Multimedia bullying using a website

Bullying, both physical and verbal, has been a part of the lives of children and adults for many years—we are all familiar with *Tom Brown's Schooldays*. It has had a high profile in the media recently—especially the “craze” for bullying by new and modern methods. We refer to so-called “happy slapping”, where a young person is assaulted, and one of the bully’s friends records the event on a mobile phone. This video is then circulated among the peer group to allow the event to be relived, furthering the bullying.

We have been treating a patient with a non-organic pain syndrome, with little success until recently. We had arranged for the patient to be admitted for intense treatment, and it was during this admission that our patient disclosed that she was being bullied. However, as well as the traditional bullying, our patient was being bullied via her website. It transpired that her website was similar to a “blog” in that it had the ability for others to leave comments. It was this facility that her bullies were using—each post was flooded with comments that were hurtful to our patient. These comments were discussed by the bullying peer group in much the same way that the “happy slapping” videos are circulated and discussed.

We believe this form of bullying has not previously been reported in the medical literature, although we suspect it is more prevalent than the literature would suggest.

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doi: 10.1136/adc.2005.086793

Competing interests: none declared

First, do no harm

The article by Dr Datta and colleagues¹ makes interesting reading. The importance of optimal neuroimaging and accurate interpretation of scans is correctly emphasised. Their first recommendation about neuroimaging in all suspected cases of non-accidental head injury (NAHI) is welcome and the point about MRI as a second line investigation contributing to prognostication in these cases has some evidence base. However, I have reservations about the evidence available to support their second and third recommendations.

The recommendation for a head CT scan to be performed as part of “skeletal survey” for children under 6 months of age where physical abuse is suspected may have the consensus of a group of respected neuroradiologists, but little good quality evidence to support it. By the time the authors reach their third recommendation of a CT scan to be strongly considered as part of a skeletal survey in any child being investigated for physical abuse, any attempt to support this with evidence is also lost.

So what are the dangers of using neuro-radiology as a potential “screening tool” for subdural haemorrhage in selective screening of “high risk” cases, as the recommendations seem to suggest? Even if we ignore the false

negatives (one can argue that the diagnosis would be missed anyway if these cases did not get the scans), the issue of inconclusive/suspicious findings on CT scans remains. It is inevitable that the majority of these suspicious findings will then need to be confirmed or rejected by performing an MRI scan. If by that time the physical injury with which the infant/child presented first was considered to be accidental, few professionals would be willing to support this position if they were aware that the CT findings were not entirely normal. Only after the MRI was reliably reported by a neuroradiologist would the child protection investigation be reliably concluded. The emotional stress of something possibly being abnormal in their child's brain would be encountered by numerous such parents, in addition to the stress of child protection procedures. Practical issues such as CT radiation, waiting times for MRI, and above all, the workload for a very small number of experienced neuroradiologists having to report a large number of such scans cannot be ignored. The potential for legal challenges, possible miscarriages of justice, and conflicting opinions from expert witnesses is unlikely to help make child protection work popular among paediatricians.

I do not intend to discredit these recommendations. We simply need to convince ourselves that they will truly benefit children.

Publication of these recommendations in a journal widely read by paediatricians in the UK, could lead some to believe that these recommendations have broad agreement among paediatricians and approval from the RCPCH. After all, these recommendations are part of the standard for skeletal surveys in suspected non-accidental injury in children (website of the British Society of Paediatric Radiology)² and are being widely disseminated at paediatric educational meetings.³ Maybe we should wait for the RCPCH to appraise these recommendations before we incorporate them into our daily practice.

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More is not necessarily better

Frances's story¹ raises several points. Firstly, I am sure I am not alone among readers in having every sympathy with Frances's mother and grandmother. I find it is a Canute-like task trying to stem the flood of expectation among professionals and parents that “more must be better”. There is an erroneous belief that more investigations, more professionals involved, more interventions, more physiotherapy or speech therapy or occupational therapy, etc, must be a good thing.

Many in the caring professions believe they are acting in a caring way by advocating more

interventions and making referrals to all and sundry. But just because the services or technology are there, we do not have to use them. As paediatricians we must take the lead and when appropriate say, “Stop”. We need to have the courage to say, for example, “Treat the child and not the growth chart” and mean it.

Secondly, the arousal gap means that every phrase, silence, and gesture is given a meaning by the patient or family far beyond its intention.² The fact that the family is aggrieved does not mean that there has been poor communication, that anyone is at fault, and that the fault automatically lies with the doctors. Families and doctors are both in a difficult position. Doctors have to give unpleasant, distressing, complicated information about issues which are not clear cut to families at times of great stress, anxiety, unhappiness, and fear. What we should remark on is not when this process goes badly but how often it goes well.

Thirdly, Harvey Marcovitch is being disingenuous when he says, “We were not in a position to ask the doctors whether their perception of the situation was different”. With the parents' permission he could have had a parallel article with the doctors' version of events. Anonymous articles are potentially a libeller's charter. The “acknowledgement” at the end of the article to staff in the Dartford area will inevitably suggest—rightly or wrongly—to readers that the incident took place around that area. This may cause immense distress to the doctors concerned who may recognise themselves and possibly be recognised by colleagues (R Taylor, personal communication). They will rightly in my opinion feel aggrieved that they have not been invited to or are unable to respond.

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Reply by H Marcovitch

When the paper was first submitted it did not identify the patient's name or address, or where she was treated. Unfortunately I did not think to seek information on the treating team from the subscriber to *ADC* who submitted it on the family's behalf. I have checked the audit trail and remain uncertain as to how the acknowledgement found its way in—but I take full responsibility and apologise to anyone who feels bruised by the publication. I had assumed that our informed readership would realise there can be a world of difference between a family's perception and the clinical facts. But I still think perceptions can be important learning points. Overall, I plead incompetence rather than disingenuousness.

H Marcovitch

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