recommended that a discussion is needed to decide whether FTT still has any use to describe paediatric undernutrition of different types.⁷ The term is certainly not useful to define the range of normality in early growth. Professors Wright and Weaver in their Perspective suggest that the views of healthcare professionals should be systematically sought, now that we know the lay view on infant size and growth.⁴ As a starter, perhaps the readership can be encouraged to submit alternative terms to FTT to define what paediatricians recognise to be the healthy infant who is just regressing to the mean or is weight faltering. For my part, it may all just be a case of weight adjustment.

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Image or reality

Image or reality: why do infant size and growth matter to parents?

Charlotte M Wright, Lawrence T Weaver

Perspective on the paper by Lucas *et al* (see page 120)

It has long been known that poor growth in infancy is associated with high morbidity and mortality in childhood. The earliest systematic records of infant mortality collated by the registrar general ascribed “debility” and “atrophy” as the principal causes of death in early life and the knowledge that undernourished babies were likely to grow up into fragile adults was one of the driving forces behind the provision of public welfare services for mothers and children.¹ So great was the concern for the future of the newborn that a parliamentary commission surveyed the physical status of babies and school children across Great Britain in the early years of the past century.² Growth charts, essential tools for such surveys, had been pioneered in clinics aimed at detecting and managing babies and children who failed to thrive,³ largely as a consequence of infectious diseases and poor feeding. Their widespread use was crucial to the success of public child health initiatives, which served to highlight the connection

between domestic and social conditions, including parenting and child health.

Although there remains a strong correlation between poverty and short stature, the fortunes of children are now immeasurably better than they were a hundred years ago. Nevertheless, growth is still used routinely to assess child health and development, and parents inevitably still attach great importance to it. Lucas *et al*⁴ in their systematic review of lay perceptions about infant size and growth, found that parents emphasise the importance of normality in growth. However, judging from the selected quotations presented, parents also strongly link quality of parenting and sufficiency of nutrition to growth, and experience great anxiety and a sense of diminished worth when their child's growth is subnormal.

Depending on your perspective, this could be bad or perfectly natural. Growth and size in early childhood can still matter a lot. Parents who have watched their sick baby lose weight know this all too well, as does any watcher of news

from regions of famine. However, there is also a view that the weighing of babies generates needless anxiety. Of course, both views are valid and consistent with each other. If one simply defines abnormal growth as falling below one of many possible lower growth thresholds, 27% of infants in Copenhagen are abnormal⁵ and for every child wasting away from illness or neglect there are many others whose growth is subnormal, but who are otherwise well.^{5–6}

So how are paediatricians and parents to navigate these complexities and where do problems most often arise? First, the distinction between association and prediction should be clearly understood. Just because a child in one setting may become undernourished because he or she is ill or neglected it does not mean all undernourished infants are ill or neglected or that all small infants are undernourished. Equally, just because a small child is not neglected or ill does not mean he or she is necessarily sufficiently nourished or growing normally. Most children with faltering weights have no underlying medical problem,^{7–8} and recent population-based work has shown that the classic association between faltering weight and poverty or maternal deprivation no longer applies in affluent societies such as the UK.^{9–10}

Arguably, problems most commonly arise when there is a mismatch between the perceptions of parents and professionals of the child's growth or the explanations of each for it. There are four basic situations where problems of perception of growth and size arise, each

Table 1 Patterns of discordance between parent and professional perceptions of child growth

	Growth normal	Growth abnormal
Parents not worried	Misdiagnosis	Unworried falterer
Parents worried	Worried well	Stuck case

with its own hazards and solutions (table 1).

MISDIAGNOSIS

It is hard enough to teach medical students, health visitors and even trainee paediatricians the concepts of how growth charts should be used and interpreted. The proper decoding of growth patterns takes time and effort, but often this process is incomplete; previous measurements are either not available or not accessed, length may not be measured and weight is rarely adjusted for height by calculating and plotting body mass index. Professionals, as well as parents, often find it hard to distinguish between size and growth. One child may be thin or small and yet growing consistently or even catching up, whereas another may be growing poorly yet within the normal range (fig 1). This situation is complicated by a lack of any gold-standard method of diagnosing either undernutrition or constitutional short stature. The combination of poor weight gain, low weight-for-height and eventually a declining height centile make undernutrition likely, but one may not have enough measurements or time to wait for it to be clear whether this, or a more benign growth pattern, is being manifested.

THE WORRIED WELL

When a child is constitutionally small and eating appropriately small amounts of food, or an average-sized child subsists on small amounts of energy-rich snack

foods, parental worries about "under-eating" can become extreme. When these worries are translated into force-feeding and meal-time battles, the child's eating behaviour can become highly disturbed. The risk with such children is that parental anxiety will trigger professional anxiety and lead to reclassification of the child as growing abnormally, leading to the prescription of food supplements and even tube feeding, when there is no potential for the growth pattern to be "cured". The solution for these families is time spent carefully explaining the growth chart and the principles of managing food refusal and faddy eating, as well as withdrawing high-energy supplements that simply serve to suppress the poor appetite the child has.

UNWORRIED FALTERERS

Parents often do not share professional concerns about growth, although they may be too polite to say so explicitly. Common reasons are ideas about smallness being normal in their family and the perception that their child cannot be undernourished, as they know they are caring parents. The risk here, particularly when parents are "respectable" and the practitioner shares the same belief that undernutrition occurs only with illness or neglect, is that the child will simply be reclassified as normal,¹¹ thus depriving the family of the opportunity to receive dietary advice and in some cases missed diagnoses of important medical or emotional issues. The solution, as well as meticulous attention to explaining the growth data, is to explain the extra vulnerability of young children to undernutrition and that, because of their high energy requirements, it is possible for a child who seems to eat plenty to still be relatively undernourished. If families can be helped to understand that undernutrition in early childhood can occur even in the most ordered and respectable households, they can often make the behavioural or dietary changes necessary to improve food intake.

THE STUCK CASE

Worrying growth patterns are all too often identified but not "treated". Children may be measured repeatedly and investigated at length, but no diagnosis or advice offered. The clinician may

wish to avoid uncomfortable issues or simply be uncertain how to proceed. However, in the absence of explanations, parents make their own attributions; to them, prolonged investigations imply serious undiagnosed illness, and repeated weighing suggests that they are "bad" parents. For these children, sometimes all that is needed is to cease investigation, explain the diagnosis and provide dietetic advice, after which catch-up growth occurs.

However, some children continue to grow poorly despite all the simple strategies applicable. In such children interventions should still be proportionate. The growth pattern should be a signal for closer assessment rather than seen as a disease that must be cured. If a child is thin, yet tracking on too low a centile, once medical causes have been ruled out and social issues thoroughly considered, there may be nothing more to do. Strong indicators prove that just as some children overeat from an early age, others have an intrinsically low drive to eat.¹² Only where growth progressively deteriorates should more intensive action be needed and, even then, it is important to take the long view. Although the growth pattern may be treated in the short term by tube feeding or supplements, the underlying problems that lead children to undereat or not be fed remain unanswered. Psychological inputs or support for the family may not have such a dramatic effect on the growth chart, but yield much greater benefit in the long term.

CONCLUSIONS

The growth chart is a useful tool for professionals. Yet, concealed beneath its neat lines and smooth curves exist layers of hidden meaning, not at all decipherable even by professionals. Discordance between image and reality may not be confined to parents and public; maybe there is a case for a systematic review of professional views about infant size and growth?

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Figure 1 Growth chart with two contrasting growth trajectories.

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From human rights to legal rights

From principle to practice: moving from human rights to legal rights to ensure child health

Barry Zuckerman, Ellen Lawton, Samantha Morton

Perspective on the paper by Waterston and Goldenhagen (see page 176)

We applaud Waterston and Goldenhagen's¹ call to arms to healthcare professionals to consider the poor health of the world's children (the United Nation's Convention on the Rights of the Child providing the framework to direct such efforts). We also agree that it is essential to deal with the pervasive structural barriers that lead to inequality, poor health and suffering.² But, as we continue to push for rights-based laws around the world, we also encourage an active strategy of promoting the enforcement of existing laws that protect children—especially those laws that ensure access to children's basic needs, such as food, housing, safety, healthcare and education. Waterston and Goldenhagen themselves lay the groundwork by noting that one triumph of recent human rights campaigns has not only been to identify rights violations but also to establish rights-based laws in 50 countries. Indeed, a strategy focusing on the enforcement of existing laws would go a long way in dealing with a number of the injustices cited by the authors, such as non-compliance with Jordanian child labour laws and Kenyan laws regarding child well-being.

Over the past several decades, the confluence of human rights work, increased humanitarian infrastructure and new progressive governments has, in many countries, laid a foundation of legal rights accruing to children. Ensuring adherence to the laws delineating those rights is the next step. When evaluating and treating sick children, healthcare professionals frequently identify how inadequate food, housing, safety, access to basic medications such as vaccines or other unmet basic needs contribute solely or partly to preventable medical illness and poor child health. Although healthcare professionals are not lawyers, experience in the US suggests that a partnership between doctors and lawyers in the clinical setting can facilitate meeting families' basic needs—resources indisputably necessary for the health and development of children. We believe that this approach (or a variation thereof) will hold government systems accountable in enforcing laws that are intended to protect children's health. Moreover, providing legal services for basic needs constitutes a concrete action step that communities can take immediately, in addition to Waterston and Goldenhagen's¹ excellent discussion of the tools available

under the UN Convention on the Rights of the Child.

CHILD HEALTH SITE TO DEAL WITH SOCIAL DETERMINANTS CONTRIBUTING TO POOR CHILD HEALTH

Doctors and other healthcare providers are uniquely situated to intervene when children's basic needs are not being met. Not only are many children seen in child health settings for immunisation and treatment of illness but also a focus on prevention includes identifying non-medical determinants of child health. Nevertheless, although child health professionals are often aware of the social context of the patients they serve, they generally do not have the capacity (knowledge, training, time, resources, etc) to effectively intervene in non-clinical arenas. We view the clinical setting, where medical providers routinely screen families for a variety of barriers to child health, as providing a virtually unrivalled opportunity to identify violations of legal rights that impair children's health, and to connect affected families with legal services to challenge those violations. This opportunity can only be exploited if there is a partnership between health and legal professionals.

AN EXAMPLE FROM THE US

In the US, medical-legal partnerships (www.mlpforchildren.org) have begun to redraw the boundaries of potential solutions.³ Close to 50 clinics and hospitals now rely on lawyers to assist paediatric teams in dealing with the health concerns of low-income populations. We think that this innovative model has global implications, especially as young democracies take hold and tackle implementation of the rule of law, a "system in which the laws are public knowledge, are clear in meaning, and apply equally to everyone."⁴ The fundamental objective of a medical-legal partnership is to radically