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Andrew M. Margileth, MD
Interviewed by Michael Rajnik, 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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Michael Rajnik, MD

Michael Rajnik is a graduate of King’s College (PA) and the University of Virginia School of Medicine. He completed his pediatric internship and residency at Wilford Hall USAF Medical Center and the San Antonio Uniformed Services Health Education Consortium. Next, he completed fellowship training at Walter Reed Army Medical Center and the National Capital Consortium (NCC) Pediatric Infectious Diseases fellowship in Bethesda, MD. He served as a pediatric infectious diseases specialist for the next 15 years in the USAF. The last 10 years he served as the fellowship director for the Pediatric Infectious Diseases program at the NCC and the Uniformed Services University of the Health Sciences (USUHS). He was also Pediatric Infectious Diseases Consultant to the USAF Surgeon General. He retired from active duty service in 2016. He is an Associate Professor of Pediatrics at USUHS.

Dr. Rajnik served on the Executive Committee of the AAP’s Section on Uniformed Services (SOUS). He was Chair of the Executive Committee for two terms. He has also been a member of the Uniformed Services Chapters of the AAP and the Section on Infectious Diseases.
Interview of Dr. Andrew M. Margileth

DR. RAJNIK: This is an interview with Dr. Andrew M. Margileth, Captain, retired, US Navy, who is a member of the American Academy of Pediatrics. It is conducted by Dr. Michael Rajnik, and Jackie Burke, from the Section on Uniformed Services at the American Academy of Pediatrics, on February 22nd, 2016, at his home in West Miami, Florida.

Dr. Margileth, we are going to start back in the beginning. Can you tell us some things about your childhood, your family, that influenced you to enter science, medicine, and then the Navy, as well? And things that you can think were formative?

DR. MARGILETH: Yes. I would say the best place is to start in Cincinnati, Ohio, where I was born, at Bethesda Hospital, in 1920. My daughter was born there as well. We lived there for about 9 months, and then moved to Pittsburgh, Pennsylvania for about a year, and then we moved to Washington, DC. My father was with a company that produced apples and apple cider.

DR. RAJNIK: Musselman?

DR. MARGILETH: No, it was National Fruit Product Company, Inc. in Winchester, Virginia.

DR. RAJNIK: Apple capital of the world, Winchester, Virginia.

DR. MARGILETH: There you go. (laughter) Anyway, we lived there for 2 years, which I remember very little, because I was 3. And then we moved to a place in mid-Florida, just below Lake Wales, called Babson Park, Florida. Babson Park is a small town of 500. We lived there for approximately 2 years. My father developed acute streptococcal pharyngitis. He died 4 days later, I think of Bright’s disease, glomerulonephritis. So that was a devastating highlight of my early childhood.

DR. RAJNIK: And how old were you when that happened?

DR. MARGILETH: Probably 4 or 5 years old. No insurance and no money was left. My mother called her brother, Uncle Andy, in Pittsburgh. We were on our way back to Pittsburgh. We lived in Pittsburgh for another 2 years. Uncle Andy was our life support. He and his wife had no children, so my brother, Bernard, and I were well taken care of by Uncle Andy. Thank God for Uncle Andy. [Laughter]

We only lived there a year and a half, and then we moved to Beaver, Pennsylvania, in Beaver County, 30 miles west of Pittsburgh, and lived there
until I was 17 or 18. That’s when I, fortunately, met my best, and really close friend, a fellow named Bill Baker. Bill's name will come up a little bit later.

We had a wonderful childhood, because my mother gave lots of love, and never questioned what my brother and I did when we got in trouble. [Laughter] She just said, “Well, let’s do the best we can,” whatever it might be. That period was a highlight of my childhood.

DR. RAJNIK: It sounds pretty interesting that you were born in a Bethesda hospital, and you worked for many years in Bethesda, and then you had a father who died of an infectious disease, which ended up being a field that you entered.

DR. MARGILETH: That’s right.

DR. RAJNIK: Some of this was maybe a little foretelling as to what was going to happen later on. You also moved around a lot as a kid, at least in your early life, and that was one of the other questions I had. You know, when I looked at your CV, you spent a lot of time in the Navy, but you didn’t spend a lot of time in any one place when you were in the Navy. You moved around an awful lot.

DR. MARGILETH: Right.

DR. RAJNIK: What difficulties did that present, for your family, or as a physician? I mean, it looked like you were moving every 2 to 3 years.

DR. MARGILETH: Well, I was married to a wonderful lady named, Ellee, who was ready for anything. She was very understanding, and loved the Navy. In fact, she joined the Navy Relief [Navy-Marine Corps Relief Society] as a volunteer. Probably the happiest 24 years of my life was the Navy life. And how did I get into that? Well, on December the 7th, 1941, when I was in college at Washington & Jefferson College, in Washington, Pennsylvania, the radio came on, President Franklin Delano Roosevelt gave a dramatic speech about the bombing of Pearl Harbor. We were all amazed, because in college, you’re not paying much attention to the news, so we heard of a war, but we were not in a war. And at that point, I’d say half of the people in my class went out and enlisted.

I just had a long talk with my brother, who was already in the Navy, as a Navy pilot. He said, “Get your education, number one. Don’t enlist if you don’t have to.” I was lucky the draft board let me stay in school. I can’t remember what happened in detail. To make a long story short, I stayed 3 years at W & J. They had a 3-2 plan where I went to Cambridge, Massachusetts to MIT [Massachusetts Institute of Technology]. That was a real jolt, because I made all As at W & J, and I made all Cs at MIT.
The classes at MIT were large, 200 in a class, and I didn’t relate to that. Particularly if you got there 2 minutes late, you were in the back row, and could hardly see the professor. Anyway, I got through a year and a half of MIT; that’s when the war really was full blown. I received a letter from the draft board saying, “You’re coming in the Army, soon.” I said, “Is there something I can do?” And the guy said, “Oh, well, you can enlist in the Navy.” So I did. And the serendipity of that was when I took the entire physical, and went to see the commander doctor who was to sign off. He said, “Oh, they forgot to do your eye exam or didn’t record it.” And, of course, I didn’t have 20/20 vision. So in those active days of the war, you had to have 20/20 to become an officer in the line. They wanted to make me a radar officer. [Laughter] I said, “Well, what can I do?” He said, “Well, you can become a chaplain, a lawyer, a supply officer, a dentist, or a doctor.” I said, “No, I haven’t really thought about any of those, but I guess -- I think I’ll try doctor.” [Laughter] So I applied for medical school, to 5 schools, and was accepted almost immediately by 3 schools.

MS. BURKE: Did you have good grades all the way through, even when you were a youngster?

DR. MARGILETH: I did, when I was in high school and college at W & J, but when I got to MIT that was another story. [Laughter] Trying to get through that was very difficult for me. I took thermodynamics and advanced calculus, which I should never have signed up for.

DR. RAJNIK: Physical chemistry, right.

DR. MARGILETH: Exactly. So, anyway, I applied to medical school and in one month got 3 acceptances. One school made a mistake and accepted me 3 weeks from today. So it was the University of Cincinnati. Thank God, because I was immediately transported, thanks to the Navy. We had no money. The same day I walked into the University of Cincinnati Registrar’s Office, she looked straight at me, and said, “You’re Margileth.” And I said, “Yes.” She said, “You’re not supposed to be here for 9 more months.” I said, “Uh-oh. I got a wife and a baby.” And she said, “Well, you sit down.” And so I sat for 4 days in a row while everybody else signed up, mostly Army, Navy, and what’s that third branch?

DR. RAJNIK: There was no Air Force back then, [laughter] so Army and Navy back then.

DR. MARGILETH: It was Army and Navy. You’re right. And so on that last day of registration, she said, “Two Army and 2 Navy people have not shown up. You’re in.” [Laughter] You talk about a stroke of luck. During the first 6 months, or first semester, we had more dropouts. The program I
had at Cincinnati was absolutely wonderful. I got mostly As. The professors were wonderful; I listened from the front row.

During the third year, every 9 month rotations, they announced, “The war is over, so you’re going to have to get out of the Navy.” I was enlisted, an apprentice seaman. So they said, “Do you think you might want to sign up for the Navy Reserve?” I said, “Why not?” [Laughter] Because they would pay me $100 a month instead of $250 a month. I had 2 jobs, as a laboratory technician, plus the Navy, and I was able to graduate 9 months later. And the other good news is I had one advisor at Cincinnati, Carl Vilter, MD, who was a professor of medicine. He advised me to consider a Navy internship. I was now an AOA [Alpha Omega Alpha].

DR. RAJNIK: AOA.

DR. MARGILETH: Yes, AOA. So I had a choice. I had to have a job, because in those days they paid no money for interns.

DR. RAJNIK: Wow.

DR. MARGILETH: None. And so I said, “Well, I’ve applied to the Navy, and they’ll accept me,” and that’s how I got to be an intern at Bethesda.

(break in audio)

DR. RAJNIK: Dr. Margileth, you were telling us a little bit about getting accepted to an internship in Bethesda, Maryland at the new Naval Hospital [National Naval Medical Center]. What was that residency, your internship, and postgraduate training like?

DR. MARGILETH: I arrived at Bethesda March the 1st, 1947. They didn’t expect me. So I started my internship on March the 1st, and I had a 15-month internship. That was probably another serendipity, because the first section was 3 months in surgery, 3 months on medicine, and then a month of ENT [ear, nose and throat] and a month of ophthalmology, and so forth. The best month I had was a one-month rotation on laboratory. I learned how tests can be erroneously reported. And so with every test I ever do, I look at the results and say, “Is that a true value?” During that month of laboratory, I spent a week on microbiology and a week looking at pathology slides, which was just fascinating. And then the pièce de résistance occurred. They said, “Well, you fulfilled your 12 months. Now you’ve got 2 or 3 months extra. Where would you like to work?” And I said, “Well, let me try female medicine.” That was a most exciting month, because it was strictly female medical ward patients. I found out that the greatest problem the women had, whether they were active duty Navy or dependent wives, was stress. And stress I’d learned about rapidly. What’s the best way to relieve stress?
Talking. I learned that one of the mothers’ greatest sources of stress was their child. In the last month of internship they opened up a pediatric ward at Bethesda. So I had a month of rotation on pediatrics by serendipity. And that, I think, sealed the opportunity to say, “I want to be a pediatrician.”

Another exciting thing was one of the first cases where I really learned rapidly, an 11-month-old with acute leukemia. In those days, leukemia patients were all dead within 3 or 4 months. There was only one treatment — it was blood transfusions. And then a doctor at NIH [National Institutes of Health] reported in a research article in *New England Journal of Medicine* about the effectiveness of Aminopterin, I think, that had prolonged the life of the child by at least 2 months or more. That was the beginning of real good research on chemotherapy for cancer in children. So the next thing I know is that once they opened up that pediatric residency program, Dr. James Fowler was the chief. He prepared an excellent protocol to get a residency program started at Bethesda. I was scheduled to go to Chelsea Naval [Hospital] for one year for a residency in pediatrics, but the program opened at Bethesda Naval [National Naval Medical Center] on July 1, 1948.

DR. RAJNIK: You were there, right.

DR. MARGILETH: Serendipity; I was there. They said, “You’re in.” [Laughter] So I spent one year longer at Bethesda Naval, which was a godsend for my family, and had a wonderful year. We rotated through Georgetown, as well as George Washington University, and occasionally went to Johns Hopkins [Hospital]. And at the end of that year, they said, “Well, there’s only one possible place to go for your second year, and that’s Chelsea Naval Hospital.” I said, “Well, I think I can get a residency at Hopkins,” and they said, “Go for it.” I applied and was accepted. I didn’t have to move again, because I just traveled to Baltimore. They paid me $25 a month at Johns Hopkins, so —

DR. RAJNIK: You were flush with cash at that point. [Laughter]

DR. MARGILETH: So I had a wonderful year at Johns Hopkins. In reviewing the oral history of Dr. Thomas Cone, he talked about all of the professors that he had coming to Bethesda Naval as consultants for pediatrics, when Tom Cone was chief at Bethesda. It was the experience of a lifetime to work at Johns Hopkins; I saw the first case of childhood autism. Leo Kanner, MD, was the head of child psychiatry at Hopkins. He demonstrated 2 patients with autism in the psychiatry unit one day. I’ll never forget it. But the real revelation was that we saw patients from all over the world coming in for consultation, and we got to see a little bit of everything: tuberculosis, tropical diseases. We had to dictate consults to the referring doctors, whether they were in Baltimore or Chicago, Florida, or
Argentina. And that was, again, an experience, to learn what happened to the patient when they returned for followup. So another fun era in my life.

DR. RAJNIK: It is amazing how many kind of parallels there are right now as people talk about the changing military health system. You referred to the fact that it was recognized back in the 1940s that the stress on families, the stress on mothers, the separation from families and stuff like that, and providing that care, that they recognized early on that a priority was to train people to be able to take care of those issues. Those problems are uniquely magnified in the military, because of the things that people get asked to do that are kind of out of the norm.

DR. MARGILETH: Exactly.

DR. RAJNIK: I also find it interesting that as I see our trainees now in Bethesda, and how they do rotations at non-military facilities, that it’s not really a new concept. It’s a concept that you were doing early on, because it was the best way for people to actually get the training

DR. MARGILETH: Yes, exactly.

DR. RAJNIK: -- and seeing things that no one else was really seeing. So it’s kind of interesting to hear you almost describe modern-day graduate medical education, but it was actually happening 60 years ago.

So you got done with your training. Was Johns Hopkins the end of your official training as a pediatrician?

DR. MARGILETH: Yes, yes.

DR. RAJNIK: So then you were subject to the whims of the Navy, I assume Where did you head off after that?

DR. MARGILETH: Well, in 1950-51, I was assigned to the main Navy dispensary, which was on the Mall, in Washington, DC. That was probably the most difficult year in the Navy that I had, because we would see no less than 80 or 90 children a day, and on a weekend we would see 200 adult and child patients, with 2 doctors. So that was a grueling episode. The pièce de résistance was the lady that came in at 3:00 a.m. on Saturday and wanted a well-baby check for her new baby. [Laughter] And I said to her, “What brought you in at 3:00 a.m.?” She said, “Well, I just don’t have time in my work to come, so I came at 3:00 a.m. I knew you’d be here.” So I said a few unkindly words, because the baby was not sick, and I thought the mother was. [Laughter] I ended up in the commanding officer’s office the next morning. It really wasn’t that difficult, but it was not a good experience; let’s put it that way.
DR. RAJNIK: Yes, not what you had hoped to do after doing all of this --

DR. MARGILETH: Yes, I thought I was going to be curing the world. Now, the good news happened in 1951, because I was assigned to overseas duty, to Oahu. This was before it was the state of Hawaii. So I had the most wonderful year as a one-man pediatrician, working at the clinic at Pearl Harbor, and this was 12 years after the attack on Pearl Harbor. That was a great experience, because as the single pediatrician I felt with all my knowledge I should take care of everything. That included infectious disease, rashes, and particularly emotional disorders in children. I was very fortunate to attend postgraduate seminars put on by the American Academy of Pediatrics each year. Two of the best speakers were doctors, pediatric psychiatrist doctors, Drs. Harry and Ruth Bakwin, who wrote a book in 1950 or so [Clinical Management of Behavior Disorders in Children]. I read the book and listened to them. They said all you have to do is set aside an extra half an hour instead of ten minutes for the patient, and you can get all the information you need, and help the patient. So that’s what I did. I set aside Friday afternoons for something like 3 or 4 patients with emotional problems. At that point I said, “Gee, why don’t I go into pediatric psychiatry?” But I, fortunately, didn’t.

Then I was assigned to Tripler Army Hospital. The experience at Tripler Army was fantastic, because the cases were just like I had at Hopkins. They were from all over the South Pacific. I worked part-time at Kauikeolani Children’s Hospital. They had one 35-bed ward full of patients with rheumatic fever. I haven’t seen a case of rheumatic fever in 30 years. It was an amazing experience, to work at the Kauikeolani Children’s Hospital. It was after hours, starting at 5:00 through overnight. I did that 2 or 3 nights a week, much to my wife, Ellee’s dismay. Kauikeolani was only 2 blocks from where we lived in downtown Oahu, so that I was able to have lunch and dinner with Ellee. After a year of Tripler, where do we go? We went to a large Naval hospital in southern California called Corona [US Naval Hospital, Corona].

DR. RAJNIK: Another rough assignment there. You’re getting really difficult places to live.

DR. MARGILETH: That was probably the best 4 years I had in the Navy, because I had 2 commanding officers, one Julian Love, who was the CO (Commanding Officer), who was an internist. Twice a week he would come to the pediatric ward and say, “Have you got any good heart murmurs today, Andy?” And I’d say, “Yes.” [Laughter] So he’d come listen to these children with their heart murmurs, and we’d talk about it. He was a wonderful teacher.
I worked with Julian Love for 3 years, and then Cecil Coggins, MD, came after him. He wasn’t the teacher that Julian was, but he was very understanding, and probably, again, one of the best COs I ever had. COs can, I think, make or break a situation. But the day that he said, “We have a very important announcement to make,” and this was in May of 1957. “We’re closing the Naval Hospital. We were delivering 400 babies a month, but we’re going to close it. All of he babies will have to be born at Long Beach, or at the Marine Corps base, Camp Pendleton.” A doctor named Delmer Pascoe was there, a pediatrician. It was a wonderful experience to work with him. I didn’t stay for the closing because I was due to rotate to Chelsea Naval Hospital, which I did in 1957, and spent the next 6 years at Chelsea Naval, until 1963.

MS. BURKE: Where was Chelsea?

DR. MARGILETH: That was on the north side of Boston, on the Mystic River. It’s no longer a hospital because they tore down the old Naval Hospital and put up Admirals Row, a group of condos. We had 6 years there. Those years were, again, just fun and education. We had a residency training program that was established by Dr. David Sherwood years earlier. I’d only been there 3 days when he had a heart attack. I suddenly became the chief of pediatrics overnight. Fortunately, he survived, but he was retired.

DR. RAJNIK: When you were in Boston, did you collaborate with the civilians that were at Boston Children’s [Hospital] and places like that?

DR. MARGILETH: That’s right. In fact, my closest arrangement was with a wonderful man, Sydney Gellis, MD. He was chief of pediatrics at the Boston Floating Hospital. I would give lectures over there. He would come over to Chelsea to give lectures. Soon we had our residents going over there for one month or 2 month rotations. Then we set up residency training with Boston Children’s Hospital [Children’s Hospital Boston]. So that, again, that was the highlight. For 6 years we had a superb residency training program. With the consultants that we had from Mass [Massachusetts] General [Hospital], Boston Floating, and from Children’s, any difficult case was quickly resolved.

During the 6 years at Chelsea, we had 2 neurosurgeons. They were 2 of the best neurosurgeons I think I’ve ever been able to work with. They would operate on children with brain tumors and literally cure these kids. It was amazing!

So the experience at Chelsea was not to be repeated! I think 3 or 4 years after I’d left they closed the hospital, and tore it down. Going to Bethesda wasn’t the icing on the cake, which was really Chelsea; but the cake was at
Bethesda, without the icing. We had good COs at Bethesda. The person I would lead was Dr. Thomas Cone. Another doctor who was there with him was Dr. Howard Pearson, who took Dr. Cone’s oral history here.

MS. BURKE: I’m starting to recognize some names now.

So you’re in Bethesda. Let’s just take a quick break here for a second. (break in audio)

All right, Dr. Margileth, when we had last broken, you had just arrived at Bethesda Naval Hospital, which would be your last tour in the Navy as a pediatrician on active duty. What was that experience like as a senior officer in the Medical Corps?

DR. MARGILETH: That was a wonderful experience because of the programs that were already set up by Tom Cone, MD, including the residency training program. I was fortunate to have a staff of doctors who were helping me; they did all the work. I sat behind a desk and wrote another paper or 2. I’m trying to find the picture of my staff pediatricians.

MS. BURKE: Oh, I remember this.

DR. MARGILETH: That is the picture of the staff and I think one or 2 residents at Bethesda Naval back in 1960s.

DR. RAJNIK: Nineteen sixty-five, 1966, your entire pediatric staff included 6 persons with one missing, so 7 people was the entire pediatric department.

DR. MARGILETH: Yes, that’s right. But of this group, everybody double-timed. They did all of the work that I had normally done in the past, and I was able to work in my office. For the first time I had a secretary whose name Tom Cone mentions. She was a good typist, and this was my golden chance to write another few papers, because I could get everything typed up and --

DR. RAJNIK: You had the support, right.

DR. MARGILETH: That is the biggest problem with research. You do the research, everything’s in a rough form, and you’ve got to translate that into a smooth form for publication. So the 4 years I spent at Bethesda were very productive years; physicians like Gordon Mella, and Dr. Luther Hansberger. They were really go-getters, and they could see 2 or 3 patients to my one patient. I always wanted to get the psychiatric point of view, and their stance was just, “Let’s stamp out the sore throat or the cold or whatever it is.” Then we started to get referrals, thanks to Tom Cone, from embassies in DC.
They’d call up and say, “My child, or so-and-so’s child, is sick, or has a heart murmur, and we want a consultation with pediatrics at the Bethesda Naval.” So that staff was probably the most supportive, fun, and a pleasure of my 4 years at Bethesda Naval, because they did the work, and I wrote the papers.

DR. RAJNIK: That’s great. Up until now you haven’t mentioned very much about your kind of academic research career, so it’s kind of almost a natural progression. What were the things at that point in time in your career that were most interesting to you?

DR. MARGILETH: Well, mainly infectious disease --

(break in audio)

DR. RAJNIK: It is February 23rd, 2017, and this is Dr. Michael Rajnik, with Jackie Burke, from the American Academy of Pediatrics, and we’re in our second day of interviewing Dr. Andrew Margileth, at his home in Miami. And Dr. Margileth, a few things that we had thought about since we were able to take a break, and one of the things is you spent a lot of time in the Navy, and during that time you were in the Navy, it was kind of controversial at some times to be associated with the military, versus now the military is held in high regard in society. What was that like, being a physician in the military at a time when not everybody agreed with the mission that was going on?

DR. MARGILETH: Well, probably the biggest problem was, for example, pediatrics and dependent medicine really didn’t get started until about 1947. It takes 10 to 20 years for new things to settle in, and during that 10- or 20-year period Congress and Department of Defense and other people that had to do with the uniformed services were just in a quandary. It seemed like every 2 or 3 years somebody in the Congress or somebody in the Department of Defense would say, “We don’t need pediatricians. We don’t need OB/GYN doctors, because we can give those to civilians.”

Anyway, that turned out to be not so, and thanks to people like Admiral [Melvin] Museles, a pediatrician. There were 10 other pediatricians who made admiral, by the way. Several of these testified in Congress, and talked to the Department of Defense, and convinced them that we needed to take care of the dependents, because they were some 90% of the concern of the active duty person in -- particularly when overseas, worrying about his family, his children, his wife, and so forth. So, fortunately, over a period of 20 years, the time pretty much that I was on active duty in the Navy, this slowly became better and better, with less concern about taking care of the dependents.

DR. RAJNIK: That’s interesting, because we still have the same arguments and conversations today. In fact, the new Defense Authorization kind
of implies that dependent care isn’t something that they should be doing, so it’ll be interesting to see how that plays out. You also talked a lot yesterday about your education, and one of the things we wanted to ask you was, who do you think the most influential people were to you? You talked about Dr. Cone and some other people, but who were the most influential people in mentoring you to become a physician, and then, you know, a leader in the field of medicine?

DR. MARGILETH: Well, it probably started back in 1946, with my Uncle Andy, who was our provider, because my father died early in life. Andy developed lung cancer, for which there was no good treatment at the time. Watching him die in Boston, Massachusetts was a real changer to my life. I had never considered that before, never even thought about. So when he died after multiple surgeries for lung cancer, I said, “I’ve got to do something to help other people.” That was probably my main stimulus to become a doctor. Then from that point on I had people in medical school, and in the Navy, particularly my brother and 2 of my friends in the Army, encouraging me. And I’m so thankful to them for their good advice, because the happiest 25 years of my life were in the Navy.

DR. RAJNIK: Like all of us, you had to make a transition from being on active duty to civilian life afterwards, and you’ve been associated with a lot of the best institutions from Massachusetts to Washington, DC to places out west. What other formal or informal medical training did you acquire?

DR. MARGILETH: I actually had no further formal training. The training was the experience of being a primary care pediatrician in the clinic in Oahu. Then I worked as a single primary care medical officer, taking care of families and active duty all in the same time. So I was a general practitioner for one year, but then I went to Tripler and became a pediatrician. The backup for pediatrics at that time was really my colleagues, 2 Army physicians and 2 Navy physicians who were stationed there. Between the 5 of us we were able to take care of many children in an appropriate fashion. We would keep up to date with a journal club. Then, going to Corona Naval Hospital for 4 years, and having a wonderful mentor in the commanding officer, Dr. Julian Love, was probably one of the most stimulating 4 years I had, because he came up once, twice every week, and made rounds with me on the pediatric ward. Plus, we had 400 deliveries a month; I was actually able to deliver 100 babies during that 4 years, no primips [primiparas], all multips [multiparas]. [Laughter] That was a real learning experience, as well as a stimulus to do the best you could. Particularly when you delivered that baby you made sure the baby was going to be well taken care of. I had 2 or 3 medical officers, pediatricians that worked with me in the clinic, and we would see at least 40 to 50 patients a day. One of the reasons I’ve stayed in the Navy was the support from nurses. Good nurses, which I was very fortunate to have throughout my Navy career, was another good reason to
stay in the Navy, because the nursing staff and the enlisted staff were so supportive.

DR. RAJNIK: It’s a little different setup than the civilian world, although nurses are great there. What enlisted people do in the military, there’s not really a corollary to that in the civilian world.

DR. MARGILETH: That’s correct, yes.

DR. RAJNIK: One of the things that you’ve always placed a great emphasis on is dermatology, and skin findings, and their usefulness in pediatric disease. I think you talked a little bit about this yesterday, but when did you first really get interested in pediatric dermatology?

DR. MARGILETH: I would say when I was at the Children’s National Medical Center for 11 years in DC, I became interested because I told people, “I really like rashes.” I knew chicken pox, measles, and scarlet fever. It was fun to look at that rash and say, “That is or isn’t chicken pox versus smallpox,” for example. So once people found out I was interested, they would refer me, or they’d just come over and get me and say, “Look at this rash. What do you think this is?” And so at the Children’s National Medical Center, for some 11 years, I was able to experience more and more time in dermatology. I had a good relationship with the head of dermatology at George Washington University, Mervyn Elgart, MD, as well as the head of at Howard University. They would attend for half a day every week, and we’d have 2 separate full afternoons of pediatric dermatology. I learned a lot from their direction in that 11 years. I was lucky to go to the Walter Reed [Army Medical Center] for another 11 years. I had the good fortune to work with Dr. William D. James, who was a well-known dermatologist and head of dermatology at Walter Reed. We set up a pediatric clinic there with his guidance. I had more and more training and experience from working with the dermatologists in those institutions.

My wife, Ellee, developed breast cancer in 1980. Unfortunately, her demise occurred 5 years later in July 1986.

DR. RAJNIK: After you left the military you’ve been associated with a lot of the most prominent medical organizations in the United States as you slowly moved your way down south to Florida. What was different about working in the civilian sector versus working in the military, or the Department of Defense?

DR. MARGILETH: Good question. Probably the major difference when Dr. [Val G.] Hemming kept urging me to retire from Uniformed Services. After 3 years I finally acquiesced and said, “I guess it’s time to retire.” So I said, “I think I will just try private practice.” Several things happened during that 4-1/2-year period in Fredericksburg, Virginia. I had a suite of 2
or 3 rooms in a general pediatrician’s office. Dr. John Painter was his name. Everything went perfect for about 4 years; I had built up more and more clientele from referrals. There were 9 pediatricians. I interviewed all 9. One doctor said he would never refer a patient to me. I’ll never forget that. And that’s a difference between the uniformed services and civilian MDs. They seem to be at odds with each other.

MS. BURKE: Make it competitive.

DR. MARGILETH: Yes, thank you. “Competitive” is the word. And it seems to me so unnecessary, because, after all, you’re there to help the mother understand what the child’s problem is; particularly, what the rash was due to. It took me a while to figure this out, how concerned a mother can be about 3 little bumps on the skin, such as Verruca vulgaris, warts, or molluscum [contagiosum]. It just drives them crazy. If you understand that, and have developed a rapport, then you know that you need to help them. Don’t send them out of the office, say, “Oh, we don’t need to do anything. They’ll go away in 4 years.”

DR. RAJNIK: So that was definitely a change for you. Now, you still practice pediatric dermatology. What’s the most rewarding thing to you now, as you’re in the twilight of your career, about still being able to work with patients and families?

DR. MARGILETH: I guess it’s just the opportunity to do what is most fun to me. After 4 years at Fredericksburg — the last year was sort of downhill, because Dr. Painter suddenly died after a hip operation. So I had to get my own office. That’s when, fortunately, I met my wife, Catherine. She was my office secretary. I practiced for another year or so, 4 days a week. One day a week I went to University of Virginia in Charlottesville, and spent the whole day there doing pediatric dermatology in the department of dermatology. At the same time, we were able to do clinical research. So that was so much fun, even though it was an hour-and-a-half drive from Fredericksburg to Charlottesville. But it was beautiful countryside. So everything was going well. Suddenly, I got a letter from the Medicaid/Medicare saying, “We need to review your charts. Just make copies of some 20 charts, and we will review these, and let you know if you’re doing the right thing.” And that was a real surprise! The support that I was getting from dermatologists in Fredericksburg continued.

At this time, one of our pediatric newsletters included a note about starting the first free clinic in Hilton Head, South Carolina. A pediatrician, Jack McConnell, MD, started it. There are now 25 of these VIM [Volunteers in Medicine] clinics around the country. I went down and he interviewed me. Jack was most enthusiastic and positive, sort of like the old Navy days. You know, “We’re here to take care of these patients.” They pay no money. It’s
all free. We had volunteers in every specialty, 2 of which were dermatologists. I learned more dermatology at the free clinic in Hilton Head, South Carolina. So that’s one of the reasons I said it’s time for me to get out of private practice and stop worrying about money and administrative details.

Much to my amazement, that’s when I learned to use the dermatoscope. The dermatoscope is probably one of the simplest and most valuable instruments that any doctor can use. I tell the students and residents here at University of Miami right now, if you’re in practice and you want to do dermatology, just lay the stethoscope aside and get a dermatoscope. The dermatoscope magnifies the rash at least 20 to 25 times, so when you look at a wart or a molluscum or any other rash, 90% of the time within 10 seconds you can say, “This is a wart. This is molluscum. This mole is nonmalignant, no evidence of cancer.” The dermatoscope provided a rapid diagnosis, mainly because it just made life so easy. I’d learned that at Hilton Head from the 2 retired professors of dermatology. One was from Brown, and the other was either Harvard or Tufts University.

DR. RAJNIK: So you learned that at a late stage in your career. Do you think that pediatricians should spend more time studying and learning about pediatric rashes and pediatric dermatology, that that would be helpful in their career?

DR. MARGILETH: I do. It sounds a bit presumptuous, but if pediatricians should simply refer to a book that Dr. James W. Bass and Dr. Russell Steele and I published, An Atlas of Pediatric Infectious Diseases, on infectious disease rashes in children. There have been 5 or 6 other books on pediatric dermatology published since then, with a similar emphasis on dermatologic findings in systemic diseases of children. It is amazing how simple dermatology can be, and that’s what makes it so much more interesting. If you know, you look at the rash and you say, “I know what that is.” If you look at it and you don’t know, you can get out the dermatoscope and hopefully that will help you. But yes, more time spent with patients, having one of these books available, would be a big help.

DR. RAJNIK: What other things do you think pediatricians need to do better in their practices to make sure that children are getting the best care?

DR. MARGILETH: That’s a real good question. Well, I suppose organization is important, having a good administrative assistant, a PA [physician assistant], a good nurse, and a set of plans to make your clinic or your private practice run in an orderly fashion. And if you do that, and have it set up ahead of time, and have one or 2 additional people to help you keep it organized and running smoothly, it’s a lot of fun. If you don’t have that, it may be chaos. [Laughter]
DR. RAJNIK: When you look at the residents that you meet now, and you see the different fields of medicine or pediatrics they’re going into, one of the things that I find interesting is that even when I trained 20, 25 years ago, there was an emphasis on being the complete pediatrician. More pediatricians tend to focus on outpatient or inpatient or not wanting to do deliveries. Do you think that pediatricians are missing something by not having that kind of full experience?

DR. MARGILETH: Well, I think you hit the nail on the head: yet, they’re missing something. Being a complete pediatrician, to me, is the way to really enjoy pediatrics. As I’m now doing dermatology, only. By the way, the best fun of pediatrics is watching the mother’s face when you say, “Oh, this is so-and-so.” And the most important thing we emphasize in caring for the patient is education. I always tell the students and residents that the 3 most important aspects of patient management are education, education, and education. And so we try to emphasize that, which greatly enhances compliance and outcome.

DR. RAJNIK: I think you’re right on.

DR. MARGILETH: Yes. I talked recently to Dr. Bartley Cilento, who just stopped private practice in Scituate, Massachusetts when he hit 80, and I talked with Jim Brien, DO, who is still in practice in pediatrics and infectious disease in Texas. They both said more and more people are just doing general or hospital pediatrics. If the diagnosis is problematic they immediately refer it out. The specialists in pediatrics have blossomed. There is just a specialty in everything, including telemedicine. They both had agreed that more and more emphasis has developed in hospitalists versus outpatient care. And to me it’s a bit of a shame to not have that broad scope to care for, but with the present administrative details, particularly the electronic health record and the litigation problems, it is difficult. I’ve had 5 lawsuits, and that would take another hour or 2 to discuss those, but they were all frivolous. We have too many lawyers, by the way. I won’t go any more detail than that. [Laughter]

DR. RAJNIK: You have 3 in your house.

DR. MARGILETH: Yes.

(break in audio)

DR. RAJNIK: All right, Dr. Margileth, you’ve been very active in research, despite all of this clinical medicine you’ve been practicing. Can you tell us a little bit about that? You know the Section on Uniformed Services at the AAP recognizes your work with the Andrew [M.] Margileth Award, given to the best clinical research project in Department of Defense pediatrics each year.
What were your areas of interest of research, and what do you think had the most impact on pediatric medicine through your research?

DR. MARGILETH: Oh, good. I think in the beginning it was mainly infectious disease. Cytomegalovirus disease is the first paper I wrote from seeing an infant with CMV at Tripler Army Hospital. It was stimulated by my colleagues saying, “You know, that’s a really unusual case. We better write this up.” So that’s exactly how it started. With help from my colleagues at Tripler, and secretarial help, we were able to write a paper easily. When I went to Corona Naval Hospital, one of the first cases I had was a child that came in with the oculoglandular form of cat-scratch disease. Almost nothing was in the literature except oculoglandular disease due to tuberculosis, but nothing due to cat-scratch, so we wrote a paper. Once I found out how easy it was, and it was accepted by Pediatrics, I just felt this is something that’s fun to do, and important to inform other physicians. Once I got started, I couldn’t stop.

DR. RAJNIK: You’ve pointed out your interest in cat-scratch disease. That went on for a long period of time. You took it from that first case report to doing clinical investigations in various areas. When you think about the impact that you had in cat-scratch disease, with Bartonella, and how that changed over the 60 years since you wrote that first paper, what was most stimulating about that process?

DR. MARGILETH: When I was at Chelsea Naval, I believe I saw one or 2 cases of cat-scratch disease from Boston. When I moved to Bethesda Naval, it was like a snowstorm of cat-scratch patients. Chronic localized lymphadenopathy in a healthy child was the usual presentation. I got a phone call from AFIP (Armed Forces Institute of Pathology), from Colonel Douglas J. Wear, a pathologist at AFIP. He said, “Are you interested in cat-scratch disease?” I said, “Oh, yes, I am.” And he said, “Please come over. I think I’ve found the bacteria.” I went to AFIP at lunchtime and under the microscope was a positive Warthin–Starry stain showing the cat-scratch bacillus. So from that point on, with the stimulus from the group at AFIP, and all of these clinical cases coming in to the Uniformed Services University [of the Health Sciences] as well as Walter Reed in Bethesda, we had to publish the papers. We had, I think, close to 1,000 patients with cat-scratch disease (CSD) over 10 years.

At the same time, there was one other location where my interest was stimulated by a Dr. Hugh Carithers from Jacksonville, Florida, who was seeing cat-scratch disease in Jacksonville. He had published several papers on CSD. One of the most unusual papers was the neurologic complications of cat-scratch disease. So, we had this great source of clinical material in both Washington, DC and in Jacksonville, Florida.
DR. RAJNIK: It was your clinical practice that led to you finding this area of interest and the fertile field to go in. When you think back to when you were going through this process, what were the biggest challenges that you faced as a clinician/researcher?

DR. MARGILETH: I guess it was having secretarial support and administrative support. It was not a major problem at AFIP. But at Walter Reed and Bethesda, it could be problematic. Probably the biggest thing is having time and administrative help.

DR. RAJNIK: Right, I think time is everybody’s biggest concern, trying to carve out the time to do that when you’re in a busy clinical practice.

DR. MARGILETH: I think another aspect is that when you see these unusual patients, as we did at Walter Reed and Bethesda, and have the interest by the interns, residents, and staff physicians, you get stimulated to say, “Gee, we better write this up so other people know about it.”

DR. RAJNIK: All right. What do you think the major differences are for pediatricians that are trying to do research now, versus when you were working?

DR. MARGILETH: Well, I believe that some ten years ago they passed the HIPAA [Health Insurance Portability and Accountability Act] law, and the HIPAA law restrained physicians from getting the clinical and follow-up information that one needed. To me, follow-up is the most important aspect of treating any child. If you don’t have follow-up, it is unfortunate. For example, telephone calls could be the simplest way. The HIPAA law limited one to provide over the phone reports. The patient must come in and see you. It’s a ridiculous situation.

Number 2 is the CLIA [Clinical Laboratory Improvement Amendments] law, which stopped us from doing laboratory work in Fredericksburg. We had an active laboratory in Dr. Painter’s office, plus a technician who ran the lab. All of a sudden they said, “You can’t do throat, skin or urine cultures anymore.” And that was just wrong to me, and to good clinical medicine, where you could do a test in 5 minutes, have the answer and the diagnosis. So CLIA is not good, and HIPAA is worse.

DR. RAJNIK: The CLIA laws, and taking the ability for physicians to interpret tests on their own, and making rapid diagnostics have made a big difference. I remember being in medical school at the University of Virginia, and if we didn’t have a Gram stain by the time the attending came in in the morning, you better have a good explanation.

DR. MARGILETH: That’s right.
DR. RAJNIK: And you better have been doing chest compressions or something. And now I can’t get a resident to do a Gram stain. They’d have no idea what to do, you know.

DR. MARGILETH: It’s a real shame.

DR. RAJNIK: So, with that being said, though, there are a lot of modern research techniques that are a lot different than even 10 or 20 years ago. If you could have any of those techniques now, to go back and do some of the studies, or some of the areas of interest, what ones do you think would be the most useful to have?

DR. MARGILETH: That’s a good question. There are 2 tests: PCR [polymerase chain reaction] and ELISA [enzyme-linked immunosorbent assay] and one other. An agglutination test? And those are most helpful. In fact, instead of doing a culture for staph or strep, they’re doing a PCR. Same thing for Bartonella. And that’s certainly a rapid, quick way to do it, a lot more expensive, and not necessarily always accurate. It’s a real step forward, no question about it.

DR. RAJNIK: Yes, we have a lot of these tests now that are panels of tests --

DR. MARGILETH: Yes, an interesting CME [continuing medical education] course I took when I was in private practice in Fredericksburg was a 2-day course in laboratory medicine in Richmond. It was probably one of the most enlightening, attending this laboratory course. I found out that if you do 20 tests, a minimum of 5% are going to be in-error reports. I think physicians need to know if you take every test at face value, you may have trouble. And the most important is treat the patient, don’t treat the test.

DR. RAJNIK: Right. That’s one I always try to get our trainees to think about. If you order a test, what are you going to do with it? Whether it’s true or false, positive or negative, whatever, you better know what your plan is, because you don’t want to be surprised by some result that would come up there.

DR. MARGILETH: Exactly.

DR. RAJNIK: The culmination of all of your clinical research was having one of the Section on Uniformed Services awards named in your honor for clinical research. How did that come about?

DR. MARGILETH: That’s the vaguest bit of memory I have. I know that Dr. William Bason, who was chief of pediatrics at Portsmouth Naval [Naval Medical Center Portsmouth], was the one back in the mid-1970s, I believe, to
get 2 or 3 physicians together. Was it Dr. Museles, or possibly Jerry Imberg, MD. He had apparently formed a small group of people and said, “We really need to set up an award system.” Dr. [Ogden] Bruton’s award [Ogden C. Bruton Award] was set up about the same time.

DR. RAJNIK: Correct.

DR. MARGILETH: And Dr. Leo Geppert, I think the Army had set up 2 separate awards for him. So they didn’t want the Army to outdo Navy. Anyway, Bill Bason, I think, is probably the stimulus for that. But I’m delighted they did, because one of my greatest joys is going back to the Uniformed Services meetings each year.

DR. RAJNIK: I think they’ve been giving that award out now for almost 35, 40 years. When you look back and you see what people are doing in the Uniformed Services in terms of clinical research, how do you kind of interpret those efforts?

DR. MARGILETH: It’s up to the individual person, but it appears to still be a stimulus for a certain group of individuals. There is a list of 30 or so recipients for the Andrew Margileth Award. Dr. [Gregory] Gorman is a good example of how he progressed and has become a full-time physician, as I would call it.

DR. RAJNIK: Right. I think the award carries a lot of weight within the Department of Defense, and people understand that those who have received the Clinical Research Award are often some of our best and brightest people.

DR. MARGILETH: Exactly.

DR. RAJNIK: They are doing exactly what you’re saying: they’re doing that complete job as a pediatrician, as a clinician, and doing clinical research.

DR. MARGILETH: Exactly, and one thing we ought to think about is increasing the check amount. Should we give them $1,000 instead of $500 for the first prize? Something like that.

DR. RAJNIK: So what other role have you had within the American Academy of Pediatrics?

DR. MARGILETH: Oh, I had an exciting 4 years. I took Dr. Cone’s place as an interviewer at the NIH [National Institutes of Health] child development section. Every 3 or 4 months we went to NIH and reviewed research papers, mainly to see if they would be funded.
Then I had a call from the Academy. Hugh Thompson, MD, was president. He asked me if I would like to work on a paper with him, so we published 3 papers. I went back to Evanston, Illinois on several occasions for meetings, and to work with Dr. Hugh Thompson. One was on medical records [Overview statement on medical records. Pediatrics. 1975 Aug; 56(2):329] and one on urinary tract infection [Management criteria, documentation, and peer review of initial urinary tract infection. Pediatrics. 1976 May;57(5):754-9]. Two other papers were done with Dr Thompson [Management criteria, recording of performance and peer review of tonsillopharyngitis. Amer J Dis Child. 131:270-274, 1977 and Standards in Child Health Care, 3rd ed. Evanston, IL, American Academy of Pediatrics, pp. 1-183, 1977].

DR. RAJNIK: So you collaborated with others from the AAP.

DR. MARGILETH: Yes.

DR. RAJNIK: Were you members of any other sections, or what other professional organizations did you work with throughout your career?

DR. MARGILETH: I think the major one is the Society for Pediatric Dermatology. I joined in 1975, and I’ve been to every meeting except 2. This year it’s in Chicago for the World Congress of Pediatric Dermatology. I would recommend every pediatrician, if he or she could, to go to the annual 3-day meeting, because it’s full of practical and very educational information. It is just so full of information that you can’t afford not to go.

DR. RAJNIK: Yes, I think that that’s one thing that pediatricians today maybe don’t take advantage of enough. There’s such an emphasis on what they call maintenance of certification, and us doing certain things, but there are certain, I think, educational items that have more value than others.

So you worked for a long time in both pediatrics and pediatric dermatology. One of the things you were just alluding to was the administrative part of things. What leadership roles have you held? I know that the military gives you ample opportunities to lead or fail in your career.

DR. MARGILETH: That’s right.

DR. RAJNIK: What opportunities did you get or have you had where you were the man in charge?

DR. MARGILETH: Well, I really became in charge at Chelsea Naval Hospital, when Dr. Sherwood suddenly had a heart attack. I became the chief of pediatrics in Chelsea, and there was already a residency program. In fact, it was the first residency training program set up in pediatrics in the
uniformed services, but there’s controversy about whether it was Walter Reed or was it Chelsea? But with that responsibility of having 6 or 8 residents, it was just natural to do everything you could to provide them as much information as you could. So from Chelsea to Bethesda, which seems, as I look back on it now, not long enough -- 6 years at Chelsea and only 4 years at Bethesda. I think I should’ve done what Jim Bass did: he stayed 39 years on active duty. I wish I’d done that. Because getting into the civilian world was another story.

DR. RAJNIK: Yes. And it certainly has different opportunities. As you look back at your career, were there opportunities that maybe you missed, like the opportunity to go overseas? You talked about your OCONUS [Outside Continental United States] assignment was Hawaii, but were there other places that you wish you would’ve gone while you were in uniform, or other opportunities you would have pursued at some point in time in your career?

DR. MARGILETH: I would say so, but I was always called from the [US Navy] Bureau of Medicine and Surgery, ahead of time, saying, “Would you like to go to Chelsea, or to Bethesda? Would you like to go to Guam as the executive officer?” Or, “Would you like to go to the research unit in Cairo, Egypt as the commanding officer?” I’d always say, “You know, I think I’m doing what I want to do best here.” So I declined all administrative jobs. And as I look back, seeing some of the mistakes that some of the good clinicians made as COs, I’m so glad I stayed in the clinical arena.

DR. RAJNIK: Yes. It’s very difficult at this point in time in the military to stay completely clinical throughout an entire career.

DR. MARGILETH: It certainly is.

One of the other things that happened, when I was at the Uniformed Services University, Dr. Jay Sanford was dean at that time. He had one of the most dynamic, exciting attitudes in his relationship to the faculty and to the students. I had, I think, at least 6 trips to Germany for teaching, mainly dermatology but some pediatrics, to people at Landstuhl and several other Army hospitals. Anyway, I got some overseas duty when I was at the Uniformed Services [University], so that was fun, lot of good experience, and very satisfying.

DR. RAJNIK: I think the Uniformed Services University has done a lot to bring the different branches of the military together, and now we all think of each other as collaborating really well on everything.

DR. MARGILETH: Exactly.
DR. RAJNIK: That wasn’t necessarily always the case when you were in the military, was it?

DR. MARGILETH: No, but much more so than in civilian life.

DR. RAJNIK: So even the worst of times in the military can be better than some of the times that you experienced --

DR. MARGILETH: Exactly correct, yes.

DR. RAJNIK: All right.

(break in audio)

DR. RAJNIK: Dr. Margileth, as we look back at most of your career, you have an interesting view on the last 60 or so years of medicine. Where do you think pediatrics is going to be going in the next 10 years, and how do you think the role of the pediatrician is going to change in the future?

DR. MARGILETH: Well, I consulted with Dr. Brien and Dr. Cilento, and I agree with them that medicine, particularly pediatrics, is headed toward more specialization and more generalization, with the general pediatrics limiting themselves to general pediatrics, and referring out anything that’s a bit unusual to the pediatric specialists. From the patients’ point of view, that’s probably better medicine; the quality of medicine is better. To me, though, being an old-fashioned pediatrician, I think it’s too bad that you’re giving up hospital practice. But time, money, and family constraints will continue to separate hospitalists in one group and generalists in the other. I think that’s the way it’s going to go.

DR. RAJNIK: I see that happening in metropolitan areas, where you have a full complement of specialists that you can send patients to. I think that one of the challenges will be providing that same type of care in areas where there’s not the number of specialists. So do you think that there still is a place for the pediatrician who wants to be kind of the jack of all trades?

DR. MARGILETH: I think so, particularly in remote areas with telemedicine being available. When I was at one of my visits to Tripler in the last 10 years, Donald Person demonstrated the system. He showed me how telemedicine worked for Guam and the Mariana Islands. I thought this was remarkable. So if they can work out the monetary aspects of this in civilian life, and the medical, legal aspects of telemedicine, it’ll go worldwide. But at least in the Uniformed Services, it’s working well. I think there are certain areas like Kentucky, the hills of Kentucky, where people have to drive 6 hours to have a rash seen, when they are able to do it by telemedicine.
DR. RAJNIK: So Dr. Margileth, you had just mentioned about telemedicine being one of the big advances, potentially, in medicine, allowing access to care in places where they don’t have it, and we do see that a lot in military medicine. Are there any other areas that you see, either technology or something else advancing medicine over the next generation of physicians?

DR. MARGILETH: I think that is happening already, and started years ago. A Navy physician, Charles Godrey, MD, taught physician assistants as part of his Navy career. When I was at the University of Florida in Jacksonville for 12 years and in Savannah, I taught physician assistants. I see this at the University of Miami now, physician assistants fulfilling the role of performing basic procedures prior to the primary physician’s examination. For example, when you go to the eye clinic at the Bascom Palmer Eye Institute, one of the top ones in the world, you spend 20 or 30 minutes with a physician assistant. He or she takes your demographics, vital signs, and the basic history, so when the ophthalmologist sees you it’s a focused ophthalmologic examination. So I think the role of physician assistants and nurse practitioners are the 2 main areas that are developing. In some remote places there are only nurse practitioners, no physicians at all. Still, we do have a need for more primary care physicians. That is one of the big things that President [Donald] Trump is now facing, because there are places around the United States that have no physicians, because they cannot hire physicians who don’t have a green card. So that’s a major problem, and it will occur more and more. In fact, on the news yesterday there are dental assistants, who are doing the drilling and filling of teeth, under the supervision of the dentist. So that’s going to be more common, I think, in the next 10 or 20 years.

DR. RAJNIK: When you think about the role of the pediatrician in the military, do you think there’s going to be any differences in what their practice will be like, or how they’re utilized?

DR. MARGILETH: I think isolated facilities, like Minot, North Dakota, there’s only one Air Force physician. So that’s going to be a general pediatrician, general internist or a family practitioner role. I don’t think that’s going to change. Another major problem, I think, is there are not enough medical schools producing physicians in the United States. However, I think the figure is about 20% of the physicians now practicing in the United States took their training in other countries. So we have a dependence and need for “foreign medical graduates” taking care of patients in the United States.

DR. RAJNIK: Right, and I think there are some new medical schools, a lot of osteopathic schools that are developing. But I think one of the other
chokepoints in the pipeline is there’s only so many graduate medical education spots that are available.

DR. MARGILETH: Yes.

DR. RAJNIK: When you think about graduate medical education for pediatricians, do you see that changing? Do you think it needs to get longer? Do you think they should have more tracks, where people focus on either hospital-based medicine, or ambulatory medicine?

DR. MARGILETH: I think the track to hospitalist is just going to expand. They probably will have 2 years of general pediatrics or adult medicine, then one or 2 more years of specialty training in hospitalism, or other specialties. I think that’s going to continue to expand as the population grows. Yes.

DR. RAJNIK: Now, as you think back over the course of your career, and you think back to the medical care that was available and that was delivered back then versus now, how do you see the general health of children in the United States, versus when you first started?

DR. MARGILETH: The health of children I see today is much better due to pediatric and family practitioner’s care, i.e., nutrition, vaccines, preventive medical care, family values, seat belts, less smoking and better public health measures. A new and very concerning problem has occurred. I have to refer to an article I just read in the AOA [Alpha Omega Alpha] Pharos magazine. They talk about how too much information is overwhelming many people. It is the electronic health record, particularly when the physician has no physician assistant to help take that history, contributes. Physicians now spend twice as much time completing the electronic healthcare record as they did directly talking to the patient. I am fortunate, because the dermatology residents I’m working with now do all of the typing and filling in of the electronic health record. I just have to review and sign the record. So I’m dumbing down as time goes on.

DR. RAJNIK: There’s so much more time spent documenting now --

DR. MARGILETH: Exactly.

DR. RAJNIK: -- and there’s less time spent with the patient, or examining the patient. It’s a definite change that I’ve even seen over the last 20 years in terms of the number of patients that a person can see. Even when you’re seeing them you spend less time with the family.

DR. MARGILETH: Some of the specialties in surgery, since the money is available, have scribes, which may be an MA, a medical assistant, or a PA. The scribe, on their tablet or pad, records the history and physical, and then
transfer that to the electronic healthcare records. So there’s a way out of this problem, if we just had enough money to have everybody have a physician assistant, or a scribe.

DR. RAJNIK: Right. We see people applying to medical schools, that’s a really common job they have as undergraduates, working as a scribe in emergency departments. They are able to get into the healthcare setting a little bit earlier, and kind of see the physician and patient interaction. It is good, but, as you said, somebody still has to pay that person to be there.

What are the problems that we face in child health now versus when you started, and how do you see overcoming those issues?

DR. MARGILETH: That’s a really good question. There are 2 or 3 aspects of quality childcare in the future. Number one is getting people to stop smoking, particularly the parent. And that’s reduced now to about 15% of the population who are still smoking. That’s a gut reaction that we’re going to have a hard time reducing. The second is improving the use of vaccines. No smoking and vaccines are the 2 greatest public health measures that have happened in the last 30 to 40 years. If that can continue without some prominent people making derogatory comments about vaccines causing autism, our children and families will be well ahead.

Probably the third item is providing more information to the public about advances in research. Also the values of preventive medical care from groups like the American Academy of Pediatrics and the American College of Physicians. Before patients go see their doctor, and they know it’s going to be a 10-minute interview, that they’ve already written down the key 2 or 3 questions that they need to be answered before they leave the doctor’s office. So education, no smoking, giving vaccines, and more research is going to advance medicine in an appropriate manner. An excellent source I would recommend reading by all physicians is Dr David B. Agus’ book, *The Lucky Years: How to Thrive in the Brave New World of Health* [2016, Simon & Schuster].

DR. RAJNIK: OK, so think about that same question when you think about underserved and developing parts of the world.

DR. MARGILETH: Wow, absolutely.

DR. RAJNIK: How have you seen the general health of people globally change over the course of [50 years]?

DR. MARGILETH: Yes, I think the major problems we have globally are poverty and starvation. Recently, India, after 4 intensive years of vaccination, eliminated polio in India. So it can be done, under very difficult
circumstances. It depends on a well-organized healthcare system that they have in India. I think that’s remarkable that those things can still happen in third world countries. So it takes special leadership to get that to happen.

DR. RAJNIK: You know, those stories are the things that kind of inspire people. And then you see issues in places like Syria where things are kind of falling backwards because public health falls apart; demonstrates the importance of public health. So what role do you see the next generation of pediatricians playing in making sure that the health of children in the United States get better, or the health of children throughout the world improves?

DR. MARGILETH: A very appropriate question. I think it comes down to the individual. Fortunately, we have people who have the leadership to move things forward in an appropriate manner. We must continue to encourage leadership development. We should encourage research and education, and more physicians to attend CME meetings every year, to keep up with the important advances in quality care. It depends upon each person, as to how motivated they are to go to meetings, to spend the money to continue their medical education, which is an ongoing necessity for good medicine to be practiced.

The MOC [Maintenance of Certification] program, about which I wrote an article in *Clinical Pediatrics* 7 years ago, with the help of Russell Steele, was controversial. The physician in a busy practice doesn’t have time to do some of the things that MOC is suggesting to get further education or provide quality care.

DR. RAJNIK: Right, so maintenance of certification, certainly, from an idealistic standpoint sounds like it’s the responsibility of everyone, but it’s practically difficult to --

DR. MARGILETH: It’s an impractical situation.

DR. RAJNIK: Yes. One of the other things that you talked about off the record was the importance of people being successful and having mentorship. When you look back, who were your biggest mentors?

DR. MARGILETH: Well, I was very lucky. I had my first experience at the Corona Naval Hospital with Dr. Julian Love, who was CO. He gave me encouragement and the satisfaction of doing a good job that was so important. Then when I retired and went to the Uniformed Services University. People like Jay Sanford, who was the dean, were very stimulating. He encouraged me to continue the research I was doing in cat-scratch disease, and allowing me to see these patients at the university. Does that still happen?
DR. RAJNIK: There are still clinics at the university, yes.

DR. MARGILETH: Oh, wonderful. So mentorship is essential. When I went to Hilton Head, Jack McConnell, head of VIM, was a very encouraging mentor, he was positive. There was no negativism. Some people didn’t show up for work, because they were all volunteers. We would fill in, do the job, and get the patients seen. When I went to Stuart, Florida to volunteer there, the same thing occurred. I became bored, because there wasn’t much business in the new VIM, so I went to the public health department and said, “Do you need a pediatrician for a couple days a week?” And they said, “You can start tomorrow.” And so I had a mentor there, Dr. Eric Ewald, who was head of the Department of Health at Stuart, in Martin County, Florida. He encouraged me. I was lucky to have superiors who were mentors who encouraged me to do the best I could. The pièce de résistance was when I was suddenly told by my wife, Catherine, that we’re moving to Miami 3 years ago. I said, “Well, what am I going to do in Miami?” And she said, “I don’t know, but you’re going to have to do something.” So she was my mentor, in a way. I immediately called Dr. Lawrence A. Schachner, who was head of dermatology at the University of Miami. Being a pediatric dermatologist, he welcomed me with open arms. I now direct one of the pediatric dermatology clinics each week at the University of Miami, with great satisfaction.

DR. MARGILETH: Yes. Very happy to do so, because I’d been at the National Children’s Medical Center in Washington, DC for 11 years, and I was getting a little fatigued from seeing so many patients and having so many responsibilities. I was chief of the outpatient department at that hospital for at least 5 or 6 years. I received a phone call from Dr. James Bass, who was the first head of pediatrics at Uniformed Services medical school. He asked if I would be interested in coming out and working with him. And it was like a call from heaven. I said, “I’ll be there tomorrow.” So I had an interview with Dr. Bass and 2 or 3 other principals at USUHS [Uniformed Services University of the Health Sciences]. In 2 weeks I left Children’s Hospital and went to work at the Uniformed Services. It was my second happiest time of my career, because I was back in a Uniformed Services scene, where people knew pretty much what they were supposed to do, and everyone was working toward the same goal.
Also, it was exciting when I had gotten that phone call from Dr. Wear, Colonel Wear, about my interest in cat-scratch. I had only been there a year or so, and I was plunged into cat-scratch disease clinical research, due to the species *Bartonella*. And the third was I was very, very fortunate to have a group of brand new medical students who were coming in every year to USUHS for training. I was able to give at least 2 or 3 lectures per month. So teaching, research, and patient care were fulfilling.

Ten or 11 years later, when Dr. Val Hemming, chief of pediatrics, said, “Did you ever think about a time to retire?” I said, “Oh, I haven’t even thought about it.” He said, “Well, would you think about it?” Then 6 months later he said the same, and by the third time he said that to me, a year later, I said, “Well, I guess I better retire.” But I wasn’t ready. Jim Bass left and Dr. Errol Alden came as chief of pediatrics, which was great! What more could a person want? So, mentorship, excellent leadership and surroundings are most important.

DR. RAJNIK: Great.

DR. MARGILETH: So, lucky years.

(break in audio)

DR. RAJNIK: Dr. Margileth, when you look in your crystal ball in the future, do you think that pediatricians that are trained or have served in the military are prepared for the challenges of the future? And what do you think those challenges will be in the future of pediatrics in the Uniformed Services?

DR. MARGILETH: Oh, a good but difficult question. I believe that, assuming that they are receiving basically the same training that I had in the Navy, that the future of pediatrics is good. I think it’s going to be a matter of taking care of the family, and the child’s needs, in a quality fashion. With the appropriate education, as we presently have in our systems, the future is positive to me. I have learned, by the way, in the last 30 or 40 years to think more and more positively. And the best book I recommend is right here on my bookshelf. It’s called *The Power of Positive Thinking*, by Norman Vincent Peale from New York. Now, the man on the scene is Joel Osteen, who has that same fantastic positive attitude, in a very simplistic manner.

DR. RAJNIK: Dr. Margileth, you had said, when we were just talking a little bit about one of the people who was a contemporary of yours, Dr. Gordon Mella, a pediatrician from Montgomery County, Maryland, and you said that, you know, one of the things that he had pointed out to you was there were 4 important things that should be the hallmark of all good pediatric care. Do you want to share those with us?
DR. MARGILETH: Yes. In talking with Dr. Mella the last 2 days, he said to me one of the best things that the physician can do, particularly the pediatrician, is to join the American Academy of Pediatrics, or a special group that you’re interested in, and stay active. The AAP promotes Medicaid for families and their children. And these goals, I think, have not changed in the last 60 years. The most important 4 steps to giving quality care are accessibility, acceptance, accountable care, and patient education. So, with that, I would will stop.

MS. BURKE: Thank you.

DR. MARGILETH: Thank you for coming!

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CURRICULUM VITAE
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PREMEDICAL EDUCATION, MEDICAL SCHOOL AND GRADUATE WORK
Washington and Jefferson College 1940-1942 B.A.
Massachusetts Institute of Technology 1942-1943 B.S.
University of Cincinnati 1943-1947 M.D.

INTERNSHIP, RESIDENCY AND POSTGRADUATE TRAINING PROGRAMS
Naval Medical Center Intern, Rotating 1947-48
Bethesda, MD & Resident 1st Year 1948-49
The Johns Hopkins Hospital, Resident, 2nd Year 1949-50
Baltimore, MD
U.S. Naval Dispensary Assistant Chief, Pediatrics 1950-51
Washington, DC
Com Serv Pac Dispensary Chief, Pediatrics 1951-52
Honolulu, HI
Tripler Army Hospital Assistant Chief, Pediatrics 1952-53
Honolulu, HI
Corona Naval Hospital  
California  
Chief, Pediatrics  
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Chelsea Naval Hospital  
Chelsea, MA  
Chief, Pediatrics  
1957-63

Bethesda Naval Medical Center, MD  
Chief, Pediatrics  
1963-67

FORMER AND PRESENT MEDICAL SCHOOL AND HOSPITAL STAFF POSITIONS
Georgetown University Medical School  
Washington, DC  
Clinical Associate  
Professor  
1963-69

Howard University Medical School  
Washington, DC  
Clinical Associate  
1963-85

Children's Hospital National Medical Center  
Senior Attending  
1967-79

George Washington University Medical School, Washington, DC  
Professor, Associate Chairman  
1967-80

Uniformed Services University  
Bethesda, MD  
Professor & Vice Chairman  
1980-90

University of Virginia Medical Center  
Charlottesville, VA  
Clinical Professor  
1990-95

Mercer University School of Medicine  
Macon, GA  
Clinical Professor  
1995-Present

University of Florida/Shands Jacksonville, FL  
Clinical Professor  
2001-Present

PROFESSIONAL AND HONOR SOCIETIES
Alpha Omega Alpha Honorary Society  
1946-Present
Fellow, American Academy of Pediatrics  
1954-Present
Fellow, American College of Physicians  
1958-Present
American Pediatric Society  
1972-Present
Society of Pediatric Dermatology  
1973-Present
Society of Pediatric Infectious Diseases  
1988-Present
Association of Military Surgeons of the U.S.  
1957-Present
HONORS RECEIVED
Andrew Margileth Annual Award, Best Clinical Paper 1977-Present
Unifomed Services Pediatric Seminar
Golden Apple Student Teaching Award 1968 & 1973
Of the George Washington University
Military Pediatric Award October, 1976
American Academy of Pediatrics
Outstanding Citizen Educator Award, USUHS May, 1982
Student Teaching Apple Award June, 2003

NEW TEACHING EXPERIMENTS: Presentations
Round Table Pediatric Emergencies. American Academy of Pediatrics Annual
Workshops: Office Laboratory Aids. Ambulatory Pediatrics Association Meetings,
PREP, American Academy of Pediatrics CME, February and August, 1997

MILITARY SERVICE
Captain, M.C. U.S. Navy, 24 years Retired 1967
Pediatric Consultant: Bethesda, MD and Portsmouth,
VA Naval Hospitals 1968-1990
Walter Reed Army Hospital 1976-1990
Malcolm Grow Air Force Hospital 1976-1990

SPECIALTY BOARD
Pediatrics Certified 1954
Recertified American Board of Pediatrics 1981, 1996

HOBBIES
Amateur Medical Photographer 1957-Present
6000 Kodachrome slides, 35mm catalogued for
teaching pediatric infectious diseases, dermatology,
and pulmonary disorders

COMMITTEE MEMBERSHIPS HELD
Children’s Hospital National Naval Medical Center (CHNMC)
Peer Review and Medical Records Committee 1969-80
House Staff Education Committee 1969-75
Audiovisual Committee (Chairman) 1968-75
Student Clerkship Committee (Chairman) 1967-76
Co-Editor for Clinical Proceedings of CHNMC 1974-80
Executive Committee for CHNMC 1973-80
Continuing Medical Education Committee 1968-79
Utilization Committee 1974-79
Medical Council, Department of Medicine, Vice Chairman 1974-79
Medical Board, CHNMC 1978-79

Local
Infectious Disease Committee for DC Medical Society 1972-75
Chapter East Uniformed Services, American Academy of Pediatrics 1983-Present

National
Member, Military Section of American Academy of Pediatrics (AAP) 1962-Present
National Advisory Council of Child Health and Human Development 1963-67
Military Pediatric Consultant to Council on Standards of Pediatric Practice of AAP 1965-67
Standards Committee of American Academy of Pediatrics 1967-76
American Academy of Pediatrics Council on Pediatric Practice 1968-72
Joint Committee for Quality Assurance, AAP 1971-76
Editorial Board of the Bulletin of Pediatric Practice, AAP 1970-75
Standing Committee of AAP for Early and Periodic Screening, Diagnosis, and Treatment Under Title 19 1973-76
Medical Department Visiting Committee - Massachusetts Institute of Technology 1974-76
Consultant, Pediatrics, Surgeon General, U.S. Navy 1977-90
Editorial and Advisory Boards, Pediatric Dermatology 1988-98
RESEARCH

1. Investigational studies to determine etiology of cat scratch disease Col. Douglas Wear, USA, MC, Department of Geographic Pathology, Armed Forces Institute of Pathology, Washington, D.C.

2. Etiology of Chronic Lymphadenopathy in Children and Adolescents includes PPD typical and atypical PPD survey, 1957 to 11/99 Bureau of Biologics, FDA, IND 1267

3. Cat Scratch antigen testing, 1957 to 1997, Bureau of Biologics, FDA, IND 1511


PRESENTATIONS


POSTER SESSIONS

I. Margileth, AM, Lazoritz S, Golden SM, Bolan JS, Longfield J, Cruess D: Interobserver and Method Variability in Tuberculin Skin Testing

Exhibited at these meetings:


3. Uniformed Services Pediatric Seminar, 19th annual meeting, Reno, Nevada, March 5-8, 1984.


III. Margileth AM: Pediatric Dermatology 1996-1997: Diagnoses in 400 Referred Patients, Backus Children’s Hospital, Memorial Medical Center, Savannah, Georgia.


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7. Margileth AM: Cat Scratch Disease as a Cause of the Oculoglandular Syndrome of Parinaud; Pediatr.ics, 20:1000; 1957.


15. Margileth AM, Museles M: Current Concepts in Diagnosis and Management of


29. Margileth AM: Abstract: Cat Scratch Disease: Nonbacterial Regional Lymphadenitis; Year


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108. Margileth AM: Cat Scratch Disease: Diagnosis and Management. Diagnosis 8:50-71; 1986.


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