Are We on the Right Track? Examining the Role of Developmental Behavioral Pediatrics
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I recently reflected on whether developmental behavioral pediatrics (DBP) is on the right track. Along with most section members of my generation, I first became involved with clinical care, teaching, and research activities as a general pediatrician (not a subspecialist) and saw and continue to view development and behavior (DB) as the foundation of pediatrics. This generalist perspective may puzzle those trained subsequently in DBP fellowships, but the generation that defined the field did so because it was concerned that many pediatricians were not adequately prepared to understand DB aspects of the care they were expected to provide, regardless of setting or venue. I am part of a generation that saw DB as so fundamental to all clinical pediatrics that it was hard to segregate it as a subspecialty. Today, fewer share this perspective, because fellowship training typically occurs before a clinician has a chance to practice general pediatrics and this historical perspective is not emphasized.

DBP has strong roots going back to the 1920s, but in 1985 Stan Friedman defined it as “Those aspects of pediatrics generally ignored by most pediatric training programs.” He believed we needed a subspecialty not to provide specialized care, but to become central teachers in departments of pediatrics to convey a body of knowledge about normal and atypical DB of children and adolescents to trainees in residency training programs and to do research to add to the knowledge-base.

John Duby’s recent tribute to 3 former Aldrich recipients pointed to great strides in DB training and research. We are now an established subspecialty with fellowship training and an organization, and all pediatric residents are required to take at least 1 month of DBP. However, despite this progress, I believe we are endangered because we have left the mainstream of academic pediatrics. We are often sequestered and siloed off-campus and are increasingly seen only as people who take care of children who have special needs, children who are unfortunately undervalued by society, rather than as key faculty, essential to the central departmental educational mission and critical to the successful delivery of care in all venues.

Like the field’s founders, I believe that DB are the core constructs of pediatrics and its backbone and that they must be incorporated into every primary care and specialty encounter and included in every educational experience. Our research questions must be grounded in the DB issues
faced by all kinds of children and families. If we only take care of the subset of children with serious DB impairments, then we are on the wrong track. These special needs children clearly need and deserve our care and expertise, and long waits make it hard to turn attention away. But they are by far and away not the only children who do! If we only care for their real needs, we will be repeating psychiatry’s mistake in separating from medicine’s mainstream. If we remain secluded, then critically important DB concepts will remain an enigma to our colleagues in general pediatrics and other subspecialties and we will have failed in our mission to train all pediatricians to deal with their patients’ common DB issues across venues and specialties.

The epidemiologic facts speak for themselves: the percentage of children with DB issues has doubled; autism diagnoses and early identification of DB issues have increased; ~20% have chronic health conditions; ~20% of children have mental health (MH) diagnoses, which are now the most costly chronic conditions of children. All 5 of the top conditions causing disability in 2008–2009 are in our domain, ahead even of asthma. A survey by the American Academy of Pediatrics reveals that 41% of parents of school-aged children had concerns about learning difficulties and 36% about depression and anxiety; 11.5% of children were diagnosed with a learning disability; 8.8% with attention-deficit/hyperactivity disorder; 6.3% with behavior problems. It isn’t just the small proportion of children with severe disorders who need our attention! Most parents are concerned at some point about some aspect of their children’s behavior and development. With >100 000 children for every DB pediatrician, we cannot care for all these children with DB issues. Moreover, we also know that “…properly trained pediatricians are cost-effective in managing many DB problems.”

The Task Force on Pediatric Education and FOPE II reports provide decades of evidence. How many more reports do we need before we believe what pediatricians have been telling us for generations? (That they are not adequately trained in these areas during residency.) The required month rotation is insufficient to prepare pediatricians to address this morbidity. How can we get back to the right track? First, while continuing programs for children with serious developmental issues, we also need to live outside our silos, to become integral to pediatric departments, and to help manage children with chronic conditions during hospitalizations and typical children in acute and primary care settings struggling with the full range of DB issues. DBP founders cautioned:

…The task now for developmental-behavioral pediatrics is to find ways to translate the findings of its research to the treatment and prevention of the large numbers of children with developmental, behavioral, and educational problems and not to become an isolated silo of expertise.

We need to be part of residents’ educational and support systems when they are confronted with daily stresses on inpatient and ICU rotations and to demonstrate actively how understanding of DB principles helps in the care of all their patients and families.

Second, we need to partner with primary care colleagues in caring for hundreds in their practices who have significant, but not extreme, MH problems and to expand practitioners’ skills and capacity to care for their patients. There are many successful models that change the way care is delivered.

Third, we need to extend our knowledge-base in partnership with social science colleagues in psychology, sociology, and other disciplines. Comprehensive DB sensitive medicine must include an appreciation of the expertise of social as well as the biomedical and molecular sciences. More recent appreciation of the important role of social determinants of health makes this more salient than ever.

Fourth, the field needs more clinicians who are strong in biomedical care of sick children. Being seen first as good pediatricians and second as experts in DBP are key to making our advice and expertise credible and useful to residents in training.

Finally, we need to develop both good outcome measures (to show the importance of applying DB knowledge to practice) and more interdisciplinary research and treatment models. When we provide the evidence for what works, successful programs can be and have been brought to scale.

I believe that DB is both a framework that should help structure every medical encounter and a subspecialty with real expertise in helping those with DB impairments, but we have moved too far toward the latter.

MH and developmental challenges are the primary issues limiting US children’s ability to thrive in the 21st century. These challenges will not be solved by biomedical interventions alone, and DBP manpower is insufficient to handle all their problems. I believe that the pediatric community has focused so heavily on molecular biology that we have inadvertently denigrated the contributions of social and behavioral sciences and epidemiology, diminishing attention to other types of knowledge supporting the science and the art of healing.

Our challenge is to move onto the ICUs, floors, clinics, and community settings; to prepare tomorrow’s workforce, not in 1- to 2-month
rotations, but throughout their residencies; to apply the lessons from biomedical and social sciences; and to work in mainstream pediatrics for the benefit of all the nation’s children. DBPs are dedicated and committed and can meet these challenges. Together with many willing partners, the 5 major steps outlined above will help us improve the outlook for the countless children who need our help.

REFERENCES

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