

2007

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Berger, M. "A 20th century pediatrician and the emergence of modern day pediatrics". The Proceedings of the 16th Annual History of Medicine Days, March 30th and 31st, 2007 Health Sciences Centre, Calgary, AB.

<http://hdl.handle.net/1880/47534>

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A 20TH CENTURY PEDIATRICIAN AND THE EMERGENCE OF MODERN PEDIATRICS

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Abstract

In 1922, in the midst of increasing infant mortality and the rampant spread of infectious disease, a small, but dedicated group of physicians founded the Canadian Pediatric Society in Toronto. Surprisingly, there was tremendous reluctance on the part of the Canadian medical establishment, comprised chiefly of academics and internists, in recognizing pediatrics as a distinct medical specialty. However, the early pediatricians were steadfast in their belief that the needs of a child were diverse, that children were susceptible to a different category of diseases and they required a continuum of care from infancy through to adolescence. They believed that only those trained to recognize these issues were qualified to nurture the growth and development of Canadian children.

Dr. Lyon Pearlman, a pioneering Ottawa area pediatrician from 1938-1989, is an excellent example of an early practitioner who initiated changes at both the local and national level and helped to establish pediatrics as a specialty that integrates clinical, psychological and social issues in the management of illness. This paper will highlight some of his major contributions and place them within the context of the emergence of modern pediatrics.

In May 1984, the Canadian Friends of the Hebrew University in Jerusalem held a dinner in Ottawa, honoring Dr. Lyon Pearlman for fifty years of dedication to the practice of pediatrics. Over 300 people attended in order to celebrate the extraordinary career of one of Ontario's pediatric pioneers (Brodie 1984, 43). Among the many former students and colleagues present, it was a teenaged patient who perhaps best captured the doctor's unique ability to understand and relate to those whom he looked after for so many years. In a statement for the Canadian Jewish News, the patient remarked, "he's interested in me as a person [and not just as a patient]...I know he really cares" (Dempsey 1984, 25).

Dr. Pearlman, Ottawa's first Jewish pediatrician, is best remembered in the community for not only his rapport with individual patients, but for his distinctive approach to the care of children and adolescents, in a time when the paternalistic physician-patient relationship was still widely practiced (Gafni and Whelan 1999). His focus on growth, development and illness in the context of both physical and social health was a precursor to the patient-centered method of care being taught in medical schools today (Schulich School of Medicine and Dentistry Curriculum Objectives, 2006). This approach was at the core of many of the discoveries and changes instituted by Dr. Pearlman and other early practitioners in reforming Canadian pediatrics. It is the purpose of this paper to examine Dr. Pearlman's specific contributions against the backdrop of 20th century pediatrics and to place them within the context of a developing medical specialty. Emphasis will first be placed on the development of the specialty, from one that was practiced informally and by few, to one that became an integral component of the health care system. In doing so, the environment in which Dr. Pearlman entered his practice will be established. Subsequently, a discussion of his career, with specific attention paid to his contributions in social medicine, will establish his place as a model Canadian pediatrician of the period and as a role model to those that followed him.

From "Stool Science" to the Canadian Pediatric Society and Beyond

When Dr. Lyon Pearlman embarked on his pediatric career in Ottawa, Ontario in 1938, he entered a field of medicine that slowly gaining credibility in the eyes of the medical establishment. At the turn of the century, pediatrics did not exist in Canada outside of a handful of doctors who were concerned over escalating child mortality rates. Although precise estimates weren't available until the 1920s, information derived from 1891 and 1901 censuses of Ontario and Quebec residents has shown that infant mortality was a significant issue (Mcinnis 1997, 266). In the U.S., it has been estimated that two out of every ten children died before reaching their fifth birthday (Preston and Haines 1991, 6). While it was becoming exceedingly important in the public's view to examine the causes of high infant mortality, the scope of investigation was limited almost exclusively to issues pertaining to communicable diseases and to rampant outbreaks of infant diarrhea (Oski 1990, 2-3). While significant advancements were being made in the fields of medicine and public health, for example through the advent of the diphtheria antitoxin in 1894, they had little impact in medical practice as physicians did little to incorporate scientific evidence in the treatment of their patients (Preston and Haines 1991, 11). Perhaps the most scrutinized example from this period pertains to the issue of infant feeding, which was approached from a perspective that could hardly be described as scientific. Summer outbreaks of diarrhea were linked to unsanitary milk used in artificial feeding. This led to the establishment of a pseudoscience called "the percentage system" for cow's milk. Developed by eminent pediatricians of the day, including the first professor of pediatrics at Harvard University, Dr. Thomas M. Rotch, the percentage

system was an attempt to modify cow's milk to resemble mother's milk to an "absurd extreme," by using random mixtures of sugar, milk and cream (Harrison 1965, 2). Reflecting on this period, Dr. Alton Goldbloom an expert in childhood medicine in the 1920's, labeled his predecessors as nothing more than practitioners of "stool science" (Goldbloom 1959, 123).

Although the issue of infant mortality was drawing attention to the diseases of children, pediatrics was still widely considered to be a sketchy practice. In describing the state of knowledge about the diseases of children at the turn of the century, Dr. Rotch surmised that, "[pediatric knowledge was] a poor subterfuge of unreal facts forming structures of misleading results which in the scientific medicine of adults would not for a second be tolerated" (Bremner, ed. 1971, 821-22).

For this reason, there may have been a reluctance to accept pediatrics as a distinct medical specialty and its proponents in were engaged in a struggle with the medical establishment over its relevance. In Canada, the situation was no different. An editorial in the *CMAJ* at the time surmised that "all [should] recognize that that pediatrics is only a department of general medicine," and it advocated for the formation of a section of the general assembly, as opposed to a separate form of governance (Mckendry and Bailey 1990, 8). Behind closed doors, those in charge were adamant that pediatrics was unworthy of distinction. An influential faculty member at McGill University in Montreal stated that he would recognize a separate department of pediatrics "over [his] dead body" (Goldbloom 1959, 207).

With the formation of the Canadian Society for the Study of Diseases in Children in 1922 and through the contributions of its founding members, the old paradigm was set to shift (Mckendry and Bailey 1990, 8). The organization, which was the precursor to the modern Canadian Pediatric Society (CPS), was founded by fifteen pediatricians from Hamilton, Montreal and Toronto at the Hospital for Sick Children in Toronto with a mandate to, "promote the advancement of knowledge of physiology, pathology, psychology and therapeutics of infancy and childhood" (The Canadian Pediatric Society 2006). This was an important step in creating a setting in which doctors across Canada, who were concerned about the health and welfare of children could share their experiences. Subsequently, pediatrics was able to establish itself as a factor in academic medicine. In 1937, the first department of pediatrics was established at the University of Toronto (Goldbloom 1959, 223). Other institutions followed this model and there soon became a widespread movement towards establishing programs in other institutions (Mckendry and Bailey 1990, 9-11).

Although the formal infrastructure was established early on, it became evident that contemporary notions about the role of the physician in daily life were inadequate with regards to the needs of children. At the time, medicine was a disease-focused entity, so

that there was no continuity of care for the well patient. One was only supposed to go to the doctor if he or she was sick. Once the disease was cured, the physician was no longer responsible for that patient. This type of practice was not suitable for children, as subtle developmental delays and behavioral issues were often overlooked, as a child would not be brought to the physician under these circumstances (Prescott 1998, 12-14). During Dr. Pearlman's career, pediatrics was to encompass more than just acute disease treatment. He was one of the first to take the specialty out of the hospital setting and into a private, community-based practice. In this environment, the physician was able to assess individual progress over a long period. With repetition, pediatricians were able to establish standards for normal growth and development, necessitating a need for "check-ups," whether the child was sick or not (Prescott 1998, 10). Becoming experts in the behavior of healthy children required an understanding of the many of the sociological determinants of health. This led to pediatrics being categorized as, "a social medicine of the 20th century," and it was in this new context of community based medicine where Dr. Pearlman made his mark (Abt ed. 1965, 130).

Starting a Career in Pediatrics in the 1940s

Lyon Pearlman was born in Ottawa, Ontario on November 17, 1911, the son of a watchmaker and the oldest of four children. After graduating from Lisgar Collegiate Institute in the late 1920s, he elected to go to medical school at the University of Toronto, with moral support and financial help from his uncle, Dr. Sam Mirsky, an Ottawa area internist. It was here that he became interested in the diseases of infants and children.

After graduation, Dr. Pearlman was left with very little choice as to where to begin a career in pediatrics. Canadian hospitals did not yet offer residency programs, so he was forced seek training elsewhere. In 1936, at the age of 25, he accepted a pediatric residency position at the Jewish Hospital in Brooklyn, NY (Pearlman, ca. 1995). Within a year, he was serving as assistant chief resident at the Children's Hospital of Philadelphia. At that time, pediatrics in the U.S. was more established and was already well received within the medical community. The infamous Canadian physician Sir William Osler was drawing attention to the value of pediatrics as president of the American Pediatric Society as early as 1892. In addition Dr. Emmett Holt, medical director of the New York Babies Hospital (the first hospital in the U.S. devoted entirely to infant care) wrote the definitive textbook on pediatric care entitled, *The Diseases of Infancy and Childhood*, which made pediatrics in the U.S. a definitive entity long before it was in Canada (Harrison 1965, 2).

The U.S. sojourn gave Dr. Pearlman some needed mentorship and practical training, but when he returned to Ottawa in 1938, he left a thriving pediatric centre for a relative wasteland. He was predated in his hometown by only five pediatricians, most of whom had little specialized training. In describing the level of knowledge possessed by these

physicians, author Donald Jack surmised that they were still practicing a sort of quasi brand of medicine rooted in folklore and superstition (Jack 1981, 125). Dr. Pearlman himself once recalled one of his esteemed predecessors, who was considered a well respected “pediatrician” because he sold raffle tickets for worthy children’s causes and prescribed hanging garlic on the door as a means of curing disease (Pearlman 1974).

In 1939, he set up a small office on O’Connor St. in the downtown area, funded by three hospital positions that he had obtained (Pearlman 1974). It took some time before he was able to establish a reputation and grow a sizable practice. Most of his patients in the early days came from referrals by obstetricians and general practitioners, as it was still uncommon to take a child to a pediatrician on a regular basis. However, while working in the nursery at the Grace Hospital in 1940, he thwarted a major diarrhea epidemic, after discovering flaws in the hospitals’ sterilization procedures (Pearlman 1940). To discover what was making the infants so sick, he wrote letters to the nurseries of hospitals across Canada and the U.S. and found an association between poor sterilization of baby bottles and infants coming down with diarrhea. By using an early case-control methodology, he raised the standard for sterilization procedures in area hospitals. After this incident, his profile rose dramatically and he started to receive more and more referrals. By the end of the 1950s, he was working 90 hours per week, seeing hundreds of patients in his office and on house calls (established through interviews with Dr. Pearlman’s wife and daughter).

The Development of Social Pediatrics

While his career was defined by his ability to recognize the varied social factors at play in childhood illness, Dr. Pearlman was the first to admit that it took him fifteen years to discover that, “illness is not just organic, but that there are many other elements outside the realm of the physical that contribute to disease” (Dempsey 1984, 25). In the 1930s and 1940s, pediatricians were still waging war on communicable disease. Issues related to immunizations and the application of antibiotics were paramount and Dr. Pearlman and colleagues were mainly concerned with establishing guidelines for the appropriation of all the new medical technology and information that was available. Sulfonamides of the 1930s and penicillin in the 1940s enabled the treatment of tuberculosis, pneumonia and sexually transmitted diseases, while gamma globulin development had reduced the severity of common childhood diseases such as measles, mumps and rubella (Prescott 1998, 11). At one time, these diseases were thought to be “unavoidable calamities,” but suddenly they were very easily prevented (Preston and Haines 1991, 13). As a result, children had a much greater chance at survival and pediatricians began examining healthier children.

Dr. Pearlman himself made some specific contributions in this forum. At the Strathcona Hospital for Contagious Disease, he was one of the first physicians to incorporate the use of sulfonamide drugs in the treatment of meningococcal meningitis (Shirreff and Pearlman 1941). In addition, he recognized that oil of wintergreen (methyl salicylate), which was a standard ingredient in candy, was actually a toxic substance. His article published in *CMAJ* in 1940 prompted the Federal Department of Health to label the substance as poisonous, thus contributing to the decline in salicylate toxicity in children (Shirreff and Pearlman 1940).

Along with lower incidences of infectious disease came a drastic decline in infant mortality. In 1921, the year before the establishment of the early CPS, the infant mortality rate in Canada for 1,000 live births was 102.1 (see Appendix A for infant mortality statistics). Thirty years later, it had more than halved to 38.5. Not only were pediatricians able to cure their patients, they were seeing a lot more of them.

As the nature of practice changed, pediatricians had to revise their standards of what constituted normal growth and development (Goldbloom 1959, 308). The goal was not just to survive childhood anymore, but also to do it in the healthiest fashion. Dr. Pearlman and colleagues began to recognize the “child as a person” that can be affected by his or her social environment (Goldbloom 1959, 311). As the problems changed, so did the pediatricians’ approach. With his socially conscious ideology, Dr. Pearlman pioneered “interdisciplinary pediatrics” in Ottawa (Pearlman 1970a). This meant bridging the gap between medicine and all of the other social institutions responsible for child welfare. The following sections will illustrate how this was accomplished in the changing pediatric landscape of the 1950s and 1960s.

Caring for the “Well Child” (Prescott 1998, 11)

As a result of the successes of the 1930s and 1940s, there was a huge growth in access to and quality of pediatric care in Canada. Dr. Pearlman and colleagues now had better equip themselves to deal with broader and more socially complex problems. In 1949, the Royal College of Physicians and Surgeons finally established proper examination and licensing requirements for pediatricians. In addition, by this time, the majority of medical faculties established separate departments of pediatrics (Mckendry and Bailey 1990, 65). Dr. Pearlman and colleagues were now on equal footing with their peers.

With a proper support system in place, pediatrics became a substantially larger specialty with an increasingly sophisticated framework. By 1961, membership in the CPS had increased exponentially since its inception (Appendix B). In addition, pediatrics was moving out of the small maternity hospitals and into government and university sponsored tertiary centres specifically designed for care and research in child health. In

Ottawa, various sites of pediatric treatment were consolidated at the Ottawa Civic Hospital in 1959 (Mckendry and Bailey 1990, 78).

Not to be discounted was the role of federal government in the establishment of this new infrastructure. Politicians recognized that child health and child welfare were not two distinct problems. Bureaucrats began to identify areas of focus that had direct implications on the responsibilities of pediatricians. A brief called, *Child Welfare in Canada* from the Department of National Health and Welfare (1959) identified programs for the “treatment and rehabilitation of crippled children, training of blind and deaf children, treatment for handicapped and cerebral palsied children” and many other social issues that required the expertise of pediatricians and other health personnel. A few years later, the Royal Commission on Health Services presented a health charter to parliament that stressed increased consideration for the health services available to children with special needs (Royal Commission on Health Services 1964). The report singled out “crippled and retarded children” as a top priority for new health service programs. Although grossly politically incorrect by today’s standards, this exemplified the heightened focus of the government on child welfare at the time.

A medium was now in place for Dr. Pearlman to use as a springboard to initiate social development and to practice interdisciplinary pediatrics as not only a clinician, but as a teacher, communicator, health advocate and innovator.

Dr. Pearlman as a Teacher

As one of the few qualified pediatricians in the city, Dr. Pearlman took it upon himself to act in multiple capacities. When the Strathcona Hospital became the main teaching hospital for medical students at Queen’s University, the responsibility for their education in pediatrics fell to him. He described his role as, “part-time resident, pharmacist, radiologist and lab technician for \$50.00 per month (Pearlman 1974).” He took on these extra duties, in part because of the lack of expertise at the hospital, but also because he wanted to ensure that there was a succession of qualified pediatricians to follow him.

In Ottawa’s Civic Hospital, he lectured nurses about the contentious issue of infant and childhood nutrition in the 1940s and 1950s. This was a relatively new area without a solid evidence base and health professionals were giving inconsistent information to patients. He was greatly concerned over the troubling trends in childhood nutrition and imparted this to his students.

Upon review of his lecture material, he was particularly concerned about three conditions that were still widespread in Canadian children; scurvy, anemia and rickets. It was not for lack of understanding of the pathology that these conditions were still prevalent, but

rather due to a lack of education for mothers and health care workers. For example, in one lecture, Dr. Pearlman made mention of *idiopathic hypercalcemia*, a recently discovered disease in children. Most physicians and nurses were aware of the association between vitamin D deficiency and rickets, but they were not familiar with recent research documenting vitamin D toxicity with high doses. Foods that were both high in vitamin D and calcium were being given to infants without regard for dosage and causing significant vomiting and pain because adequate information was not available. He was one of the first to advocate for regulating doses of vitamin D (Pearlman ca. 1960).

Dr. Pearlman also possessed a tremendous grasp of how contemporary society was influencing childhood nutrition. He realized that many of the risk factors for malnutrition revolved around social issues and it was the responsibility of the nurses he was instructing, to properly educate parents. There were two areas in particular where he felt that proper instruction from nurses could make a significant difference.

First, he was seeing a greater incidence of obesity among the children in his practice. Keep in mind, that he saw this trend fifty years before it became an issue of epidemic proportions. He was never a proponent of putting children on a fat reducing diet, but he had to modify his outlook with the advent of television. In middle class homes all over North America, television was keeping children indoors and glued to the couch. This trend, coupled, with what he saw as “a post-depression mentality of over-eating,” was the main cause of the obesity. In his own words to his students, “[we] have munchies consumed in great quantities while Roy Rogers is riding around the TV. Better he should be eating [the munchies] (Pearlman ca. 1960).” In this respect, he was able to impart to his students that improper nutrition is a function of a society and not a pathological process.

In addition to childhood obesity, he was aware that malnutrition among immigrant children was a major issue. As Canada became a more ethnically and culturally diverse country, pediatricians had to reconcile standard practices with different value systems. Accordingly, he instructed public health nurses about the importance of counseling those who were unfamiliar with western nutritional practices. Up until the early 1980s, the public health nurse was responsible for entering homes and ensuring the stability and safety of the child’s environment. In his lectures, Dr. Pearlman stressed that social awareness was an integral part of the job. “Anyone interested in public health [must also] be interested in society,” he remarked (Pearlman ca. 1960). He informed his students that immigrant families were desperate to integrate themselves into the Canadian value system in any way possible. Accordingly, these “new Canadians” identified with their new country by eating the food that regular Canadians ate, like soda and potato chips. If everything about the adopted country was great, then the food that its people eat must be good for you too. As a consequence, he saw many patients with high carbohydrate, low vitamin diets. In addition, there was an array of baby food on the market that many lower

income families could not afford. He counseled his students about the less costly, but still nutritious alternatives, such as the daily iron supply derived from the 25-cent box of cereal.

As a teacher, Dr. Pearlman was able to draw from the experiences of his own practice to show his students that negative societal influence is a major contributor to abnormal development. It was and still is possible to mitigate the impact of issues such as childhood obesity and malnutrition by understanding their social context and through simple education of parents and students.

The Pediatrician as a Communicator and Health Advocate

In an interview during the 1970s, Dr. Pearlman was asked what the major concerns to his practice were. He responded that he found it most difficult to deal with the problems surrounding children from dysfunctional homes, children of alcoholic parents, handicapped adolescents, teen pregnancy and other problems outside clinical situations (Pearlman 1975). He was distraught at the lack of training medical students received in these areas and in the lack of communication across different health jurisdictions, if a child required complex care.

He took it upon himself to help bridge the gap between the institutions that were responsible for the welfare of Canadian children. Before his time, there was no established network in place to connect pediatricians with governmental, educational and judicial resources. From the 1960s until the time of his passing in 1996, Dr. Pearlman used his previously described interdisciplinary approach to implement various reforms in effort to provide a more comprehensive form of health care delivery. Specifically, he pushed for the medical establishment to acknowledge the relevance of psycho-social factors in disease; he acted as liaison between the hospital and social workers, educators and other professionals; he encouraged and initiated programs for handicapped and obese children; he pushed for health education to children from properly trained teachers; and the list goes on.

At the root of these initiatives was the notion that inter-professional communication was the key to comprehensive care. In an abstract presented sometime in the early 1970s, he stressed the need to establish dialogue because, “no man can be omniscient with respect to knowledge” (Pearlman ca. 1970). He implied that no pediatrician is able to solve all of the child’s problems by themselves and any notion to the contrary was detrimental to practice. In his view, one of the main obstacles to inter-professional communication was poor training of medical students. First of all, the students were so engrossed in the scientific aspect of their study, that they were graduating with the view that the child is no more than a “biological specimen.” Even if they were able to recognize the

manifestation of a psycho-social problem, they didn't have the faintest idea of where to send the child for additional help.

Dr. Pearlman made it his objective to promote awareness of these issues through his efforts as the medical authority to various social organizations. He sat on the board of directors for the CPS and the Canadian Institute of Child Health (1973-1977). He was also a member of the education committee for the CPS, where he helped develop a more socially focused medical school curriculum. In addition, he was chairman of the Ontario Committee in Child Welfare (1963-1965) and the representative of the Ontario Medical Association to the Ontario Committee on Children (1968-1971), among many other positions (Pearlman ca. 1995).

While his work in this area commanded a great deal of respect, some remained oblivious to the need for inter-professional communication. While acting as representative of the Ottawa Academy of Medicine to the Social Planning Council of Ottawa (1975-1983), Dr. Pearlman was questioned by the academy president about the utility of having membership in the council (Pearlman 1975b). The president was concerned that the academy's interest in social planning was a trivial one. Dr. Pearlman was inflamed by the lack of interest displayed by members of the academy towards community development. His response to the president was that "medicine is no longer [just] a physical medicine." He suggested that a physician, who is not acquainted with the developments in social agencies, is an incompetent one. To emphasize his point, Dr. Pearlman cited the example of a handicapped child with two hearing impaired parents. The only way to care for such a patient would be for institutions such as the academy and the social planning council to use a "team approach."

The Pediatrician as an Innovator

When Dr. Alton Goldbloom, the first chief of pediatrics at McGill in the 1920s and 1930s, published his memoirs in 1959, he lamented that adolescent medicine was still a "no man's land" for research and study (Goldbloom 1959, 312). At that time, the only place in the world that had an established adolescent clinic was the Children's Hospital of Boston. Dr. J.R. Gallagher, the clinic's director, recognized that adolescents need a "doctor of their own" to focus on their complex needs (Prescott 1998, 74).

In 1967, Dr. Pearlman was invited by the chief of pediatrics at the Civic hospital to establish one of the first adolescent clinics in Canada, based on Dr. Gallagher's model. He spent a month in Boston observing the operation of the clinic before returning to Ottawa to open his own clinic at the Civic Hospital. Under his direction the clinic was open for one day per week, with a staff that included a school health officer, a consulting psychiatrist, a public health nurse and a social worker (Dempsey 1984, 25).

In the first year of operation, the clinic saw roughly 100 patients, ranging from those who were failing in school to those who were abusing drugs and getting into legal trouble. One of the important trends that Dr. Pearlman noticed was that 80% of his patients had at least one parent battling alcoholism (Pearlman 1968). Although most of these patients came from lower socio-economic classes, the problem of delinquency and alcoholic parents was not restricted to this demographic. It appeared that the child was not the root of the issue; it was the broken home that they were sent back into after receiving treatment. He described it as, “sending children back into their cesspool environment (Pearlman 1968), and breeding chronic behavioral problems” (Pearlman 1970). Instead of encouraging this vicious circle, he envisioned an establishment where an adolescent could live in an atmosphere of social stability, where education and recreation could be properly supervised (Pearlman 1970).

In 1974, the Children’s Hospital of Eastern Ontario was opened in the east end of the city and Dr. Pearlman was made acting director of its adolescent clinic. The new clinic would open for five days instead of one and a gynecologist was added to the staff. Two years later, Child Life Services announced that it was opening an entire adolescent ward at CHEO under his guidance (Pearlman 1976).

Over the course of his career, Dr. Pearlman attempted to make his colleagues aware of the unique needs of the adolescent. In a presentation to the Eastern Ontario Pediatric Association in 1987, he gave a lecture concerning adolescent girls and body image (Pearlman 1987). In this lecture, one can see how truly sensitive he was to the needs of his adolescent patients. He mentions that in his practice, he saw no other demographic that was as concerned about their weight. He attributed this to an increase in peer social pressure, a viewpoint that was uncommon to hold during his career, as opposed to now when the effect of peer pressure on body image has been well established in the literature. He estimated that 2/3 of teenage girls that he saw in his practice complained of being overweight, even though the vast majority were at or below their age-matched standard. In order for pediatricians to counsel these girls, he cautioned to avoid the use of statistics as means of reasoning with them. Instead, he encouraged his colleagues to treat them as adults and to converse with them about the reasons why they were so concerned about their weight. It was also important to explain that weight gain during adolescence is an important step in becoming a mature person (Pearlman 1987a).

In this sense Dr. Pearlman was a pioneer in adolescent medicine, not only because of his efforts on an administrative level, but because he was able to incorporate his own experiences in practice, to meet the special needs of the adolescent patient.

Conclusion

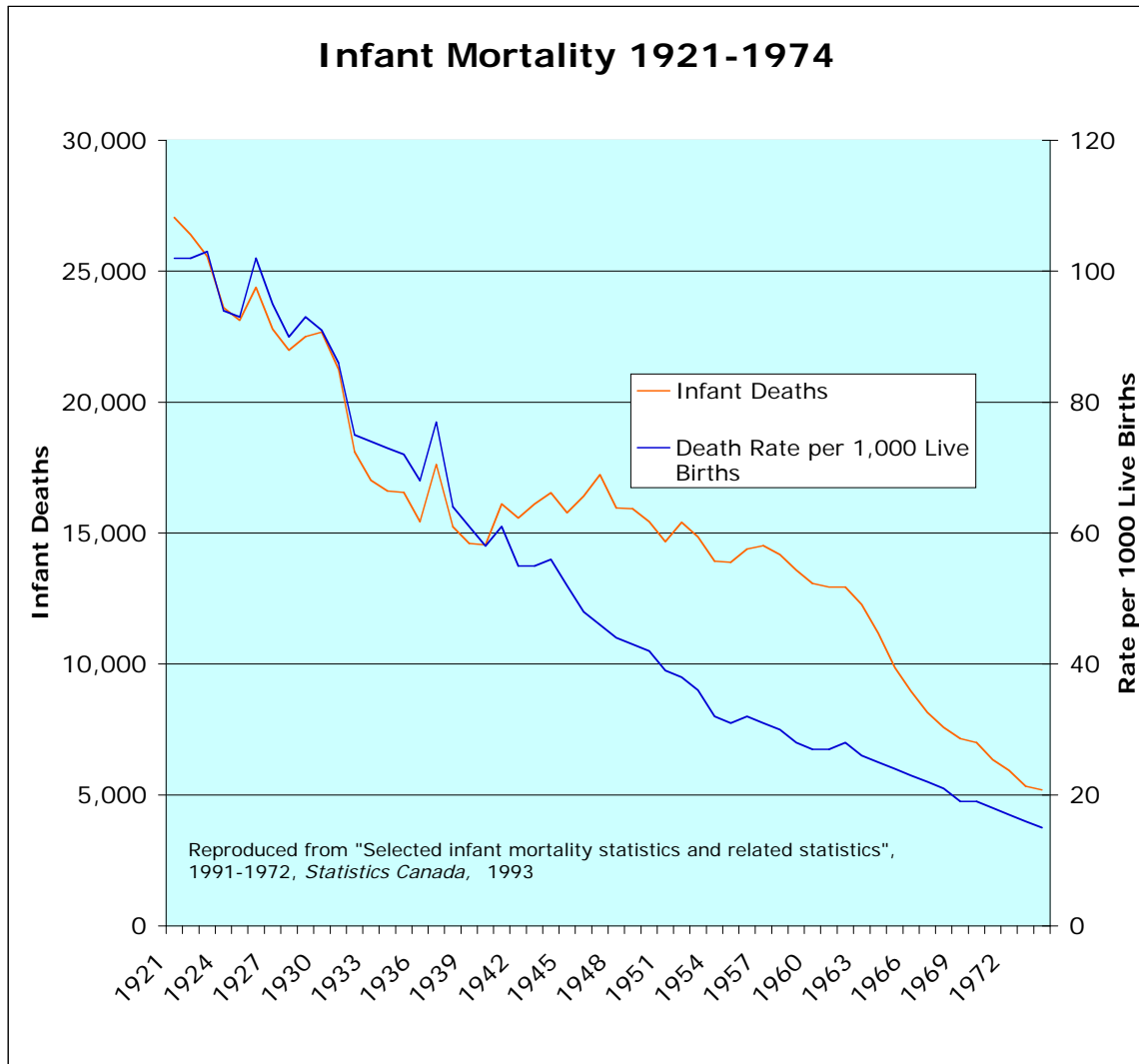
The previous discussion has given a great deal of consideration to Dr. Lyon Pearlman's contribution to social pediatrics. It has shown how he left a lasting impression on the Canadian medical landscape and helped to pave the way for many of the pediatric services that are the standard of our current health care system. However, his legacy to those whom he affected will be measured by so much more than his public accomplishments.

Dr. Pearlman was not simply a physician who pacified patients by relieving physical symptoms. He was a man who had a great deal of concern for those whom he treated, educated and worked with. He also had a profound reverence for the medical profession and recognized the tremendous responsibility that comes with being a doctor.

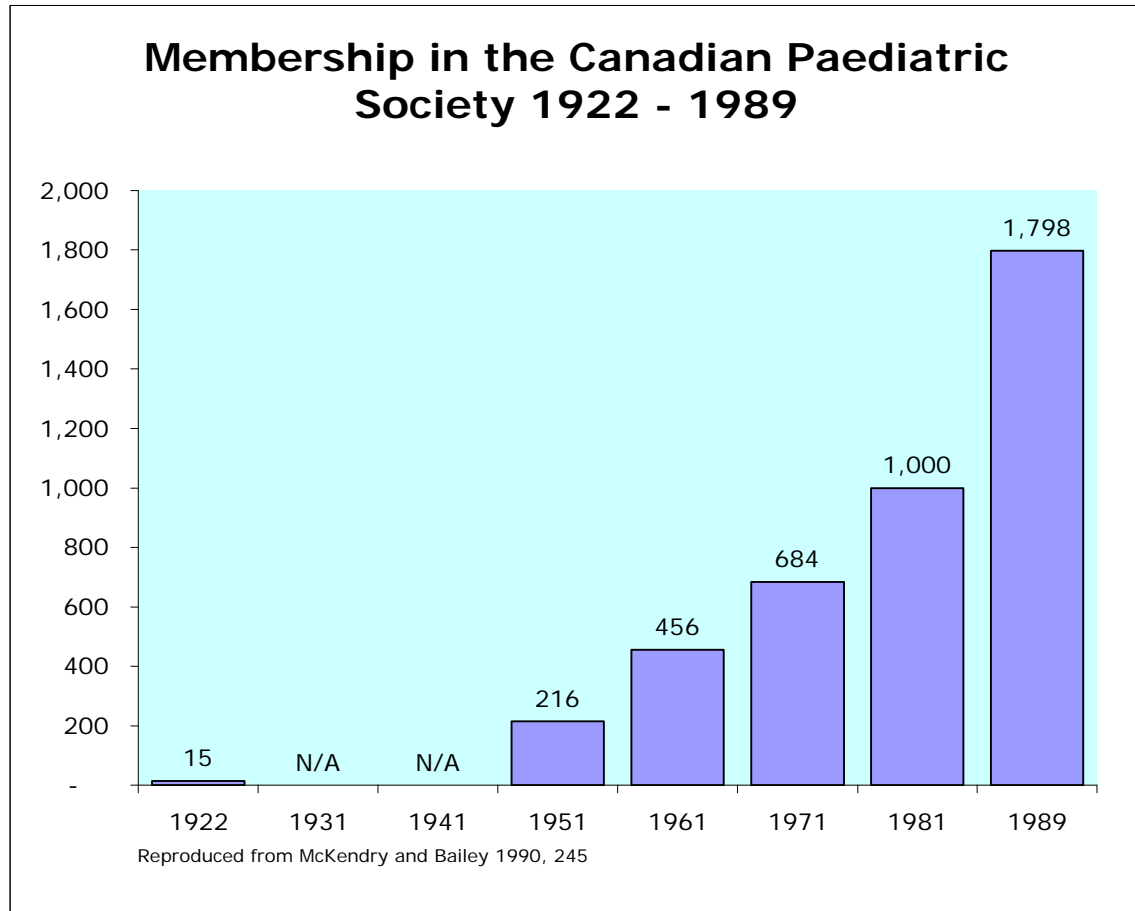
In the opening address to "The Art of Healing Exhibit" at the Bytown Museum in Ottawa, in 1988, he compared his responsibility as a physician to that of the ancient Hebrew *ozer* (healer). "The healer merely allows the patient's natural potential to play the chief role in his recovery" (Pearlman 1987b). This notion of humility and respect guided Dr. Pearlman through 60 years of practice as a clinician, teacher, communicator, health advocate and innovator among other things.

During his testimonial remarks at a dinner honoring Dr. Pearlman in 1984, former student Dr. Bill James remarked, "Dr. Pearlman is not just a teacher of the science of medicine, but rather the art of medicine (Dempsey 1984, 25)." It is hoped that this paper made this idea apparent.

Appendix A



Appendix B



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