Richard H. Schwartz, MD

Interviewed by
Russell Libby, MD

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PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

Russell Libby, MD

Dr. Russell Libby is the Founder and President of Virginia Pediatric Group since its inception in 1982. He was raised in the Washington, DC area. He received his Bachelor of Science in Zoology and his Doctor of Medicine at George Washington University and completed his pediatrics residency at Georgetown University Hospital.

Dr. Libby has been active in helping doctors evolve the tools to work together more effectively and is a founding director and president of HealthConnect IPA, a primary care Independent Practice Association. He is chief of general pediatrics at Inova Children’s Hospital and a member of the hospital leadership committee. Dr Libby has been named best pediatrician in the Washington area by Families magazine for more than 20 years and is consistently listed among Washingtonian’s and Northern Virginia magazine’s top doctors. He spent many years hosting educational television shows on medicine and healthcare, and was the host of a weekly ABC radio show in Washington. He was the lead editor and contributing author of Guidelines for Pediatric Home Health Care published by the American Academy of Pediatrics (AAP) and has authored numerous articles, chapters for books, opinion pieces for national media, and major policy statements for both the Medical Society of Virginia and the AAP. Dr Libby is past chair of the AAP Section on Home Care and a past member of the AAP Committee on Child Health Financing. He has been President of the Medical Society of Northern Virginia and was President of the Medical Society of Virginia in 2012-2013. He is a delegate for the Medical Society of Virginia at the AMA and is a Board member of the Physicians Foundation.

Dr. Libby feels it is his privilege to be a pediatrician and to have the opportunity to work with children and their families. He has three grown children and resides in Northern Virginia with his wonderful wife and dog. In his free time, he enjoys skiing, playing guitar, and creating stained glass art.

Dr Libby has had a collegial and friendly relationship with Dr Schwartz for over 35 years, dating back to his pediatric residency years. They have worked together to help grow a world class children’s hospital in their community.
Interview of Richard H. Schwartz, MD

DR. LIBBY: This is an interview of Dr. Richard H. Schwartz conducted by Dr. Russell Libby on July 1, 2016, in , Virginia. This is a very special interview with a VIP or a very important pediatrician. The American Academy of Pediatrics has developed a video archive of individuals who’ve made a special difference in the field of pediatric medicine. It’s called the oral history project. It’s a committed effort to preserve and document the rich heritage of pediatrics.

In an interview format, we get the story and personal insights from an individual who has gone far beyond the standard of providing high quality care to patients and communities and has made significant contributions to the composite knowledge and evolution of the practice of pediatrics.

Our interview today is with Dr. Richard Schwartz. He is a practicing primary care pediatrician who has done evidence-based research on a wide variety of clinical topics and has translated that work into meaningful improvements in the art and practice of pediatrics. He has published nearly 350 articles, textbook chapters, and other sorts of professional writing over his career and he continues with that output to this day. He’s also been an inspirational teacher and mentor to countless medical students and residents. Above all of these professional achievements, he’s most highly appreciated for his compassion and expert care of his patients and their families.

In this interview, we’ll learn about Dr. Schwartz, his background, his motivations, his professional career and significant achievements, as well as his thoughts on the current and future state of medicine.

So, Dr. Schwartz, it is an honor, it’s a pleasure. So good to have you here. When we go through the process of understanding who these great contributors to pediatrics are, we really start with where they came from. So, I want to ask you a lot of personal questions to start.

Where were you born and what was it like growing up where that was?

DR. SCHWARTZ: I was born in Brooklyn. My first memories were, maybe, when I was 3. At that time, we lived in a changing neighborhood that changed from religious Jewish to African-American. The first house I remember living in was my grandfather’s house. And my mom and dad were there. I think we were the only white family on the whole block, so it was a
different kind of arrangement. And, of course, all my little friends were African-American. No prejudice. We didn’t know and we got along just fine.

DR. LIBBY: So, it’s an interesting changing dynamic. Certainly, who knew how the face of America could change from those early immigrant years when second generations were all coming in. Your dad, was he involved in health care or medicine?

DR. SCHWARTZ: No.

DR. LIBBY: What kind of work did he do?

DR. SCHWARTZ: Varied. When I was growing up, he was a linotype operator. Linotypes were the people who did the printing, but they had to do it by lining metal bars and forming letters, then matching the letters so that they could print out on a sheet. Very, very detailed work. Work that no one does anymore — at least in this country. So that’s what he did. Now, noone in our house knew anything about lead poisoning in that day, but I promise you, my dad was bringing home a heck of a lot of lead.

DR. LIBBY: I wouldn’t be surprised. Sure. I think those cuniforms, those little letter pieces, were often made of that.

Your mom, did she work or was she a traditional mom?

DR. SCHWARTZ: No, she was a housewife until much later on when my dad had some business reversals, but not as a linotype operator. She went to work as a salesperson for a mattress company or a chair company. And then, she went into the yellow pages.

DR. LIBBY: Interesting place, too. Did you go to public schools in Brooklyn?

DR. SCHWARTZ: Yes. Didn’t everybody?

DR. LIBBY: Yes, I guess that was the case back then.

DR. SCHWARTZ: Private schools? We didn’t know from such things.

DR. LIBBY: Of course.

DR. SCHWARTZ: It was Public School #217.
DR. LIBBY: Right. So, you went through elementary, middle, and then high school. And it was a reasonable experience? It certainly gave you a basis of education from which you certainly were able to launch a great career.

DR. SCHWARTZ: Yes. I have good memories, yes. I wasn’t on any football or any other teams, but I managed to do okay.

DR. LIBBY: And you ended up deciding you were going to go to college. Was there ever a question?

DR. SCHWARTZ: No, really not. It wasn’t which school. It was just go to college.

DR. LIBBY: And where did you end up going to do your undergraduate?

DR. SCHWARTZ: Well, it was 2 different schools. One was New York University. I was living at the time in New Jersey and I’d commute from northern New Jersey into Manhattan. I went to downtown NYU. That was for 1 semester of business, and it didn’t take me very long to decide that that was not for me. I hated it, at least the courses. So, then I transferred to premed, and that was also at NYU, but uptown. I used to hitch rides from New Jersey to New York. One of the people who took me up — at that time it was a lot safer where there was no such, “Oh, you can't do that.” Just a thumb and a will.

DR. LIBBY: You couldn't do it now to be sure.

DR. SCHWARTZ: To be sure. He mentioned a brother or son, I don’t remember, who went to George Washington University. He said it was a really good school and that it wasn’t difficult to get into medical school from that college. I said, “Sounds good to me.” So, my dad and I took a drive down. We looked it over. We liked it. It, fortunately, liked me. I was accepted and there I went.

DR. LIBBY: So, that was for medical school?

DR. SCHWARTZ: No, that was for college.

DR. LIBBY: You finished undergraduate there, as well? So, you ended up moving to [Washington] DC and went to undergraduate school at GW in a
science curriculum, I guess?

DR. SCHWARTZ: Yes, it was.

DR. LIBBY: And then, you applied to medical school. You went to GW, as well?

DR. SCHWARTZ: I didn’t get into the medical school. I didn’t do well in physics. It was a little bit better in organic chemistry, but not that much better, so that I was a question mark. No, I didn’t make it the first time. At that time right after college, I was married, and my wife and I went to Chicago because they had a state medical school. But maybe 2 months after we moved, I was accepted to medical school, one of them being Georgetown University School of Medicine.

DR. LIBBY: OK.

DR. SCHWARTZ: Why they did it, to this day I still don’t know; but they did, and I finished, and that was fine.

DR. LIBBY: So, you ended up coming back to Washington and went to medical school at Georgetown University? That must have been a great experience.

DR. SCHWARTZ: Well, I was scared to death because of not getting in originally. I said, “Oh my God, this is really going to overwhelm me.” But I persevered. I did a little praying. I said, “You get me in, keep me in, and I’ll make sure that I do the right thing.” So, that was always over my head.

DR. LIBBY: I do think that medical schools do make that commitment to their students, and their students, certainly, are expected to make that commitment back.

That’s a great story and not atypical for the time. I think that there were a lot of applicants for a much more limited, let’s say, selection class. It was not unusual for people to go out of the country or to find some other ancillary direction in health care, but I’m glad you persevered.

DR. SCHWARTZ: Me too.

DR. LIBBY: Tell me a little bit about what you experienced while going through medical school. Obviously, that first year was a little bit intimidating.
DR. SCHWARTZ: It was. Although I know a lot of medicine, it took a lot of studying to learn that medicine. So, I would walk around with anatomy cards or whatever. Basically, my life was studying. Rose Lynne, my wife, had a weekend job and a weekday job, but the weekend job was at GW. She was in one of the offices of the hospital, a nursing office. I would drive down with her from where we were living in northern Virginia. I’d use the blackboards of an unused classroom and go over all the things, just over and over them, like you were doing when you gave the introduction, until I got it in.

DR. LIBBY: It was a time when they had a fairly traditional curriculum. It was a standard preclinical for the first 2 years. And then, you were thrust into the clinical curriculum. Was that redeeming for you? Was that really a great evolution? Were you looking forward to that? Were you thinking of academic medicine from the beginning or did you want to practice?

DR. SCHWARTZ: No, I was thinking of graduating, to tell you the truth. There were things right away I knew. I was not going to be a surgeon. So, we got that off the list very, very quickly. And I knew I wasn’t going into OB/GYN, and thousands of ladies just said, “Hurrah,” because they didn’t have to have me deliver their babies again. [laughing] So, it came down to the fact that I had a great experience with a wonderful pediatrician at Bethesda Naval Hospital [National Naval Medical Center in Bethesda, now, Walter Reed National Military Center, Bethesda], Dr. Margileth, Andrew [M.] Margileth. He was the head of pediatrics at Bethesda Naval Hospital at the time. He retired from there from the [United States] Navy and he went to DC Children’s Hospital [now Children’s National Health System]. When I saw his name there, I said, “Oh my goodness, look at that.” I had such a great experience at Bethesda Naval, I said, “I’d like to do this. I like to work with kids. I have inspiration. I have a mentor.” I said, “That’s what I’m going to do.”

DR. LIBBY: Wow! Andrew Margileth. I didn’t realize that he was someone who really would have been a mentor for you.

DR. SCHWARTZ: Oh, goodness, 1964 was the height of the rubella epidemic for congenital rubella syndrome, and we had so many babies from Bethesda.

DR. LIBBY: Right. And he’s a fascinating clinical researcher as well.
DR. SCHWARTZ: Yes.

DR. LIBBY: So, did he have a significant influence on your perspective for your career and how you developed that research niche?

DR. SCHWARTZ: Well, possibly, because we had to do a little project. It was kind of a research project or a review project. At that time, I read an article on boric acid poisoning in babies. They used to use boric acid for eye wash and different things. Children would get into it or parents would get it mixed up with the formula or with sugar. They’d put it in and the babies would get seizures and kidney poisoning. So what I did was I experimented. Boric acid was often used to wash baby diapers to get out the smell. So, we washed baby diapers in the boric acid and we tested them for boric acid residual after the diapers were washed and went through the drying cycle. We found that this qualitative — it’s called a turmeric paper, spiced turmeric — turns a purple color or something instead of yellow if boric acid is there. So, I presented a little paper and Dr. Margileth said, “That’s very good. That’s very good. Very few people do any research projects for this. That was a real one.” So, that spurred me on.

DR. LIBBY: I bet it did. Dr. Margileth was truly a master of the edge, I know, in tuberculosis, diagnosing even mycobacteria.

DR. SCHWARTZ: Cat-scratch fever [cat-scratch disease], cultures in laboratories. He was.

DR. LIBBY: What a great mentor. So, I would imagine that gave you great inspiration, gave you great confidence in going forward into pediatrics, too.

DR. SCHWARTZ: It did.

DR. LIBBY: What is it that really attracted you to pediatrics?

DR. SCHWARTZ: Kids are fun and they’re fun to take care of. They can be awfully, awfully sick, but I felt most comfortable doing that. It was between that and dermatology, and with Margileth, pediatrics won out easily.

DR. LIBBY: I would imagine it did. So, that would have been that whole evolution there. And, of course, I think in those days, working out at the Naval Center or Walter Reed or any of those places, the access to patients was pretty
dramatic. You had a real opportunity to be a doctor even before you were a doctor. And you had a very cooperative core of patients there. It was a nice place to learn.

DR. SCHWARTZ: Yes, it was.

DR. LIBBY: It really was. So, you then went and did a residency?

DR. SCHWARTZ: Well, no. That senior year in medical school was the time of the Vietnam War. You could sign up for the services, whichever one you went into, paying for your senior year as a second lieutenant. And then, most people were kind of given, not an ultimatum, but you had to go into the services to take your first year, which at that time was a rotating internship. So, I did that. After that, they gave 1 year to you as your choice. You could go work wherever you wanted to go, as long as they had an opening. I said I’d like to go to Europe and I’d like to go to a big city. So, the godfather or the good fairy came and gave me my wish, and we took our family to Europe. It was as far away from Vietnam as you could go, other than here. But anyone who stayed in the United States after that first magic year had to go to Vietnam. If they went to Alaska, if they went to Hawaii, if they went to California or even Walter Reed, they had to go to Vietnam. Because Berlin was an occupied city, it was considered still almost like a combat zone because we were 110 miles inside Eastern Germany and surrounded 100%. It was an island surrounded by East Germany. They didn’t take anyone from Berlin and bring them to Vietnam, unless they volunteered to do so. I did not volunteer to do so and I stayed there the whole 3 years.

DR. LIBBY: And then you came back.

DR. SCHWARTZ: And then I came back and started in with the pediatric residency at Children’s.

DR. LIBBY: So, you were here in DC at the old Children’s Hospital?

DR. SCHWARTZ: Correct.

DR. LIBBY: And that was really at a very early time. So, you were with Dr. Margileth, who was interested in infectious diseases. And then, I guess, at that time there was really just sort of the seeds to grow that specialty in pediatrics and you were probably around Children’s at the time that was happening.
DR. SCHWARTZ: I thought the teaching was excellent. The patient population was somewhat difficult, but we saw all kinds of things. I mean, the first week I was there, there must have been 4 or 5 children with lead poisoning, bad lead poisoning because of the summer. The sun would bring out the lead from the bones, and they would become very, very symptomatic. All that stored lead they had, a lot of it was mobilized because of the sun, just like vitamin D and calcium. They would have seizures and stomach problems and just a lot of different things.

DR. LIBBY: I guess that’s where some of the knowledge and the treatment approaches started.

DR. SCHWARTZ: Well, Baltimore, and big specialists in Baltimore, and in Children’s.

DR. LIBBY: So, those were days when you spent most of your time in the hospital.

DR. SCHWARTZ: Many, many days.

DR. LIBBY: Many, many days.

DR. SCHWARTZ: It was, I think, every third night. Except when you were in the intensive care nursery, then it was every second night.

DR. LIBBY: Isn’t that special?

DR. SCHWARTZ: By the time you drove home half asleep or sometimes fully asleep, you would hit the sack. You didn’t have energy for anything. And then you’d wake up the next morning and start all over again.

DR. LIBBY: So that was a pretty special time with the neonatal intensive care unit, the NICU, because it was really going through a transition in terms of how they could care for those babies.

DR. SCHWARTZ: Yes, hyaline membrane disease. It was evolving from bicarbonate and the Usher Regime into real science. A lot of things were happening in the nursery, the neonatal nursery. New things all the time — hyaline membrane disease and hyperbilirubinemia and giving the mothers glucocorticoids before delivery to build up the baby’s surfactant. Many, many changes.
DR. LIBBY: Those were the days when it went from a baby couldn’t survive at 32 weeks to when babies were starting to survive pretty regularly there.

DR. SCHWARTZ: Yes, down to 26 weeks when I left, yes.

DR. LIBBY: And the ventilators were being accommodated to the small lungs and really a dramatic, dramatic evolution. And the NICU is a place where you learn medicine.

DR. SCHWARTZ: Physiology.

DR. LIBBY: You see physiology happening before your eyes. It’s a great experience. So, that was an area where you spent a lot of time working and you learned a lot.

DR. SCHWARTZ: That frightened me because that was really over my head. That and the intensive care unit, which was very small, like, 6 to 8 beds at that time. But, yes, the little babies were tough, and you couldn’t afford to make a very bad mistake. You were on with maybe somebody 1 year above you, but that was it. There were no full-time attendings. They had to be woken up from sleep. They weren’t very happy about that. And then, for them to come in, it had better be a good reason.

DR. LIBBY: Twenty-eight week triplets or something like that, right?

DR. SCHWARTZ: Oh, goodness, yes.

DR. LIBBY: Those were times when you could be under duress for sure, and a lot of note writing, a lot of calculating. You didn’t have computer programs. If you had a slide ruler and a calculator you were lucky. Good times.

DR. SCHWARTZ: Yes.

DR. LIBBY: During that period of time, you started to develop some interests in pediatrics that sort of formed your future direction. Tell us how that happened.

DR. SCHWARTZ: Well, I liked outpatient very much. That was something I had a good feeling for. I had done some in the military service. I volunteered for outpatient pediatrics, and they allowed me to do that, even though I was not a pediatrician. I just thought it was a lot of fun without
going through a heck of a lot more training. Then my third year of training, I could have gone out after 2 years of pediatric training at Children’s, but I spent an extra year, as did 2 or 3 of my graduating class. I went into child psychiatry, not to go into that as a career, but to give me an extra year of mental health, which turned out to be a very wise decision. I didn’t have any employment choices at that time, so it was a question of what I was going to do now, and that opportunity came up. It was a funded program that is no longer in existence, and I’m very, very grateful that I had that opportunity.

DR. LIBBY: At the same time, you had a significant interest in infectious diseases. Was that starting back then?

DR. SCHWARTZ: It was. I would hang around the bacteriology laboratory. Dr. Margileth, after he learned that I could really read and took an interest in reading his culture plates when he wasn’t there early in the morning, elected me to be the person he trusted to read them. It must have been thousands and thousands because I got so good at it. And, yes, those things helped propel me into trying to answer some of the many, many questions that hadn’t been answered.

DR. LIBBY: That was a time where I would think that probably the majority of residents, as they graduated, went into primary care, not necessarily into a subspecialty.

DR. SCHWARTZ: Yes. I don’t remember how many it was, but by far most went into primary care.

DR. LIBBY: Was it a question for you? I mean, were you thinking that maybe you’d do neonatology?

DR. SCHWARTZ: No. [laughing] Lucky for the babies and lucky for me, no.

DR. LIBBY: Or that maybe you would go into an infectious disease track? I don’t even know if there was a subspecialty at that time.

DR. SCHWARTZ: There was. It had taken off just a little bit before my time, but there was. Dallas, Texas had a great big program, [Heinz Felix] Eichenwald and [George H.] McCracken and John [D.] Nelson. Around the country there were people who started to specialize. 
DR. LIBBY: There were Bill [William J.] Rodriguez and Itzhak Brook and all those folks who ended up at Children's, so those were people I’m sure you worked with through that period of time.

DR. SCHWARTZ: Yes, they were.

DR. LIBBY: So, you decided to go into primary care. You decided to stay in the Washington area. You said you were living in northern Virginia, so that was a natural place for you to go.

DR. SCHWARTZ: Correct.

DR. LIBBY: Tell us a little bit about moving into a private practice. What was the situation?

DR. SCHWARTZ: I answered an ad in the newspaper and the ad was the first place that I joined the practice group. There were 2 of us, 2 people. One had finished at Georgetown at the same time. Raoul [L.] Wientzen and I. We started together along with 2 more senior people, Ron [Ronald G.] Barsanti and Robert [J.] Knerr. I spent 28 years at that practice. And due to a combination of my mouth and their distaste for what I was saying — not those 2, but people who came in — I was kind of asked, “Okay, it’s time for you to go.” [laughing]

DR. LIBBY: We can get right to that, but I want to hear a little bit about practice at that time. I think it was a different world. We didn’t have pagers. We didn’t have cell phones. We didn’t even have a pediatric emergency room. And a lot of what we did was literally at the response of patient calls. So, it was a pretty arduous endeavor.

DR. SCHWARTZ: Yes, it was difficult because it was a very busy practice, so we had to be productive. I’m sure as an average I would see 30 patients a day. In the winter during flu season, 40 to 50 patients. So, it was a long day with very little break time or no break time. We also were open Saturday and Sunday. The Saturday was supposed to be a half day, but in the winter, it turned out that you went home at 3:00 PM. You had to make hospital rounds. You had to read the cultures. You had to call people back when they called an answering service, and they gave you 10 or 15 or 20 calls. By the time you finished that, they’d have another 20 calls. And all day long we’d be juggling seeing the patients, answering the phone from the hospital, calling people, and then setting up an appointment and seeing them later on.
in the day, even after you went home. It was a long, long weekend.

DR. LIBBY: It was a true commitment.

DR. SCHWARTZ: You had no choice.

DR. LIBBY: You had no choice. That’s right. It was your entire life, and that’s how you had to live it.

But during that time you also developed some interest in research. We’re going to talk a lot more about the kind of research you did, but you were talking about a relationship in a practice that went through a period of time where there was some turmoil in the payer community. Obviously, when we started off in practice, it was fee for service, and it was a basic contract between you and the patient. All of a sudden, in the 1990s, we started to see this incursion of another beast, the insurance company that seemed to put itself right in between the 2 of us, the patient and the physician. Is that a time when you felt things were changing in terms of your practice?

DR. SCHWARTZ: I took it pretty easy. The older 2 did not. It bothered the senior person Ron Barsanti a lot. He never passed or took his pediatric boards. He was an excellent pediatrician. He was always afraid of 3 things, one the insurance company and not being accredited and with his own patients, his own practice that he built up; the second from the hospital; and the third from lawyers. If he was ever sued and they hammered home, he was a non board-accredited pediatrician. He said he didn’t want to go through that experience. So, that was really, really hanging over his head. He retired early.

DR. LIBBY: Is that what cemented his retirement?

DR. SCHWARTZ: Well, he retired, I think, at 58 years old. And one of those 3 things were what, I think, impelled him to leave earlier than he probably would have otherwise.

DR. LIBBY: But you grew a practice otherwise. I mean, there could be no better place to practice than northern Virginia, as it became such a burgeoning county out here where you had lots of people moving in for any variety of reasons. But it seemed to continue to grow, and there were lots of young families. So, your practice did very well.
DR. SCHWARTZ: It was a fine place. One of the things that I did on my own from that point of view was that I was the point person for the managed care. New York Life [Insurance Company], HealthPlus [Insurance Agency, Inc.] or something.

DR. LIBBY: “Mild care,” as they called it. [laughing]

DR. SCHWARTZ: Right. I got information and I was able to translate that into the pluses and minuses in comparing and interviewing with different groups. Otherwise the practice would have dragged their feet and the practice would have waned down. They went in earlier than they probably would have. It couldn’t sustain itself without managed care.

DR. LIBBY: So, there was an evolution in that you were talking about what happened with you and your practice where there was a parting of the ways of sorts. You were saying you were 28 years into practice at that point.

DR. SCHWARTZ: Yes. I was 60.

DR. LIBBY: So, many people would be thinking, “Well, I’ve sort of lived out this career.” But that’s not what happened. So, give us a little perspective on what went on and what you ended up doing.

DR. SCHWARTZ: I didn’t want to retire. A retirement would have been the early death of me — at least that’s what I felt. I was contributing. I taught. I had published a lot by then. I had a lot of contacts all around the country. And I had people who worked with me who came with me, so I didn’t have to start from scratch. We had about 550 families that came over. We found another site at the other end of Vienna and we started our own practice. I had the lab tech who was also the research coordinator Mary Margaret Thorne, and my head nurse Lori [L. (Griffin)] Schubert, and some of the people from the business office and several nurses. So, I really didn’t have to start from scratch. I had a dedicated cadre of fine people who knew and trusted me and threw their lot in with me.

DR. LIBBY: And you were used to hard work, so that wasn’t the question.

DR. SCHWARTZ: I can’t say every day I’m smiling; but yes, I was used to hard work.

DR. LIBBY: It makes a difference. You know what it takes to make it
successful, and so I know that you’ve done that again. So, evolving in 2 spheres professionally is not an easy thing to do. But by the same token, you have excelled at something else that most people have a hard time even grasping, which is doing clinical research, incorporating your patients and your environment into the work that you do in a way that can help reveal important information that helps to advance the field.

DR. SCHWARTZ: And luck. You have to have a lot of luck.

DR. LIBBY: Luck is huge, yes.

DR. SCHWARTZ: The first project was on ear infections. It might be before your time that we had all the textbooks and all the teaching for residents stating that for an ear infection, you start with penicillin after the age of 5. You use an ampicillin, or amoxicillin later on, until 5. Because a germ called Haemophilus influenzae was never found or so rarely found after the age of 5, you could switch and treat predominantly for the major pathogen called, Streptococcus pneumoniae or pneumococcus. At age 5, that was the going thing. I started doing a lot of what’s called ear taps or tympanocentesis and I said, “I’m finding a lot of Haemophilus influenzae in older children. Something is wrong here.” We wrote up our information, and it was published in the Journal of American Medical Association [JAMA], a very prestigious journal. That was my very first publication. I was senior author. People said, “Oh my God, how did you ever get published in that?” I loved that I contributed something to the field. In that small way, I changed the way pediatrics was practiced and taught. Now, you never see anything about changing at age 5 or at any age.

DR. LIBBY: That’s also an important point, as you bring up the frequency of infection with that specific organism, Haemophilus, and the fact that we didn’t have the vaccine against it back then. It was really the cause of some serious bacterial infections: meningitis, pneumonias and other kinds of soft tissue things. Being able to reveal that, and that people came to understand what a lot of the problems with infections might have been, really advanced the field.

I know you did a lot more and I want to get back to that, but tell me, when you were working in your practice and trying to take care of patients, and at the same time starting to really become infected yourself with this research bug, so to speak, and then the publication bug because that gives you the fulfillment of making a difference; how did you get that going in your practice? What was the process? How did it work that way?
DR. SCHWARTZ: Well, I can’t say they were jumping up and down for joy, but they let me do it.

DR. LIBBY: Your partners?

DR. SCHWARTZ: Partners, yes, the partners. They rarely contributed patients of their own, but with my patients, at least the ones I had seen, the partners didn’t make too much of a stink. Every so often, somebody would complain. Patients would say, “Why do you prick my ears whenever I go to you, yet they don’t prick them?” The partners would sit me down and give me a little lecture and for a while things would improve, and then creep back up a little bit. But it never reached the boiling point where it became, you know, “You like these bugs so much? Go someplace else or stay here and forget about doing all of these little procedures.”

DR. LIBBY: But that’s where you got your data and that’s where you could make a real difference.

DR. SCHWARTZ: Well, with that. Our first incubator, on the advice of Dr. Margileth, was a chicken egg incubator. The partners didn’t do cultures before I came. And so, we had this round chicken egg incubator that could incubate 50 eggs, but we used it instead for agar plates and for strep [Streptococcus] cultures. We did probably, I don’t know, 25,000 before they finally bought an incubator.

DR. LIBBY: That’s interesting. You had the bell jars with the candle?

DR. SCHWARTZ: Peanut butter jars. We didn’t get bell jars. We got the peanut butter jars after Barsanti’s family was finished. He had 4 or 5 children. We would empty it out, clean it, and that was our anaerobic jar, our candle jar.

DR. LIBBY: So you could do the strep tests, the strep cultures, which was pretty amazing. So you developed this skill. You developed this interest. At the same time, you started to get widely published and develop a fairly diverse set of interests. Also, you were teaching. You were involved with the hospital because that was, I guess, an outlet for teaching for you. Tell us a little about that.

DR. SCHWARTZ: Teaching was easy. It wasn’t sitting down in a lecture hall and going up at the podium. It was sitting on intake rounds, which I had
done even at Children’s. I would do that as a second year more than I needed to and I loved it. I loved the challenge of cases that they hadn’t figured out, or if they did, they didn’t give the diagnosis until the end. After you attended enough of these, you began to get pretty good at it. They’d only have to mention, like, 4 or 5 sentences and you’d say, “I think they know what’s going on.” And it’s still developing now. I still do that. That love never went away.

DR. LIBBY: That’s a real issue relative to the training and continuing education. Practicing pediatricians learn so much from being in a hospital and seeing those cases that weren’t quite the standard. It wasn’t just that viral pharyngitis, but something more, Meniere's [disease] or whatever. You found there was always something that was really an intellectual game of sorts and that you could really tease out the information. You’ve always been a master of that. Do you think that that’s something that’s really an unfortunate evolution of the changes in practice?

DR. SCHWARTZ: I do. I mean, even something that I became very expert in is examination of an ear drum of a small baby or a grown up. There are some, but I don’t see the people, saying, “Oh, let me spend some time. Let me make it so that all of us have the opportunity of learning this skill that is taught.” Some do well and most not well.

DR. LIBBY: It is interesting, and I just highlight this because it’s a unique commitment that really reflects the time that you were trained and the motivations you had doing what you did. Many physicians don’t want to go to the hospital because it interrupts their patient care in the office.

DR. SCHWARTZ: Absolutely.

DR. LIBBY: It takes away from their revenue producing hours. Yet you went to the hospital, not just to see your patients, but to see and talk about other people’s patients. Now that’s a free commitment for educating students, residents and even, probably, attendings who would get great information from your interpretation of their patient’s issues. That’s a really remarkable commitment, and it certainly is something that’s unique. You wish that that was something people still persevered and wanted to do.

DR. SCHWARTZ: I can promise you, I wouldn’t do it if I didn’t love it. [laughing]
DR. LIBBY: I’m sure of that. At the same token, you’ve had the opportunity to work with students and residents. I can remind you that I was a third-year resident at one point when you were just coming into practice here.

DR. SCHWARTZ: Oh, I remember.

DR. LIBBY: You assigned me a task, which was to research bacterial meningitis.

DR. SCHWARTZ: Now, that I didn’t remember.

DR. LIBBY: You don’t remember that? I wrote this long review paper and looked at, I don’t know, I think we had 75 cases over the prior 10 years on microfilm. I had this big chart that I had to check off all the symptoms on and come up with statistical analytics to try to justify how we would look at bacterial meningitis or osteomyelitis or any of these kinds of infectious processes. But it was at your behest. Do you continue to work with students and residents and get them to do research with you?

DR. SCHWARTZ: Yes, I think, all in all there have been maybe 35, mostly case reports because they don’t have the time or the inclination to work closely with them. So we’ve had about 35 published case reports; interesting ones, unique ones. They grumble, some of them, or they mumble, and they don’t fulfill, and I whip them and whip them. They finally say, “Okay, just leave me alone. I’ll do it.” So those are in print now, and that’s a large number. Just this month we have one.

DR. LIBBY: And they take great pride in that I’m sure. They may get angry and grumble, as you say, but when it’s all said and done, it really sets a new standard for them.

DR. SCHWARTZ: Oh, sure. Well, so many of them have told me, the ones who go onto subspecialty, that they’re asked, “What are these? What are these cases that you’ve done?” When they tell them, they say, “Oh, that’s wonderful.” So many have not published anything or have never done any research papers. Doing that makes it a little bit easier for them to get into their program.

DR. LIBBY: So once again, you’ve made some great contributions, and we haven’t even touched the tip of the iceberg on them because so much of what you do involved using real patients in a practice setting and coming to conclusions that actually altered the way that we practice. So, I want to cover some of those
areas. The 350 articles is a lot and, obviously, not all of them were earth shattering or game changing. But many of them really did have significant impact. So, we talked a little bit about otitis media and the fact that you had no problem tapping eardrums and getting bacterial cultures, and really did discover a significant alteration of what people expected relative to those bacteria that we’d see in kids with otitis at that time. But you also did other things with otitis. Give me a little perspective on what some of the more significant things you think that you were involved with that really helped us.

DR. SCHWARTZ: Well, not just with otitis. That was my main thrust. So, there’s the infectious part, and then there's the noninfectious sequela, the residuum. That has to do not so much with killing of bacteria, but with drainage of gluey or gooey fluid that’s in the middle ear. What’s happened to these children? How long does fluid last? So we tracked out and we drew curves of when fluid disappears over a certain amount of time. It wasn’t earth shattering, but it was done in a private office instead of a university setting. Also, we looked at typanometry to determine how good this instrument is in a private office, and the instrument called EarCheck acoustic reflectometry.

DR. LIBBY: Right. Interesting piece of equipment that was.

DR. SCHWARTZ: We still have them. We use them for the younger kids in whom it’s hard to get because they wiggle and jiggle. They’re hard to get a typanogram. We looked at whether a tympanocentesis or myringotomy helps by draining fluid, preventing this fluid from accumulating. We tried to answer that question. We looked at the white blood cell count and compared before antibiotics and after antibiotics to see what was going on. Everything that I could think of. How many children with proven acute otitis media by tympanocentesis really have fever at home or in the office? We looked at that. We looked at pain and how many actually cried or they reported in the middle of the night crying. Well, that’s like 5%, 10% of babies or young children with acute otitis media. We tried to nail down exactly what was happening with this disease in so many different ways.

DR. LIBBY: And it helped to develop a real understanding and still a nuanced understanding that really you have to have some experience looking at ears and hearing the histories. It all makes sense when you read some of the work that you’ve written, some of the things that you’ve exposed that way. The other one, of course, was being involved in treatment guidelines or diagnostic guidelines on looking at the eardrum and what really does qualify as an ear infection.
DR. SCHWARTZ: Exactly.

DR. LIBBY: Because there was a time when, you know, if a kid came in with a fever you’d just say, “Oh, he’s got an ear infection, put him on antibiotics,” because that was the standard and that was easy. But most of the time they didn’t have their illness related to necessarily that.

DR. SCHWARTZ: That still happens now, more often, especially with these retail-based clinics you see that. What did you diagnosis and how did you diagnose it? It’s just like 40 years ago, literally, more than 40 years ago when I first started. All you have to do is have a red ear drum. One ear drum being more red than the other, or you can have equally red ear drums, and that’s all you need. Fever, crying, tugging twice. You still see it today.

DR. LIBBY: But you’ve discerned when you did all this work that actually there are other qualities to look at on the ear drum that really did represent a true infection.

DR. SCHWARTZ: It took me 30 years to finally convince our Academy. So, now, at least for the time being, we need that bulging.

DR. LIBBY: You need that bulging ear. Well, it’s good that you can do that. You also really looked into group A strep [Streptococcus] and pharyngitis and a lot of issues around that. What are some of the significant contributions that you feel you made to improve the way we deal with strep?

DR. SCHWARTZ: A few that come to mind is that we treat streptococcal pharyngitis tonsillitis for 10 days. Many infections we treat only for 7 days. The 10 days was well before. It came around the Second World War when they had groups of people at different bases or around the country. [F. E.] Warren Air Force Base in Wyoming and several places where they really did a lot of work on the Streptococcus. They found that you needed to treat for a long time or else the symptoms and signs recur within a week or 2 of stopping the antibiotic. The only antibiotic at that time was either sulfa, sulfonamides, or penicillin. That was it. You had 2 choices. I did do a study that was published, again in JAMA, of 7 versus 10 days. You had to look at so many things. Where they taking the medicine? How do you know they were taking the medicine? Did they come back for rechecks? We had to culture them for the strep to make sure that they had strep before an antibiotic, on day 3 to 5 of an antibiotic, on day 8 to 10 of an antibiotic. To
see whether they’re really taking it, we had to look at urines and do a special test called a micrococcus luteus test, where if you take any antibiotic, you can tell by this particular test that there’s antibiotic in the urine. And presumably it’s the one that you’re prescribing. If you didn’t find that, then they had to bring their medicine bottles, and we had to weigh them to see how much volume was in there. So, it was very complicated. There were all kinds of things that had to go into it.

DR. LIBBY: Interesting.

DR. SCHWARTZ: But if you didn’t have that, you wouldn’t have your study published, at least not by JAMA. So, we did.

DR. LIBBY: But it’s fascinating still because these are the patients we as primary care docs see every day. You were able to establish a protocol that you wanted to follow that had scientific validation by virtue of you getting those specimens and doing the analysis of the outcomes. Then, being able to put that together into information. I know that you really did a lot of work that you’re not giving yourself all the credit for, contributing to better understanding. For instance, very recently we learned that kids can go back to school within a day or 2 of being diagnosed and starting treatment.

DR. SCHWARTZ: One day. Not even 1 day, 12 hours.

DR. LIBBY: Which is huge. I mean, when you think about their lives, their parent’s lives, everything where it was one of those indetermined kinds of things for so many people and some would think they had to stay home 10 days. I can’t think of many pediatricians who really knew what to tell them. But to be able to document and to be able to determine that is a huge, huge contribution to society, much less the care of these kids.

DR. SCHWARTZ: Well, it didn’t make sense to me. I mean, that may be where it starts from. And then, I say, “Let’s see where they get this law from. Does it come from heaven? Is it the Ten Commandments?” So, we looked and looked at the studies, and there were just 2 or 3 studies out of 4 that showed 12 hours was probably sufficient or 16 hours was probably sufficient. The one study by a strep guru whom everyone respected, and still should, said, “No, you need 24 hours.” So from that, which was a small study, came the 24 hours. Every state law, 24 hours — every state that we could find. And, of course, in the textbooks and everything, you need 24 hours of treatment before the child can return to school. Why? Because he
could pass it on. They’re still infected or still communicable. We looked at that with rapid strep test, with overnight cultures, with group B serum, a whole bunch of different ways. You know, it turned out that only 8% still had strep in their throats the next day. Even if they started treatment at 5 o’clock in the afternoon, and then at 8:00, 9:00 o’clock the next morning showed up in the office for a retest, 90% or 93% were fine. They could not pass it on. It was not in their throat. We couldn’t recover the *Streptococcus*.

DR. LIBBY: That’s so impressive and so really, really important. And you did others. You did vaccine trials.

**DR. SCHWARTZ:** Many.

DR. LIBBY: Many of those, of course. But really important for us who use vaccines and have really changed the face of infectious disease in our populations. We won’t digress into what that all means relative to refusers.

**DR. SCHWARTZ:** I just had a kind of a refuser, just today at work before I came.

DR. LIBBY: It can be distressing for those of us who know what we’ve seen and how impressive the effects of vaccines have been. But we try to indulge people in their fears and try to work with them and get them to find the right answer, but sometimes it is frustrating. But, nonetheless, getting the documentation, the data that shows the impact of these vaccines, the safety of them, etcetera, it’s very important. I don’t think there are enough of us out there who are willing and able to do that, but thank you for being that pioneer doing that sort of thing.

And you’ve done a lot of other research, not necessarily in the clinical side, but just examining trends. I know that you’ve looked at even things like using sunscreen in adolescence.

**DR. SCHWARTZ:** Yes.

DR. LIBBY: That was a fairly progressive sort of thing. And looking at the way we treat tongue-tie or some of the other common things that we see in a pediatric office.

**DR. SCHWARTZ:** Yes. Every place that has a high school, my picture is up, and it says, “I hate this guy,” because I had 1 study on Beach Week. We had a spy who went to the parties in Ocean City. We paid her. She was a
graduating person. No names were used. We promised the kids and we gave them money. What happens, really, at Beach Week by someone who is at Beach Week. She was able to get some great data, and we had that published. This is not such an innocent week, let me tell you. Things go on that shouldn't go on and people get into trouble. The trouble is not just Beach Week trouble. The post is post-traumatic stress disorder. Lots of that because of things that were done that people are very embarrassed and ashamed about.

DR. LIBBY: So, it’s not just not using sunscreen or drinking too much. It actually is things that people said or did or abused each other through that period of time. And then, people having to deal with that as this sort of separated little thing in their lives that does measure into some pretty deep psychological problems.

DR. SCHWARTZ: Yes.

DR. LIBBY: Wow. I know that you’ve also had interest in looking at mutism.

DR. SCHWARTZ: Selective mutism.

DR. LIBBY: Selective mutism, of course. We do have a population here where you see that more often in northern Virginia, I think.

DR. SCHWARTZ: Well, it’s always been here. When I had my child psychiatry rotation, I had 2 children with that. I had never even heard of it before. And they, of course, had a Freudian interpretation of the cold mother who didn’t talk, you know, didn’t have a wonderful personality that meshed in with her child. And the child then became cold and stopped speaking. Nonsense. You know, the usual. But it’s important. It does exist. I will tell you it’s probably 5 times more common than bacterial meningitis, if not more. And there are ways of treating the children or referring them, and it isn’t speech therapy. It is not a speech disorder per se. It’s an anxiety disorder in which they just get out of their comfort zone when they speak, except at home. They have perfect speech at home and perfect speech with selected friends and maybe with close relatives like grandparents. But in some of these cases, it’s so bad that the children won’t say a word to their grandparent on telephone, and certainly not a haircutter or a store clerk or somebody who tries to strike up a conversation.

DR. LIBBY: Or a teacher.
DR. SCHWARTZ: Or a teacher. It could be a year. But there are books on how a teacher should react to this and not be coercive, because one of the worst things to do, especially with a highly anxious person, is to coerce them or try to coerce them. They’re very strong willed with this, so they’re going to resist. Then the teacher starts yelling and screaming and belittling. And the other kids jump on, and these kids are totally miserable.

DR. LIBBY: It is interesting and it can be a most pervasive family kind of ordeal where there’s a lot of denial and a lot of refusal to really respond to it by the family. It’s good to have some information that people can use to be able to actually address it because it happens a lot more commonly than people really think it might.

DR. SCHWARTZ: There’s a very big parent support group. They have a conference several times a year in different places for the parents and they bring their children with selective mutism. But that’s a toughie.

DR. LIBBY: So, through the career of doing the research, doing the writing, being published in significant journals and developing the network of people who can work with you on this, you’ve been able to really parlay that into a lot of very important and helpful publications. I know that in Contemporary Pediatrics, for instance, you’ve been able to take advantage of their desire to do science and practice. You’ve looked at things like ocular photoscreening, some of the tools, and have been able to do some comparatives to help pediatricians figure out what to do in their own offices. I’m just complimenting you on that because I know that it’s been very helpful for me. It’s been helpful for a lot of people. Also talking about the things that you can do, such as taking care of the tongue-tie and things of that nature. So, you’ve had a lot of opportunity here to do very good things for the profession, as well as for patients. And that’s been a great thing, too.

I do want to step away for a second because I think this is another focus of research, but it’s a much more personal side. I know through the course of your career, you’ve raised a family. You’ve had a great relationship with your wife and you’ve had 3 kids. That must have been really a hard thing to do at the same time. And it’s probably given you a lot of inspiration, as well as perspiration. Give us a little perspective on what it’s like to be as busy as you’ve been, and then to have the love and share the love with a family.

DR. SCHWARTZ: It is hard. It’s hard. I was not involved in sports. I
played just with other kids, but not in high school teams or anything like that. So, I wasn’t into that, at least for my son. My son and I wrote in one of our journals, *Pediatrics*, our pediatric Academy [American Academy of Pediatrics] journal. He was kind of a rebel. He was a rebel in a number of ways when he was younger, and he became a problem with trust. When he was maybe 14, he started smoking pot. The smoking pot really developed fairly rapidly. He got into police difficulty at that time. My oldest daughter said, “Keith is smoking pot, and it’s a school day.” He would breathe out of the window or do things to try to hide what he was doing. Well, he hid it well because I had no idea of what he was doing.

That was a big bell-ringing effect. Soon after that, we had him in a treatment program, a long treatment program where part of the time was spent with host families. It was a very, very strict program. The program is no longer in existence. It had terrible press and things were done there that were wrong, really wrong. I was a research director of that program. I wasn’t a clinical person, but I interviewed everyone there. Anyway, Keith finished the program. It took him 15 months. And then he quickly relapsed. It didn’t take him very long, a few months. And the relapses and bounce backs went on. Finally, he got himself in to real trouble. When that was straightened out, he seemed to do very well. But then he relapsed again, and again in a big way. So, this business with simply smoking pot, there were other drugs involved, but pot was by far the most important one. I saw firsthand, at least with him and us, that it isn’t all giggles.

**DR. LIBBY:** It was a gateway for him to much more profound and significant?

**DR. SCHWARTZ:** Even if it wasn’t a gateway — and it was — but that was his main thing.

**DR. LIBBY:** Well, let’s say, on the 2 sides, one is that that really inspired you to look more critically at what goes on in youth and their substance abuse, both with pot and alcohol. And you’ve done some pretty significant research that way and have published a fair amount on those topics. And also on urinary detection.

**DR. SCHWARTZ:** Lots of that. [laughs]

**DR. LIBBY:** Lots of that, right. And so you’ve tried to understand what happened by looking at other people, I guess. It’s a really personal, but yet, a very helpful pursuit for you. Do you currently have a lot of recriminations about what’s going on from the point of view of legalization?
DR. SCHWARTZ: Right. I do, and I think that things are beginning to show, as far as accidents. There was just something on TV where a guy went berserk. Presumably, he was smoking pot at the time and he was knocking people over the heads with a club at the Denver airport.

DR. LIBBY: Right. I saw that, actually.

DR. SCHWARTZ: Yes, and it was just for no reason. He would go over and whack somebody. And then, he'd go over and whack them again. They were down, and he'd whack them again. They finally took him away. I have no idea whether he was smoking pot, but it intimated that. Of course, then it went over to another thing where because of Denver, Colorado’s lax laws, this is what’s happening.

DR. LIBBY: It will be educational to see. Unfortunately, I think it takes a lot more years than most other states are patient to wait and see what the outcomes really are.

DR. SCHWARTZ: Well, if they don’t keep good records, you’ll never know. It’s been a long enough time that we should see what’s happening with graduation of the pot smokers, and I mean, frequent pot smokers and non-pot smokers. What’s happening with altercations, with criminal offenses. Two groups and 2 or 3 different years, you can do that. It doesn’t take a lot of money to do. Auto accidents, other accidents. You have people driving Colorado mountain roads, and if they’re intoxicated, some don’t feel it, but let me tell you, most do. It causes distortion of reality, jocularity, socialization, and you’re driving.

DR. LIBBY: Distractibility, total, and a distortion of perception. It is dangerous. I know even on the ski slopes, it’s the same sort of thing. You put on the headphones and you completely block out all of that input around you that can keep you safe and keep those around you safe as well.

DR. SCHWARTZ: From using helmets so much. Not those people. [laughs]

DR. LIBBY: So, things have changed. The world has changed a lot around us. As we go forward, one of the things that I think could be the most influential relative to our careers has been the Internet. Being able to really access information has been great, but at the same token its ability to generate unfounded rumors that relatively impair our ability to provide good care. How do you
perceive what’s going on in that sense?

DR. SCHWARTZ: I authored an article that was published in a funny journal, the Open Journal of Pediatrics. I’ve had probably 5 kids who are absolutely addicted to the Internet. And I mean, addicted. That means they go to school, but they’re not doing well in school. They think about these multiplayer games that they’re involved in while they’re at school, which takes their mind off of learning. They get home. They might grab a quick bite to eat, go to the bathroom, then they’re on their computer and playing games with people in Korea, China, Taipei, all over the world. And the games cost money to either buy armor for their defenses or offenses. They spend 4 or 5 hours average on a school day, and Friday afternoon until about 1:00 or 2:00 o’clock in the morning on Saturday. They’ll sleep till 10:00 AM. Or they’ll start in the computer games, maybe, 5:00 o’clock in the morning from Saturday to Sunday and until Monday when the whole cycle repeats itself. They’ve foreclosed on their future. They’re only interested in being so good and proving it with these scores so that a company will sponsor them for these games. They get a salary. They get a hotel. They get food. This is their goal in life, Internet, Internet games, multiplayer games. And you say to yourself, these are good people, good families, good education, and yet they wind up, basically, doing nothing.

DR. LIBBY: An interesting time for sure where you can actually have a child who has great potential and is only interested in video gaming and thinks that they can make a career of that, which, of course, I’m sure they can. But soon enough that will curtail as the computers themselves start to get more sophisticated than most people would be capable of creating a novel and new way to deal with it.

DR. SCHWARTZ: It’s not a huge problem, but if you’re the parent and you have a child, an adolescent, who’s doing this, especially with parents from India or Korea, they just feel like a prisoner. They can’t make this kid or motivate him to stop that. They can’t.

DR. LIBBY: There's an incredible apathy for everything else around them, yes.

In the world of medicine right now, there are lots of questions as to what the profession is doing, where it’s going. Is there enough energy and self-respect for it to continue to persevere at the level that we have been accustomed to? How do you see medicine in general evolving over the next 10 or plus years?

DR. SCHWARTZ: I have no idea. I mean, I’m at the end. I am not
beginning. You know, I have, who knows, let’s say less than 3 years left.

DR. LIBBY: So, that’s an issue, too, that’s impacted you, but you’ve continued to do incredible things. You’ve had some health issues and you’re still more inspired by dealing with other people’s health than your own even, it seems.

DR. SCHWARTZ: [laughs] Well, I follow the doctor’s directions mostly, but yes, I was diagnosed with a bad cancer, anaplastic thyroid cancer 40 years after I had an original thyroid cancer, but a far less of aggressive type. So, this thing was lying 40 years, sleeping, and when the time came, it woke from sleep and there was a big lump right in my neck. I was shaving one day and I said, “What is that?” The next day they had the biopsy done, and the following week we had a result. It was a big shock, but as long as I’m able to work, I have the stamina to work, then we have something. It’s shrunk down about 80%, but 2% of people live. It’s a horrible thing, but I’ll do what I can as long as I can.

DR. LIBBY: We certainly hope that the outcome there is something that does actually give you the ability to continue to do all the great things that you do and to feel healthy, because you look great, all things considered.

DR. SCHWARTZ: I do. I feel very good. My voice is a little hoarse today. I don’t know why, but it’s probably nerves.

DR. LIBBY: I know that we’ve shared this, or you have shared this whole story with our friends on the SOAPM listserv. Now, SOAPM, the Section on Administration and Practice Management at the American Academy of Pediatrics, is the largest group of primary care physicians that are organized and share all kinds of perspectives on the business and the practice and the philosophy of being a primary care doc. Although there are lots of others who, what we call, lurk, and like to read what we talk about, the outpouring!

I’m going to read a few quotes from the listserv just because I think it’s worth really keeping these in mind.

First of all, they did create the first Richard H. Schwartz Award for Research in the Pediatric Office.

DR. SCHWARTZ: Not they, you. You created it.

DR. LIBBY: Oh, no, no, not me. [laughing] Truly, this is something that was
from the heart of those docs who are involved and respect and admire the work that you do and your participation in the work that goes on with SOAPM and the Academy. So, don’t look at me that way, specifically because it was something that really has influenced people and had a great impact on their practice and they wanted to be able to give you something that you could appreciate that reflected their own admiration and appreciation. But I’m going to read a few of these quotes from the listserv.

“Dick is one of the rare people doing research who actually tries to answer questions that have clinical relevance and the potential to alter clinical practice, as opposed to academic questions that generally have little or no relevance to the practicing physician.” A great quote, post, and representative. Of course, from Herschel [R.] Lessin, a great doc who is a very active contributor there.

When I saw you shortly after your diagnosis at a 3-day intensive CME on psychopharmacology, participating like you always do, I had to say, “In his trying times, Dick continues to do the things he loves, learning and sharing his knowledge.”

Another one., “Dr. Schwartz, I know you won’t remember me, but I was a chief resident at Children’s National in the mid-1990s. I want to thank you for always inspiring and encouraging us with your active discussions during our many conferences. I promise you, the chief residents prepared extra hard for our weekly chief conferences because we were worried about what topic Dr. Schwartz would bring up that we’d never heard of before. So, thank you for all of your time, energy, insight and education. We are all better physicians for knowing you. My prayers are with you as you fight this fight.” That was from Jen [Jennifer] Mastruserio, saying you probably wouldn’t remember her name.

Another: “You have continually changed how I practice. You give me faith in how thoughtful clinicians can be the force of how we can make changes in clinical practice that truly are evidence based. Too often we are caught in the stream of jumping through hoops and feeling helpless. You teach us to stay in the driver’s seat, to do what’s best for the families who trust us with the care of their children. For this insatiable effort, my humble thanks for keeping us all in the driver’s seat where we practice. We just need the help of a navigator like you once in a while. My heartfelt prayers to you as you navigate your current life challenge.” That's from Harald [H.] Kowa.

“While I do not know you personally, I feel that I do know you from all of your many important posts. You are a strong and honorable man.” Claudia [K.]
Preuschoff.

“Beside the fact that Dick is a giant of general academic pediatrics, the likes of which there are very few, he’s one of the most prolific pediatric academicians and he is a true advocate for everything pediatrics.” That was from Peter Kosoff.

So, you know, we’re very fortunate to be pediatricians, to have patients and to be able to practice the art of medicine. It’s a true privilege to take care of kids and their families. I know that you made that commitment and we all thank you for all the work you’ve done.

DR. SCHWARTZ: Thank you and thank the Academy.

DR. LIBBY: So, in closing we just thank those who watched and who care and want to learn about what it’s like to be a great doc and to do all the things that Dr. Schwartz has done to contribute to the betterment of pediatrics. Thank you.

DR. SCHWARTZ: I really enjoyed this interview.

DR. LIBBY: Oh, good.

DR. SCHWARTZ: Thank you. Thanks.

[END OF TAPE]
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CURRICULUM VITAE

NAME-----------RICHARD H. SCHWARTZ, M.D., FAAP, FIDSA

Home address---701 Upham Place, NW, Vienna Virginia 22180

Office address--- 100 East St.SE, Suite 301, Vienna, VA  22180

Place of Birth---BROOKLYN, N.Y.

Date of Birth---JULY 6, 1938

Citizenship---U.S.A.

Marital status---MARRIED  Children---Lisa, Keith, Keira

Name of wife----ROSE LYNNE

Specialty Board certification


Fellow, American Academy of Pediatrics 1972,

Infectious Disease Society of America (IDSA), 2012

Pediatric Infectious Disease Society (PIDS) 2014

EDUCATION, UNDERGRADUATE AND GRADUATE PROGRAMS

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<td>1956-1957</td>
<td>N/A</td>
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<tr>
<td>Georgetown Univ.</td>
<td>1961-1965</td>
<td>M.D. (1965)</td>
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INTERNERSHIP AND RESIDENCY TRAINING

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<tr>
<td>Fitzsimmons Army General</td>
<td>Intern</td>
<td>1965-1966</td>
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Hospital
Children's Hospital of Pediatrics District of Columbia 1969-1971

FELLOWSHIP TRAINING
CHILDREN'S HOSPITAL OF DISTRICT OF COLUMBIA Child Psychiatry 1971-1972

FACULTY POSITIONS

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<td>Georgetown University School of Medicine</td>
<td>Clinical professor, Pediatrics</td>
<td>1974-present</td>
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<td>George Washington Univ. School of Medicine</td>
<td>Clinical Professor, Pediatrics</td>
<td>1974-Present</td>
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<tr>
<td>Virginia Commonwealth University (MCV)</td>
<td>Professor, Pediatrics</td>
<td>2005-present</td>
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<tr>
<td>University of Virginia School of Medicine</td>
<td>Professor of Pediatrics</td>
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*George Mason University Affiliate Faculty  2005*

*College of Nursing & Health Science*

HOSPITAL APPOINTMENTS

Fairfax Hospital, Active Staff, Pediatrics 1972-PRESENT

MILITARY SERVICE

U.S. Army Medical Corps, Major 1965-1969
EDITORIAL BOARD OF MEDICAL JOURNALS

Pediatric Infectious Disease ---1982-1986
Clinical Pediatrics ---1988-1990
Infectious Diseases of Children ---1988-2009

PEER REVIEWER FOR MEDICAL JOURNAL 2013

1. Pediatric Emergency Care
2. Journal of Pediatric Otorhinolaryngology

PROFESSIONAL AND HONOR SOCIETIES

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<td>Society for Ear Nose and Throat Advances in Children</td>
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National Committees

American Heart Association: Committee on Cardiovascular Disease of the Young, 1983-1986
(Section on: Rheumatic Fever and Endocarditis)

AAP, Task Force on Substance Abuse; 1984-1985,

AAP Committee for Diagnosis and Mgt of Acute Otitis Media, 2009

American Academy of Otolaryngology-Head and Neck Surgery- 2009, management of tonsillectomy- elected representative of AAP

Honors

Georgetown University School Of Medicine: Mario Mollari award for Outstanding Scholastic Achievement in Microbiology, 1965.

American Academy of Pediatrics Practitioner Research Award-4th Annual award for best clinical research by full-time general pediatrician

American Medical Association National Congress on Adolescent Health, Award for Distinguished Service by a Practicing Physician

Georgetown University, Award for 20-years teaching service to the university

Bibliography

Original research studies=121 as of 12/10/13
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drug users. AJDC 1990; 144:310-314.


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pharyngitis in a pediatric group office laboratory.


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complexion and iron deficiency: Chlorosis revisited.


276. Schwartz RH, Guthrie KL. GERD: Lessons my new grandchild taught me. Infect Dis Child 2006;19:


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