

## News in Brief

### New growth charts

The WHO has developed new growth charts for babies. What was the need? What problems made the National Center for Health Statistics (NCHS) standards less than ideal? First the NCHS standards were published in 1977 and were based on babies of the 1950's. Much water has flown under the bridge since then. Secular trends in children's growth have meant that babies born today are bigger and follow a more upward trajectory. Second, the NCHS standards were based on a mixed bag of babies - those who were breast-fed as well as those on the crude infant formulas of the 1950's. The current WHO standards are based on the growth pattern of babies who are exclusively breast-fed. It is well known that top fed babies are heavier and grow faster than breast fed counterparts. But WHO asserts that breast fed babies are the biological norm and must show us the way. So far, even more recently developed growth charts were based on the premise that they must just reflect the current situation in the population and equally include all groups of children. The flaw in this argument is that in developed countries spiraling obesity will shift the higher percentiles up. In poor countries generations of malnutrition means malnourished babies abound. What our growth charts must reflect are healthy babies with optimal growth; neither obese nor impoverished. The new WHO growth charts are based on babies from Brazil, Ghana, India, United States, Norway, and Oman, born to non-smoking mothers who exclusively breast fed their babies till 4 months. In the poorer countries only the affluent

communities have been represented. Growth means change and it is time for growth charts to change. (de Onis M, Garza C, Victora CG, Onyango AW, Frongillo EA, Martines J. The WHO Multicentre Growth Reference Study: planning, study design, and methodology. *Food Nutr Bull* 2004;25: s15-26.[Medline]; *BMJ* 18 June 2005; 330:1399-1400)

### Working hours for junior doctors

The intensity and complexity of acute medical care being given to patients is rapidly increasing. All over the world guidelines for duty hours of junior doctors are becoming stricter. And there is lot of data to suggest that increasing duty hours of junior doctors risks the health of patients and doctors too. When interns in the US were working 77 - 81 hours/ week they committed 36% more errors as compared to when they worked an average of 65 hours per week. Motor accidents in these tired junior doctors were 16% more when working extended hours as compared to when they worked for shorter hours. Consecutive night shifts have also shown grim repercussions. Risk increases exponentially over the night and further with consequent nights. When studying pilots and cabin crew, NASA discovered that short naps of 40 minutes improved performance by 34% and physiological awareness by 54%. In Britain and the US some of the guidelines already in force or suggested include a shift of no more than 13 hours with a break of 11 hours, a maximum of 3 consecutive nights, scheduled 2 hour rest in the course of the night by rotation, a high quality, restorative sleep during the day in a darkened room, with ear plugs and a mobile phone which has been switched off. (*BMJ* 18 June 2005; 330:1404).

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