Bullying

Sticks and stones can break...: building a case for when names can hurt you

M Augustyn

Commentary on the paper by Griffiths *et al* (see page 121)

"Power corrupts, and absolute power corrupts absolutely." [Lord (John Emerich Edward Dalberg) Acton]

Bullying as an international problem has been recognised in multiple studies over the last ten years. Almost 30% of teens in the United States (or over 5.7 million) are estimated to be involved in bullying as either a bully, a target of bullying, or both. In a recent US survey of students in grades 6–10, 13% reported bullying others, 11% reported being the target of bullies, and another 6% said they bullied others and were bullied themselves.¹ In a study comparing rates of bullying between England and Germany, major differences were found in victimisation rates, with 24% of English pupils becoming victims every week compared with only 8% in Germany. In contrast, fewer boys in England engaged every week in bullying (2.5–4.5%) than German boys (7.5%), while no differences were found between girls.² Few can argue that bullying is a problem, but if we are to consider solutions, we must explore what got us to the problem in the first place.

In the thought provoking article by Griffiths and the ALSPAC Study Team,³ further evidence of obesity as a risk factor for bullying victimisation and overt bullying behaviour is presented. Perhaps most compelling in this study, they found that *level* of adiposity was significant—that is, overweight status of boys and girls was not found to significantly predict bullying involvement, but obesity was. These results may be seen as further evidence supporting the Transactional Model of Sameroff.⁴ In the Transactional Model, how a child turns out is neither a function of the child alone nor of experience alone, but a combination of an individual and his or her experience. The Transactional Model embeds a child in an environment of social relationships that will amplify some early characteristics and minimise others.

In this model obesity would be viewed as another risk factor in creating a negative social relationship: bullying. It would be added to the list of other risk factors for this behaviour, including: academically advanced or challenged students, physically disabled children, homosexual and transgendered students,

and children with school alienation.^{5,6} A common thread can be seen among these characteristics: power, or more specifically those who have it and those who don't. Exploring *power*—how it is defined and maintained in childhood will be important in exploring effective intervention programmes to overcome the rising volume of bullying behaviour. This work is critically important if we are to shift the culture from one where power defines a child's future to one where equal opportunity exists for all. Only then can we make the playground a place where *even names* cannot hurt you.

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Neonatology

The nursery needs discoveries

V Harrison

Neonatologists need to readdress the factors that influenced past discoveries

"To cure sometimes, to relieve often, to comfort always"

The care of newborn babies has been enhanced significantly by these objectives, but in recent times the

pace of discoveries for curing has slowed considerably.

A GOLDEN ERA, THEN DECLINE

Consider the therapeutic advances over four decades, the two preceding and the

two following 1980. The first period was characterised by a significant decline in neonatal morbidity and mortality. It was highlighted by the prevention of haemorrhagic disease, tetanus, rhesus disease, rubella, apnoea of prematurity, hypoglycaemia, and hyaline membrane disease. Further contributions included phototherapy, resuscitation, intermittent positive pressure ventilation, and continuous positive airways pressure. A golden age of therapy indeed!

By contrast the second period looks rather sparse. It heralded the prevention of neural tube defects, but then the pace of discovery slackened. With the exceptions of surfactant and kangaroo care, advances like oscillation, nitric oxide, and ECMO are applicable to relatively

few infants in highly specialised units. They are expensive and unsustainable in all but the most affluent countries.

Have we reached a stage where every meaningful discovery has already been made?

Hardly, when one considers puzzles like prematurity, group B streptococcal infection, neonatal encephalopathy, necrotising enterocolitis, and persistent pulmonary hypertension. What then accounts for the current state of inertia?

HAZARDS OF SPECIALISATION

Individuals who were not experts in neonatology made the pre-1980 advances in therapy. Neonatologists in turn, implemented and refined the innovations, thereby improving patient care beyond measure. But why have none made revolutionary discoveries?

The most productive period of those in the biological sciences is acknowledged to be between 30 and 40 years of age. A large portion of this decade is now devoted to the ingestion and regurgitation of known facts for examinations and registration. In addition, administrative responsibilities reduce an expert's contact with clinical concerns. Problems can rarely be viewed in a new light as most specialists read standard literature, possess comparable knowledge, and pursue quests in a similar way.

REKINDLING DISCOVERY

But specialisation ensures quality control and is here to stay. How can it nourish innovation?

For a start, the expert can re-build bridges between the specialty and other sciences. Who knows what novel solutions might arise from cross-pollination with another discipline! Then too, there

must exist a spirit of generosity. This entails support for individuals who express novel ideas, no matter how outrageous the solutions offered to intractable clinical problems may be.

Next, the specialist should study the origins of the earlier advances in therapy. Broadly they resulted from paying attention to the observations or sayings of others, from chance findings and from a revival of very old ideas. Here is a selection:

- Richard Cremer, a registrar at Rochford Hospital England, heeded the instinct of nursing staff to expose jaundiced infants to indirect sunlight. By estimating bilirubin levels before and after this procedure, he gave the world phototherapy.¹
- Those prone to happy accidents are well prepared for the unexpected, like Liggins, a New Zealand obstetrician. To his surprise, immature fetal lambs given steroids to initiate parturition survived considerably longer after birth than those without this medication.² He consequently showed that antenatal steroid therapy also hastened lung maturity in the human fetus.³
- What of old or discarded ideas? In the late 1700s, resuscitation at birth differed little from current practice. Lungs were inflated by face mask ventilation or endotracheal intubation, and newly discovered oxygen was also available.⁴ This method was certainly unacceptable to misguided practitioners of the mid-20th century, who believed that reanimation could best be achieved by "see-sawing" asphyxiated infants and by filling their stomachs with oxygen! Lung inflation was eventually restored to

its rightful domain in the early 1960s, backed by physiological proof of efficacy.

RETAINING A FRESH OUTLOOK

As age advances, how can specialists continue to combine experience with a freshness of outlook? By concentrating on topics that are sufficiently unfamiliar to retain an open mind and are compatible with their investigative ability.

Louis Pasteur and Michael Faraday, two of science's greatest discoverers, constantly changed their fields of interest, with breath-taking consequences.

Finally, a discovery does not exist until it is in print. When this too has been addressed, Phoenix-like may arise the occasional specialist, who "thinks like a poet, works like a book-keeper and if gifted with a full quiver, writes like a journalist!"⁵

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Neonatology

The nursery needs discoveries

H L Halliday

A reply

Among Professor Harrison's important contributions to neonatal medicine was the discovery of the importance of grunting in preterm infants with respiratory distress syndrome¹ and the detrimental effects of endotracheal intubation, a finding that led to George Gregory discovering continuous positive airway pressure some

three years later.² This was an important development in neonatal care and Gregory had been influenced by the observations from South Africa.

However, Professor Harrison begins his review by stating, with reference to developments in care of the newborn, that "in recent times the pace of curing has slowed considerably". He goes on to

divide the last 40 years or so into two eras: 1960 to 1980 and 1981 to 2000, saying that the former was "a golden era indeed" whereas the latter period "looks rather sparse" with respect to improvements in neonatal care and declining neonatal mortality. Professor Harrison is correct in listing the prevention of haemorrhagic disease, tetanus, Rhesus disease, and rubella as important landmarks but we should not forget the errors that also occurred in this era: kernicterus, grey baby syndrome, feeding gastrostomies, and cystic brain lesions from hexachlorophene, leading Alex Robertson to name 1950 to 1970 the "heroic" years.³ Not all golden years!

After 1980 Professor Harrison names maternal folic acid supplementation to reduce the risk of neural tube defects as