

Developmental & Behavioral News

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From the Chair

Henry Shapiro, M.D., St. Petersburg, FL

It's the 40th Anniversary of the Section on Developmental and Behavioral Pediatrics, and 50 years if you count the two groups that formed in the 1950s to focus on behavior and mental health. You can be proud to be a member of a distinguished group with a great track record of service and discovery. We have always focused on educational programs for the generalist and subspecialist. See the brief article about the Section's History in the October 2000 AAP News.

Newsletter

In this edition, we feature an original commentary on the AAP guidelines for the evaluation of ADHD by Dr. Daniel Kessler. Dr. Edward Hoffman contributed an original article about life expectancy in children with severe disabilities in response to a discussion on the DBP Discussion List. Dr. Annette Lansford has contributed a thoughtful book review, and we feature an article on DBP Board Certification and a message from SDBP President Dr. Martin Stein.

Education

There are DBP programs on every day of the Annual Meeting (see Highlights, page 13). The Section works closely with the AAP in develop-

ing CME programs throughout the year. This year's Section program, planned under the leadership of Dr. Jean Smith, will feature talks on ADHD, Oppositional Behavior, and Reading Disorders. Through this Newsletter, the dbpeds.org web site, and the DBP discussion list (page 5), we offer a wide range of learning experiences for our membership. Dr. Karen Miller has taken over as the new Program Chair. She will report to the Executive Committee and will take primary responsibility for planning the annual section meeting and proposing additional DBP offerings at Academy CME courses.

Boards

The upcoming board exam in November 2002 is an opportunity and a challenge. (See article page 15). We are committed to developing educational programs to meet the needs of both generalists and subspecialists, probably in the form of a 3-day intensive update course given in Spring 2002, and a Developmental-Behavioral Pediatrics track at the 2002 Super CME course. Executive Committee member Dr. Desmond Kelly will be chairing the education subcommittee that will be responsible for planning the intensive update course. The Society for Developmental and Be-

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<http://www.dbpeds.org>

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havioral Pediatrics is interested in collaborating with us.

Strategic Planning

The Section sponsored a 2-day Strategic Planning meeting in February 2000, and developed a Mission Statement and Goals for the Section (page 18). The Strategic Planning committee included several outside consultants and several members of the Executive Committee. The Executive Committee reviewed objectives generated by this group, and decided that the Section should focus on education, and develop a long-range education plan to make sure that we meet the needs of our constituency (you).

We have a series of needs assessment surveys, and now we have a Residency Curriculum and DBP Board Content Outline to guide our educational planning. We want to be responsive to the needs of Section members and look forward to hearing your ideas for programs and materials to support your learning and practice.

Coding and reimbursement

We are interested in your input regarding the work involved in providing developmental and behavioral services, particularly screening services. There are few data to document the range of activities that go into screening – including back office procedures, cost of screening tools, professional time, and interpretation and referral skills. I would welcome input from any pediatrician about how we can measure your efforts in this area.

On the Web

The Development and Behavior Pediatric Discussion list (dbp-d@dbpeds.org) is a very active forum for case discussion and exchange of ideas. It has over 400 members, and we have been able to offer CME credit for participants. It's sister list, dbp-x@dbpeds.org, is a forum for requesting referral help for patients. We also publish a periodic News list. To join, fill out the form at <http://www.dbpeds.org/feedback.cfm>. The Pediatric Development and Behavior Homepage, <http://www.dbpeds.org>, is partly sponsored by the Section.

Bylaws Change

By a 10 to 1 vote, the Section membership approved a bylaws change to allow affiliate members to the Section. This will require final approval through the AAP, and we will need to develop a specific application procedure. I will let you know when this option becomes available. We expect that nurses, nurse practitioners, psychologists, and social workers will be particularly interested in becoming Section affiliate members. The main criteria for membership will be having a professional certification and a strong interest in child development and behavior. We hope that by reaching out to affiliates, we will improve our effectiveness and be able to produce a greater variety of educational programs.

If you know someone who wants to become a Section affiliate, have them contact Eileen Casey at the AAP (ecasey@aap.org) or encourage them to sign up to the DBP News email list.

Thanks and Welcome

Finally, a special thank you to our outgoing Executive Committee members, Dr. Peter Gorski, Dr. Gregory Prazar, and Dr. Daniel Kessler, for their many years of service and support for the Section and AAP. Thanks to Jim Blackman who had advised the Committee as Past Chair. We all work as volunteers for the Academy and spend many hours meeting, reviewing documents, and preparing educational sessions. I am pleased to announce the Dr. Annette Lansford has been re-elected for another 3 years on the Executive Committee. Bill Coleman will continue to advise the Committee as Past Chair. Heidi Feldman, David Schonfeld, and Pam High serve in liaison roles with Academy Committees.

New committee members will start their terms on November 1, 2000. They are: Dr. Lynn Wegner from North Carolina, Dr. Michelle Macias from South Carolina, and Dr. William Cohen from Pennsylvania. Special thanks to the candidates for the Executive Committee position for their willingness to volunteer to serve. ☐

Commentary: AAP Clinical Practice Guidelines for the Diagnosis and Evaluation of Children with Attention-Deficit/ Hyperactivity Disorder

by Daniel Kessler, M.D. FAAP, Phoenix AZ

With the publication of the long-awaited first installment of the American Academy of Pediatrics (AAP) Clinical Practice Guidelines on ADHD the Academy has officially come off the sidelines in the debate on the assessment and treatment of this common but still controversial clinical condition of childhood. The guidelines and the clinical algorithm provided are without question an improvement over the clinical practices reported by many parents whom I have seen and spoken too. If widely adopted the clinical care of children with behavioral and academic difficulties will experience a major step forward. Nevertheless, while the guidelines represent a good start and an excellent introduction for the practicing clinician there is still more to be done.

The guidelines represent the work of a select group of individuals chosen by the Committee on Quality Improvement of the American Academy of Pediatrics and consisting of representatives from the fields of neurology, psychology, child psychiatry, development, education, family practice and epidemiology, and included both academic and practicing pediatricians. The panel used an evidence report prepared by Technical Resources International, Washington, DC, under the auspices of the Agency for Healthcare Research and Quality.

Strength of the Guidelines

The panel included representatives from all the appropriate professional disciplines and included a most competent and expert group of individuals. AAP states that ADHD is “the most

common neurobehavioral disorder of childhood” and “among the most prevalent chronic health conditions affecting school-age children.” This places the Academy right alongside the Council of Scientific Affairs of the American Medical Association (Goldman, 1998), the American Academy of Child and Adolescent Psychiatry (1997) and the National Institutes of Health (1998) in announcing to its many critics that ADHD is both very real and a significant public health concern.

Recommendations of the panel are a significant improvement over what too often in the past has been routine (if not standard) clinical practice. An evaluation for ADHD is appropriate in the presence of difficulties of behavior and academic underachievement as well as the more commonly described core symptoms of inattention, hyperactivity and impulsivity. Troublesome interpersonal relationships with family members or peers and/or low self-esteem, troubles that might indicate coexisting conditions should also raise the index of suspicion for the existence of ADHD.

Symptoms that may herald the presence of ADHD may not always be evident in the structured clinical setting where we see our patients. Pediatricians may sometimes need to *look for* ADHD and base their assessment on something more than their global clinical impression based on observation in the office setting. We will need to talk to and more importantly listen to children and parents and

elicit through history information involving behavior at school and home. Information may be elicited through the use of a pre-visit questionnaire or through direct questions to parents or child.

When a concern about behavior at school or home is presented the pediatrician should document the presence of specific behavioral criteria (currently those described in DSM-IV) that are

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ADHD Guidelines

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present in two or more settings that adversely affect functioning in school or social situations. Information must be collected directly from parents and/or other caregivers as well as from teachers or other personnel in out of home settings such as school (where children spend considerable amounts of time). Other appropriate information should be obtained directly from professionals who have contact with children in other structured environments (after school programs, parks and recreation programs, organized athletic programs).

An evaluation for ADHD should include a search for common coexisting conditions of behavior (oppositional defiant disorder, conduct disorder), mood and emotional functioning (anxiety and depression), and learning. ADHD remains a clinical disorder and additional specialized tests and assessments (including laboratory evaluation for lead poisoning, thyroid studies, EEGs, or continuous performance tests) are unnecessary.

Limitations of the Guidelines

The Subcommittee on ADHD undertook an evidenced-based review of the existing literature on the prevalence and assessment of ADHD as well as the accuracy of available screening methods used to diagnose it. Though data on screening tests were taken from studies conducted in any setting, the remaining data included only those studies involving children 6 to 12 years of age using general, unselected populations in communities, schools or the primary care setting. This rather narrow focus eliminated from the review a large number of well-designed research studies.

Though a larger number of studies were reviewed, based on unspecified inclusion and exclusion criteria only 87 published articles and 10 manuals were used in the final analysis (Agency for Health Care Policy and Research, 1999). The report indicates that recommendations contained in the practice guideline are based on the best available data, and where data were lacking, a

combination of evidence and expert consensus was used. It is unclear, however, why the panel addressed themselves to this rather narrow focus.

The guidelines state that they address the assessment of ADHD in school-age children, though as already stated they actually limit themselves somewhat more narrowly to primary school children between the ages of 6 and 12 years. Children are entering school settings as young as 3 years of age and adolescents are one of the most important school-age populations for pediatricians. ADHD is best defined as a lifespan disorder. How should the practicing pediatrician approach children outside this narrow age range?

Preschool Children

While the assessment of preschool children may be seen as more controversial than the assessment of primary school-age children, there is clear evidence that significant problems may appear at ages younger than 6 years. The field trials for DSM-IV (Lahey et al. 1994) demonstrated that the group of children with the ADHD-Predominantly Hyperactive-Impulsive subtype consisted primarily of preschool age children while the ADHD-combined type consisted primarily of school-age children, leading them to speculate that the former might be a developmental precursor of the latter. Barkley (1998) has argued that 3 years of age should be seen as the lower bound for diagnostic applications of the ADHD label.

While the guidelines indicate, "In some cases, the symptoms of ADHD may not be recognized by parents or teachers until the child is older than 7 years of age, when school tasks become more challenging" (p. 1162), the practitioner is provided little guidance as to how to address this situation. Since the report is focused rather narrowly on the 6 to 12 year age range this is an important assessment issue and an important oversight.

Tools for Assessment

In addition to issues of prevalence of ADHD and coexisting conditions, the guidelines seek to address the question of assessment using standardized and non-standardized tools. In collecting data regarding behavioral symptoms from parents or

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ADHD Guidelines

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school personnel, the guidelines provide the practitioner with a choice between the use of open ended questions, focused questions about specific behaviors, semi-structured interview schedules (for parents), verbal narratives, written narratives (for teachers or school personnel), or questionnaires and rating scales.

As indicated in the technical review, the use of ADHD-specific questionnaires and rating scales for both parents and teachers have been shown to have an odds-ratio greater than 3 (equivalent to sensitivity and specificity greater than 94%) in studies differentiating children with ADHD from normal peers in the community. However, rather than recommending these ADHD-specific scales and questionnaires, their use is suggested as a clinical option. No evidence is presented on the validity or reliability of the other methods recommended. How can they be considered comparable?

Coexisting Conditions

The final recommendation of the report has to do with the importance of assessing coexisting conditions. Despite the strength of the evidence for this recommendation, no specific guidelines are provided to the clinician (outside of family history) for obtaining this information. In addition while the report indicated that the use of the global questionnaires and rating scales (such as the Child Behavior Checklist or CBCL) "may be useful for other purposes" little guidance is provided on what these other purposes may be. These scales are directly useful (along with other methods) for the assessment of these exact coexisting conditions that are so important to assess.

The Total Problem Scale of the CBCL (Table 5) fails to differentiate between children with and without ADHD. However, the CBCL includes several subscales (anxiety/depression, social problems, inattention, delinquent and aggressive behavior problems) that appear to cover the major dimensions of child psychopathology that should be of interest to the clinician given

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Pediatric Development and Behavior Homepage

<http://www.dbpeds.org>

- Read the **section newsletter online**, including highlights of previous newsletters
- **Links** organized by topics, including Attention Disorders, Autism, Advocacy, Academic Resources, Early Childhood, School Issues
- **Parent handouts** on Classroom Management of Attention Deficits, The Angry Child, and Sleep Tips.
- **Bookstore** in association with Amazon.com. Review the books we've selected or enter the Amazon.com site through dbpeds.org and help support the web site while getting excellent discounts and service on books and now videos and music.
- **DBP Internet mailing list.** To join, send email to: hshapiro@hsc.usf.edu or sign up at <http://www.dbpeds.org/feedback.cfm>
- **Job Listings**
- **News List**
- **Calendar** (coming soon)
- **CME.** Because of Section sponsorship, members are entitled to a **20 percent discount on CME Credit** earned on the DBP Discussion list and Pediatric Development and Behavior Homepage. To learn more, go to:

<http://www.dbpeds.org/cme>

ADHD Guidelines

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the high prevalence of coexisting conditions and their effects on children.

Conclusions:

The report also highlights the important limitations of existing diagnostic criteria (their subjective nature, lack of reliable methods to assess functional impairment in children, paucity of studies involving non-psychiatric populations) as well as important areas for future research. As such this is a document that should be seen as a beginning rather than an end.

Hopefully it is the beginning of important further work that the Academy could take a leadership role. Perhaps through its Pediatric Research in Office Settings (PROS) network, and with the assistance of important collaborators in other disciplines as well as consumers of care such as CHADD, the Academy should take the lead in filling the important gaps in the available evidence base for children.

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NIH Consensus Development Conference on ADHD, Bethesda, MD. November 1998

Dr. Kessler is a member of the Section Executive Committee. He is a member of CHADD's Professional Advisory Board. ☐



Society for Developmental and Behavioral Pediatrics™

Formed in 1982, the Society for Developmental and Behavioral Pediatrics (SDBP) is a national, interdisciplinary organization of about 700 members. Our goal is to improve the health care of infants, children, and adolescents by promoting research and teaching in developmental and behavioral pediatrics.

SDBP sponsors the *Journal of Developmental and Behavioral Pediatrics* and conducts annual scientific meetings. Annual dues are \$150 for regular members and \$95 for trainees and non-doctorates; membership includes subscriptions to *JDBP* and our newsletter, "Behavioral Developments." For information, please contact:

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C. Anderson Aldrich Award

Dr. Abraham Bergman is the 2000 winner of the C. Anderson Aldrich Award. Dr. Bergman has had a long and distinguished career, and represents the best in pediatrics both in his service to children, the profession, and the American Academy of Pediatrics.

Dr. Abraham Bergman is chief of pediatrics at Harborview Medical Center and professor of pediatrics at the University of Washington School of Medicine where he has been since joining the UW faculty in 1964. A Seattle native, he graduated from Reed College in Portland in 1954 and received his medical degree from Western Reserve University in 1958. He was a pediatric resident at Boston Children's Hospital and St. Mary's Hospital (London), and a Fellow in Pediatrics at the Upstate Medical Center in Syracuse. For 19 years he was director of outpatient services at Children's Hospital and Medical Center prior to becoming the chief of pediatrics at Harborview.

Dr. Bergman has carried out research in the fields of child health manpower, child abuse, sudden infant death syndrome, and injury prevention. For over 30 years he has been an active practitioner of what he calls "political medicine", defined as using the political process to improve the public's health. On a national level he worked closely with former Senators Warren G. Magnuson and Henry M. Jackson in consumer protection, child accident prevention, and Indian health.

His activities in this area resulted in several important pieces of health legislation including the Flammable Fabrics Act in 1967, the Poison Prevention Packaging Act of 1970, the National Health Service Corps in 1972, the Sudden Infant Death Syndrome Act of 1974, and the Indian Health Care Improvement Act (1976). He is the author of *"The Discovery" of Sudden Infant Death Syndrome: Lessons in the Practice of Political Medicine*, published by Praeger in 1986, and editor of "Twenty Common Problems in Pediatrics" (McGraw-Hill, 2000).

In 1985, Dr. Bergman founded the Harborview Injury Prevention and Research Center (HIPRC)

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devoted to research, education and prevention programs aimed at diminishing the personal impact of trauma and broadening the effectiveness of injury prevention and trauma treatment programs regionally and nationwide.

This has led to involvement in a variety of injury prevention issues including motorcycle and bicycle helmet usage, drunken driving, and pedestrian safety. He headed a bicycle helmet promotion campaign that raised usage rates among Seattle children from 3% to over 60% over a five year period. He is currently engaged in a project to improve the health services for foster children in Washington State.

Dr. Bergman has seven children, and two grandchildren. He and his wife, Suzanne Fiala, MD, recently adopted two boys, ages 6 and 3, from Russia. ☐

Call for Nominations

The Section on Developmental and Behavioral Pediatrics presents two awards at the Annual Meeting. We welcome your nominations for 2001.

The C. Anderson Aldrich Award is given for career achievement, usually to a physician who has developed a substantial body of work and made a major contribution to Pediatrics.

The Dale Richmond Award, which was created to honor the son of Section member and former Surgeon General, Dr. Julius Richmond. This award has been given to a wide range of individuals from diverse professional backgrounds, and reflects the many contributions of non-physicians to pediatrics and the life of children and families.

The Section Executive Committee will be designating a nominating committee for these awards. In the meantime, feel free to contact the Chair of the Section with proposed nominees for either award.

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Life expectancy in persons with severe developmental disability

by Edward Hoffman, MD FAAP, Kansas City, MO

"My patient with multiple disabilities died recently and I am trying to find out what is the life expectancy in a child with multiple severe disabilities. The patient referred to me was male age 21 years. He had been born very premature, experienced chronic lung disease, and developed spastic quadriplegia, severe cognitive impairment, and oral/pharyngeal dysphagia. He had epilepsy, controlled by phenobarbital. He died suddenly overnight and vomitus was found on the side of his face." (DBP Discussion Group, June 6, 2000)

The Problem

What developmental diagnostic category best predicts mortality? What functional abilities most affect mortality risk? What are typical causes of death? Some literature does exist that addresses life expectancy in persons with severe disabilities. We now know more about the problem than just the average age of death for level of abnormality.

The Evidence

Eyman et al (1990) reported on 99,543 persons with developmental disabilities who obtained services from the California Department of Developmental Services between March 1989 and October 1997. Data was based on Client Development Evaluation Reports (CDER). All had cognitive impairment. Mental retardation (MR) was the handicapping condition of focus. Functional abilities that related statistically to mortality were degree of ambulation, mobility, toileting skills, eating skills, and tube feeding. "Immobile" persons could not crawl, creep, or scoot in prone. Persons were "unable to feed" if they needed to be fed completely by others.

If a person had severe or profound mental retardation, was immobile, not toilet trained, and

was tube fed, then life expectancy was, on average, only 4 or 5 years more than the current age for those persons between the ages of 1 and 24 years at the start of the study. Mobility, or immobility, was the best single predictor of mortality risk. If others could feed a person with immobility then life expectancy doubled. If some functional mobility was also present, then life expectancy doubled again. Finally using the above categories of handicap and function, the addition of presence of seizures or of cerebral palsy (CP) did not alter the predictions of mortality.

Hutton et al (1994) evaluated 1251 cases of cerebral palsy born between 1966 and 1984 in the Mersey region of England, using hospital and community records. Functional abilities evaluated were ambulatory ability, manual dexterity, and mental ability. If severe mobility impairment (required a wheelchair and assistance for propulsion), severe manual dexterity impairment (inability to feed and dress without assistance), and severe mental impairment (Intelligence Quotient <50) were all present, then average life expectancy was 17-20 years. Again impairment of mobility was the best single predictor. Severity of mental impairment was least predictive of these three functional classifications.

Strauss and Shavelle (1999) reported on the life expectancy of adults (persons age 15 years or over) with a diagnosis of cerebral palsy. The

population, again, was from the California Department of Developmental Services consisting of 182,623 persons with developmental disabilities who received services from January 1980 to December 1995. Eight functional abilities were evaluated; rolling/sitting, hand use, ambulation, feeding, severity of CP, severity of MR, type and location of CP, presence of epilepsy, and speech and communication. Life expectancy beyond age 15 years was only 7.8 more years for persons both unable to lift his head and tube fed. If one

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If a person had severe or profound mental retardation, was immobile, was not toilet trained, and was tube fed, then life expectancy was only 4 or 5 years more than the current age.

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was able to be fed by others but still unable to lift one's head, then life expectancy was 11.3 years beyond 15 years of age.

Strauss et al (1997) using the same data set as their report on life expectancy of adults with cerebral palsy, and the UCP Research Foundation (1995), using data from death certificates provided by the National Center for Health Statistics/USPHS for the year 1987, addressed the cause of death in persons with cerebral palsy. This is of particular interest since the assumption generally is that severe motor impairment resulting in poor mobility and poor feeding skills also place one at much higher risk for death from respiratory compromise and aspiration. Indeed, respiratory causes underlie 15 to 45 per cent of deaths, a wide range due to the imprecise nature of data collection. Another large category was circulatory system or heart disease.

Summary

Anticipating the death of a person with severe functional impairments is imprecise. There are several controversies, such as the effects of institutional or community placement or of when and how tube feeding is used (Blacher 1998; Strauss 1997). A family member's ability to cope with the death of a loved one who has severe developmental disability, family financial planning, medical-legal malpractice awards, and state and federal disability budgets are all affected by these uncertain estimates.

Functional motor impairment so severe that head control and rolling or scooting mobility and oral feeding ability all are poor appears to result in drastically reduced life expectancy. Conversely, persons with developmental disability of cognitive or neuromuscular function who have some functional mobility or ambulation and have some functional oral feeding skills seem to have only mildly or moderately reduced life expectancies, depending in part on the degree of functional impairment. Function, rather than diagnos-

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tic category, seems to be most predictive of early mortality.

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Dr. Hoffman is the Director of the neonatal follow-up clinics at Children's Mercy Hospital in Kansas City, Missouri, and a member of the Section on Developmental and Behavioral Pediatrics. ☐





Book Review

AS NATURE MADE HIM: The Boy Who Was Raised As A Girl. By John Colapinto Published by Harper-Collins, 2000.
Reviewed Annette H. Lansford, M.D. Urbana-Champaign, IL

The July 2000 issue of *Pediatrics* has a case report and discussion on Gender Self Reassignment, written by Phornphutkul, Frusto-Sterling and Gruppauo. This report is followed in the same journal by an AAP statement on the evaluation of the newborn with development anomalies of the external genitalia. The Phornphutkul et al report mentions the famous John/Joan case, the long-term outcome of which was reported by Diamond and Sigmundson in 1997 in the *Archives of Pediatric and Adolescent Medicine*.

The John/Joan case was that of a normal infant boy whose penis was ablated during circumcision at age seven months; he who was subsequently raised as a female, on the recommendation of John Money, Ph.D., psychologist and internationally known sex researcher at John Hopkins. Dr. Money's theory was that gender identify at birth is highly malleable. He believed that children are born wholly undifferentiated in terms of their psychological sex and they form a conception of themselves as masculine or feminine solely through rearing.

The reported success of the John/Joan case stood as the precedent upon which a great number of sex reassignments in infants were done. However, this child (John/Joan) ultimately reassigned his own gender during mid-adolescence. Study and the follow-up of this case lead Dia-

mond and Sigmundson to propose alternative principles for the management of intersexual children and of boys suffering from penile trauma.

As a result of the outcome of this case and a number of others which have been studied and reported, including the case reported by Phornphutkul et al, the American Academy of Pediatrics' recent statement (2000) has altered its recommendation. Although the AAP statement continues to recommend that the newborn and infant with abnormal genital development be quickly diagnosed to allow for a comprehensive and appropriate treatment plan, it acknowledges that the decision as to appropriate sex of rearing for a baby born with ambiguous genitalia should be based on a number of considerations that have an impact on the infant's future.

It is noted in the AAP statement that historically, it has been assumed that the psychosexual development of infants with an intersex disorder is largely the result of rearing rather than intrinsic. However, the statement observes in the past decade, it has become apparent that testosterone imprinting of fetal brain may play a role in determining male sexual orientation. The statement goes on to state that until further data become available, caution should be exercised when a recommendation is made that the sex of rearing should differ from the chromosomal sex.

John/Joan would certainly agree with this last statement. The book by John Colapinto, *AS NATURE MADE HIM*, is the fascinating and tragic story of Brenda/David Reimer. John Colapinto originally wrote about David as John/Joan in the magazine *Rolling Stone* in December 1997. David Reimer wanted his story told in greater detail by this journalist and agreed to have his identity revealed in Mr. Colapinto's book.

Making David's story even more fascinating is the fact that he is one of identical twin boys, making his brother a "matched control". From the time of David's sex reassignment, which occurred at age seven months, initiated by a series of surgeries, until he was 14 years old, he strug-

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gled and attempted to reconcile his emotions of not feeling that he was truly a girl. He was finally informed of his medical history at age 14, after many trips to see Dr. Money at Johns Hopkins. Social rejection and ridicule by peers due to his masculine behavior, and feelings of isolation, depression and suicide, resulting in years of psychotherapy, David made the decision to live as a male. The toll that this journey took, not only on David, but his parents and twin brother, was tremendous. David is now married and living with his wife and two stepdaughters in Canada, attempting to live a normal life as a male adult, husband, and father.

The historical and medical context of this case is intriguing to the reader, as it looks at the age-old nature vs. nurture debate and how it has influenced researches' biases, perceptions and interpretations of this complicated issue. Nature was destined to win out in this case. By virtue of this young man's long-term trauma, his case has resulted in a major change in current thinking regarding how intersex cases should be handled. This book offers engrossing and enlightening reading for pediatricians, psychiatrists, psychologists and others who treat children.

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Dr. Lansford is a member of the Section's Executive Committee. ☐

Dale Richmond Award

The 2000 Dale Richmond Award recipient is Dr. Frances Page Glascoe. The Richmond Award is usually given to a non-physician who has made outstanding contributions to the lives of children and families.

Dr. Frances Glascoe is an Adjunct Associate Professor of Pediatrics at Pennsylvania State University and Vanderbilt University. She holds an M.S., Ed.S., and Ph.D. in Special Education from Vanderbilt and has been on the faculty in the Department of Pediatrics since 1983. From 1987 to 1999 she directed the rotation in child development for interns and medical students.

Her research includes studies evaluating the accuracy of many different developmental and behavioral screening measures. Dr. Glascoe has been a frequent speaker at the AAP and has volunteered her time to serve on many Committees and Task Forces. She has conducted many national studies relating to developmental screening and pediatric education.

A major focus of Dr. Glascoe's work has been the validation of parents' concerns in predicting developmental and behavioral problems. Her work has produced striking evidence that clinicians can effectively screen for childhood developmental problems by briefly eliciting parent concerns. As a result of these observations, Dr. Glascoe developed the Parents' Evaluation of Developmental Status (PEDS) a very brief screen for developmental and behavioral problems for children birth to age eight for use in primary care settings

Dr. Glascoe presents frequently at meetings of the American Academy of Pediatrics and the Ambulatory Pediatric Association and is the North American Editor of *Ambulatory Child Health: the Journal of General, Community and Social Pediatrics*. She is the author of over 140 publications including peer reviewed articles and chapters, not counting numerous scientific abstracts and invited presentations. ☐

2000 Annual Meeting Program

Sunday, October 29
8:00 a.m to 4:00 p.m.
Register for: H211

Program Chair:
Jean Smith, M.D. FAAP

Moderator:
Karen Miller, M.D. FAAP
8:30 a.m.

Welcome
Henry L. Shapiro, MD, FAAP
8:45 a.m.

*What Every Pediatrician Should Know About
Oppositional Defiant Disorder*
Ross Greene, Ph.D.

10:15 a.m.
C. Anderson Aldrich Award Presentation
Supported by a grant from Ross Products Division
Abbott Laboratories, Inc.
Recipient: Abraham Bergman, M.D. FAAP

11:15 a.m.
Section Business Meeting and Lunch
(Advance registration required for tickets)

12:30 p.m.
*The Implication and Application of New Re-
search on Reading*
Henry L. Shapiro, MD, FAAP

1:30 p.m.
*The NIMH Multimodal Treatment Study of
ADHD*
Peter Jensen, MD

2:30 p.m.
Break

2:45 p.m.
Dale Richmond Award Presentation
Supported by a grant from Procter & Gamble
Baby Care
Recipient: Frances Page Glascoe, Ph.D. ☐

MEDEM: The Academy builds practice Web sites for member pediatricians

Is your practice online? Now it's just a mouse click away.

Since this summer's launch of *Your Practice Online*, thousands of physicians have built practice Web sites. Now, the Academy is extending this service to help you meet your patients' and parents' demands for online access to your practice.

"As an additional member benefit, the Academy is building preview sites for every member using Medem's Your Practice Online service. By doing the initial legwork, we are making it easier for all of our members to have a strong Web presence," said Joe M. Sanders, Jr., MD, FAAP and Executive Director of the Academy.

Preview sites are customized for you using your AAP member information. The sites include articles and information from the Academy's patient education library, as well as general information about your practice. Members who have not yet built a practice Web site will be contacted to preview their customized site, where you will have the option to publish the site live on the Internet.

Or, you can modify the site by selecting additional patient education content, adding practice announcements and custom pages, or even changing the Web site address (URL). If you have a group practice, Medem's Member services can assist you with adding your partners to the site.

The online library of content available for pediatricians to include on their practice Web sites continues to grow as new materials are produced and new societies partner with Medem. Medem also continues to layer advanced features and additional services onto

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DEVELOPMENTAL-BEHAVIORAL TOPICS:

Annual Meeting, 2000

Highlights of the Annual Meeting Program.

Saturday, October 28

9:30 AM - 11:30 AM

J112 *Teaching Health and Wellness at School*
Paula Duncan, MD, FAAP Paul G. Vallas,
CEO

9:30 AM - 11:30 AM

S113 *Approach to Spasticity and other Motor Problems: Practical Applications for the Pediatrician*
Ann Henderson Tilton, MD, FAAP Leland Albright, MD

9:30 AM - 12:30 PM

S117 (DBP) *Pervasive Developmental Disorders: What the Primary Care Provider Needs to Know*

9:30 AM - 12:30 PM

A120 (DBP) *Management of Common Sleep Problems: Simple Principles & Challenging Cases*
Ron Dahl, M.D. FAAP

2:30 PM - 5:30 PM

S156 (DBP) *Management of Common Behavioral Problems*
Barbara Howard, MD

4:30 PM - 5:20 PM

F163 *Universal Hearing Screening: The Challenge and the Conquest*
Betty R. Vohr, MD, FAAP

Sunday, October 29

8:30 AM - 4:00 PM

H211 (DBP) *Section on Developmental and Behavioral Pediatrics*
Ross Greene, PhD, Henry L. Shapiro, MD, FAAP, Peter Jensen, MD

9:30 AM - 10:20 AM

X225 (DBP) *Cases in ADHD*

Esther Wender, MD, FAAP

11:30 AM - 12:20 PM

X226 (DBP) *Cases in ADHD*
Esther Wender, MD, FAAP

2:30 PM - 4:30 PM

D257 *Prevention, Diagnosis, and Treatment of Neural Tube Defects in the 21st Century*
Joseph Bruner, MD Larissa T. Bilaniuk, MD, FACR Alan R. Cohen, MD, FAAP

2:30 PM - 5:30 PM

S261 (DBP) *Addressing Parents' Mental & Physical Health Needs as Part of Pediatric Care: Why and How*
Barbara Howard, MD FAAP, Larry Wissow, MD, MPH, FAAP

2:30 PM - 5:30 PM

S262 (DBP) *ADHD: Practical Guidelines for Diagnosis & Treatment*
Esther Wender, MD, FAAP

4:30 PM - 5:20 PM

F268 (DBP) *Caring for Children with Down Syndrome*
Nancy Roizen, MD, FAAP

Monday, October 30

9:30 AM - 11:30 AM

S308 (DBP) *Sexuality Education in the Office: Birth to Adolescence What parents want to know but might be afraid to ask.*
Paula Duncan, MD, FAAP Edward Schor, MD, FAAP

9:30 AM - 11:30 AM

S309 (DBP) *Child Care and the Pediatrician*
Carol Weitzman, MD, A. Joseph Avni-Singer, MD, FAAP

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9:30 AM - 12:30 PM

S319 (DBP) Peer Mentoring for Violence Prevention

Kim Spearmon, Karen Sheehan, MD, MPH, FAAP, Joseph DiCara, MD, MPH

2:30 PM - 3:20 PM

F370 Promoting Positive Youth Development

Paula Duncan, MD, FAAP

2:30 PM - 5:30 PM

S367 (DBP) The Use of Children's Drawings in Primary Care

Suzanne Dixon, MD, MPH, FAAP

Tuesday, October 31

9:30 AM - 11:30 AM

S411 International Adoption: Behavioral & Developmental Challenges

Robert D. Needlman, MD, FAAP, Scott H. Faber, MD, FAAP

9:30 AM - 12:30 PM

S417 (DBP) Depression and its Treatment in Primary Care Pediatrics

Chris Varley, MD, FAACAP

9:30 AM - 12:30 PM

A420 (DBP) Enuresis & Encopresis: An Update and Practical Guide to Diagnosis and Treatment (ARS)

Leonard Rappaport, MD, MS, FAAP

Wednesday, November 1

9:30 AM - 11:30 AM

S505 Eating Disorders: Anorexia/Bulimia Nervosa

Richard E. Kreipe, MD, FAAP

9:30 AM - 11:30 AM

J504 Street Children of the World

Swati Bhave, MD, Dilipkumar Patel, MD, FAACPDN, FAAP

2:30 PM - 3:20 PM

X560 The Weak Child: What to Do When The

Muscles Don't Work

Thomas Koch, MD, FAAP

2:30 PM - 4:30 PM

S552 (DBP) Management of Obesity in Primary Care

Richard E. Kreipe, MD, FAAP

2:30 PM - 5:30 PM

S555 When Technology Isn't Enough: Caring for Children With Life Limiting Conditions

Suzanne S. Toce, MD, FAAP, Jeanne G.

Lewandowski, MD, FAAP

MEDEM

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Your Practice Online to enhance all practice Web sites. Just a few of these include:

- **Secure messaging:** Secure, encrypted online communications between the physician's office and designated patients.
- **Statistics tool:** Measure patient traffic to practice Web sites by the day, week, or month.
- **Search engine registration:** Medem will automatically register practice Web sites with the most popular search engines on the Web, helping patients find your site.

If you have any questions, or did not receive a notification regarding your customized preview site, please contact Medem Member Services toll free at (877) 926-3336 or e-mail info@medem.com

Stop by the Medem booth (#1200) at the Annual Meeting. It will be located outside of the Main Entrance to the Exhibit Hall.

Update on Board Certification

by Ellen Perrin, M.D. FAAP, Worcester, MA

Last year's big news was that the American Board of Medical Specialties had approved the creation of a formal subspecialty of Developmental-Behavioral Pediatrics. Shortly afterward, the American Board of Pediatrics appointed a Subboard consisting of seven developmental-behavioral pediatricians and three consultants.

In the past year the Subboard has done a considerable amount of work. Its tasks have been in three areas: (1) creation of a certifying exam; (2) definition of the criteria for eligibility to take the exam (especially during the grandparenting period); and (3) development of guidelines for training programs.

- (1) Creation of a certifying examination is a complex process. The Subboard has expanded the curriculum outline that was included in the original ABMS application, and written "Content Specification Statements" that describe the substance of our discipline. That in itself has been an impressive task, and highlights the breadth and depth of developmental-behavioral pediatrics. These Content Specification Statements will be posted on the ABP website soon.

From these Content Specification Statements the exam questions are written. So far about 350 draft questions have been written—mostly by members of the Subboard and some by other colleagues. Over the coming several months these questions will be reviewed carefully to be edited or discarded, and another group of the same size will be written. Colleagues wishing to participate in this process should contact a member of the Subboard.

- (2) Fellows entering training after January 1, 2002 must complete three years of training in an approved subspecialty training program in order to be eligible to apply to take the DBP certifying exam. This training must be three years in duration and include evidence of a

"meaningful accomplishment in research," as is true for all ABP subspecialty certification.

During the grandparenting period, eligibility to take the certifying examination is more complex. Two years of documented fellowship training or five years of practice during which at least 50% time has been devoted to behavioral-developmental pediatrics will constitute eligibility. Shorter periods of training will be adjusted with practice experience to constitute eligibility during this period. The practice experience must have been accrued prior to 12/31/06. Individuals' unique professional histories will be reviewed by the Credentials Subcommittee of the Subboard.

- (3) It is the Residency Review Committee that credentials programs; the ABP Subboard has only an advisory role. The Subboard has been working with the RRC to outline standards for the components and structure of training programs. These guidelines will be discussed by the RRC during the coming year.

Subcertification in Neurodevelopmental Disabilities was approved by the ABMS at the same time as was subcertification in Developmental-Behavioral Pediatrics. Certification in ND is co-sponsored by the ABP and the American Board of Psychiatry and Neurology, and the examination process is being administered by the ABPN. The first ND examination is scheduled for April, 2001. Subsequent examinations will be administered in 2002, 2004, and 2005. The outline for the ND exam is posted on the ABP website.

The first DBP examination will be administered on November 18, 2002 and every two years thereafter. During the grandparenting period, a candidate could conceivably be eligible to take *both* the ND *and* the DBP examination. *Such dual eligibility would exist if acceptable fellowship training and practice experience could be documented for each subspecialty.* The same training and practice experience cannot be counted towards eligibility in more than one of the examinations.

Developmental-Behavioral News

For further information please contact the American Board of Pediatrics (919-929-0461), or wwt@abpeds.org.

- Members of the DBP Subboard are: Forrest Bennett, Daniel Coury, Heidi Feldman, Ellen Perrin (chair), David Schonfeld, Paul Wang, and Mark Wolraich.
- Consultants to the Subboard are: Dennis Drotar (pediatric psychology), Marvin Fishman (child neurology), and Robert Harmon (child & adolescent psychiatry).

Dr. Perrin is the Chair of the DBP Board and a Section member. ☐

Topic Areas for DBP Boards

The American Board of Pediatrics has published a preliminary content outline for Developmental-Behavioral Pediatrics on their web site. Here are the main headings.

1. Foundations of DBP
2. Influences on child development and behavior
3. Elements of assessment and management
4. Adaptation to general health problems and their treatment
5. Developmental-behavioral aspects of chronic conditions and treatment
6. Developmental disabilities
7. Attention deficit hyperactivity disorder
8. Externalizing conditions
9. Internalizing behaviors and conditions
10. Substance use/abuse
11. Child abuse and neglect
12. Somatic symptoms
13. Sleep problems
14. Feeding and eating problems
15. Elimination disorders
16. Sexuality
17. Atypical behaviors
18. Law, policy, and ethics
19. Principles of research
20. Teaching
21. Administrative skills

Source: <http://www.abp.org>, 10/2000 ☐

The Society for Developmental and Behavioral Pediatrics

Finding common grounds with the AAP Section on Developmental and Behavioral Pediatrics

by Martin T. Stein, M.D. FAAP, San Diego CA

Members of the AAP Section on Developmental and Behavioral Pediatrics recognize that at the core of pediatric practice is the adaptation of knowledge about child development to the care for children and adolescents.

Section members are involved in specialty practices, primary care, community agencies and educational programs that promote the optimal growth and development of children. It was this same perspective and clinical experience that led to the development of the Society for Developmental and Behavioral Pediatrics (SDBP) over twenty years ago.

SDBP was founded in 1982 to improve the health care of infants, children and adolescents by promoting research and teaching in developmental and behavioral pediatrics. A major goal of the founders of the Society was to encourage young pediatricians to develop an interest in teaching and research in areas of development and behavior that would enhance health care for children. They believed that, if the field was to thrive in academic and teaching institutions, a cadre of clinicians that devoted a significant portion of their time to research and teaching must be developed.

The founders of the Society also saw the value to including other mental health professionals who work with pediatricians. Among the nearly 700 members of the SDBP, 20% are pediatric psychologists.

There are many signs that the goals of the founders have been achieved. The Pediatric Residency Review Committee now requires a formal curriculum in development and behavior

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SDBP

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including at least one month of a block rotation supervised by an individual trained in DBP. At our last annual meeting, over 75 directors of DBP training programs met to learn about program goals, innovations in teaching, and evaluation methods. Journals that are read frequently by pediatric trainees and practicing pediatricians, such as *Pediatrics* and *Pediatrics in Review*, now include increasing numbers of articles focused on developmental and behavioral problems.

The Society's bimonthly publication, the *Journal of Developmental and Behavioral Pediatrics*, includes original articles, review articles and special sections on challenging cases, reviews of recent literature and book reviews; the Journal is devoted to new ideas that will enhance the quality of care we provide to our patients and their families. With leadership from the Section, workshops and seminars at pediatric CME programs have increased significantly.

Recently, Developmental and Behavioral Pediatrics was recognized as a subspecialty. The process for board certification is under development at the present time. I believe that the emergence of DBP as a board certified sub-specialty should enhance the growth of our field. It should also encourage more collaboration between primary care pediatricians and DBP specialists.

This idea may seem paradoxical. However, as subspecialty status in DBP carries with it a stronger position in academic departments of pediatrics, there will be opportunities for DBP programs to expand in clinical care, teaching and research. This should lead to more opportunities for pediatricians in practice to become involved in expanding programs in teaching and clinical research. It will be the responsibility of both the generalists and the specialists to discover the common ground on which to build collaborative programs and projects.

Members of the AAP Section on Developmental and Behavioral Pediatrics are welcome to participate in many of the activities of the SDBP. The annual meeting in late September is open to

Developmental-Behavioral News

non-members and includes workshops on clinical hypnosis in pediatric settings and teaching DBP to pediatric residents; additional workshop and seminars this year included complex sleep problems, psychopharmacology, faculty development, ADHD, and psychological aspects of asthma.

The meeting includes two sessions where original research is present and discussed. In addition, primary care pediatricians with an interest in DBP will find the *Journal of Developmental and Behavioral Pediatrics* stimulating and relevant to pediatric practice.

A word on membership in the SDBP. The Society is open to all professionals committed to scientific inquiry, teaching and/or clinical excellence in developmental and behavioral pediatrics. Membership requirements can be met by documentation of this commitment in one of three categories: research, teaching or clinical practice. Primary care pediatricians are eligible for membership if a considerable amount of their time (50%) is spent in the clinical practice of developmental-behavioral pediatrics.

Information on membership, the annual meeting, and the *Journal of Developmental and Behavioral Pediatrics* may be obtained at: The Society for Developmental and Behavioral Pediatrics, c/o Ms. Noreen Spota, Administrative Director, 19 Station Lane, Philadelphia, PA 19118-2939; (215) 248-9168 (nmospota@aol.com).

I look forward to greater participation from primary care pediatricians in the activities of the SDBP. There are many challenges in the practice of pediatrics that impact our mutual interests. Among the most important is the implementation of best practice models that will ensure quality services in screening, diagnosis and management of children and adolescents with problems in development and behavior. The goals of both the Section and the SDBP are consistent with this pursuit.

Dr. Stein is the immediate past president of the Society for Developmental and Behavioral Pediatrics and a member of the Section. ☐

Section Strategic Plan

The Section sponsored a Strategic Planning Meeting in February 2000. The planning group included: Henry Shapiro, MD; Peter Gorski, MD; Mark Wolraich, MD; Daniel Kessler, MD; Karen Miller, MD; Frances Glascoe, Ph.D.; William Lord Coleman, M.D.; Martin T. Stein, M.D.; and James Blackman, MD. This two day meeting resulted in the following mission statement and goals.

Mission Statement

The Section on Developmental and Behavioral Pediatrics is committed to improving the developmental and psychosocial well being of children and their families through education, advocacy, research, service and collaboration.

Health Systems

The Section on Developmental and Behavioral Pediatrics will encourage health systems to include appropriate programs to address the psychosocial and developmental needs of all children and their families. They will promote quality assurance measures and financing pertinent to developmental and behavioral pediatrics. The Section will also encourage collaboration with other child-focused organizations.

Section Governance and Activities

The Section on Developmental and Behavioral Pediatrics will assess and monitor the needs of Section members in order to encourage greater participation and diversity. The Section will also encourage and formalize relationships within the Academy and with outside organizations.

Education

The Section on Developmental and Behavioral Pediatrics will provide interdisciplinary and collaborative learning opportunities in developmental and behavioral pediatrics that meet the needs of pediatric care providers and subspecialists in developmental and behavioral pediatrics at both training and continuing education levels.

Research

The Section on Developmental and Behavioral Pediatrics will increase the research focus

on the evidence base for primary and subspecialty care interventions in the prevention, diagnosis and treatment of developmental and behavioral problems.

Advocacy

The Section on Developmental and Behavioral Pediatrics will encourage advocacy activities to promote conditions and services that enhance the biopsychosocial development of children and families.

Service

The Section on Developmental and Behavioral Pediatrics will promote and improve a continuum of clinical services in development and behavior for all pediatric care providers and developmental and behavioral subspecialists. The Section will also promote and improve patient care during all pediatric encounters that strengthen developmental competence of the child and family. ☐

<http://www.dbpeds.org/section/>

Section on Developmental and Behavioral Pediatrics

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