MDForLives

THE GLOBAL PULSE OF HEALTHCARE · PEDIATRICS INSIGHT REPORT

Pediatric Developmental Screening: Why Early Detection Still Hits a Referral Wall

Responses from pediatricians on developmental screening and early intervention: when concerns first surface, which tools enter routine care, why screening is still squeezed by well-child visit capacity, how parent hesitation affects next steps, what happens during specialist backlogs, and which system changes could shorten the path from developmental signal to support.

Context → Signal → Judgement → Action

125	6	73.6%
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate

WHY THIS REPORT

Developmental screening is designed to identify concerns early. The harder question is whether the care pathway can move at the same speed.

Primary pediatric care has a clear early-development mandate. In current U.S. guidance, the American Academy of Pediatrics recommends developmental surveillance at health supervision visits, standardized developmental screening at 9, 18, and 30 months, and autism-specific screening at 18 and 24 months. The purpose is not only to detect a possible delay. It is to trigger further evaluation, follow-up, and intervention when concern is identified.

The MDForLives survey focuses on the operational space between those steps. Pediatricians were asked which screening tools they routinely use, when speech, motor, or social concerns most often become visible, what prevents universal screening during well-child care, why families sometimes hesitate, how long developmental-behavioral pediatrics or child-neurology referrals take, what clinicians do while families wait, which autism signals are most often missed, where allied-service shortages are most severe, and what could accelerate earlier identification over the next three to five years.

The central pattern is a timing mismatch. Concerns commonly surface between 12 and 18 months, but screening must fit inside already crowded visits and the next specialist appointment can be months away. The pediatrician is therefore not simply a detector or referrer. In many pathways, primary care becomes the continuity layer that explains uncertainty, activates early intervention, organizes therapy, monitors progress, and decides when the child needs a different level of assessment.

> **Methodology and data note.** Audience: pediatricians. Survey ID 8943296. The source export contains 125 survey records and a 73.6% completion rate across the USA, UK, Canada, Italy, France, and Germany. The hidden country-punching item contains 118 responses and is used only for geography metadata. Core developmental questions contain 96 to 99 responses. The source displays 18 open-text entries, of which 13 contain substantive interpretable content. Administrative tracking, bad-ID, required-text, after-question, and honeypot fields are excluded. The requested reader-facing report does not display the complete-response count.

EXECUTIVE SUMMARY

Six signals that define the gap between early developmental concern and early developmental support

INSIGHT 01

INSIGHT 02

Concern concentrates in the 12–18 month window

59.2% say suspected speech, motor, or social delays are most commonly identified, or first raised by parents, at 12–18 months.

Well-child time is the leading screening barrier

41.2% identify insufficient consultation time as the greatest operational barrier to routine universal developmental screening.

INSIGHT 03

Waiting is the most common parent hesitation

39.6% say a belief that the child will outgrow the delay is the most common reason for resistance to screening or formal evaluation.

INSIGHT 04

Referral access can stretch beyond a year

25.0% report waits longer than 12 months for developmental-behavioral pediatrics or child neurology.

INSIGHT 05

Early intervention becomes the bridge

45.8% refer directly to public early-intervention programs when specialist waitlists are excessively long.

INSIGHT 06

Child psychology is the tightest allied-service bottleneck

53.1% identify child psychology or mental health services as the most severe shortage or referral backlog in their community.

01

SCREENING ARCHITECTURE

Pediatricians are using structured tools, but the survey also shows how developmental and autism screening blend together in real practice

41.4% select ASQ-3 / ASQ-SE-2 as their routine developmental-tracking tool, while 33.3% select M-CHAT-R/F.

CONTEXT

Developmental surveillance and standardized screening are related but distinct parts of pediatric preventive care. Current AAP guidance recommends ongoing surveillance, standardized general developmental screening at defined ages, and separate autism-specific screening. The exact instrument is not mandated by the AAP, and practices may build different combinations into the well-child workflow.

WHAT THE DATA SHOWS

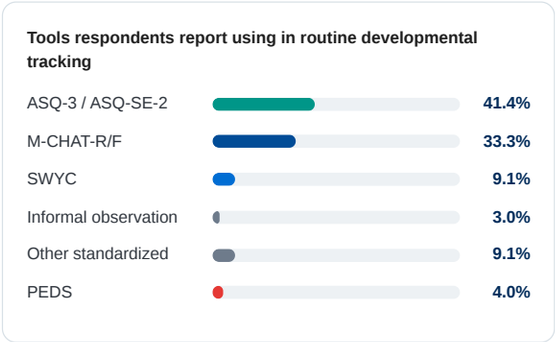
ASQ-3 / ASQ-SE-2 is the most selected survey option at 41.4%. M-CHAT-R/F follows at 33.3%, SWYC at 9.1%, informal clinical observation and milestone checklists at 9.1%, other standardized tools at 4.0%, and PEDS at 3.0%. The source item asks about general developmental tracking but includes M-CHAT-R/F, an autism-specific instrument, among the answer choices.

THE INSIGHT

The second-place M-CHAT-R/F result should therefore not be treated as a claim that respondents consider it interchangeable with a general developmental screen. A more careful reading is that autism-specific screening is deeply embedded in the developmental-monitoring workflow for many respondents. The item also shows that structured tools dominate over informal observation alone.

WHY IT MATTERS

For pediatric teams, the implementation question is not simply which tool is preferred. It is whether the practice has a repeatable process for distribution, completion, scoring, interpretation, family discussion, referral, and follow-up. A tool without that workflow can still become a checkbox rather than a pathway.



02

RECOGNITION WINDOW

The dominant recognition window is 12–18 months, which makes every delay after concern more consequential

59.2% say they most commonly identify, or receive initial parental concerns about, suspected speech, motor, or social delay between 12 and 18 months.

CONTEXT

The 12–18 month period is clinically busy. Communication, joint attention, motor development, social reciprocity, and caregiver expectations are becoming more visible at the same time that scheduled developmental and autism screening enters the preventive-care calendar. AAP guidance specifically places a general developmental screen and autism-specific screening in this age range.

WHAT THE DATA SHOWS

The 12–18 month interval accounts for 59.2% of responses. The next largest group, 19–24 months, is 20.4%. Under 12 months is 12.2%, 25–36 months is 7.1%, and over 36 months is 1.0%.

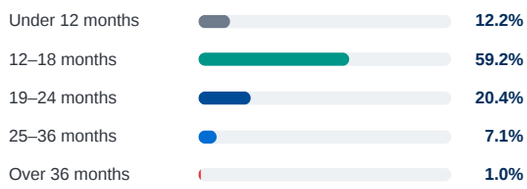
THE INSIGHT

The survey therefore places most first concerns inside a period when there is still substantial opportunity for early developmental support. That is a strength of pediatric primary care. It also means that a long diagnostic or referral delay does not occur late in the pathway. It begins soon after the concern is first recognized.

WHY IT MATTERS

When a concern appears at 12–18 months, the practice needs a plan that does not depend on a single downstream appointment. Developmental follow-up, early-intervention referral, therapy access, hearing or other medical evaluation where indicated, and repeated surveillance can all help preserve momentum while diagnostic clarification proceeds.

Age when developmental concerns are most commonly identified or first raised



03

WELL-CHILD VISIT CAPACITY

The biggest barrier to universal screening is not lack of awareness. It is the number of tasks competing for a brief preventive visit.

41.2% identify insufficient consultation time during brief well-child visits as the single greatest operational barrier.

CONTEXT

A developmental screen creates work before and after the score. Families need instructions, results need review, positive or borderline findings need interpretation, language and cultural context may change the discussion, and follow-up must be documented. This sits alongside immunization, growth, feeding, sleep, safety, acute concerns, social drivers, and the rest of preventive pediatrics.

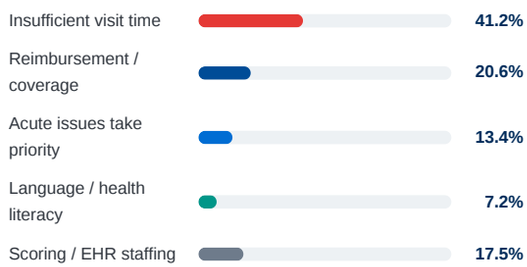
WHAT THE DATA SHOWS

Insufficient consultation time leads at 41.2%. Inadequate reimbursement or insurance coverage for screening tools follows at 20.6%. Acute clinical issues taking priority over prevention are 17.5%, language, cultural, or health-literacy barriers 13.4%, and staffing constraints for scoring or EHR logging 7.2%.

THE INSIGHT

The barrier profile is operational rather than conceptual. Respondents are not primarily saying that screening lacks value or that they do not know what to do. They are saying the workflow competes for time, payment, attention, communication capacity, and staff support.

Greatest operational barrier to routine universal developmental screening



WHY IT MATTERS

The AAP STAR Center describes screening as a process that includes early identification, family-centered discussion, referral, and follow-up. That is important because it reframes screening from a questionnaire to a care pathway. Practices can protect physician minutes by moving appropriate steps upstream through pre-visit completion, team scoring, reliable EHR capture, and predefined follow-up workflows.

04

FAMILY HESITATION

“Wait and see” creates more friction than distrust, so the parent conversation is fundamentally about timing and uncertainty

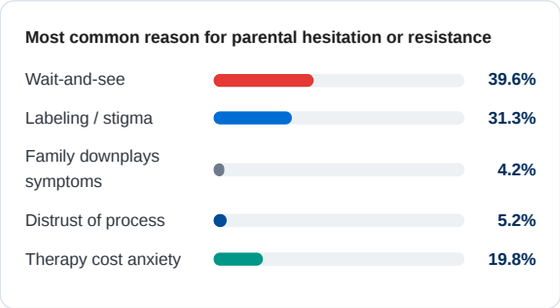
39.6% say the most common reason for parental resistance is a belief that the child will outgrow the delay.

CONTEXT

Parents may hesitate for many reasons. Development varies widely, formal labels can feel frightening, extended therapy may carry practical consequences, and family members may have different interpretations of the same behavior. A pediatrician has to acknowledge that uncertainty without allowing reassurance to become indefinite delay.

WHAT THE DATA SHOWS

Wait-and-see leads at 39.6%. Fear of developmental labeling or social stigma is close behind at 31.3%. Family members or partners downplaying symptoms account for 19.8%, distrust of screening or diagnostic processes 5.2%, and anxiety over long-term therapy cost 4.2%.



THE INSIGHT

The data suggests the dominant challenge is not opposition to medicine. It is a familiar developmental narrative: children mature at different rates, so perhaps more time will solve the problem. That belief can be understandable and still clinically risky when it postpones evaluation of a persistent concern.

WHY IT MATTERS

A useful conversation separates support from certainty. A child can receive closer surveillance, early intervention, speech or occupational support, or additional evaluation without the clinician claiming a diagnosis that has not been established. That framing can reduce the false choice between 'wait' and 'label'.

05

SPECIALIST ACCESS

The referral queue can outlast several developmental follow-up cycles

27.1% report typical waits of 4–6 months, 24.0% report 7–12 months, and 25.0% report waits longer than 12 months.

CONTEXT

Developmental-behavioral pediatrics and child neurology are often used for diagnostic clarification, complex neurodevelopmental presentations, and management decisions that extend beyond routine primary care. The problem is supply. A 2024 Pediatrics workforce analysis describes the U.S. developmental-behavioral pediatrics workforce as markedly inadequate and notes that referral wait times are measured in months.

WHAT THE DATA SHOWS

In the MDForLives survey, 4–6 months is the largest single category at 27.1%. More than 12 months follows at 25.0%, 7–12 months at 24.0%, 1–3 months at 18.8%, and less than one month at 5.2%. The question asks for the typical wait from the respondent's practice to developmental-behavioral pediatrics or child neurology.

THE INSIGHT

The distribution turns the referral into a care interval. A pediatrician cannot assume the specialist visit will occur before the next well-child review, before the next developmental milestone concern, or before a family needs guidance about preschool, therapy, behavior, communication, or safety.

WHY IT MATTERS

Referral quality therefore includes what happens before the appointment. The primary-care plan needs a waiting-period strategy: activate eligible early-intervention services, address hearing or other medical contributors when relevant, connect appropriate therapies, document functional change, support the family, and update the referral if the child's needs escalate.

Typical wait for developmental-behavioral pediatrics or child neurology

06

INTERIM CARE

Most pediatricians do not treat the specialist waitlist as a reason to postpone support

45.8% refer directly to state or local early-intervention public programs when specialist waitlists are excessively long.

CONTEXT

Current U.S. AAP and CDC resources explicitly support action before diagnostic completion. AAP guidance states that intervention for identified developmental delays should begin at the time of identification, and CDC notes that healthcare providers or families can refer directly to early-intervention systems for assessment. These are U.S.-specific pathways, but the underlying principle is broader: support does not have to wait for every diagnostic question to be settled.

WHAT THE DATA SHOWS

Direct public early-intervention referral is selected by 45.8%. Private speech, occupational, or physical therapy is next at 30.2%. Co-management through schools or community programs is 13.5%, remaining on specialist waitlists with primary-care monitoring is 7.3%, and home-based activities with re-evaluation in 3–6 months is 3.1%.

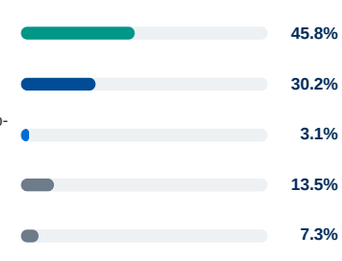
THE INSIGHT

The largest groups choose an active service connection rather than passive observation. That pattern is especially important when read next to the 39.6% parent wait-and-see finding. Pediatricians may be trying to counter delay by giving families something concrete to enter now.

WHY IT MATTERS

The interim pathway should still be individualized. Not every child requires the same therapy or urgency, and local eligibility varies. The broader lesson is organizational: practices need a current map of early-intervention contacts, therapy options, school resources, family navigation, and escalation criteria so that a positive screen does not end with a referral fax.

Primary clinical strategy when specialist waitlists are excessively long



07

AUTISM SURVEILLANCE

The most commonly overlooked ASD signal is absence of joint attention, but the answers are spread across several subtle behaviors

30.2% identify absence of joint attention as the most commonly overlooked early ASD sign, narrowly ahead of atypical or inconsistent eye contact at 28.1%.

CONTEXT

Autism-specific screening is standardized at defined ages, but surveillance occurs across repeated pediatric encounters. Caregiver observations, social communication, gesture use, response to name, regression, sensory patterns, and the clinician's longitudinal knowledge of the child all contribute to deciding whether a concern needs more evaluation.

WHAT THE DATA SHOWS

Absence of joint attention leads at 30.2%. Atypical or inconsistent eye contact is close at 28.1%. Subtle speech or vocal-tone regression is 18.8%, atypical sensory response 17.7%, and lack of response to name by 12–15 months 5.2%.

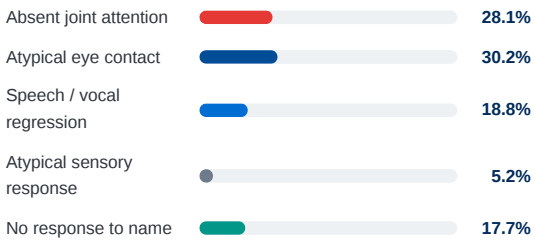
THE INSIGHT

The distribution resists a one-sign model of autism recognition. A familiar sign such as eye contact does not dominate. Joint attention is slightly more prominent, while regression and sensory differences also attract meaningful shares. The survey therefore reinforces the value of looking at the developmental pattern rather than waiting for one stereotyped presentation.

WHY IT MATTERS

For pediatricians, a standardized autism screen is most useful when it sits inside broader developmental surveillance. A concerning history or clinical observation can justify further evaluation even when a single screening item or familiar sign is absent. Repeated visits are an advantage because change over time can be as informative as one cross-sectional snapshot.

Early ASD sign most often overlooked during primary-care screening



08

ALLIED-SERVICE CAPACITY

The referral wall does not end with developmental specialists. Child psychology and behavioral services are the next major choke points.

53.1% identify child psychology or mental health services as the allied health area with the most severe local shortage or referral backlog.

CONTEXT

Children with developmental concerns often need more than one destination. Depending on the child, care may involve psychology, behavioral therapy, speech-language pathology, occupational therapy, physical therapy, educational services, and primary-care follow-up. A diagnostic appointment is therefore only one part of the access map.

WHAT THE DATA SHOWS

Child psychology or mental health services lead at 53.1%. Applied behavior analysis or behavioral therapy is second at 33.3%. Pediatric occupational therapy is 5.2%, speech-language pathology 4.2%, and pediatric physical therapy 4.2%.

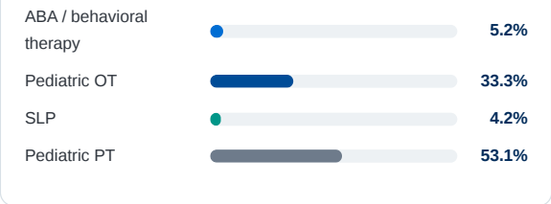
Allied health service with the most severe shortage or referral backlog

THE INSIGHT

The striking pattern is concentration. Respondents do not distribute shortage evenly across all allied services. They identify behavioral and mental health capacity as the dominant bottleneck. That matters because developmental concerns frequently overlap with behavior, emotional regulation, family stress, school functioning, and diagnostic uncertainty.

WHY IT MATTERS

A practice can improve referral coordination by knowing not only who diagnoses, but who can support function while diagnosis proceeds. Capacity mapping should include behavioral health, psychology, therapy, early intervention, schools, and family support. Without that wider network, earlier detection can simply produce a longer list of needs that families cannot access.



09

NEXT THREE TO FIVE YEARS

The future vote is almost tied between making screening easier and making intervention easier to enter

26.0% choose universal funding and rapid early-intervention enrollment, while 25.0% choose AI-assisted parent-completed screening before office visits.

CONTEXT

The survey's future-facing options span technology, payment, workforce, and care delivery. That is useful because developmental delays are not a single-stage problem. Earlier identification depends on screening, but better outcomes also depend on what families can access after the screen.

WHAT THE DATA SHOWS

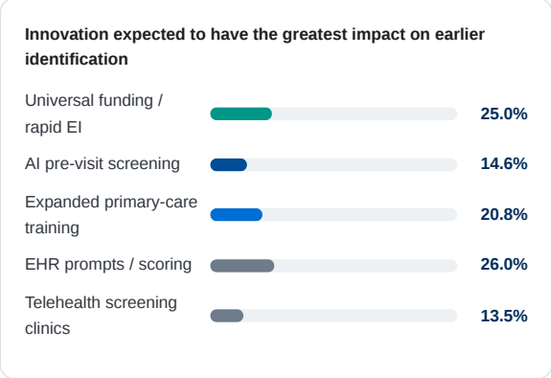
Universal funding and rapid-enrollment pathways for community early-intervention programs lead at 26.0%. AI-assisted digital screening apps completed by parents before visits are 25.0%. Expanded primary-care training enabling pediatricians to make provisional diagnoses is 20.8%, automated EHR prompts and scoring 14.6%, and telehealth-enabled rapid developmental screening clinics 13.5%.

THE INSIGHT

No option dominates. The top two represent opposite sides of the pathway: one improves access after concern, the other aims to make detection and pre-visit preparation easier. The 20.8% support for more primary-care diagnostic capability adds a third strategy: increase what the pediatric medical home can resolve without waiting for subspecialty capacity.

WHY IT MATTERS

The implication is to avoid technology-only solutions. A faster screen is valuable if it saves time and finds the right children, but it can worsen the referral queue if capacity downstream remains unchanged. The strongest system design pairs screening efficiency with early-intervention access, primary-care capability, and clear escalation pathways.



OPEN-ENDED PERSPECTIVE

When pediatricians describe the one change they want, they keep coming back to capacity

The open-ended question asked for the single most critical change needed in healthcare policy or primary-care practice to ensure children with developmental delays receive intervention before age 3. The source displays 18 entries. Thirteen contain substantive, interpretable text and five are non-substantive strings. The substantive responses are read qualitatively without assigning theme percentages.

More specialists and more people who can diagnose

Respondents ask for more developmental pediatricians, more practitioners able to evaluate and diagnose, better access to specialists, and more funding for specialist services. The message is consistent with the closed-question referral waits: the diagnostic workforce is a limiting resource.

Coverage, reimbursement, and public funding

Several responses explicitly mention reimbursement, insurance coverage, universal access independent of insurance, and greater government funding. Access is being framed as a financing problem as well as a workforce problem.

More time, staffing, and primary-care capability

Respondents ask for extra time at 12-, 18-, and 24-month assessments, more staff to handle caseloads, more training for general pediatrics, and greater primary-care awareness of developmental issues. Earlier intervention is therefore linked to strengthening the medical home, not only expanding referrals.

Family resources and clearer navigation

Comments mention parent education, misinformation, access to therapy, difficulty finding services, time away from work, and the challenge of locating neurologists or developmental clinicians. The pathway can be clinically correct and still be practically inaccessible to a working family.

What the qualitative responses add: the requested change is not one new screening instrument. Pediatricians are asking for a larger care system around the screen: enough time to assess, enough training to act, enough specialists and therapists to receive referrals, enough funding to make services reachable, and enough navigation support for families to move through the pathway.

PEDIATRIC DEVELOPMENTAL SCREENING PRACTICE LENS

What a more workable early-development pathway could look like

The survey does not define a universal protocol. It does show where pediatric practices can reduce friction while preserving individualized clinical judgment and local referral requirements.

Move screening work upstream

Use parent-completed pre-visit tools, team scoring, and reliable EHR capture so physician time can focus on interpreting results, examining the child, and discussing what happens next.

Make the positive-screen pathway visible

Predefine who contacts the family, which referrals are placed, what can start before diagnostic completion, how follow-up is scheduled, and what triggers faster escalation.

Build an active waitlist strategy

Connect children to eligible early intervention, therapy, school or community services, and primary-care reassessment rather than treating the specialist appointment as the only meaningful next step.

Support the family through uncertainty

Explain that early support does not require premature certainty. Give families clear reasons for acting now, practical navigation help, and a plan for what will be reviewed at the next contact.

PEOPLE ALSO ASK

Frequently asked questions about pediatric developmental screening

What developmental screening is recommended for young children?

In U.S. pediatric guidance, developmental surveillance is recommended at every health supervision visit, with standardized developmental screening at 9, 18, and 30 months. Local schedules and tools can differ by country and health system.

At what ages should children be screened for autism?

The American Academy of Pediatrics recommends autism-specific screening at the 18- and 24-month health supervision visits, alongside ongoing developmental surveillance.

What is the difference between developmental surveillance and developmental screening?

Developmental surveillance is the ongoing process of listening to caregiver concerns, observing development, reviewing milestones, and tracking risk over time. Screening uses a standardized tool at recommended ages or whenever concerns arise.

Can a child start early intervention before an autism diagnosis?

Yes. U.S. AAP and CDC resources state that children with identified developmental delays should be referred for intervention when the delay is identified and should not have to wait for an autism diagnostic evaluation before receiving needed support.

What does the M-CHAT-R/F screen for?

The M-CHAT-R/F is an autism-specific screening tool for toddlers. It is not a general developmental screening instrument, so it is usually used as part of a broader developmental surveillance and screening workflow.

What happens after a developmental screening concern is identified?

The next steps can include a more detailed developmental and medical evaluation, referral to early intervention or early childhood services, appropriate therapy referrals, and closer follow-up in primary care. The exact pathway depends on the child's needs and local services.

CLOSING PERSPECTIVE

The developmental screening challenge is becoming less about finding a signal and more about protecting momentum after the signal appears

The survey describes a pathway that often begins at the right time. Most respondents say speech, motor, or social concerns are first identified or raised between 12 and 18 months. Structured screening tools are already part of practice, and pediatricians report active interim strategies when specialist care is delayed. The problem is what accumulates around that early recognition.

Well-child visits are crowded enough that consultation time is the leading screening barrier. Parent hesitation is most often a wait-and-see belief or concern about labeling rather than outright distrust of formal care. Developmental-behavioral pediatrics and child neurology can be months away. Child psychology and mental health services are described as the most severe allied-service shortage. Pediatricians therefore spend a significant part of the pathway doing work that sits between traditional categories: explaining uncertainty, rechecking development, activating early intervention, arranging therapy, supporting parents, updating referrals, and deciding whether the child's trajectory warrants more urgent evaluation.

That work is not a temporary workaround. It is becoming a core part of developmental care in a constrained system. AAP and CDC guidance already supports intervention when developmental delay is identified rather than waiting for autism diagnostic completion. The survey shows why that principle matters in practice. If the specialist appointment is delayed, the child still has a developmental timeline, the family still needs direction, and primary care still has repeated opportunities to observe change.

The future options selected by respondents also argue against a single solution. Universal funding and rapid early-intervention enrollment narrowly lead AI-assisted parent-completed screening. Expanded primary-care training remains close behind. The improvement agenda therefore spans both sides of the pathway: make screening easier to execute, and make services easier to enter after a concern is found.

1 · Protect the 12–18 month window

Make developmental and autism screening workflows dependable during the period when concerns are most often first recognized.

2 · Design the visit around the full screening process

Include completion, scoring, interpretation, family discussion, referral, and follow-up rather than treating screening as a questionnaire alone.

3 · Replace indefinite waiting with a staged plan

Use surveillance, early intervention, appropriate therapy, and scheduled reassessment while specialist diagnostic questions remain open.

4 · Talk about support before labels

Help families understand that acting on a developmental concern does not require predicting the child's future or forcing premature diagnostic certainty.

5 · Map the real local capacity

Know the availability of developmental specialists, child psychology, behavioral therapy, SLP, OT, PT, early intervention, schools, and family navigation resources.

6 · Pair digital screening with downstream access

Adopt technology when it reduces visit friction, but measure success by whether children reach evaluation and intervention faster, not simply whether more screens are completed.

Help future pediatric insights reflect what happens between developmental concern and intervention.

Share your pediatric perspective with MDForLives and help build a clearer view of screening, family conversations, referral capacity, autism identification, early intervention, and developmental care in real-world practice.

Join the Panel

Sources used for this report

1. **MDForLives Pediatric Insight Survey_Aug, SGID 8943296.** Source survey report: 125 survey records and 73.6% completion rate across six countries. Country metadata and developmental-screening question values were extracted from the supplied PDF. The source displays 18 open-text entries, of which 13 contain substantive content. Themes were interpreted qualitatively without percentage coding. Administrative and validation fields were excluded. Per the requested display rule, the complete-response count is not surfaced in the report.
2. **American Academy of Pediatrics.** Autism Resources for Pediatricians. Updated January 21, 2026. Recommends general developmental screening at 9, 18, and 30 months, autism-specific screening at 18 and 24 months, and intervention for identified developmental delays without waiting for autism diagnostic completion. https://www.aap.org/en/patient-care/developmental-behavioral-pediatrics-a-resource-guide-for-general-pediatricians/autism-spectrum-disorder-resources-for-pediatricians/
3. **American Academy of Pediatrics.** Surveillance/Monitoring and Screening, Screening Technical Assistance and Resource Center. Updated May 13, 2026. Describes developmental screening as a workflow that includes early identification, family-centered discussion, referral, and follow-up. https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/surveillancemonitoring-and-screening/

4. **Centers for Disease Control and Prevention.** Clinical Screening for Autism Spectrum Disorder. Updated April 15, 2025. Summarizes AAP developmental screening at 9, 18, and 30 months and autism screening at 18 and 24 months. https://www.cdc.gov/autism/hcp/diagnosis/screening.html
5. **Centers for Disease Control and Prevention.** Developmental Monitoring and Screening, Learn the Signs. Act Early. Updated February 16, 2026. Notes that healthcare providers and families can refer directly to early-intervention systems for assessment. https://www.cdc.gov/act-early/about/developmental-monitoring-and-screening.html
6. **Baum RA, Berman BD, et al. Pediatrics.** Child Health Needs and the Developmental-Behavioral Pediatrics Workforce Supply: 2020–2040. 2024;153(Supplement 2):e2023063678H. Describes an inadequate U.S. developmental-behavioral pediatrics workforce and persistent access pressure, including referral waits measured in months. https://publications.aap.org/pediatrics/article/153/Supplement%202/e2023063678H/196575/Child-Health-Needs-and-the-Developmental

MDForLives

The Global Pulse of Healthcare

MDForLives is a global healthcare insights platform where healthcare professionals, patients, and caregivers discover, share, and shape the future of healthcare. This report presents aggregated perspectives for professional insight and discussion. It is not clinical guidance, treatment advice, or a substitute for patient-specific judgement, approved product information, or local practice standards.

© 2026 MDForLives

A Borderless Access platform

Real Opinions to Insights. Validated by Data.