

READING 3

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ETHICS IN LACTATION CONSULTANT PRACTICE: SOME CASE STUDIES

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Abstract

The work of a lactation consultant requires knowledge and skilled action that is client-focused rather than provider-focused, protecting the formation of strong mother-baby bonds. There is no standard one-size-fits-all answer in this work. Just as breasts and nipples and babies and mouths come in a multitude of shapes and sizes; just as past experiences and personal desires of each person are unique to that person, so the advice and care given needs to be tailor made.

Critical reflection on incidents and episodes of care enable the practitioner to link theory and practice, to question one’s own actions, and to learn from the experience. Three case studies, looking mainly at the first week in a baby’s life, are considered using practical approaches to critical review.

Introduction

In every situation in which I find myself acting professionally as a lactation consultant I need to be sure that I am doing what’s right in that situation. Right means it’s not just what a text book or service guideline says, but also what is respectful of the individual mother and her baby as people. My actions need to be not only theoretically correct, but also ethically responsible. My actions as a practitioner are influenced by my knowledge, scope of practice, and rights, and how these interact with the rights and needs of my two clients in any lactation situation, the woman and baby.

Ethical action is built on a framework of values:

1. universal basic values, essential for survival
2. core values held by our society
3. the individual’s values

Universal basic values include safety, freedom from threat or exposure, freedom from hunger, and freedom from pain.

Our society’s core values include respect for the individual, truth telling, empathy, and trust. These values are further expanded in health care to empowering informed decision making in relation to care, equity of access to resources, confidentiality, and accountability.

An individual's values may be related to their particular family, culture, religion or beliefs. Some people value wellness, sustainability, and the natural order. Some place high value on technology, scientific knowledge, or historical contexts. Others value beauty, wealth, social standing, possessions, or physical ability.

Everyone, from a newborn baby onward, values a good meal, a good sleep, and love. An expert in lactation is often called in when one (or more) of these three components is not being achieved, and this is the situation in the case studies I want to look at today. Baby isn't getting a good feed, neither mother nor baby is getting a good sleep, and the love or attachment between mother and baby is being sorely tested.

Case studies

In each of these cases (Table 1), I have noted what was happening immediately after birth, day 3 and day 5. I will then present a couple of ways in which I attempt to learn from an experience, and link theory with ethical practice.

Table 1: Case Studies

	Mother / baby 1	Mother / baby 2	Mother / baby 3
Birth	28 yo, first baby, uncomplicated birth at Birth Centre. No medication. BF in first hour. Large fibrous nipples, difficult attachment.	33 yo, third baby, uncomplicated birth at home. Breast reduction surgery age 20; BF other 2 children well. One breast better than other. Baby BF at birth.	35 yo, first baby, private hospital, induction at term, Pethidine, Epidural, Emergency C/S. Baby to nursery. Attempted BF at 3 hours – did not attach.
Day 3	LC visit – home. feeding frequently, nipples grazed, partial attachment, blistered, creased nipple, graze forming – attempted correction. Continue BF.	LC visit, feeding 3-4 hourly, using dummy to space feeds. M confident –LC questioned baby's intake – to review.	LC in hosp – baby not attaching well. Nipples grazed. Small amount EBM + formula.
Day 5	Visit to lactation clinic. Painful nipples, full breasts. Baby frequent long feeds. M tired, distressed. Advised to express and cup feed. M thought this was not a good idea and persevered – damaged nipples.	LC visit home. M confident but tired. Breasts soft. Baby placid, dummy ++ weight loss > 10%.	LC in hosp. Using electric pump. Small amounts EBM. Baby settled – formula in bottle. M upset – feels that she failed both birth and BF. Breasts soft, nipples healing.

In summary, by the end of the first month,

1. the first mother and baby were struggling, with continuing nipple damage, mastitis, thrush, sleep deprivation ... Mother was upset by different advice from different sources
2. the second mother was supplementing with artificial milk at every feed. Her baby's weight had dropped significantly and had never regained birth weight while she attempted exclusive breastfeeding or supplementing expressed milk
3. the third mother never did establish breastfeeding, and was experiencing postnatal depression. By one month she had decided to wean completely.

Critical reflection links theory and practice

Each of these mother/baby pairs faced serious feeding difficulties, despite the early availability of a skilled LC and supportive services.

In reflecting on any situation it helps me as a practitioner to look at it from as many ways as possible. I try to understand what that particular baby experiences every time the need for food rouses him instinctually to call his mother and seek the breast. I try to understand what each mother feels every time she hears her baby's cry, holds him in her arms, talks to him, sees and feels his rooting movements, and what she feels when attempts at breastfeeding are less than satisfactory. I try to peel back the layers of my own knowledge, beliefs, and reactions.

In theory a mother's milk is ideally suited to the baby's needs, and almost all mother-baby pairs are able to achieve a stable and satisfying breastfeeding relationship. Protecting the wellness of the mother and baby, preventing unnecessary use of dangerous drugs in birth, and enhancing the loving bond between mother and baby through skin contact and unrestricted feeding are well supported strategies within my body of knowledge (Kroeger 2004). Two of the cases I am describing today had all this. But in both these cases the feeding was not going well by the end of the first week. The third mother and baby were caught up in Australia's caesarean epidemic. I am pleased to be able to tell you that this particular mother has recently given birth to her second baby, without drugs or surgery, and is happily breastfeeding.

Applying the DeBono (1985) 'thinking hats' to any of these case studies gives me an opportunity to reflect on what I experienced.

Wearing the Thinking Hats, using the cases mentioned ...

Thinking hat	Example – As the LC wearing this hat, I ...
White hat – pure facts	can see that the baby has lost too much weight, and appears under-nourished
Red hat – feelings	assess that the mother is upset and depressed, baby cries a lot; that mother doesn't know who to trust
Grey hat – negative aspects	see that nipple trauma and poor breast drainage have progressed to mastitis and thrush
Yellow hat – right and constructive	am confident that the mother is very attentive and responsive to her baby
Green hat – creative thinking	wonder should I have acted more decisively about the early introduction of a dummy? How can I plan to act in this situation next time?
Blue hat – summary	seek an opportunity to review the care with the mother, to encourage questions, to acknowledge the mother's concerns

Critical reflection is not about laying blame. It is often impossible to know why or how decisions were made. The LC is often consulted only after a downward spiral has already begun, and is gaining momentum.

Case presentations and peer review often take place in a professional setting when an adverse event such a preventable death, or a near-miss, occurs. In those rare cases in which a coroner's inquiry, or a professional regulatory body is called upon to investigate, the case is intensely scrutinised, and disciplinary action may ensue. This may or may not be done by peers.

For the lactation consultant, failure of breastfeeding is an adverse event that needs to be reviewed. When we go through a reflective process we are able to check our own knowledge, learn from the experience, ask questions, and possibly gain some insight into how we could provide more effective professional support next time.

Another system of reflection, similar to the 'thinking hats', is described by Gibbs (1988, quoted in Chesney 1996). In applying Gibbs' reflective cycle to the lactation consultant's practice, the mother and baby are in the centre of the picture. For any incident or episode of care, the LC undertakes critical reflection.

- Description - What happened?
- Feelings thoughts - How does this make me feel?
- Evaluation - The good and the bad.
- Analysis - What sense can be made?
- Conclusion - What else can be done?
- Action Plan - If it occurred again ...?

Applying Gibbs' reflective cycle to mother and baby #1 at the 6-week review, in summary:

- **Description** – Early breastfeeding problems that were associated with physical difficulties (large fibrous nipples, incorrect attachment) and became progressively more complicated. Baby has grown well. Now (at six weeks) much improved feeding; but mother is emotionally fragile.
- **Feelings, thoughts** – M is still tired, upset and angry. I feel sorry for M&B, that they have had such a difficult time. When I saw M postnatally she appeared to be struggling with different advice from several sources, including professional, family, and her own understanding. I don't think my advice was trusted any more than that from other sources. I am pleased that M&B have persevered, and appear to be succeeding.
- **Evaluation** – Breastfeeding is progressing well now at 6 weeks. Baby is thriving and the relationship between M&B appears to be good - eye contact, responsiveness ... Mother has recovered from last bout of mastitis in which she was treated with antibiotics. ? getting adequate sleep. M has expressed anger about what she perceives to be conflicting advice presented in a rigid, inflexible way, and not seen as useful in her particular situation. The baby's father also seems to be angry.
- **Analysis** – I acknowledge the anger and feelings of distress at what happened. Breastfeeding is not easy, and certain physical features make it a big challenge for some mothers and babies.
- **Conclusion** – In retrospect I believe my advice on the occasions I saw M&B was reasonable, yet it may have contributed to the confusion experienced by M.
- **Action Plan** – I think this case would be better managed, with better coordination of health professionals so that advice by different people is less conflicting to the mother's mind. A woman identified with a particular breastfeeding problem may benefit from a 'case manager' who coordinates contact with other services, such as hospital LCs and MCH nurse and GP. This ideal may not be achievable, with service limitations. I will attempt to counsel a woman in this situation so that she understands the possibility of conflicting advice, and how to overcome the conflict.

Woman-centred care

Effective maternity care is client-focused or woman-centred; the centre or focus of every care episode being the mother and her baby or babies rather than being problem-focused or outcome focused. Effective care by a team or individual LC leads to effective mother-baby relationships, not just in nourishing the baby, but also in all areas of nurture and in meeting the mother's own needs.

The LC's client is the mother, and through the mother, her baby. In complex situations where a mother's or baby's health is compromised, the LC collaborates with the medical, midwifery and nursing members of the care team.

The problem of conflicting advice identified by mothers has to do with the mother's own understanding of all the information and advice she receives. In the brief few days that most new mothers spend in hospital or under the care of home-based maternity services, there is a barrage of information.

If breastfeeding is a natural process, why can't more mothers and babies work out for themselves how to do it?

Service provision

In the past couple of decades we have become increasingly aware of the impact of hospital and other medical practices on breastfeeding especially through the Baby Friendly Hospital Initiative (BFHI).

A woman can now achieve uninterrupted skin to skin contact with her baby immediately after birth. There is not the same likelihood of 'comp feeds' (formula) in the nursery at night, as there would have been even 10 years ago.

Mothers and babies who progress through the first week without significant difficulty are probably establishing exclusive breastfeeding and rightly feeling very proud of themselves. These are the ones who would probably manage well even without professional help. However the other group of mothers and babies – those who do experience difficulties – are not doing as well.

Some may disagree with me on this, but I believe that a down-side of the BFHI has been a growing rigidity about breastfeeding care in maternity hospitals. This rigidity has to do with standardising advice, and probably with the intention of reducing conflicting advice. It has instead tended to become provider-focused, giving simplistic answers to very complex problems. A maternity service which emphasises individual, client-focused care requires processes that are flexible and highly sensitive to the mother and baby.

Breasts and babies come in all shapes and sizes: a one-size-fits all solution is no solution. The lactation consultant is the expert who can make and review a management plan that takes into account the individual mother-baby pair's needs; who supports and educates that woman to understand how she can achieve her goal.

In the end it may not really matter if a mother with sore nipples continues to put her 3-day old baby to the breast for each feed, or learns to express her milk and give it to the baby some other way. The LC who is able to give woman-centred care, focusing on the needs and preferences of the individual woman, will support a mother in making informed decisions about how to progress through the most complex and challenging situation.

Gadgets like pumps and nipple shields can be at times useful, or a barrier to progress. The LC who respects each woman's knowledge will be careful to work with what that woman believes is good, and will not criticise the advice given to her by another practitioner. Even if that advice seems to be wrong, the LC will offer the woman options, and a believable pathway. It's amazing how a little success leads to bigger success.

Conclusion

Breastfeeding is a basic human activity that belongs to mothers and their babies. As with pregnancy and birth, breastfeeding is not an illness, and does not require a strict set of rules of management or behaviour.

An effective bond between a mother and her newborn baby is one of the most amazing and satisfying relationships I know of. Witnessing the formation of that bond is immensely satisfying for me, as midwife and LC. Protecting the formation of that bond, and intervening at times to avert trouble, is part of my guardianship role.

I have talked a lot about working with the mother. Let's never forget the baby. A healthy newborn baby has an amazing capacity to communicate his or her needs. A baby's values are clear and basic: safety, warmth, food and love. When a mother gives birth in a supportive environment, she quickly finds out how to give the safety, warmth, food and love all in one amazing package: breastfeeding. That marvellous relationship continues, and provides a foundation for a healthy life. We are privileged to come alongside mothers and their new babies at a most intimate and memorable time of their lives. Our work demands a high level of skill, knowledge, and especially respect for the individual mother and her baby.

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