave there?

JR: The main force for my leaving was when my children reached college age – I was going to need tuition for our three children. If I retired from the Public Health Service, I would collect a generous pension that would cover their tuitions. If I stayed at the NIH, they wouldn't allow me to collect my pension, even though it was legal in retrospect that we could, but they wouldn't let us.

GM: So, you were in the Public Health Service all that time?

JR: Yes, I stayed in the U.S. Public Health Service for a very long, enjoyable, and stimulating stretch of time.

GM: Then you've had a lot of other activities since you left NIH. Tell us about them.

JR: After the desegregation of hospitals, my NIH colleagues and I joined with other healthcare professionals in the area to improve health for the impoverished families of Washington DC. One of the

areas that I worked at was the federally sponsored Head Start program, which was just beginning. It provided an enhanced education for preschoolers from impoverished families. I volunteered to be the pro-bono physician for all of the Head Start programs in Washington. There were about two dozen Head Start branches within Washington. Hiring a physician and nurse would have eaten up a lot of the Head Start budget, so we volunteered to do it pro bono. My colleagues and I did all the examinations and lab work that needed to be done on all the children. We also volunteered to do many of the follow-ups.

GM: Well, that was very generous. You were truly social activists at that time, having come through the previous experiences.

JR: There was a whole group of social activists at NIH. We were joined by volunteers of the Bethesda Naval Hospital, at Walter Reed, and at the three universities' medical schools in the Washington area. Each of them had volunteers that came and each of them kind of did different things.

Another example was Anacostia, a region in Washington away from the center. They had very poor public health facilities, so a group of our volunteers set up a night clinic that met once a week. The patients' demands for care grew so that within a couple of years, the Health Department of Washington DC government took over full time.

Let me give another example. A group in rural Alabama was bringing a suit against the U.S. Department of Agriculture because their rules for obtaining food stamps and other kinds of help from the Department of Agriculture was so meager compared to others. At the request of the Alabama farmers, we organized a nutrition survey along the Alabama citizens. We got nutritionists from universities to come help us and we put together a report complaining about what the U.S. Department of Agriculture was doing and submitted it as part of a demand for better participation by the Alabama State Department of Agriculture and the U.S. Department of Agriculture. Those are the kinds of things we would do pretty regularly. All work was done by skilled volunteers, and it was a very energized group and worked well.

GM: That's exciting. What else did you do in terms of your professional life from that point on? For example, you went to Hopkins as head of geriatrics.

JR: When I left the NIH, I moved to Johns Hopkins. I was head of geriatrics there. But even before then, when we were still at NIH, in the summer of 1965, the residents of the Watts neighborhood in Los Angeles shocked the country with civil disobedience associated with large amounts of property damage and mass arrests. After what happened with the Newark and Baltimore riots in 1967, it became clear that there might be civil disobedience every summer in the impoverished areas of the cities. We looked around to see who was getting ready for the civil disobedience that might afflict Washington. Our group (the Medical Committee for Human Rights) decided that we would get ready to do everything that the other people weren't going to do. We were prepared to fill in the missing spaces and thought of all the things that might happen or be needed during those periods of civil disobedience. We got together a group of physicians and other health professionals from the DC and Bethesda area and recruited them to the Medical Committee for Human Rights. We recognized that the hospitals would be prepared but

we thought of what other health needs would arise that the hospitals were not organized for. Our worries became real sooner than we expected.

In the spring of 1968, Martin Luther King was shot and killed in Memphis. It was a Thursday night when the news came in. I, and my partner, Sidney Wolf, who was my co-chairman of the Medical Committee for Human Rights in DC said, "Wow, what's going to happen?" The next morning, instead of covering the events, the news media decided to hold back as much information as possible. That was the policy in those days of civil disobedience: the newspapers tried to hush it up so as not to encourage non-participants to become participants in the riots. That Friday morning, we tried to find out what was going on and we couldn't. Sidney and I, the two co-chairs, went to the top of the NIH main building, which was fourteen stories high. We could see a lot of smoke coming up out of Washington. So, we said, "Okay, let's go look." We got in our car and drove downtown. We didn't have to go far, because in fact, the roads leaving Washington were filled with people evacuating the city. The workers were going home early because civil order was disintegrating. We got to the first police station that we knew of where we could get the news. There were many, many fires, and thousands of people had been arrested. We knew that when you jail thousands of people, the government officials probably weren't going to be prepared to provide medications or food for the prisoners. So, we jumped into action with a plan we had in advance.

As soon as we got back to Bethesda from Washington, we called up our group and told them to meet us at Henry Metzger's house at 5 o'clock with your white coat and your black bag. From there, we went back to Washington and convinced the police to let us into the jails so we could take care of the many medical needs, including medications and modest wounds. The other thing was that the jails weren't prepared to feed thousands of people, so we called up the headquarters of the biggest retail grocer in Washington and they said for us to come to their warehouse and line up our station wagons. We went to their wholesale supply areas and loaded up with food to bring to the jails. So, we were able to help feed the people who had been arrested, as well as provide some medical needs. We got the telephone company to give us emergency telephone lines, we were able to get private healthcare deliverers to make themselves available for emergencies. The hospitals were fully geared up to handle their end of it, so our responsibility that we assigned to ourselves was to take care of those areas that the hospitals and medical centers didn't have covered. For several days, we were supplying the missing pieces in the healthcare area.

GM: You were an activist in that role in that area as well. That was very good. That was a very uncomfortable period of time in many communities. I remember it.

JR: In 1969, we published a paper in the New England Journal of Medicine describing the things that we were successful in doing during the civil disorder.

GM: That was very good. When did you become Assistant Surgeon General of the United States?

JR: I spent twenty-seven plus years at NIH and retired as an Assistant Surgeon General of the United States, a rank I held for several years prior to retiring.

GM: Were there social implications of being in that position?

JR: Not really, though the medical staff at NIH in general was sensitive to these issues. There were attempts, and successful efforts, to promote more members of minority groups in professional tracks in medicine and create more equality between men and women. The women at that time, if you recall, were being promoted very slowly and their opportunities were only slowly developing. So, in those days you could see the beginnings of a momentum to provide better opportunities for everybody, more equal opportunities. I think that those of us who were in the upper echelons of the Public Health Service, especially at NIH, were very sensitive to that issue.

GM: Do you think that all your efforts accomplished a great deal in terms of equity in the South?

JR: Well certainly the hospitals were desegregated, and the medical schools became much more sensitive. Throughout my time at the NIH, I saw opportunities being continuously but slowly expanded. It all happened much more slowly than we thought it deserved, but it has been very real. Nowadays when you go to a medical school or university, the number of deans, professors, and leading scientists have many more minority members and women than we ever dreamed of when we were young professionals.

GM: Right, that's right. It truly has changed over this period of time. I just wondered whether you felt you had contributed to that?

JR: I think we do feel that we contributed to every one of these things that we see. We feel, “Oh yeah, we were there.” Sometimes we had no visible effect then, but I think we all felt this move and the physicians and other healthcare workers were in general very forward-looking, very much willing to experiment and move things forward.

GM: With all this activity did you ever find yourself in any dangerous situations, any threats to your well-being?

JR: The most dangerous thing that I can think of was when I started in the Head Start program in the mid-1960s, Washington DC was a very segregated city and parts of it were very impoverished and also high in crime. I remember going with my then fiancé, who was a teacher and soon to be my wife, to visit homes at night in tough areas. Looking back retrospectively we were careless about our own personal safety, but I think I can't remember a time when I really honestly felt dangerously at risk.

GM: Okay. Anything else you want to talk about in your whole scheme of things because you've been a major contributor?

JR: I think that the volunteer movement has diminished in many areas. Two things happened with professionals: the young people became less interested, but also the people who started as volunteers then became full-time professionals. Instead of volunteering part-time as we did, they became either full-time or no time. So, the role of the volunteers diminished a great deal over the last couple of decades. That's what we need to do is to try to rebuild that spirit of volunteerism and support it, starting with part-timers.

GM: That's interesting. I certainly thank you for this interview. You've taught me a great deal and I learned a lot about your contributions in medicine which are obviously forever standing and forever used and looked at by scientists. I thank you and I'm grateful to you for this contribution.

JR: Let me thank you very much, Gordon, for doing this because there's no question that young volunteers get inspired—if they're on the fringe of volunteering and don't think about it, but if they see past examples of where people did it at an earlier age, it gets them stimulated and lights the fire for them in the younger generations.

GM: You're truly a role model and you will be looked up to for generations.