

President's Message

Submitted by Adrian Sandler, MD

The mismeasure of medicine: the promise and tyranny of measurement

Every three months, I receive patient satisfaction data based on post-visit telephone surveys.

Once again I am trying to make sense of a graph entitled "Key Drivers of Excellence" displaying the quality of my care. I think it says that 71% of the sampled patients rated me "excellent." This seems pretty good, but puts me only at the 36th percentile for percent excellent - compared with whom? Are most other doctors much more excellent than I am?

Many of my patients thought I was only very good. I am conflicted. On the one hand, I am genuinely motivated to sharpen my empathic listening skills. On the other hand, I suspect that one or two of those who considered me to be less than excellent were doctor-shopping and drug-seeking and didn't get exactly what they wanted from me. On balance, I have to say that my colleagues and I do not give these data much credence. We all want to take excellent care of our patients, and it is hard to see that these patient satisfaction measures add to that intrinsic motivation.

Our hospital has moved from straight salary to production based compensation (measuring RVU widgets of work) to a complex formula based on RVUs and quality metrics. The quality metrics – accounting for 10-15% of our compensation – include some system-wide priorities (improving access to care, performing med reconciliation) and some metrics that each group develops each year. In the past 3 years, our DBP practice has chosen metrics such as increasing the use of Vanderbilt scales at follow-up ADHD visits, increasing the percentage of children <6 years of age with ADHD referred to behavior therapy first, and improving our motivational interviewing skills. This commitment to ongoing QI is a very positive development in healthcare. The opportunity each year to set a worthwhile and meaningful goal, commit ourselves to doing things differently, measure our progress, and receive an incentive payment for doing so is undoubtedly a win-win proposition. The problem is that it takes an army of managers to implement projects, and to monitor and report data. The data are usually weak and unreliable, but the managers and providers seem happy with the results and the exercise is repeated the next year. "Performance-based reimbursement" seems a grand name for all this.

Clearly, there is a critical need in our field for discussion and consensus about meaningful process and outcome measures. Although a broad range of outcome measures may be needed to monitor and report outcomes of care, a generic approach that emphasizes functional impairments and participation may be applicable to the vast majority of children with different diagnoses. The World Health Organization's International Classification of Functioning, Disability and Health (ICF) provides a useful framework for measurement of outcomes (<http://www.who.int/classifications/icf/en/>). Our 2017 guest lecturer Dr Peter Rosenbaum will address this in depth in Cleveland Oct 13-16. Save the dates!

There are some promising developments on the measurement front in SDBP. The DBP Research Network is



conducting research on patient-reported outcome measures (PROMIS) <http://www.healthmeasures.net/explore-measurement-systems/promis>. Stay tuned for more information. My group is developing a Clinical Functional Improvement Scale (CFIS), and we hope to disseminate this freely for others to use in their clinics. SDBP is engaged in the development of a clinical guideline on the care of children with complex ADHD, under the leadership of Bill Barbaresi. This work is critically important, but progress is slow and incremental.

Some pediatric professional societies, including American Academy of Neurology/Child Neurology Society (AAN/CNS) and American Academy of Cerebral Palsy and Developmental Medicine (AACPD) have moved to develop measurement sets and common data elements to capture process and outcomes.

[https://www.childneurologysociety.org/resources/resources-detail-view/child-neurology-quality-measurement-set-public-comment-\(respond-by-sept-28\)](https://www.childneurologysociety.org/resources/resources-detail-view/child-neurology-quality-measurement-set-public-comment-(respond-by-sept-28))

<https://www.commondataelements.ninds.nih.gov>

How do you measure if a health care provider is really going that extra mile for their patients, providing the exemplary individualized care that truly makes a difference? Will these measurement sets give rise to robust measures that can be reliably reported? Will these drive us to excellence in our clinical care? Or will clinicians tweak their EHRs to appear “compliant” and to create the illusion of progress? I am reminded of Stephen Jay Gould’s seminal book *The Mismeasure of Man* https://en.wikipedia.org/wiki/The_Mismeasure_of_Man. Gould cautioned us about reducing complex concepts into measurable small entities and then placing too much stock in those flawed entities. Will the tyranny of measurement ultimately undo its promise in health care? Time will tell...but in the meantime I would be interested in your responses on the Discussion Board!

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Past President's Column: ADHD - A Personal History

Submitted by Esther H. Wender, MD

When I first began pediatric training in 1963, the condition that was then called Minimal Brain Dysfunction (MBD), was barely known in pediatrics. Forty years later, when I officially retired, the condition, now known as ADD or ADHD, was the most common, significant behavioral disorder encountered in pediatric practice. What happened over those forty years makes an interesting story of how this medical condition evolved, was affected by research and publicity and how the pediatric medical community responded. As my career spanned that evolution it may be of interest to hear about my participation in the unfolding of these changes and my view of how it happened.

Back in 1963, the official psychiatric nomenclature was a mere shadow of its current form. The only reference to what is now ADHD appeared as the "Hyperkinetic Reaction of Childhood" and only a general description was given. However a few physicians and researchers, especially in child psychiatry, were aware of the work of Charles Bradley, a pediatrician who directed a special residential program in Rhode Island to treat the difficult behaviors of children who had recovered from encephalitis. These children were now difficult to manage because of their aggressive and hyperactive behavior. Bradley reported an accidental finding that some of these children, who were given Benzedrine, a stimulant, to treat their allergies, were greatly improved in their behavior. Coincidentally, Dr. Bradley gave a talk to the pediatric department during my last year of medical school (1963) at the Oregon Health Sciences University. I attended this talk and was fascinated. The syndrome of hyperactive and aggressive behavior was, at this time, given the label of "minimal brain damage" or "minimal brain dysfunction", since the behaviors were thought to be due to the brain damage produced by encephalitis and "minimal" because there were few, if any, hard neurologic signs.

In 1965 I had completed my first two years of pediatric training in Boston and I then moved to Baltimore and The Johns Hopkins Hospital where I enrolled in a special program that combined six months of pediatrics and six months of child psychiatry. The child psychiatry program included an active research component headed by C. Keith Conners, Ph.D. I was able to obtain a fellowship with Dr. Conners during the 1966-67 year. He was studying the effects of Ritalin on Children with MBD and comparing it to Dexedrine. He was also studying the specific behaviors reported by teachers and parents of children with MBD looking at statistically analyzed clusters of behavior in the attempt to better define the syndrome. This work led to the Conners Questionnaires, which are still used today to diagnose and follow the progress of children with this disorder. This fellowship year launched my career-long interest in this syndrome.

In 1971, I was married to Paul Wender, M.D., a child psychiatrist then working at NIMH. That year he published the book called "Minimal Brain Dysfunction in Children", describing the syndrome, proposing its neurological origins and recommending biological treatment with stimulants. This book was quite influential in the field. In 1973 both Paul Wender and I joined the faculty (me in pediatrics and Paul in psychiatry) at the University of Utah Medical Center. In Utah I began a private practice evaluating and treating children with MBD. As one of the few pediatric academicians

with experience in diagnosing and treating this condition, I was asked to lecture and conduct workshops on this topic at national meetings of the American Academy of Pediatrics (AAP). In the 1970s these lectures were typically attended by only a handful (12-20) of pediatricians reflecting the relative lack of interest in the condition.

It was during the 70s that Dr. Ben Feingold, an allergist, published a book claiming that artificial flavors and coloring in foods plus foods containing salicylates, were the cause of hyperactivity in children. The Feingold diet became highly popular and did much to popularize the existence and clinical importance of this syndrome. I was quite caught up in this controversial issue, first explaining the claims to parents and school personnel, answering questions at public meetings, and then becoming immersed in the research attempting to determine the validity of the claims. As students of behavior can attest, the general public, when faced with difficult behavioral issues, readily embrace explanations such as diet, though these claims were largely discounted by the research that followed. For those of us treating patients and their families, the Feingold claims were a significant distraction. However one result was an increase in public awareness of the behavioral syndrome and recognition of the need to address the problem. In the late 70s, as a reflection of this increased interest, the lectures on ADD that I was asked to give at AAP venues were now attended by 500-1,000 physicians eager to learn more.

In 1978, our pediatric program at the University of Utah, was awarded one of the eleven grants from the W. T. Grant Foundation to develop training in behavioral pediatrics. I was the project director. This additional funding allowed us to develop, among other things, specific training for our pediatric residents in the diagnosis and management of MBD. Also, the eleven program directors met together once a year to discuss training strategies and it was out of those meetings that the decision was made to found the Society for Developmental-Behavioral Pediatrics, which happened in 1982.

Meanwhile, by the mid-70s, families and school personnel increasingly resisted the label Minimal Brain Dysfunction with its implications of significant neurologic pathology. Responding to these concerns, in 1980 the leaders in Psychiatry published a new, official psychiatric nomenclature accomplishing two important changes: the syndrome was now called Attention Deficit Disorder (ADD), and for the first time a definition was provided by listing specific behaviors that needed to be present at a specified degree of severity to warrant a diagnosis. This specific definition made it possible, for the first time, to compare research findings from different institutions.

In 1982, I moved to NY and a position at Albert Einstein College of Medicine. During my years there I continued to present at AAP annual meetings, continuing education programs (CMEs), and programs designed to prepare pediatricians for sub-Board examinations in Developmental-Behavioral pediatrics, always addressing ADD, its diagnosis and treatment. I was also involved in research looking at sugar as a possible cause for ADD. Again, this and subsequent research largely discounted this claim.

The increase in awareness of ADD in the 80s and 90s led to controversies, many of which continue to this day. First, defining the syndrome became a significant question and over the years there have been a number of revisions of the diagnostic criteria. Also many people questioned the very existence of this set of behaviors as a disorder. The defining behaviors were said to be characteristic of all children and it was seen as a mistake to advocate treatment, especially medication. It was even more difficult for families and school personnel to understand how behaviors such as excessive activity and distractibility could be explained as a disorder of brain development. Parents and others saw these behaviors as requiring discipline rather than medication. As research began to show that the syndrome ran in families, the proposed genetic etiology was often strongly resisted by families who felt unjustly labeled. Questions arose, and continue to be voiced, as to why ADD seemed to be so much more common than in the past. Those of us in the field argued that the syndrome was not more common, but only more frequently recognized. All of these issues were being

addressed by a huge increase in research but those of us identifying and treating ADD needed to educate families and school personnel as part of our clinical care. Addressing these issues was always a focus of my teaching.

Another controversy stemmed from the increase in prevalence of the disorder in environments of poverty and in minority populations. In the 80s there was a particularly contentious claim that black children in inner city schools were being inappropriately diagnosed with this condition as the result of discrimination. Research has shown, however, that the increase in prevalence in these populations is due largely to genetic factors rather than only to race or poverty, though race and poverty clearly have a deleterious impact.

Over the past 30 years there have been hundreds of pediatricians and psychologists collaborating in both the research and clinical care of children with ADD and our Society has been instrumental in promoting this work. The understanding and care of children with this disorder has become a core issue in pediatric training and clinical care - something I could not have anticipated when I first entered this field back in 1963.

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Past President's Column: Global Health Issues and the SDBP

Submitted by Karen Olness, MD

Introduction

In recent months there has been huge publicity about the Zika virus; this was triggered by recognition that Zika virus infection in a pregnant woman may cause the infant to be born with microcephaly. Articles include statements about the difficult lives of microcephalic children. This is only the latest tip of the cognitive impaired iceberg. In recent years there has been increased recognition that early malnutrition leads to cognitive impairment in children and that this has long term negative consequences for the individual, the family, and the wider community. Other causes of long term physical and /or intellectual disabilities include infectious diseases such as polio and cerebral malaria, iron deficiency in infancy, lead poisoning, fetal alcohol spectrum disorder, many genetic abnormalities, sickle cell disease, child abuse and trauma from natural and man made disasters or from untreated pain. The current world population is 7.4 billion. Twenty four percent (159 million) of children under five years are stunted. 50 million children under five years are wasted and at great risk of cognitive impairment. In November 2015 it was estimated that 35 million children were displaced from their homes because of disasters. As a result, many of these will suffer long term psychological problems.

Pediatric Developmental Behavioral Resources in the US and in other countries

In the US there is an insufficient number of pediatric developmental behavioral professionals, of specific programs for children, and also of professionals with expertise in the care of the adults who have had physical and/or intellectual disabilities since early childhood. However, the lack of such expertise is far greater in resource poor countries. Over the past 25 years relatively few developmental behavioral pediatricians from resource poor areas have been trained in the US. Some have returned as the first developmental behavioral pediatrician in their home country. Examples of these pioneers are Ilgi Ertem (Turkey), Vibha Krishnamurthy (India), Saleh Al Salehi (Saudi Arabia), Chanyut Suphakunupinyo (Thailand) and Orawan Louthrenoo (Thailand). Each has faced difficulties but has established successful clinical and training programs.

Ilgi Ertem and Vibha Krishnamurthy organized the first ever International Congress on Child Development, held in Turkey in December 2015. This amazing conference included 600 representatives from 58 countries. Many of the participants represented various UN agencies and NGOs. The Congress included several courses on the International Guide for Monitoring and Supporting Child Development, including English, Turkish, Russian and Spanish versions. The Congress leaders have organized an International Developmental Pediatrics Association (IDPA). And the second Congress will take place in Mumbai in December 2017.

Over the past 20 years there has been increased recognition that the effects of disasters on children are lifelong. Many studies document the long term trauma experienced by children who experience either natural or man made

disasters. Yet training programs to train relief workers about child development and the special needs of children are insufficient.

90 percent of children in 2016 are born into resource poor areas. If, during their childhoods, they experience acute or chronic pain it is unlikely that they will receive adequate pain management. As a result there are untold numbers of children and the adults they become who have post traumatic symptoms related to their suffering. Pain that is inadequately treated also has deleterious effects on the immune system, wound healing, and gastrointestinal functioning. There is a great need for training on management of both the sensory and affective components of pain in resource poor countries and therapy for the negative outcomes related to inadequate pain treatment.

Collaborative Research with Resource Poor Countries

Many members of the SDBP have done outstanding collaborative research in resource poor countries and have increased world knowledge about cognitive impairment. For example, Janina Galler has followed a cohort of malnourished children from Barbados for more than 40 years. Betsy Lozoff has followed a cohort of iron deficient children for more than 20 years. Michael Boivin has demonstrated that cerebral malaria is associated with cognitive impairment. Many psychologists such as Frances Page Glascoe and Gerry Taylor have been generous in sharing their expertise with overseas collaborators. From collaborative research in resource poor countries we have learned much about the negative outcomes from early insults to the brain. There is also ongoing global collaborative research involving children that does not include experts in child development or in assessments of child behavior and development. Opportunities to learn more about the developmental consequences of infectious diseases or environmental exposures are missed. Undoubtedly, we need to do a better job in advising and training so that worthwhile child development information is coming from all of the large, expensive research studies that include children.

There is a great need for treatment programs for children with special needs as a result of impairments that began early in life. I have seen many impressive programs throughout the world including Dr. Krishnamurthy's UMMCEED program in Mumbai, India, Dr. Chanyut's clinic for children with ADHD and ASD in Thailand and Dr. Naeem Zafar's child protection program in Pakistan.

However, there are simply not enough treatment programs for impaired children; at present, a main focus must be on prevention. A number of specific programs for children are capable of reducing cognitive impairment if they continue. These include programs such as the American Academy of Pediatrics Helping Babies Breathe program, Baby Friendly Hospital programs, treatment of newborns born to HIV infected mothers, malaria prevention programs, water and sanitation programs and a variety of feeding programs including those for pregnant and nursing mothers.

My pet idea - A Cognitive Watch Program

I first described this idea in a 2003 paper. Throughout the world there are systems for keeping watch over infant mortality figures, under fives mortality, numbers of vaccines given and numbers of children with various infectious diseases. I suggested that it is equally important to develop systems for assessment of the extent and causes of cognitive impairment in defined areas of the world. In some areas the primary cause may be infant malnutrition; in other areas iron deficiency, in other areas lead poisoning. When this information is known programs to treat the condition and to prevent more can be designed and implemented. Repeat assessments at regular intervals will provide information about whether or not the chosen interventions are succeeding or sufficient.

What can members of the SDBP do?

1. Join and participate in the global health interest group of the SDBP. One of the objectives of this interest group is to

- be supportive to colleagues who trained in the US and who are now working in their home countries, often alone.
2. It is important that members of the SDBP continue collaborative research with colleagues in resource poor areas.
 3. Join the new International Child Development Association and submit programs for its Congresses.
 4. Volunteer as relief workers in disasters or in refugee clinics in the US.
 5. Share expertise on child pain management in resource poor areas.
 6. Whenever one has the opportunity, contribute to publicity about child development needs both in the US and abroad. We need Zika virus type PR to emphasize the unfortunate long term outcomes when those needs are not addressed.
 7. Attend the second International Congress on Child Development in December 2017.

Karen Olness, MD
Professor Emerita of Pediatrics, Global Health and Diseases
Case Western Reserve University

Medical Director
Health Frontiers

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SDBP/JDBP Media Highlights Blog

Submitted by Jeffrey H. Yang, M.D., SDBP Communications Committee Member, JDBP Web Editor

Dear members,

SDBP, in collaboration with *JDBP*, maintains a Media Highlights blog as part of our ongoing efforts to educate and share information with each other. The blog appears on the front of both websites as well as the *JDBP* Twitter and Facebook feeds.

The goal of the blog is to highlight new research, interesting discussions, and other current events in areas that impact our practice and our patients. We are seeking contributions from all members (including trainees).

If you have some interesting current events that you think should be highlight in the blog, please submit information by clicking on the link below.

<https://goo.gl/forms/fn8Gm7zvYydVoFcy1>

Thanks for your help!

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IDPA Congress Mumbai 2017

Submitted by Adrian Sandler, MD

Dear Colleagues,

It is with great pride and pleasure that I invite you to Mumbai, India for the Second International Developmental Pediatrics Association Congress from 7th to 10th December 2017. The second congress is being held in early December to commemorate the International Day of Persons with Disabilities (December 3rd).

For many of us, the First International Developmental Pediatrics Congress in Istanbul in 2015 felt like 'coming home' -- we were part of an international platform where professionals working in the field of child development and disability from all over the world could share ideas, experiences and research. We experienced the incredible coming together of over 600 professionals from 57 countries! The International Developmental Pediatric Association (IDPA), which was formed then, and Ummeed Child Development Center are now hosting the second IDPA Congress in Mumbai, India in 2017.

The theme of the Mumbai 2017 Congress is 'A World of Difference' -- we will explore the continuum of developmental differences in childhood, children at risk and children with disabilities. Once again we will come together to try and bridge the gaps in policy, practice and research that exist between low and middle-income countries (LMICs) and high-income countries (HICs). The First International Developmental Pediatrics Congress made it amply clear that there is a wealth of experience and knowledge in LMICs as well as HICs that can serve to bridge this gap, and we hope that at IDPA Congress 2017 there will be a rich sharing of these across disciplines.

The theme of the 2017 Congress also represents International Developmental Pediatric Association's strong belief in the value of interdisciplinary teams and family centered care. We invite professionals from all disciplines involved in supporting children and families including pediatrics, family medicine, public health, child mental health, physical medicine and rehabilitation, physiotherapy, occupational therapy, speech and language therapy, child development and education, early intervention, special education, and social services, to come and share their passion, knowledge, experience and research at this exciting international platform.

IDPA and Ummeed Child Development Center invite you to experience the warmth of India at the 2nd International Developmental Pediatrics Association Congress in December 2017. We look forward to welcoming you in Mumbai!

Vibha Krishnamurthy

President, International Developmental Pediatrics Association Congress

Congress website: www.idpacongress.org

IDPA website: www.developmentalpediatrics.org

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Childhood Disintegrative Disorder

Submitted by Abha R. Gupta, MD, PhD

In November 2005 I arrived in the laboratory of Matthew State, MD, PhD at the Yale Child Study Center (CSC) as a postdoctoral fellow. Intending to study the genetics of autism spectrum disorder, I discovered a collection of frozen DNA samples from families affected by childhood disintegrative disorder (CDD). CDD is a rare form of late-onset severe regressive autism. I didn't realize at the time that the CSC had an international reputation for the clinical evaluation of patients with CDD, based on the work of Drs. Donald Cohen and Fred Volkmar, past directors of the CSC. When they started seeing these patients decades ago, they had the foresight to collect blood samples for future genetic analysis. Systematic analysis of the genetics of CDD did not become possible until years later, when technical advances made whole-exome sequencing possible. Fortunately, this coincided with my arrival in the lab. As a neuroscientist, I was intrigued by the mystery of CDD, and when I got to know some of the patients, I came to appreciate the devastation it causes families.

Along with the frozen samples, I was fortunate to find a group of enormously talented colleagues at the CSC to help me. Along with Dr. Volkmar, Drs. Alexander Westphal, Pam Ventola, and Julie Wolf performed comprehensive clinical characterization of patients with CDD; and Kevin Pelphrey, Fred Shic, and their research groups performed non-sedated fMRI and eye-tracking protocols to study the brain activation patterns and social phenotype of CDD. They spent years optimizing the protocols, since obtaining fMRI and eye-tracking data from individuals with significant intellectual disability and severe autistic symptoms is quite challenging. There are clear differences in the clinical manifestations of ASD and CDD. We wanted to know if there were neurobiological features that distinguish the two disorders. This question became particularly timely when CDD was subsumed by ASD in the DSM-5, a change justified by the lack of evidence that CDD is a separate diagnostic entity.

We expected to find mutations and neuroimaging and eye-tracking features in children with CDD which were more severe than what had been identified for ASD, since these patients are more severely affected. For example, we know that subjects with ASD look less at the eyes and more at the mouth when looking at pictures of faces, perhaps explaining in part the social skills deficits in ASD. To our surprise, we found that children with CDD looked at the eyes *more* than did other children with ASD, who are less impaired as a group. More-normal eye gaze may reflect the preservation of some neural circuits due to the prolonged normal development which characterizes CDD.

Past studies of eye gaze have largely examined individuals with ASD who were relatively high functioning. Our results indicate that what is true for those individuals might not be relevant to individuals who are more impaired, a substantial proportion of the spectrum. Recognizing specific ASD biotypes may translate into more targeted diagnostic tests and treatments, furthering progress toward precision medicine. But this work is still exploratory. It will be critical to confirm our results in larger cohorts. By learning more about the pathophysiology of CDD, we hope to gain a better

understanding of the spectrum as a whole. We're in the process of publishing our preliminary findings, and further studies are underway. If you have patients with CDD, their families may choose to take part in our ongoing program of research. Please contact me at abha.gupta@yale.edu.

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From the Trenches

Submitted by Eric Tridas, MD, FAAP

I have practiced as a developmental & behavioral pediatrician in a private setting for over 30 years. After completing my fellowship I worked in an academic institution for 1 1/2 years. Since my interests were the development and improvement of clinical programs and teaching pediatric residents, the chairman of my department suggested private practice as a more appropriate setting for my goals. In 1984 there were very few developmental & behavioral pediatricians and most of them were practicing in academic settings. No one seemed to know of any private practice models at the time. So, at the age of 30 and after too many years of schooling, I had no idea what I was going to do. Frustration soon led to despair and ultimately to panic. Soon thereafter I convinced myself that it was possible to pursue my career goals by developing a business model that would allow me to deliver the highest level of care to my patients. With the help of colleagues, friends and advisors I followed my delusional thinking and in the process learned a few things. Here are some of the principles that, over the years, have been very helpful in my practice.

Keep your eye on the ball: My professional mission has never changed; I want to provide the best possible developmental & behavioral services to mitigate my patient's functional impairment. Every decision in the practice has been based on this premise. This model of care allowed us to deliver services in a professional, comprehensive, clear and cost-effective manner. Every staff member and consultant in our center has the same goal and they are held accountable to maintain it at all times.

Time is money. Really! My best friend, an accountant, asked me early in my career a very simple question: What do you sell? What is it that you offer that people are willing to pay for? The answer is FACE TO FACE TIME. Therefore, the more efficiently I was able to manage my time, the more effective my clinical and business operation became. My staff taught me how to make better use of their skills. I didn't have to do it all! I used technology to lower our operating costs, improve consistency of the care and increase revenue and work efficiency. These improvements in efficiency allowed the clinicians in our center to see more patients in the same amount of time, and occasionally made it possible for me to leave work a bit earlier. My most valuable commodity is time. The more efficient I am, the more time I can spend with family and preferred activities, while still making a living.

You are not alone: Leaving an academic and hospital setting made me feel isolated. Initially, I was working by myself and making all the decisions, including many I was not trained for. So, I sought advice, did what business professionals suggested and worked collaboratively with colleagues of other disciplines. In the end I learned valuable professional lessons and made really good friends. I also volunteered for projects I enjoyed. As a member of the clinical faculty at the USF medical school, I volunteered to run the DBP pediatric resident rotation. This was a most rewarding and highly stimulating. I also gave talks to any audience that was willing to listen and volunteered on the boards of many not-for-profit organizations. These experiences allowed me to meet many community leaders and other professionals in the

field. In addition, working collaboratively within these organizations gave me a better understanding of how intervention services are provided in different settings. These contacts made the coordination of care for my patients more effective and I and enhanced my business practices.

Have fun: Our type of work is demanding and we deal with difficult, chronic problems that can drain us. I feel that I leave a bit of myself with every patient that I see. At times, this feeling can be daunting and somewhat overwhelming. So, I identified issues that I am passionate about and pursued them. I looked for opportunities that would allow me to help many children at a time, rather than one family at a time. In the pursuit of this goal, I met many great people, made wonderful friends, got to travel some and, above all, made a difference in the lives of the children that we served, their families and communities. In other words, I got out of the office, talked to anyone that was willing to listen and in the process had a lot of fun and personal fulfillment.

I look forward to hearing from you. Your suggestions and contributions will help make this column relevant to practitioners in the field of child development and behavior.



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Comments/Suggestions? Please email the editors: [Beth Wildman](#) or [Robert Needman](#).

Society for Developmental and Behavioral Pediatrics
6728 Old McLean Village Drive, McLean, VA 22101
Phone: 703-556-9222 | Email: info@sdbp.org



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