Mining for liquid gold

An analysis of the language and practices of midwives when interacting with women who are establishing breastfeeding

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACM</td>
<td>Australian College of Midwives</td>
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<tr>
<td>AHS</td>
<td>Area Health Service</td>
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<td>AIFS</td>
<td>Australian Institute of Family Studies</td>
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<td>BFHI</td>
<td>Baby Friendly Health (Hospital) Initiative</td>
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<tr>
<td>CER</td>
<td>Centre for Epidemiology Research</td>
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<tr>
<td>EOI</td>
<td>Expression of Interest</td>
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<td>FG</td>
<td>Focus Group</td>
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<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
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<tr>
<td>IBCLC</td>
<td>International Board Certified Lactation Consultant</td>
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<tr>
<td>Int</td>
<td>Interaction</td>
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<td>IV</td>
<td>Interview with breastfeeding woman</td>
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<td>MAIF</td>
<td>Marketing of Infant Formula</td>
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<td>MUA</td>
<td>Maternity Unit A</td>
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<tr>
<td>MUB</td>
<td>Maternity Unit B</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<td>PEd</td>
<td>Parenting Education Session</td>
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<td>SSIV</td>
<td>Senior Staff Interview</td>
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<td>UNICEF</td>
<td>United Nations Childrens Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

This thesis reports on a qualitative study of midwifery support for women who are breastfeeding during the first week after birth. In Australia, nine out of ten women initiate breastfeeding, yet the average duration of breastfeeding is well below World Health Organization recommendations. Approximately one quarter of women who commence breastfeeding, cease, or introduce supplemental formula, during the first few weeks after birth. This is a time when midwives are available to provide support. However, women report widespread dissatisfaction with midwifery care during the early postnatal period, particularly hospital-based care. The aim of this study was to examine the nature and impact of the language and practices used by midwives when providing breastfeeding support in the early postpartum period. Identification of the facilitative or inhibitive components of support, as well as insight into the impact on women, can lead to improvements in midwifery practice and inform the education and training of midwives.

This study is underpinned by a social constructionist epistemology, situating an understanding of reality within a social and cultural frame. A post structuralist approach informed the methodology and discourse analysis has been used to examine the way in which language and discourse shaped the beliefs and practices of participating midwives, and postpartum women, around breastfeeding. Data were collected from midwives and breastfeeding women at two geographically distant maternity units in New South Wales. This study is based around the observation of midwife-woman interactions during the provision of breastfeeding support in hospital, and, to a lesser extent, in home environments, during the first week after birth. In total, 85 breastfeeding interactions between women and midwives were observed, audio recorded and then transcribed verbatim. Additional perspectives were gathered from participants at 34 individual interviews and four focus group discussions. Nine antenatal breastfeeding education sessions were also observed and audio-recorded, to gain an insight into the language used to describe breastfeeding during pregnancy.

The ‘texts’ generated from this study have been analysed using critical discourse analysis. This approach facilitated the identification of words, actions, social
practices and contextual information related to midwifery support for breastfeeding women.

Analysis revealed three discourses in the language and practices of midwives. In the dominant discourse, evident in 68 / 85 (80%) of the interactions, midwives held great reverence for breastmilk as ‘liquid gold’ and prioritised breastfeeding as the mechanism for transfer of this superior nutrition. This discursive approach to midwifery support has been labelled ‘mining for liquid gold’. In taking this position, midwives focused on the product of breastfeeding and when deemed necessary would draw on their expert knowledge to introduce a range of techniques and technology to ensure the infant received breastmilk. These practices were prioritised over the process of the relationship between mother and infant. In the institutional hospital setting midwives were observed focusing on the physical body, rather than engaging with women on an emotional level. In this context midwifery care became ‘breast centred’ rather than woman-centred.

The second discourse ‘not rocket science’ accounted for 9 / 85 (11%) of the observed interactions. Here breastfeeding was constructed as ‘natural’ or ‘easy’ something that all women could do if they were sufficiently committed. In this approach, midwives tended to leave women to ‘their own devices’ unless they requested help, which was considered a demonstration of commitment to breastfeed. The ‘not rocket science’ discourse enabled the midwife to prioritise other aspects of care such as giving medications and completing observations and documentation. This discourse was aligned with the institutional priorities of managing risk, ensuring ‘patient’ safety and efficiently moving women into and out of the system. This focus rendered breastfeeding unimportant and something women could be left to get on with.

The least well represented discourse constructed breastfeeding as a relationship between mother and infant and was observed in 8/85 (9%) of the interactions. In this minority discourse, women were considered to be knowledgeable about their needs and those of their infant. The language and practices of midwives in this approach facilitated communication and built confidence.

The three discourses reflected in the communication between midwives and women in the first week after birth are themselves embedded within and constructed by powerful institutional, professional and public discourses such as the science of
lactation, breastfeeding medicine, the Baby Friendly Hospital Initiative, technocratic medicine and to a lesser extent, the midwifery discourses of woman-centered care and partnership. Significantly, facilitative communication styles emerged from interactions with midwives who prioritised breastfeeding as a relationship and spent time engaging with women on a personal level.

These powerful institutional discourses inhibited effective support for women who were establishing breastfeeding and at times disrupted the mother-infant relationship. Institutional constraints led to prescriptive and authoritative communication styles, which denied fulfilment of midwife-woman partnerships. These study findings confirm the need for alternative models of midwifery care, which facilitate relationship formation between midwife and woman and enable flexibility in care provision.
CHAPTER ONE

Establishing Breastfeeding

This thesis is an examination of the discourses influencing midwifery practice and breastfeeding women, in the first week after birth. Early establishment of breastfeeding represents a transitional time in a woman’s life, which can be both rewarding and challenging. Sociocultural mores, professional discourses and personal experiences influence women during this time. As mother and infant learn new ways of ‘being’ in the world, support from others can facilitate or inhibit maternal confidence. In Australia, support during the initiation of breastfeeding is the professional domain of midwives. The language and practices adopted by this professional group have the potential to shape how a woman experiences her body, and her infant, during breastfeeding.

Nine out of ten women initiate breastfeeding in Australia (Australian Institute of Family Studies, 2008). The majority give birth in hospital settings and have ongoing contact with midwives throughout the early establishment phase. During this time women experience a range of emotional, hormonal and bodily changes which, combined with sleep disturbances and the learning of new skills, make this a time when additional support is often needed (Dixon, 2006) and expected (Sheehan, Schmied, & Barclay, 2009). Midwives provide care and support in this environment according to professional and institutional parameters.

Midwifery care is underpinned by a ‘partnership’ orientated philosophy which encompasses ‘woman-centred’ care. The partnership model, articulated by Guilland and Pairman (1995), and later Pairman and colleagues (2006), and others (Homer, Brodie, & Leap, 2008; Kirkham, 2000, 2010), forms the philosophical foundation for midwifery care in Australia. This approach acknowledges the international definition of a midwife which states:

A midwife is recognised as a responsible and accountable professional, who works in partnership with women, to give the necessary support, care and advice, during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own
responsibility, and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures (The International Confederation of Midwives, 2005).

Midwives view pregnancy, birth, and the postnatal period, as normal physiological life events. Midwifery practice therefore is about valuing a woman’s own expertise and knowledge and supporting her on her journey into mothering (Leap & Pairman, 2006). Woman-centred midwifery care is individualised and wholistic, encompassing the infant and the woman’s significant others, her right to self-determination is respected, and collaboration and continuity of carer are prioritised (Australian College of Midwives, 2004). The partnership model in midwifery has been described as:

A relationship of ‘sharing’ between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding (Guilliland & Pairman, 1995:7)

One of the fundamental aims of this model includes the provision of ‘continuity of caregiver’, in other words, provision of care from one midwife who establishes a relationship with a woman, and maintains this throughout the period of maternity (Pairman & McAra-Couper, 2006). However, in Australia, the majority of maternity service models aim to ensure continuity of service (referred to as continuity of care) during pregnancy, birth, postnatal and beyond. This refers to the provision of care by multiple service providers who subscribe to a common philosophy (Hodnett, 2000; Waldenström, Brown, McLachlan, Forster, & Brennecke, 2000).

In New South Wales (NSW), where this study is based, midwifery care is predominantly provided according to the continuity of care model. Women potentially meet a multitude of midwives during discreet episodes of maternity, for example during antenatal, birth and postnatal care (NSW Health, 2000, 2003). However, increasingly continuity of caregiver models are becoming available. In fact, the recent NSW Health Department ‘Towards Normal Birth’ policy has set a target for the year 2015, stating that 35% of women should have access to continuity of midwifery caregiver by this time (NSW Health, 2010).

Disappointingly, women in Australia rate postnatal midwifery care lowest, when compared to other episodes of midwifery service provision (Brown, Davey, &
Bruinsma, 2005). In particular, women report dissatisfaction with breastfeeding support provided during the early establishment period (McInnes & Chambers, 2008; Schmied, Beake, Sheehan, McCourt, & Dykes, 2011). This was captured in an ABC radio interview, which I heard at the beginning of this study. The prompt for the radio interview was the release of the Australian Institute of Family Studies (AIFS), longitudinal study data, reflecting the most up-to-date statistics on breastfeeding initiation and duration (Australian Institute of Family Studies, 2008). Several individuals called to speak with the radio guest about their experiences of early infant feeding. One caller criticised health professionals for continually telling women that breastfeeding should not hurt. The caller asked, ‘if other parts of the human body were stretched to twice their normal length, would that not hurt initially?’ She argued women were being ‘sold’ an unrealistic expectation, which did not live up to the reality of the experience and she added that as the mother of eight children she should know. Another caller reported her experiences when things with breastfeeding ‘just weren’t working’. This woman found another mother to be the best source of support and practical instruction on how to overcome the problems she had been having. The caller referred to hospital staff as ‘nipple nazis’ who would continually ‘flick’ the nipple out of the baby’s mouth to reposition the baby. This was in stark contrast to the effective peer support she had received which involved simple relaxation techniques and ‘common sense’ solutions. One lone male caller rang in to speak about his wife’s experience of breastfeeding. He disclosed that his wife had tried ‘everything’ and was eventually ‘pushed’ to ‘breaking point’ before switching to formula feeding. He went on to say that when their next baby was born his wife did not even attempt to breastfeed. He argued for more individualised care and support for breastfeeding women. This interview played on the radio as I was preparing to commence data collection for this study. It reinforced the need for further investigation into midwifery and lactation consultant practices around breastfeeding. The emotion and opinion generated in this short ten-minute radio session was indicative of the level of sentiment and dialogue in the community regarding this issue (Cameron, 2008).

Women have indicated a desire for health professional support during the early establishment of breastfeeding. Yet building confidence and capacity, for ongoing breastfeeding, requires support which truly meets the needs of individuals (McInnes
& Chambers, 2008; Schmied, Beake, Sheehan, McCourt, & Dykes, 2011). The next section of this chapter will include necessary background information for the study, including initiation and duration rates, women’s experiences of breastfeeding and the nature of midwifery support.

1.1. Background to the Study

Whilst more than 90% of mothers in Australia commence breastfeeding, by the end of the first week approximately 12% will have introduced other forms of nutrition, or ceased breastfeeding altogether. The rate of full breastfeeding (providing no other liquid or formula) decreases at one month to approximately 71% and continues to decline each month thereafter until by four months approximately 46% of infants are fully breastfed (Australian Institute of Family Studies, 2008:15). This is despite the World Health Organization (WHO) recommendation for exclusive breastfeeding during the first six months (Kramer & Kakuma, 2002).

The National Health and Medical Research Council of Australia (NHMRC) has endorsed the global strategy to promote breastfeeding as the most nutritionally beneficial form of infant feeding, with proven benefits for both infants and women (NHMRC, 2003:1; WHO & UNICEF, 2003). Recommendations for exclusive breastfeeding, during the first six months of life, and continued breastfeeding following the introduction of solid foods, have been embedded into National and State health policy (Australian Health Ministers' Conference, 2009; New South Wales, 2006). Benefits from breastfeeding extend well beyond the first year and promotion of sustained breastfeeding, for as long as the mother and infant desire, is recommended by both the WHO and NHMRC (NHMRC, 2003). Yet, of the 92% of women in the AIFS longitudinal study who commenced breastfeeding, only 28% continued to breastfeed until at least 12 months of age (Australian Institute of Family Studies, 2008). Known factors mitigating against extended duration of breastfeeding, include socio-demographic, biomedical aspects and health service related variables, such as the method of birth and routine procedures (Forster & McLachlan, 2007; Scott & Binns, 1999). Women who are older and have higher educational attainment, are more likely to breastfeed, and for longer periods, than women aged under 20 with low literacy. Ethnicity, geography and employment status can also, each, adversely influence breastfeeding longevity (Scott & Binns, 1999).
Significantly, health service related variables have been linked to suboptimal initiation and duration of breastfeeding (Hailes & Wellard, 2000; Hauck, Fenwick, Dhaliwal, Butt, & Schmied, 2011; Manhire, Hagan, & Floyd, 2007; Scott & Binns, 1999; WHO, 1989). Detrimental factors include, in-hospital formula supplementation and the use of pacifiers, whereas mother-infant rooming-in together and demand feeding have been shown to have a beneficial effect on breastfeeding (Forster & McLachlan, 2007).

A causal relationship between hospital practices, such as those described above, and breastfeeding initiation and duration rates, was identified by nutritionists and public health advocates in the 1980s (Palmer, 1993). The WHO and the United Nations Children’s Fund (UNICEF) acknowledged the instrumental role of maternity services in the early establishment of breastfeeding. They devised the ‘Ten Steps to Successful Breastfeeding’ which became an endorsed strategy, and later a template, for hospital improvements. The resulting global policy entitled the ‘Baby Friendly Hospital Initiative’ (BFHI) began, in 1991, to transform hospital environments into breastfeeding friendly cultures. Broadly, the initiative resulted in improvements in breastfeeding initiation rates however, duration rates continue to fall below recommendations from the WHO (Bartington, Griffiths, Tate, Dezateux, & the Millennium Cohort Study Child Health, 2006; Broadfoot, Britten, Tappin, & MacKenzie, 2005). To date in Australia, 77 hospitals have achieved BFHI accreditation (BFHI Australia, 2011). In Chapter Two I provide a more detailed review of this policy initiative.

Effective promotion of breastfeeding by midwives, as well as supportive practices in the initiation phase (such as those advocated by BFHI), can impact upon how a woman interprets her body and her infant in the early days and weeks after birth. This study is an examination of this early formative phase of breastfeeding, when prior expectations of breastfeeding are merged with the embodied reality.

1.2. The Experience of Breastfeeding

An examination of the literature on women’s experience of breastfeeding indicates a diversity of views and attitudes. Some women have described breastfeeding as a deeply personal and enjoyable experience, which enhanced their relationship with their infant, while others have described it as a demanding activity which resulted in
disconnected feelings towards their body and their infant (Schmied & Barclay, 1999). Hence, breastfeeding experiences can be complex and variable, influenced by a woman’s confidence, self-concept, physical health, the health of her baby, the family’s living conditions, her access to support and other demands on her time and energy (Forster & McLachlan, 2010; Larsen, Hall, & Aagaard, 2008; Nelson, 2006). Research suggests that women find the first six weeks to be the most difficult time for breastfeeding (Cooke, Sheehan, & Schmied, 2003; Hailes & Wellard, 2000; Scott, Landers, Hughes, & Binns, 2001a; Semenic, Loiselle, & Gottlieb, 2008; Sheehan, Schmied, & Barclay, 2010). Anxiety about breast milk supply, infant positioning, nipple trauma, pain, mastitis and infant distress are common problems experienced by women during this period (Cooke, et al., 2003; Dykes, 2002; Hailes & Wellard, 2000). These experiences can lead some women to abandon breastfeeding or to introduce formula supplementation.

A number of recent meta-syntheses, investigating the experience of breastfeeding, have highlighted both commonality and variability in women’s experiences. For example, Nelson (2006) conducted a meta-synthesis of 15 qualitative research papers on maternal breastfeeding experience. The findings encompassed one universal theme: breastfeeding as an ‘engrossing personal journey’ and four underlying themes which outlined the various phases of the breastfeeding journey: ‘the embodied reality’, ‘becoming a breastfeeding mother’, ‘a need for support’ and ‘the journey must end’ (p.15). Nelson concluded that improvements in clinician sensitivity, during breastfeeding support, might lead to enhanced maternal confidence with this aspect of early mothering (Nelson, 2006).

In addition, a recent Scandinavian meta-synthesis of seven qualitative studies on breastfeeding articulated the influence of expectations, professional support and the discourses of ‘nature’ and ‘body as machine’ on a woman’s confidence with breastfeeding (Larsen, et al., 2008:657). Discursive influences such as these will be a particular focus of this thesis.

Early in my candidature I also conducted a meta-synthesis of qualitative papers exploring women’s experience of breastfeeding (see Appendix 1). I adopted a meta-ethnographic approach to synthesising qualitative research, as advocated by Noblit and Hare (1988). This synthesis included analysis of the original researcher
interpretations of narratives, evident in the themes and sub-themes presented, as well as analysis of recurring words and metaphors in the included participant quotes (used by researchers to exemplify themes). This aggregation of first and second order interpretations (Schutz & Natanson, 1990) facilitated third order elucidation of the similarities and differences across the included studies (Burns, Schmied, Sheehan, & Fenwick, 2010). The analysis of seventeen qualitative studies revealed two overarching themes. The first, labelled ‘expectations and reality’ and the second labelled ‘discourses of connection and disconnected activity’. The first theme represented the phrases and metaphors women used when describing their expectations of breastfeeding as a ‘natural’ process, ‘best’ for the baby and aligned with ‘good’ mothering. Women’s narratives, in the included studies, indicated a perception that it was important to get breastfeeding ‘right’. Descriptions of the reality of breastfeeding however, reflected a sense that it was not necessarily natural or easy, but rather ‘demanding’ and required ‘perseverance’. Ceasing breastfeeding was often associated with ‘guilt’ and ‘failure’, and women described feelings of disillusionment about breastfeeding. The second theme reflected descriptions of the experience of relationship and support during breastfeeding. Women who articulated their enjoyment of breastfeeding, referred to the special relationship it afforded them with their infant. Maternal confidence, combined with appropriate support, were key factors for those women who positively articulated the pleasures of breastfeeding.

In contrast, women who experienced difficulties, and described negative experiences, expressed a lack of confidence in their body and their baby. An inadequate level of support from both family, and professionals, was also an area of critical reflection by women (Burns, et al., 2010). Biomedical and scientific discourses were reflected in the language women used to describe their body, and their baby. In addition, the availability of options for support appeared to be fundamental to the early establishment of breastfeeding.

One of the key concepts in women’s narratives of early breastfeeding experience is the importance of building confidence (Blyth et al., 2002; Ertem, Votto, & Leventhal, 2001; Grassley & Nelms, 2008). Women with high levels of breastfeeding confidence have been known to breastfeed for longer durations than women without (Papinczak & Turner, 2000; Semenic, et al., 2008). Time spent
building confidence, with support and assistance, can be reimbursed in the form of improvements in breastfeeding duration.

Grassley and Nelms (2008:846) utilised women’s own descriptions of their breastfeeding experiences to reveal the impact of ‘expectations’, ‘infant behaviour’ and ‘support’ on maternal confidence. Women in their study articulated the need for support, which they described as someone to ‘mentor’ them, who could encourage them and maybe offer ‘physical help’ (Grassley & Nelms, 2008). Women reported that emotional support was crucial to breastfeeding confidence, including a sense of feeling cared for by support people and interactions with professionals who demonstrated concern and empathy (Dykes, 2006a; Hauck, Langton, & Coyle, 2002b; Sheehan, et al., 2009). Women have also described a sense of moral obligation to breastfeed which has added an additional level of intensity to the early establishment of breastfeeding (Crossley, 2009).

1.3. The Moral Imperative to Breastfeed

Descriptions of the experience of breastfeeding, or infant feeding decision making more generally, indicate this sense of a moral obligation to breastfeed (Maushart, 1997; Murphy, 1999; Sheehan, Schmied, & Cooke, 2003). Schmied and Lupton (2001) identified in the late 1990s that breastfeeding was inextricably linked to a woman’s sense of herself as a mother and represented ‘good mothering’. Later research, by the same authors, confirmed the alignment of breastfeeding with ‘good mothering’. In this context, a decision to prematurely cease breastfeeding can lead to feelings of being judged a ‘bad mother’ (Sheehan, et al., 2010). This link, between breastfeeding and ‘good mothering’, has been well established elsewhere also (Crossley, 2009; Payne & Nicholls, 2010).

Public health campaigns have drawn on the ‘good’ mother discourse to reinforce the moral imperative to breastfeed. For example, Glenda Wall’s discourse analysis of Canadian breastfeeding educational material, from the 1990s, highlights the sense of ‘moral authority’ embedded into health promotional literature (Wall, 2001). In this work, Wall argued that women were encouraged to ‘give’ of their most ‘precious gift’ for the benefit of their baby. Wall contends that women who chose not to breastfeed were depicted as ‘irrational’ or ‘selfish’ (Wall, 2001:599). Interestingly the incentives used to convince women that breastfeeding was ‘the’ best option
included references to the ‘convenience’ of breastfeeding and of its body ‘reshaping’ potential, reflecting a stereotyped image of women (Wall, 2001). Breast milk was also constructed as ‘pure’ but with the caveat that this milk was only as healthy as the woman who generated it (Wall, 2001). Hence, the moral obligation to provide breast milk included conformity to additional ‘good’ mother parameters to ensure the provision of wholesome milk.

Discussion around breastfeeding as ‘good’, or ‘morally right’ has also recently been infused with ‘risk’ avoidance imperatives (Knaak, 2010; Lee, 2008). Here the moral obligation to provide the best has been elevated to new heights of individual and ‘self-monitored’ risk aversion, in keeping with public health discourse more generally (Petersen, 1996; Wolf, 2001). Women have become the ‘risk managers’ of parenting, where breastfeeding is no longer a personal choice but rather the fulfilment of a moral obligation (Lee, 2008).

Yet breastfeeding represents a dilemma for ‘good’ mothers. While culturally the ‘good mother’ breastfeeds, this is contrasted against social norms demanding that ‘good’ women refrain from exposing their breasts in public (Henderson, Kitzinger, & Green, 2000; Mahon-Daly & Andrews, 2002). The confusion that these sociocultural mixed messages cause not only restricts the performance of breastfeeding (Hoddinott & Pill, 1999; Shaw, 2004), but can be sufficient deterrent for women to avoid, or cease, breastfeeding altogether (Earle, 2000; Raisler, 2000; Sheehan, et al., 2003).

The meta-synthesis findings discussed suggest women feel guilty, or feel a failure, when breastfeeding has not progressed as planned, and regularly report that their expectations of breastfeeding and the subsequent reality of the experience are often at odds (Burns, et al., 2010 see Appendix). In addition, the ‘moral’ overtones associated with breastfeeding, and good mothering, highlight the importance of this transitional phase in a woman’s life. Moral ‘baggage’ (Murphy, 1999; Shaw, 2004) associated with breastfeeding has the potential to result in the feelings of guilt and low self-esteem, and potentially depression, described by women whose breastfeeding experiences have not progressed as anticipated (Cooke, Schmied, & Sheehan, 2007).

Sheehan and colleagues (2010), conducted a grounded theory analysis of interviews with 37 women in NSW, regarding their early breastfeeding decision making. This
work highlighted that the embodied reality of breastfeeding can sometimes alter a woman’s conceptualisation of what is ‘best’ for her infant. Women in this study reassessed their commitment to the ‘breast is best’ message when breastfeeding did not proceed as planned. Instead they asserted that ‘everybody’s best is different’ with regard to infant feeding. Women identified the need for support which was both confidence building and empathic, during this early establishment phase of breastfeeding (Sheehan, et al., 2010:376). Support from professional and peer sources is clearly important to women during this transitional life stage.

1.4. Midwifery Support

Women have described both positive and negative aspects of professional and peer support for breastfeeding in recent years. Schmied and colleagues (Schmied, et al., 2011) conducted a meta-synthesis of qualitative research papers exploring women’s experience of support for breastfeeding. The findings have demonstrated that support occurs along a continuum. Women have described positive professional and peer support, from individuals who have engaged with them in an ‘authentic’ way, as well as negative interactions which represented ‘disconnected encounters’ (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011:51). Positive support styles included displays of empathy, listening, taking time, and sharing the experience with the woman. In contrast, a lack of time, pressure to breastfeed, demoralising comments and unwanted touch, reflected the style of support women found least helpful. This latter approach, termed ‘reductionist’ by the authors, failed to meet individual needs for support (Schmied, et al., 2011). Components of this inhibitive style of breastfeeding support are abundant in the literature, especially pertaining to the hospital environment (Baker, Choi, Henshaw, & Tree, 2005; Dykes, 2006a; Hailes & Wellard, 2000; Hall & Hauck, 2007; Hauck, et al., 2011; Hauck & Irurita, 2002a; Hoddinott & Pill, 2000; Shakespeare, Blake, & Garcia, 2004). In addition, research by Sheehan et al., (2009), regarding the experience of support in the second to sixth week post birth, has highlighted the impact of directive, dismissive, and conflicting health professional interactions on diminishing confidence with breastfeeding (Sheehan, et al., 2009).

A dissonance between the health professional language of ‘support’ and ‘advice’ regarding breastfeeding, and women’s own descriptions of needing ‘help’ and ‘reassurance’ with this, has been illuminated by Hoddinott and Pill (2000:230-232).
In this research women and health professionals were identified as having different infant feeding ‘goals’, which contributed to dissatisfaction and the sense of isolation experienced by some women. In contrast, breastfeeding peer role models were identified as more helpful than formal professional support measures (Hoddinott & Pill, 2000).

This resonates with another meta-synthesis, conducted by McInnes and Chambers (2008), which analysed maternal and health professional perceptions of breastfeeding support. The findings indicated a maternal preference for social or volunteer support networks and the need for ‘emotional’ support alongside ‘practical’ and ‘informational’ (McInnes & Chambers, 2008:422). The most helpful supportive styles adopted by health professionals included, observing a complete feed, as well as confidence building. By contrast, health professionals who were ‘bossy, judgemental, inaccessible and uncaring’ and who undermined confidence were decidedly unhelpful (McInnes & Chambers, 2008:418). Conflicting information about breastfeeding and the tendency to ‘manage’ the woman, rather than develop dialogue, was the most common complaint. In addition, due to perceived time constraints, health professionals often resorted to ‘doing for’ rather than ‘teaching’ women how to initiate breastfeeding, which further undermined confidence (McInnes & Chambers, 2008).

Retrospective recall of early breastfeeding support experiences is an important strategy for the identification of components of support which enhance, and those which inhibit, breastfeeding. This is especially so in the context of the latest Cochrane systematic review of interventions to support breastfeeding women. This review has demonstrated improvements in breastfeeding exclusivity and duration from both lay support, and a combination of professional and lay support (Britton, McCormick, Renfrew, Wade, & King, 2007). The components of health professional support which facilitate or extend breastfeeding require further, and ongoing, examination.

The majority of women initiate breastfeeding in hospital settings and have ongoing contact with midwives during the first week. Whilst we know that women are often dissatisfied with the support provided by midwives, at this stage we can only speculate as to the components of support which might be helpful for ongoing breastfeeding and those which might be detrimental. Thus far, midwives have relied
upon retrospective recall from women regarding their experiences of midwifery support, in order to gain insight into midwifery practice in this area. The study described in this thesis will include observation and analysis of the actual language and practices used by midwives when supporting women.

It is anticipated that examination of the discourses and professional practices surrounding infant feeding might reveal where and how improvements can be made particularly in the interactions between midwives and women. Women report midwives are ‘pushing breastfeeding’ with little consideration of the practical, emotional and relational support necessary to achieve the goal of sustained breastfeeding (Hauck, Langton, & Coyle, 2002; Manhire, et al., 2007; Mozingo, Davis, Droppleman, & Merideth, 2000). Given that negative hospital experiences have been seen as an impediment to optimal breastfeeding (Coreil, Bryant, Westover, & Bailey, 1995; Dykes, 2006a; Sheehan, et al., 2009), it is timely that midwifery language and practices be explored in this milieu.

The partnership orientated philosophical underpinnings of midwifery, described at the beginning of this chapter, clearly do not align with these negative descriptions of breastfeeding support. It is important to explore and explain the origins of unhelpful or disruptive midwifery practices. An analysis of the broader sociocultural and professional discourses shaping the language and practice of midwives offers the potential to do this. Ultimately, this research will contribute to a greater sociological understanding of breastfeeding which has, until recently, been largely ignored by midwives and rarely made part of midwifery education.

1.5. Aim

The aim of this research is to use discourse analysis to study the nature, and impact, of midwifery language and practices during early breastfeeding support.
Objectives

The objectives of the study are to:

- Describe and analyse the language and practices employed by midwives when supporting breastfeeding women during the first week after birth.
- Identify the patterns and components of verbal and non-verbal interactions which facilitate or inhibit support for breastfeeding women.
- Analyse the impact of these interactions on women in the post-birth period.

In order to meet these aims I have collected data utilising participant observation, individual interviews, and focus groups at two geographically distant hospitals. The data collected comprised 85 audio-recorded interactions between midwives and women, 23 focused interviews with women approximately 4-6 weeks following discharge, 11 focused interviews with senior staff, four focus groups with staff and nine parenting education sessions on breastfeeding. Intentional use of a variety of data collection methods has strengthened the interpretive conclusions drawn from this study. This research represents more than an examination of language and semantics, but rather reveals the underlying discourses influencing midwifery practice.

1.6. Discourse and Practice

The epistemological foundation for this study is social constructionism. Cultural and social processes, in combination with language and power, construct social reality. Beyond this, the post-structuralist turn towards an analysis of power and knowledge in the creation of discourse, has informed this study. I have adapted an understanding of discourses as ever present sets of ideas, beliefs, metaphors, and utterances which take on legitimacy in a variety of social contexts and which have powerful constitutive effects over the behaviour of individuals (Freundlieb, 1994; Lupton, 1992; Rabinow, 1984). In this study the formative power of discourse was examined in the context of the language and practices adopted by midwives. The range of data collected was subsequently exposed to an analysis of discourse.

The method of discourse analysis adopted has been informed predominantly by the work of Norman Fairclough, and to a lesser extent Teun van Dijk, Ruth Wodak and Michael Meyer (Fairclough, 1992; van Dijk, 2009; Wodak & Meyer, 2009).
Examination of the textual data collected from interactions between women and midwives involved a period of immersion ‘in’ the text of each interaction, followed by identification of recurring themes, metaphors, language and discursive practices. The context of each individual interaction was then assessed using an observational guide and field notations. Data have been analysed at the level of observation, text, and context. Interview and focus group data served to confirm the language and non-discursive practices observed at each site. The trials and tribulations traversed during this research journey have been detailed in a reflexive recount in Chapter Three.

1.7. Researcher Reflexivity

In the interests of reflexivity, it is important to situate myself within this project. My professional background as a midwife and my experiences as a breastfeeding woman, have each contributed to my desire to further explore the discourses effecting breastfeeding activity and midwifery practice. Dominant contemporary discourses depicting breastfeeding as the ‘best’ and ‘natural’ way for a woman to feed her infant, influenced my own infant feeding choices, despite growing up in a bottle-feeding culture in Northern Ireland.

As the oldest of five children, one of my earliest childhood memories is of visiting the local community health centre for the immunisation of one of my siblings. Greeting us at the entrance to the community health centre was a neatly stacked pyramid of SMA infant formula tins, almost floor to ceiling in height. The tins of formula were available for free, or at a reduced cost, to families who met a particular socioeconomic criteria. As a child, I recall being in awe of the generosity of the community health centre.

Despite living in close proximity to five of my mother’s sisters, and socialising regularly with these large families of 4-6 children of similar ages to my own siblings, breastfeeding was not a practice I ever observed. I have vague recollections of my mother breastfeeding my siblings when they were newborns. However, beyond the first couple of weeks, bottles warming in pots were the more familiar scene. Clarification of this memory has revealed that my mother, and her siblings, often had continued to breastfeed (in combination with bottle-feeding) however not in front of others, even children.
As a teenager I later emigrated to Australia with my immediate family and became socialised within a different cultural context. Despite my exposure to such a strong bottle-feeding culture as a child, my background as a midwife, combined with contemporary public health discourse, influenced my decision to breastfeed my own three children. I recall early pain and discomfort with breastfeeding, requiring support and guidance from others. However, following these early difficulties, breastfeeding became integral to my relationship with my infant and was an experience that I cherished. For me, the need for health professional support rapidly diminished after the first few weeks as my confidence grew and my infant and I became attuned to each other. Yet, despite having breastfed my first child, I found the first few weeks of breastfeeding my subsequent two children again represented a period of pain, and adjustment, requiring midwifery support and guidance.

The midwifery and peer support I accessed during the early establishment phase of breastfeeding was invaluable and confidence enhancing. However, as a midwife I find it concerning that so many women experience early breastfeeding as an anxiety-provoking and disconnected time, where access to effective support is suboptimal. Descriptions of midwives as the ‘breast police’ or ‘nipple nazis’ are completely at odds with the partnership-orientated and woman-centred model upon which midwifery care is based. This study represents a desire to gain insight into midwifery practice to improve the experience of this transitional phase of mothering.

1.8. Summary of Chapters

This first chapter has introduced the issues around the experience of breastfeeding. The need for an investigation into the supportive practices engaged by midwives during the first week after birth is clear. A critical discourse analysis of the language and practices adopted by midwives can provide a new and innovative way of examining this issue. The remaining chapters of this thesis will provide the relevant historical background including an analysis of the contemporary global initiatives shaping midwifery practice, the methods of data collection and the significant findings from this analysis. The following is a brief synopsis of each chapter.

In Chapter Two, I examine some of the important historical background shaping breastfeeding performance in contemporary society. Infant feeding discourses, during most of the 20th century, privileged scientific formula over ‘simplistic’
breastfeeding. However, breastfeeding was reinstated as the ‘gold’ standard in infant nutrition following scientific interest in breast anatomy and milk analysis. At the same time, the feminist movement and the natural childbirth movement each impacted positively upon breastfeeding practice. The devastating effect of infant formula supply in the developing world led to international collaboration for the promotion of breastfeeding. A WHO and UNICEF partnership has successfully facilitated changes in national and international policy on infant formula. Mounting scientific and research evidence has reinforced the superiority of breastfeeding for infant and young child health.

An ‘imperative to breastfeed’ (Sheehan & Schmied, 2011) has emerged from this historical backdrop as Australian women enact the ‘breast is best’ message. The BFHI has become the most significant initiative to influence health professional practices over the past 30 years. This initiative seeks to encourage health care services to ‘promote, protect and support’ breastfeeding. Discourses emerging from the BFHI have influenced health professional practices at both BFHI accredited, and non-BFHI accredited hospitals, making this a significant discursive influence on midwifery practice. However, as highlighted earlier, the duration of breastfeeding is still well below WHO recommendations in Australia. Maternal dissatisfaction with health professional communication and support, in the first few weeks after birth, has been the impetus for this study.

Chapter Three includes a discussion of the theoretical underpinnings for the research. Foucauldian concepts such as discourse and power, and their influence on the objective and subjective manifestation of professional practices, have informed this study. This chapter also provides details of the approach to discourse analysis, including the three moves of the discourse analyst (Fairclough, 1992). Data have been analysed at the level of text, context and social practices. An integral component of this chapter is the detailed account of my experiences as an organisational outsider but professional insider, engaged in participant observation for the collection of textual and contextual data. Study setting and participant statistics are also included here, as well as the detailing of the method of data collection.

Critical discourse analysis has revealed three distinct influences on the language and practices of midwives. In Chapter Four, I present the first and most prominent
discourse within which breastmilk is prioritised as ‘liquid gold’ and breastfeeding conceptualised as the transfer of nutrition. The practices associated with this discourse positioned midwives as ‘expert clinician’ available to support women in the operation of their breastfeeding ‘equipment’. The construction of the infant as an inefficient extractor and the woman as inefficient operator, led to midwives assisting with attachment and generally managing breastfeeding ‘for’ the woman, and the infant. In addition, concerns about infant intake and breast performance led to referral to a specialist level of midwife: the lactation consultant. This specialist approached the woman in a ‘medicalised’ way as a consultant who aimed to assess, and palpate the breast, then diagnose and prescribe a plan, to maintain functioning of the lactating breast. Within this approach breast milk was revered as a nutritional, sometimes medicinal, product which midwives had right of access to for the benefit of the infant. The enactment of this ‘liquid gold’ discourse led to practices which were analogous to midwives ‘mining for liquid gold’. Labelling the discourse in this way captures both the language and practices of the majority of midwifery participants.

The alternative two discursive influences on breastfeeding support are presented in Chapter Five. The first discourse, apparent in 11% of interactions has been termed ‘not rocket science’. Midwives, who practised within this discursive frame, tended to leave women to their ‘own devices’ as far as breastfeeding was concerned and instead focused their energy on other more clinical aspects of care. Here midwives demonstrated their expert clinical skills and were focused on managing risk in the postnatal period.

In direct contrast to this was the third and least well represented enactment of a ‘breastfeeding as relationship’ discourse. A belief in the importance of ‘relationship’ formation for breastfeeding was apparent in only 9% of interactions. Of note, within this exceptional approach to midwifery care, the discourses of ‘partnership’ and ‘woman-centred’ care were prioritised.

In Chapters Six and Seven I discuss the study findings in the context of the relevant literature. The dominant ‘mining for liquid gold’ approach revealed a prioritising of breastmilk ‘the product’ and a focus by midwives on protection of ‘production and supply’. Here I apply Foucauldian concepts to articulate the objectification of midwives, women, breasts and breastfeeding, during the first week after birth. In
Chapter Six, I discuss the scientific discourses and institutional practices contributing to this objectification. Advances in science and technology, combined with global initiatives, have fuelled the ‘mining for liquid gold’ approach. This was especially noticeable at the BFHI accredited hospital site. Scientific scrutiny of the breasts and the emergence of breastfeeding medicine, were implicated in the disembodied positioning of the breasts noted in the language and behaviour of participants. Data analysis revealed a privileging of the hospital environment and a prioritising of BFHI discourses, which had ramifications for the practices adopted by midwives. In fact, overall, midwifery discourses of ‘partnership’ and ‘woman-centred’ care were subsumed under the weight of more powerful, national and international discourses. In general, midwives were denied discursive freedom to engage with women as partners and instead satisfied the objective ‘expert clinician’ stance.

In Chapter Seven, I explore the subjective position taken up by women and midwives during the first week after birth. The powerful constitutive effect of institution-specific discourses influenced the uptake of characteristic subject positions. In the busy postnatal environment, midwives were denied time for relationship building and instead adopted a position as expert clinician within both the ‘mining for liquid gold’ and the ‘not rocket science’ discourses. However, the detectable difference between the language and practices of midwives within these two discourses was the prioritising, or not, of breastfeeding and breast milk. Breastfeeding was overtly prioritised at the BFHI hospital, where specialised lactation consultant midwives were given a key role in ‘managing’ breastfeeding problems. The subject position taken up by women entering this hospital environment reflected that of ‘passive novice’. Yet midwives working in alternative models of care, where time and autonomy were prioritised, approached breastfeeding as a relationship between the woman and her infant. These midwives practised in a different way, where the integration of midwifery discourses of partnership and women-centred care manifest in individualised relational communication. This finding has significant implications for the future of postnatal midwifery care. The midwives who prioritised breastfeeding as a ‘relationship’ also sought to ‘keep breastfeeding normal’, a goal which exemplifies midwifery practice.

Adopting a social constructionist view of reality, I set out to uncover the discursive determinants of midwifery practice. Breast milk, the ‘product’, was prioritised over
breastfeeding, the ‘process’, in the majority of interactions observed. In Chapter Eight, I conclude with a summary of the four main discourses currently influencing midwifery styles of communication and practice during the first week after birth. The discourses of breast milk as ‘liquid gold’, the ‘body as machine’, technomedicine and to a lesser extent woman-centred care, each influenced midwifery communication and language in various and disparate ways. The implications for midwifery practice, arising from these significant study findings, are detailed in this last chapter.

1.9. Conclusion

In this chapter, I have introduced the thesis and outlined the aim and objectives of the study. Consideration of women’s experience of breastfeeding has set the scene for an exploration of the determinants of breastfeeding practices and professional support. Midwives are the key professional group providing support to women during the early establishment of breastfeeding. An examination of the language and practices used by midwives might unlock opportunities for improvements. Knowledge gained from this endeavour will add to an existing body of work on professional breastfeeding support and extend current theoretical conceptualisation of the discursive influences on practice and support. The findings from this study can subsequently inform breastfeeding policy, practice and the education of midwives and ultimately begin to improve women’s experience of breastfeeding and the achievement of desired breastfeeding goals.
CHAPTER TWO

Promotion, Protection and Support for Breastfeeding

2.1. Introduction

In this chapter, I examine the relevant historical and contemporary breastfeeding customs and practices, in order to situate current midwifery support for breastfeeding. There have been numerous sociocultural messages and practices associated with breasts, breastmilk, and breastfeeding. Mythology and religion, trends in fashion, iconography, elitism, feminism and medicine have all influenced breastfeeding behaviour. Scientific and technological advances have led to the creation of an artificial substitute for breastmilk. Effective marketing, and aggressive promotion of infant formula, contributed to a decline in breastfeeding last century. More recently, scientific and technological advances have revealed the benefits of breastmilk and breastfeeding for both women and infants. Yet discourses originating from the early advent of artificial formula and scheduled breastfeeding persist.

Today, global public health strategists seek to ‘promote, protect and support’ breastfeeding as the ‘gold’ standard in infant feeding. Global initiatives such as the Baby Friendly Hospital Initiative (BFHI) have highlighted areas for improvement in maternity services and have subsequently influenced midwifery practice. It has been argued that supportive midwifery practices can be instrumental in developing the confidence to achieve breastfeeding goals. However, little is currently known about the components of midwifery support which are facilitative, or inhibitive, for ongoing breastfeeding.

In this chapter, I will explore the role of midwives in supporting breastfeeding women during the antenatal and postnatal period. I will examine existing knowledge about how midwives communicate with breastfeeding women and will highlight the type of support provided. I will also emphasise the limitations in current research.
2.2. Infant feeding: Historical Context

2.2.1. Breasts and breastfeeding

Depictions of breastfeeding are found in ancient texts and mythology and date back to biblical times and beyond. In ancient civilisations, breastmilk was considered a ‘miraculous’ substance with ‘mystical connotations’ and even ‘healing powers’. The ancient Egyptians even believed it offered the promise of eternal life (Yalom, 1997:9-12). Revered images of Mary, breastfeeding an infant Jesus (the nursing Madonna and child), highlight the sacred significance of breastfeeding in early Christian societies (Baumslag & Michels, 1995; Yalom, 1997). Supplying breastmilk to an infant was seen as part of a ‘blessed’ duty bestowed upon women, which could be taken away, by an angry God, with the affliction of ‘dry’ breast (Baumslag & Michels, 1995:5). Biblical references indicate that breastfeeding reflected ‘true’ maternal and spiritual love (Fildes, 1988:87).

Traditionally, breastfeeding was an essential component of maternity. Women acquired familiarity with breastfeeding through observation of their mothers, sisters and extended family. Support for new mothers, during the early establishment of breastfeeding, came from this experienced family and peer group (Bartlett, 2005; Hausman, 2003; Palmer & Kemp, 1996; WHO, 1989). Breastfeeding one’s own infant remained a social norm until around the 16th century, the period of Enlightenment, when social changes began to influence infant-feeding practices (Fildes, 1986).

Perhaps one of the most significant changes at this time was the growth in popularity of ‘wet nursing’. Whilst breastfeeding another woman’s baby was initially reserved for situations where the infant was orphaned, or the mother was ill, during the 17th and 18th centuries, in England and Europe, affluent women increasingly abandoned the notion of breastfeeding in favour of employing lactating women (Fildes, 1988; Palmer, 2009). In effect, this created a viable industry for poor women. In many instances infants were sent to live with the wet nurse for the first two years of their life, to be fed and cared for by this surrogate mother (Yalom, 1997). This practice quickly became a status symbol for wealthy families as women could attend to other duties and return to social engagements. Commentators argue that ‘wet nursing’ simultaneously enhanced opportunities for the ongoing production of aristocratic
heirs, due to the rapid return of fertility for non-breastfeeding mothers (Fildes, 1988; Palmer, 2009; Yalom, 1997).

The desire to engage a ‘wet nurse’ was also augmented by both the fashion of the time and the growing trend towards sexualising the breasts. Wearing tightly fitted clothing which featured ‘corsets of leather and bone’ and exposed the breasts in a ‘titillating’ way, meant that breastfeeding became uncomfortable, unfashionable and restrictive. All three social phenomena played a part in the gradual decline of breastfeeding amongst the elite (Baumslag & Michels, 1995:6; Yalom, 1997:90). Wet nursing increased in popularity, and breastfeeding became a practice that predominantly poorer women engaged in.

Rising infant mortality rates, during the 18th century, began to raise concern about the quality of the wet nursing environment into which upper class infants were entrusted. Fildes (1988), notes that fear of an infant ingesting some undesirable characteristics from their wet nurse, via the breastmilk, led to a growing preference for wet nurses to co-locate with their employers for scrutiny and surveillance. This afforded ample opportunities to assess the wet nurse diet, general health, sexual activities and behaviour (Fildes, 1986, 1988; Palmer, 2009; Yalom, 1997). Medical texts from this era detail characteristics of the suitable wet nurse, which even maintained currency into the 20th century (Baumslag & Michels, 1995; Fildes, 1986, 1988; Yalom, 1997). For example, at the turn of the 20th century, medical texts continued to provide recommendations for the selection of a suitable wet nurse which included assessment of infant wellbeing, as a mark of the breastfeeding woman’s suitability (see Thompson, 1905).

These medical discourses gained prominence during the 18th century. Recommendations from William Cadogan, the so-called ‘father of paediatrics’, became increasingly influential during this time. Cadogan challenged the practice of wet nursing, and instead advocated that infants were healthier when fed by their own mothers. His ideas were captured in an essay ‘Notes on Nursing’ written in 1748. The subsequent growth of ‘paediatrics’, as a specialty area of medicine, saw Cadogan’s recommendations gain increasing leverage. However, whilst Cadogan supported breastfeeding, he used his position as a ‘learned’ man to dismiss women’s own knowledge about the daily cycle of breastfeeding. Instead he promoted a regimented approach which included timed feeds on a routine schedule (Palmer &
Kemp, 1996:23-4). Women began to accept his advice to restrict breastfeeding, and eliminate night feeds, believing this was best for infant wellbeing and made breastfeeding more manageable and predictable. Palmer and Kemp (1996) have argued that the unconditional acceptance of Cadogan’s ideas, about restricted and scheduled feeding, continue to persist in some communities even 200 years after they were first espoused.

The 19th century heralded growing scientific interest in the functional anatomy of the breast. It has been speculated that this interest may have been sparked by the taxonomic classification ‘mammalia’ by Linnaeus, during the 18th century, which highlighted the importance of mammary glands for human development (Bartlett, 2005). Interest in breastfeeding by scientists, physicians and other professionals (such as chemists), began a period of increasing study, by men, of the anatomy and function of the female breast. Again it has been argued that this scientific interest in breasts has led to the dissemination of incorrect and damaging information about breastmilk, colostrum and the natural rhythm of breastfeeding ever since (Palmer & Kemp, 1996).

During the 18-19th centuries, medical men interested in paediatric medicine became derided as ‘inconsequential baby doctors’, due to their interest in infants and young children (Wolf, 2001:5). In their efforts to prove their worth they increasingly adopted the role of medical ‘managers’ of mothers (Wolf, 2001:86). Recommendations made by paediatricians from an earlier era, such as Cadogan’s restricted feeding regime, persisted and interfered with the supply and demand nature of breastfeeding, creating breastmilk ‘supply’ problems (Palmer, 2009). Consequently, Wolf (2001) argues it was around this time that women began doubting their ability to provide sufficient milk for their infants and interest in supplemental feeding options emerged.

The Industrial Revolution also brought significant changes to women’s lives, such as the need to feed infants whilst their mothers worked. A market for breastmilk substitutes grew from the demand created by the Industrial Revolution, as well as the need for alternative nutrition sources for orphaned or sick infants. Unaltered cow’s milk was used initially, but was linked to infant mortality and dehydration in infants (Weaver, 2006). For example, an orphanage in Dublin, Ireland, reported untreated
cow’s milk feeding resulted in 99.6% of infant deaths in 1829 (Baumslag & Michels, 1995:50).

Scientific scrutiny, of breast milk, led to the emergence of a ‘scientific’ formula, believed to maintain good health in infants. Wet nursing began to wane in popularity around this time, as artificial substitutes for breastmilk became increasingly available (Weaver, 2006; Wolf, 2001). The development of a commercial substitute for breastmilk, at the turn of the 20th century, marked the beginning of new science-based infant feeding discourses.

2.2.2. The rise of a scientific product

Scientific discoveries during the 18th century led to the emergence of chemical experimentation and analysis of the properties of food (Weaver, 2006). As a result, a scientific alternative to breastmilk became a reality. The first commercial breastmilk substitute was developed by a German chemist named Justus von Leibig in 1860. Leibig became interested in developing a breastmilk substitute when his own two grandchildren were deprived of breastmilk, after their mother could no longer feed them. His powdered formula combined wheat flour, malt flour and potassium bicarbonate, which was subsequently added to heated cow’s milk and fed using a teat and bottle (Apple, 1986; Palmer, 2009; Weaver, 2003). Ten years later, Henri Nestlé and Gustav Mellin each developed alternative powdered artificial formula. These new products were however, somewhat cheaper than the Leibig variety and so began the competitive market and manufacture of powdered infant formula (Apple, 1986).

Modern manufacturing methods meant that the dried milk powder was able to be produced in abundance and was promoted to be as close in composition to human breast milk as possible. This ‘nutritionally’ sound creation provided modern manufacturers with a marketable substance, which they could subsequently promote and inevitably derive a profit from. The advent of sterilisation, and the availability of glass bottles and rubber teats, accelerated the uptake of this artificial substitute for breastmilk (Apple, 1986; Fomon, 2001; Weaver, 2003). Chemists created and experimented with artificial formulae for the remainder of the 19th century. Formula milk was marketed as a scientific advancement which was nutritionally balanced and would ensure newborn infants thrived.
By the turn of the 20th century, paediatricians began to show an interest in the nutritional composition of infant formula. In particular, Thomas Rotch advocated diluting cow’s milk (to lower the protein level) by adding sugar and cream at calculated percentages, to increase the carbohydrate and fat content. The prescriptive variations of amounts, recommended by Rotch, were based on a scientific formula, calculated using the infants’ age, medical condition and growth rate. Weaver states that Rotch developed his own ‘milk laboratory’ where he could experiment with various nutritional compositions which included, for example, investigating which cows produced the ‘best’ milk (Weaver, 2003:308).

American historian, Rima Apple (1986), argues artificial formula manufacturers targeted advertising towards medical journals, and national medical meetings, in an effort to ensure product endorsement from physicians. Strategies included the provision of free samples of formula to physicians in the hope that they would preferentially recommend one variety of formula, over another (Apple, 1986). At the same time, physicians began to act as medical managers of mothers by ‘prescribing’ breastmilk substitutes when breastmilk was not available for infants, or when breastmilk supply was considered ‘unreliable’ (Apple, 1986). Evaporated sweetened condensed milk was also marketed as an alternative to breastmilk, this however, did not receive support from medical practitioners due to the higher sugar content used as a preservative (Bryder, 2009; Fomon, 2001; Wolf, 2001).

The endorsement of certain products, by physicians, led to the emerging acceptance of infant formula as important for the maintenance of optimal infant health. Apple (1986:16-18) and Bryder (2009:58) demonstrate that words and phrases used to promote formula, such as ‘scientific’, ‘chemical composition’, ‘life saving’, ‘pure’ and ‘safe’ were prominent in advertising during the last century. The rise of modernity, mass manufacturing and marketing led to an increasing acceptance of, and justification for, the need for this newly marketed nutritional product (Apple, 1986; Weaver, 2003; Wolf, 2001). Apple comments that women who introduced formula supplementation were considered ‘conscientious’, as it was believed that infant growth needs often surpassed breastmilk availability. These ideas ‘most likely’ fuelled a lack of confidence in breastmilk supply and validated the need for artificial supplements (Apple, 1986:21). At the same time, developmental surveillance of children emerged as an important health strategy to ensure healthy citizens for the
nation. Weighing stations, for the monitoring of infant and young child health and growth, led to the gradual and subtle undermining of breastfeeding. Health professionals, who were eager to optimise infant health, equated substantial weight gain with robustness. In this context, infant formula was often recommended as a replacement for breastfeeding if weight gain was not in alignment with the prescribed growth chart (Baumslag & Michels, 1995).

2.2.3. The ‘modern’ method of infant feeding

At the same time, the rise of modernity was also mitigating against breastfeeding. During the 20th century, not unlike the early sexualisation of the breasts during the 18th and 19th century, the female breast began to take on new social significance and meaning. During the First World War, and more overtly during the Second World War (WW2), the emergence of iconography exploiting the breast as the symbol of femininity and sexuality was enlisted by the war effort. Voluptuous women came to represent the ultimate reward for courageous returning soldiers (Yalom, 1997). This is highlighted by Yalom (1997) who wrote that photographer Ralph Stein commented that women were regularly encouraged to enhance their breasts with extra padding when appearing in staged photographs for WW2 soldiers (Yalom, 1997:137).

The rise of mass media, during the latter half of the 20th century, also played a major role in further portraying the breasts as sexual apparatus and objects of male desire (Baumslag & Michels, 1995; Dykes & Griffiths, 1998). Increasing trends towards apparel accentuating the breast and cleavage reflected the widespread acceptance of the breast as defining femininity and sexuality (Bordo, 2003; Carter, 1995; Maguire, 2008). In this context, breastmilk substitutes became an attractive option for women who considered it necessary to return to the more accepted non-pregnant and lactating figure. It has been regularly argued that this sexualised focus on the breasts contributed to a waning interest in breastfeeding in western countries (Dykes & Griffiths, 1998; Hausman, 2003; Hoddinott & Pill, 1999; Wallace & Chason, 2007).

As the female breasts became increasingly associated with sex, breastfeeding activity became progressively restricted. For example, concerns about body image and fear of bodily exposure (Carter, 1995; Hausman, 2003; Shildrick, 1997; Wallace & Chason,
2007) impinged upon a woman’s willingness to breastfeed, especially in public (Dykes & Williams, 1999; McInnes & Chambers, 2008).

In addition, the rise of a feminist critique of breastfeeding began to link artificial formula feeding with gender equality. Claims that breastfeeding was ‘autonomy compromising’ whilst bottle feeding restored bodily control and integrity, led many women to abandon the practice of breastfeeding (Hausman, 2003).

These western constructions of the female breast, and of breastfeeding, need to be considered against the economic push to expand formula company profit margins. Advertising campaigns, at this time, were specifically aimed at convincing as many women as possible to accept artificial milk as a scientifically prepared product. Infant formula was promoted as not only ‘equivalent’ to breast milk but also more ‘modern’, ‘convenient’ and less modesty-compromising (Bryder, 2009; Palmer, 2009). The use of ‘trendy’ language in advertising campaigns, such as ‘really up-to-date mothers use [insert name of product] …’, accelerated the uptake of artificial formula (Bryder, 2009:58). Similarly, the distribution of formula samples to women before, and after, birth in hospital was utilised as a concerted strategy to plant the ‘seed of need’ in new mothers’ minds and to link formula feeding with health professional endorsement (Palmer, 2009; Rosenberg, Eastham, Kasehagen, & Sandoval, 2008). Construction of the breasts as ‘sexual’ was also manipulated by artificial formula advertisers to persuade as many women as possible to stop, or supplement, breastfeeding with the more ‘socially’ acceptable and convenient bottle feeding. The lack of a vested interest group, correspondingly marketing and advocating for the importance of breastmilk and breastfeeding, provided a solid ground for artificial formula manufacturers to dominate ‘consumer’ thinking (Palmer, 2009:4).

These strategies led to an accelerated growth in artificial formula feeding in Westernised countries until at its height, in the 1960s, approximately 40-50% of Australian infants were artificially fed at discharge from hospital (NHMRC, 2003). It was only when infant formula companies began promoting their product to developing countries, that the dire infant health outcomes from artificial feeding, in these countries, began to capture the world’s attention.
2.2.4. The decline of the scientific product

A commercial shift to expand the promotion and distribution of breast milk substitutes to resource poor countries, eventually led to the re-emergence of the importance of breastfeeding. In both resource rich, and resource poor countries, infants whose mothers had been persuaded to abandon breastfeeding, by aggressive advertising and free distribution of formula, often did so because they aligned infant formula with modern scientific advancement. However, women who lived in improvised and unsanitary environments, where access to clean water was restricted, had difficulty preparing uncontaminated infant formula. In addition, insufficient supplies of artificial milk further compromised the health of infants in these countries. Even in resource rich countries, it was noted that socioeconomic disadvantage led to higher use of breastmilk substitutes and greater risk of ill health (Bader, 1976; Cunningham, 1977; Eastham, Smith, Poole, & Neligan, 1976; Jelliffe, 1976; Jelliffe & Jelliffe, 1977; Palmer, 1993; Salokoski, 1983). Realisation of a connection between formula use and declining infant health, prompted international public health strategists to collaborate and bring about improvements in the health of the world’s most disadvantaged, and vulnerable, populations (Palmer, 2009; WHO, 1981; WHO & UNICEF, 1991a). So began the global interest in ‘promoting, protecting and supporting’ breastfeeding.

2.3. The ‘Gold’ Standard Revolution

Changes in breastfeeding practice, charted in this chapter so far, have been linked to industrialisation and scientific developments. The eventual return to, and validation of, breastfeeding similarly emerged from scientific arguments and technological advances. Over the past four decades, controlled methodical analysis of breastmilk has facilitated the systematic itemising of the micro nutrient qualities, including immunological factors. This level of analysis has demonstrated that human milk is the best source of nutrients and immunity for infants, when compared to artificial substitutes (Barlow et al., 1974; Gibson & Kneebone, 1981). For example, comparisons between the whey/casein ratio (72:28) in breastmilk, compared to formula (18:82), have provided irrefutable evidence for the superior digestibility of breastmilk, as whey is known to be more digestible than casein (Fomon, 2001; Leung & Sauve, 2005). The presence of amino acids, such as taurine and cysteine, have been found in much greater abundance in breastmilk, compared to formula. In
addition, the bioavailability of factors such as secretory IgA, T and B lymphocytes, and iron, provide further evidence for the superiority of breastmilk (Leung & Sauve, 2005). In particular, it is now known that colostrum (the initial breastmilk) is very high in lymphocytes, macrophages, neutrophils and ‘inoculating’ microflora, important for gut digestion (Leung & Sauve, 2005). Scientific evidence for the nutritional value of breastmilk has validated breastfeeding as the ‘best’ nutritional option for infants and young children.

Drawing on accumulated evidence the WHO confirms that breastfeeding affords substantial health benefits for both infants and women (WHO, 2007). For example, infants who are breastfed are less likely to experience diabetes, obesity or allergies. Breastfeeding is known to protect infants against gastroenteritis, otitis media, upper respiratory tract infections, Type 2 diabetes, necrotising enterocolitis and atopic disease (Leung & Sauve, 2005; Marild, Hansson, & Jodal, 2004; Oddy, 2001; Quigley, Kelly, & Sacker, 2007; Sadauskaite-Kuehne, Ludvigsson, 2004; Young et al., 2002). The benefits for women extend beyond lactation amenorrhea, and weight loss, to include, protection against breast and ovarian cancer, and Type 2 diabetes (Hoddinott, Tappin, & Wright, 2008; Labbok, 2006; Leung & Sauve, 2005; Schwarz et al., 2010).

As a result of the increasing knowledge about the health benefits for infants and women, exclusive breastfeeding has become aligned with the ‘gold standard’ in infant feeding. Breastfeeding is recommended for the first six months of life, and thereafter as a complementary feeding source until the infant is two years or more (Godfrey & Lawrence, 2010; Kaplan & Graff, 2008; Newton, 2004; Walker, 2010). Consequently, in an effort to replicate breastmilk, newer generations of infant formulae contain additional ‘immunoregulatory’ ingredients, such as prebiotics, probiotics and nucleotides (Riva, Verduci, Agostoni, & Giovannini, 2005). Manufacturers have also attempted to exploit the discursive turn towards the ‘gold standard’ by labelling their own products as ‘gold’, for example ‘S26 GOLD’ or ‘NAN PRO GOLD’. However, initiatives such as the ‘International Code of Marketing of Breast-milk Substitutes’ ensure manufacturers are obliged to inform consumers (with a statement on their product) that breastmilk is indeed the true gold standard in infant nutrition (WHO, 1981).
2.3.1. The International Code

The ‘International Code of Marketing of Breast-milk Substitutes’ (hereafter referred to as The Code), has grown out of collaborations between the World Health Organisation (WHO) and the United Nations Children’s Fund (UNICEF). The Code was developed after consultation with all member states and other relevant parties. It was adopted in 1981, after many years of debate and planning. The Code aims to prevent malnutrition and ‘protect and promote’ breastfeeding by regulating the marketing and distribution of manufactured breastmilk substitutes. This document has embedded social and economic determinants of breastfeeding into global policy and international initiatives. The Code advocates for government involvement in the ‘protection and promotion’ of breastfeeding and seeks to eradicate all inappropriate advertising, distribution of free samples, promotion of artificial formula, and images which represent bottle feeding as a cultural norm. This global Code, also seeks to ensure that information about breast milk substitutes affirms breastfeeding as the superior option for infant health (WHO, 1981, 2009).

The mantra ‘breast is best’ elucidates the point that despite ongoing scientific enhancement of infant formula, breastmilk substitutes are not equivalent to breastmilk. The Code overtly promotes breastfeeding as the gold standard in infant nutrition and creates an alternative reference for breast milk substitutes. Messages presented in The Code, include recognition of the social and economic implications of not breastfeeding and the importance of government and health professional support in promoting the superior quality of breastmilk (WHO, 1981). Australia is a signatory to The Code, and the Australian Government has responded with the development of a regulatory authority calling manufacturers to account. The agreement, ‘Marketing in Australia of Infant Formula’ (MAIF), is a self-regulatory code of conduct which requires manufacturers (and importers) of infant formula to comply with The Code (Advisory Panel for the Marketing of Infant Formula, 1995; Australian Government Department of Health and Aging, 2011).

Beyond decreasing the supply and distribution of formula, ongoing collaborations between the WHO and UNICEF have resulted in the identification of additional factors which impact on breastfeeding internationally. In 1989, a joint statement from WHO and UNICEF outlined the pivotal role maternity services play in ensuring breastfeeding is supported and promoted within organisations. Hospital practices
were identified as potentially disrupting the establishment of breastfeeding. For example, the separation of mother and infant, the widespread use of glucose water or formula, or the inappropriate care or advice provided by staff with limited knowledge about breastfeeding, have each been considered detrimental to breastfeeding (Lozoff, Brittenham, Trause, Kennell, & Klaus, 1977; Scott & Binns, 1999; WHO, 1989:3).

To address these poor hospital practices and improve organisational capacity to support breastfeeding women, WHO and UNICEF have articulated the ‘Ten Steps to Successful Breastfeeding’ (see Table 1) in maternity facilities (WHO, 1989:iv). This joint WHO and UNICEF statement highlights the significance of health professional care and support, during the period of maternity, and the potential to influence a woman’s understanding and confidence with breastfeeding during this time (WHO, 1989:4).

A year after the above statement was released, policy makers from WHO and UNICEF met at the Spedale degli Innocenti hospital in Italy, to produce the now renowned ‘Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding’. This Declaration reinforced the global goal of enabling exclusive breastfeeding and developing supportive environments. The Declaration highlighted the importance of the ‘Ten Steps’ and ‘The Code’ along with the need for legislation to protect the rights of women who work and breastfeed (WHO & UNICEF, 1991a). Significantly, the year after this a new initiative directly targeting hospital compliance with the ten steps was launched entitled the Baby Friendly Hospital Initiative (BFHI). This initiative articulated the important components of a breastfeeding friendly hospital culture and aimed to transform institutions to reflect this tenet (WHO & UNICEF, 1991b).
Table 1: Ten Steps to Successful Breastfeeding

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<tr>
<th>TEN STEPS TO SUCCESSFUL BREASTFEEDING</th>
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<tr>
<td>Every facility providing maternity services and care for newborn infants should:</td>
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<tr>
<td>1. Have a written breastfeeding policy that is routinely communicated to all health care staff.</td>
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<td>2. Train all health care staff in skills necessary to implement this policy.</td>
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<td>3. Inform all pregnant women about the benefits and management of breastfeeding.</td>
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<td>4. Help mothers initiate breastfeeding within a half-hour of birth.</td>
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<td>5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.</td>
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<td>6. Give newborn infants no food or drink other than breastmilk unless medically indicated.</td>
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<td>7. Practise rooming in – allow mothers and infants to remain together – 24 hours a day.</td>
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<td>8. Encourage breastfeeding on demand.</td>
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<td>9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.</td>
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<tr>
<td>10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.</td>
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<td>* Step 4 has been rewritten to read: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed and offer help if needed.</td>
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(WHO, 1989; WHO & UNICEF, 2009:34)

2.3.2. The Baby Friendly Hospital Initiative (BFHI)

The BFHI was endorsed at the Forty Fifth World Health Assembly in 1992. This initiative summoned health care services to accept responsibility for transforming hospital environments in an effort to ‘protect’ breastfeeding. For the first time, health services were provided with a framework and guidelines to proactively develop a positive breastfeeding culture within their institution (WHO & UNICEF, 1991b). It was anticipated that an institutional commitment to breastfeeding would lead to improved health professional practices, to support the early establishment of breastfeeding. The ‘Ten Steps’ have become the universal template upon which much contemporary health professional breastfeeding support is based (WHO & UNICEF, 2009).

In order to achieve BFHI status, hospitals and health services must meet minimum outcome measures. For example, 75% of women attending the maternity service must be exclusively breastfeeding from ‘birth to discharge’ and must meet all the standards set by the global criteria for BFHI. Accreditation as a baby friendly
hospital is provided for a period of three years, whereupon institutions must seek re-accreditation to maintain their BFHI status (WHO & UNICEF, 2009:27). The BFHI represents the most significant public health initiative to have impacted upon contemporary health professional practice over the past 20 years. Some of the steps in this initiative have influenced hospital culture individually, such as the practice of placing the infant skin-to-skin with mother at birth and after (Cooke, Cantrill, & Creedy, 2009), as well as collectively, through incorporation of all ten steps (Bartington, et al., 2006).

2.3.3. Acceptance of BFHI

The BFHI has placed breastfeeding on the agenda as an institutional priority, not just for governments, but also for hospital executives. In Australia, 23% of maternity hospitals have become BFHI accredited (BFHI Australia, 2010). Practices associated with the BFHI have been known to influence hospital culture beyond the confines of the BFHI accredited hospital. For example, Merten and colleagues (2005) demonstrated strategic benefits, in Switzerland, from educational awareness raising for BFHI, which influenced even those hospitals not currently seeking accreditation (Merten, Dratva, & Ackermann-Liebrich, 2005). The authors speculate that increased breastfeeding rates across Switzerland can be attributed, in part, to BFHI. For example, the eradication of scheduled and timed feeding in hospitals, rooming-in, and the importance of skin-to-skin contact at birth, are each reflective of practices originating from BFHI (World Health Organization & UNICEF, 2009).

Yet in the Australian context, Reddin and associates (2007), found senior midwives had a level of ‘passive resistance’ to BFHI accreditation, and implementation, at an accredited hospital in South Australia (Reddin, Pincombe, & Darbyshire, 2007). The aim of the study was to ascertain the beliefs and experiences of newly graduated midwives, regarding breastfeeding support, as well as to identify factors which enhanced or impeded knowledge integration. Three separate reflective and semi-structured interviews were conducted with 17 beginning midwifery practitioners. The findings revealed that exposure to ‘outdated’ midwifery practices, poor role modelling by senior staff, as well as time pressures on the postnatal ward, made compliance with BFHI difficult, for both the new graduates and the supervising midwives. The newly graduated midwives reported a degree of disillusionment as to the efficacy of BFHI accreditation (Reddin, et al., 2007).
Similarly, participants in another Australian study have identified that implementation of BFHI can be a challenging process hampered by confusion around the nature of the initiative (Walsh, Pincombe, & Henderson, 2010). This study into the attitudes of staff at six South Australian maternity hospitals (three of which were either BFHI accredited or were seeking accreditation) sought to identify factors which promoted or hindered accreditation. The authors conducted focus groups with 31 participants and discovered that staff were daunted by the prospect of implementing many of the steps. In fact, a derisive attitude towards the BFHI was detectable at the non-BFHI accredited hospitals. Staff implied that the accreditation process created health workers who increased the pressure on women to breastfeed and became ‘breastfeeding nazis’ or mother ‘unfriendly’ (Walsh, et al., 2010). The authors speculated that retention of traditional outdated practices, such as rooming out at night, even within BFHI hospitals, destabilised the consistency of breastfeeding support information and potentially sabotaged ongoing breastfeeding (Walsh, et al., 2010). The authors recommend nine individual strategies to improve BFHI uptake in the Australian context, including the appointment of BFHI coordinators at hospital and at area health service levels.

Similar findings have been reported by Taylor and colleagues (Taylor, Gribble, Sheehan, Schmied, & Dykes, 2011). These authors consulted with midwives and nurses regarding their perceptions of the implementation of BFHI in Neonatal Intensive Care units. Participants confirmed a commitment to promoting and supporting breastfeeding, however, they acknowledged the process of BFHI implementation was difficult. Barriers to implementation included disagreement over the new ‘rules’ imposed by BFHI and concerns regarding the availability of time to adequately support breastfeeding women (Taylor, et al., 2011).

2.3.4. Improvements from BFHI

Establishing breastfeeding in a breastfeeding friendly environment has been prioritised at government level, due to the known association between BFHI and improvements in breastfeeding initiation rates (Bartington, et al., 2006; Broadfoot, et al., 2005; Kramer et al., 2001). The recently released ‘Australian National Breastfeeding Strategy 2010-2015’ reveals government endorsement of the ‘Ten Steps’ approach to improving breastfeeding initiation and duration rates. Incorporation of the ten steps into maternity hospital policies and practices have been
advocated, even when formal accreditation is not being actively sought (Australian Health Ministers' Conference, 2009).

BFHI has been credited with improving the number of women who initiate breastfeeding and who exclusively breastfeed (Duyan Çamurdan et al., 2007; Martens, 2000; Merten, et al., 2005; Rosenberg, Stull, Adler, Kasehagen, & Crivelli-Kovach, 2008). However, there is widespread debate about the impact of BFHI on sustained breastfeeding (Coutinho, De Lira, De Carvalho Lima, & Ashworth, 2005; Fallon, Crepinsek, Hegney, & O'Brien, 2005; Pincombe et al., 2008). So whilst BFHI has been linked to increased breastfeeding initiation, improvements in duration rates are less consistent.

Although the ten steps advocate for changes to hospital environments in order to facilitate establishment of breastfeeding, support for sustained breastfeeding is embedded into step 10. This final step recommends establishment of post discharge support groups for breastfeeding women. Yet the failure of many health services to adequately enact this step has prompted a shift in the new revised BFHI package, towards enhancing community initiatives for a baby friendly culture (World Health Organization & UNICEF, 2009). The BFHI 7-point plan for community health care settings has been recommended since the late 1990s (UNICEF, 2008) but the development of this component of BFHI is less well developed in Australia. New government and institutional initiatives, which focus on community BFHI, can be anticipated in the future. In preparation for the expansion of BFHI, into the community sector, the initiative is now called the Baby Friendly Health (not Hospital) Initiative in Australia (BFHI Australia, 2010).

The narrative studies reported in Chapter One, reflected the sense of a moral obligation to provide the gold standard in infant nutrition in women’s descriptions. Women who had commenced breastfeeding often indicated a desire to get breastfeeding ‘right’. In Australia, more than 90% of women initiate breastfeeding, yet expectation and reality of the experience are sometimes at odds. Women indicate that the first few weeks of breastfeeding represents a time when they require additional support. Midwives seek to fulfil this role during the early establishment phase by providing support and guidance to meet the woman’s own breastfeeding goals.
2.4. ‘Breast is best’ with Support

As discussed in Chapter One, research from the Australian Institute of Family Studies reveals a decrease in ‘full’ breastfeeding rates, from 92% at initiation, to 80% at one week, then 56% at 4 months and 14% at 6 months (AIFS 2008). This represents a significant decline, especially within the first few weeks of breastfeeding, despite this being the time when most women in Australia have ongoing access to health professional support. As highlighted previously whilst breastfeeding initiation rates are high, duration rates are well below WHO recommendations.

Midwives represent a knowledgeable resource for women during this time. The education and training of midwives, in Australia, has an emphasis on the ‘breast is best’ message and includes education on the relevant anatomy and physiology and management of breastfeeding problems (Henderson & Scobbie, 2006). Women have extensive contact with midwives both in hospital, and in home, environments during pregnancy and the early postnatal period. In fact, the Australian College of Midwives (ACM) is the governing body currently managing Australia’s international responsibilities under the BFHI initiative. Midwifery commitment to evidence-based practice has ensured that breastfeeding has remained high on the agenda in promoting the health and wellbeing of mothers, infants and their families. Subsequently the ‘protection, promotion, and support’ of breastfeeding have become fundamental components of competent midwifery practice (Australian Nursing and Midwifery Council, 2006).

2.4.1. Antenatal promotion of breastfeeding

The ‘breast is best’ message, promoted during pregnancy, has influenced broad public discourses about the benefits of breastfeeding. For this reason, early in pregnancy many women have already made their infant-feeding decisions (Sheehan, et al., 2003). Sheehan and colleagues (2003) concluded, from their qualitative study into antenatal infant feeding decision making, that this was a complex process for some. The authors highlighted the need for ‘diverse educational opportunities’ to address the range of sentiments and assumptions couples may bring to the infant-feeding decision-making process (Sheehan, et al., 2003). In Australia, midwifery promotion of breastfeeding predominantly occurs during antenatal parenting
education sessions, which first-time mothers are encouraged to attend. These education sessions serve the dual purpose of providing ongoing education about pregnancy, birth and beyond, whilst also facilitating familiarisation with other couples in the community.

It has been argued however, that antenatal preparation for breastfeeding merely serves to reinforce a commitment to breastfeed, rather than influence a change of mind (Forster et al., 2004; Handfield & Bell, 1995; McAllister, Bradshaw, & Ross-Adjie, 2009). Forster and colleagues (2004) measured the effectiveness of an antenatal educational intervention, to determine the impact on initiation and duration rates of breastfeeding. This study randomised 981 women, during the second-third trimester of pregnancy, into standard care or an intervention group. The intervention group participated in a ‘class’, on practical aspects of breastfeeding and a ‘class’, with small group discussion, on attitudes and experiences of breastfeeding. The results revealed no statistical difference in initiation or duration of breastfeeding compared to standard care. The authors concluded that high existing initiation rates for breastfeeding were indicative of an already motivated population who benefited little from antenatal breastfeeding education (Forster, et al., 2004).

However, more recent research by Tender and associates (2009), found a positive correlation between antenatal breastfeeding education attendance and exclusive breastfeeding in hospital (Tender et al., 2009). This study explored the reasons for in-hospital supplementation with artificial formula in a cohort of women from disadvantaged backgrounds. The findings have confirmed the advantages of raising breastfeeding awareness during pregnancy, especially for women living in communities where the ‘breast is best’ message has been muted. For groups such as young women, migrant women and women of low-income, the availability of professional and peer support for breastfeeding, which commences during pregnancy and continues postnatally, has been shown to be beneficial for breastfeeding outcomes (Hannula, Kaunonen, & Tarkka, 2008).

Systematic review findings from Dyson and colleagues (2005), revealed that ongoing education sessions, which adopt ‘informal’ approaches to learning, are more successful in increasing breastfeeding rates when compared to the more official standard styles of education (Dyson, McCormick, & Renfrew, 2005). This is reinforced by a systematic review of professional support for breastfeeding,
conducted by Hannula and colleagues (2008), which showed that interactive antenatal group sessions were more effective than didactic lecture style education (Hannula, et al., 2008).

In Australia, the dominant mainstream service model for childbirth and parenting information takes the form of typical ‘class’ format. Yet expectant parents have indicated a preference for a range of innovative learning opportunities during pregnancy (Svensson, Barclay, & Cooke, 2008).

It is largely unknown whether the current approaches to providing antenatal education in group settings, are more or less effective than individual education, in improving breastfeeding exclusivity and duration (Gagnon & Sandall, 2007). Yet the popularity of such sessions are testament to the perceived need for ‘education’ pre-birth, as well as the desire to meet and develop friendships with others experiencing the similar life events. Little is known about the ways in which breastfeeding is presented in these antenatal education sessions. The language used by facilitators may influence perceptions of early breastfeeding experiences. An analysis of the style of presentation adopted, as well as the actual information communicated, may provide greater insight into the expectations and experiences of women during the early initiation of breastfeeding.

2.4.2. Postnatal support for breastfeeding

The early phase of breastfeeding begins in hospital environments for the majority of women in Australia. The average length of hospital stay however, has decreased from 5.3 days in 1991 to 3.7 days in 2000, and this trend is continuing (AIHW NPSU, 2003; McLachlan, Forster, Yelland, Rayner, & Lumley, 2008). In NSW, the average length of stay after birth varies from 2.6 days to 4.8 days, depending upon the geographical area, the individual hospital, and the private health fund status of families (Centre for Epidemiology and Research, 2009a). Cochrane systematic review findings indicate no adverse outcomes from early hospital postnatal discharge, providing this is followed up with midwifery support in the home (Brown, Small, Argus, Davis, & Krastev, 2002 (updated 2009)). This has also been confirmed in an exclusively Australian context (Brown, Bruinsma, Darcy, Small, & Lumley, 2004). While rates do vary, most Australian women, who give birth in the public sector, are offered follow-up midwifery support at home after discharge. This form
of support predominantly comprises regular contact with a midwife, either face to face, or by telephone, during the first week after birth (Brown, et al., 2004).

Research has measured the potential benefits of extending the provision of midwifery support beyond the first week. The work of McDonald and colleagues (2010), in Western Australia, is an example of this. A randomised controlled trial of 849 breastfeeding women measured breastfeeding duration following provision of an extended midwifery support service, until six weeks post birth, and compared this to the standard model of midwifery support. The findings revealed no added benefit in the duration of full, or any, breastfeeding to six months, when compared to the standard model. The authors speculated that high initiation rates at this hospital indicated an already motivated population which an extended midwifery support approach did not benefit (McDonald, Henderson, Faulkner, Evans, & Hagan, 2010). However, it is worth noting that extended midwifery support in communities where there is disadvantage, and a lack of support, has been shown to be effective for ongoing breastfeeding (Kemp et al., in press; Porteous, Kaufman, & Rush, 2000).

In Australia, the standard model for breastfeeding support commences with midwifery support, both in hospital and in the home for the first week, followed by referral to a child and family health nursing service for ongoing support. Australian midwives Cooke and Stacey (2003) conducted a review of the literature and identified five components of midwifery support provided during the postnatal period. These comprised baby care, which included practical assistance with infant feeding, health of the mother and infant, emotional support, environmental support, and discharge support (Cooke & Stacey, 2003). More recently, in the UK, Hall Moran and colleagues (2007) adapted Sarafino’s (1994) five components of support, to their review of adolescent mothers’ support needs. The five aspects identified were: emotional, esteem, instrumental, informational and network support. Of note, instrumental support included practical assistance with breastfeeding. This was valued if provided in a caring way, by a known midwife, rather than during rushed encounters (Hall Moran, et al., 2007). Contemporary midwifery texts describe the instrumental and informational midwifery support roles as education and guidance with ‘positioning’ and ‘attachment’, as well as the provision of assistance and management of breastfeeding problems (Henderson & Scobie, 2006:513-517). Here, ‘positioning’ at the breast refers to the alignment of the infant and mother’s
body, whereas ‘attachment’ is the placement of the infant’s mouth at the breast (Inch, Law, & Wallace, 2003).

Midwifery texts highlight the role of the midwife as a skilled assistant, educator and problem solver (Cadwell, 2007; Henderson, Pincombe, & Stamp, 2000; McAllister, et al., 2009; Rayner, Forster, McLachlan, Yelland, & Davey, 2008). Many argue that infant positioning and optimising attachment to the breast are two key modifiable factors that, if addressed through interventions, can improve support for breastfeeding women (Blair, Cadwell, Turner-Maffei, & Brimdyr, 2003; Henderson, Stamp, & Pincombe, 2001a; Law, Dunn, Wallace, & Inch, 2007; Powers, 2008). Health professionals consistently report that ‘teaching’ women to position and attach their infant, to their breast, is a fundamental component of midwifery and lactation consultant practice (Blair, et al., 2003; Cadwell, 2007; Hannula, et al., 2008; Rayner, et al., 2008).

Some midwives however, challenge the accepted knowledge about the best positions for breastfeeding. For example, Colson (2008) questions some of the unreferenced and non-evidence based recommendations, which midwives provide, regarding optimal posture for breastfeeding. Colson argues that the tendency for midwives to manage maternal posture for breastfeeding reflects compliance with social norms. She provides the example of sitting upright in a chair to breastfeed, which resembles sitting at a table to eat a meal, but does not resemble the instinctive positions which women assume when breastfeeding unaided (Colson, 2008).

Indeed, as indicated in Chapter One, several scholars have criticised the professional rhetoric around breastfeeding for failing to account for the diversity of women’s experiences. Professional support based on generic assumptions, professional expertise and technical prescriptions, rather than genuinely focused on individual women’s needs, contributes to the lack of satisfaction with midwifery support which women report (Carter, 1995; Dykes, 2006a; Maclean, 1990; Schmied, et al., 2011; Sheehan, et al., 2010).
2.4.3. Midwifery knowledge

Midwives’ knowledge of breastfeeding is obtained in a variety of ways and can be dependent upon individual and organisational motivation to seek out best practice recommendations. Midwives have reported that practical experiences, and their own personal experiences, sometimes inform their midwifery practice. Researchers suggest this has resulted in practices which are often contrary to best practice guidelines (Battersby, 2000; Creedy, Cantrill, & Cooke, 2008). The BFHI, discussed earlier, seeks to redress this tendency. Recent research findings demonstrate midwives appreciate having access to ongoing education regarding breastfeeding, such as regular updates and in-service sessions, to ensure best practice guidelines are disseminated and practised (Furber & Thomson, 2008b; Marshall, Renfrew, & Godfrey, 2006; McFadden, Renfrew, Dykes, & Burt, 2006; Wallace & Kosmala-Anderson, 2007). However, as discussed in the previous section, a level of passive resistance to new evidence-based practice guidelines sometimes impedes integration of practice improvements.

In Australia, increasing numbers of midwives have sought out additional education and training related to breastfeeding. Many have attained qualification as lactation consultants, having passed the International Board Certified Lactation Consultant (IBCLC) examination. This trend may reflect a perceived need to supplement the knowledge and skills attained from undergraduate midwifery education, in order to adequately assist and support women who are breastfeeding (Cantrill, Creedy, & Cooke, 2003). Whether this additional knowledge has actually improved the experience of breastfeeding for women, and translated into improved breastfeeding duration rates, is less clear (Donath & Amir, 2000; Schmied, Sheehan, & Barclay, 2001). The fact that duration rates for exclusive breastfeeding have remained in steady decline, may indicate that the proliferation of highly qualified midwives has not prevented the steady decline in breastfeeding beyond the first month after birth. Instead, additional factors may be implicated.

2.4.4. Postnatal ward environment

The WHO argues that the lack of a culture of breastfeeding, within health care institutions, interferes with breastfeeding initiation (WHO, 1989). As discussed previously, routine hospital and health professional practices have been impacting
unfavourably on breastfeeding for many years (Bruce, Khan, & Olsen, 1991; Lozoff, et al., 1977; Nicholson, 1986). Over the last 10 years, the postnatal ward environment has come under scrutiny as midwives seek to capture the determinants of maternal dissatisfaction and declining breastfeeding duration rates (Cooke & Stacey, 2003; Schmied, Cooke, Gutwein, Steinlein, & Homer, 2008).

Cooke and Stacey (2003) surveyed 365 women regarding their experience of postnatal midwifery care. The findings revealed that midwives had insufficient time to spend with women to meet their emotional needs. Reports of inconsistent advice and inadequate support, from midwives, also featured in participant replies (Cooke & Stacey, 2003). More recently, Schmied and colleagues (2009) conducted an action research project with midwives at a metropolitan hospital in NSW, to identify and implement improvements in postnatal care. The research was conducted over three phases, which ensured input from both midwives and women. A key strategic intervention, labelled ‘one-on-one’ time, prioritised uninterrupted time between the woman and midwife. Pre- and post- intervention survey data revealed that the anticipated 20-30 minutes of uninterrupted time with a midwife, manifest as less than 10 minutes for most women (Schmied, et al., 2008; Schmied, Cooke, Gutwein, Steinlein, & Homer, 2009). Time factors were identified as a key determinant of dissatisfaction with postnatal midwifery care.

Analysis of postnatal hospital ward environments, in other western countries, has identified similar time pressures restricting midwifery support in this milieu. Fiona Dykes’ (2006) ethnographic study at two maternity units in the north of England, revealed ‘linear time’ was a key influence on all aspects of midwife-woman exchanges in the hospital context. Dykes likened the postnatal ward environment to that of a ‘factory’, where a ‘production line’ mentality had pervaded midwifery care, and conceptualisations of breastfeeding aligned with factory production according to supply and demand. Many woman-midwife interactions were characterised by a lack of ‘taking time’ and ‘touching base’ and represented ‘disconnected encounters’, as midwives sought to move people through the hospital ‘factory’. Midwives communicated ‘temporal pressure’ during interactions with women in this milieu and women described midwifery care as rushed, disconnected and authoritative (Dykes, 2006a).
In Australia, population-based surveys have confirmed that women rate postnatal care, in hospital environments, well below other aspects of midwifery care, such as labour and birth care (Brown, et al., 2005; Bruinsma, Brown, & Dary, 2003). Women often blame the busy, chaotic, nature of the postnatal hospital environment for dissatisfaction with midwives, in addition to receiving conflicting advice about infant care, delayed response to calls for assistance and insensitive staff (Brown, et al., 2005; Rayner, et al., 2008). This is particularly concerning given that women identify a need for sufficient time with health professionals, during the first week after birth, for confidence building around breastfeeding (McInnes & Chambers, 2008; Schmied, et al., 2011). Even at one week postpartum, confidence with breastfeeding can be predictive for ongoing duration of breastfeeding (Baghurst et al., 2007; Blyth, et al., 2002; Dennis & Faux, 1999).

McLachlan and colleagues (2008) state that, in Australia, the structure of postnatal care in hospital environments represents a barrier to the provision of optimal support. The building of a woman’s confidence in these busy ward environments, where midwife availability is restricted, is dependent upon the quality of communication between midwife and woman. Brown and colleagues (2005) found that aspects of care which were most likely to influence a woman’s satisfaction, during the postnatal period, included the sensitivity and empathy displayed by staff. Communication styles adopted during brief interchanges, in busy postnatal hospital environments, might subsequently influence the quality of support for breastfeeding.

2.4.5. Communicating breastfeeding

The recent Garling report into health services in NSW identified the need to examine and improve communication by health professionals in hospital settings (Garling, 2008; New South Wales Parliament Legislative Council, 2004). The approach to communication or the communication style used by midwives in maternity settings has become a focus of research (Dykes, 2006a; McCourt, 2006; Stapleton, Kirkham, Thomas, & Curtis, 2002). As discussed in Chapter One, women receiving support with breastfeeding in the early postnatal period, report a high level of dissatisfaction with health professional communication (Coreil, et al., 1995; Dykes, 2006a; Hoddinott & Pill, 2000; Shakespeare, et al., 2004).
Hoddinott and Pill (2000) conducted interviews with 21 women from a disadvantaged community in London, regarding their experiences of health professional communication around breastfeeding. The findings revealed women felt a degree of ‘pressure’ from health professionals to initiate and continue to breastfeed. Communication was also directed at ‘breastfeeding’ information rather than being more woman centred. Women resented midwives who took over the care of the infant and interfered with the woman’s breast during attachment. Developing a connection with a midwife and being given suggestions, enabled confidence building (Hoddinott & Pill, 2000). Later, using qualitative interviews, Shakespeare and associates (2004), explored the difficulties with breastfeeding experienced by women with postnatal depression. The recorded narratives captured descriptions representing midwives and lactation consultants as the ‘breast police’, who were bossy, or judgemental, and communicated a ‘pressure’ to breastfeed. The authors concluded that ‘baby friendly’ policies may have influenced health professional communication and the heightened intensity reported around breastfeeding (Shakespeare, et al., 2004). Baker and colleagues (2005), whose research into women’s experiences of maternity care more broadly, reported a similar finding. Women described a degree of ‘forceful’ encouragement to persevere with breastfeeding in the face of difficulties (Baker, Choi, Henshaw, & Tree, 2005).

Findings of two meta-synthesis on women’s experience of support for breastfeeding, presented in Chapter One, have provided an insight into the style of communication preferred by women (McInnes & Chambers, 2008; Schmied, et al., 2011). McInnes and Chambers’ (2008) qualitative synthesis of 47 papers on women’s experiences, and health professional perceptions of breastfeeding support, highlighted a maternal preference for peer support. Women described a feeling of being under surveillance, from expert health professionals, where communication was mostly focused on the technical aspects of breastfeeding. Significantly, women demonstrated a preference for the ‘enabling’ style of communication utilised by peer supporters. This form of support validates the woman’s knowledge base, utilises lay-person language and is based on a trusting relationship (Ahmed, Macfarlane, Naylor, & Hastings, 2006; Battersby & Sabin, 2002; Hannula, et al., 2008; Hoddinott, Lee, & Pill, 2006).

The more recent meta-synthesis by Schmied and colleagues, discussed in the introduction, reflected women’s experience of a continuum of breastfeeding support
from an authentic presence at one end through to disconnected encounters at the other (Schmied, et al., 2010). The nature of the support received was deemed either ‘facilitative’ or ‘reductionist’ dependent upon the style of communication and practices adopted by individuals. Peer support was again rated highly, due to the relationship formation and shared experience (Schmied, et al., 2010).

There has also been qualitative research which has considered the perceptions and experiences of midwives providing breastfeeding support. For example, Furber and Thomson interviewed 30 midwives providing infant feeding support in UK hospitals (Furber & Thomson, 2006; 2007, 2008a, 2008b; 2010). The authors grounded theory analysis revealed the tendency for midwives to engage in deviant behaviour or practices that were contrary to evidence-based guidelines. These practices were adopted when the midwife believed it was in the woman’s best interests to do so. An example of this behaviour was the provision of artificial formula overnight, when the woman was sleep deprived. Midwives described how they chose their words carefully to conceal these deviant behaviours, such as the clandestine ‘special cup feed’ overnight, which was in reality a bottle of formula (Furber & Thomson, 2006:369). The interviews with midwives also revealed the ‘rationing of time’ to survive the busy postnatal ward. This included adopting ‘task orientated’ approaches to care (Furber & Thomson, 2007). Some midwives described their communication style as sensitively enabling breastfeeding initiation and continuation (Furber & Thomson, 2008a). Yet others indicated that they used language to direct a woman’s decision making to ensure compliance with the professional recommendation. The midwives interviewed by Furber and Thomson (2010) acknowledged that they often used language in this way to persuade, manipulate, control and direct women. The authors also noted a level of paternalism in the midwives narratives of women (Furber & Thomson, 2010).

The majority of information gathered, regarding midwives approach to communication with women during breastfeeding, has been collected from the perspective of women’s experience of receiving support. What are missing from the literature are in-depth studies of the interactions or encounters between midwives and women in relation to breastfeeding. In the past two decades only a handful of studies have examined the communication processes, both the verbal and non verbal exchanges, between women and midwives in relation to breastfeeding (Dykes,
Mary Renfrew identified in the 1980s that, despite increasing knowledge around optimal infant positioning and attachment at the breast (Woolridge, 1986), interactions between midwives and women failed to communicate information effectively. Renfrew observed midwife-woman interactions and concluded that staff took control of breastfeeding, focused on the infant’s contribution rather than the woman’s, and assessed ‘correct’ attachment to the breast by visual inspection rather than an assessment of how the woman felt (Renfrew, 1989).

Dykes’ (2006) in her foundational work on ‘breastfeeding in hospital’, undertook observations of midwifery practice in two postnatal units in the north of England. Dykes (2006), similar to Furber and Thomson above, identified ways in which the language adopted by midwives can be used to ‘manage’ women, communicate temporal pressure and focus on the midwife’s agenda rather than the woman’s. She reported that the communication styles of many midwives appeared to silence the woman and elevate the midwife to the role of expert. The power imbalance created in this environment limited opportunities for dialogue and relationship formation between the midwife and women (Dykes, 2006a). Whilst Dykes’ study was focused on the culture of the postnatal hospital ward environment, and women’s experience of breastfeeding in this milieu, it highlighted the importance of individual interactions on a woman’s sense of herself as a mother and her confidence with breastfeeding.

These studies have not specifically examined in-depth, or critically analysed, the interactions or encounters between women and midwives. The work of Fenwick and colleagues (2001) in neonatal nurseries in NSW, Australia, demonstrates the value of audio-recording and analysing the interactions between women and health professionals. Fenwick et al revealed the significant impact of the communication styles of nurses on a woman’s confidence with her infant and her developing sense of self as a mother (Fenwick, Barclay, & Schmied, 2001a, 2001b). Interactions included inhibitive communication styles, which privileged the nurse’s position as the expert in charge of the infant. In these exchanges, the woman was reduced to mere bystander status as the nurse busied herself with the management of care. By contrast, facilitative communication was characterised by social interactions, especially the use of ‘chat’, which Fenwick argued can be used to build positive
relationships and maintain rapport and trust (Fenwick, et al., 2001a:587). The incorporation of chat into the clinical repertoire facilitated dialogue, and built the woman’s self-esteem and confidence with mothering. Fenwick and colleagues (2001) have argued for further analysis of language ‘in use’ in hospital settings, as this is an important clinical tool utilised in the delivery of health care.

An exploration, into the way in which midwives and lactation consultants communicate about breastfeeding with women, is timely. Whilst a great deal is known about women’s experience of breastfeeding support from midwives, and some insight has been gained into midwives’ experiences of providing this support, we know very little about the actual verbal and non-verbal communication used during the provision of breastfeeding support. Midwives have previously identified that they use certain words or phrases to control interactions, and have acknowledged the adoption of deviant behaviours to do what is ‘best’ for the woman or infant. Women describe a feeling of pressure to breastfeed and of midwives controlling breastfeeding. Using discourse analysis to analyse the verbal and non-verbal communication used during interactions, may help to identify the origin of midwifery language and practices and to understand the impact this has on maternal subjectivity. This study will investigate midwifery language and practices ‘in use’ during periods of participant observation and in individual and group interviews. Discourse analysis of audio recordings and observational field notes, will provide a multi-dimensional picture of current midwifery communication styles and practices around breastfeeding. Exploration of the discourses influencing postnatal midwifery practice, will also broaden the scope for analysis. Illumination of the components of midwifery communication which are facilitative, or inhibitive, for ongoing breastfeeding, can highlight areas for improvement. This knowledge can ultimately enhance women’s experience of breastfeeding in contemporary health care environments and inform midwifery education and practice.

2.5. Conclusion

This chapter began with a historical overview of factors associated with breastfeeding. Consideration of the history of breastfeeding, and the circumstances behind the WHO and UNICEF desire to ‘protect, promote and support’ breastfeeding, provides a deeper understanding of contemporary issues around the provision of appropriate support for women. Fluctuations in the status of infant
formula corresponded with changing constructions of breastfeeding, and breastmilk, at the time. The eventual endorsement of breastmilk as the gold standard in infant nutrition, led to the development of global policies to raise national and international awareness. The rationale behind these contemporary global policy initiatives can be understood in the context of historical developments.

An investigation into the language and practices of midwives, during encounters with breastfeeding women, is timely. Personal accounts of breastfeeding distress, discussed in Chapter One, suggest that the language and practices of midwives may influence a woman’s experience of breastfeeding. Unrealistic expectations sometimes clash with the embodied reality of breastfeeding and the availability of appropriate midwifery support is reportedly insufficient. Communication exchanges between midwives and women, during the early establishment of breastfeeding, have the potential to facilitate, or inhibit, a woman’s attainment of breastfeeding goals. Maternal dissatisfaction with breastfeeding support has been well established, yet there has been little corresponding investigation into the actual language and practices adopted by midwives when interacting with new mothers. This study will begin to fill this gap by providing an analysis of midwifery practices and language ‘in use’. In the next chapter, I will present the theoretical underpinnings of the study, and approaches to data collection.
CHAPTER THREE
Exploring Midwifery Language and Practice

3.1. Introduction

In this chapter, I present the theoretical assumptions underpinning this study, the study design and the methods of data collection and analysis. In Chapters One and Two, I have highlighted the need for an investigation into the language and practices of midwives during the first week after birth. Communication exchanges during early breastfeeding have the potential to facilitate, or inhibit, ongoing breastfeeding. In Chapter Two I established breastfeeding as a ‘socially constructed’ human behaviour influenced by public, and professional discourse (Blum, 1993). The practices of midwives are also constituted by social and cultural conditions, and, historical events have shaped the trajectory of breastfeeding and the support role of midwives. Social constructionist epistemology therefore, suited this study. Social constructionism recognises that all ‘reality’ is created by cultural and social processes, which are mediated by language, knowledge, social organisation and power relations (Berger & Luckman, 1966:225). As individuals are historically and socially constituted (Crotty, 1998), so too analysis of human behaviour should be context specific and historically situated.

At the outset, I aimed to uncover the multiple ‘truths’ apparent in midwifery communication around breastfeeding (Crotty, 1998). A rejection of ‘absolute truth claims’ and acceptance of multiple realities, situate this project within a post-structuralist framework (Sarup, 1989). Post-structuralist concepts therefore have informed the design and methodology for this study.

This study utilised critical discourse analysis to examine the language and practices of midwives and to consider the impact of these on women’s experiences and decisions about infant feeding. This approach draws on Foucauldian understandings of discourse, power and knowledge. In this chapter, I will begin with an overview of the theoretical concepts informing the study. I will then describe the study design,
the participants and the multiple forms of data which were collected. This will be followed by a detailed description of the approach to discourse analysis applied to the empirical data. In the last section I have included a reflexive account of some of the challenges which accompanied the collection of this data.

3.2. Power, knowledge and discourse

Various methodological approaches have been utilised to study human actions, interactions, meanings and experiences, depending upon the philosophical foundation, and the belief system inherent within each alternative (Dreyfus & Rabinow, 1983). Structuralism traditionally attempted to define human activity within scientifically derived parameters (Dreyfus & Rabinow, 1983:xix). One of the aims was to discover the common constituents of thought and the structures which governed human behaviour (McHoul & Grace 1993).

Taking a different approach, hermeneutic enquiry sought to derive multiple interpretations from individuals’ lived experiences (Dreyfus & Rabinow, 1983). However, the post-structuralist turn in explaining human behaviour and social organisation, moves beyond these traditional approaches to grapple with power, knowledge and discourse in a new way. Post-structuralists contend that human beings are multi-dimensional entities, influenced by powerful discourses (or ‘bodies of knowledge’ (McHoul & Grace 1993)) and by subtle means of controlling and managing behaviour. Central to a post-structuralist perspective on human behaviour, is the influence of power, knowledge and discourse and the social determinants of each (Singer, 1990; Weedon, 1997).

The design of this study has been influenced by post structural thought and in particular the work of Michel Foucault. Foucault spent most of his adult life exploring questions such as ‘What factors have led to ‘reality’ as we know it? (Foucault, 1972; Sarup, 1989). As a genealogist (who was heavily influenced by Nietzsche), Foucault explored contemporary issues by tracing backwards through history, critiquing as he went. His intention was to locate the multiple ‘historical beginnings’, and eventual convergence, of dominant powerful discourses. In the process he uncovered taken-for-granted assumptions and ‘subjugated knowledges’ (Sarup, 1989:63-4). For example, Foucault argued that since the 16th century, the rise of ‘pastoral power’, and later sovereign or state power, led to discourses which
sought to deny individuality and instead focused on the common good (Foucault, 1983). The emergence of the ‘state’, during the 17th and 18th centuries, became a protective force guarding the welfare of the people and one of the many mechanisms of power over individuals (Sarup, 1989:65). These oppressive, or as Foucault termed them ‘totalising’, forms of power prescribed the subject position of individuals and demanded compliance with established social order (Foucault, 1983:213). The crucial element here is not the structure of state power itself, but rather, the emergence of powerful discourses, laws and institutions which subsequently produce and reproduce hegemonic forms of knowledge (Sarup, 1989).

Thus, post-structuralist conceptualisations of power extend beyond merely physical forms to incorporate the multiple forms, and faces, of power influencing the behaviour of individuals in predictable and determined ways. Knowledge is conceptualised as a form of power that one can use over others which in this way becomes a mode of ‘surveillance, regulation, [and] discipline’ (Sarup, 1989:73). According to Foucault’s early work, ‘power produces reality’ via the internalisation of dominant discourses which seek to subjugate the individual (Sarup, 1989:82). Disciplinary power therefore, which emanates from superior knowledge claims, can produce a submissive subject position, whereby the individual becomes complicit in their own surveillance and control (Sarup, 1989). Individuals become ‘self-governing’ subjects who monitor and control their own behaviour to ‘fit’ within the social constraints (Foucault, 1977). This was particularly well illustrated in Foucault’s work on prisons and the notion of the Panopticon (Foucault, 1977).

Theoretical concepts, such as those articulated by Foucault, have been applied to breastfeeding research in the past. Some good examples can be found in the recent work of Payne and Nicholls (2010) and Ryan and colleagues (2010). Payne and Nicholls (2010) utilised a Foucauldian framework to demonstrate the ‘disciplining of the self’ which breastfeeding women undertake when combining breastfeeding and work. Maintaining compliance within dominant workplace parameters saw breastfeeding women engage in behaviours which concealed their breastfeeding status, in favour of maintaining worker conformity (Payne & Nicholls, 2010). Juggling the subjective identity of ‘good mother’ and ‘good worker’ led women to restrain breastfeeding activities and, in so doing, succumb to dominant discursive constraints (Payne & Nicholls, 2010).
Similarly Ryan and colleagues incorporated Foucauldian concepts into their analysis of the narratives of breastfeeding women. The authors identified ‘punishing discourses’ which contributed towards the ‘moral work’ women engaged in around breastfeeding, and the subsequent creation of a mothering subjectivity (Ryan, Bissell, & Alexander, 2010). Punishing and liberating discourses, such as those described above, can be made visible through an examination of language and practices, each of which are influential in shaping an individuals’ own sense of themselves.

3.2.1. Language and subjectivity

The origins of language and discourses (Crotty, 1998:204) and the construction of the ‘self’ are each crucial in understanding human behaviour. The ‘self’ is believed to be constituted both ‘within talk’ and within social contexts (Rose, 1996:175). Rose asserts human beings are an ‘historical and cultural artefact’ (1996:22) whose notions of self are dependent upon reflexivity and can be shaped and moulded over time in response to dominant and marginal discourses (Lupton & Barclay 1997:18). The shaping of an individual’s subjectivity therefore occurs through a dynamic interaction between language and discourses (Lupton & Barclay 1997:8-9).

Language is a system through which meaning and reality are created and reproduced (Weedon, 1997). In this way, communication from one individual to another cannot merely be defined as ‘information transfer’ but rather as the process of shaping two personas and subjectivities (Lupton & Barclay, 1997:9). Subjectivity can be defined as one’s sense of self in relation to the world mediated by individual thoughts and feelings about oneself, and others (Weedon, 1997:32). Lupton and Barclay describe subjectivity as “…varying forms of selfhoods by which people experience and define themselves” (1997:8). Subjectivities are formed within language (Davies et al., 2006:90) and are continually evolving in response to our own individual interpretation of discourses, language and practices ‘in use’. Hence, subjectivity is not something ‘we are born with’ but rather something which we continue to develop over time (Davies, et al., 2006; Hollway, 1989; Lupton, 1995; Weedon, 1997).

The language used to promote and portray infant feeding can provide insight into the cultural norms of our society. Sociocultural, professional, and public health discourses influence the subjective experience of breastfeeding (Bartlett, 2005; Blum, 1999; Hausman, 2003). Whilst discourses emerge from a variety of sources,
individuals often judge their importance according to an assessment of the source (Fairclough, 1992; Foucault, 1972; Lupton & Barclay, 1997; Parker, 1992).

Consideration of the particular words, phrases and metaphors women use can enhance our understanding of the ways in which women are influenced by, and are ‘adapting’ to, social, cultural and institutional systems (Anderson & Jack, 1991:19). More significantly, an examination of the words, phrases and metaphors used by midwives and lactation consultants, during the early establishment of breastfeeding, will provide a greater depth of understanding regarding the discourses influencing midwifery and lactation consultant language and practices. Knowledge is transferred through language, therefore an examination of language ‘in use’ can be suggestive of constitutive factors. Post-structural and Foucauldian concepts, such as the construction of knowledge, the use of powerful discourses, and the subsequent influence on individual subjectivity, have informed the methodology for this exploration of communication exchanges (Crotty, 1998; Macnaghten, 1993; Mills, 1997).

3.2.2. Discourse and power

Central to this study is an appreciation of discursive influences on individual subjectivity. Discourses have been described as ‘bodies of knowledge’ where language is considered a ‘social and political entity’ which can create as well as represent reality (McHoul & Grace, 1993:4&13). Foucault extends our collective understanding of discourse to include not only the bodies of knowledge represented in discourses but also the ‘disciplinary practices’, or forms of social control and social possibility, which accompany discourse (McHoul & Grace, 1993:26). Foucault asserts that, “… in every society the production of discourse is at once controlled, selected, organised and redistributed…” according to certain parameters (Foucault, 1972:216).

Contemporary understandings of discourse and the conceptualisation of ‘discursive formation’ has been informed by interpretations of Foucault’s theories (Freundlieb, 1994). For example, Foucault demonstrated that discourse was not merely “…an obscure web of things”, instead he revealed the ‘rules’ which influenced discursive practices stating “…these rules define not the dumb existence of a reality…but the ordering of objects…[and] practices that systematically form the objects of which
they speak…” (Foucault, 1972:48-9). In this way, language formation during interactions can be viewed as more than individual compilations, but rather reflecting and creating wider discourses (Freundlieb, 1994).

Foucault differentiated between external rules and systems of discursive exclusion (such as institutional or state governance) and the internal rules where discourse gains legitimacy via commentary (Foucault, 1972:220). In this manner, discourses can be seen to be generated from a ‘primary text’ and then reinterpreted into ‘secondary texts’ via communicative interaction. Foucault asserts:

...the top heaviness of the original text, its permanence, its status as discourse ever capable of being brought up to date, the multiple or hidden meanings with which it is credited, the reticence and wealth it is believed to contain, all this creates an open possibility for discussion (Foucault, 1972:221).

It is within the discussion that new and competing discourses are generated and take form. Yet, some discourses are suppressed due to social constraints or the marginalisation of the source, for example the discourses espoused by the ‘mad’ (McHoul & Grace, 1993), or indeed by pregnant or breastfeeding women. The rules controlling discourses create the conditions within which certain bodies of thought can be shared, and by whom. The social ‘label’ ascribed to the speaker can qualify (or not) their authority to produce and disperse certain discourses. The power of the discourse therefore, resides with the legitimacy of the speaker (Foucault, 1972). For example, as Foucault articulated in the *Archaeology of Knowledge*:

Medical statements cannot come from anybody, their value, efficacy, even their therapeutic powers, and, generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them, and to claim for them the power to overcome suffering and death (Foucault, 1972:51).

Foucault was acutely interested in analysing institutional sites of knowledge and discourses which he termed “…the objects and instruments of verification” (Foucault, 1972:51). Foucault’s interest in ‘disciplinary power’ centred around the mechanism of power and authority in society. He identified three ways in which human beings were made ‘subjects’ through powerful institutional and disciplinary discourses. The three modes of ‘objectification’, articulated by Foucault, were firstly, “dividing practices” such as institutional exclusivity, secondly, “scientific classification” of human conditions, and thirdly, “subjectification” of the individual
(Rabinow, 1984:8-11). Foucault articulated the ways in which disciplinary power ‘objectified’ the individual, creating certain conditions for subjectivity.

From a sociological perspective, dividing practices have been used to denote, categorise and order human beings (Rabinow, 1984). Foucault’s most famous pieces of work in this area include the titles *Madness and Civilisation*, *The Birth of the Clinic* and *Discipline and Punish* (Foucault, 1967, 1975, 1977).

In each of these monographs, Foucault charted the discourses used to control and dominate groups of individuals such as the psychiatrically ill, the sick and criminals. These groups were created by, and identifiable by, the very dividing practices used to control them, such as inmates in prison, or mentally ill clients in the mental health institution (Rabinow, 1984). In this light, Foucault’s genealogical work has drawn attention to some of the powerful discursive influences on individuals living within oppressive, and non-oppressive, social conditions. Applying some of Foucault’s concepts to this study of women entering the spatial confines of an ‘exclusionary’ hospital environment, might highlight some taken-for-granted assumptions and practices in this milieu.

The second approach to objectification, articulated by Foucault, involved the construction and constitution of disciplines such as ‘science’ and ‘medicine’ and the resulting powerful discourses emanating from these organised ways of viewing ‘life, labor and language’ (Rabinow, 1984:9). Foucault acknowledged that these discourses could be amended over time but their powerful constitutive effect on human behaviour confirmed the objectification inherent in their existence (Rabinow, 1984). Careful examination of the historical conditions within which contemporary maternity practices can occur, highlights the discursive influence of medicalised scientific discourses, on the hospital environment, and also the practices of clinicians within this milieu. A genealogy of the powerful influences on maternity hospital practices can be linked to discourses of science, medicine and the economy.

The third mode of ‘objectification’, articulated by Foucault, captured the internalisation of discursive and non-discursive practices by individuals. This internalisation resulted in self-monitoring of thoughts and behaviour to maintain consistency with the expectations of various ‘subject’ positions. In hospital environments this can result in the adoption of an identity as ‘passive patient’
awaiting curative treatment from the health professional. The submissive and confined subject fulfils the aims of objectification by contributing to their own ‘surveillance’ of the self. Individuals as ‘subjects’ engage willingly in monitoring and adapting their own behaviour to maintain social order. This was aptly demonstrated in the work of Payne and colleagues presented earlier, where breastfeeding workers monitored their own activities to maintain alignment with ‘good worker’ status (Payne & Nicholls, 2010). When individuals engage in this type of self-governance, established power and control structures can be maintained (Rabinow, 1984). Whilst Foucault acknowledged a variety of alternative subject positions, such as “the questioning subject”, the “listening subject”, the “seeing subject”, and the “observing subject”, he postulated that each was dependent upon the situational possibilities within a discursively formed grid (Foucault, 1972:52). In other words, as Freundlieb described it, “[S]ubjects only have the amount of freedom that the system of rules make available” (Freundlieb, 1994:174).

Herein lies one of the many criticisms of Foucault’s work: his lack of acknowledgement of the relation between discursive and non-discursive practices and his disregard of gender and human agency (Bartky, 1988; Bordo, 2003; Freundlieb, 1994). Foucault saw power as a multifaceted force continually impacting upon, and being resisted by, the discursively formed individual rather than a force within which the individual had autonomous freedom to manipulate (Rabinow & Rose, 2003). Foucault’s later work included an analysis of the “technologies of the self” and the rise of “bio-power” as forms of social management (Sawicki, 1991). Whilst in his most recent work, The History of Sexuality, Foucault acknowledged the need for an analysis of discourses and practices governing the female body, he did not specifically consider female subjugation in his exposé of power and the sexual body (Foucault, 1988).

Despite these shortcomings, Foucault’s analysis of discourse, power and knowledge has applicability for this contemporary analysis of human behaviour (Rabinow & Rose, 2003). In terms of the objectification of individuals, the hospital environment is a ‘dividing practice’, where the tenets of ‘science’ and ‘exclusion’ are combined with spatial manipulation of behaviour. There is a large body of work critiquing the use of ‘scientific discourses’ to control and modify the behaviour of women, within health care paradigms. Authoritative knowledge, which health care practitioners are
deemed to possess through the social privileging of certain forms of knowledge, ultimately subjugates individuals and ensures compliance with procedures and recommended practices (Davis-Floyd, 2001; Davis-Floyd & Sargent, 1997; Jordan, 1993; Katz Rothman, 1982). The applicability of Foucauldian concepts to the exploration of discourses and customs within regulated institutions, and the origins of power and the subject, have also been demonstrated by others (Bartky, 1988; Dykes, 2006a; Lupton, 1995).

Beyond the institutional sites of discourse, Foucault’s later interest in the ‘body’, and ‘bio-power’, extends our understandings of the pervasive influence of health care discourses. According to Foucault, bio-power was linked to the rise of capitalism and resulted in the “…insertion of bodies into the machinery of production” (Foucault, 1988:141). In this way the ‘body’ is understood to be a site which is inscribed with power relations and which can be read as a discourse.

Foucault identified forms of power, which directed perceptions of the body, such as ‘disciplinary power’, where the body was positioned as a machine, bound by preset performance criteria. In addition, ‘regulatory power’ was used to govern and manage the whole of the population, or ‘species body’ as Foucault termed it (Sawicki, 1991:67-8). Contemporary strategies utilised to organise this species body include public health surveillance, assessment, monitoring and intervention (Foucault, 1988; Sawicki, 1991). The medicalisation of women’s bodies for the benefit of children, the family, and society, has become an integral component of the ‘management of life’ which bio-power represents (Foucault, 1988:147). Analysis of disciplinary control and regulatory power in institutional and professional health discourses may provide insight into the performance of breastfeeding, and breastfeeding support, in this milieu.

Foucauldian concepts have informed methodological approaches which seek to explore power and discourse in contemporary reality. Foucault is considered “one of the theoretical godfathers of critical discourse analysis”, which is the method of data analysis used in this study (Wodak & Meyer:10). Critical discourse analysis is an approach which focuses on an examination of power and on the ways in which discourses reproduce social reality (Phillips & Hardy 2002; Wodak & Meyer 2009). It incorporates a Foucauldian understanding of discourse (Jager & Maier 2009). Multiple forms of data are therefore required to provide both textual and social
practice clues to the nature of the discourses drawn upon during interactional exchanges. The next section of this chapter will describe the study design and data collected, followed by a more thorough explanation of the approach to critical discourse analysis used.

3.3. Study Design

This study seeks to explore discourses and rituals apparent in midwifery practice during the first week after birth, as well as the subject positions taken up by both women and midwives during this period. As I have detailed here, the design of this study has been informed by social constructionism and Foucauldian concepts. The collection of empirical data for analysis took approximately 12 months of ongoing engagement with, and presence within, two midwifery communities. In order to gather data that would allow the identification and analysis of a range of contemporary discourses, I utilised some of the principles of participant observation. These have been described in the last section of this chapter.

This study was conducted at two hospital sites and the methods of data collection were deliberately identical at both. However, my experiences as a midwife researcher, entering two different maternity units, highlighted some of the advantages and disadvantages of professional insider belonging. In a reflective account I have detailed the process of gaining entry and negotiating a presence at both sites. These ethnographic reflections are described in the final section of this chapter. In the next section of this chapter, however, I outline the study setting, the ethical considerations, the study participants, data collection and the methods of data analysis.

3.3.1. Study setting

This examination of breastfeeding interactions was conducted during 2008–2009 and was funded by an Australian Research Council Linkage grant, in partnership with two participating Area Health Services (AHS) in NSW, Australia. The two hospitals were chosen based on established research links with key stakeholders at each hospital. Both hospitals were publicly funded and offered general, and specialist, medical, surgical and paediatric health services along with maternity services. Each maternity unit was obstetric consultant led with similar caesarean section rates of approximately 26% (Centre for Epidemiology and Research, 2009b). Maternity unit
A (MUA) was part of a smaller ‘general’ teaching hospital (Level 4 Neonatal Intensive Care Unit (NICU)) which had less than 3000 births per year. Maternity unit B (MUB) was situated within a larger tertiary referral teaching hospital (Level 6 (highest) NICU) with less than 4000 births per year (Centre for Epidemiology and Research, 2009b).

During the period of data collection MUA had 24 antenatal/postnatal hospital beds and a well-established seven day per week maternity support-at-home service, as well as a continuity of caregiver midwifery service for women who met preset criteria. According to data published in 2009, the average length of postnatal hospital stay was under three days (Centre for Epidemiology and Research, 2009b), however, staff commented that the current length of hospital stay, for most women, was much shorter than this. At the time of data collection, the staffing mix consisted of regular permanent midwifery staff as well as relocated midwives from a smaller satellite unit. This was welcomed by most staff at MUA, as the unit was in a staffing deficit of eight full-time equivalent midwives.

The physical layout of the postnatal ward, at MUA, included a central work station where an administrative clerk, midwives, and other health personnel, gathered to record notes and follow-up on clinical results on the ward computers. This workstation was ‘a hive of activity’ always populated with workers completing various tasks. Visitors seemed to approach this desk area often, to ask where their family member or friend was located. The ward had a mixture of antenatal and postnatal rooms which flanked the central work station, and which could be pictorially represented by the shape of a U. Four of the two- and one-bedded client rooms were able to be viewed from the workstation. Despite the fact that all of the rooms had doors which could be closed, most of the doors remained open. Visiting hours were unrestricted at this maternity unit and there was a constant flow of people into and out of the ward, during the daylight hours.

The two hospitals were located in different area health services in NSW, Australia. The area surrounding MUA was characterised by higher numbers of people born overseas, living in public housing, employed in clerical and trade work, and higher proportions of one parent families when compared to the geographical area encompassing MUB (ABS 2007). The women who accessed both hospitals were predominantly English speaking.
MUB is a large tertiary referral teaching hospital and the largest trauma centre in the region. During the period of data collection the maternity unit had 45 designated postnatal beds and a separate maternity support-at-home service and caseload midwifery services. The average length of hospital stay was 3.3 days (Centre for Epidemiology and Research, 2009b). In comparison to MUA, the staffing at MUB was optimal. Midwives had access to additional personnel during the postnatal period. Staff had access to a supernumerary senior midwife or ‘team leader’ on morning and afternoon shifts, and a supernumerary lactation consultant was available during office hours seven days per week.

The ward area at MUB was specifically reserved for postnatal women and consisted of two long corridors with predominantly four-bedded rooms, and several one-bedded rooms, branching off in opposite directions from a central communal reception area. Within this central area was a reception desk and ward clerk who provided information to visitors and staff. The reception area also included a large whiteboard which detailed the location of ‘patients’ and which enabled visitors to self-locate their family or friend. This communal area also had a large parenting/breastfeeding room and a designated staff work area. Within this central workspace, midwives and lactation consultants conducted their written and computer tasks and engaged in clinical discussions with colleagues. Three separate hospital midwifery services also utilised this work area, as well as medical and allied health personnel. Consequently, there was a lot of traffic through and around this area. The two corridors leading to the ‘patient’ bedrooms however, had a door, which remained closed during the designated ‘rest period’ and visitors were denied access during this two-hour period. These doors were also noted to be closed at other times, which seemed to limit the noise and unnecessary traffic into and out of these corridors.

MUB was also Baby Friendly Hospital Initiative (BFHI) accredited (in 2007) and was the only hospital in this respective AHS to have achieved this status. Of note, MUA was not BFHI accredited, nor were there plans to seek BFHI accreditation during the data collection phase of this study, however, one hospital in this AHS had recently gained BFHI status.

The NSW population health survey results, published in 2008 (for the years 2005-2006), revealed that the area within which MUB was situated had a higher than State average breastfeeding initiation rate at 96.1% and a significantly higher number of
infants who continued to receive breastmilk until at least 12 months at 40.2% (CER 2008:18-19). The specific rates for the area which encompassed MUA were not reported in the Centre for Epidemiology and Research report in 2008 however, the breastfeeding initiation rates from the 2001 population health survey were reported at 82.6% and the percentage of infants receiving breastmilk at 12 months of age was 19.1% (NSW CPHN 2006:15&17). According to the population health survey, these results reflected current percentages due to minimal fluctuation in breastfeeding rates between the years 2001-2006 for this AHS (CER 2008:19).

Interestingly, the most recent population health survey results have painted a different picture with regard to breastfeeding initiation and duration rates in these two respective area health services. The 2010 population health survey results (for the years 2007-2008) reveal a drop in the breastfeeding initiation rates at the area health service encompassing MUB from 96.1% to 85.2%, and a rise in the initiation rate in the area health service to which MUA belonged, from 82.6% to 91.3%. The duration of breastfeeding at both sites showed a similar trend. The AHS where MUB was situated, had a 27.7% rate of breastfeeding duration to 12 months, compared to 34.4% at the area health service where MUA was located. The exact initiation and duration rates for each of the individual hospitals in this study cannot be extrapolated from these statistics as the figures refer to combined health service rates in each AHS, rather than individual hospitals per se. Across Australia, the definition of exclusive, partial or full breastfeeding differs making inter-hospital, and interstate comparisons difficult. Currently, there is no standard point in time when breastfeeding data is consistently collected and no standardised method of doing this.

The recent Australian Breastfeeding Strategy has prioritised this as an area in need of further development (Australian Health Ministers' Conference, 2009). What these rates do reflect however, is the decline in breastfeeding duration at both area health services, even with contemporary BFHI discourses embedded into area policy.

It is important to highlight at this point that the two hospitals included in this study were not chosen for the purposes of making comparisons between BFHI, and non-BFHI, accredited institutions. Rather, the inclusion of two geographically distant hospitals for the observation of discursive activity around breastfeeding, was for the purposes of capturing the breadth of midwifery language and practice, around breastfeeding, and thus to add depth to the study.
3.4. Ethical Considerations

Human Research Ethics Committee (HREC) clearance, granting approval to access the participating institutions and conduct the research, was obtained from the participating Area Health Services, as well as the University of Western Sydney. Approved statements, inviting midwives and women to participate in the study, can be found in Appendix 2. Participant Information Statements, outlining the privacy issues, the purpose of the study and the risks and benefits of participation, are also available at Appendix 3 along with a sample of consent forms (Appendix 4). The following section details the recruitment procedure and ethical considerations for this study.

3.4.1. Recruitment procedure

Following HREC clearance, at both sites, I attended staff meetings several months in advance of the commencement of data collection. I became a familiar face during this time, as I sought to establish rapport with key midwifery informants at each site.

I provided written invitation letters to all of the midwives at the respective maternity units and placed laminated photo-style posters, accompanied by ‘expression of interest’ forms, in the staff ‘tea rooms’. In the weeks prior to planned data collection, I scheduled meeting times with staff to explain the project in person and to answer any questions that midwives may have had. Those who expressed an interest in participating in the study were approached at a later date, to schedule an observation shift. Midwives were reminded that they could withdraw from the study at any time without consequence and that the data were confidential and would be de-identified from the outset.

This study was an exploration into the language and practices adopted by midwives therefore, in the first instance, ethical consent for participation was sought from individual midwives. Midwives who agreed to participate were then asked to nominate a day for observation. I accommodated the midwives’ preferences, which included observation across morning, afternoon and night shifts. Given the need to observe interactions with women, this was followed by a period of identification of potential participants for interaction around breastfeeding. Midwives identified women, from their allocated number, who were currently breastfeeding and who may require assistance during the shift.
I approached the women in each midwife’s allocation and explained the study, inviting them to participate. I subsequently provided all of the women I approached with a participant information statement and answered any questions they may have had. I then returned approximately 30 minutes later to answer any further questions and ask if the woman would like to consent to participate in the study. Of the women approached (approximately 90), only one woman declined to participate. I reassured participants of the strict privacy and confidentiality requirements of this study and reinforced the fact that participation was completely voluntary, and that withdrawal from the study could occur at any time without consequences. Women were also asked to indicate, on the consent form, whether they would be prepared to participate in an interview following discharge from the service, at a time and place convenient to them. Most women indicated a willingness to participate in this component of the project.

Antenatal parenting education classes were also observed for this study. In this instance, women and their partners were provided with participant information statements one week prior to the proposed class. At the commencement of each session women and their partners were provided with an opportunity to ask questions about the study and decide whether or not observation of the class was acceptable.

A description of the purpose of the study, and the reasons for observation, were presented. I stressed the voluntary nature of participation and withdrawal at any stage without consequence or question. All of the groups approached provided permission to observe their class. Consent forms were signed, and participants were reminded that they could withdraw consent at any time, without repercussion.

A similar procedure was followed during the collection of focus group interview data. Some of the midwives included in focus groups had already participated in the observational component of the study. Post-discharge interviews with women, as well as the interviews with senior staff, included a period of discussion about the purpose of the study and the provision of participant information statements, before written consent was sought.

3.4.2. Ethical protocols

Prior to the commencement of data collection, a ‘project steering committee’ was established between the researcher, midwifery manager, midwifery consultant, and
clinical midwifery specialist from the ward. This committee was established in advance to ensure ethical standards were maintained in the event of observation of ‘dangerous’ or ‘neglectful’ practice. This committee was utilised once during the data collection period, when the dangerous ‘practice’ issue observed was resolved whilst preserving the privacy and confidentiality of the particular individuals observed.

The audio-recording of interactions between women and midwives in ‘public’ facilities posed several ethical dilemmas. For example, in most instances women shared a room with 1-3 other women. In these instances, I sought permission to audio-record from the roommates also. I stipulated that the audio-recorder would be unlikely to pick up conversations beyond the two-metre radius between beds. Nevertheless, it was important to be upfront about the recording in a shared room. Occasionally, on recorder play-back, there were muffled voices and babies crying from the adjoining bed, but this was not audible enough to be understood. Women unanimously agreed to audio-recording in shared rooms. In addition, I placed a sign outside the room to notify visitors or staff, who may subsequently enter the room, that audio-recording was occurring. Often staff and visitors did not read the sign and my voice can be heard on the recorded interactions as I explained to midwives, or visitors, who had arrived during an interaction, that I was audio-recording.

Data collection for this study proceeded without any ethical infringements. Standards of data collection were meticulous and data de-identified from the outset. Aside from focus group and antenatal group participants, each and every participant was allocated an individual code. Information detailing the link between an individual’s name and their code was stored on an Excel spreadsheet which has been password encrypted. Observational tools, field notes and recorded observations were similarly de-identified. All recorded data and signed consent forms have been stored at the University of Western Sydney in a locked cabinet. Regular reporting of the progress of this study has been provided to the relevant ethics committees throughout the data collection phase of this project.
3.5. Study Participants

3.5.1. Midwives, student midwives and lactation consultants

Midwives who were interacting with breastfeeding women on the postnatal wards at both units were included in the study if they expressed an interest in participating. Student midwives were also included if they volunteered to participate, as it was believed they would provide the most recent example of contemporary professional discursive constructions of the breastfeeding support role in tertiary hospital settings. For the remainder of this thesis, student midwives will be included in the descriptor ‘midwife’ as only three student midwives were included in the total study data set.

Thirty-six midwives participated in the postnatal observational component of this study and 11 senior midwives participated in an interview. At MUA, four of the 18 participating midwives had lactation consultant education whilst at MUB 10 of the 18 participating midwives had additional lactation consultant skills. The average years of midwifery experience at MUA was 12, and at MUB midwives had on average 15 years of experience. The range of midwifery experience spanned from a one-year Bachelor of Midwifery student through to a lactation consultant with 43 years of midwifery experience. A full breakdown of the years of experience can be found in Table 2. All of the lactation consultants in this study were also midwives so, these practitioners will be grouped together with the term ‘midwife’ unless a specific point about lactation consultant practice is being made.

Table 2: Demographic summary – Midwives

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>MUA</th>
<th>MUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student midwife</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Midwife</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Midwife with LC qualifications</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Part-time</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 5 years</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>6-10 years</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>11-20 years</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>21-30 years</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>&gt; 30 years</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total number midwifery Participants</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>
3.5.2. Women

On the postnatal ward, women were included if they were aged 16 or over, could understand written and verbal English and were currently breastfeeding. Exclusion beyond these stipulations only occurred if the infant was in the neonatal intensive care unit at the time of observation. In total, 77 women participated in the observation of breastfeeding interactions and 23 of these women also participated in a follow-up interview, approximately 4-6 weeks after discharge. Of the 77 women included, 45 were breastfeeding their first infant and 32 were breastfeeding a subsequent child. In total, 74 women had singleton births whilst three had twin births. The birth history for participating women included 49 normal vaginal births, three forceps births and 25 surgical births (see Table 3).

Commensurate with the data presented earlier, the proportion of postnatal participants born in a country other than Australia was 37% at MUA, and 19% at MUB. Socioeconomic status was determined from information about the highest level of educational achievement. At MUA, almost one third of the participants (31%) had completed less than six years of high school, whilst at MUB, this was one quarter of participants (26%). This demographic profile data mirrors the Australian Bureau of Statistics snapshot provided earlier for these AHS localities, and is consistent with demographic expectations for those regions.

Table 3: Demographic summary – Women

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>MUA</th>
<th>MUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiparous</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Primiparous</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td>Mode of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>Instrumental</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Operative</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 20 years of age</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>20-29 years of age</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>30-39 years of age</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>40 years of age and over</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>22</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Educational attainment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 years of high school or less</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>6 years of high school or less</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Further education – technical</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Further education – university</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>42</td>
</tr>
</tbody>
</table>
3.5.3. Participants in childbirth education

The observation and audio recording of parenting education sessions captured the language used during the promotion and discussion of infant feeding during pregnancy. This complemented the postnatal data set and was a supplementary aspect of this study. In total, 122 pregnant women and their partners consented to the observation of parenting education sessions and nine parenting educators volunteered to have their breastfeeding education session observed and recorded. I did not collect demographic data from this group of participants, as the focus was on the language and practices utilised to describe and promote breastfeeding in the antenatal period. Each of the observed presenters was a senior midwife working within the respective maternity units in a midwifery role.

3.6. Data Collection

3.6.1. Observations and audio-recordings of midwife-woman interactions

In total, 85 face-to-face interactions, between women and midwives during breastfeeding support, were observed and audio-recorded, and transcribed verbatim by a professional transcription service. I subsequently carefully checked the transcripts for accuracy and amended incorrect transcription. The total number of audio-recorded hours of midwife-woman interactions was 33, which included interactions ranging in length from as little as 30 seconds to as much as 55 minutes. The average length of an interaction around breastfeeding was 14 minutes at MUA and 33 minutes at MUB. Interactions were observed, and audio-recorded, in the home (n=20), and on the hospital postnatal ward (n=65). At both sites, a total of 10 interactions were collected in the woman’s home. The average length of time spent on a home visit was similar across both sites.

At MUA, 12 of the observed interactions were with midwives who had acquired lactation consultant qualifications. Whereas at MUB, 29 of the interactions were with midwives who had additional lactation consultant qualifications, which is commensurate with the level of additional LC qualification noted at this unit at the outset. Of the 64% (n=29) of interactions between lactation consultant midwives and women, at MUB, 38% (n=11) were working in a designated lactation consultant role during the recorded observation. Table 4 provides summary characteristics of the
interactions observed. Later in this chapter, I will outline in detail my experiences in negotiating the collection of this data.

Table 4: Interaction Summary

<table>
<thead>
<tr>
<th>Characteristics of Interactions</th>
<th>MUA</th>
<th>MUB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife/Student</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>LC</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Designated LC Position</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Home</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Time spent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 10 mins</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>11-20 mins</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>21-30 mins</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>&gt; 30 mins</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total number of Interactions</strong></td>
<td>40</td>
<td>45</td>
</tr>
</tbody>
</table>

3.6.2. Interviews with women

Following observation and recording of the language and practices adopted by midwives in the first week after birth, both in hospital and home environments, it was important to gain an insight into the perspectives of both contributors to the interaction: the midwife and the breastfeeding woman. During the consent process for face-to-face interactions, permission was sought for participation in an audio-recorded interview following discharge from hospital. Most women agreed to have a follow-up interview. Consent forms, which indicated permission for follow-up interview, were grouped together at this stage. Random selection for interview followed. Women were contacted via the telephone number they had provided and asked again if they would be interested in participating in a follow-up interview. If agreeable to an interview, the woman then nominated a suitable location and time.

One woman requested an interview ‘on the spot’ (on the ward) as she had several experiences she wanted to share and was travelling overseas after discharge. This request was accommodated. A total of 21 interviews were conducted in the homes of participating women, approximately 4-6 weeks after discharge, at a time convenient to the woman. One interview was conducted via telephone. In this instance the woman had to reschedule our arranged appointment time and preferred to conduct
the interview by telephone, rather than reschedule an alternative time for a face-to-face meeting. The average length of interview was approximately 30-40 minutes.

Interviews focused upon the women’s experiences of health professional support during the first week after birth. Interview discussion starters included, “Cast your mind back to your early experience of breastfeeding, in particular during the first week after birth, can you tell me about your experience of commencing breastfeeding”. Women were often keen to talk about their early experiences and at times launched into the discussion before I had a chance to switch on the recorder and finalise the introductory formalities. Overall, women tended to speak about their experiences of positive support, and helpful staff, before indicating any degree of dissatisfaction with certain staff members and/or the lack of availability of health professional support.

3.6.3. Interviews with senior midwives

Prior to exiting the field, at each site, I collected individual ‘consensual’ interviews with senior members of the postnatal ward team. These data were gathered to gain an insight into the organisational facilitation, or hindrance, of optimal breastfeeding support. In total, 11 interviews were conducted with senior staff, including managers, midwifery educators, senior lactation consultants and senior clinicians. The interviews ranged from 23 minutes to 70 minutes depending on the staff member’s availability. Interview starters included, “As a key person in the organisation, what do you see as the priorities for postnatal care in the first week after birth?” Later in the discussion I asked questions about the implementation (or not) of the BFHI. These interview data provided greater depth of understanding about the managerial and organisational factors impacting upon the provision of postnatal breastfeeding support. All interviews were transcribed verbatim.

3.6.4. Focus groups

I also arranged two focus groups at each hospital and invited midwives from each maternity unit to attend to ‘have their say’ and ‘tell it like it is’ when supporting women who were establishing breastfeeding. I placed posters in the staff tearoom and (strategically) in the toilet/change room area, to ensure as many midwives and lactation consultants as possible were aware of the focus group dates and times. I emphasised on the posters, and to attendees, that the focus group would be conducted
according to strict ethical guidelines and individual participants would not be identifiable. The focus group data were referred to simply as focus group 1, 2, 3 or 4. I provided afternoon tea at all focus group interviews as midwives were asked to attend the focus group during their 2-hour staff overlap in the afternoon, which was traditionally when staff attended in-service and had afternoon tea. As staff mingled at the beginning of the focus group, I endeavoured to create a comfortable atmosphere by welcoming staff into the room and inviting participants to help themselves to refreshments. The formalities included providing information about the purpose of the focus group and answering questions, before ensuring all participants signed the consent form before audio-recording commenced. Each focus group had between 5-15 participants and discussion starters included, “How would you describe your role in postnatal care” and “Can you tell me five main things that you think about when providing postnatal care” or “How would you describe working in postnatal care”. Discussion was generated naturally during the focus groups and midwives and lactation consultants, at both sites, seemed comfortable to put forward their own ideas, even if they were different to the majority opinion. There were however, also many moments of ‘head nodding in unison’ when a statement made by one individual was validated by the majority. The focus group interviews lasted approximately one hour and were again professionally transcribed verbatim and checked for accuracy.

3.6.5. Field notes
At the conclusion of each period of observation, I collected field notes on my experiences and observations. This included a comprehensive record of the observation of staff behaviour around the desk area and throughout the shift. The general activity, or inactivity, on the ward on particular days was captured in this way. At times, on the trip home from data collection, I audio-recorded my field notes and personally transcribed them at a later date. These data were always de-identified and stored alongside the recorded data, in a locked cabinet at the University of Western Sydney.

My field notes represented a useful reference point for clarifying the order of interactions and providing contextual information. I also enlisted an observational guide for the documentation of specific practices during each individual interaction. This captured any non-verbal exchanges, the use of touch and body language, the
demeanour of the midwife and the woman, infant behaviour, initiation and closure of the interaction and the outcome of each interaction. An example of this observational guide can be found in Appendix 5. This structured form of note-taking formed an integral component of the ‘analytical log’ and complemented my ‘personal log’ (Minichiello, Aroni, Timewell, & Alexander, 1990) collected at the end of each period of data collection.

3.7. Analysing Discourse

Discourse analysis offers a window into the communication between individuals, in this case, midwives and women around the sociocultural practice of breastfeeding. It represents a ‘new way’ of analysing the use of knowledge and power during these interactions (Phillips & Hardy, 2002:59). As argued previously, discourse analysis is much more than simply an analysis of ‘language in use’, but necessarily encapsulates language as representative of social and cultural reality, as well as the analysis of non-verbal practices (Jaworski & Coupland, 2006). Scholars such as Habermas and Pêcheux, in addition to Foucault, have contributed to contemporary understandings of discourse (Abell & Myers, 2008; Jaworski & Coupland, 2006; Mills, 1997; Phillips & Hardy, 2002).

As a method, the analysis of discourse has moved beyond scrutiny of the spoken word, or the structure of conversations, to incorporate the social aspects of discourse (Jaworski & Coupland, 2006; Mills, 1997). The inclusion of ‘discourse practices’ such as ‘embodied’ and ‘physical systems of representation’ for example, signs, symbols, iconography or paintings (Jaworski & Coupland, 2006:7), as well as other aspects of performance, increases the utility of this method for analysing interactions in institutions.

In this study, the approach to analysis stems from the work of Fairclough, and to a lesser extent van Dijk and Wodak, whose methods of discourse analysis include consideration of the central concept of power and the socially constitutive effect of discourse upon reality (Dijk, 2009; Fairclough & Wodak, 1997; Wodak & Meyer, 2009). This style of analysis has been termed ‘critical discourse analysis’ due to the focus on power and control. Building upon the work of Foucault, and other post-structuralist thinkers, critical discourse analysts perceive discourse as firstly contributing to the broader societal ‘consciousness’ and individual subjectivities and
then secondly determining the actions of individuals and groups (Jager & Maier, 2009). My interest in discourse analysis is derived from a desire to discover not only the ‘life’ of discourses but the meanings and understandings constructed within observed midwife-woman interactions. As indicated by Foucault, “People know what they do, they frequently know why they do what they do, but what they don’t know is what ‘what they do’ does” (Foucault, 1983:187(cited in Dreyfus & Rabinow 1983)). In Chapter Two I identified the lack of current knowledge regarding ‘what midwives do’ and ‘why they do what they do’ with regard to breastfeeding support. The adoption of discourse analysis, for this study, aims to reveal what midwives do, why they do it and what effect this has on the practice of breastfeeding. Some of the questions posed include: What are the subject positions available to, and taken up by, participants in the study? In what way do the discourses and discursive practices constitute these subjective positions? and, What impact does this have on women’s experience of establishing breastfeeding?

There is no one agreed method of ‘doing’ discourse analysis (Cheek, 2004:1140) although several authors have shared their own methods of approaching the analysis of discourse (Burman & Parker, 1993; Jaworski & Coupland, 2006; Powers, 2001; Wetherell, Taylor, & Yates, 2001). The approach articulated by Fairclough, has been well utilised by discourse analysts in the health arena and has been most influential in this study (Crowe, 2005; Powers, 2001; Smith, 2007). Fairclough insists, however, that the approach outlined in his books (Fairclough, 1992, 2001, 2003) represent merely ‘guidelines’ for discourse analysis, not the ‘blueprint’ for analysts (1992:225). Phillips and Hardy (2002) similarly provide a practical guide to performing discourse analysis whilst acknowledging that due to the ‘emergent’ nature of analysis the provision of comprehensive ‘recipes for success’ are not possible.

The analysis adopted for this study was a three-dimensional approach incorporating the interplay between text, discourse practices and context (Fairclough, 1992; Phillips & Hardy, 2002). Fairclough describes three moves of the discourse analyst: from interpretation of discourse practices, to descriptions of textual analysis and back again to interpretation of both the text and the discourse practices in context, incorporating the ‘social practice’ (Fairclough, 1992:231, 237). Fairclough describes the first move as operating at the macro level revealing the intertextual and
interdiscursive links between text, and discourse. The second move, textual analysis, represents the microscopic analysis of data and captures the intricacies of the exchange such as turn-taking rules, how topics are introduced and by whom, metaphors, recurring words, ideas and interactional control. The third move specifies the contextual boundaries of the discursive practice, or the social and hegemonic relations and knowledge structures within which the discourse is reinforced (Fairclough, 1992).

A total of 81 continuous hours (4863 minutes) of recorded data, field notes and observational data have been analysed using critical discourse analysis. Prior to the coding of data, I had a very general sense of the overall discourse practices I had observed. However, at the beginning of analysis the observations seemed to represent individual encounters, with little in the way of connections aside from a few practices commonly adopted by midwives. For example, common practices such as the wearing of gloves and the provision of hands-on assistance indicated a level of midwifery protection and detachment from women. Table 5 provides a diagrammatic representation of the process of data analysis adopted for this study. This table outlines the way each piece of empirical data was utilised to complete the picture to provide a more detailed understanding of the complexity of these interactions.

Table 5: Data analysis

<table>
<thead>
<tr>
<th>Three moves of discourse analysis</th>
<th>Sources of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Practices</strong></td>
<td>• Observation</td>
</tr>
<tr>
<td></td>
<td>• Field notes</td>
</tr>
<tr>
<td></td>
<td>• Interviews</td>
</tr>
<tr>
<td></td>
<td>• Focus groups</td>
</tr>
<tr>
<td><strong>Text</strong></td>
<td>• Transcribed interactions</td>
</tr>
<tr>
<td></td>
<td>• Transcribed interviews</td>
</tr>
<tr>
<td></td>
<td>• Transcribed focus groups</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>• Field notes</td>
</tr>
<tr>
<td></td>
<td>• Interaction log</td>
</tr>
<tr>
<td></td>
<td>• Focus groups</td>
</tr>
<tr>
<td></td>
<td>• Interviews</td>
</tr>
</tbody>
</table>

The actual coding of data began at the textual level in the first instance according to the appearance of recurring themes, words, metaphors, ideas, beliefs, turn-taking rules, the focus of the interaction and who dominated the interaction. I began by
identifying themes, which were unconnected to each other. I identified words, ideas, attitudes and beliefs, which I labelled with a code name. I coded freely at this stage, and identified areas which I initially thought were significant, but which later turned out to be particular to only one or two individuals. After a period of ‘getting a feel for the data’ the common themes, words and metaphors became apparent. I coded the textual representations of: the woman, the infant, the midwife, the lactation consultant, breastfeeding, and of relationality during the interactions.

I used the interview and focus group data to contextualise the findings from interactions and substantiate some of the apparent beliefs, practices and discourses, drawn upon during interactions. The coding of this data included the woman’s positioning of the midwife, both positive and negative, and her descriptions of early experiences of support. The interviews with senior midwives included the positioning of the midwifery role and the organisational context.

Following the coding of the full textual data set, I began a contextual analysis utilising the guided notes taken at each interaction (observation log), my field notes, and the focus group data. In particular, I subjected these forms of note-taking to a combined analysis, deriving a contextual record of each and every interaction. This provided a contextual situatedness for each interaction. Data collected for this purpose included the demographics of participants, ward happenings during the interaction, the demeanour of the midwife, infant behaviour, tone of voice, initiation and closure, an outline of additional tools/equipment/plans introduced into the interaction, recording of eye contact, glove usage and engagement in hands-on practices (see Table 6 number for some examples of this).
### Table 6: Example of contextual analysis log

<table>
<thead>
<tr>
<th>Number</th>
<th>Time spent (mins)</th>
<th>Woman (age, parity, day post birth)</th>
<th>Midwife (experience and context)</th>
<th>1.Initiated by 2.Non verbal communication 3.Focus of interaction</th>
<th>Hands-Off or Hands-On Description</th>
<th>Outcome of interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>39.04</td>
<td>42 yo, Multip, LSCS, Day 1</td>
<td>1. Midwife/LC, 25 years experience 2. Ward</td>
<td>1. LC referral 2. Gloves on, baby searching for breast, LC encourages woman to shape breast, then LC does this, touches around babies mouth to stimulate open, 3. Getting baby fed</td>
<td>ON- helps the woman to attach baby, hands over the woman’s, shaping the nipple, midwife takes charge when babe not sucking “I might just get a syringe and express some”, there is a “knack” to expressing. Midwife hand expresses for the woman while she chats to her visitors, half way through she says do you want to “have a go” mother declines, “we’ll just get it out and get it into her”, LC feeds colostrum to baby without offering to mother to do this.</td>
<td>Closure initiated by the LC, baby fed and settled.</td>
</tr>
<tr>
<td>51</td>
<td>11.49 9.55</td>
<td>32 yo, Multip, LSCS, Day 1</td>
<td>1. Midwife/LC, 17 years experience 2. Ward</td>
<td>1. Woman 2. Standing, assesses attachment, no gloves. 3. Attaching baby</td>
<td>ON- midwife encourages the woman to latch baby before visitors come in, tells mum not to stroke baby’s head then the midwife does this, takes control, getting pillows set up, sense during the interaction that the midwife is in control of the feeding and the mother is the means to getting the baby fed. (NB. Does not check in with the woman about prior knowledge until about two thirds into the interaction).</td>
<td>Both times closure initiated by the midwife 1. baby left skin to skin (not latching) 2. baby feeding.</td>
</tr>
<tr>
<td>62</td>
<td>22.18, 1.16, 19.2</td>
<td>27 yo, Primip, NVB, Day 2</td>
<td>1. Midwife/LC, 12 years experience 2. Ward</td>
<td>1. Midwife 2. Friendly introduction to the woman, gloves on as observes the feed, focus is on the breast throughout interaction, midwives hand positioning makes it difficult for the woman to see the baby at the breast. 3. Attaching baby correctly</td>
<td>ON- Midwife commences interaction with gloves on, observes woman attaching babe to begin with then says let me just give you a hand there, midwife starts attaching baby for the woman and is repeatedly ‘tweaking’ at either the position the woman is in, or the baby. Midwife in charge, kind of takes over the feed and instructs the woman as to what to do, at times when she is called away she encourages the woman to ‘try’ herself and to keep putting the baby to the breast in her absence. The woman is keen for additional support from the midwife but she is genuinely needed elsewhere. Midwife fails to engage in any of the chit-chat the woman offers. Wants to get in, get baby on, and get out.</td>
<td>Closure initiated by the midwife each time as she was needed elsewhere</td>
</tr>
</tbody>
</table>
Following analysis of the text, and the context, pertaining to each of the 85 interactions, the apparent discourses and discourse practices were extrapolated. Social practices were captured using my observational field notes, interviews and focus group data (see Table 5).

Confirmation of this stage of analysis, and the discourse and practices identified, were measured against the interviews, with women and staff, and the focus group data. The use of metaphors and dominant organisational discourses, were confirmed using the interview data gathered from senior staff. Focused interviews with women following discharge, were utilised to explore the impact of midwifery interactions and different support styles, on breastfeeding women. In particular, I sought to gain an understanding of what women felt was helpful, and unhelpful, in the language and practices adopted by midwives or lactation consultants.

I eventually identified three predominant discourses after several months of immersion in the data. However, the initial articulations of these grouped discursive support styles, seemed to lack the essence of the midwifery language and practices they represented. For example, the initial grouping of the predominant language and practices used by midwives and lactation consultants was entitled ‘breastfeeding is complicated’. This reflected the observed support style which seemed to focus on ‘problematising’ breastfeeding. However, backward and forward engagement with the coded data, and different levels of discourse analysis, combined with discussions at supervision team meetings, revealed the broader elements apparent in this support style. These incorporated a prioritisation of breastmilk as ‘liquid gold’ and midwifery, or lactation consultant, focus on ensuring the provision of breastmilk to infant ‘patients’ by any means possible. Women seemed invisible in the pursuit of the ‘liquid gold’ and breastfeeding became complicated and problematic. Eventually it became clear that there were three distinct modes of supporting women, each with their own underpinning philosophy and inherent way of positioning breastfeeding.

The alternative discursive influences on breastfeeding support reflected a prioritising, or not, of breastfeeding and the mother-infant relationship. It became apparent that the discourses influencing practice often aligned with sociocultural discourse, organisational priorities and dominant institutional practices.

In keeping with an acknowledgement of the co-produced nature of human enquiry, the last section of this chapter will provide a reflexive record of my positioning of
‘self’ during this research journey. In addition, my experiences as a professional insider but organisational outsider challenged expectations and are an important component of this field data.

3.8. Reflexivity

Critical discourse analysis represents but one reading of the landscape albeit influenced by researcher interpretations and data sources. Integral to this approach therefore is the importance of reflexivity and ongoing consideration of the co-constituted and reality-producing nature of research (Phillips & Hardy, 2002). Researchers who engage in reflexivity acknowledge ‘we are part of the world we study’ (Allen 2004:15; Hammersley & Atkinson 1983) and accept the fact that the ‘interpretive lens of the researcher’ influences the way interactions are perceived (Allen 2004:15).

Reflexivity has become an integral component of qualitative inquiry. It represents critical self-awareness of the subjective positioning of the fieldworker and acknowledges the co-produced nature of qualitative research (Finlay & Gough 2003:4; Lipson 1989; Baillie 1995; Allen 2004; Toffoli & Rudge 2006). Critical reflection gives rise to greater insight into the relationships between participant-researcher (de Laine 2000:212; Finlay 2003). Making the research process visible in this way, adds rigour and transparency to the study. It is hoped the inclusion of vignettes, from my field notes, will provide the reader with an insight into the meticulous and ongoing reflexive analysis central to this study.

3.8.1. Facilitating data collection

In order to gather data which would allow for an analysis of discourse, both at the textual and contextual level, it was important to observe practice and behaviour in the participants’ own milieu. For this reason, it was necessary to undertake long periods of participant observation at both sites. The aim of observational research was to gain insight, from both an emic (insider) and etic (outsider) view of the culture and practices of this particular group (Hammersley & Atkinson, 2007; Spradley, 1980). Gathering data required gaining the confidence and trust of the study group. This required spending some time ‘hanging out’ with and getting to know potential research participants (Adler & Adler, 1987:12). Making decisions around the level of engagement [for example from complete observer to complete
participant (Atkinson & Hammersley, 1994; Gold, 1958)], and getting the balance right, was a challenging task, as others have also reported (Borbasi, Jackson, & Wilkes, 2005; de Laine, 2000; Hammersley & Atkinson, 2007; Simmons, 2007). Consideration of how best to position ‘myself’ as a midwife, and a researcher, observing professional colleagues who were performing familiar activities in well-known clinical contexts, was an area of much contemplation.

Predictably, conducting participant observation within one’s own professional group can produce challenges between being known as an ‘insider’ whilst endeavouring to observe with an ‘outsider’ lens (Allen, 2004; Leslie & McAllister, 2002). Role confusion and over-identification with participants are two examples of challenges regularly reported in the literature (Bonner & Tollhurst, 2002; Gerrish, 1997; Groenkjaer, 2002; Klein & Johnston, 1979; Lipson, 1989; Reid, 1991; Toffoli & Rudge, 2006). Adler and Adler (1987:17) describe how over familiarity in an area, might result in the loss of ‘analytical perspective’ and may risk the researcher ‘going native’.

At the outset it was anticipated a ‘peripheral member’ status (Adler & Adler, 1987:36) would facilitate inconspicuous observation and an emic perspective without the need to actually participate in core activities. The advantages of utilising professional insider knowledge to enhance accessibility, minimise researcher effect on the midwife-woman interactions, and facilitate ‘unobtrusiveness’ was viewed favourably (Condell, 2008; Fetterman, 1989; Field, 1989; Hammersley & Atkinson, 2007). The importance of ‘unobtrusiveness’ was a crucial aspect of this study as participant observers need to assume a ‘low profile’ so as to limit influence on the social situation being observed (Spradley, 1980:48).

Asking women to allow a complete stranger to observe their very early breastfeeding experiences, which can be intimate, and for some, profoundly private experiences, was also considered potentially difficult and sensitive. Disclosure, to participating women, of my own midwifery background was deemed beneficial for enhancing participant ease with the observation of breastfeeding. This reflexive account of the participant observational component of this study highlights the complexity of the insider-outsider experience. The following text has been published in a paper entitled “Reflexivity in midwifery research: the insider/outsidder debate” see Appendix 6.
3.8.1 (a) At MUA

When introducing myself, at the beginning of the data collection at MUA, I discussed my background and interest in the midwifery support given to breastfeeding women. I indicated a level of understanding of the resource constraints midwives were working within and was sympathetic to the fact the unit was short staffed and often very busy. Over the intervening months, I also became increasingly aware of the impact this busy, under-resourced working environment had on staff morale. I felt able to relate to the midwives’ frustrations and dissatisfaction having worked previously in very busy, understaffed hospital environments. As I listened to the stories of workload issues, feelings of discontent and helplessness, I found myself relating in an empathic collegial way.

Overcoming suspicion

As indicated earlier, one month prior to the planned commencement of data collection, I attended staff meetings to invite midwives to participate in the study and asked for expressions of interest. I provided a written invitation for each staff member and posted an expression of interest (EOI) form in the staff tearoom. The EOI form hung on the staffroom wall for two weeks without any names being listed. I sensed there was a certain level of suspicion amongst the staff as to what the study might involve and who the findings might be reported to. Researchers conducting studies within their own health care settings have reported similar experiences (Allen, 2004; Asselin, 2003; Simmons, 2007). Staff at this hospital seemed ‘stressed’ at the outset and appeared not to have time to participate in any additional activities, not directly related to providing care to women and newborns.

From the beginning, I felt it important to break down any ‘hierarchies’ between myself as the researcher and potential participants (Karnieli-Miller, Strier, & Pessach, 2009; Leslie & McAllister, 2002). I also felt a strong desire to avoid adding additional tension, by assuring midwives that confidentiality was a high priority and that the study was not about scrutinising individual practice but rather aimed to capture the broad spectrum of practice.

As a professional member of the group under study, I had the added benefit of identifying a ‘commonality’ between myself, as the researcher, and participants (Dwyer & Buckle, 2009:58). During an informal chat at an ‘afternoon tea get-
together’ several staff asked questions about the project and generally chatted about the importance of gaining insight into midwifery practice. Midwives seemed keen to ascertain the aspects of midwifery care which women find beneficial and to identify those areas where improvements could be made. During this informal discussion, several senior members added their names to the EOI and by the end of the ‘afternoon tea’ I had eight potential midwifery participants. My perception was that the midwives became more willing to contribute as a result of an increased level of shared understanding between us. Shared understanding of this nature, has been found to be especially beneficial for observational research conducted in health care settings (Toffoli & Rudge 2006; Dwyer & Buckle 2009).

**Getting in**

Despite being an outsider in an ‘organisational’ sense my ‘professional’ midwifery insider status seemed to facilitate early acceptance of my regular presence on the ward (Simmons 2007:12). Strategies utilised to limit researcher obviousness have included paying close attention to the mode of dress and deportment of the observer (Groenkjaer 2002; Bonner & Tolhurst 2002; Allen 2004; Hammersley & Atkinson 2007). Nurse researchers, observing in health care settings, have reported feeling fearful of ‘flaunting’ their university status by dressing in their own clothes and wearing their hair down (Borbasi, 1994; Reid, 1991:547). I dressed in a subdued understated way, similar to the uniform style worn by the midwives. A concerted effort was made to avoid wearing red as this was the colour worn by managers and it was important to avoid being cast as a ‘management spy’ (Simmons 2007:13). As reported by other clinician researchers, I found it beneficial to wear an identification tag in the same style of lanyard card holder as the staff wore, and I generally sought to present myself as more ‘like’ than ‘different’ to the larger group of potential participants (Reid 1991; Gerrish 1997; Groenaker 2002). Staff questioned me on my midwifery background when meeting me for the first time and this represented a period of ‘sussing’ out my credentials and deciding if I were a suitable person to be observing clinical practice.

**Fitting into the context**

Gaining acceptance into the study setting involved approval for researcher presence from not only the participants, but other non-participating team members.
The desk area was a large square space in the centre of the ward, closed at two sides and open at two. The open sides were flanked by large bright signs warning that this area was for ‘authorised personnel only’. This space was strictly a staff-only domain, despite the fact that it represented a short cut from one side of the ward to the other. Women and their visitors were seldom permitted to take this short cut. My perception was that staff closely guarded this domain and continually reinforced to outsiders that this was their territory. Initially, I remained outside the midwives’ station whilst introducing myself, and the research study, to staff. However, being on the outside of this area seemed to highlight my outsider status, so to minimise outside observer effect I began positioning myself within this area. Acceptance into staff-only domains such as the midwives’ station and staffroom, where staff could speak freely amongst themselves, seemed to represent a degree of acceptance into an unspoken ‘circle of trust’ and confirmed a degree of insider status. Vignette 1 (from my field notes) highlights insider acceptance by staff. This notation was documented during my first arranged data collection day on the ward, when I was invited to attend handover with the rest of the midwives at the beginning of the shift.

Vignette 1:

Two afternoon staff went off to the tearoom for handover whilst I stayed at the desk. The morning staff then asked if I also wanted to attend handover and I agreed this might be helpful. The afternoon staff accepted me into the room to sit in on handover. Initially I thought this was a useful way to firstly blend in, secondly, gain an idea of the number of potential breastfeeding participants and thirdly, gain acceptance from the midwives. However, during the handover session it became obvious that it would not be appropriate for an ‘organisational outsider’ to continue to sit in on these sessions for three reasons. Confidential information was discussed about clients, without their prior knowledge that a researcher might be present, secondly the researcher’s presence may have caused uneasiness for non-participating midwives who were giving or receiving handover, and thirdly, information gained from this forum could not be utilised in the study in any case.

Consequently, I refrained from attending handover for the remainder of the study. Whilst this vignette indicates a level of insider acceptance, it also served as a reminder to me of my organisational outsider status and commitment to ethical practice.
Fitting in with the midwives

Fitting into the setting represented not only a period of blending in, to minimise disruption of the day-to-day activities on the ward (Gerrish 1997; Bonner & Tolhurst 2002), but also becoming attuned to the individual needs of midwives who consented to participate (Reid 1991; Borbasi 1994). Midwives who had previously identified themselves as interested in participating in the study were approached, at a later date, to negotiate the most appropriate day to schedule for observation. Initially I planned to attend the maternity unit for 4-hour sessions of observation. Following my first few observation sessions, and after discussion with my supervisors, it became apparent that it was important to work an entire shift with the midwife as this seemed the least disruptive approach, and facilitated my desire to obtain an emic perspective and authentically represent the complexity of the postnatal midwifery role. Throughout this process, I sought to fit around the midwives’ own schedules. This involved availability across the three shifts: morning, evening and night shift, and included weekends.

Once I began data collection, it also became important to be ‘in tune’ with the day-to-day stressors on the ward. Midwives were often working with insufficient staff and regularly seemed to be in ‘distress’ with the number of women they needed to care for on the ward. Staff availability for the provision of breastfeeding support was compromised in this context as staff sought to direct their energy towards other priorities. This type of authentic reflection of restrictions on staff accessibility, for optimal breastfeeding support, was a central component of the research agenda. However, at times in the early stages of data collection, whilst staff were getting to know the researcher and there was still a degree of unease and unfamiliarity about the project, I felt that being present on the ward exacerbated staff stress and added to their feelings of being burdened. Vignette 2 from my field notes illustrates this situation.

Vignette 2:

I arrived today (day 3) to collect observations with a midwife I had spoken to previously, and who had expressed an interest in participating in the study. On arrival, the midwife was obviously distressed and didn’t look very pleased to see me. She stated: “I don’t know how much observing you will get today as it is so busy”. The ward was short staffed, and she was frantically trying to get another staff member to cover… I could see that she was distressed and I offered to return on another shift when staffing was better. I felt that to proceed with the plan to observe this midwife’s interactions on this
This vignette highlights the influence of professional insider knowledge on decision making. A professional outsider may have proceeded with the planned observation shift regardless of the midwives’ distress. This type of action could be considered exploitative, and had the potential to damage the rapport established thus far. Although an objective of the study was to observe breastfeeding support provision on busy understaffed shifts, at the time this vignette was documented, I considered it important to prioritise the building of ongoing respectful and trusting relationships with participants in the study. This strategy was successful as there were numerous opportunities at subsequent visits to gather rich data on very busy, understaffed shifts, with midwives who happily gave permission for me to stay and observe. This experience revealed that while professional insider knowledge influenced researcher decision making at certain times, ultimately it did not limit data collection and in fact may have enhanced opportunities via mutual respect and trust.

‘Fitting in’ also represented an uncomfortable period of identifying where best to position myself within the physical layout. As discussed previously, I initially hovered around the perimeter of the midwives’ workstation until I felt a level of acceptance to remain within this space. However, quite unexpectedly, once I had become comfortable interacting with midwifery participants within this ‘inner sanctum’, I found myself slipping into clinician ‘worker’ mode at times as indicated below, when the boundary between clinician and researcher became blurred. The nature of this particular ward environment, which was often short staffed and busy, meant that I often felt a strong desire to ‘help out’, as others have reported (Gerrish, 1997; Lykkeslet & Gjengedal, 2007; Morse, 1989; Reid, 1991; Simmons, 2007).

**Blurring of boundaries**

As a midwife, I was very comfortable relating to midwife participants within this environment. I could relate to their frustration when working shifts with insufficient staff. Whilst at times, I felt it important to ‘help out’ whenever I could, this was hampered by my limited capacity, due to ethical and legal requirements associated with organisational outsider ‘researcher’ status. Vignette 3 highlights the dilemmas associated with this:
Vignette 3:

When call alarms are activated, and at times go unanswered, my natural inclination (or perhaps conditioned response) is to go and answer them. I am finding it unsettling knowing that someone is needing assistance and yet staff are busy and cannot attend. Today I noted a buzzer ringing during a staff member’s whole tea break (20 minutes continuously) as none of the other midwives had answered it. I wanted to help out today by answering the call for assistance when staff were busy. However, due to my organisational outsider status, inevitably I needed to find a staff member to assist with the woman’s request. This is becoming very frustrating when, with my ‘clinician hat’ on, I could easily be of assistance to both the woman and the staff member.

Scenarios such as these became commonplace whilst I maintained a presence within the midwives’ working station. As a pseudo-member of the team, within the boundaries of the midwives’ station, I also found staff would seek me out to ask advice on a particular clinical problem they were having. This resulted in further reflection on my position as researcher or midwifery colleague.

Vignette 4:

Today the staff were tending to check what I thought about particular clinical decisions they were making. During these discussions I felt hesitant to participate as I normally would in a clinical setting as I felt I would be stepping outside of my role as a researcher to engage in clinical decision-making discussions (on issues such as whether a particular medical recommendation was appropriate). I felt constantly in limbo between outsider ‘researcher’ and insider ‘clinician’.

As the study drew to a close at MUA, I began to feel a level of ‘protectiveness’ towards the midwife participants. Staff began to question me, during the last few weeks, about ‘how bad’ the study findings might be and there was an undeniable sense of dread from staff about the final analysis.

Vignette 5:

I am beginning to feel like it is a breach of trust to report any negatives about the way midwives conduct their work. I feel that the midwives have generously offered to let me observe their practice and it subsequently feels wrong to highlight the areas of poor practice observed.

This trend towards over identification with participants represented the commencement of a period of re-thinking the merits of insider positionality. Slowly I began to acknowledge some of the benefits of highlighting my organisational outsider status whilst in the field (Burns, Fenwick, Schmied, & Sheehan, In press).

Vignette 6:

As an organisational ‘outsider’ it felt good to be removed from the interpersonal clashes which inevitably plague any workplace and I have felt a certain degree of freedom to be able to attend staff
meetings and workshops without any of the ‘baggage’ that others seemed to bring to these meetings. This experience is highlighting for me the importance of maintaining a certain ‘outsider’ distance whilst in the field.

3.8.1 (b) At MUB

In the 12 months prior to commencement of data collection at MUB, I met key gatekeepers and attended several staff meetings, to introduce the study and provide information to staff about what the study would involve. Again, I introduced myself as a midwife conducting research and was warmly received by staff who seemed genuinely interested in seeking to improve clinical practice through research. At the meetings, midwives asked many questions about the study and were clearly open to learning new ways to improve practice. The midwives seemed to interact with each other, and with managers, in a professional collegial way and morale appeared to be high. I noted that there was no clear sense of a hierarchical structure and managers and midwives wore an identical uniform. During the preliminary discussions with staff it was clear that midwives at MUB had strong links with senior midwifery academics from the local university, and that some midwives had participated in research previously. Midwives also spoke about current research in the area of postnatal care and were interested in how this study might add to the current knowledge around midwifery support.

Unlike MUA, I did not feel the same need to establish an ‘insider’ identity in this unit as the staff seemed to welcome and accept me as a midwife/researcher without any hesitation. One month prior to commencing data collection, I returned to invite staff to participate in the study, both via written and verbal means. I posted an EOI in the staff tearoom and within a couple of days several midwives had put their names on the form.

**Instant acceptance**

I commenced data collection in this second unit with a midwife who had previously expressed an interest in participating. I utilised the same strategies for ‘getting in’ as at MUA, such as paying attention to how I dressed, wearing an ID, and observing at a time convenient for the midwife. Vignette 7 highlights the setting factors influencing my ability to establish a clear researcher/observer status as professional insider status was readily implied.
Vignette 7:

First shift on the ward today and I was warmly welcomed by the midwives. The midwife I was due to work with was keen to introduce me to other staff and was generally eager to help out. I felt an instant researcher acceptance and instant welcoming into midwifery areas. I felt that I had an ‘access all areas’ status and did not feel a need to gain acceptance, as it was already implicitly offered.

Trust and acceptance for my ongoing presence on the ward were implied in the midwives’ behaviours towards me from the outset. Due to this, I was able to observe practice without the need to ‘prove’ my professional insider knowledge. I felt a strong sense that I was an outsider who was being accepted as a ‘colleague’ observing the team for a short period, and was entrusted to do this in a balanced way.

Fitting in

The ward area had a designated staff work area similar to MUA and the midwives conducted their written and computer tasks within this space. Three separate hospital midwifery services utilised this work area, as well as medical and allied health personnel. Consequently, there was a lot of traffic through the desk area. This space was also where clinical discussions took place. Despite the instant level of ‘professional insider’ acceptance, I often felt it important to remain on the outer boundary of this work area, contrary to the experience at MUA. Sitting inside the workstation was not conducive to blending in but rather highlighted my lack of insider knowledge about how things ‘work’ in this place, as I frequently seemed to be sitting in someone’s designated place.

Fluctuating insider/outsider positioning

As discussed previously, the research team had agreed that working the ‘shift’ with the midwife would be the most beneficial way to conduct observations. At times this was difficult, due to the location of the sites, however, it became clear that this was crucial to gaining staff respect and trust in my researcher role.

Vignette 8:

Today I arrived half way through the morning shift. This was unavoidable because of a car accident on the way to the hospital this morning but on my arrival I sensed that the staff felt I had missed most of the shift. The midwife I was due to work with said ‘you have missed lots of potential interactions’. I had previously observed the regular pattern of care-giving which seemed to focus around the morning until about 12.30pm when staff would be writing up notes or updating the computer or handing over to team leader. As I was just arriving at 11.30 the staff probably felt there wasn’t much point in being there. After explaining the reason for my lateness and re-negotiating with the midwife
whether to remain for the rest of the shift or not, she agreed that it might be beneficial if I continue to observe for the rest of the shift, (another 4 hours) which I did and in the end I gained valuable data today.

This encounter highlighted both my outsider and insider status. My outsider status was clear, as I was a transient sporadic member of the group. However, my professional insider status was also in question here. This is the kind of reaction I would have anticipated had I been working clinically on the ward that day, but as an observer midwife there was still valuable research data to be gathered on this day. Respecting participants and blending into the expected pattern of midwifery behaviour, was important for maintaining access to the research site and for ensuring ongoing participation.

Midwifery staffing at MUB was optimal and midwives had access to additional personnel and resources to assist with their work throughout the day. Midwives seemed to spend most of their time with women and the ‘staff-call buzzers’ were mostly answered promptly. At times I helped out by fetching things for the midwife. However, while interacting with the midwives at this site I maintained an ‘observer midwife’ status and seldom felt the need to engage in ‘hands-on’ help whilst there.

I believe this was partly due to my position at the outer perimeter of the workstation, and the optimal staffing levels. When call buzzers would alert I did not feel obligated to answer the call if the midwife was busy. The staffing levels at this site meant that another staff member would invariably leave the central workstation to answer the call. I did notice however, that on evening or night shifts, whilst I was sitting within the workstation, I often helped out in more practical ways, such as settling babies.

Clinical discussions often occurred within the designated staff workstation. Whilst midwives permitted me to observe these discussions, they did not ask for my opinion or input into the discussion. Despite being accepted as a professional insider, my outsider status was also acknowledged by the midwives.

Vignette 9:

During a clinical decision-making discussion about a client today I was included as an observer but was not asked for my opinion or to contribute my own clinical experience to the discussion. There was an obvious sense of confidence between the staff that even if they didn’t have the answer or solution to the problem, their colleague would. I observed that additional opinions were gleaned from senior staff working on the ward today.
Role ambiguity

The challenges to role boundaries, experienced in this setting, often occurred when
the midwife left the room momentarily. There were a number of occasions when the
woman and/or her partner would use this opportunity to ask what I thought about
their situation. Having introduced myself to participants as a midwife, there followed
a tendency to ‘check out’ what I thought about whether the breastfeeding, or related
issues, seemed ‘normal’ or not. This became especially uncomfortable when
observed practices around breastfeeding were causing distress to the woman.

Remaining a silent observer when the midwife had left the room was especially
challenging. For example, during an observation of a discussion about infant care,
with a first-time mother, the midwife continually spoke to the woman as though she
was a novice at handling infants. When the midwife left the room (to get a nappy) the
woman and I engaged in chit-chat. During this brief exchange the woman indicated
that she had a professional background as an early childhood worker. When the
midwife returned, I was torn between telling the midwife this additional information
or continuing to observe the conversation that ensued, to determine how far into the
interaction it would be before the midwife elicited this information herself. I found it
agonising to observe the resultant interaction because the midwife continued to speak
to the woman as a novice and did not engage in any ‘checking in’ with the woman
about prior knowledge. Despite my maintenance of an outsider observer
positionality, the relationship formation, which inevitably occurs between researcher
and (in this case midwife) participants, meant that observing this midwife, without
supplying her with the additional information I had gained, felt like ‘spying’ or what
some researchers describe as ‘exploitative interloper’ behaviour (Adler & Adler

As the study drew to a close, the high morale, resilience, and sense of being ‘valued’
that I had observed within this group of midwives meant that they seemed keen to
hear both the ‘good’ and the ‘bad’ stories and to learn new ways to improve their
practice. Unlike MUA, I did not experience any sense of betrayal in highlighting the
negative practices observed.
The middle ground

These nine vignettes have provided insight into the complex nature of the negotiation of access, and maintenance of access, at both study sites as a ‘professional insider’. Consistent with previous work in this area, adopting a professional insider status enhanced credibility and facilitated ease of access and initial acceptance at each site (Field 1989; Reid 1991; Groenkjaer 2002). Similar to Leslie and McAllister (2002:701), naming myself as a ‘midwife’ highlighted a commonality in cultural identity between myself and participants and implied a level of ‘trustworthiness’. The socially constructed meaning of professional identity, offered an expedient way of communicating certain positive researcher characteristics such as caring, capacity to listen and empathy (Leslie & McAllister 2002). In this study, highlighting a shared embodied understanding (Savage, 1995) of the nature of midwifery care, also contributed to the development of trusting and respectful ‘field’ relationships with midwifery participants. Identifying mutual desires, such as improving clinical practice, alleviated some of the suspicion towards the study purposes. In addition, professional acculturation and a level of ‘cultural competence’ facilitated ongoing acceptance of researcher presence (Borbasi, et al., 2005; de Laine, 2000; Kanuha, 2001).

The presence of a research culture at MUB meant acceptance of an outsider researcher, observing practice, was rapid and welcomed. The high morale noted amongst the midwives at MUB, conveyed a sense of openness to scrutiny and staff seemed committed to improving practice. By contrast, midwives at MUA had less familiarity with clinician researchers, apparent low morale, and an initial reluctance to participate. As a result, negotiation and maintenance of access to this site was much more delicate. Research suggests that midwives who have been working in understaffed areas for prolonged periods of time, report high levels of stress, low morale and ‘diminishing competence and confidence’ in their role as a midwife (Brodie, 2002:8; Curtis, Bally, & Kirkham, 2006). Leslie and McAllister (1998) further point out that a heightened level of suspicion towards ‘outsider’ observers is often the result of participants perceiving themselves to be on the bottom of the hierarchy. In this context, outsiders and their behaviour, whether belonging to the profession or not, might be interpreted pessimistically as ‘spying’ and/or an opportunity to exploit the negatives (Adler & Adler 1987).
The vignettes have also served to highlight some of the moral, and ethical dilemmas which accompanied this research journey. The complex nature of negotiating ‘relational closeness’ whilst ensuring ‘analytical distance’ (Lykkeslet & Gjengedal 2007:701), represented a dilemma for me as participant observer. However, the process of reflexivity facilitated awareness of the variability of my insider/outsider experience, and the fluctuating nature of the peripheral and active membership roles (Adler & Adler 1987). The ‘story behind the story’, which reflexivity provides, inevitably gives rise to greater insight into the participant-researcher connection and the co-produced nature of qualitative research (de Laine, 2000:212; Finlay & Gough, 2003:x). Reflexivity has been described as ‘methodological self-consciousness’ (Finlay & Gough 2003:4) and has become an integral component of qualitative enquiry (Allen, 2004; Baillie, 1995; Lipson, 1989; Toffoli & Rudge, 2006).

Self-awareness of prior socialisation as a midwife, and a nurse, was prominent in both study sites. Whilst highlighting my professional ‘insider-ness’ implied certain desirable midwifery characteristics, it also, unintentionally, entailed some unwanted socially constructed meanings. The socially constructed nature of the identity of ‘nurse’, ‘midwife’ or ‘researcher’ (Allen 2004) meant that potential participants brought their own preconceived notions about the researcher-clinician role, independent of my desired positionality. The implicit understanding that I could ‘pitch in’ if it was busy (Beale & Wilkes, 2001) and work the full shift was an unspoken feature of the clinician-researcher relationship. The balancing act between being a stereotypical ‘good’ clinician and/or a ‘good’ researcher seemed at times an impossible tightrope to walk (Beale & Wilkes 2001:38). This was especially the case when staff were busy and working with less than the full complement of staff. During observation shifts such as these, my embodied knowledge of midwifery practice presented a dilemma for me in terms of capacity versus incapacity to ‘lend a hand’.

Awareness of the potential influence of embodied midwifery knowledge on participant observer performance, especially in busy understaffed environments, was a potent reminder of the importance of balancing these insider and outsider perspectives. Reflexive analysis presented here, highlights the degree of juggling of various insider-outsider attributes in order to achieve the desired level of familiarity with, and distance from, participants. It was only within this ‘middle ground’,
between ‘insider’ and ‘outsider’, that ‘emic’ and ‘etic’ perspectives could be realised. The moral and ethical challenges, which arose as part of this observational study, were viewed as opportunities for reflexivity and further exploration of my subjective positioning.

3.9. **Conclusion**

Social constructionist epistemological and ontological perspectives have informed this study and the subsequent choice of methodology. Post-structuralist concepts, the work of Michel Foucault, and critical discourse analysts have informed this understanding of discourse, the influence of power in social exchanges and the importance of gathering a variety of data to facilitate multi-dimensional analysis of language and practice.

The previous chapters have highlighted the need for an exploration of health professional communication and support for breastfeeding, in light of consumer dissatisfaction and declining breastfeeding exclusivity. Discourse analysis can illuminate the historical and ‘real time’ factors contributing to both suboptimal and optimal breastfeeding support, alongside the contextual inhibitors and facilitators for genuine midwifery care. Reflexive consideration of the co-produced nature of research also enhances transparency of researcher positionality and illuminates the ‘story behind the story’. The next two chapters will reveal the discourses that emerged from this analysis of midwife-woman interactions, interviews, focus groups and education sessions.
CHAPTER FOUR

‘Mining for Liquid Gold’

4.1. Introduction

This is the first of two chapters which present my analysis of midwife-women interactions during the first week after birth. In this chapter, I reveal the dominant discourse which influenced midwifery language and practice styles during the early establishment of breastfeeding. The analysis of interactions, interviews, focus groups, parenting education sessions and fieldnotes exposed public and professional representations of breastmilk as ‘liquid gold’. On the whole, midwife-woman exchanges around breastfeeding reflected the prioritising of infant access to ‘liquid gold’. The language and practices adopted by midwives communicated a hierarchical expert-novice positionality, which subordinated women in the pursuit of this precious resource.

In contrast, the second discourse represented breastfeeding as ‘not rocket science’, that is something which is not complex and which women should be left to get on with. This was distinguishable from the third discourse which positioned breastfeeding as first and foremost about the ‘relationship’ between mother and infant. These latter two discourses will be presented in Chapter Five.

In this chapter, I will describe the dominant approach to breastfeeding support which I have termed ‘mining for liquid gold’. The ‘liquid gold’ discourse was prominent at both sites, and midwives promoted breastfeeding as the gold standard in infant nutrition. Discourse analysis has revealed linguistic, visual, symbolic, and performance clues to a discourse which overtly prioritised the nutritional aspects of breastfeeding. The female capacity to produce and provide the ‘gold’ standard was both revered, and considered axiomatic, by midwives performing within this discursive framework. However, whilst women were positioned as potentially possessing limitless amounts of ‘liquid gold’, their capacity to harness their natural resource was often doubted and midwives felt an imperative to intervene. Midwifery intervention to ensure the infant ‘patient’ obtained adequate nutrition resulted in the...
disembodied separation of the woman from her breasts. Midwives who provided expert advice about liquid gold and who physically assisted women to provide breastmilk to their infant, or advocated technology to enhance supply, fully enacted this ‘mining for liquid gold’ approach. Prioritising breastfeeding as the supply of ‘liquid gold’ was apparent in eighty percent of the interactions observed across both study sites.

4.2. Colostrum and Breastmilk: ‘Liquid Gold’

During this study, the majority of midwives prioritised both colostrum and mature breastmilk as a precious resource. Midwives were observed treating the acquired colostrum, or mature breastmilk, as if it were in fact more valuable than ‘gold’. The references to breastmilk as ‘liquid gold’ were both verbal and non-verbal, and became apparent during analysis of the full data set as the most dominant discursive influence on practice.

Providing an infant with access to the rich, thick substance colostrum, with its abundance of nutrients and protective antibodies, was considered a natural decision for women given its ‘gold’ standard status. Colostrum was highly regarded as the concentrated version of ‘mature’ breastmilk, and was variously referred to as ‘super milk’, ‘three times’ the strength of mature milk, ‘undiluted cordial’, or an ‘atomic bomb’ of breastmilk. It was positioned as crucial, for colonising the infant’s digestive system, and for supplying antibodies as these quotations from antenatal parenting education sessions (PEd) reveal:

PEd 2- They’re only living on drops [in the first few days]. The drops will line the gut, which is important. We talked about the protective function and they get a hit of antibodies as well.

PEd 3- It’s the milk that’s really high in the antibodies, and really high in sugars and so forth. So baby doesn’t need a lot of colostrum to make it feel full and satisfied.

The valuing of colostrum as a medicinal, antibacterial remedy was commonplace within this approach. Midwives took many opportunities to inform women of the ‘super healing’ powers of colostrum and of mature milk. Women were encouraged to utilise these properties to best advantage during the early postnatal period for healing both their own nipples and even their infant’s potential ‘sticky eye’ infection.
Interaction (Int) 23:

Midwife: It’s got great healing properties the colostrum, lots of antibodies and good stuff and even, say, if baby’s got a mucky eye and squirt a bit of milk in the eye…

Woman: Okay. I’ll remember that one.

Midwife: Really good stuff. So you can imagine how good it is for their tummies and everything. But yeah you just put a bit on your nipples it will really help them, any damage they’ll heal and just really protect them. You can do that after each feed or in between.

Following a face-to-face interview with a woman who had ceased breastfeeding prematurely, due to suspected ‘hypoplastic’ breast tissue (insufficient glandular tissue), she expressed a sense of relief that at the very least her infant had received some precious colostrum, reflecting the construction of colostrum as a ‘super milk’ (Interview (IV) 9).

Colostrum was considered such a precious resource that, whilst in hospital, midwives reserved the right to extract and feed this precious elixir to infants, lest a valuable drop be wasted in the woman’s potentially awkward attempts to do so. The enactment of this ‘liquid gold’ discourse included practices around the collection and storage of colostrum, which highlighted the significance placed on every single drop. If an infant was not feeding at the breast ‘effectively’, and there was concern about colostrum intake, midwives tended to retrieve some ‘liquid gold’ with gloved hands for the infant. Gloves were worn to ensure the colostrum was not contaminated, and to maintain compliance with occupational health and safety requirements. The colostrum was commonly collected into a syringe, or a cup, and then fed to the infant by the midwife. If an infant was not ‘due to feed’, the colostrum was stored in the fridge for later use. Even one or two single drops, were collected into a labelled sterile container and stored.

Int 46:

LC: Probably at this stage we’ll just get it out and get it into her, because there is a bit of a knack to it and if you were up it’s easier you know if you were standing in front of a mirror you can sort of see where to squeeze… [Lactation Consultant hand expressing for the woman]…We’re doing pretty well here… she will probably lap it out of a cup but I might syringe it into her you don’t want to waste any drops.
Woman: That’s a fair bit, yeah.

LC: At least about four millilitres so that’s great. I’ll see if I can get her to suck it off my finger…we want it all down the hatch.

The tendency for the midwife or lactation consultant to feed the ‘drops’ of colostrum to the infant even extended to finger feeding, which the woman was often not invited to do herself.

Admiration for colostrum as ‘liquid gold’, however, began to wane by postnatal day three. Notably by this stage, midwives began to talk about colostrum as lacking in volume and as not ‘satisfying’ the infant. Health professional focus shifted from the acquisition of colostrum as ‘liquid gold’ towards replacement with the superior fluid: breastmilk. Much discussion occurred around the ‘hope’ that colostrum would soon be replaced with the much more desirable, gratifying and voluminous breastmilk.

‘Mature’ breastmilk represented a whole food source for the infant. Metaphors used to describe the breastmilk included ‘sweet drink’, ‘entrée’, ‘salad, steak and chips’, ‘breakfast, lunch and dinner’, or ‘dessert’. Again women were encouraged not to ‘waste a precious drop’, whether expressing for comfort or for convenience, all expressed milk was stored in a sterile container, labelled and placed in the fridge or freezer. Women were given both documented and verbal information, regarding the handling of expressed breastmilk, including the recommended storage temperatures and the shelf life of their ‘product’.

Int 65:

Midwife: …and then it just talks about the fact that you can actually use your breastmilk, it can be stored in the fridge for three to five days and how to freeze it and things like that as well...

Midwife: Now, with your breastmilk you can just pump it into a bottle and pop it in the fridge.

Midwife: Make sure it’s a sterilised bottle that you’re pumping into.

Woman: Excellent.

Midwife: And then you can just pop it in the fridge as soon as you’ve expressed it and then it will be ready for the next feed.

Woman: With the breastmilk do you heat that up or do you just take it straight from the fridge?

Midwife: You do heat it up.
Midwife: You just – what we normally tell the mums to do is just get a cup of hot water, boiling water, just put it in a cup or something and just pop the breastmilk or the formula in there…

Woman: Okay, just like melting chocolate.

Midwife: ...and it will just get warm and then you just make sure that it’s not too hot for bub, okay?

Woman: No worries.

Women were instructed by midwives how to express, store and feed their ‘liquid gold’ to their infant. In addition women were encouraged to prepare the nipple for the next breastfeed by either placing some expressed milk onto the nipple and letting it air dry or (at site two only) applying some ‘Lansinoh’ cream.

Interaction (Int) 2:

…then when he finishes and comes off, you just rub some of your milk onto your nipple and just let the air dry, that’s all you need to put on your breast don’t put any creams on, don’t wash your breast with soap, or anything like that cos it will dry it out you just put your breastmilk on, your breastmilk has got healing properties, it has natural antibiotics, and it will heal the breast, ok, so nothing else, ok.

Visual representations of the ‘liquid gold’ discourse adorned the hospital environment in the form of promotional posters. The areas dedicated to the storage and labelling of colostrum and breastmilk, were decorated with pictures demonstrating the amount of this ‘golden’ liquid produced as colostrum, then later as mature milk. In addition, pictures of the difference between colostrum, foremilk and hindmilk were also on show. Women who were supplementing with artificial formula were strongly encouraged to give the breastmilk first followed separately by the formula, to ensure every drop of the ‘gold’ was consumed.

Int 65:

Midwife: You can give it in the same bottle but you need to give the breastmilk first and then try the formula because…

Woman: Is that so if he does like vomit he will…

Midwife: It’s also because of the fact that if you mix the breastmilk with formula you’re not making sure that bub’s taking all the breastmilk, okay?

Woman: Okay. Yeah.
Midwife: The other thing too is that all the good bacteria and things like that if you mix it with the formula it’s really important for them to get all the good bacteria of the breastmilk, okay? So that’s really important for their immunity and things like that. So it’s better to give that first and then give the formula after that, okay?

Woman: Yeah. Cool.

As discussed in Chapter Two, the scientific analysis of breastmilk, into its inherent attributes, has added weight to the prioritising of breastfeeding for all infants. Midwives in this study, particularly at MUB, promoted breastfeeding by providing breastfeeding education and preparation, during the antenatal period, and prioritising and advocating for the supply of premium nutrition to infants in the postnatal period. The following excerpt is of an interaction between a midwife and a woman whose premature infant was in the special care nursery, receiving tube feeds of formula whilst awaiting the milk coming ‘in’. This quotation indicates the importance of breastmilk for premature infants as well as the need to ensure women are aware of this.

Int 29:

Midwife: Okay. But you will. You’ll do it. He’ll do well. Breastmilk is best. Do you know, in Royal Prince Alfred Hospital, they’ve actually got donor milk coming to their premmie babies?

Woman: I heard that they were starting to do that, so yeah.

Both antenatally, and postnatally, women were reminded of the importance of ‘liquid gold’ for their infant’s health and wellbeing. The imperative to ensure that as many infants as possible had access to breastmilk meant that midwives adopted ‘awareness raising’ strategies. These awareness raising strategies began during the pregnancy in the form of the group health promotion ‘parenting education’ sessions.

4.3. Prospecting for Gold

All pregnant women were positioned as possessing this, as yet, untapped rich resource (breastmilk) which, according to policy recommendations, every infant had an entitlement to receive. However, midwives acknowledged that some women may ‘choose’ not to breastfeed for a variety of reasons. So a range of tools, resources and strategies were used to convince women of the merits of breastfeeding. The prioritising of breastfeeding antenatally, heralded the beginning of a health
professional dialogue with women, which aimed to encourage as many women as possible to provide their infant access to the ‘gold’ standard in infant nutrition. The ‘infinite’ value of the supply of resource rich nutrients was impressed upon women and their partners.

Much time and effort was spent giving women opportunities to learn about this ‘miraculous substance’. At the hospital ‘booking-in’ visit, women were offered attendance at the ‘parenting’ education program. These group gatherings offered education to the woman and her partner (or support person) on many aspects of pregnancy, birth and the postnatal period. The education sessions ran once per week, over a six-week period (or for two full days), and included orientation to the hospital environment and birth facilities. An integral component of the ‘parenting’ education program was the promotion and prioritising of breastfeeding. A dedicated breastfeeding session comprised one week of the six-week program, at both sites. Parenting educators, who were all midwives, disclosed to me that they also wove the promotion of breastfeeding into other sessions across the full six-week course. Artificial formula feeding was not discussed during these sessions.

Midwives ensured that women had access to as much information as possible regarding the inherent benefits of breastfeeding but, in compliance with the ‘International Code’, did not present information about formula feeding. At times, midwives prefaced their dialogue, regarding the benefits of breastfeeding, with the caveat that they were obliged to promote breastfeeding because of their firm belief in the superiority of breastmilk, over artificial formula, and because of the supportive breastfeeding philosophy of the health service (or, at site 2, the hospital BFHI status which mandated breastfeeding promotion). In this way, midwives fulfilled their global health obligation to ‘protect and promote’ breastfeeding.

PEd 5:

Midwife: I can’t hide the fact that I am biased towards breastfeeding and because this is a baby friendly accredited hospital it is our duty to ensure that everyone has knowledge about breastfeeding. But I do want to make it clear that we would respect anyone’s decision if for good reasons they actually choose to artificially feed their babies. But if you could bear with me, and, no matter how you have decided to feed your baby already, maybe you have already made a considered decision but um bear with me for the next hour as I share
with you the cleverness of the body and of a baby’s ability to breastfeed, okay.

Women who may have decided during pregnancy to bottle feed, were encouraged to attend breastfeeding education sessions regardless, in an effort to ensure their choice was made with accurate and appropriate information. Midwives stipulated their role as ‘facilitator’ was to provide accurate and current information so that the woman and her partner could subsequently make an informed decision on the matter. Yet these ‘midwife-led’ education sessions paid ‘lip service’ to the notion of informed choice as they exclusively supplied families with all the current available knowledge regarding the ‘gold standard’ in infant nutrition. Midwives indicated that should a woman choose the, albeit inferior, option of artificial formula, her decision would be respected and she would not be treated any differently during the postnatal period.

PEd 3:

Midwife: So we all know there are two different types of feeding, don’t we? Bottle feeding and breastfeeding. We don’t really talk too much about bottle feeding, other than if you want to bottle feed you need to bring your own formula and bottles into the hospital with you. And they’ll help you set it all up and all that sort of stuff. Show you how to mix it all up and so forth. What are some advantages of breastfeeding?

Having fulfilled their duty to raise awareness of the importance of breastfeeding midwives then began the process of motivating women to breastfeed.

4.3.1. Convincing the supplier – the woman

At the outset, midwives who conducted parenting education sessions endeavoured to ‘convince’ women, and their partners, that breastfeeding was the best option for their infants and that it was worth persevering through the ‘difficult’ times to achieve this. Acknowledgement of the ‘horror stories’ circulating in the community, about breastfeeding, were commonplace. Midwives considered these stories to be a sufficient disincentive for women to opt out of breastfeeding. During classes midwives discussed their desire to ‘excite’ women and their partners about the prospect of breastfeeding.

PEd 5:

Midwife: Ok, so today I can’t go into the whole box and dice… I could talk for 8 hours about breastfeeding, but I am not going to do that today, so this is just
a snippet to excite you about it, I hope, some very ‘quick grab’, ‘must know’ information, and then I will be referring to our breastfeeding class for some more practicalities and techniques of how to do it and to troubleshoot some of the issues, if that’s ok. As I was talking about it this morning during labour, at the end of labour, when the baby is born, one of the best things to do for mother and baby is to have the baby on the chest and let’s see what this baby can do so I have got a little snippet here to show you how clever brand new babies can be (plays video).

Exciting developments emerging from scientific research into the superior nutritional components of breastmilk, antibody protection for infants, and also the emerging long-term benefits for the woman, were emphasised. The additional cost savings which breastfeeding represented for families was a supplementary drawcard used to gain commitment to breastfeed.

During the antenatal period, women were positioned as lacking much of the knowledge about breastfeeding but nonetheless were ‘equipped’ to perform breastfeeding, provided they received education, and subsequently developed a commitment to do so. Breastfeeding was positioned as something which all women could do, and also something which all women should at the very least ‘try’ to do. Breastfeeding ‘activity’ was presented as normal and an important component of life with a new baby. There was a clear emphasis on giving breastfeeding ‘a go’. Facilitating ‘skin-to-skin’ contact with the infant, following birth, was viewed as the ‘golden’ opportunity to convince those women who might have previously been undecided about breastfeeding.

Partners and support people were also assumed to have limited breastfeeding knowledge. Interestingly, during the group sessions, partners were constructed as the ‘protectors’ of women and breastfeeding. For this reason men were encouraged to participate in the education sessions, and alternative educational strategies were utilised by educators to target men specifically, often using humour to get the message across. The following strategy was used to educate the couple about optimising infant attachment to the breast.

PEd 1:

Midwife: Anyone got lipstick? And I need male volunteers.

The facilitator then blew up several condoms and the women were instructed to put lipstick on their partners.
Midwife: Guys, place your mouth over the nipple (tip of condom), then compare the
imprint from the lipstick if you do it with your bottom lip first. See the
difference in the size of the lip placement.

The laughter and frivolity which this simple strategy evoked seemed to lighten the
mood and possibly generated an increase in male participation in discussions.
At one session, the women and men were separated into two rooms. The men were
asked to consider: Why would women choose to breastfeed? What would influence
their decision? and, What support would be required? In contrast, the group of
women were asked: Why do some women choose to artificially feed? What
influences this decision? What sources have you used to inform your decision? Are
they the latest in science and research and does this matter? Interestingly, according
to the men’s group, the main reasons women choose to breastfeed were: to provide
the best food for the baby and to accelerate the return of pre-pregnant body shape.
Women responded to their consideration of the choice of formula feeding with the
view that mothers who choose to artificially feed, do so, due to reasons of pain and
discomfort or insufficient supply. The consensus gleaned from this group of women
was that often the decision to ‘artificially feed’ was made for ‘selfish’ reasons.
Notably, the educator later discounted many of the reasons women gave for
commencing formula feeding as potentially preventable, provided women accessed
midwifery support measures and additional health professional availability (PEd 5).

4.3.2. Effortless extraction – the infant

Videos shown to women during breastfeeding classes portrayed the infant as an all
knowing individual who would take a ‘lead’ role in breastfeeding and would merely
need a gentle helping hand to be positioned with ready access to the nipple.
Breastfeeding was depicted as ‘clever’, and infants were constructed as innately able
to attach and suckle. However, infants were also positioned as in need of protection
to sustain breastfeeding. For example, midwives recommended restricting the
‘cuddling’ of the baby by the multitude of visitors, in the first few days after birth.
One of the videos shown during antenatal ‘classes’, encouraged the woman’s partner
to act as the ‘midwife’ when the midwife was not available, and to act as the
‘mother’ when the mother was not available, during the first day or two after birth.
This was in contrast to the more common constructions of men along traditional
gender lines, as the ‘protectors’ and ‘providers’ for women and children. Acceptance
of this important role was promoted as enabling women to fulfil their important ‘job’ of providing the ‘best food’ and ‘medicine’ for infants.

Many of the practicalities of breastfeeding were discussed during the classes, and various myths about breastfeeding dispelled. Discussions around identifying whether the baby was receiving enough breastmilk, as well as simple positioning techniques, formed a significant component of the one- to three-hour generic sessions on breastfeeding. The message that breastfeeding should ‘never’ be painful was delivered loud and clear. One educator midwife encouraged women to go home after the session and “…get to know your own breasts” (PEd 4, 5). This was deemed a desirable activity to desensitise the women to the sometimes ‘necessary’ midwifery touch during breastfeeding assistance. Anticipation that women would not be so “…confronted when a midwife touches your breasts” followed (PEd 4). This particular educator disclosed to women that midwives “…try to sit on [their] hands but it doesn’t always work” (PEd 4) when providing assistance with breastfeeding.

On the whole, these sessions were conducted in a light-hearted, jovial, and informal way which set breastfeeding up as a fun, enjoyable, rewarding experience. Breastfeeding difficulties were discussed and some solutions to problems supplied. The overwhelming take-home messages for women, and their partners, were that women were well ‘equipped’ to breastfeed, most infants were born knowing how to breastfeed, and that health professional ‘help’ would always be available to overcome any difficulties encountered. Educators positioned specialist lactation consultants as “…whizz bang experts on breastfeeding” (PEd 5) and women were encouraged to seek help following discharge from other associated health organisations. For example, midwives sought to ‘wave the flag’ for child and family health services and ‘put in a plug’ for the Australian Breastfeeding Association (PEd 5,8).

4.3.3. Additional promotion

At site 2, an additional three-hour breastfeeding session was available to all women (partners were not encouraged to attend this session) who were seeking information and strategies to overcome potential breastfeeding difficulties. These sessions represented additional opportunities to promote breastfeeding, albeit with an audience who were keen to make it work. Women who had never breastfed,
alongside those who had previously experienced breastfeeding difficulties, attended these sessions. The following question came from a woman who was concerned about having trouble in the first few days:

PEd 8:

Woman: Can I just ask a question, before I forget, you know how you have to bring in your own formula, what happens if you want to breastfeed do you still have to bring your own formula?

Midwife: No, because we are a baby friendly hospital, if you have come into hospital with the intention to breastfeeding you don’t have to bring anything else with you, except the breasts and the right attitude, which is a good thing.

Woman: So if you can’t?

Midwife: If you choose to change over to artificial feeding while you are here, then we have some formula that we can give you while you are in hospital but then we will ask you to bring in your own formula so that we can teach you how to make up your own formula because all of them have different ratios.

This woman clearly wanted to find out if she should bring the formula ‘just in case’ of breastfeeding difficulties. This seemed logical given that the very premise behind this ‘additional’ breastfeeding session was to raise awareness about breastfeeding difficulties. Common breastfeeding scenarios which might precipitate the choice to cease breastfeeding, were considered within a group dialogue format. The session was prefaced on a classroom format, where the ‘expert’ lactation consultant quizzed participants about the ‘correct’ responses to various scenario dilemmas (nine in total), and even provided ‘homework’ for participants. Whilst the scenarios often led to self-disclosure from women, and a dialogue between the woman and facilitator, the ‘educator’ retained her position as authoritative expert.

During this session, there was an emphasis on building women’s confidence to breastfeed independently, with a subtle flagging of the need for expert assistance and guidance at the beginning of, and during, the breastfeeding journey. The educator confessed that in hospital, midwives sometimes cannot help providing hands-on support.

PEd 8:

Midwife: Because we know how to (attach baby to the breast correctly) sometimes it is hard for us not to do it for you, not to put the baby on the breast for you…
Although this midwife acknowledged that putting the baby ‘on’ for the woman was actually detrimental for breastfeeding, especially when the woman returned home, lactation consultants were positioned as the ‘troubleshooters’ for breastfeeding problems. Breastfeeding sounded complicated and troublesome during this session and the midwife commented a few times that breastfeeding was harder work than formula feeding. This educator also made reference to the breast as though it was a detached piece of apparatus. She made comments such as:

PEd 8:

Midwife: …Wish we had a full and empty gauge on the breast….When the breast is trying to heal itself it will make the milk a bit salty….Before you leave hospital we will show you how to hand express your breast…

This midwife also suggested to women that if they wanted a night off, they simply had to ask their partner to attend to the infant overnight, and attach the baby to the woman’s breast whilst she slept. This suggestion reflects the positioning of the breast as a separate piece of bodily equipment which will be expanded upon later in this chapter.

Antenatal prioritising of breastfeeding and the provision of educational opportunities for women and their partners seemed to have two broad aims. Firstly, breastfeeding was constructed as an essential activity embedded within the pregnancy, birth and postnatal journey. Secondly, the imperative to ‘convince’ as many women as possible to ‘commit’ to breastfeeding antenatally, clearly motivated health service expenditure for the provision of breastfeeding classes. The overarching aim was to ensure women and their partners were armed with as much information as possible about the nutritional benefits of breastmilk, and practical strategies to deal with early breastfeeding challenges, whilst also acquiring a positive affect towards breastfeeding. Antenatal commitment to breastfeeding was deemed necessary if women were to overcome potential hurdles, and maintain commitment to the supply of ‘liquid gold’.

4.4. Bringing the Gold ‘IN’

4.4.1. Colostrum

During the first few days after birth, midwives promoted unlimited, untimed access at the breast for the infant, on demand. When infants did not demand often enough,
or if their feeding time was deemed too short, the midwife as expert clinician, would hand express small drops of colostrum and feed this precious resource to the infant (this practice will be further analysed later in this chapter). Midwives, at both sites, expressed total amazement at those women who disregarded colostrum as an ‘inferior’ substance in comparison to breastmilk. Midwives were incredulous when anecdotally reporting observation of ‘certain cultural groups’ who seemed to negate the need for colostrum in the first few days, by supplementing with artificial formula until day 4-5 when the milk had come in (Field notes Day 17).

Women were universally encouraged to ‘put the baby to the breast’ as often as possible and for as long as the baby would suck. This ‘essential’ activity was required to ensure the infant received sufficient quantities of ‘liquid gold’. Infants who were sleepy, or seemingly not interested in feeding, often raised suspicion amongst midwives, about their effectiveness at acquiring ‘liquid gold’. Women experiencing nipple pain and discomfort, were subsequently encouraged to hand express colostrum to feed to the infant. Hand expression of colostrum became a ‘tool’ to be used, at the health professional’s discretion, in the pursuit of ‘liquid gold’. Midwifery role modelling of the use of this tool will be expanded upon later in this chapter.

4.4.2. Superior ‘gold’

Colostrum was revered as ‘liquid gold’ right up until the time an infant exhibited signs of ‘difficulties’ with breastfeeding, raising concern about adequate breastmilk supply. At this point, the focus shifted towards endeavouring to ‘bring the milk in’ quicker, to satiate the hungry and frustrated infant. In this context, the antenatal appreciation of colostrum as a rich, thick ‘wonder drug’ rapidly diminished as the hours ticked by in the postnatal period. Instead, the focus became the pursuit of the availability of ‘mature’ milk. Questions such as, ‘How is the feeding going?’ and ‘When did you last feed?’ were common interaction starters by midwives. This was invariably followed by advice on ensuring the baby unrestricted access to the breast. Midwifery discussions with women focused around ‘wees and poos’, specifically the number of ‘wet nappies’, and the ‘colour of poo’, the signs of low blood sugar level, or dehydration, and the signs that the milk might be ‘coming in’. Of particular significance, the language used to describe colostrum changed from ‘healing’ or ‘rich’ colostrum to ‘only’ or ‘just’ colostrum. The recommendations for women also
changed from, access and supply of colostrum, to more importantly ‘stimulating the
nipples’ to bring ‘in’ the volumes of breastmilk for superior ‘liquid gold’.

Clearly, the means to acquire this more desirable ‘mature’ gold involved sufficient
stimulation of the woman’s body to facilitate the abundant supply of breastmilk. The
use of skin-to-skin contact between mother and infant was promoted as ‘stimulating’
the ‘oxytocin’ release and ‘naturally’ manoeuvring the woman’s body towards milk
production. This tool for bringing in the milk, and for settling the infant prior to a
breastfeed, was extensively promoted as important to the ‘success’ of breastfeeding.
The following quote indicates the importance placed on skin-to-skin contact at birth.

Int 41:

Midwife: Unfortunately, it sounds like she missed out on that skin-to-skin as soon as
she was born. Her heart was a bit fast. Had she swallowed some
meconium or did they put her on your chest straight after she was born?

Woman: They put her straight on me but it was only for about 10 seconds and then
they put her over on the resuscitator under that heat thing...Does that mean
that she won’t breastfeed or just...

This woman’s fear, that the lost opportunity for early skin-to-skin contact had
long-term ramifications for breastfeeding accomplishment, reflects the importance
placed on initial skin-to-skin time.

Women were encouraged, and at times pressured, to remove their restrictive clothing
to enable the infant easy access to the breast regardless of the context. The following
excerpt reveals the tendency for midwives to request a woman to remove her top and
bra despite the obvious discomfort indicated by the woman. In this scenario, the
woman was entertaining visitors the day after birth.

Int 51:

Midwife: That’s alright. Because you said she’d get about four hours’ worth. That’s
fine, so have your friends with her, then strip her off, put her on your skin
so you’ll – while they’re here, well if you’re comfortable, we can do that.

Woman: Yes, yes.

Midwife: Well, I can help you do it now if you like.

Woman: No, that’s okay. It’s just a matter of having her on my skin, isn’t it?

Midwife: Yes, that’s right, so singlet off, you can leave her nappy on so we don’t
have any accidents [laughs]. Then just put her on skin to skin for a while
and then we’ll have another go in a little bit. It’s probably a good idea to take the bra off too, but I can get something to cover you right over.

Woman: Yes.
Midwife: Yes, alright, you’re alright. Do you need me to undo something?
Woman: No, I’ll just do it when you get the sheet, is it alright if you go get that?
Midwife: Yes, that’s alright. She’s a bit sleepy still, so she’s going to get a bit of skin to skin and we’ll see if she’ll have a little bit of a wake up and get on. See, she’s starting to mouth around a little bit now. Even if she sort of starts to look around and you want to express some into her mouth again. She’s starting to look around already (to partner) she is going to just take her bra off and do some skin to skin.... (to woman) do you want dad to take the singlet off? yeh he could do that, here you go...And then yeh ... Just give her a bit of time on there and she’ll probably wake up and have some then. But as I said, if she looks like she’s [looking around] and you want to put her on, and then you can just want to express some into her mouth, you can have a go at latching her, give us a buzz and we’ll come and give you a hand okay?

Woman: Good.

As alluded to earlier, women were primed, in the antenatal period, for the eventual prioritising of skin-to-skin contact in the postnatal period. Antenatal parenting education participants were shown videos which emphasised the importance of skin-to-skin for enabling an infant to ‘perfect’ breastfeeding. During one of the parenting education sessions, a video shown to participants implied that the physical stimulation of oxytocin, would be enhanced as a result of an infant’s moving hands and feet massaging the woman during skin-to-skin contact (PEd5). During this video, women were also advised to express colostrum regularly in an effort to bring in the milk sooner especially if a medical recommendation to supply the infant with water for rehydration was pending (PEd5).

Much midwifery discussion with women focused around when the milk comes ‘in’. Anticipation of the bodily changes associated with the milk coming in, was a common topic for discussion and there was a detectable ‘buzz’ around the milk coming in. Midwives spent time preparing women for the discomfort and surprising intensity that they may experience in their breasts around this time. Strategies to prevent discomfort were readily offered to women, often long before any problems had manifest. The desire to forewarn women of these problems appeared to be part of
the discharge process, which saw many women leaving the hospital environment around 48-72 hours after birth. This was the time when the first signs of the milk ‘coming in’ were expected to emerge. Discharge from hospital also signalled the beginning of restricted access to midwifery support and guidance. Women were warned to expect their breasts to feel like ‘rockmelons’, and strategies for coping during this transition time were shared in abundance, well in advance of this happening as the following quote highlights.

Interaction 73:

Midwife: Yeah, that bottom lip’s right down now isn’t it? Yeah, it looks good. Yeah, so if you do start to fill up, that, what will happen is the brown area will get quite taut...

Woman: Mmm hmm.

Midwife: ...and she won’t be able to get a good grasp.

Woman: Okay.

Midwife: So, and you spend a couple of minutes just taking a bit of milk off, hand or a pump, whatever. It doesn’t need to be a huge volume, and then they will be able to get on a bit easier, but that will be probably the day after tomorrow.

Woman: Mmm hmm.

Midwife: That will be sort of coming up to the 72 hours then won’t it?

Woman: Yeah.

Midwife: Yeah. Because when was she born? Yesterday morning was it?

Male: Yesterday, seven.

Woman: Seven o’clock.

Midwife: Yesterday morning.

Woman: Yeah.

Midwife: So she’s just 24 hours really.

Woman: Mmm hmm.

Midwife: Yeah.

The clear message to women was that around 72 hours after birth their real ‘liquid gold’ would begin to flood into their breasts.

Interaction 75:
Midwife: Yeah. So usually they’re losing weight for the first three days. Like even though your milk’s coming in, it’s probably going to come in a bit more tonight.

Woman: Yeah. They’re not as sore as they should be.

Midwife: Yeah.

Woman: They’re massive.

Midwife: So that might not happen. But odds are it will. It’s usually around that 72 hour mark that…

Woman: That’s right, the magic 72 hours.

Midwife: …the milk comes through. Yeah. So when is that? Is that tonight, would you say?

Woman: He’s 48 hours today. At 6.30 this morning, he was 48 hours. So it’s more like tomorrow.

Midwife: Yeah. So it’ll be 72 hours, early hours of the morning. So yeah. It’ll probably be tonight I’d say you really know about it. So that’s when they start to put the weight back on then.

The prospect of infants having large volumes of milk readily available which would make them sleep for longer periods appeared to be so exciting for all concerned that this was a feature of many conversations during the early postnatal period. The suspenseful wait for this saturation of breastmilk seemed overwhelming for some women, who began quite early in the postnatal period to construct themselves as having under supply issues, with comments such as ‘I have got no milk’, or that their infant was ‘starving’.

Concerns about infants becoming jaundiced, tended to heighten concern around whether the milk was in, or would come in soon, to offer a solution to the emerging problem. Whenever an infant exhibited signs of dehydration, or jaundice, midwives and lactation consultants equally began to seek avenues to speed up the process of milk coming in, in an effort to avoid transfer to the Special Care Nursery for treatment. Unfortunately, this heightened level of concern seemed to set the midwife and the woman up in a scenario whereby one party, the midwife, sought to obtain ‘liquid gold’ from the natural ‘supplier’, the woman, through expressing, in order to assist the ‘vulnerable’, and inefficient extractor, the infant. In this context, assessment of adequate performance of breasts came under health professional
scrutiny.

4.5. The ‘Faulty’ Equipment

Breastfeeding performance, for the ongoing supply of ‘liquid gold’, was expected from women who wanted the ‘best’ start in life for their offspring. Midwives positioned themselves as ‘expert helpers’ during this period and positioned women as the owners of the ‘equipment’ which supplied breastmilk. This was evident in midwifery and lactation consultant language and practices centred around the breasts and nipples rather than on personal engagement with women.

A tendency to segment the female body into its various components began during pregnancy. At parenting education classes, each week, one aspect of the woman’s bodily performance was scrutinised. During one of the recorded breastfeeding sessions the parenting educator, in an effort to be light-hearted and jovial, alluded to the role of women’s breasts during breastfeeding when she said “…You have got the equipment and the equipment is good to go” (PEd 2).

This metaphorical representation of the breasts as the machinery for ‘liquid gold’ supply was not an isolated occurrence. The following quotes from another parenting education session compared the breasts to apparatus such as vending machines:

PEd 2

Midwife: If the vending machine isn’t getting pressed it won’t make enough….The more often the baby presses the button, the more milk you make.

In this way, the breasts were represented as equipment from which to extract milk. During one antenatal education session ‘mastitis’ was positioned as a functional mechanistic problem of “…a blockage in the pipes” (PEd 2).

Interviews with midwives and lactation consultants confirmed the continued use of the ‘equipment’ discourse into the post-partum period:

Senior Staff Interview (SSIV) 10

Lactation Consultant (LC): If the milk is in and they’ve got nice equipment then they can do it…I suppose you can’t generalise on everything. You have to look at if there’s milk there, if they’ve got good equipment, the baby can get on.

The notion of breasts as equipment extended to discussions around nipple shapes and sizes, nipple damage, breast size, breast implants or reduction surgery (i.e. equipment
which is inadequate or has been tampered with), breastmilk over or under supply, or infected breast tissue. Faulty bodily equipment, which was not achieving at maximum production levels, was often cast as sabotaging breastfeeding efforts. In particular, ‘inverted nipples’, or ‘flattish nipples’, emerged as the most common and most challenging equipment failure which perturbed midwives and lactation consultants.

SSIV 5

LC: …depending on the problem that presents, sometimes it’s very complicated like the baby might have tongue tie, the mother may have inverted nipples, a bit of both. She might be a very big busted woman. Complications occur. I think your job is to get this baby feeding first and foremost, show her how it’s done and then get her independent in doing it herself.

It was as a result of these perceived ‘equipment problems’ that midwives and lactation consultants adopted an expert ‘helper’ approach to assisting women provide breastmilk to their infants.

Infants were often blamed for ‘damaging’ the nipples. Midwifery language included warnings that the infant might ‘rip’ the nipple off, or that the nipples are ‘falling off’, indicating the extent to which an infant could potentially damage the breastfeeding equipment. Suffice to say midwifery ‘protection’ of breastfeeding led to infants at times being positioned as destructive beings:

Int 79:

Midwife: Well it looks like it’s damaging your nipple. That’s what you just need to think about, really trying to get that good attachment. See, there she probably doesn’t have enough of that areola in her mouth again. Her lips are probably not quite wide enough. You just really need to encourage that wide mouth open. After a couple of weeks you’ll be undoing your bra [unclear]. You just really need to encourage her to do the wide mouth. It’s very easy for us to go, oh, you know, just put her on, but teaching her to get the wide mouth, before she gets the reward, which is the feed, then she’ll get the message after a couple of feeds.

The focus on acquiring ‘liquid’ nutrition resulted in the breast being likened to a ‘hamburger’ by one midwife who advised women to squish the hamburger (shape the breast) when attaching the baby to the breast. Midwives also variously referred to the breast as, the ‘milk bar’, a ‘cow’s’ udder, or the ‘pot’ with “…there is milk in the pot
for you” (Int 72). Whilst women were entrusted to operate the ‘equipment’ which supplied ‘liquid gold’, within this discourse it was predominantly assumed that women were inexperienced in this area.

4.6. The Woman as Inexperienced Operator

Prioritising ‘getting the baby fed’ first and foremost was abundantly apparent within this dominant approach. Midwives and lactation consultants indicated an obligation to ensure that infants had as much access to breastfeeding as possible. In this context, there was incorporation of language associated with teamwork to ensure the infant was adequately fed. Midwives regularly referred to ‘we’, for example ‘what have we been doing about X’, or suggesting ‘what we could do is…’. However, midwives and lactation consultants belonged to a health care system which, from the moment the pregnant woman entered the institution, positioned her as lacking in the knowledge and skills for pregnancy birth and the postnatal period.

The fact that the woman owned the ‘equipment’ from which to extract the ‘gold’, meant that her ability to ‘operate’, or ‘drive’ the process of providing ‘liquid gold’ for her infant was constantly under scrutiny. Within the health care system, infants were discursively positioned as vulnerable to the risky decision making of their mothers. Much effort was expended in ensuring women made ‘informed’ choices in the ‘best interests’ of their infant. Later in this chapter, the discursive positioning of the infant and its capacity to extract breastmilk will be presented. At this point however, it is important to consider the positioning of the woman as the owner of the ‘equipment’ and her exposure to surveillance of her ability to manage her bodily equipment.

4.6.1. Lacking knowledge

In general, women were collectively positioned as lacking in up-to-date information about providing ‘liquid gold’. As presented earlier, during the antenatal period, women were encouraged to attend breastfeeding education classes to learn as much as possible about the importance of breastfeeding and ‘how to’ perform it. Women, who had previous experience with breastfeeding were offered additional education and opportunities to increase their understanding around some of the difficulties they may encounter.
The presumption that women know very little about the practicalities of breastfeeding a newborn, continued after birth. Women were encouraged to call the ‘expert’ midwife when necessary and the ‘expert’ often offered unsolicited help and advice. However, when staff were busy it seemed that assumptions were also conveniently made about an individual woman’s ability, or not, to independently breastfeed, dependent upon her previous experience. At times, the anticipation that a woman’s knowledge base was minimal seemed based simply on the fact that she had requested assistance.

Previous breastfeeding experience was rarely discussed when women requested assistance, instead the focus moved straight onto ‘this’ breastfeed, ‘this’ baby and the ‘status’ of the milk arrival. In the following interaction the midwife had helped the woman to breastfeed several times during the shift but had not engaged in any discussion of the woman’s previous experiences with breastfeeding. Instead, the midwife’s focus was on ‘this’ breastfeed only. Therefore, any additional contextual information was deemed irrelevant. The following excerpt was collected five and a half hours into the shift, the midwife had consistently utilised a hands-on approach when assisting with the attachment of the infant to the breast:

Int 51:

   Woman: Because I’ve seen mothers, they just do it and it takes five minutes and they’re done and they continue their shopping.

   Midwife: [Laughs], yes, that’s right, but this is the learning phase, and it’s normal for everything to take a bit of time, this is your first baby?

   Woman: No, second, but I didn’t want to feed the first one.

   Midwife: Okay, so this is sort of like, if you’re feeling up to it, maybe next feed you might want to try in the chair. I think you might find it a bit easier and you’ll be able to see better. Sometimes your bottom gets sore in these beds …

The lack of discussion around this change of mind from ‘not wanting to breastfeed’ previously to being motivated to breastfeed this time, and the experiences associated with this decision, indicates a ‘missed cue’ for engagement with the woman beyond simply getting the baby ‘on’. This interaction highlights the perceived inconsequentiality of the woman’s prior experience in relation to the ‘here and now’ of getting this baby ‘fed’, especially in the presence of the ‘superior’ and authoritative knowledge possessed by the midwife.
In comparison to midwifery experience and education around breastfeeding, women were collectively assessed as lacking in relevant knowledge and skill development. The health professional inclination to provide long spiels of information to women, in order to compensate for their lack of knowledge, was all consuming at times. It seemed the more knowledge the midwife or LC had, the more they wanted to share and transfer to the woman. This was often regardless of whether the woman had indicated any desire for the details. The following quotation was taken from an interaction between a midwife and a multiparous woman preparing for discharge three days after birth. Significantly, this woman had breastfed previously for six months:

Int 26:

Midwife: Do you have any questions about breastfeeding?
Woman: Well, my breasts are a little tight…
Midwife: Yes, they’re full. So that’s quite normal, the fullness in your breasts. It usually lasts about two or three days, okay. What you need to do with the fullness is try not to express any milk and try to feed from – still alternate your starting breasts, but completely drain the first breast first before you offer the second breast. Once that first breast is soft, like it was when you were pregnant, then it’s okay to give your baby that second breast. So it might take a couple of days, baby might only want about half of that first breast per feed. Then the next feed you go on the other side and start feeding on the other side, and your body’s like a vending machine. So the more baby sucks on that one nipple, your body is telling your brain to make that much milk. So your body will adjust, if you know what I mean. That fullness in your breast will probably only last for a couple of days.

Woman: So I needn’t worry about it – do I need a breast pump or anything?
Midwife: I wouldn’t really, because the more that you take off, your body will replace it as well. So I’d let the baby do it. Again, however much the baby sucks, that’s what will be replaced.

Woman: Great, thank you…
Midwife: Things to look out for if your breasts are really quite full is mastitis, to look out for signs of mastitis. Do you know what they are?
Woman: What are they?
Midwife: Mastitis is an inflammation of the tissues around the milk ducts, so it’s not actually in the milk, it’s the tissues that are around the milk ducts. And it’s
caused by a blockage. So it might be because, sometimes if you have your finger there on your breast it can stop the milk from draining down, because you have breast areola or the breast tissue up here as well, and underneath your armpits as well, so you need to let that drain. So it’s good to let your breasts have no bra on when you’re breastfeeding, and that just allows the breast to drain. Another thing that can cause it too is if you’re really quite full and the breasts aren’t draining properly. So the signs of mastitis are if you have a lump. Now it’s quite normal to have lumps that are a little bit tender, but if they’re more extremely tender and also red, and you feel like you’re getting the flu, then that can be signs of mastitis. If you do start to develop that don’t stop -

Woman: No, I don’t think I have.

Midwife: No. You would know.

Woman: Just a little tight, that’s all…

Midwives often gave similarly long monologues about things to watch out for over the next few days and following discharge. The desire to bridge the gap in knowledge between the midwife and woman was a common finding and many midwives stated part of their role, postnatally, was to impart their ‘knowledge’ to women.

Assisting the inexperienced operator of the ‘equipment’ in this way, by sharing all of one’s knowledge, seemed to be discursively embedded into midwives and lactation consultants who subscribed to the ‘liquid gold’ philosophy. During a phone conversation, prior to attending the ward one day, a midwife indicated to me that she had another breastfeeding woman who would be happy to be included in the study but that she had ‘cured’ her, as she was now breastfeeding independently. This noticeable midwifery focus on transporting breastfeeding knowledge from health professional to the ‘operator’ of the ‘equipment’ was abundant. The woman was often positioned as being in need of a ‘crash course’ in breastfeeding during the first few postnatal days.

Commonly, midwives offered suggestions, instructions directions and advice, to women, as the following excerpt indicates:

Int 67:

Midwife: So [participant name] it’s really important that you continue trying to increase your fluid intake. Okay? To about two to three litres a day.
Woman: Okay.

Midwife: Really important.

Woman: Yep.

Midwife: That will help the milk come in. Okay? It’s also really important to try and get as much rest as you can. Okay? To try and eat three meals a day to help bring your milk in. Okay? There’s the tea and coffee rooms out there. There’s bread in the fridge and you can make toast at any stage. There’s also butter and some jams [unclear] as well. So you know, any time you’re feeling hungry just go and eat.

Woman: Yep.

Midwife: Breastfeeding does make you hungry, okay? So that will help, okay?

Woman: Are there any particular foods [unclear]?

Midwife: No. Just a good diet. Nutritional [unclear]. That’s really important to try and help bring that milk.

Woman: Yep.

Women were often reminded of these types of ‘commonsense’ messages, as it appeared no opportunity was lost to ‘inform’ the woman of her responsibility to produce ‘top quality’ breastmilk, made available as soon as possible and for as long as possible. The following excerpt indicates midwifery interest in potential factors which may inhibit adequate supply of ‘liquid gold’:

Int 18:

Midwife: That’s good. That’s excellent. Now did anyone talk to you about contraception?

Woman: They did ask me about it but I said that I’d be fine.

Midwife: You’re right?

Woman: Yeah, yep.

Midwife: Do you know what you want to do?

Woman: I’ll probably go back on the pill.

Midwife: Okay, mini pill with breastfeeding.

Woman: Oh, yeah.

Midwife: We don’t want ...

Woman: I do remember reading that not long ago.
Midwife: We don’t want to dry your milk up.

Whilst midwives endeavoured to transfer their knowledge to women by offering unsolicited suggestions, instructions, directions and advice, they were also supervising and assessing the woman’s skills at ‘getting the baby on’ and at hand expressing ‘liquid gold’.

4.6.2. Lacking skill

The positioning of women as universally lacking the necessary level of skill to ensure adequate supply of ‘liquid gold’, was a recurrent theme in the analysis of this data. Expert supervision was deemed necessary to ensure the baby was ‘getting on right’, was sucking ‘nutritively’ and was not causing ‘damage’ to the breasts. This communicated an impression of the woman as a novice.

Observation of breastfeeding, by a midwife or lactation consultant, invariably generated a variety of ‘faults’ in the woman’s technique. Midwives verbally ‘tweaked’ at positioning by advising the woman to change her hand positioning, to hold the baby in a particular way, to take the baby off and ‘try’ again after waiting until the infant’s mouth was open wider, and generally give directive instructions. The common scenario of a woman ‘trying’ to put the baby on whilst a midwife observed, offered suggestions and advice, or physically intervened on the infant’s behalf, often played out as a teacher and novice situation. The following excerpt shows the midwives’ own presumed preparation for ‘helping’ with the reference to ‘popping’ on the gloves:

Int 60:

Midwife: I’ll get you to try and pop him on and I’ll just pop my gloves on.

Woman: Okay. Good boy.

Midwife: Keep that hold until he really continues with the big sucks. Should just take a little bit more I think. I’m going to move his arm just – I’m going to move it down. Would you mind just moving over a little bit? Beautiful. Try again…Remember that little trick we did before. I actually (remember) let him suck on my finger. Okay now I’m going to quickly get you to turn him around now. Yep, quick. That’s it. Beautiful.

There was a presumption that all women would want their breastfeeding skills assessed by ‘an expert’ health professional, as the following excerpt indicates.
Int 84:

LC: Okay. Would you like me to come back then and check your latch for you?

Woman: If you want.

LC: No, would you like that to happen or you’re happy with what’s going on?

Woman: I’m happy at the moment but she’s still not staying on there. But I mean she mightn’t have been hungry – are you going to be around all day?

LC: Yes.

Woman: Because I can feed her at 11 and see how she goes …

LC: Certainly.

Woman: … and come back this arvo or something maybe?

LC: Yes, no problem at all. You only have to buzz and ask the staff and we have the phone and they can call us and we can come.

Woman: Yes, okay, that sounds good.

LC: So you have a little try at 11.

The lactation consultant, in this scenario, conveyed a degree of doubting the woman’s skill and reinforced the need for assessment. Health professional references to ‘it’ when referring to the breast, further indicated a discursive separation of the ‘equipment’ known to produce ‘liquid gold’ from the known provider.

The impression that women were being ‘tested’ to ‘check’ if they had learnt how to breastfeed ‘properly’ was apparent in both the language and behaviour of midwives. The regular supervision of feeds, and interjection when the actor was not performing to the predetermined script, was ongoing.

Int 52:

Midwife: Okay. Alright. Well, how about you show me how you do it. [Inaudible]

Woman: Yep…

Midwife: Make sure his nose is in line with the nipple, it shouldn’t be too far down, too far up, should be just in line there. Okay, that’s it. So just make sure his mouth opens really wide, okay, and then bring him towards you. Wonderful. Okay, now can you see the way he opens his mouth quite wide.

Woman: Yep.
Midwife: The moment he does that pop him straight onto your breast. Do you see the way your hands are shaped? You shape them like a C position. Try to get your hands right under your breast into a U shape. That’s it, wonderful. See that we’re trying to shape – he’s a bit bored there. Do you see your hands are shaping into the shape of a C again? Try to get – that’s it.

Women were repeatedly placed under health professional scrutiny of competency attainment with breastfeeding. During observational periods, at MUB in particular, midwives were observed studying performance without any associated ‘chit-chat’. The prolonged uncomfortable silences that ensued were captured on the audio-recording of the interactions and, as an observer, were at times quite uncomfortable.

Int 33:

Midwife: Okay let’s put her on. I want to see what you’re doing…(inaudible) performance anxiety. [prolonged period of silence while woman sets up for feed]

Testing the woman to determine if her technique with ‘latching’ baby to the breast was consistent with a particular midwives’ preferences was commonplace, and this ‘service’ was offered to women whether they requested it or not.

Int 9:

Midwife: Let’s get ready. Let’s do all the things we talked about earlier hey. Let’s wake him up. Okay, so you’re all nice and comfy?

Woman: Yeah.

Midwife: Alright. Alright, I’m going to sit back and see how much we learnt, huh? Okay, so we’re going to unwrap him to a singlet because this baby needs to be kept awake because he does the boy thing, he expects it to just pour out. He doesn’t like working. That’s the way. Are you right, just pop his head on to the side. That’s the way, fabulous.

At times, the woman was positioned as a child, and the language adopted by the midwife reflected this. Women were variously referred to as, ‘sweetie’, ‘honey’, ‘girl’ and ‘sweetheart’ by the midwives at both sites. This type of language positioned the woman as vulnerable and in need of a paternalistic style of nurturing and guidance:
Int 63:

Midwife: Okay, good. You show me what you’ve been doing, sweetie, and I won’t be sort of be hands-on unless you need help.

In this paternalistic way, midwives made decisions for women and even recommended that women adhere to the professional recommendations for comfort adjustments, as the following quotation highlights:

Int 62:

Midwife: …you just need to keep stimulated under here. If she’s getting frustrated, move your hand across your breasts; that will help a little bit more milk to flow. If you want to come out here and grab her under there, that’s it, is that still comfortable?

Woman: Yes.

Midwife: You don’t look comfortable actually. Try and see if you can straighten up those shoulders. I’d like to see you probably a little bit higher actually. She’s comfy there now. Let’s just see what she does. See if you can adjust her a little bit higher actually; have you got her?

Woman: Yes.

Notably, encouragement was provided to women as they and their infant began to achieve the picture perfect ‘Special K’ latch (lips flanged out in the shape of the red Kelloggs ‘Special K’ breakfast cereal shape). Until such time as the ‘latch’ was perfected however, women were encouraged to continue to ‘try’ to put their baby ‘on’ the breast preferably with midwifery supervision or help.

The use of the language of ‘trying’ to attach the infant to the breast mirrors antenatal declarations of ‘trying’ to breastfeed. This language illuminates the fact that the process of extracting ‘liquid gold’ requires more than simply the woman perfecting the art of getting the infant ‘on’ correctly. Instead, in order for ‘liquid gold’ to be provided ‘successfully’ there has to be infant participation in the process. The role of the newborn in the extraction of ‘liquid gold’ emerged as a focal point within this discourse.

4.7. The Infant as Inefficient Extractor

4.7.1. Antenatal genius

The construction of the infant antenatally, as an ‘all knowing’ individual, set breastfeeding up as a skill the ‘woman’ had to learn. The infant was presented as
‘born knowing’ how to breastfeed. Women could be forgiven for anticipating antenatally that as long as the infant was provided with ready access to her breast, it would virtually attach itself with minimal guidance and support. One of the antenatal educators referred to infants as having “…read all the books” and know that their “…job in life is to make milk” (PEd 1). Infants were also positioned as being ‘smart’ and having a ‘job’ to do. In fact, breastfeeding difficulties were situated antenatally as predominantly connected to the woman’s lack of skill and knowledge. Newborn physical impediments for breastfeeding (such as tongue tie) were not mentioned antenatally, in favour of promoting the ease with which infants take to the breast.

The first breastfeed was prioritised, during antenatal classes, as crucial to the ongoing success of breastfeeding. The impression that the “…baby shows mum how it is done” and that the infant does not operate in line with a particular routine or ‘timing’ was reinforced during ‘classes’ (PEd 8). The importance of baby-led feeding was reiterated often and women were reassured that their infant would always love them, even when it seemed that they were resisting latching to the breast. The reason given by one parenting educator was that the woman represented the ‘milk bar’ for the infant (PEd 1).

The notion that an infant ‘thinks’ and ‘decides’ what to do, was introduced during pregnancy. The infant was at times constructed as ‘selfishly’ demanding its needs be met, to be fed and loved and cuddled (PEd 8). Some of the observed parenting educators depicted infants as ‘impatient’, getting ‘antsy’, and ‘expecting’ the milk to be there when they wanted it.

4.7.2. Postnatal problem

During the postnatal period, faith in the infant’s ability to attach to the breast, and lead the process, began to rapidly diminish following the first feed. Recognition that not all infants found the breast and commenced breastfeeding unassisted, heralded the beginning of a period of reframing infant capacity to extract ‘liquid gold’ efficiently. Observations on the postnatal ward, revealed that the infant was positioned as a separate individual whose physical attributes, personality and capacity for active agency, impacted significantly on whether breastfeeding progressed uneventfully or not.
Overall, the mother and infant were seen as two completely separate individuals each with their own ‘job’ to do. When gauging expected infant behaviour, and milk arrival, the health professional language seemed to shift from ‘how long ago did you have the baby’ to ‘how old is he?’ reflecting the shifting focus from mother to infant. Health professionals quickly adopted the role of ‘infant interpreter’ and offered many ‘explanations’ of what the baby was thinking:

Int 21:

Midwife: Look at her sleeping on the job, she just feels comfortable there, that’s why.

Int 22:

Midwife: Yeah, so what we can do is because she’s already had a feed we can just pop her back in the cot, because at least if she’s in the cot – like if she’s being held a lot she’ll sort of be like oh okay this is comfortable. But if she’s in the cot she’ll realise when she’s hungry and she’ll let you know because she’s not being sort of as comforted.

This woman’s desire to hold her infant was discouraged because the infant would, apparently, not ‘demand’ as much ‘liquid gold’ if it was being held or comforted when not being fed. Midwives attempted to avert the ‘danger’ of an infant becoming an ‘inefficient extractor’ by encouraging the woman to restrict holding the infant when not feeding. The woman’s desire to remain with her newborn infant at all times was surprising to some midwives who clearly saw no need for the mother to be present at certain times:

Int 60:

Midwife: Blood collector’s here, so are you okay if I bring [Name] into the nursery – they’ve got a little bit more room and they can do his blood tests?

Woman: Yeah that’s okay.

Midwife: Are you okay [mother indicated non-verbally she was coming too] do you want to be with us?

Woman: Yeah, yeah I’ll come.

Midwife: [surprised] You want to be with us?

Woman: Yeah.

Midwife: Okay.

Woman: I was with him last night when he got them.
Midwife: Okay. Alright. We’ll get that done and then we’ll...

This type of non-verbal separation of the infant, as a completely separate individual from the woman, was also reflected in the assessment of infant performance at breastfeeding and the verbal positioning of the infant as a problem. This tendency to position the infant as ‘problematic’ began sometimes with simple ‘indicators’ such as the way the infant cried:

Int 68:

Midwife: Now he goes on all right, doesn’t he?

Woman: Yeah, no, he’s good.

Midwife: With a cry like that, he’d want to. What would we do with him if he didn’t?

Woman: I know. It’ll be the one where he goes on too quick and then realises he’s not on and then he’s like...[baby still crying].

Midwife: Goodness me, young man.

This woman’s feelings towards her infant could have been compromised by this brief communicative exchange, yet the importance of attachment and bonding seemed to be dismissed by the midwife in this scenario.

Assessing the infant’s performance included checking the nipple for elongation, checking whether the infant had ‘brought the nipple out’, or had ‘damaged’ the nipple. The infant’s ability to damage the ‘equipment’ meant that the newborn was often positioned as an ‘antagonist’ to the woman. At the extreme end of this antagonistic discursive positioning of the infant the language used to describe breastfeeding included a ‘battle’ or ‘fight’. The breastfeeding infant was ‘fighting at the breast’ or ‘fighting at the nipple’, ‘ripping the nipples off’, ‘dragging on the nipples’, ‘cracking’ and ‘blistering’ the nipples, ‘pleating’ the nipple, ‘doing damage with every feed’, ‘chewing the nipples’, ‘hurting’ the woman, and generally ‘fussing at the breast’.

This incorporation of negative language into the descriptors of infant performance at breastfeeding has been one of the most revealing aspects of this empirical analysis. The influence of midwifery language on maternal interpretation of her infant’s behaviour has been succinctly captured in the following:
Int 13:
Midwife: …your nipples are a bit tender because you’re not used to having this little
piranha hanging off them every five minutes.

Six weeks later when I interviewed the woman at home she made the following
interpretation of her infant:

IV 1:
Woman: …with the latching on and that, she’s a bit like a piranha. She grabs
straight on…

Infants were accused of ‘getting impatient’, having ‘temper tantrums’, getting into a
‘tizz’, ‘using mummy as a dummy’, getting ‘cranky’ or ‘angry’, ‘playing up’, and
‘complaining’ when not getting their needs met.

Int 70:
Midwife: Okay? Babies will cry. They’ll cry about everything, that’s how they talk.
They talk with their eyes and they cry.
Woman: Oh okay.
Midwife: So it doesn’t mean something bad. Just means that he’s complaining, and
he’s allowed to complain. So you’re going to complain all you like. Yeah
you’re complaining, see it’s not coming quick enough mum, hurry up
mum, I don’t want to do this mum, my jaw’s sore mum.
Woman: Yep, yep, all right.
Midwife: Okay? So he’s a boy, so he’ll probably complain more than a girl.
Woman: Yeah and he was 13 days late so…
Midwife: Oh there, so you’re a lazy fellow?
Woman: Yeah.

The gendered nature of this midwife’s criticism of the infant is particularly alarming.
Universally, the most frequent ‘personality trait’ assigned to newborn infants by
midwives assisting with breastfeeding, was the ascribed infant tendency to be
‘impatient’ or ‘lazy’. Midwives deemed an infant ‘lazy’ if it was not sucking for long
enough and consequently not acquiring a sufficient amount of ‘liquid gold’ at each
breastfeed. The following interview with a woman, six weeks following discharge
from the health service, is an example of this language and the impact on the woman:
Interview 11:

Woman: …I think they just wanted to make sure he had a certain amount. I think that was their main priority. Yeah….Well he kept coming off anyway and the first woman just said he’s just a little bit lazy with his feeding. But that wasn’t true because (a) he’s a big boy and you know hungry and secondly a couple of days down the track I realised that that wasn’t the problem at all (laughs). That doesn’t sound very good, but yeah I mean it wasn’t like it was the midwives’ fault or anything, but I mean he was having…I was having trouble latching on right from the beginning. We had to actually express some of the colostrum so he had the proper amount…In fact I think a couple of them said that to me…At the time I believed them because I thought maybe that was why that was happening, why he wasn’t latching on properly.

Interestingly this woman changed assignment of blame for breastfeeding difficulties from ‘he’ was having trouble latching to ‘I’ was having trouble latching.

The construction of an infant as impatient seemed to be practised by some midwives more than others. Commonly, references to infant impatience were focused on the beginning of the feed; ‘they’re impatient’, ‘they want it right now’. However, occasionally the infant was cast as having an impatient personality, resulting in an inability to bring the milk ‘in’ due to a lack of sufficient sucking and disinterest in doing the ‘work’ required to retrieve the ‘liquid gold’.

The following excerpt is from an interaction between a woman receiving midwifery support at home on day five and a midwife whom, I had noted, regularly constructed infants as ‘impatient’. This passage from interaction six is quite lengthy. This is deliberate, as it provides the reader with an insight into the pervasive extent of this negative positioning of the infant. This excerpt is one of the strongest illustrations of negative representations of the infant, as an antagonist.

Int 16:

Midwife: Why are you bringing yourself off mister? Going on much easier now that your nipple’s softened. (midwife had hand-expressed for the woman)

Woman: Yeah and that’s what I thought last night. It’s just it’s all so hard.

Midwife: Yeah. When you’re too hard and his little chin it was just making it too hard for him to get on, but he’s now actually going on quite easy. You’ve just got to keep him on. What he’s trying to do is work that next let down and he’s too impatient to do it.
Woman: Come on. Because yeah it seems to take forever to feel it come down as well.

Midwife: Yeah, he’s just impatient. That’s what it is. He’s wanting instant reward. No you keep sucking, that’s the only way we’re going to let down.

Woman: Come on bub.

Midwife: It’s two sucks, stop, get cranky.

Woman: Let go and then hurt mum. Come on... Mummy’s not sad, come on. Open…Come on darling. That’s it.

Midwife: He will come. Come on. **If he mucks up too much on one side**, just pop him onto the other. Just switch feeding because whilst he’s been feeding on this one this one has let down, so it’s just sitting there. Often when they muck up too much just pop them over.

Woman: He seems to like my left breast better for some reason.

Midwife: Okay, let’s pop him onto the other side. I’ll just put this under. You can just go back to the other one if you need to.

Woman: I know darling but mummy wants to feed you. Yeah. Oh.

Midwife: **It’s a hard life for little boys.** I’ll just pop that right under there. Okay…[later in the interaction]

Midwife: **Getting himself into a tizz and he’s not even doing anything. He’s just thinking about it. Whose personality’s he got? Who’s impatient in your house?**

Woman: I don’t know.

Midwife: Who’ve you taken after?

Woman: Yeah he wasn’t this bad in the hospital but he certainly wasn’t easy to attach. He sort of had a wriggle.

Midwife: Because he’s not wanting to do the work.

Woman: No.

Midwife: **He’s his own worst enemy here.** He’ll get going but he’s only prepared to do so many sucks and then he comes off and gets the cranks because it’s not continuing. Oh he actually started again then himself. That’s what we want. **He might have decided he’s not going to muck up any more.** I’ll get a blanket for you to put over him so he doesn’t get cold. I’ll put this over him. He’s doing it properly…[towards the end of the interaction]

Midwife: It’s just a bit trying to avoid him getting too easily frustrated and cranky.
Woman: Dad would say it’s your mum’s personality.

Midwife: [Midwife Laughs]

As discussed previously the tendency to imply that infants had active agency to ‘think’ and make ‘decisions’ about breastfeeding was a widespread discursive tendency in the postnatal period. Infants who ‘cooperated’ with the midwife and the woman, and became ‘efficient extractors’, were labelled ‘good’, ‘clever’, and ‘smart’. However, those who made the ‘decision’ not to cooperate, were instead positioned negatively, as the antagonist, or lacking in patience, as outlined above.

As indicated previously, some gender differences were detected in the positioning of infants. Most notable was the tendency to cast male infants as especially ‘problematic’. Male infants were often positioned as ravenous and loud ‘little men’. At times, this was constructed as a good thing “…he says you’re not getting rid of my booby that quick…”, and “…little boys especially, let me tell you. They like to get on the booby…” (Int 28). However, the predominant references to male gender set infants up as different, and more problematic, than females. References to ‘funny man’, ‘little man’, ‘cheeky boy’, “…he’s a boy, so he’ll probably complain more than a girl…” (Int 70), or “…he does the boy thing, he expects it to just pour out. He doesn’t like working…” (Int 9) and “…these boys have got an endless appetite…” were common during the postnatal period. The following excerpt highlights widespread exposure to this kind of discourse.

Int 16:

Woman: He’s pretty good like it’s…

Midwife: Now he’s relaxed and he’s doing it beautifully.

Woman: Yeah, alright.

Midwife: Oh dear… boys!

Woman: That’s what the nurse at the hospital said. Wait on, you’ve got a boy. You’ve got a big boy. I think it was day two or something she was saying yeah day two is the worst. You can’t give them enough anyway like and you’ve got a big boy she said. But yeah I do feel that once the breastmilk sort of settles I’ll be okay. Yeah I’m just so engorged today.

In addition, a sexualised discourse also surrounded male infants, and at times this was initiated by the midwife:
Int 18:

Midwife: But it will only do your milk supply good him wanting ...

Woman: I did and then I thought I’ll give him the dummy and see if he settles. I thought I can’t let you sleep sucking on my boob.

Midwife: He says I wouldn’t mind, I’m a boy.

Woman: They’re getting a bit sore.

Midwife: Boys like their boobies.

Woman: I thought they’re getting a bit sore, mummy needs a little bit of a rest.

Midwife: Don’t want your clothes off but you want your boobies.

This type of discourse constructed male infants variously as either better or worse ‘extractors’ of ‘liquid gold’ depending upon the source of the language. Interestingly a gendered discourse in representations of female infants was not detected.

The physical attributes of individual infants were also deemed to be potentially improving, or restricting, the infant’s capacity to efficiently breastfeed. For example, midwives commented on the ‘beautiful breastfeeding mouth’, or ‘good jaw movement’, or ‘good jaw action’. Infants who sucked well were referred to as a ‘good little sucker’, or ‘sucks like a trooper’. Physical attributes, which restricted the infant’s capacity to extract ‘liquid gold’, were identified by midwives and discussed with women. For example, infants were assessed as having a ‘tiny little mouth’, a ‘receding chin’, or a ‘tongue tie’. Whilst a receding chin, small chin or small jaw, were attributes which were not rectifiable in the short term, a ‘tongue tie’ was identified early and a plan of action devised.

Int 44:

Midwife: Okay, well if it’s done tomorrow, what usually happens, with the tongue tie, if you’re in for a couple of days they usually put you on a nipple shield so you have those and then they get you doing that to get the feeding, get the milk established. Then in two weeks time they send you to a paediatric doctor and he might just snip that tongue tie. It’s done there, then and there. No locals, no anaesthetics needed, it’s just a very quick snip and then we put the baby on the breast.

When assessing the infant’s capacity to breastfeed efficiently, midwives often focused on the infant’s chin. Midwives indicated repeatedly that there were opportunities to intervene during the breastfeed to improve the ‘liquid gold’
extraction by pushing the infant’s chin further down whilst attached to the breast – thus ensuring the acquisition of the much desired ‘Special K’ lips, combined with improvement in effective chin massage on the breast. This type of ‘hands-on’ intervention represented one component of a smorgasbord of interventions which the midwife, and later the lactation consultant, compelled women to take advantage of during the first few weeks after birth. Pursuit of the ‘Special K’ was an identifiable goal of both midwives and women alike within this support style:

Int 69:

Midwife: All right then. Now do you need a hand to put this little one on? (baby was feeding throughout this interaction and it was the woman’s 3rd breastfed baby)

Woman: I think we’re going okay. My nipples are getting really sore.

Midwife: They are?

Woman: Yeah. But I think he’s going okay. Like, he’s got that Special K...

In order to achieve the goal of maximum operation of the equipment, and efficient extraction of ‘liquid gold’, it seemed that often expert assessment and guidance was imposed. The broader data set provided a sense that without the expert assessment the woman might never know what the ‘Special K’ looked like and whether she had acquired the ‘picture perfect’ latch. Midwives therefore, offered their services to women in an effort to ‘save’ the woman and infant from potentially sub-optimal ‘liquid gold’ production, supply and removal.

4.8. The Expert Midwife

Midwives represented the main group of health professionals women were exposed to during the first week after birth. During pregnancy and birth women often interacted with medical, midwifery and some allied health care practitioners however, the postnatal period represented a time of extensive and ongoing midwifery care. During focus groups midwives highlighted that medical practitioners seemed to ‘back away’ from the postnatal period, especially when it came to breastfeeding. The perception was that obstetricians (and medical practitioners in general) regarded breastfeeding as ‘women’s business’ and ‘let the midwives deal with it’. Unlike other aspects of maternity care, the establishment of breastfeeding was constructed as exclusively a midwifery domain. Midwives who were wedded to the ‘liquid gold’
discursive approach integrated their commitment and desire for adequate amounts of ‘liquid gold’, available ‘on tap’, into their practices and communication.

4.8.1. Getting the baby ‘on’

Midwives adopted the role of ‘expert’ at ‘getting the baby on’ the breast. The differences in power, between midwives and women in the hospital environment, seemed inconsequential in the pursuit of ‘liquid gold’. Instead, midwives concentrated upon acquiring the ‘knack’ of getting infants to attach to the breast in the most desirable position and with their lips, jaw and nose in optimal alignment. Being able to attach infants to the breast ‘correctly’ was a skill midwifery colleagues seemed to hold in high esteem and one which generated observable levels of performance pride within the midwifery workforce. Midwives who were identified by their colleagues as having the ‘knack’ of getting infants ‘attached’ to the breast, were highly regarded as a valuable resource in the maternity unit.

During one observation session, at site one, non-participating midwives sought out the individual midwife whom I had been observing for the day, to see if she could get a particularly ‘difficult customer’ onto the breast. I was not present on the ward at the time but arrived as the participating midwife was coming back to the desk area, following the provision of assistance, where she remarked “…just got 12 on the breast, fussy little bugger, naughty boy, got him on though…” (Field notes day 7).

The sense of achievement at getting ‘fussy’ infants ‘onto’ the ‘breast’ was apparent as midwives sought to utilise their expert skills to achieve the desired mother/infant breastfeeding dyad. Midwives were observed guiding student midwives to achieve the picture perfect ‘Special K’ latch, and student midwives were observed using similar ‘hands-on’ (midwife attaching the baby for the woman) approaches to breastfeeding assistance. During the focus group interviews, some midwives acknowledged their tendency to ‘do for’ the woman, inferring an inability to resist placing their hands on the woman and fixing the poor positioning they observed. Some midwives indicated that the ongoing time constraints made it ‘very hard to do hands-off’ breastfeeding assistance, as this invariably took more time. During this same focus group the midwives agreed that sometimes “…it’s just easier and quicker to lean in over the top and to put those little babies on” (FG 4).
The midwifery focus on acquiring the knack of getting babies ‘on’ the breast meant that many spent their early years as a student and junior midwife acquiring these skills. Once obtained, the desire to utilise these skills to help women who were struggling to attach their infant was overpowering for some:

FG 1:

Midwife 4: Practice makes a big difference too. I know as a student, I was buggered if I could get a baby on the breast for a long time and I was forever having to ask some poor midwife to come and help me. They’d walk in and go [baby on] every time. Soon that was me, eventually. You get to be able to do it. So it’s a practice thing.

Midwife 2: The hardest thing is doing the no hands.

Midwife 4: It’s much easier if I can do it…

Midwife 2: It’s easier, but…

Midwife 4: Get your hands out of the way, let me do it.

Midwife 2: It’s easier, but it’s better if you can talk her around.

Midwife 4: But sometimes they can’t do it themselves until you’ve done it for them.

Midwife 1: That’s it, some need to be shown.

Midwife 2: Some people don’t like you touching their breast. Some don’t lift their arms up, they expect you to do it all.

Midwife 4: I actually had a woman smack my hand away one day.

Midwife 1: Some don’t like it at all.

Midwife 4: She said don’t touch me. I said, well I wish you’d warned me before I’d actually touched you and you smacked me.

This midwifery dialogue indicates a certain degree of ‘right of access’ to the breasts indicated by the observation of ‘hands-on’ midwifery practices and confirmed here in the focus group data. The bodily boundary between what ‘belonged’ to the woman and what was ‘required’ by the midwife became blurred in this context.
4.8.2. Rights to the ‘equipment’

The midwives’ desire to ‘advocate’ for the ‘vulnerable’ infant meant that the breasts were constructed as equipment the midwife felt she had a ‘right’ of access to. The previous examples of midwifery requests for the removal of clothing, which might be restricting access to the ‘breast’, represented an example of this discursive positioning of the ‘equipment’.

Int 51:

Midwife: Okay, so we’ll just get maybe one more pillow here. Okay, so have you got a bra on? Do you want to take the bra off? Sometimes it’s easier so your breast just sort of hangs.

Woman: No, I think I’d prefer it on.

Midwife: That’s okay, as long as it’s not cutting into you at all, and especially when your milk comes in just be careful because some of these sort of do cut in, and especially when you’re at home take it all off to feed so your breast hangs naturally. Okay, so the important thing for this is that you keep your shoulders fairly straight, so the baby’s got lots of room to get from here to here.

Noticeably, one of the ways midwives exercised their perceived ‘right’ to access the breast, was to adopt the inclusive pronoun ‘we’, when interacting with women. This was done in an attempt to include women in the decision making and planning that the expert clinician was engaging in: ‘we’ will do this and ‘we’ will do that, as the following, customary, scenario reveals.

Int 72:

Midwife: Let me get some gloves. We’ll see if we can get the baby on…[then later]

Midwife: I’m a little bit quicker… (at putting the baby on)

Accessing the breastfeeding ‘equipment’ appeared to be something midwives often felt able to do, sometimes without checking with the woman first. In addition, a certain ‘professional’ status seemed to ensure that women freely offered up their body to the expert clinician in a quietly compliant way:

Int 12:

Midwife: [baby crying] Yes, get cross, get very cranky.

Midwife: Big mouth. [Midwife supervises the woman attaching the infant to the breast]
Woman: Really big Special K mouth.

Midwife: Cheeky boy.

Woman: Bigger.

[Midwife leans in and ‘puts the baby on’ using a hands-on approach]

Midwife: [to the baby] You can do it… [to the woman] Okay… He has a wider mouth. He’s further on and he’s scrunched up against the breast and that’s better. He’ll do you less damage that way.

Woman: Yes.

Midwife: So you should just be able to let go. That’s it and relax…[to the baby] I thought you were starving. What are we waiting for?

Woman: He’s beautiful.

Midwife: So the closer he is to the breast, the less he’ll drag on your nipple and it should be quite comfortable.

Woman: Yes…

Midwife: [to the woman] Don’t pull…You don’t need to do that.

Woman: I’m trying to see what’s going on.

Midwife: It’s very tempting but if he’s properly positioned at the breast you won’t need to put your fingers anywhere near him…[to the baby] I thought we were starving…Ah that’s better.

The desire to point out the difference between the woman’s ‘awkward’ efforts at getting the baby ‘on’ the breast when compared to the midwife’s expertise served two purposes. Firstly, it reinforced the superiority of the midwife’s skill and knowledge and secondly, it indicated, to the owner of the equipment, how breastfeeding should look, and feel, when the infant was on ‘properly’. Women commented on this ‘hands-on’ approach during the post discharge interviews. Some women clearly appreciated all the extra guidance whereas others found it intrusive and demoralising.

Int 11:

Woman: The only thing was like that first feed the midwife took over basically rather than me trying it first for myself. I would have liked to have tried just you know me and the baby by ourselves, with a midwife there but not taking control.

EB: Yes. So when you say she took control what sort of things did she do?
Woman: Well she basically put him on my breast for me and I wasn’t really doing anything.

Midwives ‘taking control’ was a common theme in the days after birth. However, as mentioned previously, during periods of high demand and inadequate staffing midwives prioritised those women deemed most at risk of allowing the ‘liquid gold’ to ‘dry up’, from those who were providing ‘gold’ unassisted (and who had previously committed to, and had successfully, breastfed, thus representing less of a ‘quitting’ risk). Responsibility for ‘first timers’ was ‘passed on’ from one shift to the next and the woman’s progress verbally updated at the shift change handover.

4.8.3. ‘Hands-on’ management

Midwives’ socialisation as students, and subsequent acquired embodied knowledge, resulted in repeated use of ‘hands-on’ instruction methods to teach breastfeeding attachment to women. Midwives, who had for many years ‘successfully’ provided breastfeeding assistance using a ‘hands-on’ method, seemed to favour this approach. Physical demonstration of how ‘best’ to attach an infant to the breast to achieve the correct alignment of ‘nose to nipple’, flanged ‘lips’, and ‘massaging chin’ was reportedly ‘quickest’ and most ‘efficiently’ achieved if conducted by the midwife in the first instance. The provision of ‘hands-on’ assistance was not solely reserved for first-time breastfeeding women either, as the following quote confirms:

IV 8:

Woman: I found that really confronting as a first-time mum, like having some stranger grabbing your boob and – ‘cause you really don’t think about any of that till after you’ve had them. Whereas with [second child] it didn’t bother me ‘cause I sort of knew that’s how they showed you how to do it.

On the postnatal ward, women who had breastfed before and were not making requests for assistance, whose infants were settled, sleeping or breastfeeding, were considered a ‘bonus’ by staff, as they were providing ‘liquid gold’ without requiring any management. However, women who requested assistance with breastfeeding were invariably assumed to require ‘hands-on’ help, indicated by the donning of gloves at the beginning of interactions (at site two) and the inspection or touching the breast or infant to improve the ‘latch’.

The ‘hand expression’ of colostrum, was used as a tool for ‘getting the baby on’, and was a commonly observed midwifery practice. Midwives often assisted women, who
were experiencing difficulties attaching their infant, by ‘hand expressing’ colostrum ‘for’ the woman in order to give the infant a ‘taste’ of what was on ‘offer’. Midwives began interactions (at site two) with gloves on ready to ‘express’ that initial colostrum and provide the ‘hands-on’ assistance. Midwives were observed to be very much in control during these interactions and once again the woman invariably ‘submitted’ to the ‘expert’ clinician.

Int 58:

Midwife: I would suggest try squeezing a little bit of colostrum on then, that’s it, see if we can get him to get a bit of a taste for it.

Woman: I don’t seem to squeeze as hard as you do.

Midwife: [laughs] Well that’s not necessarily a good thing. You know what you can stand.

Woman: Don’t go to sleep.

Midwife: What we might do is, I might take this little suit off and see if we can get him to wake up a little bit more. What do you think?

Woman: Yes, he’s pretty sleepy.

Midwife: I’m kind of thinking it might be worthwhile if we just express a little bit of milk and give it to him. Then try and get him to attach.

Some midwives recommended the application of additional tools to assist with breast ‘attachment’ such as nipple shields. The following quote came from a midwife who was frustrated with an infant on the day of birth, as she could not ‘attach’ the infant to the breast readily “…I’m going to use a nipple shield for this woman - I can’t get that baby on for love nor money” (Field notes on Int 41). The preference for introducing supplemental measures for attaching infants to the breast was especially noticeable at site two.

4.8.4. Concern for the ‘extractor’

Commonly, midwives asked women the simple question ‘when is he/she due’ to feed. Inherent within those four simple words was a message which was completely at odds with the ‘baby-led feeding’ discourse which dominated at both study sites. The expert clinician in this instance demanded an answer to a question which was the opposite of what the expert clinician had told the woman to expect. The mantra ‘babies don’t have clocks’, or ‘don’t run to routines’, was completely undermined by
this one simple question asked frequently at both sites. However, this question may have represented the midwives’ clinical ‘fear’ of infant dehydration or ‘low blood sugar level’ and subsequent transfer to the special care nursery restricting access to ‘liquid gold’. So midwives seemed to ask this contradictory question, and act on the information gained, perhaps in an effort to maintain the breastfeeding dyad.

As the shift progressed, the midwife’s desire to ensure that all the infants in her care had been fed increased. Getting the baby fed by the end of the shift, and prior to handover, was an identified priority apparent in the increasing intensity with which midwives encouraged the infant to feed. Midwives at times resorted to ‘hand expressing’ colostrum for the infant and cup feeding the precious elixir, as discussed previously. At other times, the midwife took control of putting the baby ‘on’ to the breast utilising their finely honed skills at attaching newborn infants to the breast.

The following interaction shows the domineering way in which the midwife ‘took control’ of the woman’s body, and even tried to control the woman’s engagement with her infant, in order to ensure the infant was ‘fed’ by the end of the shift. This excerpt is quite long but provides the reader with a better insight into the ‘bossy’ and ‘controlling’ midwifery behaviour:

Int 70:

Midwife: You sit there and I’ll do it. (The midwife placed her gloved hands on the woman and attached the baby to the woman’s breast, The woman was non-verbally instructed to keep her hands out of the way)

Woman: Okay.

Midwife: You just deep breathe and talk to your bub.

Woman: Come on bubby.

Midwife: Now he will take a little while so don’t expect him to do it straight away. There’s a good boy, you talk to your mum and you complain. [infant grizzling]

Woman: That’s it. That’s it.

Midwife: See he nearly had it there, so that’s good. [inaudible]

Woman: Come on bubby.

Midwife: It’s all right. Good boy. Rub his little hand for me. That’s it. See, see what he’s getting. Oh, that was a little suck, good boy. Good boy.

Woman: Come on bubby.
Midwife: There you go. He keeps spitting it out. Now are you pushing it?

Woman: No.

Midwife: You’re loose enough?

Woman: Yeah.

Midwife: You just, can you rub his little hand for me?

Woman: Yep. Oh yep.

Midwife: That’s it. There bubby come on. Now you’ve tightened that shoulder up again, it’s not quite as relaxed as it could be. What happens is the hormones won’t flow as nicely if you’re not relaxed. They’ll still flow but they’ll take longer.

Woman: So if I’m all tense…?

Midwife: Yeah.

Woman: Oh okay.

Midwife: Now if you listen to me rather than focus on him trying to get on.

Woman: Oh all right.

Midwife: Yeah because I can sense you getting, like come on, come on. So let him take his time, because he has to think about what to do and it’s a hormonal sort of a thing. So you try and relax and just think about, we’ll talk to you or rub his little hand. Here you are, that’s all right. And don’t let him overwhelm you with his fussing, because that’s normal. Like you know if you try to do something the first time? Use a computer and you can’t do it and you get frazzled?

Woman: Yep.

This midwife went on to share with the woman her distress at the number of infants she had to ensure were fed on her shift. This midwife clearly felt that all the infants in her care were her responsibility and she felt a degree of pressure associated with this:

Int 70:

Woman: I’m so tired.

Midwife: I can understand how you feel. So I’ve got nine babies to look after tonight. And they’re all cheeky one way or another…

This brief exchange is an example of the observed failure to engage with the woman regarding her needs and wants. Instead, meeting organisational requirements and
completing preset work parameters, before the end of a shift, seemed to be a common midwifery focus. Midwives who became frustrated with the demands of getting the infant fed, had the opportunity at site two, to refer to the Lactation Consultant service during the daytime. Women were referred to the consultant lactation specialist routinely, at this site, if breastfeeding was ‘problematic’ and requiring more of the midwives time than she had available. In this instance, midwives completed a paper-based referral letter.

4.9. Referral to the Specialists

Referral to the specialist lactation consultant represented the transfer of responsibility for the acquisition of ‘liquid gold’ to a highly qualified and skilled breastfeeding expert. The lactation consultant role involved assessing, diagnosing, offering ‘treatment’ and monitoring the breastfeeding ‘equipment’, including ‘operation’ of the equipment and the extraction of the ‘liquid gold’. Midwives’ focus group discussions around the topic of specialist referral, indicated a consensus amongst hospital-based midwives that time pressured interactions with women resulted in inefficient breastfeeding management, whereas referral to the lactation consultant offered infants greater likelihood of receiving adequate amounts of breastmilk. Midwives made referrals to this specialist group in order to ‘get the job done’ as lactation consultants were able to focus fully on breastfeeding. This however, further heightened the focus on the ‘equipment’ and the ‘product’. Even lactation consultants, working on the postnatal ward as a regular midwife, opted to refer women to the lactation service when extra breastfeeding assistance was required:

FG 4

Midwife 4: But I’m an LC but I’ll do a referral [when working as a midwife] because I know that if this woman is having a lot of difficulties, I might be able to help her now but next shift maybe somebody that may not be as familiar as I am and so if I put in a referral I know that the lactation may be able to spend a bit of time with the woman and talk about what she wants and do a plan without having to answer a buzzer and get somebody up for their shower.

In addition to the referral process, lactation consultants attended the midwives’ morning shift handover, to detect if there were any ‘breastfeeding issues’ which had occurred overnight and which needed ‘checking’. The availability of this expert
practitioner, at MUB, left midwives reportedly feeling obliged to refer all women, requiring ongoing assistance, for specialist review. During a focus group session, midwives discussed this feeling of obligation to refer to the specialist:

FG 4:

Midwife 4: Well yes, I believe that there’s a bit of a problem with midwives believing that LCs are the answer to all breastfeeding problems and I think that all midwives should be able to assist with breastfeeding, that just should – you know.

Midwife 3: I find it confusing though and I had this dilemma today because I have done a lactation course. I didn’t go on to do the exam because of financial reasons. So I have the knowledge and quite often I feel like whoever will say ‘have you done a lactation referral for that patient?’ and I’m like ‘well no I haven’t’ because I’ve handled the situation and I don’t need to refer that’. But now I’m feeling that I have to refer it whether I can handle it or not and so today I did a referral against what I felt needed to be done simply because I felt that I have to do it and I handled that situation and so forth but still did a referral and thought well you’ve got to, haven’t you.…

Lactation consultants at this focus group session suggested that their additional education did not mean they were better at ‘managing’ breastfeeding problems than midwives without the extra qualification. Rather, that the specialist lactation consultant role involved a more long-term commitment to assist women and infants in the supply and extraction of ‘liquid gold’, whereas hospital-based midwives represented short-term sporadic contact with women and infants. The discursive positioning of midwives as ‘expert technicians’, able to ‘operate’ the ‘equipment’ and facilitate ongoing breastfeeding, meant that the true problem solving role was reserved for the ‘expert specialist’ lactation consultant. These specialists, commonly referred to as the ‘troubleshooters’, were held in high esteem as the prescribers of breastfeeding ‘solutions’.

The goal of the hospital lactation service was to ensure infants acquired sufficient quantities of ‘liquid gold’, or breastmilk, to sustain them until the milk came ‘in’ or until the infant, and their mother, had learnt how to achieve optimal positioning for extraction. Lactation consultants seemed to position themselves as ‘infant saviours’, warding off any factors which might inevitably deny the infant access to ‘gold’, such
as a lack of adequate breastmilk supply, infant dehydration, jaundice or low blood sugar level, or worst of all, ‘voluntary maternal withdrawal’ of the precious product.

At MUB the lactation consultant service was available seven days per week until 5pm (weekends until 3.30pm). The service included both an inpatient component, and a 30-day community-based clinic, for women who had been discharged from the hospital. The community clinic represented a longer-term commitment to professionally supporting and ‘managing’ breastfeeding difficulties over the first four weeks post-partum. Some women self-referred themselves to the lactation service antenatally if they had previously experienced breastfeeding difficulties or had concerns about prior breast surgery, or ‘flat’ or ‘inverted nipples’ affecting ‘performance’. During the antenatal period the lactation consultant arranged a clinical consultation with the woman and devised a ‘plan’ for optimising breastfeeding performance.

4.9.1. The specialist assessment

Following birth, most women first met the consultant from the lactation service whilst an inpatient on the postnatal ward. The lactation consultant initially responded to inpatient referrals by consulting the woman’s hospital notes to gather as much information as possible about the history of the ‘problem’ prior to meeting the woman for the first time. Following this, the lactation consultant introduced herself to the woman and offered to be of assistance when the woman next fed. Questions such as ‘how old is he/she now’, and ‘when did he/she last feed’ were common interaction starters. The focus was on the infant and rectifying the woman’s difficulties with ‘getting the infant fed’. Women were offered lactation review such as, “Do you want to have another go, [and I] talk you through it?” (Int 49), or “Do you want me to have a bo peep (look)?” (Int 43).

During this assessment phase of the consultation, the lactation consultants made repeated references to ‘what have we been doing’. Similar to the midwife use of the term ‘we’, the lactation consultants adopted this same language but in this context ‘we’ referred to the multitude of health professionals involved in the attempts at ‘getting baby fed’.
Int 46:

LC: Have we just been expressing a bit of milk out for her up until now?

Woman: Yes. When she was really fussing I’d try that.

LC: Just bring her back again and just tease her for a minute until she does that big open mouth…. She’s just thinking about it again.

Woman: Look at the look on that face.

Perhaps the woman in this exchange was keen to re-establish some sense of control over her body and her infant by changing the ‘we’ to an ‘I’, thus subtly reminding the consultant whose body it was.

The specialist consultations tended to follow a similar pattern of assessment of the ‘equipment’ followed by attempts to latch the infant. When assistance was requested, the lactation consultant put on her gloves as she approached the woman’s bed and immediately got down to the ‘business’ of helping the baby to get on the breast, either by verbally instructing the woman on what to do or by physically expressing colostrum and proceeding to ‘latch’ the infant for the woman. The provision of an expert demonstration on ‘how to’ get a baby feeding was paramount. During the consultations there was an expectation that the woman would demonstrate her latching technique whilst the lactation consultant was available to assist. This occurred to enable the woman as much time as possible with the ‘specialist’, prior to discharge. Noticeably some infants seemed disinterested in feeding whilst the lactation consultant was present. Rather than be seen as a negative, the consultants invariably used this opportunity to teach the woman about hand expression of colostrum or milk. The hand expression of ‘liquid gold’ was viewed as an essential skill, at MUB, which all women should leave the health service knowing how to do. Alternatively, the breast pump was introduced to ‘stimulate those nipples’ to enhance production of milk. The general impression was that breastfeeding was not something to be ‘done’ in response to the demands of the infant but rather could be managed and controlled quite expertly independent of the infant via the expression and storage of milk for use at a later date.
4.9.2. The ‘plan of attack’

Three predominant problems emerged from the breastfeeding assessments observed. The majority of presenting problems fell within the scope of either nipple pain and trauma, or difficulties ‘getting baby on’ due to faulty breastfeeding ‘equipment’ (flat nipples), or inefficient extraction by the infant. Depending on the presenting problem, lactation consultant recommendations involved for example, introducing a nipple shield, or resting the nipple and expressing the breast. The following interaction between a lactation consultant and woman one day following the birth of her first baby is a good example of this:

Int 44:

LC: There’s two problems. Your nipples are a little bit flattish and bubby has a tongue tie, right?

Woman: Yes.

LC: So I think it’s really good if you try and get the milk flowing [by hand expression]

Woman: Yes.

LC: And get a nice lot of milk and then we put the baby on properly with the nipple shield okay. That’s there. If I hurt you just tell me to stop ok. (LC commences hand expressing for mum) Have you had a quiet morning?

Woman: Yes, pretty much. She hasn’t woken up yet.

LC: Good, I mean that’s nice for you.

Woman: We’ve had a couple of checks.

[long silence on recording whilst lactation consultant continues to hand express colostrum]

Lactation consultants tended to return to the desk area to document their recommended breastfeeding plan. I observed this happening without much in the way of input from the woman. Instead, the plan represented a prescription for solving the breastfeeding problem and was created, at times, in consultation with other lactation consultants. At MUB, ‘resting and expressing’ was a predominant practice and was a significant part of the prescriptive lactation consultant repertoire. Predictably, at MUA, written prescriptions were not a feature of lactation consultant input as lactation consultants were incorporated into the regular midwifery staff complement and were often unavailable for consultation. Instead lactation consultant
midwives, at this site, tended to offer additional suggestions, directions, instructions and advice.

It appeared that ‘resting and expressing’ was ‘prescribed’ to women, at MUB, to ‘protect’ the breastfeeding ‘equipment’, to increase ‘supply’ of the product and to sustain the breastmilk ‘extractor’. The ‘breast expression plan’ traditionally recommended electric breast pump use, for 10 minutes each breast, followed by 5 minutes each side at third-hourly intervals during the day and four-hourly intervals at night. Breast massage was often encouraged during pump expression. Additional recommendations included the use of skin-to-skin contact with the baby, and application of breastmilk and cream to nipples following expression. In the event of inadequate ‘supply’ of breastmilk, to meet the infant’s daily needs, a quota system of topping up with formula was devised. Each day the top-up quota was increased, in accordance with the infant’s anticipated needs. The method used to calculate the infant’s quota was 120 mls per kilogram per day divided by eight feeds. An infant on day three was ‘prescribed’ 50 mls of top-up formula every three hours, and 65 mls overnight (when women were recommended to feed their infant four hourly), the next day the ‘prescription’ was amended to 60 mls three hourly and 80 mls four hourly overnight. Infant bowel motions were assessed by the lactation consultant to ascertain if the infant was hydrated and receiving sufficient volumes of breastmilk. For example, an infant who was still passing meconium on day three, or continuing to show urates in the urine, was considered ‘dehydrated’ and a ‘top-up’ regime devised. The documented plan, for resting and expressing and ‘topping up’, was then provided to the woman.

In situations such as those described above, the woman was encouraged to express her breast using the electric breast pump then feed the expressed breastmilk to the infant, followed by the formula top-up with the remainder of the quota. For example, if the woman expressed 30 mls of breastmilk, the formula top-up would be an additional 30 mls. As discussed previously the ‘liquid gold’ was fed to the infant first followed by the formula milk. The following excerpt is from a discharge conversation with a woman who was returning home on a ‘breast expression plan’, due to nipple pain and trauma. This woman’s partner had rushed out before she left the hospital to obtain all of the required paraphernalia to sustain breastfeeding. The infant had been born at 36 weeks following an emergency caesarean section for
placenta previa and had lost 11.5% of birth weight on day six. The lactation consultant plan was to ‘rest and express’, and top-up the infant according to the method prescribed above. The following excerpt from the discharge interaction is long but this dialogue captures the marketing power which hospital recommendations can introduce:

Int 55:
Midwife: Yeah. Are you borrowing a soft cup feeder?
Woman: We’ve bought it all.
Midwife: You bought the whole lot?
Woman: Just spent a fortune but we bought the whole lot.
Midwife: That’s alright.
Woman: Yeah, it’s worth it.
Midwife: It sure is. Where are you getting the [expresser] from? The actual pump.
Woman: We got it.
Midwife: Oh you bought a pump? Oh wow. Okay.
Woman: We bought an electric pump. We bought the soft cup.
Midwife: Oh my goodness. Those [swing] ones are meant to be pretty good. It’s just there’s a mob down the road that hire the pumps like those ones...
Woman: So 10 mls of formula.[top-up]
Midwife: Yeah.
Woman: That’s one thing we didn’t buy. We have to buy formula.
Midwife: Okay. While you’re giving bubby – so you’re just expressing at the moment, you’re not putting bubs to the breast.
Woman: Yeah, she [lactation consultant] said for three days because they’re so sore.
Midwife: While [partner] can be giving bubby the milk in the soft cup feeder.
Woman: Yeah, that’s the plan.
Midwife: Yeah, don’t put it in the microwave ever…
Woman: We bought the bottle warmer [identical to the hospital version]. I went downstairs to the chemist and spent a fortune.
The perceived need to replicate all of the equipment used by hospital-based specialists, to enhance performance of the woman’s bodily functioning, was astounding. One of the women I interviewed for this study had gone so far as to purchase a full set of infant scales to ‘weigh’ her infants before and after a feed to ensure they were ‘getting enough’ breastmilk and ‘top-up’ (IV 8). Interestingly though, most of the women observed adhering to this type of ‘prescribed’ top-up quota regime, used bottles to feed their infant rather than soft cup feeders. Clearly, the discursive construction of bottle feeding as a cultural norm persisted, even with the feeding of expressed breastmilk.

4.9.3. ‘Tell me if I am hurting you’

The widespread lactation consultant preference for hand expressing early ‘liquid gold’ and subsequently feeding it to the infant for women was the most obvious discursive enactment of the ‘inefficient operator’ and ‘inefficient extractor’ discourse. This also represented ‘protection’ of breastfeeding as midwives and lactation consultants sought to avoid transfer of the infant to the neonatal intensive care unit. At MUB, the prevention of dehydration, and low blood sugar levels in infants, seemed to be at the forefront of practitioners’ minds. These concerns motivated practices such as expressing and feeding colostrum, and formula topping up ‘just in case’. The following interaction is an example of this pressure to prevent transfer to the NICU. This exchange occurred when the lactation consultant was asked to review an infant whose blood sugar level was low. The infant was the smallest of a pair of twins:

Int 66:

LC: What we’re going to do is try and express some milk from both sides and give that to bub, if this is okay with you, obviously. And then in half an hour to an hour check bub’s sugar again. And if that’s still a little bit low then we might need to get the NICU people to actually see bub, which is the Neonatal Intensive Care Unit, just to make sure, okay?

Woman: Yeah.

LC: ‘Cause with these sugars low we need to really get on top of it and make sure that these sugars are coming up.

Woman: Well, give it a go, that’s all right.

LC: So do you want to do some expressing or do you want me to do it?
Woman: Maybe if you could do it, yeah.

LC: That’s okay. Now, you just let me know if it hurts or anything like that.

Woman: Yeah.

The lactation consultant proceeded to express the colostrum quietly and efficiently then fed it to the infant. The woman was asked to participate by scooping up the last few drops with her finger and allowing the infant to lick off the precious ‘gold’ drops.

This request ‘tell me if I am hurting you’ was a common appeal made by lactation consultants who tended to ‘hand express’ colostrum for women. Despite concerns about ‘hurting’ the woman, most of the lactation consultants observed tended to engage in ‘hands-on’ practices quite readily. The following interaction highlights the ease with which the lactation consultant felt able to monopolise the woman’s body. References to the ‘nipple’ and the ‘breasts’ appeared to separate both from the woman and resulted in the lactation consultant behaving as though both were available for her management and control:

Int 44:

LC: Because bubby’s not going to the breast it’s really important that the nipple has stimulation because if the bub was feeding the breast would be stimulated okay. So every three hours do you think you could try and express your breasts?

Woman: Yes.

LC: So do you want to have a go? See what…[visitors arrive]…

Woman: You can come in…this is my best friend and her little girl.

LC: How old is the little girl?

Visitor: Eight months

LC: See they do sleep…

[conversation ensues between participants and visitor while LC hand expresses for the woman]

LC: Do you want to have a go…See this, right back, right, right back as far as you can go but I want you to squeeze behind the nipple. Right back, right back, fingers right back. Just go right back, beautiful. [unclear], that’s lovely…oh someone’s awake (re 8-month-old visitor)…(Lactation
consultant has another ‘go’ as the woman was not able to express any
colostrum...continues to hand express) am I hurting at all?

[conversation continues between the participant and visitors while LC hand expresses
for the woman]

This exchange demonstrates a level of acceptance of the need for health professional
interference for the ‘extraction’ of ‘liquid gold’, apparent in both the behaviour of the
consultant and of the woman.

4.9.4. Mining for liquid gold

Lactation consultants were observed approaching the expression of colostrum, or
breastmilk, with the intensity of a miner digging for ‘gold’. The perceived ‘right’ to
access the woman’s breasts to acquire this precious resource, for the sustenance of
the infant ‘patient’, was non-verbally communicated to women. At the
commencement of interactions, the LC applied her gloves as she approached the
woman. This image represented the discursive enactment of the ‘miner’ preparing for
work. Whilst at times the ‘miner’ sought permission to touch the woman’s breasts,
this was not consistently so. The need for touch was sometimes non-verbally
communicated to the woman and, for the most part, she received this ‘professional
touch’ without question. In order to illustrate the essence of this ‘mining for liquid
gold’ discourse, a case study has been included in the Appendices (Appendix 7). This
case study (Helen and Ethan) reveals the intensive input from Sonia the lactation
consultant over a four-hour period on the ward, and epitomises the enactment of the
‘mining for liquid gold’ discursive practice.

Helen was a 23 year old woman who was experiencing difficulties breastfeeding her
first baby Ethan, whom she had birthed three days before. She was first referred to
Sonia, the lactation consultant, the day before due to the difficulties she was having
with latching Ethan to the breast due to ‘flat nipples’. Sonia had provided assistance
with ‘latching and attaching’ the day before. Overnight however, Ethan had been
‘topped up’ with artificial formula. This interaction began with Helen using skin-to-
skin contact to encourage Ethan to self-latch. The lactation consultant began the
interaction with gloves on and began ‘assisting’ Ethan to latch ‘on’ using hands-on
support. The cascade of intervention which followed over the next four hours
escalated from discussions around the use of a nipple shield, to the introduction of a
double pump to ‘trick’ Helens body into bringing the milk in sooner. During the
consultation the lactation consultant maintained composure as a detached clinical consultant, even when Helen became upset.

Helen’s journey over this one four-hour period highlighted the lactation consultant’s desire to use technology to enhance the performance of faulty ‘equipment’. The possibility that Ethan might be so full from the formula top-ups, that he was no longer behaving as a hungry ‘day 3’ breastfed baby, was not even considered by this consultant. Instead, the lack of colostrum derived from electric pump use, led to further pathologising of Helen’s body. The appliance was ‘revered’ as a wondrous machine with the power to ‘trick’ Helen’s body into producing ‘gold’. The consultant regularly gave Helen options to solve the problem of the faulty ‘equipment’ and the ‘sleepy’ baby not wanting to suck. However, each time there appeared to be a choice between different options, it was the consultant, Sonia, who decided which course of action to take. The following excerpt highlights these points:

Int 67

Sonia: It (the electric pump) mimics the baby, okay. So the baby actually gets on and does really slow sucks and really fast sucks.

Helen: Yep.

Sonia: Then once the milk starts to let down it goes into the slow sucks. This pump does that automatically for you, like a baby would. (silence) Then the other option Helen you’ve got is just to pump until we get another five to 10 mls of breastmilk. Then try bub back on the breast then. So it’s really up to you, whichever way you want to go. If you want to keep trying bub on the breast each feed, you can. Or you can just go the pump and try it just by the pump. Okay? So we might stop that now and try bub because I can actually see some breastmilk on the end there as well which is good.

This case study revealed the overarching lactation consultant desire to gain control over the woman’s body for the benefit of the infant. This ‘down to business’ approach, adopted by many lactation specialists, conveyed the need to optimise all available time effectively to ensure continued breastfeeding. This approach denied the woman agency, instead positioning her as a ‘patient’ in need of ‘specialist intervention’.

Lactation consultants credited the Baby Friendly Hospital Initiative with elevating the importance of specialist lactation positions within the health system. One of the lactation consultants I interviewed spoke about the ‘credibility’ BFHI
afforded the lactation consultant and the gravity it gave to their recommendations. For example “…Baby Friendly has given us more power … so they [midwives] have got to take notice a bit more” (SSIV 9).

This lactation consultant spoke disparagingly about midwives’ collective lack of regard for the importance of ‘protective’ breastfeeding strategies such as denying access to artificial ‘infant pacifiers’ and avoidance of bottles. Many of the lactation consultants at MUB represented the discursive champions of the ‘mining for liquid gold’ approach. The language and practices adopted by this group of specialised midwives incorporated detached and medicalised approaches to the ‘management’ of breastfeeding for women, rather than with women. I would argue that at MUB the desire to ‘protect’ breastfeeding and maintain the high rates of initiation and duration, for hospital statistical purposes, contributed to some of the language and behaviours observed. The lack of genuine engagement with women was consistent with the general mode of operation detected within standard postnatal care. Protecting and ensuring a woman’s ongoing commitment to breastfeeding, revealed a midwifery and lactation consultant tendency to focus on satisfying the needs of the institution, rather than orientating practice towards genuinely meeting the needs of mothers.

4.10. Maintaining the Gold Supply

Women reported feeling at times ‘pressured’ to breastfeed rather than supported. Discursive enactment of this ‘pressure’ to maintain commitment to breastfeed was especially evident during discussions around planning for discharge and health professional follow-up. Yet wavering breastfeeding commitment represented a breach of the discursive border between what was freely spoken about and what was taboo.

Within this framework, women were universally encouraged to remain in hospital until they felt comfortable ‘latching’ their infant to the breast and until their milk had come in.

Int 47:

Midwife: The milk is starting to come already so that’s a good sign. So, do you think you will stay or do you think you’ll go?

Woman: I’d like to go home for the weekend but we’ll just see what happens.
Midwife: I mean realistically I’d say your best chance with the feeding is probably
to stay another day so we can sort of get something happening, either her
latching with the shield or the milk flowing with the pump. Okay, you can
probably hop up and we’ll see how we go, round two [attaching infant].

Prior to discharge midwives endeavoured to give women as much information as
they thought might be required to maintain breastfeeding at home. High on the list of
priorities was the crucial information about how to look after their precious ‘gold
product’.

4.10.1. Looking after the product

Information on storage and shelf life of the ‘product’ was delivered to women both
verbally and via the comprehensive ‘discharge book’ at MUB. Every woman at this
site was provided with written information prior to discharge from hospital. The
home maternity service was funded separately from the in-hospital postnatal service,
therefore, women were discharged from the hospital environment and subsequently
admitted into the midwifery support-at-home program. At MUA however, there was a
seamless transition between the hospital and home maternity service, and discharge
information was provided over an extended period of time.

Discharge information, at MUB, was delivered almost verbatim to every woman,
using a discharge booklet which included all the necessary information to sustain
breastfeeding. There was a sense of urgency around the need to capture this rare
opportunity to educate women regarding solutions to predictable scenarios. It was as
if the maintenance of breastfeeding was dependent upon this crucial information
being given in the first week after birth. There was an unspoken sense that woman
may not follow-up with a knowledgeable breastfeeding advocate after the first week.

Observation of the types of information given to women reflected a focus on
‘protection’ of the infant also. The following excerpt shows the midwives’ focus on
providing information about the storage of ‘gold’, and the woman’s sense of
separation from her ‘product’:

Int 55:

Woman: Do I have to sterilise after I do a breastmilk?

Midwife: No, you put the extra formula ...
Woman: Straight in, and what’s the best thing to freeze all the portions of breastmilk in the freezer?

Midwife: Well you don’t need to freeze them. They can last for four to five days in the fridge.

Woman: Oh in the fridge? Four to five days.

Midwife: Yeah, I’ll give you some information on that.

Woman: Yeah.

Midwife: I’ll give you a thing on expressing and storing it. Because it can last up to five days in your fridge. In freezers, depending what type of freezer it is, it can last up to 12 months. You know they’re all different – whether you’ve got a chest freezer.

Woman: Alright, yeah. Can I ask a question about me?

Midwife: Yeah.

Communication of the health professional preference for women to remain in the hospital until their milk was ‘in’, and until they were confident with breastfeeding, was both subtle and overt. Midwives clearly prioritised the hospital environment as the most beneficial for the establishment and maintenance of breastfeeding. Factors such as 24-hour access to expert ‘technicians’, 8-hour per day access to specialist consultants, access to machinery and appliances, combined with controlled visitor access, were all identified as positively influencing the establishment of breastfeeding and facilitating ongoing commitment.

Int 65:

Midwife: Yes, exactly. So, I mean, that’s the benefit of staying here for that next 24 hours in the fact that we’ve got those pumps here but obviously you want to go home.

Woman: I’m just so keen to be at home, yeah.

Int 40:

Midwife: When do you think you will go home? It’s up to you. I just want to make sure. You have had problems with feeding I think it’s best to stay a couple of days to get familiar.

Women gave the impression that they felt they needed permission to go home, with some even asking when would they be ‘allowed’ to go home. Whilst a majority of midwives in the ‘liquid gold’ group advocated remaining in hospital, returning home
was seen by some as potentially facilitating earlier milk production and thus early discharge was supported:

Int 65:

Midwife: You know, if you’re going to feel more comfortable at home that will probably help bring in milk and things like that but as long as you feel comfortable doing that it can be a lot of hard work though. Okay?

Woman: I think I just [Inaudible] I just want to be at home now, I’ve really had enough.

Midwife: Yes, that’s okay. That’s okay. So I will discuss with [name omitted] regarding a ‘plan of action’ for home and what we need to do when you go home. Now, if you go home today the home maternity services will come and see you tomorrow and just see how [name omitted]’s going and how you’re going tomorrow and how you’re going with the expressing and things like that and then they will come and see you the following day. So today’s Wednesday, they will come and see Thursday and Friday and then we could probably – where do you live?

Woman: [Inaudible].

Midwife: Okay. So if you want to you could come back to the breastfeeding clinic as well and we could make an appointment for say Monday or something like that.

Woman: Just like to help me?

Midwife: Yeah, to see how the breastfeeding’s going and see how you’re going expressing and to make sure that everything is coming together okay for you. How does that sound?

Woman: Yes, that sounds good.

Midwife: Does that sound all right?

Woman: Yeah.

Women whom midwives predicted might need extra support with breastfeeding post discharge were referred to the Breastfeeding Clinic and ‘booked in’ prior to discharge. In addition, midwives preferentially referred women to other services which similarly ‘promoted and protected’ breastfeeding. For example, health department-funded child and family health services and the Australian Breastfeeding Association.
Midwife: The early childhood centres are really great resources.

Woman: Yeah.

Midwife: Okay, so they’re free. We pay for it in our taxes so we need to utilise them.

Woman: Yeah.

Midwife: The [unclear] Breastfeeding Association is a big one [unclear].

Women’s experiences of health professional support in the first week after birth confirmed the power of some of the antenatal discourses on their subsequent early breastfeeding experience. The following quote, from a woman who had a caesarean section and ‘missed out’ on skin-to-skin contact, is but one example of this:

IV 12:

Woman: Yeah, and skin-to-skin is really important. The midwives will chuck that down your throat and then my midwife didn’t bother bringing my baby to me to give me the skin to skin. It was really confusing that whole time because everything we’d prepared for and read and wanted to happen, didn’t happen.

The nature of the postnatal environment meant that regardless of the importance attributed to factors for optimising breastfeeding performance, at times, these were not facilitated in the busy, chaotic hospital system.

4.11. Conclusion

In this chapter, I have presented the analysis of the dominant language and practices adopted by midwives in antenatal education and in the first week after birth. The social construction of ‘liquid gold’ emerged during pregnancy and was further emphasised during the early postnatal period. Colostrum as ‘liquid gold’ was rapidly superseded in the first few days after birth in the pursuit of the more voluminous ‘mature breastmilk’.

The inhibitive nature of the ‘mining for liquid gold’ approach has been demonstrated. Women were constructed as the suppliers of the precious resource: breastmilk, but were disconnected from their ‘machine-like’ breasts in the process. In this context, midwives adopted the role as ‘expert clinician’ available to ‘manage’ breastfeeding, to ensure the infant adequate exposure to ‘liquid gold’. Midwifery practice during
this time, focused on the achievement of a functioning breast and a functioning baby, rather than meeting the express needs of women. Maternal and infant competency was measured by midwives, which led to episodes of ‘taking control’ and even of ‘pressuring’ women to comply with the midwives’ agenda. In addition, lactation consultant practices reflected a pathologising of breastfeeding and the introduction of a medicalised approach to the management of this natural bodily process.

In combination, these practices represented a midwifery ‘protection’ of breastfeeding, for the benefit of infants and the institution. The positioning of women as owners of the ‘equipment’, and in need of protection, will be further explored in the discussion chapters. The passive position adopted by women, within these institutions, resonates with the Foucauldian constructs introduced in Chapter Three and will be explored further in Chapter Seven.

In the next chapter, I will explore the two opposing or alternative approaches to breastfeeding support, evident in 20% of all the interactions observed. The depiction of breastfeeding as ‘not rocket science’ introduced a different set of practices and style of communication and alternative positioning of breastfeeding. Further, midwives and lactation consultants who engaged with women whilst prioritising breastfeeding ‘as a relationship’ made up the smallest group of practitioners in this participant cohort. The language and practices inherent in these communicative exchanges are presented in Chapter Five.
CHAPTER FIVE

Considering the Mother Lode

5.1. Introduction

In this Chapter, I examine the two alternative discourses identified in this study of the language and practices adopted by midwives in their interactions with women around breastfeeding. In Chapter Four, I highlighted the disconnected management of women and the treatment of women’s breasts as breastfeeding ‘equipment’, in the pursuit of ‘liquid gold’. The analysis presented in this chapter reveals how the communication style and practice approach of some midwives positioned the woman as central to breastfeeding. Extending the ‘mining for liquid gold’ metaphor, these two discourses represent the ‘mother lode’, or the prioritisation of the ‘source’ of gold ore. This discursive prioritising of the mother elevated her to a position of significance, both in relation to her infant and in the midwife-woman interaction. In both approaches, the woman was seen as central in infant feeding decision-making and in contrast to the ‘mining for liquid gold’ approach, she was afforded a level of autonomy and control over this, albeit in discursively diverse and opposing ways. The ‘not rocket science’ and the ‘breastfeeding as relationship’ approaches represent two ends of a spectrum of midwifery approaches to support for breastfeeding. Consideration of these two less well represented discourses provides greater insight into the range of communication and support provided by midwives at these two maternity units.

5.2. Breastfeeding is ‘Not Rocket Science’

The allegorical statement adopted by midwives and women alike, predominantly at MUA, that ‘breastfeeding is not rocket science’ reflected an approach to breastfeeding support which constructed women as capable of providing ‘liquid gold’, if they held, or developed some level of commitment to do so. In other words, breastfeeding was positioned as an ‘elementary’ activity which women could choose to do, or not, without judgement or recrimination.
SSIV 10:

Midwife: ...If [women] take some time and are prepared to put in the hard yards [they will] get there. It’s not rocket science. Anyone can do it. You don’t have to have an IQ or, you know.

Midwives tended to leave women to ‘their own devices’ unless called to provide assistance. The prevailing discourse, that ‘committed’ breastfeeding women would succeed regardless of health professional input, freed midwives up to prioritise other aspects of the postnatal midwifery role.

The belief that breastfeeding was dependent upon the woman was prominent at site one. It appeared that the dominant breastfeeding discourse, at MUA, was a somewhat dismissive ‘not rocket science’ approach, a simple decision between breastfeeding or not. This was confirmed during interviews with staff, as well as during observational periods. For example, in this interview with a senior staff member she indicated her belief in waiting for women to ask questions about breastfeeding rather than actively offering assistance

SSIV 3:

Midwife: It is up to the woman (to seek out information or assistance for breastfeeding)...But if they don’t really – it’s not high on their agenda, they’ll just go with whatever they decided … we don’t really have that much impact. I can’t remember ever thinking – well personally myself about the midwife, and what impact she really ever had on me, because I really made my own mind up what I was going to do. Yeah, and if I choose to (breastfeed) or if I didn’t.

Very few midwives who subscribed to the ‘not rocket science’ approach however, agreed to participate in this study. Instead, participating midwives tended to be those who prioritised breastfeeding as the provision of ‘liquid gold’. One possible explanation for this is the view that midwives who dismiss breastfeeding as ‘not rocket science’, are likely to similarly dismiss the necessity for research into breastfeeding support. In my field notes I have noted some of the statements made by midwives who declined to participate in this study such as: breastfeeding is ‘not my area’, or ‘I don’t do much’ when supporting women who were breastfeeding. In any case these midwives were clear to highlight that their responsibility towards other more essential ‘professional’ activities, negated the need to assist women with
tasks which they could ostensibly accomplish unaided. As this senior midwife indicated:

SSIV 3:

Midwife: Yeah, those other things (breastfeeding support) that … the women think are important, happen if they can. They’re just a bonus.

5.2.1. ‘Anyone can do it’

The notion that breastfeeding is an activity which all women could do, if they so chose, underpinned all aspects of this discursive approach to ‘support’. Women were often positioned as proactive and autonomous individuals who sought out information about breastfeeding, if, and when, they needed it. Alternatively, women were variously positioned as planning to ‘wait and see’ how breastfeeding went, or, as not planning to breastfeed at all.

Midwives anticipated that during pregnancy women would gather the information required, regarding feeding options, from a variety of sources and would invariably base decision making on the opinions of those who mattered the most: their family and friends. This excerpt from a focus group interview indicates this:

FG 1:

Midwife 3: Because a lot of them don’t take much notice of what we’re saying.
Midwife 2: It’s what mum and grandma and aunty…
Midwife 3: They more listen to the, ‘I never had enough milk’. I won’t have enough milk. ‘I was never able to do it, you won’t be able to do it either.’
Midwife 2: Yes, there’s a lot of that…
Midwife 4: I think family has a much more important influence than we do.

At times women were predicted to have already ‘made up their mind’ regarding the best feeding option for them. Midwives, taking this approach, indicated a strong commitment to respecting a woman’s right to choose how to feed her infant.

Some midwives dismissed the need for antenatal breastfeeding education and instead believed that women could not truly ‘learn’ about breastfeeding until it became a physical reality. This emerged as a fundamental principle, underpinning this discourse. As one midwife described it
Other midwives working within this approach identified attendance at antenatal classes as demonstration of an individual’s firm commitment to breastfeeding. The construction of breastfeeding as an ‘activity’ which, if chosen required individual commitment and some degree of hard work, was obvious.

Midwives who espoused the importance of commitment and hard work for breastfeeding ‘success’, consequently attributed ‘achievement’ to the woman’s own resolve. Midwives highlighted a sense of futility in ‘trying’ to convince a woman to breastfeed when the choice and commitment inevitably resided with the woman. Whilst midwives believed that all women could potentially breastfeed, they attached the caveat that this would only be achieved if there was sufficient commitment demonstrated by the woman.

5.2.2. Women ‘just need commitment’

A belief that midwifery input was superfluous for women who were ‘committed’ to breastfeeding was highlighted within this approach. There was a ubiquitous notion, that if ‘they’ find ‘it’ easy ‘they’ will breastfeed, emerging from both individual and group interviews with midwives as well as field observations. There was also the notion that ‘if they are committed they will succeed’. In addition, there was a belief held by some midwives that women who were ‘unsuccessful’ with breastfeeding were ‘not committed’ enough in the first place. This is illustrated in the following quote:

SSIV 3:

Midwife: I think it comes back to the women, and whether they really want to breastfeed as well. You know, some people come in with the idea that yes, I do want to breastfeed, but don’t realise how much hard work it is, initially. Not for all women, but sometimes it is hard work. Sometimes I think I could just say to them put it on the bottle because it’s not going to work, because it is hard work for everybody. You know, it gets handed over from shift to shift. This baby’s not feeding and it’s not settling, and all that sort of stuff, but the women really want to persevere and breastfeed. You’ll get another lady whose baby has a feed and then she gets to the next feed and goes oh, it doesn’t want anything, just give me a bottle, type thing, you
know. I’m prepared to – and I think most of us are prepared to give as much support as we can, as far as breastfeeding goes, but the women have to have some sort of commitment as well. If they don’t have that commitment, then there’s no point in us busting our gut to do it, either.

The collective grouping of women using the pronoun ‘they’ highlights a common form of stereotyping of breastfeeding women. As the quote above highlights, if ‘they’ were not committed to breastfeeding, did not find ‘it’ easy and were not prepared to put in the ‘hard’ work required, then it was pointless for the midwife to put in the hard ‘yards’. Women were judged on whether they could ‘tough it out’ through these hard times to achieve the rewards which breastfeeding could bring.

Focus group 1:

Midwife: It’s hard work. If you’re not prepared to put the hard work in, well you’re really not going to succeed.

Midwives were observed ‘sussing out’ whether individual women had the stamina to continue or whether they would be inclined to quit at the first challenge, hence justifying the minimal assistance provided. Midwives commented on the futility of spending long periods of time with women to ‘help’ with breastfeeding if ‘they’ inevitably ‘bail’ out at the first sign of trouble.

SSIV 4:

Midwife: …the women change their mind in mid flight. You’ll have someone who works really hard for eight hours on that particular thing, and then mid flight the second shift they’ll go “no, I don’t want to do this any more”.

In other words, the expectation within this discourse was, if breastfeeding was easy women would continue, if it was not easy then the committed would persevere, but those with minimal commitment would quit regardless of the midwives’ input.

SSIV 4:

Midwife: Really at the end of the day it’s how they cope. Some people cope really well. They find breastfeeding easy, so they go, “well, this is easy, I’ll just do it”. If it’s not easy, then I think no, we don’t really make any decision over that. I don’t think that we have a huge impact, no…But no, I don’t think that we make anybody’s mind up for them at the end of the day. What it is, is pure information and if they choose to use this, then it makes an impact.
Within the hospital environment women were also deemed to be testing out their own breastfeeding coping abilities and subsequently making decisions about continuation or not. The midwife above implied that women viewed midwives as merely a ‘tool’ at her disposal:

SSIV 4:

Midwife: …we are just like more information and we’re just a tool to them. If I want it, I’ll get it from you. If I don’t, it doesn’t matter. You made no impact on me. You know what I mean? It’s just pure information.

The tendency to view women in this light, led to further suspicion regarding the genuineness of an individual woman’s breastfeeding commitment. There was a detectable intolerance by some midwives for women who might only be breastfeeding to be ‘seen to do the right thing’, and to avoid being labelled a ‘bad mother’. In fact, some midwives clearly believed that women sometimes breastfed in hospital to keep the staff ‘happy’ but then ceased when they returned home:

SSIV 4:

Midwife: …when the women get home they make up their own mind what’s going to suit their lifestyle…they want to do their best while they are in here…

Midwives expressed frustration when women later divulged that their breastfeeding motivation in hospital was staff dependent:

SSIV 3:

Midwife: …if you see them a week down the track or whatever, [the woman] will go oh, I only did it in hospital because that’s what they expected, and I wasn’t going to do it anyway…

This social practice highlights two prominent facets of hospital-based postnatal care. Firstly, women adopted an unwanted position as a breastfeeding woman, to keep midwives happy. Once they left the hospital they ceased to breastfeed and thus staff gained confirmation that ‘breaking your back’ to help women with breastfeeding was futile as some were not really ‘committed’ and would cease the practice when discharged. Secondly, with this information the midwife was freed up from assisting with breastfeeding and could use her ‘expertise’ as a skilled clinician in other ‘more important’ areas, which were within the midwives’ control. The midwife then responded to the call for breastfeeding assistance from those women who were ‘genuinely’ committed to breastfeeding.
In this context, an indicator of a genuine commitment to breastfeed was interpreted as women who utilised the call bell to request assistance. The perception that midwives could not influence whether or not a woman would continue to breastfeed, was pervasive within this discourse. In any case, breastfeeding was ‘not rocket science’ and this appeared to provide justification for midwifery focus on the more technological aspects of care, such as post-operative care, medication provision and collection of observations. Midwives indicated a belief that their professional skills would best be focused on the areas of care that the mother could not personally attend to.

5.2.3. Women should not be ‘pressured’ to breastfeed

The woman’s decision to feed her infant with breastmilk or formula was deemed inconsequential to the ‘not rocket science’ midwife. It was considered the woman’s ‘business’ how she fed her infant. The midwife positioned herself as being available to provide rudimentary assistance to the woman regardless of the feeding option she chose. Infant feeding was ‘not rocket science’, which roughly translated into midwifery interactions which focused on other aspects of care, whilst meeting ‘basic feeding’ information needs.

A laissez faire attitude by midwives towards infant feeding choices, seemed to emerge from the above discourses. This ‘attitude’ to feeding choices appeared to be connected to a societal discourse which represented midwives as ‘breastfeeding nazis’, as presented in Chapter One, who focused exclusively on ensuring breastfeeding compliance. Midwives practising within the ‘not rocket science’ discursive approach, sought to distance themselves from the ‘nipple nazi’ label. Interestingly as part of the desired discursive separation from ‘nipple or breastfeeding nazi’ discourses, some midwives constructed formula as ‘God given’ for those who do not like breastfeeding. The following excerpt from a focus group interview indicates some midwifery responses to women who had indicated a desire to bottle feed:

FG 1:

Midwife 4: That’s fine. That’s why God made formula, for people who don’t like to breastfeed.

EB: Do you think it’s okay for people to say that?
Midwife 2:  I think it is.

Midwife 4:  I say it all the time.

Midwife 1:  Sometimes you get that vibe from people, like they look disgusted…(about breastfeeding).

Midwife 2:  Well I ask the people. I say do you want to breastfeed? It’s okay if you don’t. But if you want to breastfeed, we will do this, this and this. But if you don’t want to breastfeed, that’s fine by me. Because there is nothing worse, and I know I had it, than some midwife coming along and shoving that baby on your breast. It’s a horrible feeling, and they can make you feel like you don’t care about the child.

The apparent ‘breastfeeding nazi’ behaviour of another midwife, had significantly influenced the midwife above to adopt a more ‘laid-back’ attitude towards infant feeding choices. Midwives were keen to be remembered as the opposite of a ‘breastfeeding nazi’ by endeavouring to keep the woman ‘happy’ if her feeding choice included the introduction of formula.

Focus group 1:

Midwife 3:  I find that some women need permission [not to breastfeed]. They’re like little girls that need permission. So look, I won’t give you a hard time. If you want to bottle feed, I don’t care, just do it. Be happy. And I’m never going to give you a hard time. I don’t care what you do. Just do what makes you happy, and they go, “okay”.

Midwife 4:  The baby will still be a healthy, happy baby.

Midwives conveyed an attitude of whichever option the woman chose would be ‘no big deal’ and she would be given the necessary information either way.

SSIV 3:

Midwife:  …I know we have to have strict guidelines as to what happens as far as your breastfeeding goes; that you shouldn’t give them anything else, and do all those sorts of things, and I understand why it is, with research and stuff like that. I think sometimes we’re too stringent with it, as well. I think you need to maybe have a bit of give and take there as well. I don’t think it should be an easy way out, like as far as giving them something else. I know we have a form now about [comp]-feeding and I can tell you all the reasons why. I had a baby that screamed for three days, gave them one bottle, and then I breastfed for twelve months. That was my saving grace, and I understand why you’re not supposed to do that, but sometimes…
This self-disclosure indicated the influence of personal experiences on a midwife’s attitudes to decisions around combining breastfeeding with formula feeding. The influence of prior personal experience on midwifery beliefs about breastfeeding was a recurring theme. The following interaction further demonstrates this tendency to incorporate personal experience. At the change of shift handover, a midwife was informed that one of the women she was to be caring for had decided to switch from breastfeeding to formula feeding during the day. The midwife (Michelle) introduced herself to the woman (Ella) two and a half hours into a very ‘quiet’ shift (very few women were on the ward on this particular day).

Michelle introduced herself and asked Ella if she was breast or bottle-feeding. Ella stated she was now bottle feeding so Michelle enquired as to why she had decided to cease breastfeeding. Ella replied that her nipples were ‘sore’ and Michelle offered to ‘have a look’ (at nipples). Ella showed Michelle her nipples and was reassured that her nipples looked ‘good’. Michelle then stated, “…if you would like to put your baby to the breast next time he wakes just give me a buzz” (Int 19). Ella responded and the recording commenced:

**Int 19:**

Ella: Last night it was pretty much every 3-3.5 hours, it’s just that he wasn’t settling down and that was all he wanted pretty much...It was just that he wasn’t slowing down.

Michelle: Are you starting to feel fuller?

Ella: Yes.

Michelle: Because that nipple looks okay. Can I just have a look at the other one? A bit red, but they are not cracked or anything...Ok oh ok well I will leave it up to you...next feed if you want to try getting him on. Do you want to give me a call and I will help you get him on just to make sure that he is getting a nice big mouthful. Because if he is just chomping on the nipple then that can be excruciating, okay…but it’s entirely up to you alright but if you decide that you want to give it another go just give me a call. Okay, then.

Despite having very few other women to support, Michelle did not return to speak to Ella – instead, she left Ella to work out her feeding options alone. Later in the shift, Michelle disclosed to me her own personal experiences with breastfeeding and the guilt she had felt when she herself had switched to bottle feeding in the first two
weeks post birth. Michelle felt it inappropriate to ‘push’ breastfeeding if the woman was not indicating a desire to continue.

Whilst it was obvious that midwives, subscribing to this approach, did not want to ‘pressure’ women to breastfeed, there were some recorded examples of midwives ‘pressuring’ women to ‘make up their mind’ about continuation of breastfeeding, or cessation. This was especially apparent when women were experiencing ongoing difficulties breastfeeding. Women, and their partners, disclosed to me during interviews, and in unrecorded conversations, that they sometimes felt midwives were pressuring them into making a decision:

IV 7:
Partner: Just sort of happened during the shift change. The first lady she was helpful and then all of a sudden a new lady came and all of a sudden started saying, like making my wife to make a decision, do you want to breastfeed continue or you want to give formula. But it’s not the nurse’s decision, it is my wife’s decision but is saying like that she should make a decision. I said just listen she’s forcing my wife to make a decision at that moment. But yeah, I just found that, yeah. But she didn’t say make a decision but in a way it sound like you have to make a decision quickly because your baby is hungry or some sort like…

In the ‘not rocket science’ approach not only was decision making around infant feeding constructed as something which was a simple binary choice: either one breastfeeds or not, but the decision to switch from one or the other was also seen as a straightforward, uncomplicated choice.

5.2.4. We are here if you need us…

As indicated above, once women had made their choice to continue with the ‘hard yards’ whilst awaiting the ‘milk coming in’, midwives were available to help if required. However, the manifestation of this ‘help’ seemed to be influenced by the proliferation of a midwifery ‘hands-off’ approach to breastfeeding support.

SSIV 4:
Midwife: I still think it’s a hands-off approach. See how you go. If you’re having trouble, I’ll help you with it…

This senior midwife described leaving women to their own devices to initiate breastfeeding whilst being available for assistance if deemed necessary by the
woman. Yet the hands-off approach to breastfeeding support observed by others in this study included ‘talking’ the woman through optimal positioning and attachment, whilst avoiding physical touch, and included long periods of verbal and non-verbal support and education. The ‘not rocket science’ interpretation of this approach was devoid of long verbal exchanges. Instead, what was observed were short directive communication exchanges, between midwives and women, where the midwife remained detached from the interaction. Midwives within the ‘not rocket science’ support style were observed spending significant periods of time at the staff desk area, awaiting the call for breastfeeding assistance, whilst taking the opportunity to ‘catch up’ with colleagues.

Observation of staff behaviour indicated that when a woman used the call bell for assistance with breastfeeding, the response she received was largely dependent upon the beliefs of the attending midwife. The midwife with a ‘not rocket science’ approach adopted either, a quick ‘check’ or quick ‘fix’ approach to the interaction, or else engaged in a dismissive exchange. The following interaction represents the ‘quick check’ approach to breastfeeding support. This interaction commenced when the midwife answered the ‘call’ for assistance:

Int 5:

Midwife: How does that feel for you? Is that ok? Not painful at all?
Woman: No.
Midwife: That’s lovely, is it your first baby?
Woman: Second.
Midwife: Oh ok and you breastfed your first?
Woman: Yes.
Midwife: Good, well that looks good to me.
Woman: Yeah.
Midwife: Yes if it feels ok.
Woman: Yes, is it the right position?
Midwife: She’s nice and close to you, that’s right, beautiful.
(To me): Simple enough… then Midwife leaves. Interaction completed.
During observational periods at MUA, this approach to breastfeeding support was observed frequently. Midwives answered the call for assistance then returned rather rapidly to the desk area, to resume their paperwork or their interrupted conversation with a colleague.

At times, midwives were observed resorting to the use of ‘hands-on’ approaches to achieve the ‘quick fix’ of infant attachment at the breast.

\textbf{Int 3:}

\begin{quote}
Midwife: That’s it, now is that hurting you at all?

Woman: Just a tiny bit but I think she pulled at it before and she hurt it before, (to baby) “see what are you doing you keep coming off all the time…”

(midwife puts the baby back on the breast)

Midwife: How does that feel?

Woman: So long as she’s happy I’m happy, that’s all that’s wrong with her she keeps wanting more milk, and more milk and she’s probably got more wind, (to baby) “you in boob now?”
\end{quote}

This ‘quick fix’ approach resulted in infants being put ‘on’ the breast by the midwife who left soon after to return to other ‘more important’ responsibilities. Women referred to a level of frustration when receiving care from midwives with this type of approach, as the following excerpt from an interview reveals:

\textbf{IV 13}

\begin{quote}
Woman: [The] Midwife put him on my breast and left.

EB: As in put him on your breast by physically…

Woman: Yeah, just physically put him on for me. Didn’t talk to me about the process or anything. Just put him on and then she was gone and I was just feeding the baby and my husband was there and we were just like, well what do we do now. The midwife was more concerned – because I was a private patient – and they put me in a room with four and she said, we’re working on kicking one of the other girls out to get you a private room. That was it. For the next three hours we were alone with the baby. So it wasn’t a pleasant experience and I’ll never go back to the [name omitted] as a result.
\end{quote}

Interestingly, these ‘quick fix’ approaches occurred both when the postnatal ward area was busy, as well as when the postnatal ward had very few ‘inpatients’ (sic).
Reports of dismissive encounters were also disclosed, at interview, with women. The following excerpt is from an impromptu interview on the postnatal ward, with a woman and her partner, which was requested prior to discharge. This excerpt captures the dismissive nature of some interactions:

IV 7:

Woman: Yeah but the other example of the lady was that the baby was not settled and we have tried everything and at the back of my mind I think okay we have tried, let’s try the expert. So I make a buzz again to call them to come in and when she came in and what did she say again …

Partner: In aggressive voice again, yah, yah, yah, it’s not rocket science practice or something, rocket science just to figure this thing out, all this stuff. It’s not nice…

Woman: …But she didn’t ask me what I want as well. She said, blah, blah, it’s not rocket science and you usually figure it out yourself. Like sounding like accusing my husband of not helping.

Woman: …And after having said all that she left…Without helping…Without offering…

Partner: Suggestion or anything.

Woman: And at the back of my mind, what is her role here. Why is she here on her shift for?

Whilst I did not have the opportunity to observe these types of overtly dismissive interactions, the distress felt by this couple at the complete lack of regard demonstrated by the midwife, captures dismissive ‘not rocket science’ at its extreme. The notion that a midwife’s responsibility regarding breastfeeding support was to ensure the woman could just ‘get on with it’ was influenced not only by the interpretation of the hands-off discourse and elementary breastfeeding but inevitably by the personality, and demeanour of the individual midwife. The following field note recollection, from a post-interview conversation with a senior midwife, reveals this:

Field note (Following SSIV 4): Following today’s interview the senior midwife disclosed that she felt breastfeeding was ‘not rocket science’ and that midwives should simply help women to ‘get on with it’. She went on to say that if breastfeeding doesn’t work out then women should not be concerned because when the child grows up they “won’t thank you for it anyway…”
This senior midwife went on to explain how her own children were appalled that she had breastfed them and were most ungrateful for her efforts. This midwife indicated her acceptance of alternative options for infant feeding and the importance of providing women with a choice.

Midwives working within this approach, clearly did not prioritise breastfeeding, and were observed to place the care and support for women around infant feeding choices at the bottom of their daily list of priorities. Instead, midwives focused their energy and attention on aspects of care which could not be delegated to the woman but rather were fundamentally within the ‘health professionals’ domain, such as the more medical aspects of care.

5.2.5. There are other ‘priorities’

Midwifery care at both participating postnatal wards included general medical and surgical aspects of care alongside traditional ‘midwifery-based’ woman-centred activities, such as breastfeeding assistance and newborn care. Interpretations of which aspects of midwifery and general nursing care should be prioritised, differed across the two study sites. At MUB, where the ‘liquid gold’ phenomenon was most prevalent, midwives prioritised breastfeeding support. In contrast at MUA, where the ‘not rocket science’ discourse was dominant, midwives prioritised support but this appeared to follow a much more traditional ‘nursing’ pattern. In this context, breastfeeding was not top of the priority list and medical aspects of care were deemed essential ‘…things that have to be done’ (SSIV3). The following excerpt from an interview with a senior staff member, captures entirely the preferential ‘priorities’ midwives identified:

SSIV 3:

Midwife: …so basically I would check the notes, I would have their – first I’d have a diagnosis, then I’d check the notes and see if there’s anything else that I need to know. Then I’d prioritise who needs medications, who needs them when, who is the most dependent, which would be surgical patients, which would be a Caesar. Who needs to get up and those sorts of things, who needs my help the most, physical help, and who needs that nursing care type thing first. There’s no way you can do it any other way, because if you try to go well let’s just do the breastfeeding first, we’d have patients sitting in the bed all day. And it doesn’t really work that way, because then we create other problems for them… So I’d probably go and do the nursing things
first, knowing that there’s midwifery things to do and then I’d work my way through the midwifery things, would be postnatal checks or whatever it is. But I’d try and do that on an individual case. I’d do the baby check and the mother’s check at the same time and try and talk to them, and I’d probably time manage a few of these things. I’d probably put people in showers and then do the postnatal things at the same time to the patient next door… So there’d be two types of nursing going on at once. That’s what I’d be doing. I’d do midwifery and I’d be doing nursing. So if there were no Caesars and it was just postnatal, like you didn’t have Caesars come back to this ward, then it would probably be totally different how I’d do it. But you’ve got antenates [pregnant women] in amongst all that.

The prioritising of what the staff termed ‘nursing’ aspects of care, such as the routine collection of observations, implied a separation of ‘rocket science’, i.e. nursing and medical care, from ‘not rocket science’, i.e. midwifery and breastfeeding care. This separation prioritised medical tasks over supportive engaged midwifery care.

Midwives felt that at times their entire shift was devoted to ‘clinical things’ like caring for surgical ‘patients’ or giving out medications, doing observations, collecting cardiotocographs (from pregnant women), preparing women for discharge, and restocking.

SSIV 3:

Midwife: Sometimes I think just getting through the day is what you do on the ward, because we get the women going home, then we get the Caesars in, then we get whatever. Your medical things are the things that have to be done, so if you’ve got someone with blood pressure problems or whatever, or Strep B obs or those sorts of things, yes, they have to be done. Safety and stuff as well, so making sure your baby’s fit.

In between completing clinical aspects of care, midwives confirmed that they tended to ‘deal with problems’ as they arose throughout the day. This form of routinised postnatal care was viewed as the only way to ‘get through the day’ without omitting any important ‘safety’ (or ‘rocket science’) aspects of care. As part of the coping mechanism for ‘getting through the day’ assumptions were made about women:
SSIV 1:

Midwife: …we just assume that they’re okay, and even if they’re battling on and
doing whatever they’re doing with their feeding, we just go, we haven’t
heard from them, they must be okay…

The prioritisation of other aspects of care, alongside the time pressures and lack of
staffing on this postnatal ward, seemed to contribute to the approaches to midwifery
care described here. At MUA, the group consensus was that “You do your necessary
things and answer the buzzers in between” (FG 1). This mirrored completely the
observed behaviour of the ‘not rocket science’ discursive approach.

When midwifery and breastfeeding care were dismissively categorised as ‘not rocket
science’, midwives indicated that the influential institutional ‘production line’ (SSIV
3) activity, attributed to hospital-based care, impacted upon their interactions with
women. Senior staff spoke of the damaging effect of ‘the churn’ (SSIV4) (the high
turnover of clients) on the day-to-day work of the midwife. One senior staff member
identified that within the hospital environment there was no other way ‘to survive the
day’ than to ‘…become a part of that churn and get them in and get them out’
(SSIV4). Managers identified that they inevitably placed ‘pressure’ on midwives to
move women through the organisation as pressure was equally being placed upon
them to do this. This aspect of hospital postnatal ward experience was recognised as
contributing to ‘…break the relationships down’ (SSIV3) between women and
midwives, which some perceived had a detrimental effect on breastfeeding support.

In order to fulfil the institutional prioritisation of ‘safety’ aspects of care, midwives
engaged in time management and prioritised aspects of care, which demonstrated
adherence to ‘safe care’. Institutional markers of quality postnatal care appeared to
be the absence of complaints about unsafe care:

Focus group 2:

Midwife: They only see you when you get a complaint. [Laughter]

EB: Is that how it feels?

Midwife: Yeah. No one ever comes and says yeah you’re doing great, or thanks for
turning up.

Senior staff confirmed the widespread acceptance of this as an institutional outcome
measure:
SSIV 5:

Midwife: Quite frankly, as long as there’s not a complaint coming through the door, that’s fine, everything is fine. The only time that we really see it [poor practice] is if there is a complaint.

The lack of institutional monitoring of breastfeeding initiation and duration rates at MUA, was further indication of a lack of prioritising of breastfeeding in the organisational context. This subsequently provided a fertile breeding ground for a discourse that was dismissive of breastfeeding. Whilst this discourse inevitably underpinned some individuals’ practice, it was overshadowed by the more dominant ‘breastfeeding is the acquisition of liquid gold’ discourses.

Some midwives recognised institutional restrictions on breastfeeding performance, such as the focus on medicalised aspects of care and routines. Midwives within this ‘not rocket science’ approach therefore, seemed to encourage women to return home on early discharge, as soon as possible.

5.2.6. You are better off at home

Home-based midwifery care was advocated as the best option for women, wishing to establish and maintain breastfeeding, as they would be in their own environment, surrounded by their close family and friends. In any case, access to expert professional help was not prioritised within the hospital environment at MUA, because the midwife, and the institution, had other priorities. Therefore, the consensus was that the woman might as well be at home. Some women, at MUA, reportedly felt inundated with various ward staff (midwives and administration clerks) offering to place her name on the ‘early discharge list’, an offer which began from the time they arrived on the ward. Staff ensured that women were aware of the benefits of the home-based service. The postnatal hospital ‘churn’ was manifest by short postnatal hospital stays:

FG 2:

Midwife: And it might help with the breastfeeding. But I’ve had the opportunity to do MSP [Midwifery Support Program], and you can do more for women at home than you can on the ward. Because you’re in their environment, they’re comfortable. They actually ask questions that need answering...

However, in practice, the postnatal breastfeeding support provided to women in their own homes by midwives who subscribed to a ‘not rocket science’ discourse
remained minimalist with a focus on completing allocated tasks. Although there was noticeably more dialogue from women, in the home-based transcribed interactions, compared to those in hospital, this was perhaps the result of the change in ‘subject’ positions available to participants beyond the confines of the institution. Women appeared to be more proactive, in asking questions, and midwifery practice was noticeably less invasive of personal space.

In summary, aspects of the ‘not rocket science’ discourse, and the prioritising of ‘liquid gold’ discourse could be tracked through all facets of maternity service provision. Midwifery practice appeared to be biased towards either ‘mining for liquid gold’ or ‘not rocket science’. In fact, these two dominant discourses represented either end of the spectrum of language and practice approaches towards breastfeeding support. The remainder of this chapter will consider the least common discursive approach to breastfeeding support. This approach revealed midwifery prioritisation of the relational aspects of breastfeeding over and above any other features.

5.3. ‘Breastfeeding is a Relationship’

In this study, the majority of midwives, at both sites, prioritised the nutritional aspects of breastfeeding; however, alternative discourses were also identified. The symbolism inherent in prints and paintings featuring images of mothers and infants swaddled together while breastfeeding, which adorned the hospital walls (especially at MUB), suggested the existence of alternative discursive references for breastfeeding. Data analysis revealed only 9% of interactions positioned the relationship between the woman and her infant as central to the breastfeeding experience. Significantly, midwives participating in the eight interactions representing this alternative support style, were working in models of midwifery service provision which differed from the norm. In particular, three midwives worked in ‘continuity of carer’ models, four midwives worked in designated lactation consultant positions, and one Bachelor of Midwifery student midwife was working in a supernumerary capacity. The difference here is that these practitioners had the capacity to organise their own work and spend as much or as little time as the woman needed. Not all midwives working in continuity of carer models, or designated lactation consultant positions, however, engaged with women in
interactions which were rich with relational foci. Alternative discursive influences obviously contributed to the way these practitioners connected with women.

Certainly for some, the relationship formation which naturally occurred within ‘continuity of carer’ models, seemed to translate into a prioritising of the relational aspects of the mother/infant breastfeeding relationship. As stated above, in total, eight interactions were observed where relationship formation between the mother, her infant, her family and the midwife, were prioritised. Four of these exchanges occurred in the hospital environment and four in the woman’s home. The midwives ranged in experience from first-year student midwife to a midwife with more than three decades’ experience, who had also worked as a lactation consultant for many years.

5.3.1. Getting to know the woman

The first demonstrable difference between ‘relationship orientated’ practice, and the previous practices presented, was the value attached to getting to know the woman. Midwives and lactation consultants within this approach tended to begin their interactions with women by engaging in friendly ‘chat’ for a period of time before enquiring about the areas the woman would like to discuss. The woman was clearly at the ‘centre’ of care. Midwifery communication styles, within this discourse, included open-ended questioning and opportunities for women to lead and dominate the discussions.

Int 35:

Midwife: What do you feel about your supply?

Woman: I was actually glad I was making her feed yesterday because my milk had come in and I was just so sore. And I was having obviously trouble, because I was so hard here, she couldn’t get that mouthful and so it was hurting because she was only trying to grab the very tip.

Midwife: That’s right, so what did you do about that?

Woman: So I stuck my finger in there to try and – and it was hard too, because I couldn’t press in here too much – to get her to stop so that then I could try getting her to go back on again. And by that stage obviously this had gotten a little bit softer so she was able to get back on. And obviously the initial, I’m like, especially on this side, and I think some of it is psychological because I can remember that’s the side I had trouble with, with [name given] on that side. And I had a cracked nipple on that side. So I really tense
up and I think, no, I have to relax, I have to relax. And the initial, it’s sort of like, ooh, and then either it just goes away or I have to reattach her and then I find...

Midwife: That’s right, if it’s persisting, yes, you’re doing the right thing, you take her off and then you put her back on.

Midwives and lactation consultants spent time ‘checking-in’ with women. This approach included enquiries about how other aspects of her life were going, and did not focus exclusively on breastfeeding. During interviews with women this was described as the desire to want ‘to know my story’ (IV 12). Women valued health practitioners who wanted to know ‘me’ and who went out of their way to be friendly and form connections with the woman. The following quote describes a woman’s experience at having met a midwife like this, on the postnatal ward, whose approach to practice was in stark contrast to others she had contact with:

Int 12:

Woman: She was. She was great. I would love to have bottled her and kept her but I had her in my life for two hours.

This same woman later described the care she had received from a lactation consultant which she described as affirming and confidence building. The infant had been placed in the neonatal intensive care unit due to one low blood sugar level reading. The woman became increasingly frustrated with the control exerted, by the neonatal intensive care unit, over her infant and his feeding. She described the advocacy role the lactation consultant took and the importance of the relationship links with her infant, her husband and the health practitioner:

IV 12

Woman: Finally, the lactation consultant just butted in and said, ‘this baby needs to go back on the ward with his mum’ and she falsified the feeding time record to reflect that and they let us back down on the ward….She was great. I can’t remember her name anyway to mention it. We sought her out because she wasn’t always there. But we went in and requested her once I got that relationship happening with her because she was the only one that seemed to be interested in me and the relationship I was having with the baby…Well, I really felt she was the only one that was listening to me. The rest were either just looking at [infant] and not paying any attention to me or they didn’t even think I was a new mum down in the ward. She was the only one that was kind of there and she was listening to me and looking
It was a combination of the two whereas the others … The lactation consultant didn’t treat me like I was an idiot, for a start. She actually respected that I had my own ideas about how I wanted to work with my baby. The attachment issue was very important to me. I guess bonding with him and making sure they could see that we were a unit, not just individual people. All the midwives who I didn’t so much feel that with, they didn’t see that… They just saw two individuals rather than a unit. Whereas, the lactation consultant saw that. She also respected my husband and his views as well, which was very important because he was my spokesperson. So he was the one that went and sought her out, he continually went and sought her out. She remembered who we were… She wanted to know the story. She asked the story. So how did the birth go? She was the first person who asked who really listened to that story.

The midwives who asked questions and wanted to “…find out my history” (IV 9) demonstrated an interest in the woman which was important in building a sense of rapport. The importance of body language was also identified by women during interviews.

Int 6:

Woman: Just their body language. They smile, they don’t look grumpy. Their personalities, like in customer service someone walks up to you and they look grumpy and they’re frowning you don’t really want to speak to them. But when you smile at someone, your eyes are open and you’re speaking with a happy voice then that makes you happier and more comfortable, so that’s what they did.

A soft tone of voice and sense of calmness were additional factors described by women when portraying their experiences with midwives they had developed a connection with.

Relationship formation based fundamentally on ‘respect’ was especially noteworthy when women recalled their experiences with a variety of health professionals. One young couple, from a non-English speaking background, noticed a marked difference in midwives’ verbal and non-verbal communication around breastfeeding when based on ‘respect’ for cultural diversity and acceptance of language barriers (IV 7). Midwives and lactation consultants who took the time to talk and showed they cared about the woman were remembered and described positively:
Int 18:

Woman: One lady [midwife] – because I had a lot of the swelling – and one lady, she does reflexology, so she actually came in and gave me a foot massage, which was just lovely...It was lovely. And that actually did help me, they felt a lot better after that. So, yes, that was absolutely brilliant.

The ability to convey a sense of having ‘all the time necessary’ to spend with the woman, even though the ward was ‘busy’, was especially valued. Relationship-focused midwives and lactation consultants, conveyed a genuine passion for their work and a joy in engaging with people.

Int 8:

Woman: It wasn’t just a job…[when collecting information] somehow it just came across as more of a conversation than a checklist…they’re actually just really interested in the people that are sitting in front of them…

This is not to say that midwives in the ‘mining for liquid gold’ or ‘not rocket science’ approaches did not also display a passion for their work and friendliness, but rather this approach highlighted a genuine interest in wanting to get to know the woman beyond breastfeeding. Being interested in the woman, her family, and her life was a common thread amongst the eight observed relationship-focused interactions. The following exchange is between a midwife providing ‘continuity of carer’ throughout pregnancy, birth and the postnatal period. The discussion, recorded at a regular postnatal visit, had moved beyond the introductory pleasantries onto how the woman was feeling. This quote highlights the midwife’s knowledge of the family and the importance of these relationships to the woman:

Int 35:

Woman: Yes, I have. I did, actually the day before I came home because I was – I built myself up thinking I was going to be home. And so when they left [husband and toddler] I was a bit teary. I said – they actually left so I could have a sleep in the afternoon and I got a bit teary then because I said I miss them. I don’t like them having to leave and I’m still there. So I was ready first thing in the morning...[for discharge]

Midwife: That’s right, to come home and to be all together.

Woman: Yes. And then I was a bit teary last night, we were sitting here at dinner time because we were all together so I was a bit overwhelmed but I said, I
tell [partner], I said, these are good tears, I said this is normal and these are
good tears. And he goes, okay.

The significance attached to connections between all members of the family, and the
midwives’ established knowledge of the family ties, was an important aspect of this
relational approach to postnatal care. Family relationships were recognised and
prioritised through the provision of home-based continuity of midwifery care from as
early as six hours post birth. Concern for the woman’s wellbeing extended beyond
the provision of adequate milk supply, for the infant, to include the importance of a
general, overall sense of wellness. The focus on relationship building commenced
with a period of getting to know the woman and was followed by encouragement to
‘tune in’ to the infant cues and emerging communication patterns.

5.3.2. Getting to know the baby

Within this relationship-focused approach to breastfeeding support, infants were
constructed as deeply connected to the mother. The mother and infant dyad were
seen as two components of the one system. For this reason, women were encouraged
to engage in ‘tuning in’ behaviours such as watching for signs that the infant was
hungry, closely observing the infant’s discovery and learning phase of breastfeeding,
and recognising when the infant was tired and needed rest. This style of engaging
was especially detectable in an interaction observed between a lactation consultant
and a woman who had just arrived on the postnatal ward following birth. The
lactation consultant had not met the woman previously and yet her soft, gentle
manner facilitated rapport building in a very short period of time.

Int 45:

Midwife: You just bring baby straight to the breast and let baby feel where the breast
is.

Woman: She doesn’t know how to suck.

Midwife: That’s alright. She’s very clever, you watch. She will have a little lick and a
little feel and she’ll smell it.

Woman: Actually she sucks this nipple this morning very well but this one is not so
[inaudible].

Midwife: She doesn’t [inaudible].

Woman: No, so she cannot do this.
Midwife: Okay. But she can, she doesn’t know the difference from one side to the other. So we just leave her to have a little feel. She will just start moving her head in a minute, just like that. See how she is moving her head and she is feeling it with her cheek? [Inaudible].

Woman: [Inaudible]. She just cannot get the nipple.

Midwife: She will if we just wait. She will just be able to move her little head around. See how she is doing that again now?

The consultant encouraged the woman to observe the infant and ‘let her tell us’ what she wants.

Midwife: She’s happy to stay there and she’s not pulling off or crying. She’s happy to be there.

Woman: Yeah. She’s not sucking.

Midwife: That’s okay, she’s [inaudible] out here and she can hear your voice, she knows your voice, she’s heard it for a long time.

Woman: Yeah.

Midwife: She can hear both our voices very clearly now. She has waited to see your face like you have waited to look at her for a long time.

Woman: Can she see us?

Midwife: Yes. When you cuddle her and hold her in your arms, she can look up into your face and see your eyes and your eyebrows. She stares at you and watches you and when you talk to her and smile at her she can watch what you do now and mimic what she can see you doing. You will find she starts to make little faces. Then she watches you doing that when you talk to her and so she learns from now, straight away. [Inaudible]. She may want to feed now or she may just want to be near you and hear your voice and you could just give her a little cuddle with her lying on your chest and then when she is ready she will crawl across and tell you that she wants to feed.

This is an important interaction as it demonstrates the ability to develop rapport and a relational approach within a very short space of time. The language used by the lactation consultant facilitated ‘tuning in’ behaviours in the mother. The lactation consultant reinforced that the infant was ‘learning’ to breastfeed, just as much as the mother was. Behaviours such as ‘licking at the breast’, maintaining proximity to the breast, and ‘feeling the breast with her cheek’, were identified as performance clues that the infant was on a journey of discovery of the mother. The woman in turn was encouraged to travel along a path of revelation about her infant.
Midwives practicing within the relational approach opportunistically dispelled common myths about infants and breastfeeding. Midwives actively engaged in counteracting any normative societal induced tendencies to negatively construct the breastfeeding infant as ‘demanding’ or to represent breastfeeding and breastmilk unfavourably. For example, the following excerpt indicates how the woman at times variously referred to her milk as ‘stuff’, implying that it was a substance which did not belong to her. The interaction also highlights the woman’s inclination to construct her infant as ‘disinterested’ in breastfeeding or as ‘stubborn’ and ‘sleepy’.

The lactation consultant chooses to either ignore such negative statements or offer an alternative interpretation of the infant’s behaviour. In the end, the maintenance of a positive stance eventually influenced the woman’s discursive representations of her newborn infant’s behaviour.

Int 49:

Woman: …I’ve only put him on this one. I wanted to try this one but I thought, well maybe if I could just get a bit of stuff out I might be able to entice him to feed, but I don’t know…he’s a stubborn little bugger…

LC: He’s having a little lick with his tongue and feeling whether it’s there. He may still come back or you may need to relatch him but he had a feel and he’s checking it out…He’s thinking about it, isn’t he? Slowly.

Woman: Yes. You don’t make decisions real quick do you mate? A bit like your father [laughs]. Takes him for ever to make a decision…

LC: That’s great. You’ve stimulated him and offered it to him now and he just may not be quite ready yet and it’s okay if you’re comfortable just to do some skin-to- skin with him. You may find that he’ll just crawl across and hop on…

Woman: See what you’re doing to me?

LC: Oh no. He’s just saying, ‘mum, I don’t know what to do’.

Woman: I suppose he came out a couple of weeks early too [laughs]. You didn’t get that lesson, did you?

LC: He’s listening to your voice and smelling and feeling.

Woman: He just went to grab my finger. He’s doing that himself so he must be wanting to feed.

LC: So would you want to keep trying?
Woman: Yes I would.

LC: Sometimes just give him a little bit. It stimulates him and then he says, ‘oh you’ve taken it away’.

Woman: He did, he grabbed hold of my finger and sucked it like it was going out of fashion.

LC: He talks to you that way. Beautiful.

Woman: He has a little – like he just does two or three and then he stops. Maybe he’s just having a little rest.

LC: You can just give him a gentle little rub on the palm of his hand. That’s okay, he just wants to have a little bit of a practice.

The potentially powerful impact of this type of intersubjective relationship between the woman and midwife is remarkable in the context of early breastfeeding language and practices. Through the simple act of ‘normalising’ infant behaviour, this midwife avoided the tendency to ascribe personality traits and grossly negative behaviour traits, onto the newborn infant. In this way, the bond between the woman and her infant was potentially enhanced.

5.3.3. Creating connections

Midwives and lactation consultants who practised within a ‘relationship-focused’ approach were observed engaging with the woman’s visitors during interactions rather than excluding them, or bemoaning the influx of them. Prioritising connections with loved ones was a feature of this style of support.

At MUB, the importance of partner involvement in pregnancy, birth and postnatal support was communicated from the outset with the provision of a one off ‘male only’ antenatal session. The session, entitled Tools for Dads, was delivered by a male midwife and facilitated information sharing amongst men. The session content included information on becoming a dad, newborn infant care and supporting breastfeeding. This prioritisation of male involvement seems to reflect a discursive turn towards the importance of relationship factors for breastfeeding.

Similarly, the expansion of ‘midwifery support at home’ models of care and ‘continuity of carer’ models facilitate the building of connections between women with a known midwife. The ability to engage with a woman within the full context of her life and on several levels simultaneously; seemed to facilitate rapport building
and maintenance of ongoing engagement. When the woman was permitted to lead the exchange, the midwifery role was one of support. This support style emerged from interactions with midwives who incorporated ‘relationship-focused’ discourses into their language and practices.

5.3.4. Building confidence

Relationship-focused midwives and lactation consultants were consistently observed providing positive feedback to women about their breastfeeding progress. They communicated appropriately, using both verbal and non-verbal language, to convey an inherent confidence in the mother and infants’ abilities to breastfeed independently. An attitude of ‘respect’ towards the woman and her infant, and her family, underpinned this approach. The woman’s own knowledge about her infant was sought, and prioritised, by the midwife as was the use of open-ended questions which facilitated the gathering of woman-led information. Genuine support was offered by practitioners with the flexibility to adapt to the woman’s circumstances.

The preferred style of support was gauged during a period of ‘tuning in’ to the woman’s feelings and preferences regarding breastfeeding. Interactions commenced with a period of getting to know the woman and incorporated ‘hands-off’ breastfeeding support. However, if the woman indicated a desire for ‘hands-on’ assistance or a demonstration from the midwife or lactation consultant, this was also accommodated. There was a noticeable midwifery and lactation consultant focus on facilitating the development of the woman and infant’s ‘own way’ of breastfeeding rather than adhering to a prescriptive regime advocated by the health practitioner.

The following excerpt demonstrates this woman’s sense of relief at not being offered a prescriptive health professional-generated plan ‘of’ attack’ to improve her breastfeeding. The negative outcomes this would have had for her relationship with the lactation consultant are apparent.

Int 2:

Woman: No. That would not have been a good thing for me. If she had told me there was another plan I don’t think I would have had that relationship with her. Because she said ‘let’s just see how things go, let’s try this, let’s try that’. If she’d actually said that we were going to have a plan I think I would have bit her head off. Would have been the last straw. If someone who wasn’t
listening that, the current plan’s not working. I don’t need a new plan. I need some freedom to try some different things.

The discursive polarity between relationship-focused approaches and ‘liquid gold’ prescriptive advice giving, have been highlighted in this quote. Midwives who prioritised relationship building gave many suggestions and options for women to choose from but universally avoided merely giving instructions. In this way, the woman’s right to self-determination was respected and facilitated. The detrimental effect of prescriptive plans ‘of attack’ generated without consultation with the woman, and superimposed over a relationship based on a power differential, highlights the disempowering nature of traditional models of postnatal care provision.

In contrast, the relational approach instantly placed the woman in the picture as an equal, autonomous human being. Health professional connections were maintained because of respectful engagement with women and the honouring of her right to accept or reject suggestions regarding breastfeeding and her newborn infant. This form of respect captured the vision of a service which could be authentically ‘woman centred’. Aspects of current service delivery, which ostensibly inhibit midwifery relationship formation with women, and which limit the time available for midwives and women to engage in genuine dialogue, were repeatedly mentioned by staff as barriers to effective breastfeeding support. However, the ‘relationship prioritising’ approach to breastfeeding support clearly indicated that, even within the fragmented health system, genuine dialogue and support could be facilitated when health practitioners engaged with women on a respectful ‘mother affirming’ level. The expert use of clinical skills enhanced confidence, via the utilisation of professionally acquired communication skills, rapport building, positive language, and appropriate use of physical touch.

5.4. Conclusion

In this chapter, I have revealed the two less prevalent discourses apparent within the textual analysis of all 85 observed interactions and 48 recorded interviews. The findings presented in this chapter represent a dialectic testament to the diversity of midwifery support styles in contemporary hospital environments. The ‘not rocket science’ and the ‘mining for liquid gold’ approaches, represented two clear points along a continuum of breastfeeding support styles. On one extreme end of the
spectrum of discursive practices lay the passive and dismissive ‘not rocket science’
approaches. At the opposite and extreme end of the scale, the active and intensive
‘mining for liquid gold’ performances dominated. Yet the mid-point of this
discursive spectrum was populated by a discourse which represented a prioritising of
the very ‘actors’ in the breastfeeding performance: the mother and the infant, in
context. This central point of a linear range of support styles appeared to be
suppressed by the dominance of the discourses on either side. Yet within this very
small sample of alternative discursive styles lay the realisation of an authentic or
genuine relationship-based professional support style, which facilitated ongoing
breastfeeding and enhanced mother-infant synchronicity.

In the next chapter I will discuss the origins of these discursive practices. Adopting
Foucauldian concepts, I will argue that the process of objectification, of both
midwives and women, in contemporary maternity systems has led to the adoption of
restrictive subject positions which limit relationality. Institutional discourses and
scientific discoveries have contributed to the midwifery language and practices
observed. In the next chapter, I will explore the focus on breastmilk the product, and
the management of breastfeeding women, and the disregard of the relationship
aspects of breastfeeding.
CHAPTER SIX

Protecting Gold

6.1. Introduction

In Chapters Four and Five, I presented the study findings from an examination of the language and practices of midwives at two maternity units in New South Wales, Australia. Eighty percent of the interactions observed reflected what I have termed a ‘mining for liquid gold’ approach, where breastmilk was revered as ‘liquid gold’ and extraction of this precious elixir was prioritised over the relationship between mother and infant.

There were however, two alternative discourses apparent in the analysis of findings from this study. In eleven percent of interactions breastfeeding was viewed as ‘not rocket science’, something which all women could do if they were sufficiently committed. The other nine percent of interactions reflected ‘breastfeeding as a relationship’ between mother and infant, where midwifery support included working in partnership with the woman. In this discourse, women were considered to be knowledgeable about the needs of their infant and themselves.

In this chapter, and in the next, I consider the origins of these discourses and practice styles and the constitutive factors shaping the ‘subject’ positions taken up by midwives, and women, during the first week after birth. In Chapter Three, I discussed Foucault’s three modes of objectification: dividing practices, scientific classification and subjectification. These three modes, highlight the influence of institutional and disciplinary discourses in the creation of subjectivities.

The positions taken up by women and midwives, during the postnatal period, can be better understood through an examination of the disciplinary power currently acting to ‘objectify’ individuals. Confinement within the hospital environment suggests a level of institutional control over the behaviour and practices of midwives and women. These objectifying strategies create certain conditions for subjectivity within contemporary maternity health care systems. In this chapter, I will explore the first
two modes of objectification, in particular the prioritisation of breastmilk the product, and the role of the BFHI in reinforcing this. Later, in Chapter Seven, I will discuss the third mode of objectification, the internalisation of contemporary and institutional discourses, resulting in the self-monitoring of behaviour to maintain compliance with a designated subject position. The influence of feminist discourse and the professional socialisation of the midwife, are also examined in the next chapter.

I will begin this chapter with a short summary of the ‘mining for liquid gold’ approach. Recognition of the overt prioritising of infant access to ‘liquid gold’ has clarified some of the discursive influences on midwifery practice during the first week after birth.

6.2. Breastmilk as ‘Liquid Gold’

The findings presented in Chapter Four revealed that breastfeeding was promoted as the ‘gold’ standard in infant health and wellbeing at both study sites. Colostrum was elevated to a position as ‘liquid gold’ during pregnancy and following birth. In this context, colostrum was treated as a precious resource in need of protection. Skin to skin contact was venerated as a crucial ingredient for early breastfeeding ‘success’ and was promoted for the stimulation of milk production and optimal infant to nipple attachment.

Infant access to ‘liquid gold’ was prioritised so much that, at times, midwives ‘took over’ infant feeding from the ‘unskilled’ mother. Midwives did this by assisting with infant ‘attachment’ or by hand expressing colostrum and subsequently cup or syringe feeding the infant. These practices seemed to be considered an ‘efficient’ use of time as the midwives ‘knack’ at retrieving breastmilk, or at ‘attaching’ the infant to the woman’s breast, was presumed to surpass the woman’s own awkward attempts at doing this. Once extracted, colostrum represented a precious elixir which could not be squandered. This style of practicing reflected the essence of the ‘mining for liquid gold’ approach.

Noticeably however, reverence for colostrum began to wane by day two. Improving the availability of superior ‘gold’, by ‘bringing in the milk’, became a focus of midwifery activity beyond day two (and sometimes even before this). At times, midwives recommended the introduction of additional equipment to bring ‘in’ the
milk and increase breastmilk supply. The woman’s breasts thus became viewed as the ‘equipment’ from which to ‘extract’ the ‘product’ for the infant. References to breasts as equipment began during the antenatal period and persisted well into the postnatal period, as reflected in both the language and practices of midwives. Lactation consultants epitomised the enactment of a ‘mining for liquid gold’ approach by focusing their attention on the breasts, and seeking to diagnose and manage problems from the outside-in. Communication tended to focus exclusively on the ‘breast problem’ or on the infants capacity to extract breastmilk. Social interaction beyond this was rare. Instead, breastfeeding was viewed as a mechanical process which benefited from the introduction of technology to enhance production.

I argue this focus can be traced back to the discourses of science and medicine, in particular the science of lactation. The growth of the medical specialty ‘breastfeeding medicine’ has also enhanced midwifery knowledge and understanding of breastmilk production, but concomitantly has led to a detached view of the breasts and an increased reliance on technological enhancement. These discourses appeared to be shaping the midwifery prioritising of ‘liquid gold’ and optimising of ‘breast’ performance. In this context, the midwifery discourses of woman-centred and partnership care appeared to be suppressed.

In the next section, I will further discuss the influence of lactation science and breastfeeding medicine on the language and practices of midwives. The elevation of breastmilk to the status of a product, with intrinsic properties which enhance infant health, has led to specialised medical management of breastfeeding women. In the second part of this chapter, I will examine the role of global strategies in ‘promoting, protecting and supporting’ breastfeeding within a global template for postnatal care. Whilst the BFHI emphasises the ‘quality’ of hospital environments for breastfeeding ‘success’ the integration of scientific and medicalised discourses into midwifery practice have led to prescriptive and authoritative communication and rigid interpretation of BFHI.

6.3. The Product: Breastmilk

As highlighted in Chapter Two, an infant feeding revolution occupied most of the last century. Scientifically-prepared artificial formula gained momentum as the preferred infant feeding option, until the 1960-70s, when breastmilk started to gain
ground as the ‘gold’ standard. In the last 30 years there has been a re-emergence of breastfeeding and breastmilk as the superior option for optimal infant and child health and wellbeing. This has been achieved largely due to the work of committed breastfeeding advocates, armed with the scientific evidence proving the superiority of breastfeeding for infant and maternal health (Hausman, 2003; Palmer, 2009:1292-6). Scientific interest in the composition of breastmilk, along with research detailing the health benefits, have collectively ensured that contemporary breastfeeding discourses are as scientific, and credible, as those promoting advances in infant formula production. The emergence of specialist scientific enquiry into lactation, has transformed professional, and in some quarters public, conceptualisations of the female breast and breastmilk.

6.3.1. Lactation science

The science of lactation began in earnest during the 1970s with biological erudition (Schmidt, 1971), neuroendocrinology of lactation (Meites, 1974), investigations into breastmilk composition (Kulski & Hartmann, 1981) and an increase in knowledge regarding the changes in breastmilk during a feeding session (Neville et al., 1984). The components and properties of breastmilk have been carefully and scientifically itemised and the ‘lists’ of beneficial ingredients continue to expand with each new discovery.

Lactation science, by the very name, reflects a disembodiment of the breast from the woman. I would argue that contemporary scientific discourses have moved beyond highlighting the many benefits of breastfeeding, towards the more technologically sophisticated analysis of the components of breastmilk and the physiology of lactation, as the work of Ferro et al., (2009), Kent (2007), and Walker (2010) attest. For example, the energy content of breastmilk has been analysed to reveal changes in content dependent upon the gender of the infant (Powe, Knott, & Conklin-B Brittain, 2010). Scientific analysis of the shelf life of breastmilk includes consideration of factors such as the “…antioxidant and toxin refractory capacity” of the milk (Ankrah, Appiah-Opong, & Dzokoto, 2000:113). Itemisation of ‘lactogenesis 1’ and ‘lactogenesis 2’, including the hormonal and volume changes accompanying these stages of milk production, proliferate in the biomedical literature regarding breastfeeding (Kent, 2007). Scientific comparisons have been made between breastmilk and formula, which expose formula milk as “… just a food …” whilst
breastmilk is “...a complex living nutritional fluid which contains antibodies, enzymes, and hormones” (Hoddinott, et al., 2008:881).

Enlisting the power of ‘science’ has elevated breastfeeding to a level of prominence in sociocultural and professional discourse. Breastmilk has been represented as a nutritional bodily fluid, which can be extracted and stored by individuals and machines. The objectification of breastfeeding in this way encourages health professionals and others, to view the breast in a disembodied way, with breastmilk seen as a ‘commodifiable’ product ‘manufactured’ by the woman. In efforts to demonstrate the significance of breastmilk, for national and international wealth and prosperity, the production of breastmilk has become effectively disconnected from the woman.

As observed in this study, the status of breastmilk as a precious substance colloquially known as ‘liquid gold’, appears to be gaining momentum. However, despite the growing body of scientific knowledge regarding the benefits of breastfeeding, subsequent links to national prosperity and infant rights-based discourses, breastfeeding remains a choice or an option for women. For obvious reasons women cannot be compelled to provide breastmilk. Instead, alternative strategies are utilised to promote breastfeeding and educate women about the importance of providing breastmilk to their infant. Mechanisms of ‘self-surveillance’ or ‘self-policing’ have been incorporated into health promotional imperatives (Lupton, 1995:138-9). However, the capacity to supply this much desired ‘product’ has placed women in the invidious position of having their bodily processes scrutinised and monitored for the benefit of the nation (Jansson, 2009).

6.3.2. Representations of the product

In Chapter Two I discussed the transformation of breastmilk, from a form of nutrition which infants could do without, to a marketed ‘product’ which all infants have the ‘right’ to receive. Scientific analysis has confirmed the status of breastmilk as the superior choice for optimal nutrition (Kaplan & Graff, 2008; Newton, 2004; Walker, 2010). Breastmilk has therefore been variously portrayed as ‘white blood’, ‘white chocolate’, and the ‘milk of human kindness’ in contemporary discourse (Giles, 2003; Hird, 2007; Weaver & Williams, 1997). Providing the bodily gift of breastmilk, to one’s own infant, or an infant belonging to another, has attracted both
admiration and controversy in recent decades (Shaw, 2003; Shaw, 2007; Weaver & Williams, 1997). During breastfeeding, women have described feeling as though their breasts are not their own, as though their breasts have been ‘hired’ for the supply of a nutritional fluid to their offspring (Giles, 2003:xii). This is not surprising given the tendency in capitalist societies to value and commodify the “… essential fluids of life – blood, milk, and semen – [which] are all for sale…” and are all products in their own right (Katz Rothman, 2008:2).

The findings from this study confirm the elevation of breastmilk to the status of an objectified commodity, constructed as ‘liquid gold’, in the practices of a majority of participating midwives. References to colostrum as ‘super milk’ or an ‘atomic bomb of breastmilk’ were apparent at both study sites. Whilst a dialogue around breastmilk as ‘liquid gold’ is not overt in the literature, this terminology has been used for much of the last 10-15 years, in the wider community (Baumslag & Michels, 1995). For example, Bernice Hausman in her book *Mother’s Milk*, highlights the tendency for breastfeeding ‘advocates’ to promote breastmilk as a ‘miraculous’ substance known as ‘liquid gold’ (Hausman, 2003:17,104).

A brief perusal of online parenting blogs, and health care organisation internet pages, confirms the widespread use of the term ‘liquid gold’ to refer to breastmilk:

A woman’s breastmilk has a unique composition of nutrients, enzymes, growth factors, hormones, and immunological and anti-inflammatory properties that can reduce the risk of a wide range of illnesses for a child well beyond infancy. Essentially, it is like ‘liquid gold’ for a growing baby (First 5 LA, 2007).

Indeed, for sick or premature infants, breastmilk has been referred to as more of a medicine than nutrition (Godfrey & Lawrence, 2010; Quigley, Henderson, Anthony, & McGuire, 2007). As a result of the scientific knowledge around the superiority of human breastmilk, an emergent need for ready supplies of breastmilk for sick or premature infants has grown over recent decades (Arnold & Larson, 1993; McGuire & Anthony, 2003; Rangecroft, Lazaro, & Scott, 1978). Whilst the first international human milk bank began in 1909, in Vienna, very few milk banks have existed internationally (Weaver & Williams, 1997). Human milk banking emerged in Australia during the 1940s, however, concerns about HIV in the 1980s led to their demise (Australian Health Ministers' Conference, 2009). Milk banking resumed in 2006 in Australia and there is now a growing demand from consumers and hospitals
(Australian Health Ministers' Conference, 2009). Australian regulations for quality management of human milk banking however, are lacking, and without government support, declining economic viability of milk banks has led to several closures.

Recent newspaper reports on the imminent closure of a human milk bank in Queensland, Australia, drew on the ‘liquid gold’ discourse to generate community interest in keeping the milk bank open (McKean, 2010). The capacity to pasteurise, store and sell breastmilk has also led to the emergence of a ‘black market’ in human milk sales. Another recent local newspaper report, lending support to their local milk bank, claimed that one woman had been offered human milk for $1000 per litre on the internet, significantly more than the $50 per litre charged by the milk bank (Hind, 2009). Despite the demand for breastmilk, putting a price on the supply of this precious ‘resource’, and providing the infrastructure required for production, and pasteurisation, have proved challenging. A process of collaborative lobbying for nationwide breastmilk banking, linked to major metropolitan hospitals, has now begun in Australia (Keene, 2010).

Harnessing the collective potential of postpartum women to provide ‘liquid gold’ has become a goal of public health policies. The global desire to counteract powerful marketing campaigns for breastmilk substitutes has led to health department initiatives directed at individual, institutional, and community level changes to promote breastfeeding, and facilitate ‘breastfeeding-friendly’ policy changes (Kaplan & Graff, 2008). Scientific discourses have been co-opted to lend weight to the importance of breastmilk promotion.

6.3.3. Breastfeeding medicine

In line with the scientific insight into lactation a medical specialty referred to as ‘breastfeeding medicine’ has emerged. Increasing medical knowledge about lactation has provided a platform for the monitoring and surveillance of breastfeeding women, for the benefit of society, and the health care system. This specialty has grown over the last 20 years, along with the advances in lactation science. The Academy of Breastfeeding Medicine recently celebrated their 15-year milestone as a worldwide organisation “…dedicated to the promotion, protection, and support of breastfeeding and human lactation through education, research, and advocacy” (Academy of Breastfeeding Medicine (ABM), 2010:website). In response to the backlog of
scholarly scientific and medical research papers featuring ‘lactation science’, which were awaiting publication, the official journal of the Academy was launched in 2006 titled simply *Breastfeeding Medicine* (Academy of Breastfeeding Medicine (ABM), 2010). The focus of this journal is to “…provide the international medical and scientific community with the latest peer-reviewed reports of laboratory, field and clinical investigations” into breastfeeding (Lawrence, 2006:1). The journal content includes investigations into ‘Measuring milk synthesis’, ‘Milk ejection in women expressing breast milk’, ‘Human Milk Product for the Preterm Infant’ and ‘Human milk banking’ (Lois D.W. Arnold, 2006; Czank, Simmer, & Hartmann, 2010; Lai, Hale, Simmer, & Hartmann, 2010; Ramsay et al., 2006).

Undeniably obtaining the scientific evidence for promotion of the benefits of breastfeeding has been a necessary scholarly activity, as this has provided the evidence to challenge dominant discourses regarding scientifically prepared artificial formula. However, this scientific knowledge has also been used to advise and instruct women on how to ‘use’ their body effectively. The authoritative status, and the ‘superior’ knowledge, possessed by scientists and medical practitioners, privileges these discourses over and above the aspirations and experiences of breastfeeding women themselves.

A good example of this is the recent paper published in the journal of *Breastfeeding Medicine* by Lai and colleagues (2010). Their research was conducted ostensibly to allay the concerns of ‘mothers’ regarding ‘insufficient milk supply’, and included the examination of the reliability of ‘milk removal’ and ‘milk production’ during hourly breast expression with an electric breast pump (Lai, et al., 2010). The authors justified their research on the basis that “…the lactating breasts are the only major organs in the human body without clinical tests to determine their normal function” (p.106). Taking a critical perspective on this research, it is of particular significance that the study was also funded by the major suppliers of breast pumps, Medela. This company, whilst supporting breastfeeding with breast pump manufacture, has a vested interest in aligning their product with professional endorsement. The growing trend, in breastfeeding medicine and lactation science, towards research funded by Medela, is significant. This company presents international breastfeeding symposia which showcase key research conducted by renowned scholars in breastfeeding
medicine and lactation science, who have also utilised Medela products (Medela, 2011).

In Australia, perhaps the best example of the transformation of breastfeeding into a legitimate scientific and medical specialty is the work of renowned lactation scientist, Peter Hartmann. Hartmann began his career researching dairy cows during the 1970s, until a change in funding directed his research interests towards human lactation. Early in his career he recalls being asked by the NHMRC why he was researching ‘those unusual women’ who breastfeed. Hartmann was at the forefront of research into breastfeeding. His contribution to lactation science has been significant and is ongoing. However, his recent summation of the need for better recognition of the ‘lactating breast’, typifies the scientific approach to breastfeeding. Hartmann asks …why an organ that requires 25% of daily energy production and contributes to much intellectual and physical development…is not accorded the same scientific and medical status as other equivalent organs in the human body (Hartmann, 2007:8).

Hartmann laments that “…much less is known about the physiology and pathology of the lactating breast” compared to other “…metabolically equivalent organs in the human body”, no “standard diagnostic tests” are available to assess the normality of the lactating breast (Hartmann, 2007:8). What is interesting about the scientific analysis of the lactating breast is the persistent focus on optimising performance of the ‘organ’ and creating measures by which to assess an underperforming ‘breast’. Without these measures Hartmann states, we can only measure ‘effective’ breastfeeding performance according to whether an infant was exclusively or partially breastfed (Hartmann, 2007), an approach considered to be decidedly unscientific.

Similarly Anne Walshaw, a medical practitioner from the UK, has recently turned her attention towards lactation science and breastfeeding medicine. In a paper published in the International Journal of Pediatrics, Walshaw asked doctors to consider whether medical practitioners were currently “…getting the best from breastfeeding” for their infant ‘patients’ (Walshaw, 2010:1292). This author has constructed an argument for changes to breastfeeding management based on the science of lactation. Walshaw advocates for “…regular short feeds from each breast” for optimal infant ‘physiology and growth’ (p.1292). Breastfeeding physiology, and endocrine and biochemical functioning of the breast tissues, are utilised to advocate
this ‘best’ method of breastfeeding. Walshaw’s review of the literature on milk production, osmoregularity of hormones, the milk ejection reflex and breastmilk flow, have led her to recommend what she calls a “…modified traditional breastfeeding method” (Walshaw, 2010:1292-6). In particular, Walshaw recommends the first feed should occur within 10 minutes of birth and be followed by two hourly feeds for 10 minutes from each breast, until the milk comes in. Walshaw suggests it may be the number of feeds rather than the time elapsed which results in the milk coming ‘in’. After the milk has come ‘in’ Walshaw recommends breastfeeding should continue according to a 3-4 hourly routine, dependent upon the infant. According to the author, the rationale for this regime is: firstly, that this is in alignment with breast physiology and milk composition during feeds. Secondly that “… newer baby-led demand feeding” results in unnecessarily long feeds, often at one breast only, with associated lower weight gain, and thirdly that ‘baby-led’ feeding results in a ‘failure’ to establish a consistent let-down reflex (p.1295). In contrast, she asserts that her recommended method for breastfeeding is ‘mother directed’, and facilitates ‘successful breastfeeding’ because firstly the woman begins to recognise ‘breast filling’, secondly she develops a reliable ‘let-down reflex’ and thirdly she has a ‘structure’ for breastfeeding (Walshaw, 2010). The assertion that women who demand feed have an ‘unreliable’ let-down reflex resulting in sub-optimal and haphazard breastfeeding performance highlights the medical tendency to want to control and manage biology.

The superiority of breastfeeding medicine thus can be used in a myriad of ways to ‘manage’ breastfeeding women and infants. Optimising performance of the breast by utilising the knowledge gained regarding the mechanics of correct positioning, nipple shape and function, and infant anatomical structures (Breward, 2006; Hargreaves & Harris, 2009; Powers, 2008) must be appealing for practitioners, and researchers alike, who are seeking to utilise their expertise to enhance performance. Optimising the performance of a disembodied breast is analogous to some of the practices of midwives and lactation consultants observed during this study, such as the extensive and early use of the breast pump, a practice recommended in lactation consultant texts (Riordan, 2005:195). This fits with the current trend towards maximising bodily performance in public health discourse more broadly (Bauman, Bellew, Vita, Brown, & Owen, 2002; Bauman, 2004; Lupton, 1995). Assessing and measuring the
performance of the lactating breast is similar to the scrutiny the body undergoes as researchers continue to investigate ways to improve body shape and fitness and thus enhance effective performance (McArdle, Katch, & Katch, 2000).

Walshaw’s challenge to the dominant demand feeding discourse harks back to an era of scheduled feeding and the strict regulation of infant access to the breast. Yet Walshaw enlists ‘newer’ scientific evidence to substantiate her claim that traditional scheduled feeding can optimise performance of the lactating breast. This argument resonates with Cadogan’s early feeding regimes (Palmer & Kemp, 1996) and reflects the pervasive linear time construct described by Dykes (2006a) which is implicated in hospitalised management and control of breastfeeding. Recent research by Pincombe and colleagues (2008) however, may lend support to Walshaw’s argument. These authors found ‘demand’ feeding to be the only significant predictor of early cessation of breastfeeding (Pincombe, et al., 2008). Yet demand feeding is one of the central tenets of the BFHI, thus raising the question whether the ‘ten steps to successful breastfeeding’ can be considered a guaranteed template for breastfeeding ‘success’.

Hartmann believes that further scientific scrutiny of the breasts and further optimising of breast performance will “do much to ensure that 95% of mothers who commence breastfeeding in Australia will have a sustained and successful breastfeeding experience” (Hartmann, 2007:8). However, such medical and scientific ‘lactation’ discourse ignores the sociocultural and personal aspects of breastfeeding. The empirical data, presented in this thesis, strongly suggests that medicalising the breast and breastmilk in this way might be contributing to the disembodied, and nutrition-focused midwifery discourses and practices observed.

Certainly, many of the specialist lactation consultant midwives observed appeared to have incorporated nutrition-focused discourse into practice. In the early 1990s, lactation consultants questioned the need for the specialty ‘breastfeeding medicine’, given that most women breastfeed without medical intervention. These specialist consultants also harboured some fear that practitioners of ‘breastfeeding medicine’ might exclude workers such as lactation consultants from their ‘elitist’ group of practitioners (Auerbach, 1995). Interestingly, the findings from this study suggest that many lactation consultants have embraced the scientific findings emerging from ‘breastfeeding medicine’ and have even begun to model their own practices on this
type of ‘medicalised’, even ‘elitist’, approach to breastfeeding ‘management’. It is not unusual for practitioners who perceive themselves to be hierarchically inferior to medicine to begin to incorporate medical discourses into their own practices, as a means of establishing legitimacy and equality (Foley & Faircloth, 2003). The practices of lactation consultants have also incorporated global and institutional prioritising of breastfeeding, which I will elaborate on later in this chapter.

Breastfeeding has emerged from this medical and scientific scrutiny as an activity worth ‘protecting’ for the ‘good’ of the infant and future of the nation (Jansson, 2009:242). Breastfeeding is therefore viewed as a crucial factor in optimal infant health and wellbeing with proven benefits for the long-term health of the child and growing adult (WHO, 2007). From a population health perspective therefore, ‘getting the best out of breastfeeding’ equates to ‘getting the best out of the child/adult’. In the following section, I examine the role that the global initiatives to ‘protect, promote and support’ breastfeeding may have had in influencing the practices of midwives in this study.

6.4. Promotion and Protection of Breastfeeding

Global initiatives, which aim to advance the health of populations, have progressed alongside the scientific focus on lactation and the emergence of breastfeeding medicine. Armed with the increased knowledge gained from scientific enquiry into breastfeeding, the World Health Organization and UNICEF have led an international campaign to ‘promote, protect and support’ breastfeeding. Chapter Two outlined the chronology of international initiatives seeking to improve the initiation and duration of breastfeeding. To maximise the production and supply of breastmilk, for the benefit of the world’s children, the ‘Global Strategy for Infant and Young Child Feeding’ (WHO & UNICEF, 2003) renewed international attention towards the importance of nutrition for early infant and young child survival and health. This strategy particularly identified a lack of breastfeeding, during the first six months of life, as an “…important risk factor for infant and childhood morbidity and mortality” (WHO & UNICEF, 2003:v).

The ‘Global Strategy’ sets the context within which governments and health care institutions are urged to renew their endorsement for breastfeeding as a public health imperative (WHO & UNICEF, 2003). A critical analysis of the Global Strategy
however, identifies a predominantly ‘top-down’ approach to facilitating breastfeeding, which advocates ‘supporting’ and ‘protecting’ the behaviour of women for the “…very survival of infants and young children” (WHO & UNICEF, 2003:v). The Global Strategy has been informed by, and is, a global response to the scientific knowledge regarding the importance of breastfeeding. The following analysis of this strategy reveals some of the constitutive factors shaping the language and practices of the midwives observed in this study.

6.4.4. Global Strategy

Firstly, it is important to acknowledge that the Global Strategy was written from a ‘majority world’ perspective. Infants and young children, living in resource poor countries, are still currently dying in the millions every year from a lack of adequate nutrition. This strategy represents a ‘guide for action’ for governments and international organisations (WHO & UNICEF, 2003). Part of the call for action includes the ‘protection’ of the basic human rights of women as an essential global activity for the preservation of the health of infants and young children. This is based on the premise that the health of young children is inextricably linked to the health of women (WHO & UNICEF, 2003). In the global campaign to protect the ‘rights of the child’, women and their bodies have come to represent a ‘resource’ in need of protection.

Critical review of the Global Strategy reveals a level of paternalism within the document. This strategy seeks to ensure essential nutrition is provided to infants whilst also highlighting the economic, social and health benefits from healthy nutrition. The document represents a template for government policy makers, and health sector managers, for reorientation of health services towards ‘baby friendly’ environments. The language adopted throughout the Global Strategy emphasises the ‘imperative’ to act in the interests of infants and young children using phrases such as “…ensure appropriate feeding” and prioritise “…evidence-based feeding practices” as well as operating in the national interest to “…accelerate economic development” (WHO & UNICEF, 2003:3-4). Women, and their capacity to produce breastmilk, are increasingly seen as the means to achieving international economic and health goals for populations and as such pregnant and lactating women are identified as being in need of global ‘protection’ (WHO & UNICEF, 2003:26). The document however, does not situate breastfeeding within the context
of women’s lives and basic human rights. Rather, the focus is exclusively on ‘promotion’ and ‘protection’ of the supply of nutritional breastmilk. In fact parents and caregivers who choose alternative feeding options are referred to as making ‘inappropriate feeding’ choices and positioned as a ‘major threat’ (WHO & UNICEF, 2003:5).

The Global Strategy represents a prescription for national interests based on scientific evidence, rather than advocating respectful partnerships between parents and governments, or the wider community. The very voices of those directly responsible for providing nutrition to infants and young children are absent from the document and instead women are depicted as impressionable and defenceless against the might of formula companies and alternative discourses. For example, health care professionals are reminded to ensure that the provision of breastmilk substitutes in hospital, for social or medical reasons, does not result in a ‘spillover effect’ into the general population (WHO & UNICEF, 2003:18).

The protection of infants from a variety of ‘risks’ associated with not breastfeeding appears to be justification enough for this type of paternalistic attitude towards women. As Bartlett highlights:

The notion of risk is [so] prescient in public health rhetoric generally and breastfeeding specifically, [that] it becomes incumbent upon individuals to assess their risks and responsibilities (Bartlett, 2005:171).

The public health idiom reveals a powerful moral imperative to protect infants from risk of harm (Bartlett, 2005; Lupton, 1995). In resource rich countries the minimisation of risk has become a dominant cultural construct, so much so, that women are discursively positioned as ‘risk managers’ in relation to infant and young child health (Knaak, 2010:345; Lee, 2008). Underpinning the Global Strategy is the belief that women are morally obliged to breastfeed for the good of their infant and the nation. Arguably the power imbalance between the vulnerable infant and its mother can be used in global policy to, as Jansson (2009:245) argues “…legitimate the imposition of social norms and control on the practices of motherhood”. The use of a ‘risk’ discourse taps into biologic essentialist and good mothering discourse to ensure breastfeeding becomes the common sense, and morally ‘right’, option for women (Jansson, 2009; Knaak, 2010; Lee, 2008). According to this rationale, individuals who choose to ignore health recommendations and subsequently place
their infant in danger are deemed ‘irrational’ and an economic strain on the nation (Faircloth, 2010; Knaak, 2010; Lupton, 1995:90).

Jansson’s critique of global initiatives such as the Global Strategy, the Innocenti Declaration and The Code for the marketing of breastmilk substitutes, argues they hold a ‘normative view’ of what constitutes the right choice for child nutrition (Jansson, 2009:244). This reduces breastfeeding to simplistic decision making based on exposure to appropriate information (Jansson, 2009). These documents make contradictory statements about the importance of ‘informed choice’ regarding infant feeding but repeatedly focus on the morally ‘right choice’ indicating degrees of overt manipulation (Jansson, 2009:244; Law, 2000; Wall, 2001). The gendered nature of international breastfeeding documents, position women as particularly in need of global protection and imply a level of subordination (Jansson, 2009). Drawing on the work of Eduards (2007), Jansson articulates that “…to be protected entails subordination to the protector” (Jansson, 2009:245). Moralistic arguments about what is “…best for the child” (Jansson, 2009:245) further objectifies women as a national resource who can meet the needs of the world’s children. In this context, women become ‘tools’ for the implementation of global policy and for economic prosperity (Jansson, 2009). The emergence of breastfeeding as a ‘social resource’, and an international concern, reflects gendered essentialist discourse which reduce breastfeeding to mere anatomical and nutritional components, and interfere with intrinsic motivations for breastfeeding (Jansson, 2009; Law, 2000). Jansson highlights the discursive influence of ‘medical evidence’ in ‘depoliticising’ the debate around breast and formula feeding with ‘objective’ scientific claims (Jansson, 2009:242). Breastfeeding has emerged from this medical and scientific scrutiny as an activity worth ‘protecting’ for the ‘good’ of the infant and future of the nation (Jansson, 2009:242).

The Global Strategy seeks to protect breastfeeding via the promotion of strategies such as ‘skilled counselling and help’ for breastfeeding women (WHO & UNICEF, 2003). This is deemed crucial for the initiation and continuation of breastfeeding. Health care professionals are expected at a minimum to have knowledge of: lactation physiology, exclusive and continued breastfeeding, complementary feeding, feeding in difficult circumstances, as well as additional knowledge on legislative requirements and recommendations for the feeding of breastmilk substitutes (p.20).
The importance of relationship building between breastfeeding women and those who assist is not mentioned, despite the fact that peer support options have been identified in the document as important and effective.

Whilst the Global Strategy has provided the template for government and health sector improvements, the document seems to separate ‘nutritious’ breastmilk from the woman who provides it. The focus instead is on ensuring women provide the ‘appropriate feeding option’ for the benefit of infants and the national economy. Individual choice, personal responsibility and the importance of relationships for breastfeeding were lacking from this strategy.

Taken from a Foucauldian perspective, the Global Strategy represents a form of ‘disciplinary control’ deemed necessary to ensure the ‘welfare’ of the population and is a recognisable feature of governmentality (Rabinow, 1984:16). Whilst the aims of the strategy were to revise efforts to ensure children under three years of age had access to safe and healthy nutrition, I would argue, alongside Jansson, that the document goes further than this, to dictate what women ‘should’ do with their bodies (Jansson, 2009).

Australia, as a member of the World Health Organization, supports the international strategies emerging from the WHO and UNICEF collaborations such as the Global Strategy. The most recent articulation of governmental support for breastfeeding, the ‘Australian National Breastfeeding Strategy 2010-2015’ has been informed and guided by these global approaches to the ‘promotion, protection and support’ of breastfeeding. In turn, Australian hospitals are encouraged to ensure the education and training of staff, and incorporate the ‘ten steps to successful breastfeeding’ into their policy and practices (Australian Health Ministers' Conference, 2009).

The Global Strategy and the BFHI draw predominantly on the discourses of the science of lactation, the importance of optimising nutrition for the wellbeing of the child/adult, and society, as well as the medicalisation of maternity. These discourses subsequently inform national and state policy frameworks. The BFHI and the ‘ten steps to successful breastfeeding’ have been prioritised at global, national and state levels. In the next section of this chapter I mount the argument that in the resource rich context of Australian maternity care, the BFHI and the ‘ten steps’ ‘protect, promote and support’ breastfeeding ‘for’ the woman rather than ‘with’ her.
As a result, the language and practices adopted by midwives around breastfeeding have shaped breastfeeding support in a way that appears to be to the detriment of breastfeeding women.

6.5. Protecting Production and Supply

As detailed in Chapter Two, hospital practices have been implicated in declining breastfeeding initiation and duration rates for many decades. For example, formula supplementation, mother-infant separation overnight or routine and scheduled feeding have been identified as having a detrimental impact on breastfeeding progress (Lozoff, et al., 1977; WHO, 1989). Many researchers have sought to identify the multifactorial inhibitors for breastfeeding within the hospital environment (Baker, et al., 2005; Brown, et al., 2005; Dykes, 2005a; Forster, McLachlan, Yelland, Rayner, & Lumley, 2005; McLachlan, et al., 2008). The assumption underpinning the BFHI document is that the ‘ten steps to successful breastfeeding’ can be used in the hospital environment to address and eliminate identified barriers and facilitate ongoing exclusive breastfeeding (WHO, 1989; WHO & UNICEF, 2009).

The findings from this study, reveal that some of the more restrictive or insensitive practices of midwives embedded in the ‘mining for liquid gold’ approach, can be linked to interpretation of the ‘ten steps’ and the BFHI. Whilst components of the ‘ten steps’ were incorporated into the practices of midwives at MUA, the dominant institution specific discourse at this non-BFHI accredited site was, as articulated by senior staff, focussed on ‘safety’ and risk aversion. However, all ‘ten steps’ were incorporated into hospital policy at the BFHI accredited hospital MUB. It was at this site that I observed some of the most disembodied and disconnected practices. As a result, I postulate that the rigid interpretation of the BFHI ‘ten steps’ has led to many of the inhibitive midwifery practices observed. Furthermore, BFHI accreditation standards appear to dictate certain practices, which are at odds with woman-centred, and partnership orientated discourse. In the last section of this chapter I will focus on some of these practices and the BFHI determinants.
6.5.5. Baby friendly: An overview of the ten steps

The BFHI is a complex, innovative approach to system wide change made accessible and manageable via the implementation of ten ‘best practice’ principles. The initiative as a whole has demonstrated a variable influence on breastfeeding exclusivity and duration. In some accredited hospitals, the BFHI has resulted in improvements in breastfeeding initiation rates however, increases in duration of breastfeeding are inconsistent, particularly in resource rich countries (Bartington, et al., 2006; Broadfoot, et al., 2005; Kramer, et al., 2001). Yet despite limited current evidence for some of the ‘ten steps’ this template continues to be held up as the crucial marker of a breastfeeding culture in institutional environments.

In this study, there were similarities across both study sites around many of the ‘steps’ considered easiest to implement (Schmied, Gribble, Sheehan, Taylor, & Dykes, in press). For example, both hospitals had: a policy for breastfeeding (step 1), prioritised skin-to-skin contact at birth (step 4), facilitated 24-hour rooming-in (step 7), promoted demand feeding (step 8) and discouraged the use of pacifiers and artificial teats (step 9). The proliferation of some of the ten steps, such as these, at the non-BFHI hospital also resonates with the work of Swiss researchers, Merten and colleagues (2005) who similarly demonstrated a flow-on effect from BFHI implementation to the practices of staff at non-accredited hospitals (Merten, et al., 2005).

The five steps described above (1, 4, 7, 8 and 9), have become embedded into most westernised maternity services however, the extent to which they authentically reflect BFHI standards can differ markedly between BFHI and non-BFHI sites. In this study for example, while the importance of skin-to-skin contact following birth was promoted at both hospitals, women who participated in the study at the non-BFHI hospital (MUA) reported less skin-to-skin time and perceived the midwives to be less interested in assisting them to undertake this activity. This was supported in the analysis of individual and focus group interviews with midwives at MUA which indicated a resistance to BFHI. Staff articulated concerns that strict adherence to BFHI principles might mean incorporation of a ‘bullying’ mentality towards breastfeeding, resulting in pressure being exerted upon women to breastfeed. A qualitative study by Walsh and colleagues (2010) into the attitudes of midwives towards BFHI reported similar results. Midwives described behaviours that
distanced them from the label of ‘breastfeeding nazi’. Likewise, Australian participants preparing for BFHI implementation were noted to be concerned about the effect of stringent compliance and the provision of prescriptive advice to women. Participants expressed concern that this might limit their ability to tailor support and care to individual women (Schmied, et al., in press). Certainly, other authors have identified similar challenges and concerns with implementation of all ten BFHI steps (Merewood & Philipp, 2001; Moore, Gauld, & Williams, 2007; Walsh, et al., 2010).

Predictably, given the successful navigation of the BFHI accreditation process at MUB, the remaining five steps were integrated into midwifery policy and practice at this site. These included: additional education for staff (step 2), the provision of additional problem-solving education for pregnant women (step 3), ‘showing’ women how to breastfeed and hand express breastmilk (step 5), restricting additional alternative fluid intake, unless medically indicated (step 6), and establishing post discharge support (step 10). Analysis of the language and practices adopted by midwives in this ‘baby friendly’ environment, is timely, given the national and international support for BFHI.

I will now examine five of the ten steps, commonly observed at MUB, and the implications for midwifery practice. I will describe the ways in which the interpretation of each of these five steps may have influenced the inhibitive midwifery practices observed. BFHI discourse represents a form of institutional ‘disciplinary control’ over the practice of midwives. The objectification of the midwife, as BFHI enforcer, and the woman as ‘protected mother’, inevitably influenced practices at MUB. A critique of the implementation of BFHI, challenges the widespread acceptance of this strategy as the ‘liberator of breastfeeding’, and breastfeeding women, in hospital environments.

6.5.6. **The use of skin-to-skin: essential for breastfeeding ‘success’**

Prioritising skin-to-skin contact between the mother and her newborn infant immediately after birth and during the postnatal period was apparent at both study sites. The merits of early skin-to-skin contact, and the likely positive impact of this on the establishment of breastfeeding, were widely promoted and linked to improvements in breastfeeding more than a decade ago (World Health Organization, 1998). Findings, reported in this thesis, confirm that women who were denied the
opportunity for skin-to-skin contact, at birth, indicated a sense of foreboding that breastfeeding might be doomed as a result of ‘missing out’ on this crucial step. Midwives contributed to the positioning of skin-to-skin contact as essential for the ‘success’ of breastfeeding. For example, the dialogue reported in Chapter Four captured this when the midwife said: “Unfortunately it sounds like she missed out on that skin-to-skin as soon as she was born” (Int 41). The disappointment apparent in this midwife’s tone of voice, as she assisted the woman to breastfeed her infant, communicated a view that this might be the reason breastfeeding was not problem-free.

The opportunity for ‘skin-to-skin’ contact at birth appears however, to have been misrepresented as a singularly crucial step in the early establishment of breastfeeding. A meta-analysis of 30 randomised and quasi-randomised studies on skin-to-skin contact, published in the Cochrane library, confirmed the benefits of skin-to-skin for mother-infant attachment, management of infant crying and infant temperature control. (Moore, Anderson, & Bergman, 2007:2). There was insufficient evidence however, to substantiate a categorical statement on the influence of skin-to-skin contact on breastfeeding. Whilst the authors acknowledged the poor methodological quality of the studies, they could only conclude that skin-to-skin ‘may’ lead to improvements with breastfeeding.

Despite the equivocal nature of this evidence the findings from the study presented in this thesis confirm the overt prioritising of skin-to-skin contact as crucial for ongoing breastfeeding. This discourse has resulted in recommendations for skin-to-skin to extend beyond birth into the early postnatal period (Chiu, Anderson, & Burkhammer, 2008). At both study sites midwives and lactation consultants demonstrated a prioritisation of skin-to-skin in the early postnatal period for optimal ‘infant to breast’ positioning. This is perhaps not surprising given many well-known and published Australian midwives and lactation consultations, such as Sue Cox (2006), recommend unrestricted skin-to-skin access in the first 24 hours to ‘maximise breastfeeding output’ (Cox, 2006). Observation of the use of ‘skin-to-skin’ contact as a tool to ‘bring in the milk’ was consistent with this advice. Rather than maximising mother-infant synchronicity however, I observed women at times being coerced into utilising skin-to-skin contact, in the early postnatal period, as a device for optimising infant attachment to the breast and enhancing milk production. Instead, this special
period of ‘bonding’ between the mother and infant, appeared to be co-opted within
the ‘mining for liquid gold’ approach, as an integral component of the ‘management’
of breastfeeding.

6.5.7. ‘Teaching’ breastfeeding and breast expression

In Step 5 of the BFHI, midwives are advised to ‘show mothers’ how to breastfeed
and how to maintain lactation with hand expression. Critical analysis of the words
and phrases used in many of the ten steps reveals the directive nature of the BFHI.
For example, language such as ‘inform’, ‘manage’, ‘maintain lactation’, ‘give no’
and, ‘show’, sets limits on individual care and on professional decision making. This
style of language establishes a uniform approach to breastfeeding information and
advice in an effort to prohibit deviation from the ‘template of success’.

In addition, the BFHI accreditation standards assess midwifery compliance with the
ten steps by outlining a number of specific outcome measures or targets. For
example, 80% of midwives should confirm they ‘teach’ mothers how to attach their
infants to the breast. Likewise 80% of mothers questioned during accreditation
should be able to describe ‘correct’ positioning of their infant for breastfeeding,
including the ‘signs’ of correct infant attachment and sucking style (WHO &
UNICEF, 2009:35). The need to meet performance measures such as these were
played out in the intense focus on educating women how to ‘correctly’ position their
infants at the breast and were most prominent at MUB.

This BFHI standard advocates routine ‘teaching’ of positioning and attachment yet
there is a lack of evidence to suggest that this improves breastfeeding duration
(Forster, et al., 2004; Henderson, Stamp, & Pincombe, 2001b). While there is little
doubt that sharing information and advice about breastfeeding is central to postnatal
midwifery care and includes the provision of ‘practical help’ with attachment and
positioning (Rayner, et al., 2008), the BFHI rhetoric of ‘teaching and demonstrating’
highlights an assumption regarding the knowledge and skill a woman possesses.
Midwifery discourses of partnership and woman-centred care begin with the premise
that women hold existing acquired knowledge which is ideally discussed during
pregnancy. This premise therefore, is at odds with the directive and prescriptive
nature of BFHI accreditation standards.
It can be argued that an accreditation standard or performance measure, which dictates that 80% of women should receive instruction on the principles of breastfeeding ‘success’, such as correct positioning and attachment, sets the breastfeeding interaction up as a professional opportunity to deliver predetermined authoritative knowledge by an expert health professional. As a result, the opportunities to identify the woman’s individual learning needs and desires are suppressed. Others have similarly argued that breastfeeding education fails to incorporate women’s own experiences in the pursuit of professional standards for ‘teaching’ breastfeeding (Bartlett, 2005; Carter, 1995; Dykes, 2006a; Maclean, 1990; G. Palmer, 2009; Schmied, et al., 2001). The majority of interactions observed within the ‘mining for liquid gold’ approach reflect this type of authoritative expert communication, which positioned women as novice ‘students’. These subject positions, and the influence on the mother-infant relationship, will be explored further in Chapter Seven.

Similarly, enactment of the second part of step 5 (assisting and advising women about maintaining lactation, even when separated from her infant) saw midwives promote hand expression of breastmilk as an essential skill which all women should learn. Some midwives utilised teaching props or verbal recommendations for teaching hand expression whereas others provided a physical demonstration. The BFHI accreditation standard measures whether 80% of ‘clinical staff’ can confirm that they “…teach mothers how to hand express and can describe or demonstrate an acceptable technique for this…” (WHO & UNICEF, 2009:35) or that they can identify an alternative person whom they can call on to do this. Correspondingly, 80% of women should be “…shown how to express their milk by hand” or be “…given written information and told where they could get help when needed” (WHO & UNICEF, 2009:35). Yet I seldom observed women in the hospital environment hand expressing. Rather, when difficulties with breastfeeding arose, midwives and lactation consultants tended to initially hand express for the woman, and later show her how to acquire the ‘knack’. Often this progressed to introducing the breast pump if hand expression was not productive.

The interpretation of Step 5 by the participating midwives appeared, at times, to result in a violation of personal space, which women have previously described (Schmied, et al., 2011), and may also be linked to the ‘nipple nazi’ label attributed to
midwives. The objectification of the breasts as disconnected bodily equipment, which requires the ‘owner of the equipment’ (the woman) to be trained in order to operate effectively, is reinforced in this circumstance.

6.5.8. Breast, cup, bottle: Does it matter?

The BFHI aims to ‘protect’ breastfeeding, through the elimination of inhibitive practices such as the provision of substitutes for breastmilk during the hospital stay. To protect breastmilk supply, Step 6 stipulates that ‘no fluid’, other than breastmilk, should be given to infants unless medically indicated. Further, to avoid nipple-teat confusion (from bottle or pacifier), Step 9 states that artificial teats should not be used with breastfed infants. Midwives at both MUA and MUB were observed adhering to these recommendations. However, within the hospital environment, the feeding of breastmilk to full-term infants was not always a maternal ‘responsibility’. Instead, at times, midwives and lactation consultants were observed feeding breastmilk to infants by cup, or syringe.

Midwives and lactation consultants were observed retrieving colostrum or breastmilk from the woman and then assuming responsibility to syringe or ‘cup feed’ this to the infant. At times, this occurred whilst the woman commenced breastmilk expression using an electric breast pump, but it was also observed when the woman was available to cup feed her infant herself. Cup feeding had seemingly become such a routinised practice that midwives were oblivious to the symbolic separation of the woman from her breastmilk represented by this practice. The provision of breastmilk in this way epitomised the ‘mining for liquid gold’ approach.

Further investigation of this practice revealed that cup feeding was introduced into the health care environment to avoid nipple-teat (bottle) confusion, and to maintain compliance with the BFHI Step 9 (Cloherty, Alexander, Holloway, Galvin, & Inch, 2005). However, this recommendation comes with the caveat that, whilst in hospital, cup feeding should be performed by clinical staff only. This is due to the perceived risk of breastmilk aspiration, by the infant, when cup feeding is conducted by an inexperienced person (the mother) (Lang, Lawrence, & L'E Orme, 1994; Thorley, 1997). Despite a level of scepticism amongst staff, and women, regarding the detrimental effect of short-term bottle feeding (on breastfeeding) (Cloherty, et al., 2005) cup feeding has become a widespread practice in hospitals, especially
noticeable at the BFHI study site. The mother-infant separation, which this practice introduced, was particularly concerning.

A review of the literature on this topic indicates widespread debate regarding the advantages and disadvantages of cup feeding breastmilk compared to bottle-feeding. Two systematic reviews have concluded that there is currently a lack of evidence to support cup feeding in hospitals, over and above bottle feeding. Cup feeding was associated with longer length of hospital stay for both preterm and term infants and did not correlate with longer duration of breastfeeding post discharge (Collins, Makrides, Gillis, & McPhee, 2008; Flint, New, & Davies, 2007). Yet breastmilk feeding with a cup continues to be recommended in BFHI hospitals resulting in a separation of the product: milk from the supplier: the woman.

The impact of these ‘breastmilk feeding’ messages on a woman’s construction of breastfeeding is poignantly symbolised in the stories of two women interviewed following discharge from MUB. Both stated they had breastfed for the first few weeks. However, further discussion revealed that the infants had indeed received ‘breastmilk’ but this had predominantly been via the use of a breast pump and a bottle. These women had been content to continue to provide their milk in this way, comfortable in the knowledge that their infant was receiving the most important outcome from breastfeeding: nutrition.

Significantly, infants “…exclusively fed expressed breastmilk” (WHO & UNICEF, 2009:36) by syringe, cup or bottle, continued to meet the BFHI performance measure for exclusive ‘breastfeeding’. Geraghty and Rasmussen (2010:135) ask, “…if an infant is receiving bottled, stored breastmilk can it still be classified as breastfeeding? And if so ‘what is breastfeeding?’ if not feeding at the breast” (Geraghty & Rasmussen, 2010:135). The merging of ‘delivery methods’, breast, cup or bottle, effectively isolates the actual supply and distribution of breastmilk as THE KEY modifiable factor in the ‘baby friendly’ initiative. Whether the breastmilk was provided by the woman via her breast to her infant, or whether it was provided by cup, or finger fed by the health care worker, appeared insignificant so long as the infant received the necessary nutrition.
Geraghty and Rasmussen (2010) highlight the emerging social trend towards ‘breastmilk feeding’ and the dilemma it produces when defining breastfeeding. They ask:

What if a mother stops lactating completely and the child continues to receive her stored milk until the supply is gone for a period that could be weeks? Traditional definitions of breastfeeding classify a mother as still ‘breastfeeding’ for the duration that her child is receiving breastmilk regardless of whether she has ceased lactating (p135).

Furthermore, we know little about the outcomes from this form of infant feeding. Geraghty and Rasmussen (2010) suggest ‘breastmilk feeding’ behaviours may have implications for the health and wellbeing of mothers which we are as yet unaware of (Geraghty & Rasmussen, 2010:135). This is an area for further research.

The women from MUB described above, had ceased breastmilk feeding after several weeks postpartum. Yet their initial commitment to this practice revealed a level of acceptance of breastfeeding as merely a ‘manufacturing process’ for the production of ‘milk’ demanded by a ‘consumer’, rather than a relational interaction in and of itself (Dykes, 2002; Van Esterik, 1996). I argue that interpretation of BFHI Steps 6 and 9 are contributing to this conceptualisation.

6.5.9. Education and training for expert health workers

In accordance with Step 2 the latest BFHI policy documentation (WHO & UNICEF, 2009) stipulates that BFHI hospitals should engage in training all health workers for the implementation of breastfeeding policy. The definition of a ‘health worker’ incorporates all individuals who work for the health service, whether in a professional capacity or not (for example it includes cleaners and volunteers). Significantly, the Certified Lactation Consultant has been singled out as crucial for the creation of a breastfeeding-friendly culture in hospitals. The availability of this certified specialist has been identified as a marker of hospital commitment to improving breastfeeding support (WHO & UNICEF, 2009:9).

The findings from this study confirm the prioritisation of lactation consultant expertise and knowledge at MUB. Not only did this hospital have a significant number of midwives with additional qualifications in lactation, through the IBCLC program, but there were also a number of designated lactation consultant positions.
This commitment to obtain additional qualifications in lactation is not unusual. In Australia, increasing numbers of midwives and other health professionals sit the IBCLC annually. Cantrill and colleagues (2003) argue this is indicative of, not only a desire to improve knowledge around this particular area of practice, but also of a commitment to improve support for women (Cantrill, Creedy, & Cooke, 2003). Certainly many health professionals, including those in Neonatal Intensive Care Unit, believe that education around breastfeeding can make a difference to the quality of support provided to breastfeeding women (Taylor, Gribble, Sheehan, Schmied, & Dykes, 2011).

In Australia, where the initiation of breastfeeding is already high, it is disappointing that the education and training of large numbers of lactation specialists has not resulted in widespread increases in breastfeeding duration. Likewise, while BFHI prioritises access to this highly skilled group of health professionals there has been no improvement in breastfeeding duration. The findings from this study perhaps provide some indication as to why this might be the case. Lactation consultant practices within the ‘mining for liquid gold’ approach could be interfering with the developing mother-infant relationship, inhibiting exclusive breastfeeding and pathologising breastfeeding challenges (Schmied, et al., 2001; Thompson, Kildea, Barclay, & Kruske, in press).

In contrast, BFHI training programs conducted in countries with low breastfeeding initiation such as Italy, Belarus and the UK, have demonstrated improvements in the initiation and exclusivity of breastfeeding in the hospital environment (Cattaneo & Buzzetti, 2001; Kramer, et al., 2001; Radford, 2001). Interventions such as an extended breastfeeding education program, which also measured breastfeeding exclusivity in the hospital, reported an increase attributable to the educational intervention (Martens, 2000). According to Cattaneo and colleagues (2001), a three day educational intervention increased the rates of exclusive breastfeeding at discharge, and the rates of full breastfeeding at three months post discharge (Cattaneo & Buzzetti, 2001).

However, a review of interventions to improve breastfeeding duration conducted by Spiby and colleagues (2009) was not able to draw strong conclusions about the influence of breastfeeding educational interventions, and duration rates. Furthermore it is still unclear whether, during the early establishment of breastfeeding, the
availability of highly specialised lactation consultants, is by itself facilitative of breastfeeding (Britton, McCormick, Renfrew, Wade, & King, 2009:7). Instead, it seems to be assumed that availability of highly specialised practitioners will correspond with better quality breastfeeding support. The findings from this study cast doubt on this assumption.

In addition, little is known about which components of BFHI are most likely to be facilitative or inhibitive for ongoing breastfeeding. For example, Dykes advocates for the incorporation of “…embodied, vicarious, practice-based and formal knowledge” in current educational programs for midwives (Dykes, 2006b). The appropriate use of ‘self’ when interacting with breastfeeding women might be instrumental in the provision of support. Critical reflection of one’s own experiences with regard to breastfeeding, might improve the style of support provided (Dykes, 2006b). Certainly the midwives observed during this study at times made reference to their own ‘personal’ breastfeeding experiences when making decisions about the level of support to provide to women. Midwives who had limited additional exposure to breastfeeding education, beyond their undergraduate education, were represented in this group.

The provision of supplementary education for midwives, which focuses on communication and reflexive practice, may be more beneficial for extending the duration of breastfeeding than the widespread availability of specialist consultant midwives. In this study, increased knowledge regarding the science of lactation, and the tools for management of breastfeeding, did not appear to result in improved communication and support for women. Instead the relational aspects of communication appeared to be most effective.

6.5.10. All or some of the ‘ten steps’?

This review of the BFHI ‘ten steps to successful breastfeeding’ has revealed the predominantly directive nature of this policy. Contrary to the ‘protection of breastfeeding’ discourse accompanying BFHI, it was the ‘protection of breastmilk supply’ which dominated at MUB. The incorporation of specialised lactation consultant services, deemed crucial to the generation of a breastfeeding friendly hospital culture, contributed to the increasingly ‘medicalised’ and ‘pathologised’ view of breastfeeding in this environment. The midwifery and lactation consultant
practices observed, indicated incorporation of disconnected ‘machine like’ metaphors related to the breasts and breastfeeding women.

In contemporary discourse, the ‘ten steps’ have been advocated as a collective ‘good’ yet little is known regarding which steps are crucial, which are modifiable and which are facilitating or inhibiting ongoing breastfeeding. Research by DiGirolamo and associates in the US (2001, 2008) suggests that exposure to some of the ten steps can be beneficial for improving the rates of breastfeeding (DiGirolamo, Grummer-Strawn, & Fein, 2001; DiGirolamo, Grummer-Strawn, & Fein, 2008). Further investigation into the impact of individual steps at a ‘practice’ level is required in order to identify the steps which impact favourably upon breastfeeding initiation and duration.

6.6. Baby Friendly or Mother Friendly?

Despite the disembodied practices engendered by the BFHI, midwives and lactation consultants at MUB did provide highly relevant information for families around normal infant behaviour. Women were much better informed about feeding cues and where to go for additional support after discharge, compared to those at MUA. A discourse around mother-infant bonding and ‘tuning in’ to the infant were evident at MUB even though the dominant practice of midwives around breastfeeding did not overtly facilitate maternal-infant synchronicity beyond the first day. Whilst the ‘ten steps’ have been credited with significant improvements in hospital practices, the findings from this study reveal that the language and practices of midwives inadvertently disembody the breast, casting it as the ‘revered’ source of nutrition, limiting meaningful interactions with the owner of the ‘breast’, the woman.

It is important to note however, that the most recent iteration of the BFHI places emphasis on mother-friendly care. This inclusion directly responds to the identified factors known to impact upon a woman’s early breastfeeding experiences (Murray, 1996; WHO & UNICEF, 2009). However, examination of the language adopted in this revised version of BFHI, reinforces the fragmented view of maternity and ascribes a passive subject position for the woman. Women are repeatedly referred to as ‘mothers’, and infants are considered to be ‘delivered’ by health personnel, rather than the more active midwifery language of ‘birthed by the woman’. Disappointingly, each of the new ‘mother friendly’ requirements apply exclusively to
labour and birth care, such as access to non-pharmacologic pain management, ambulant labour, access to nutrition and known companions in labour. From this omission it can be assumed that the postnatal period is already considered to be ‘mother friendly’ as a result of the ‘ten steps’. The study findings reported here indicate the need for an integration of holistic ‘woman-centred’ and ‘partnership’ discourses into postnatal engagement with women about breastfeeding. The silencing of these discourses, despite midwifery involvement in BFHI implementation, is worthy of more attention.

6.7. Conclusion

In this chapter, I have argued that the discourses emerging from the science of lactation and breastfeeding medicine have influenced the superior positioning of breastmilk, the product, over the process of a woman breastfeeding her newborn. I have discussed the way in which global initiatives, particularly the BFHI, have shaped the dominant ‘mining for liquid gold’ approach.

Modes of objectification, such as these scientific and medicalised discourses, have resulted in midwives taking a position as ‘expert’ and engaging in professional practices which effectively disconnect breasts and breastfeeding from the woman. The BFHI has introduced a different discourse into midwifery practice which seems to alienate midwives from women and result in the types of breastfeeding support practices which women find objectionable, reflecting the ‘nipple-nazi’ label.

Commitment to breastfeeding support by midwives fulfils institutional priorities, particularly the implementation of the BFHI, rather than the provision of ‘woman-centred’ individualised care. The institutional commitment to BFHI appears to have introduced an extra level of intensity into breastfeeding encounters within the accredited maternity unit, as midwives have become the ‘enforcer’ of BFHI. The findings from this study also highlight a disregard for ‘at the breast’ feeding apparent in BFHI, as exclusive breastfeeding incorporated ‘breastmilk feeding’ delivered by bottle, cup or syringe. This approach rendered the woman invisible during the extraction of the precious ‘elixir’. Practices associated with BFHI have magnified the woman’s breasts as the body part in need of professional protection, manipulation, management and control. This objectification of the woman positioned her as a
passive, malleable function of the organisation, who midwives were employed to ‘manage’.

These ‘subject’ positions were also influenced, more broadly, by sociocultural discourse. The next chapter will explore the creation of subjectivities in the early postnatal period and the dynamic interplay of language and practice on the intersubjective midwife-woman relationship.
CHAPTER SEVEN
The Midwife-Woman Relationship

7.1. Introduction

In Chapter Six, I examined the role that discourses such as lactation science, breastfeeding medicine, the BFHI and the Global Strategy had in shaping the midwifery prioritisation of breastmilk as ‘liquid gold’. The language and practices of midwives and lactation consultants reflected these discourses and appeared to reduce breastfeeding to mere nutrient transfer. These discourses objectified the woman and the midwife as expert and novice. In this chapter, I draw on feminist, anthropological, sociological and midwifery literature to examine the way in which both maternal and midwife subjectivities have been constructed in the recorded and observed interactions around breastfeeding. The breastfeeding woman and the midwife came to these interactions with their own sociocultural history, knowledge, experiences and identity. I examine some of the discursive influences informing these subject positions, and consider the impact of the institutional, professional and public discourses on the midwife-woman relationship, and on the provision of breastfeeding support.

First, I draw on the work of feminist scholars examining the construction of breastfeeding in sociocultural discourse, and I discuss notions of the ‘good’ mother and the ‘moral’ imperative to provide the ‘best’. I then explore the changing cultural perceptions of breastmilk and breastfeeding, identifying the recent elevation of breastmilk to the status of ‘liquid gold’ and the ramifications of this for how women and midwives view the ‘lactating’ breast. In this study, the analysis revealed a level of detachment for the woman from her breasts which came to represent the breastfeeding ‘equipment’. This detachment was apparent in both midwifery and maternal language and behaviours around breastfeeding. The construction of the woman as an inefficient ‘operator’ of her ‘equipment’ and the infant as inefficient ‘extractor’ is explored.
The professional socialisation of midwives within technomedical institutions has influenced midwifery practice in ways that are at odds with professional ideals. In the second part of this chapter, I examine the origins of the authoritative communication style observed in the majority of midwife-woman interactions, and the impact of the power differential between the woman as ‘novice’ and the midwife as ‘expert’. Davis-Floyd’s work (Davis-Floyd, 2001) on technocratic medicine is used to critique the influence of medical and institutional discourses on breastfeeding women and midwives.

7.2. The Breastfeeding Woman

Women in this study commenced their mothering and breastfeeding journey in a hospital environment. The aspiration to breastfeed was inevitably shaped by personal desire, social and cultural factors and the public imperative to provide breastmilk. In Chapters One and Two, I have established breastfeeding as more than a biological function, but rather a socially and culturally mediated practice, and one which is now also surrounded by institutional, public and personal performance measures.

Traditionally confined to the private sphere, breastfeeding has become a rights-based issue, representing both a woman’s right to breastfeed and an infant’s right to receive breastmilk. Women have fought for their right to ‘perform’ breastfeeding in all aspects of public life, and at times, to even challenge social ‘taboos’ associated with public breastfeeding (Bartlett, 2002; 2011). Early lack of regard for breastfeeding activity has been linked to gendered biological and essentialist depictions of women (Hausman, 2003; Van Esterik, 1994).

Since the 1970’s, feminist research has illuminated the range of factors impacting upon women as they experience pregnancy, birth and new motherhood in contemporary society (Kitzinger, 1972). These have included the historical influences on infant feeding practice (Apple, 1986; Baumslag & Michels, 1995; Yalom, 1997) and the contemporary economic and labour market factors inhibiting breastfeeding duration (Galtry, 2000). Feminist positions on breastfeeding however, reflect a wide variety of scholarship, and represent both opposing and consensus perspectives.
Law (2000), and earlier Blum (1993), and Carter (1995) (albeit to a lesser extent), have critiqued the ways in which breastfeeding limits a woman’s autonomy in favour of meeting the needs of another. Their arguments emphasise the ways in which scientific discourses have sought to promote a certain type of mothering which suits the interests of the ‘State’. In addition, they challenge the scientific ‘truth’ claims regarding the benefits of breastfeeding. These scholars have aligned the ‘breast is best’ mantra with social subordination and control of liberty (Blum, 1999:49; Carter, 1995; Law, 2000). Law (2000) has argued that some of the health promotional material, directed at pregnant women, represents a form of social pressure exerted on women by advocates of breastfeeding. He asserts this pressure contributes to the guilt, and sense of failure that some women describe.

By contrast, breastfeeding advocates who include anthropologists and feminists, have used the growing scientific evidence to highlight the benefits of breastfeeding. This group promotes breastfeeding as an evolved biologic activity, with inherent health benefits for women and infants. Breastfeeding is enabled or hindered by sociocultural beliefs and practices (Dettwyler, 1995; Maher, 1992; Palmer, 2009). Breastfeeding advocates have endeavoured to move the infant feeding debate beyond a simple decision-making binary: breast or bottle, to include consideration of the determinants of breastfeeding ‘success’. The renowned breastfeeding advocate Gabrielle Palmer, incorporated an economic rationale into breastfeeding advocacy. Palmer argued that capitalist principles, associated with the sale of formula, were depriving women of their natural ability to breastfeed (Palmer, 2009). Perhaps predictably, Law has critiqued such advocacy arguments as conservative, and as encouraging a return to domesticity, and essentialism (Law, 2000). Yet anthropologists such as Penny Van Esterik (1989) have articulated the case for the empowering nature of breastfeeding stating:

…it encourages a woman’s self-reliance, confirms a woman’s power to control her own body, challenges models of women as consumers and sex objects, requires a new interpretation of women’s work, and encourages solidarity among women (Van Esterik, 1989:69)

Van Esterik has also highlighted breastfeeding as ‘productive work’ which should be valued and supported socially, by gender specific policies and systems (Van Esterik, 1989).
The findings from this study of midwife-woman interactions corroborate Van Esterik’s prediction, 17 years ago, that the breasts have been objectified in sociocultural discourse, to the extent that they are now considered ‘optional equipment’ for infant sustenance. In addition, her cautionary advice that the prescriptive nature of breastfeeding ‘management courses’, delivered by expert health professionals who advocate one ‘correct’ way to breastfeed, may lead to a lack of confidence with breastfeeding, has certainly been demonstrated in the experiential accounts from women.

Similarly, Bernice Hausman’s critique of the influence of biomedical discourses on the medicalisation of breastfeeding has revealed some of the ways in which women have been subordinated to medicine during breastfeeding (Hausman, 2003). For example, the focus on biologic ‘lactation’ which has emerged from biomedical discourse, excludes the social and cultural conditions of women’s lives in representations of breastfeeding. Hausman (2003) argues further that:

Feminist inattention to breastfeeding as a maternal practice has allowed public debates to be dominated by medical practitioners, maternalistic breastfeeding advocates, and business interests (Hausman, 2003:230)

In this way, breastfeeding women have been situated between several differing paradigms. For example, on the one hand women can choose to fulfill the socially constructed ‘stay at home’ mother role and become enmeshed in traditional domestic duties, or they can be derided as the career woman who must ‘displace’ her maternal responsibilities onto an electric breast pump. Either way the breastfeeding woman is restricted to an alliance with a limited range of subjectivities which fail to accommodate the diversity of the experience. Like Hausman (2003), I argue that this approach does not accommodate ‘embodied mothering’ and negates the need for organisations, including health organisations, to provide for women who are breastfeeding. In the study findings reported in this thesis, the tendency for midwives to focus on biological lactation was evident, and the social aspects of infant feeding were almost completely disregarded and the disembodied equipment prioritised.

Alison Bartlett’s work, on the cultural meanings which shape women’s experience of their breastfeeding body, is particularly applicable to the study findings. Bartlett highlights the depiction of women, in medical literature, as “…novitiates in need of tuition” from expert clinicians (Bartlett, 2005:52). Within this biomedical paradigm
women are viewed ‘as bodies’ with biological needs, where subjectivity is discounted. Women, in this sense, are considered empty vessels. A woman’s prior knowledge of her body and her embodied knowledge are considered irrelevant as biomedical descriptions of breastfeeding revolve around hormone control and biophysical processes. Bartlett argues for a reconceptualising of the breastfeeding body to include the merging of mind and body and acknowledgment of ‘embodied intelligence’ (Bartlett, 2005:64). In this realm, women would be seen in the full context of their life as individuals with “…intelligence, embodied and learnt knowledge, racial and class histories, sexuality, religion, emotions, economics, medical histories, friendships” (Bartlett, 2005:46).

Postmodern perspectives have revealed the diversity of women’s embodied experience and the multiple meanings attributed to breastfeeding within different cultural contexts. Breastfeeding has been identified by women as both a “…powerful transforming experience” blurring the boundary between the ‘self’ and ‘other’ as well as “…a terrifying loss of personal autonomy” (Schmied & Lupton, 2001; Van Esterik, 1994:S47). The merging of conflicting emotions, simultaneously a ‘burden’ and ‘pleasure’, makes the intersubjective nature of the breastfeeding relationship an important, and as yet, still under researched area for consideration (Hausman, 2003; Schmied & Lupton, 2001).

Gendered activities such as breastfeeding, whilst initially ignored by feminists, have become an area of research interest in recent years, especially in the reporting of individual experiential accounts. This has provided insight into subjective interpretations and embodied experiences of this activity (Britton, 1997; Hall & Hauck, 2007; Schmied & Lupton, 2001; Sheehan, et al., 2010; Stearns, 1999). Consideration of subjective experiences, such as this, can provide insight into the ways in which power is used to meet societal goals (Weedon, 1997:8).

7.2.1. The ‘Good’ Mother

Like some of the women who agreed to participate in this study, many women presume they will breastfeed in an effort to provide what is ‘best’ for their infant, although infant feeding ‘choice’ can sometimes be complex (Bartlett, 2002; Giles, 2003; Sheehan, et al., 2003). Women’s decisions are influenced by public and professional discourses which define and limit the parameters by which a woman can
comfortably identify herself as a ‘good mother’ (Knaak, 2010; Sheehan, et al., 2003). Some women in this study grappled with early breastfeeding difficulties and persevered in order to maintain their commitment to providing the ‘best’. Intensive self-management, at times, also facilitated the maintenance of their subjective position as a breastfeeding mother. Breastfeeding sits within the current discourses of ‘good’ mothering (Lee, 2008; Marshall, Godfrey, & Renfrew, 2007; Murphy, 1999). Dominant discourses can alter over time, and the popularity of alternative subjectivities can rise and fall during different eras (Lupton, 1995:7). Exploration of women’s experiences of breastfeeding confirms the importance of breastfeeding for ‘good mother’ status (Knaak, 2010; Schmied & Barclay, 1999).

In taking up the subject position as a ‘good’ breastfeeding mother, women automatically fulfil the health promotional ‘imperative to breastfeed’ (Sheehan & Schmied, 2011). Lupton (1995) and Wall (2001) argue that techniques of moral regulation are utilised in health promotional discourse which encourage women to ‘freely’ accept a particular recommended position. Lupton argues “…public health and health promotion act as apparatuses of moral regulation, serving to draw distinctions between ‘civilised’ and ‘uncivilised’ behaviour, to privilege a version of subjectivity that incorporates rationality…” (Lupton, 1995:159). For example, the promotion of ‘regular exercise’ for optimal health attainment sees individuals dutifully attend the gym regularly. The use of morality in breastfeeding discourse ensures women are not free to make any choice with regard to infant feeding, but rather must make the ‘right choice’, according to the hegemonic scientific recommendations and ‘good mother’ parameters.

Following incorporation of ‘good mother’ status into one’s sense of ‘self’, women begin the process of getting breastfeeding ‘right’ (Hall & Hauck, 2007; Kelleher, 2006; Manhire, et al., 2007; Shakespeare, et al., 2004). In order to do this, the ‘good mother’ must commence breastfeeding in the hospital environment, and enlist the help of health professionals whether or not they are experiencing difficulties (Dykes, 2006a; McLachlan et al., 2009). Within this milieu, women in this study appeared to willingly accept a position as a subordinate ‘patient’ and ‘novice’ breastfeeding woman. This occurred even when the woman’s previous experiences, or professional background, meant that the information provided by the midwife was not entirely ‘new’. A good example of this was provided in Chapter 3, page 88. In this encounter,
the woman ‘allowed’ the midwife to speak to her as a ‘novice’, with regard to the care of her newborn infant, despite her professional background as an early childhood worker. It would seem the commitment to getting breastfeeding ‘right’, and even more broadly getting mothering ‘right’, meant that this woman was prepared to open her eyes and ears to everything the health professional had to offer (Marshall, et al., 2007). The focus on learning breastfeeding as a ‘competency’ (Larsen, et al., 2008) encourages women to accept this position as ‘novice’ and then comply with their own domination by regularly seeking expert assessment of performance (Bartlett, 2005; Hall & Hauck, 2007). Despite the fact that, in this study, midwifery practices often undermined, rather than increased a woman’s confidence with breastfeeding, the midwives’ position as ‘expert’ remained unchallenged.

A woman’s ‘success’ or ‘failure’ with breastfeeding, during the first week after birth, became dependent upon her capacity to learn the ‘art’ or ‘skill’ of breastfeeding. The labelling of women as ‘successful breastfeeding’, ‘successful mothers’, or ‘successful women’ (Dykes & Williams, 1999; Leff, Gagne, & Jefferis, 1994; McInnes & Chambers, 2008; Nelson, 2006) correspondingly implies that women who have prematurely ceased breastfeeding are ‘unsuccessful’ as mothers or women (Burns, et al., 2010). Clearly, in contemporary discourse the success or failure of breastfeeding resides with the woman and her ‘management’ of her infant (Bartlett, 2005; Lothian, 1995).

During follow-up interviews women who had ceased breastfeeding often spent time justifying their decision. This involved redefining what constituted ‘good mothering’. Overwhelmingly, this redefinition was linked to the supply of adequate nutrition. Consistent with the discourse of ‘inadequate milk’, which seemed most common at MUB, infants seemed to be often ‘topped-up’ with formula, when ‘liquid gold’ intake was deemed insufficient. In this context, infant formula became a ‘saviour’ for women whose supply did not meet the demands of their infant. The routine weighing of infants, even at four days after birth, reinforced concern about ‘inadequate milk’ supply (Dykes, 2002; Sachs, Dykes, & Carter, 2005; Thomson, Hall, Balneaves, & Wong, 2009). Professional practices such as this, prompted some of the women interviewed during this study to progress from ‘topping-up’ with infant formula to switching to full formula feeds.
Women indicated that at times they felt ‘bullied’ into continuing with breastfeeding and required the permission from health professionals to quit. The findings suggest what may be the origins of these feelings of pressure. The scientific rationale for breastfeeding has led to what Sheehan and Schmied (2011) argue is an ‘imperative to breastfeed’ (Sheehan & Schmied, 2011). Women who comply, report that the reality of breastfeeding does not always match the idealised expectations anticipated (Hauck & Irurita, 2003; Larsen, et al., 2008). In this context, some women reassess their position as a breastfeeding mother. As Cannold (1995) and Law (2000) have argued a discourse of the ‘right not to breastfeed’ has been muted. This was especially noticeable within the dominant health professional approach ‘mining for liquid gold’. However, women who discarded the label of breastfeeding mother to incorporate the culturally tainted label ‘bottlefeeding sinner’ (Cannold, 1995:2), appeared to do so in the context of reframing their ‘good mother’ credentials. Lupton’s assertion that “[S]ubjects are neither wholly governed by discourse nor fully capable of stepping out of discourse” (Lupton, 1995:137) has application here. Whilst women might choose to discard the prescriptions for good mothering they will often do so by expanding the discursive limits of the label. In addition, antenatal and postnatal representations of the breasts as equipment, combined with the use of supplementary technology to enhance performance, may hasten the dismissal of breastfeeding as merely one of a variety of options for nutrition.

7.2.2. The breastfeeding ‘equipment’

One of the key findings from this study has been the representation of breasts as equipment and the positioning of the woman as the ‘inefficient operator’ of her ‘equipment’. References by participating midwives to the breasts as equipment, began in the antenatal period, “…you’ve got the equipment and it’s good to go” (PEd 2) and continued into the early postnatal period, “If…they’ve got nice equipment then they can do it ” (SSIV 10). Bartlett highlights that breastfeeding texts, targeted towards pregnant and breastfeeding women, reflect ‘owners manuals’ which borrow on the ‘body as machine’ metaphor to provide the correct ‘instructions’ for the body mechanic (Bartlett, 2005:41). These ‘manuals’ often adopt a patronising tone and stress the importance of professional assistance, similar to the global initiatives described in Chapter Six. These texts also focus on the problems associated with breastfeeding and present ‘how to’ advice on solving issues. This literature surrounds
the woman with a discourse of ‘breastfeeding as problematic’ and in turn influences how she perceives her body and the functionality of her ‘lactating breast’ (Bartlett, 2005).

In this study, women communicated through body language a widespread acceptance of the position as owner of the equipment, for example obediently following the midwives instruction to keep her arms by her side and allow the midwife to attach the infant to her breast. Disconnection from her own body and ‘lactation equipment’ led to passive acceptance of the ‘right of access’ by midwives to the woman’s breast for the benefit of the infant. During interviews, some women described physical intervention as expected, necessary, and helpful for breastfeeding assistance, yet others described this contact as unwanted and indicated a level of surprise at the presumption of consent for this form of bodily contact.

Significantly, not one of the 77 women observed during breastfeeding interactions declined, or objected, to this ‘hands-on’ practice from midwives. The literature however, confirms the dissatisfaction women feel when experiencing ‘hands-on’ breastfeeding support (McBride-Henry, White, & Benn, 2009; Mozingo, et al., 2000; Schmied, et al., 2011). Further, as discussed in Chapter One, midwives have been described as the ‘breastfeeding’ or ‘nipple nazis’. This presumably relates to promotion of the importance of breastfeeding combined with the tendency to ‘hone in’ on the breast and ‘take over’ during breastfeeding. The passive acceptance by women of this, sometimes undesired intrusive midwifery support, reflects an exchange of power between novice and expert, a common feature of professional practice in this institutional milieu. In the following section, I examine in more depth the possible origins of this passive acceptance of breast and body manipulation.

7.2.3. The breast as object

McBride-Henry and colleagues (2009) reported references to the ‘breast as object’ in the narratives of 19 New Zealand women who were breastfeeding, or had breastfed recently. These authors asserted a connection between medical discourses and women’s beliefs and understandings of their body within a subject-object context. In this sense the subjective interpretation of the body, which was apparent in women’s dialogue, was of the “body as object” (McBride-Henry, et al., 2009:36). Similarly, Dykes’ (2006a) analysis of breastfeeding in hospital environments in the
UK, revealed mechanistic descriptions of breastfeeding by both women and midwives, and the objectification of women’s breasts as “faulty machines” (p.85). Within this setting breastfeeding became part of the production process, as women were moved along a metaphorical conveyor belt, where requirements for ‘quality control’ centred around the efficient use of time (Dykes, 2006a). Recent meta-synthesis findings demonstrate the prominence of this discourse and the influence on women’s confidence with breastfeeding (Larsen, et al., 2008). Larsen and colleagues (2008) discovered that women participating in a range of studies and settings viewed breastfeeding as a mechanistic process, where supply was coordinated by demand. The machine-like breast was managed within this discursive frame by breastfeeding experts who focused on “…timing, duration and amount” of milk delivered (Larsen, et al., 2008:658).

McBride-Henry et al., (2009), and earlier Dykes (2006) and Bartlett (2005), have made the link between the ‘body as machine’ metaphor and biomedical conceptualisations of the body arising in the 17th century from the concept of Descartes’ body-mind separation. Passive acceptance of a midwife’s direct contact with the breast, can be understood using this Cartesian dualist conceptualisation. When Descartes introduced his view that the body was merely an extension of the mind, with no inherent intelligence, or power beyond that which the mind permitted, it facilitated the ascension of medicine (Leder, 1984). Descartes’ theory depicted the human body as a passive machine-like entity governed by mechanical and mathematical factors. Fundamental to this approach was an understanding that the ‘machine-body’ was extrinsic to the essence of one’s being and was thus available for experimental testing, dissection, surgical manipulation, mechanical enhancement, and medical treatment (Leder, 1984:30). This conceptualisation of the ‘body’ became accepted wisdom, and has proliferated in medical discourse. The emergence of Husserlian phenomenology and the work of Merleau Ponty during the 20th century, has challenged Descartes’ understanding of mind-body separation positing a view of the “lived body”. They argue that experiential understandings of the ‘world’ are derived through sensory perception, bodily intelligence and active movement which introduced the sense of “embodied knowledge” and understanding into ‘body’ paradigms (Leder, 1984:31).
Leder asserts that, in health care settings, the ‘patient’ presents their ‘lived body’ for ‘expert’ assistance and intervention. Drawing on this concept, I would argue the ‘body as machine’ metaphor, so pervasive in medical discourses and practices around breastfeeding, constructs the breastfeeding woman as a ‘patient’ with faulty ‘equipment’. This discursive reference confines the parameters of the women-midwife interaction. In this context, the process of ‘bodily objectification’ influences the subject position taken up by the breastfeeding woman, as she too begins to view her breast as ‘object’, and breastfeeding as a mechanistic process (Bartlett, 2005; Dykes, 2006; Hausman, 2003; McBride-Henry, et al., 2009; Schmied & Barclay, 1999; Schmied & Lupton, 2001). Midwives’ right of access to the breast occurs in this context as the woman has effectively separated her ‘inner self’ or her subjectivity, from the external ‘breast as object’. Leder’s use of ‘Cartesian medicine’ presents an interesting explanation for this type of typical passive ‘patient’ behaviour. Whilst the woman presents herself in a lived body, the ‘clinical detachment’ associated with the clinician-patient inter-subjective interchange allows the ‘patient’ to remove her ‘inner self’ from the potential pain and suffering associated with health professional manipulation (Leder, 1984:34). As Leder articulates, this inevitably creates a problem for the lived body especially during experiences of pain:

...while alienating the self from its corporeality [the experience of pain] is ... an irrefutable experience of mind-body unity. That the body is not a mere extrinsic machine but our living center from which radiates all existential possibilities is brought home with a vengeance in illness and suffering... (Leder, 1984:34).

This is echoed in the more recent work of Bartlett (2005) who proposes that the body has intelligences which are not mediated by the mind. Bartlett effectively challenges the Cartesian notion of the body as merely an object governed by the mind. Instead, she argues that there are a number of sites of intelligence in the body, such as the gut and indeed the breasts. The “satellite breast brain” therefore is capable of “…thoughtful, emotional and knowledgeable” embodied performance (Bartlett, 2005:60). However, women lack a language to articulate the embodied experience of breastfeeding (Bartlett, 2005; Dykes, 2006a; McBride-Henry, et al., 2009; Schmied & Lupton, 2001). Instead, the acceptance of ‘management’, ‘control’ and ‘manipulation’ of one’s body becomes the norm in the context of this mind-body
split (Dykes, 2006a; McBride-Henry, et al., 2009:39). Lived and embodied understandings are obscured, and rendered irrelevant, in this context.

The subject-object separation of the mind and body, during breastfeeding, also facilitates construction of women as poor ‘learners’ or unsuccessful students when breastfeeding does not proceed as planned. As Bartlett articulates this is a “…particularly debilitating narrative for those women who struggle to breastfeed, who persevere for weeks and months through excruciatingly painful conditions” and then are inevitably deemed ‘unsuccessful’ at accomplishing ‘mind over matter’, necessary for ‘object’ breastfeeding (Bartlett, 2005:56). The tendency for women to construct the breasts as ‘faulty equipment’ can be seen as an attempt to maintain a subject identity as an intelligent, organised and effective ‘good mother’. Women and midwives each ‘buy in’ to this reframing of the breasts when difficulties arise. However, midwives go one step further to adopt the role of ‘efficient operator’ of the ‘faulty equipment’.

Accounts from women in the literature indicate an integration of mechanistic ‘breast as object’ metaphors into their own descriptions of breastfeeding (Schmied & Barclay, 1999) and in the descriptions of their breasts as being ‘on hire’ for breastfeeding or ‘on loan’ to their infant (McBride-Henry, et al., 2009). Getting one’s pre-pregnancy, pre-lactating body ‘back’ is another common refrain (Leff, Gagne, & Jefferis, 1994; Schmied & Barclay, 1999).

Acceptance of the superior ‘wisdom’ of the midwife has also led to passive acceptance of advice, whilst ignoring, or suppressing, embodied knowledge. For example, the following was a common interchange: “Midwife: You don’t look comfortable, Woman: No I feel fine, Midwife: I will just move this pillow and get you to sit up further”. The woman invariably behaved as an obedient subject and followed the advice and directions from the midwife without further ado.

Bartlett’s analysis has highlighted the lack of embodied intelligent “breast speak” in communication around breastfeeding (Bartlett, 2005:60-61). The findings reported in this thesis confirm the silencing of ‘breast speak’ in contemporary hospital environments. For example, in order to prepare a woman for the bodily changes she will experience over the first week after birth, midwives ‘tell’ the woman what to expect, often giving much more information than was ever desired by the woman, as
demonstrated in Chapter Four. What a woman hears about, and reads about the expected bodily sensations associated with breastfeeding, inevitably influences how she experiences her body, and later the ‘product’ of her body (Bartlett, 2005). Women communicated an internalised level of ‘concern’ about bodily production as a result of health professional practices. In one instance, a woman disclosed at interview that she had purchased a full set of infant weighing scales to maintain surveillance of her infant’s growth. In another instance, the family had drawn up an elaborate excel spreadsheet detailing infant intake and output.

Experiencing one’s breast as an ‘object’ has ramifications for how the woman perceives the individual whose ‘job’ it is to ‘work’ the breast. These findings have revealed that in fact two individuals ‘work’ the woman’s body: the infant, and the midwife. Significantly, the infant was at times constructed as an ‘inefficient extractor’ or as possessing the potential to ‘damage’ the ‘equipment’. Further exploration of the language used to describe the infant contextualises health professional contribution to the mother-infant relationship in the first week after birth.

7.2.4. It takes two

In the interactions observed for this study midwives commented upon the infant’s role in breastfeeding. Van Esterik’s (1989) conceptualisation of two contrasting models of infant feeding provides a rationale for alternative representations of the infant. For example, within the bottlefeeding model, the infant has been constructed as a ‘passive’ consumer, controlled by others, who can be fed by a multitude of people. By contrast, within a breastfeeding model, the infant is an ‘active’ individual who controls the supply of breastmilk, and who is fed by the mother only (Van Esterik, 1989). This construction of the infant ascribes agency, which had positive as well as negative ramifications.

I would also speculate that the recent discourses around ‘baby-led’ or ‘self-attached’ or ‘infant-led’ breastfeeding (Australian Breastfeeding Association (ABA), 2011; Cadwell, 2007) seem to transfer some of the ‘blame’ for breastfeeding ‘problems’ to the infant. Baby-led feeding refers to placing an infant skin-to-skin between the mother’s breasts, followed by observation of the infant’s movements towards the breast, and then enabling infant ‘self-attachment’ to the breast (Australian
Breastfeeding Association (ABA), 2011; Cadwell, 2007). This baby-led feeding practice was observed infrequently at MUA, but was widely promoted at MUB. In the ‘mining for liquid gold’ approach, skin-to-skin was used as a tool to improve attachment. Infant ‘self-attachment’ was sometimes interrupted by ‘hands-on’ contact, and the infant at times constructed negatively such as ‘fighting at the breast’ or ‘having a tantrum’. By contrast in the ‘not rocket science’ approach midwives left women to work out their own method of attachment. It was only within the relational approach to breastfeeding support that I witnessed genuine facilitation of mother-infant synchronicity.

In this study, the negative references to infant behaviour corresponded with the portioning of ‘blame’ for breastfeeding difficulties. At times, infants were constructed as the ‘problem’, as hampering breastfeeding progress, yet at other times infants were positioned as the ‘tool’ to accelerate ‘production’. As previously discussed, the application of ‘skin-to-skin’ contact was associated with maximising supply. There was also frequent talk by both midwives and women of putting babies ‘on’ to the breast. This further reinforced the infant role as ‘tool’ for successful breastfeeding.

Significantly, infants were not constructed as a passive tool in this process. When placed near the breast (for either baby-led or manual attachment) infants were deemed to be ‘thinking’ about breastfeeding and ‘deciding’ whether to ‘cooperate’ or not. Invariably infants were described as ‘knowing’ what their ‘job’ was, with one parenting educator implying that this ‘knowing’ came from reading the right books. Maternal and infant embodied knowing were disregarded as the Cartesian mind-body split, central to technomedicine (Davis-Floyd, 2001), seemed to influence interpretations of infant behaviour. Correspondingly, those infants believed to be ‘un-cooperative’, were depicted as having a difficult personality or temperament, or gendered traits, which explained their disagreeable behaviour. For example, infants were described as being ‘lazy’, ‘impatient’, ‘bad tempered’ or behaving in a gender typical way, such as simply doing ‘the boy thing’. The presence of these descriptive labels for ‘uncooperative’ infants was also apparent in the interview dialogue with women. Clearly, the ‘labels’ attributed to infants, by midwives and family members, such as the ‘piranha’ or ‘lazy baby’, at times became integrated into women’s
description of their infant and subsequently influenced a negative reading of normal newborn infant behaviour.

This trend was especially concerning given the reported link in psychological discourse, between maternal sensitivity towards infant distress and secure parent-infant attachment. If a mother interprets her infant’s behaviour as an exercise in active agency, whereby the infant is choosing to cooperate or not with breastfeeding, or is being lazy, this has the potential to influence her empathic responses to the infant (Ainsworth, 1978; Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; McElwain & Booth-LaForce, 2006; Oppenheim, Goldsmith, & Koren-Karie, 2004). If infant distress or behaviour is dismissed as merely the result of ‘problematic’ personality traits, then maternal responses may be less than optimal. We know from the seminal work on attachment, by Ainsworth (1978), that maternal sensitivity to infant behaviour, facilitates the development of secure attachment. Recent research by McElwain and Booth-LaForce (2006) showed that maternal sensitivity to infant distress, at six months, was a predictor of attachment security. Indeed, the way in which a mother conceptualises her infant can influence care-giving behaviour (Oppenheim, Goldsmith, & Koren-Karie, 2004). The findings from this study have demonstrated the influence of the language and practice of midwives on a woman’s early interpretations of her infant’s behaviour. This is of concern given the postpartum period marks a critical time for the development of sensitive mothering.

The satisfaction a woman has with her breastfeeding experience, has also been linked to her interpretations of her infant’s enjoyment (Leff, et al., 1994; Lothian, 1995; Mathews, 2000). Much of the data analysed for this study lacked references to maternal enjoyment of breastfeeding. Instead, as highlighted by Sichtermann (Sichtermann, 1986:57) and Van Esterik (1994:S44) “…the sensual pleasure of breastfeeding has been repressed” and instead has become part of the “…tamed, pleasureless, domesticated world of maternal duties”. In turn, the midwifery ‘duty’, apparent in this study, was to ensure adequate supply of nutrition by one ‘patient’, the woman, to another ‘patient’, the infant. In this context, maternal or infant pleasure during this transfer of nutrition seemed unrelated. In fact, the construction of the infant as a ‘patient’ seemed to imply a certain level of ownership by the midwife, evident in the midwifes description from Interaction 70 in Chapter Four of
“I’ve got nine babies tonight” (page 137). Data analysis revealed the level of responsibility midwives felt for ensuring the infant was ‘adequately fed’.

Whilst the woman and infant each remained ‘patients’ on the postnatal ward both infant and maternal ‘performance’ at breastfeeding were scrutinised. In particular, ‘sucking competence’ was under the microscope and midwives adjusted infant attachment at the breast to obtain the ‘picture perfect’ latch, combined with ‘effective’ sucking. Midwives were often observed leaning in, and using their finger to force the infant jaw down further, thus enabling a bigger lip flange. This midwifery preoccupation with obtaining the ‘Special K’ lip flange (lips spread out in the shape of the Kellogg’s letter K) has been reported elsewhere (Thompson, et al., in press). Dialogue from women during interactions confirmed the prioritising of this visual assessment of infant ‘latch’.

Research by Lothian, 15 years ago, included references to the importance of assessing ‘sucking competence’ prior to discharge from hospital (Lothian, 1995). Recommendations for success included the importance of “correcting faulty sucking” (Lothian, 1995:333). Furthermore, Lothian went so far as to suggest that “…mothers should be taught to assess their baby’s contribution to breastfeeding in a methodical way” (Lothian, 1995:334). The observed interactions, in this thesis, have revealed the methodical assessment of both maternal and infant competency at breastfeeding. Assessing the disconnected ‘consumer’, the infant, and the supplier of the ‘product’, the mother, allowed for a detached scrutiny of ‘performance’. Infant consumption was recorded on a feeding chart, which included assessment of time, duration and the quality of attachment and sucking. The mechanistic positioning of the breast as object, necessarily detached from the owner, supplying ‘liquid gold’ for a demanding consumer, represents both symbolic and tangible separation of the breastfeeding dyad. I would speculate this inevitably interrupted maternal and infant synchrony.

These depictions create a disharmony between the goals and aspirations of each participant in the breastfeeding exchange. Breastfeeding ‘success’ was dependent upon maternal and infant adherence to the recommendations from health professionals. While the woman was assessed for performance of competencies, and her bodily ‘equipment’ scrutinised for ‘faults’, the infant was simultaneously assessed. The inefficient operator of the equipment and the ineffective extractor were at times, if not physically, discursively set apart from each other. The midwife
assumed the intermediary role as ‘facilitator’ of ‘successful breastfeeding’ and fulfilled the global imperative as ‘protector’ of breastmilk supply. Midwives did this by protecting the ‘equipment’ from ‘damage’ by the demanding consumer. Interference in mother-infant inter-subjective synchronicity resulted. Breastfeeding, at times, resembled a ‘battle’ between mother and infant. This experience of breastfeeding, as a ‘battleground’, has been reported by other researchers; see for example (Bottorff, 1990; Hegney, Fallon, & O’Brien, 2008; Schmied & Lupton, 2001).

The study findings indicate that the language and practices of midwives can influence a woman’s early breastfeeding experiences. Subjective integration of the body as machine metaphor confirms Foucault’s assertion that the body is a site ascribed with discourse. The ‘disciplinary power’ exerted by ‘experts’ over the objectified ‘patient body’ reflects the subject position taken up by midwives. The construction of the infant as an independent decision maker led to unfavourable assessments of infant behaviour. Midwifery language and practices often appeared to interfere with mother-infant relationship building as midwives engaged in ‘competency’ assessment of both maternal and infant performance. Women tended to passively accept unwanted body contact from midwives and in turn the midwife seemed oblivious to the detrimental effect these practices may have on the woman. In the next section I will examine the discourses which have shaped the professional identities of midwives and lactation consultants, and the context within which these have developed.

7.3. Midwives and Professional Subjectivity

In the first section of this chapter, I have discussed the way in which maternal subjectivity and breastfeeding have been constructed in interactions with midwives. It appears that women were positioned as passive ‘patients’ for their short postnatal stay and afforded little autonomy to make decisions about themselves and their infant. In Chapter Six, I discussed the powerful influence of lactation science and breastfeeding medicine in privileging breastmilk over breastfeeding as a process and I identified the coercive nature of breastfeeding policies on subsequent midwifery language and practices. In the next section of this chapter, I will consider the impact of additional factors which are shaping the practice of midwives. These include the professional socialisation of midwives, the authoritative medical
model, and technocratic specialisation of midwives in contemporary Australian maternity systems.

7.3.1. **Professional socialisation**

Early professional socialisation through education, training, health politics, institutional culture and individual belief systems influence the subjective identity of midwives (Parsons & Griffiths, 2007). A brief historical overview of the development of the profession of midwifery in Australia provides some understanding as to the styles of practice noticed in the interactions between midwives and women in this study.

Until very recently, most midwives in Australia began their professional career as registered nurses (Barclay, 1985a). All but one of the participants in this study completed nursing education prior to becoming a midwife. In fact, many of the hospital midwives I spoke to, especially at the general hospital MUA, referred to themselves as nurses and spoke about the ‘nursing’ aspects of care. Midwifery discourses of ‘woman-centred care’ and working in ‘partnership’ seemed to be suppressed at MUA by the more dominant, traditional ‘nursing’ and ‘medical safety’ discourses. Whilst at MUB these midwifery discourses seemed suppressed by the global BFHI policy.

Authors undertaking an historical analysis of midwifery in Australia have provided significant insight into the development of the profession, during the last century, as a ‘speciality’ area of nursing (Barclay, 1985a, 1985b, 2008; Fahy, 2007). Midwifery, previously a ‘profession’ in its own right, was formally subsumed under nursing in 1928, when the Midwives’ Board was abolished, and only those midwives who had trained as nurses were permitted to provide care during pregnancy and birth (Fahy, 2007). It became usual thereafter, for individuals to ‘complete’ their nursing credentialling with the addition of extra specialty qualifications, such as midwifery certification or mental health training. This led to many nurses commencing midwifery education within one year of gaining a primary nursing qualification. Career progression within nursing became linked thereafter to the successful attainment of additional certificate qualifications (Barclay, 1985a, 1985b).

Barclay’s latest historical overview of midwifery, highlights a trend last century towards converting midwives into ‘obstetric nurses’. Hence, within the Australian
health care context, for most of the past century, midwives were perceived as nurses but with additional knowledge around pregnancy and birth (Barclay, 1985a, 1985b). This legacy has resulted in many hospital-based midwives retaining practices and beliefs stemming from their socialisation as nurses (Parsons & Griffiths, 2007), and often engaging with pregnant or breastfeeding women, in ‘expert nurse’-‘novice patient’ exchanges (Barclay, 1985a, 1985b; Fahy, 2007; Parsons & Griffiths, 2007). This historical influence may have led to the lack of skills in, or disposition towards working in partnership with women observed in this study. Midwives who appeared to have maintained traditional nursing orientated practices, were observed interacting with women in a way which portrayed the woman as a ‘sick patient’ requiring health professional ‘treatment’ in order to return to optimal health and wellbeing. As Parsons and Griffiths (2007) argue the socialisation of midwives as nurses first, has led to an obedient acceptance of policy and a reluctance to question the rationale for certain medicalised practices.

This historical legacy also helps to explain the pursuit of ‘safe practice’ or the risk averse practices at MUA. The presence of a discourse of risk management and ‘safe practice’ reflected the ‘nursing’ orientation to care at this site. There was a detectable apathy towards midwifery practices such as breastfeeding and a prioritisation of clinical aspects of care. Staff at MUA, disclosed during focus groups that ‘nursing’ tasks such as observations, medications, and post-operative care, were key organisational priorities and needed to be recorded at specific time intervals. These time-driven rituals of care have been associated with busy, ‘chaotic’ postnatal ward environments in other acute hospital settings in Australia, and the UK (Dykes, 2006a; Furber & Thomson, 2007; Rayner, et al., 2008). Others have reported that organisational priorities, particularly efficient admission and discharge procedures can prohibit optimal midwifery care provision affording minimal time for midwives to spend with women (Rayner, et al., 2008; Schmied, Cooke, Gutwein, Steinlein, & Homer, 2009).

In recent years there has been a recognition of the different competencies required for midwifery practice, compared to nursing practice, which has seen the development of direct entry midwifery education for midwives in Australia (Barclay, 2008). Therefore, midwives are no longer obliged to complete a nursing educational program before becoming a midwife. Both organisational and
professional distinctions between the two professions have recently been officially recognised in Australia. Socialisation of midwives is undergoing transformation in this country, but it may be some time before significant benefits for women are seen.

This overview of the historical influences on midwifery in Australia and the socialisation of midwives in the hospital environment, offers some explanation for the practices observed during this study. This socialisation has resulted in interactions with women as ‘patients’ which align with a medical paradigm (Dykes, 2006a). In the following section, I discuss the impact that medical and technocratic discourses have had on shaping midwifery practice.

7.3.2. The technocratic model

In Chapter Six, I argued that the interpretation and apparently rigid implementation of BFHI, especially noticeable at MUB, has shaped some of the disembodied practices observed. Alongside this, the socialisation and education of midwives within nursing and medical paradigms, seems to have produced what Davis-Floyd describes as a “technocratic” midwife (Davis-Floyd, 2001:S6).

Davis-Floyd (2001) asserts that ‘Cartesian medicine’ fundamentally underpins much health professional practice in hospital environments and breeds ‘technocratic’ health professionals (Davis-Floyd, 2001). Within this technocratic model, the body is viewed as a ‘machine’ and is compartmentalised into its various components (Davis-Floyd, 2001; Leder, 1984). As described earlier in this chapter, the ‘body as machine’ metaphor separates the mind and body and applies mechanistic principles to bodily performance. From a technocratic perspective therefore, the body “…can be overlooked when functioning well” and only becomes ‘interesting’ when malfunctioning (Leder, 1984:35). This principle is evident in the review of professional literature which reports many studies of breastfeeding ‘problems’ but tends to ignore analysis of trouble-free breastfeeding performed without incident (Burns, et al., 2010).

The technomedical paradigm dominates in hospital environments and objectifies individuals as either ‘patient’ or ‘expert’. The relationship between the two is often hierarchical and emotionally estranged (Davis-Floyd, 2001). The body of the ‘patient’ is scrutinised and when it ‘fails’, the technocratic health professional enlists treatments and technologies to ‘fix’ the problem. Individual ‘patients’ may
experience aspects of their care as “…reductionist or dehumanizing” but invariably they assent to the expert intervention regardless (Leder, 1984:36).

The technocratic professional focuses on the ‘problem’ to be solved, and disregards communication incorporating any additional information, beyond what is needed to solve the physical body ‘problem’. Care is standardised and communication kept to a minimum to reinforce the ‘interchangeability’ of the health professional and the lack of continuity inherent in hospital-based care (Davis-Floyd, 2001; Leder, 1984:37). The ‘diagnosis’ and ‘treatment’ of the broken machine happens from the ‘outside in’ and ‘patient’ input is kept to a minimum. Within this paradigm ‘science and technology’ are paramount and ‘authority and responsibility’ reside with the health professional not the ‘patient’ (Davis-Floyd, 2001:S7-8).

The dominant style of midwifery practice observed at both hospitals reflects the incorporation of a Cartesian medical view of the body into hospital-based midwifery practice. As discussed earlier the woman was positioned as a ‘passive’ subject where her self-acquired knowledge, and even her embodied knowledge (Bartlett, 2005) were dismissed along with the sociocultural aspects of her life. In this approach, expert ‘technocrats’ scrutinised and assessed for malfunction, and intervention followed the detection of bodily transgressions. The technocratic midwife utilised her ‘expert’ skills to ‘fix’ problems and introduced ‘sophisticated’ machines when necessary. In fact, observations at MUB saw the introduction of technological bodily enhancement well before the natural bodily process had time to ‘work’. This ‘elevation’ of technology represents a central tenet of the technocratic model and reflects a desire to ‘control nature’. Within this view of the body, the ultimate sign of ‘defeat’ (Davis-Floyd, 2001:S8-10) or ‘technocratic failure’, is clearly breastfeeding cessation. The woman can be dismissed at this point, as breastfeeding or breastmilk extraction is beyond ‘fixing’ by the technocrat.

This technocratic model mistakenly assumes that the provision of ever increasing amounts of health information for breastfeeding women, alongside the provision of expert support, will be effective in the ‘protection, promotion and support’ of breastfeeding. The decrease in breastfeeding following discharge from maternity services, and maternal dissatisfaction however, indicate that this strategy does not appear to be working. In her monograph *Breastwork: Rethinking Breastfeeding*, Bartlett (2005:57) also questions this overemphasis on education or information
giving, asking “…if breastfeeding can be learned as a bodily activity, in the same way that we learn to walk or to raise one eyebrow, then why can’t every mother breastfeed successfully?” The provision of increasing levels of education, for both the woman and the health professional, do not appear to be achieving the desired results. Yet the focus of health policy continues to be on the importance of education and improving health professional knowledge and expertise.
The midwife as technocratic expert

The dominance of ‘technomedical’ hospital systems, socially sanctioned as ‘best’ in western maternity care, has shaped ‘authoritative’ communication patterns such as those observed in this study (Jordan, 1993). It is not surprising therefore, as Hoddinott and Pill (2000b:229) report, that women feel “…everyone seem[s] to be an expert [about breastfeeding] except them”. In the technocratic model, breastfeeding represents an unpredictable bodily activity requiring ‘management’ and ‘control’ (Davis-Floyd, 2001:S6). Midwives influenced by the ‘mining for liquid gold’ discourse, adopted a role as manager of breastfeeding. This involved a range of tasks, for example, the midwife acted as ‘breastfeeding assessor’ (Blair, et al., 2003; Cadwell, 2007), the provider of practical assistance (Hannula, et al., 2008; Rayner, et al., 2008), and the educator or teacher (Cattrell, Lavender, Wallymahmed, Kingdon, & Riley, 2005; Rayner, et al., 2008). In this context an authoritative approach to communication dominated. Typical interactions were rushed and involved getting ‘down to the business’ of getting the baby ‘on’ the breast. In most interactions, ‘midwife-speak’ dominated with closed-ended questions and didactic advice giving, including directions and recommendations. The technocratic midwife interacted with the woman in a way that communicated, what Dykes (2006a:130) has described as “temporal pressure”, using “insensitive and invasive touch” as described by Schmied et al. (2011:54). Lack of time was blamed for rushed communication which failed to situate the woman, and her breastfeeding infant, in the context of their lives.

Within the conventional hospital-based mode of midwifery care, the postnatal period was a distinct component of maternity separated from pregnancy and birth. Midwives had the opportunity to specialise in this area, and hone their midwifery skills in postnatal support. Within this fragmented system of care, women were cast in the ‘sick’ role as ‘patients’ in hospital (Dykes, 2006a). Dykes’ influential work on the impact of hospital environments on the mother-infant breastfeeding dyad, has highlighted the ways in which technocratic midwives approached breastfeeding support within this milieu. Dykes revealed the hospital environment as a ‘productive factory’ where ‘patient care’ was monitored and managed and midwives approached their caring role as merely the provision of a ‘service’ rather than a relational encounter (Dykes, 2006a). In this context, the industrial metaphors of ‘production, demand and efficient supply’ were applied to the breastfeeding relationship.
Midwives effectively served the needs of the institution, via routinised accomplishment of tasks however, this significantly compromised their capacity for relationality with women (Dykes, 2006a).

Dykes also demonstrated that the pervasive influence of linear time in the hospital environment contributed to constraining breastfeeding support (Dykes, 2006a). The findings reported in Chapters Four and Five of this thesis are supported by the work of Dykes. Dykes’ use of a factory metaphor highlights the adoption of a role as ‘shop floor worker’ in the busy hospital ‘factory’ by the technocratic midwives at MUA and MUB (Dykes, 2006a). These midwives sought to manage the postnatal process, whilst maintaining a level of emotional distance from the ‘patient’. In this factory-like environment the breasts were ‘functional machines’ and breastmilk became the much sought after ‘product’ which was positioned as belonging to the infant ‘consumer’.

Attempts to reorganise work within technomedical institutions have yielded variable results. For example, an action research study conducted by Schmied and colleagues (Schmied, et al., 2008; Schmied, et al., 2009) identified several strategies for improving postnatal care. Midwifery working group meetings determined that uninterrupted time, described as ‘one on one’ time, between the woman and the midwife was crucial for improving postnatal care. However, when efforts were made to restructure the daily tasks, the midwives reported that spending a longer period of uninterrupted time with women was an unachievable goal (Schmied, et al., 2008). At MUA and MUB, care was standardised according to documented clinical pathways where the information given at each breastfeeding exchange was retrospectively logged for the next staff member to see. This form of ‘tick box’ communication has been shown to limit individualised care and can prohibit relational interactions (McLachlan, et al., 2008).

The findings of this study indicate that the communication style which emerged from technocratic models of midwifery care, is consistent with findings by Kirkham (1999), Dykes (2006), Fenwick (2001), McInnes and Chambers (2008) and Furber and Thomson (2006, 2010). Midwives used language that effectively controlled and limited decision making by the woman and ensured a superior position in the relationship with the woman. For example, rather patronisingly many midwives referred to women as ‘ladies’, ‘girls’ and ‘my mothers’. A similar finding, described
by Furber and Thomson (2010), indicates a comparable authoritative approach in the narratives of UK midwives. Midwives described the provision of breastfeeding support whilst referring to women as the ‘girls’ or the ‘ladies’ and indicated a ‘domineering approach’ to postnatal care (Furber & Thomson, 2010).

Fenwick and colleagues (2001) have demonstrated that for some Neonatal Intensive Care nurses, the maintenance of a position as ‘expert’ was integral to the retention of control, structure and routine in the care of the infant. In contrast, nurses who adopted facilitative approaches to care, utilised interpersonal social interaction to engage with women on a more personal level, and effectively built positive relationships, elevating the woman to a position of power in the care of her sick and/or premature infant (Fenwick, et al., 2001a). In this study of breastfeeding interactions, midwives at both sites used what Fenwick and colleagues have described as ‘dismissive chat’ (Fenwick, et al., 2001a) to facilitate their priority for getting straight down to the business of getting the baby ‘on’ the breast. This type of approach seemed to be as a result of managing time efficiently.

Time management strategies used by midwives to get through their day’s work, led to a devaluing of the importance of effective communication with women. Midwives elsewhere have reported the detrimental effect of encroachments on midwifery time, such as administrative tasks and computer work (Cattrell, et al., 2005). Furber and Thomson (2007) have similarly reported a ‘rationing’ of time, undertaken by midwives, when the ratio of ‘midwife to woman’ was inappropriate. Midwives, in the study by Furber and Thomson (2007) reported prioritising care and adopting ‘popping in’ strategies, or waiting for calls for assistance, while moving onto other ‘tasks’ (Furber & Thomson, 2007). Analysis of the data, from MUA and MUB, goes further than this to demonstrate a tendency for midwives to focus on the breast, not the woman, during these rushed exchanges. The technocratic midwife engaged with the woman about ‘this breastfeed’ and ‘this baby’. Discussion or ‘chat’, beyond this was infrequent. Often closed-ended questions were used or closed-ended statements, which limited responses from the woman. Advice giving, and more broadly ‘midwifery speak’, dominated. The professional ‘knack’ for getting infants onto the breast, or for expressing colostrum, was also communicated in a non-verbal way to women. This ‘knack’ seemed to be acquired by midwives during their ‘on the job’ professional socialisation into the breastfeeding support role.
Midwives in Australia have revealed that ‘on the job’ experience forms a significant component of their knowledge base around breastfeeding (Cantrill, Creedy, & Cooke, 2003; Marshall, Renfrew, & Godfrey, 2006). Midwives in two studies (Cantrill, et al., 2003; Furber & Thomson, 2008a) have also reported using their acquired ‘craft’ knowledge to provide assistance with breastfeeding. This craft knowledge includes a component of learning the ‘hands-on’ knack of getting ‘fussy’ babies onto the breast, as my field notation (day 7) and FG data (FG1) from Chapter Four demonstrate (pages 130 & 131).

Some practitioners, observed in this study, displayed an inclination towards these familiar ‘professionally socialised’ and accepted ways of practising. Furber and Thomson (2008) found that conformity to the socially acceptable status quo on the ward often resulted from a widespread misperception that the newer practices, such as ‘hands-off’ support, would be more time consuming (Furber & Thomson, 2008b). Midwives, in this study, who adhered to best practice recommendations, were also occasionally observed resorting to the professionally acquired expert ‘knack’ of expediently getting the baby ‘on’. The routine wearing of gloves prior to breastfeeding interactions, at MUB, certainly communicated the assumption that ‘hands-on’ support would be acceptable and necessary.

During focus group interviews midwives at both sites emphasised their support for a ‘hands-off’ approach when helping women but acknowledged that in practice, in the busy postnatal environment, they often expedited attachment by doing it ‘for’ the woman. The notion that it was quicker to ‘do for’ rather than ‘teach’ resonates with McInnes and Chambers (2008) meta-synthesis findings. Significantly, some of the women interviewed following discharge from MUA and MUB indicated a preference for this form of practical assistance. This raises the question whether it is the technocratic use of ‘hands-on’ support which women find objectionable rather than the actual use of physical touch.

There has been debate over the past ten years, as to whether ‘hands-on’ or ‘hands-off’ approaches, effect the initiation and duration of breastfeeding (Furber & Thomson, 2008a; Henderson, et al., 2000:15). Ingram and colleagues have demonstrated improvements in breastfeeding duration rates, following education on ‘hands-off’ approaches to midwifery professional support (Ingram, Johnson, & Greenwood, 2002) and yet other research has shown no improvement (Wallace et al.,
Adoption of ‘hands-off’ practices for breastfeeding support has been associated with increased maternal confidence with breastfeeding (Fletcher & Harris, 2000; Furber & Thomson, 2008a, 2008b; Inch, et al., 2003; Napier, 2001; Tweedie, 2000). However, problematic research designs have made definitive conclusions elusive, regarding which approach is most effective (Furber & Thomson, 2008a). Considering the widespread dissatisfaction expressed by women who have experienced unwanted touch from midwives (Hailes & Wellard, 2000; Kelleher, 2006; Mozingo, Davis, Droppleman, & Merideth, 2000; Raisler, 2000; Weimers, Svensson, Dumas, Navér, & Wahlberg, 2006), this is clearly an area in need of further research. On the basis of these study findings however, I would argue that it is not the use of physical touch which is necessarily causing maternal dissatisfaction but rather, whether the touch was wanted or unwanted.

Henderson and colleagues (2000) argue that ‘hands-on’ approaches to breastfeeding support, reflect a midwifery tendency to ‘take control’ of the woman’s early breastfeeding. Negotiation for ‘hands-on’ support requires effective communication skills and a period of ‘getting to know’ the woman, a facet of communication absent from many of the technocratic midwife exchanges observed. The use of ‘hands-on’ support therefore was often a tool used by ‘expert midwives’ in an authoritative way to manage breastfeeding, rather than the result of careful negotiation with the woman to elicit her preferences for learning.

Overall, midwives were observed engaging in a degree of self-monitoring of their technocratic position, and maintaining adherence to the ‘rules’ of the institution. However, during focus groups midwives reported that the rules were sometimes bent when the ward area was particularly busy, especially at night. For example, midwives described the practice of feeding unsettled infants with formula if the woman was distressed and sleep deprived. This has been reported by others such as Furber and Thomson (2006) and Reddin et al., (2007). Whilst rule breaking behaviours such as these were alluded to by midwives at MUA and MUB, somewhat predictably, I was not able to observe this behaviour. Practices such as these are mostly hidden from view, and are often discussed only amongst other ‘like minded’ practitioners (Furber & Thomson, 2006). In this circumstance, technocratic midwives made an assessment of what they believed would be ‘best’ for the woman and infant.
Technocratic midwives also positioned breastfeeding as a ‘competency to be attained’ in a timely fashion and at least prior to discharge. Viewing breastfeeding as a ‘competency’ appeared to fracture the relationality between the woman and infant. Instead, a pre-determined health professional standard superimposed a disconnected inter-dependence on each other’s ‘scripted’ performance. The woman’s bodily ‘equipment’ inevitably became part of the ‘competency’ assessment. If her ‘equipment’ was deemed to be ‘underperforming’, then the midwife did what a technocratic health professional would do, by suggesting the introduction of ‘artificial equipment’ to optimise performance of the natural ‘equipment’ or referring the woman to a specialist.

The lactation consultant as technocratic specialist

The technocratic positioning of breasts as equipment, prone to production problems, necessitated the development of a specialist ‘technocrat’ with the capacity to ‘repair the machinery’ and maximise performance. Since 1985, when the first examinations were introduced in the US, there has been a rapid growth nationally and internationally in the number of professional lactation consultants. In Australia, this additional tier in breastfeeding management and support, advocated by the BFHI, is particularly evident. International Board Certified Lactation Consultants (IBCLC), are predominantly midwives or nurses committed to learning more about ‘lactation’, although increasing numbers of medical practitioners are also seeking IBCLC certification (Chin & Amir, 2008; Drew & Escott, 1997; Smith & Tully, 2001). Lactation consultants in Australia and New Zealand make up half of the total lactation consultants available in the Asia Pacific region, which includes Australia, Asia Pacific and Africa (n2412) (Drew & Escott, 1997; Thompson, et al., in press).

In the study findings reported in this thesis, most lactation consultants were observed approaching breastfeeding women in a ‘problem orientated’ fashion as ‘troubleshooters’. At times at MUB, women indicated surprise that a referral to the lactation consultant had even been initiated by the midwife. The expert midwife, whose job it was to ‘get the infant on the breast’ referred to the lactation consultant to ‘get the baby fed’ sometimes in the absence of a problem. Lactation consultants were observed assessing breastfeeding ‘problems’, by focusing on the breast and the infant, and subsequently engaging in a technocratic pattern of “…diagnose…cure…and repair” to manage dysfunction from the outside-in (Davis-
The woman’s breast was often palpated and scrutinised, infant attachment to the breast assessed, and a diagnosis of the problem deduced, then a management plan prescribed.

In these interactions, communication was focused on the breast ‘problem’ and there were multiple ‘missed cues’ and ‘lost opportunities’ to engage with the woman on a relational level. These disconnected encounters have been reported by Dykes (Dykes, 2006a) in her study of midwives on postnatal wards in the UK and also by Kirkham and colleagues (2002) who described a similar phenomenon in their observations of the way in which midwives provided information to women in antenatal clinics.

In order to ensure sufficient opportunity to assess infant behaviour (when attaching to the breast) and to gather enough information upon which to base a management plan, lactation consultants encouraged women to feed their infant when they were available. This involved, at times, the initiation of breastfeeding before the infant was exhibiting signs of a readiness to feed. If an infant did not readily commence breastfeeding, or if there were concerns about fluid intake, then either ‘hand expression’ or the electric breast pump, were introduced. This practice seemed analogous to interventions used by medical specialists (obstetricians) to speed up labour, simply because of the availability of medical intervention, which subsequently compromised the normal process. If the breastmilk retrieval was insufficient, the infant was provided with a formula ‘top-up’. This seemed to mark the beginning of a cascade of intervention, similar to that reported by critics of technocratic birth (Davis-Floyd, 2001; Jordan, 1993; Roberts, Tracy, & Peat, 2000).

**Iatrogenesis of breastfeeding in the technomedical model**

In Chapter Six, I highlighted the prioritisation of lactation consultant positions for breastfeeding ‘success’ by the BFHI. The elevation of the lactation consultant to the role of ‘supervisor’, and ‘protector’ of breastfeeding has led to the injection of specialist intervention into mother-infant breastfeeding dyads, when difficulties or challenges are apparent and at times even when not evident. This sometimes occurs regardless of the woman’s desire or not, for this type of specialist intervention. In the technomedical hospital environment therefore, women are sometimes manipulated to accept specialist professional assistance. In the BFHI environment, the discursive prioritising of ‘liquid gold’ privileges lactation specialist assessment, or at the very
least midwifery assessment, of competency with breastfeeding prior to discharge, regardless of maternal preference.

At MUB, the lactation consultant came armed with ‘specialised’ lactation knowledge, management plans and technology. Breast pumps were readily recommended to solve a multitude of problems ranging from ‘drawing the nipple out’ to improving ‘supply’ and ‘bringing the milk in sooner’. Women and their families integrated the importance of technology when preparing for discharge by purchasing their own equipment. Pathologising breastfeeding in this way appears to have further alienated the woman from her body and her milk, and introduced the type of mechanistic approach to breastfeeding described by others (Blum, 1999; Dykes, 2006a; Schmied, et al., 2001; Van Esterik, 1996).

The findings from this study are also supported by Thompson and colleagues (in press:4) that ‘elaborate techniques’ necessary to attach a baby to the breast are “…making the act of breastfeeding too complex for many women and neurologically disturbing for the baby” effectively prohibiting “…the instinctive or mammalian act of breastfeeding”. Improvements in the duration of breastfeeding may result from facilitating ‘instinctual’ mother-infant contact and eliminating unwanted physical contact. Some lactation consultants in this study were observed practising in ways which could be described as genuinely facilitating mother-infant instinctual behaviour. However, the majority of observed lactation consultants approached breastfeeding interactions according to a biomedical framework, and participated in both ‘pathologising’, and ‘problematising’, breastfeeding thereby further complicating the process. Breast ‘expression’ plans were often complicated regimes which the woman was professionally recommended to comply with. The incorporation of prescriptive breastfeeding ‘expression’ plans constructed the ‘breastfeeding challenge’ as abnormal, thus requiring a complicated regime to fix.

Despite increased scientific knowledge about breastfeeding, education of midwives and lactation consultants, increasingly sophisticated machinery for breastfeeding, and expert teaching of breastfeeding, the duration of exclusive or even partial breastfeeding do not appear to be improving (Amir & Donath, 2008; Australian Institute of Family Studies, 2008). The health professional focus on ‘correct’ techniques for breastfeeding and the importance of supplying adequate amounts of the product, breastmilk, are in stark contrast to the support provided by peers and
family. Peer support has been devalued in contemporary health care systems despite the known benefits of, and preference for, this form of breastfeeding support (Hannula, et al., 2008; Ingram, Rosser, & Jackson, 2005; Kirkham, Sherridan, Thornton, & Smale, 2006; McInnes & Chambers, 2008).

Midwifery specialisation in the form of lactation consultancy has been questioned by midwifery scholars for some time (Schmied, et al., 2001). The increasing professionalisation of breastfeeding and the technocratic approach to breastfeeding women, positions breastfeeding as complicated, an activity that is hard to master and requiring expert assistance and guidance (Schmied, et al., 2001; Thompson, et al., in press). The findings from this study provide evidence for the argument raised by Schmied and colleagues (2001) and others (Van Esterik, 1994) a decade ago that breastfeeding is being pathologised. Breastfeeding is now viewed as a medical event, similar to the way in which birth has been pathologised. Similarities between the ‘pathologisation’ of breastfeeding and the medicalisation of birth have become a focus of midwifery scrutiny in recent years (Schmied, et al., 2001; Thompson, et al., in press). A similar argument has also been posed by Bartlett (2005) and Hausman (2003). This argument aligns the ‘iatrogenesis’ related to unnecessary labour and birth interventions with the problematic interventions noted during breastfeeding support provision.

Hausman highlights the lack of dialogue in health professional literature regarding the social and experiential aspects of breastfeeding, which limits the health professional focus to ‘biologic lactation’ (Hausman, 2003). This is certainly evident in a critical review of a popular lactation consultant text (Riordan, 2005) which does not account for women’s experiences of breastfeeding. Instead, the text takes a problem-orientated approach to diagnose and manage breastfeeding. Many of the technocratic specialist practices observed are exactly as prescribed in this textbook (in particular see page 195: Guidelines for the infant who does not Latch-On).

Significantly, however, not all lactation consultants engaged with women in this technocratic specialist way. Instead, those who viewed breastfeeding as primarily about building a relationship between the mother and her infant, approached interactions with women from a wholistic perspective, and adopted partnership approaches to care.
7.4. Facilitating Partnership

Technomedicine appears to have shaped the professional identity of a majority of midwives and constrained maternal subjectivity. The technocratic expert midwife or specialist consultant, engaged with the breastfeeding woman in an efficient yet disconnected way. Many of the practices interrupted the midwife-woman relationship formation and potentially may have impacted on the woman’s relationship with her infant.

The promotion of breastfeeding as the socially and morally ‘correct’ option for infant feeding was evident in some of the assumptions made by midwives during interactions with women. For example, midwives often expected women to persevere with breastfeeding regardless of the distress experienced. Traditional technocratic hospital-based systems of care, focused on the body and ignored relationship formation. Maternal motivation to breastfeed is most often focused around providing the infant with the ‘best nutrition’ and extending the symbiotic relationship from pregnancy. This relationship is not one of ‘duty’ but rather one of pleasurable interconnection (Hausman, 2004) and one which many women desire. Whilst breastfeeding can be viewed as a ‘labour of love’ by those who are deemed ‘successful’ (Smith, 2008), for those who find breastfeeding untenable, the overwhelming guilt and sense of failure can impact upon their experiences of early mothering.

While the provision of nutrition is one aspect of early mothering, relationship formation is crucial for infant wellbeing in the early postnatal period, regardless of the feeding option chosen. The findings from this study demonstrate that during breastfeeding, the infant and woman often came to represent two competing subjectivities. In addition, relationship formation or a partnership with midwives was constrained and at times fraught with competing priorities.
7.4.1. The partnership approach

In this study, nine percent of interactions observed reflected a relational approach, based on the principles of partnership. Midwives observed to be genuinely relating with women included caseload midwives, lactation consultants and one bachelor of midwifery student. In each instance, the staff member was operating outside of the pressures and time constraints of the mainstream organisation. The student midwife was working in a supernumerary capacity. The lactation consultants were working in designated consultant roles and had time to devote to each woman. Finally, the caseload midwives could autonomously arrange their own work schedule to provide as much time as necessary for each woman. Of the eight interactions observed that demonstrated a relational approach, four occurred in the hospital, and four in the woman’s home. Communication styles that facilitated relationship building were possible in the hospital environment when time constraints were no longer impinging upon the interactions. Yet not all lactation consultants or caseload midwives interacted with women in a relational way, with some retaining the detached clinician stance associated with the technocratic expert. Midwives who worked in a relational way stood out as different. The primary difference was related to their capacity to work in partnership with the woman.

A partnership approach to midwifery has been defined in Chapter One as including “…trust, shared control and responsibility” (Guilliland & Pairman, 1995:7). This approach has several conceptual underpinnings including the normalcy of pregnancy and childbirth, the importance of continuity of carer, and a woman at the centre of care approach (Pairman & McAra-Couper, 2006; Pairman, et al., 2006). The woman is viewed within the context of her life and relationships with her significant others. She and her infant are conceptualised as a complete unit, not separated into two distinct individuals. Within this approach, midwives were observed interacting with women as equals, where power and responsibility were shared and relational communication resulted in mutual respect and trust.

7.4.2. Relational communication

The centrality of relationship formation was evident in quotes from women regarding their connection with particular midwives (see Chapter Five). Genuine relational communication included a period of ‘touching base’ with the woman, and of
interpersonal social engagement. Dykes’ (2006) description of ‘touching base’ resonates here as midwives clearly engaged in a period of checking in with the woman. This involved the use of open-ended questioning to elicit how the woman was feeling, and how her children and significant others were, and general familiarising with each woman’s individual situation. Elsewhere this type of engaged and responsive two-way dialogue has been described as an ‘authentic presence’ featuring empathic listening, genuine support, taking time, sharing the experience and providing positive confidence-building encouragement (Schmied, et al., 2011).

Midwives and lactation consultants also used ‘chat’ to establish rapport. These interactions closely reflected those identified in Fenwick’s study of facilitative communication styles in the NICU (Fenwick, et al., 2001a). Social interaction during communicative exchanges facilitated engagement with women on a personal level, and at times allowed midwives to share aspects of themselves in the process. The relationship between the midwife and woman protected the woman’s dignity (Berg, 2005) through ongoing dialogue, trust and shared responsibility. Interactions noticeably focused upon the woman’s needs. When interviewed, women disclosed that staff who expressed genuine interest in them as a person and whom they subsequently established a relationship with, were particularly valuable and stood out in their minds. Key markers of positive experiences of breastfeeding support have been identified as having a midwife or lactation consultant, who could ‘sit through a feed’, who could provide some degree of continuity of care and who had a non-judgemental and affirming communication style (McInnes & Chambers, 2008:418; Schmied, et al., 2011).

The value of ‘embodied knowledge’ (Berg, 2005; Leder, 1984) was also integral to the provision of genuine midwifery care. Midwives at MUA and MUB who communicated in this way trusted their instincts and trusted the woman’s body. They encouraged women to ‘tune in’ to their body and to ‘tune in’ to their infant. They communicated a belief in the normalcy of breastfeeding, conveyed confidence in the woman and offered assistance in whichever form the woman desired. For example, they did not have a fixed view on the merits or not, of providing ‘hands-on’ support but rather were guided by the woman. The lived body was viewed as “…an agent of self expression” and the “…very centre of one’s experience, mood, expressions and projects” (Leder, 1984:36). The midwife-woman relationship therefore demonstrated
both verbal and non-verbal communication, activity and inactivity, embodied and literal intersubjective exchange. As Taylor (2010) articulates, the ‘conversation’ between a breastfeeding woman and her infant is a physically intimate exchange which midwifery support can facilitate rather than interrupt. The primary function of the midwife therefore, during breastfeeding support, is prioritising the “…act of listening” (Taylor, 2010:234). As one of the interviewees in this study stated, it was only through listening that the midwife can ‘know her story’, yet listening was not a feature of the midwifery support she had received (IV 13).

Collaborative conversations between midwives across several countries, recently captured the crucial but often invisible, nature of relationships in midwifery care. The authors have used the metaphor of a tapestry to utmost effect:

... maternity care is a tapestry, in which the weft threads are the visible factors such as the clinical outcomes, technologies, policies and protocols. Relationships are the warp threads that hold it all together, but which are hidden in the final work (Hunter, Berg, Lundgren, Ölafsdóttir, & Kirkham, 2008:136).

The focus in health service delivery is arguably on the ‘weft’ threads which conceptualises midwifery care as primarily about ‘outcomes’, guided by policies and institutional procedures and designed to meet performance measures. This focus however, denies the importance of the ‘warp’ threads, the fibres which maintain the ‘integrity of the whole’ (Hunter, et al., 2008). The relationships between the woman and midwife, the woman and her significant others, and the midwife and the woman’s family are integral to optimal midwifery care around breastfeeding. The other integral component identified in these findings is the importance of keeping the process normal.

7.4.3. The midwife-woman relationship

The medicalisation and potential iatrogenesis of breastfeeding appear to disconnect the woman from her infant and her body, as discussed throughout this chapter. Breastfeeding was problematised, especially at the BFHI accredited hospital, as evidenced by the language, discourses and proliferation of specialist lactation consultant practices. This study has demonstrated the primacy of the relationship between mother and infant in the first week after birth and the need for midwives to relinquish connections to technomedicine in favour of full incorporation of midwifery discourses of partnership and woman-centred care.
The relationship between the midwife and the woman is the foundation upon which midwifery care was built. As Kirkham states, “Where the mother feels safely held by her midwife, this can facilitate the establishment of a positive relationship between the mother and her baby” (Kirkham, 2010:254). This is, after all, the aim of midwifery care during pregnancy and birth. Midwives and lactation consultants in this study have demonstrated that ‘genuine’ relationality can be established, with a woman, even if they have never met before and in one single exchange. Lundgren and Berg’s (2007) central concepts for midwife-woman relationship, derived from a secondary analysis of eight of their own research papers on this area, provides a starting point. Taken from interviews and recorded diaries of 96 participants some of the central concepts identified, resonate with the relational communication observed in this study. In particular, the concepts identified demonstrated the two-way process of the formation and sustaining of a midwife-woman relationship which includes binary groupings such as surrender (by the woman) and availability (of the midwife), participation and mutuality, trust and mediation of trust (Lundgren & Berg, 2007). Central to the midwives’ focus is the importance of keeping the process normal and only intervening when requested or in response to deviations from normal. Within this approach, midwives trust their ‘gut feelings’ or embodied knowledge and most importantly trust the woman and her body. Women are encouraged to fully participate in decision making and to develop, and use, their own bodily skills. In turn, midwives participate by engaging in dialogue, allowing themselves to be present in the moment, seeing the woman as mind and body connected, giving of themselves and equally sharing responsibility. The normality of pregnancy and birth, whilst central to the midwife-woman relationship, seems sadly neglected during the postpartum period.

The silencing of midwifery partnership discourse within the technocratic hospital environment denies the development of alternative breastfeeding ‘body affirming’ discourses. This is despite the proliferation of the ‘keeping birth normal’ (Kennedy & Shannon, 2004; Lavender & Kingdon, 1999) discourse during pregnancy and birth. In an effort to mitigate ‘risk’ and teach competency skills, the technocratic midwife ignores this central component of the midwife-woman relationship – keeping the process normal.
Analysis has revealed the ways in which the hospital environment ‘objectifies’ not only the woman as ‘patient’ but also the midwife as ‘worker’ (Baker, Choi, Henshaw, & Tree, 2005; Dykes, 2006). Hospital institutional control represents a ‘dividing practice’, as articulated by Foucault, where behaviour can be controlled, the setting modified and the practices of individuals monitored and analysed. The subject positions taken up within the institution mitigate against genuine intersubjective communication between two equals working in partnership together.

7.5. Conclusion

The findings from this study clearly demonstrate that hospital-based midwives, working in traditional time-pressured fragmented models of care, adopted a role as breastfeeding ‘expert’ during postnatal interactions around breastfeeding. This role appeared to involve, at a minimum, managing the breastfeeding woman, teaching breastfeeding as a competency, monitoring infant intake, and identifying the need for specialist referral. The midwifery focus on ‘product over process’ and the influence of a Cartesian dualist technocratic view of the body, led to ‘disconnected encounters’ and incorporated ‘reductionist approaches’ (Dykes, 2006; Schmied, et al., 2011) to breastfeeding support.

In this chapter, I have illuminated the various subject positions adopted by midwives and lactation consultants, at both respective institutions. Some practitioners approached interactions with breastfeeding women with the view that breastfeeding was the continuation of a symbiotic relationship established during pregnancy. In this context, midwives and lactation consultants prioritised ‘tuning-in’ to the woman and emphasised the importance of learning to ‘tune-in’ to the infant. However, this representation of a relational approach to breastfeeding support was minimal when compared to the existence of other more powerful discourses impacting on midwives’ and lactation consultant’ language and practices. I argue the technocratic medical discourse, prolific in the hospital environment, has limited midwives’ opportunity to form partnership-based relationships with women. The technocratic midwife’s adherence to institution-specific priorities revealed a midwifery alliance ‘with the institution’ rather than ‘with the woman’ (Dykes, 2006a).

The findings from this study support Dykes’ call for action to reorientate the provision of midwifery support for breastfeeding women to reflect
genuine confidence enhancing engagement. Replacing technomedical practices with midwifery orientated models of care, has the potential to positively influence a woman’s breastfeeding journey and contribute towards keeping the process normal. Whether provided in the hospital or the home, midwifery care for women who are breastfeeding can be genuinely supportive, when partnership orientated ‘woman-centred’ discourse influences the language and practices of midwives.
CHAPTER EIGHT

Conclusion

In this study, I have used discourse analysis to examine the nature and impact of the language and practices used by midwives when interacting with women around breastfeeding in the first week after birth. I have identified a variety of discourses influencing communication styles and practices. These discursive influences can be either encouraging and confidence enhancing, or can impede and complicate the process of establishing breastfeeding. Discourses such as ‘liquid gold’ and ‘it’s not rocket science’ have highlighted the position of power and control that midwives and lactation consultants can occupy during this time. The findings demonstrate how individual midwives can influence a woman’s sense of herself as a mother, and her interpretations of her body and her infant. These findings extend our understanding of effective and ineffective midwifery support for women in several important ways.

Three distinct discourses influenced practice in diverse and opposing ways. Exposing the broader sociocultural and institutional determinants of these three discourses, in Chapters Six and Seven, has provided insight into possible avenues for change.

In the dominant discourse, midwives prioritised breastmilk as ‘liquid gold’. This meant that the language and practices used by these midwives focussed around ensuring the infant ‘patient’ had ample access to this precious nutritious milk. This approach was predominantly influenced by powerful institutional and professional discourses to ‘protect, promote and support’ breastfeeding. The second although far less prevalent discourse, ‘it’s not rocket science’ represented a resistance, by some midwives, to the dominant ‘mining for liquid gold’ approach. Within this discourse, midwives on the one hand afforded women a position of independence and autonomy in relation to infant feeding decision-making, but on the other hand directed their attention towards medical ‘safety’ aspects of care. In this discourse, tasks such as administering medication and taking observations were prioritised and breastfeeding was dismissed as a process which women could engage in unaided. In the third and least common discourse, ‘breastfeeding as a relationship’ midwives
prioritised the relationship formation between mother and infant and normalised breastfeeding challenges. In this approach the midwifery discourses of partnership and woman-centred care overtly influenced practice.

Drawing on an understanding of subjectivity and objectification, I have argued that these three forms of discursive practice have been influenced by four significant historical and contemporary discourses. First, as a result of the discoveries made by lactation science and breastfeeding medicine, a widespread acceptance of breastmilk as ‘liquid gold’ has emerged. This has led to a focus on breastmilk the product, over breastfeeding the process. Within these scientific discourses breastfeeding has been ‘pathologised’ and ‘problematised’. Second, the technomedical treatment of the body as a machine, has led to a mechanistic viewing of breastfeeding as milk production and supply only.

The prioritisation of the hospital as the best environment for initiation of breastfeeding constitutes the third influential factor. Institutional discourse, related to efficiency, safety and the achievement of performance measures, positions the clinician as ‘expert’ and the woman (patient) as ‘novice’, resulting in interactions that prioritise the needs of the institution and not the needs of the woman. This creates a technocratic midwife whose practice is shaped by Cartesian dualist principles and as a result, engages in unwelcomed body contact and authoritative communication with women.

Lastly, contemporary midwifery discourses and alternative models of service provision which emphasise genuine and connected ways of engaging with women were apparent in a small number of interactions observed. The prioritisation of relationship formation was paramount within this style of communication.

In this conclusion, I will summarise the impact of these four dominant discourses on the language and practice of midwives. I will then outline some of the implications for policy, practice, education and research arising from these research findings.

8.1. Prioritising ‘Liquid Gold’

One of the most significant findings from this study has been the prioritising of breastmilk as ‘liquid gold’ by midwives. Communicating reverence for this ‘precious elixir’ began during pregnancy and continued following birth. Midwifery admiration for breastmilk seemed so potent that communication and support deviated from
‘woman-centred’ approaches towards ‘breast-centred’ communication and practice. The midwifery acceptance of the woman’s breasts as ‘equipment’ supplying the ‘product’ breastmilk, led to disconnected mother-midwife relationships.

The cultural ascension of breastmilk to the status of liquid gold has implications for breastfeeding women also. Whilst the gold standard revolution, discussed in Chapter Two, has created much needed social, cultural and professional change, these study findings demonstrate that women have become objectified in the process. The imperative to supply this nutritional ‘gold standard’ has placed pressure on women to perform a bodily activity which some have found unsustainable. The effect of this on the early establishment of breastfeeding in the hospital environment, has meant that women are objectified as breastmilk suppliers. It also means that midwives are correspondingly objectified as workers, employed to optimise the productive capacity of the supplier, placing additional pressure on women to perform to preset clinical standards. As a result, women who cease or introduce supplemental formula often report feelings of guilt and a sense of failure. Alternatively for some, the social construction of colostrum as concentrated ‘liquid gold’, provided a source of comfort that at least their infant had received this precious substance.

Discourses articulating ‘good mother’ behaviour have permeated public rhetoric around infant feeding, in westernised cultures. These discourses have created a social and moral imperative for women to breastfeed their infants, as this behaviour is aligned with ‘good mothering’. Providing the ‘gold standard’ in order to maintain ‘good’ mother status, ultimately fulfils the aims of subjectification, as described by Foucault. Women began to monitor their own performance of breastfeeding in order to maintain alliance with ‘good mothering’ practice. When faced with difficulties, women turned to midwives for assistance and reassurance that what they were doing was ‘right’. However, many of the directive and prescriptive midwifery practices observed in this study, undermined confidence, rather than built confidence and, at times, even created tension between the woman and her infant. Midwifery language and practice reflected a ‘mining for liquid gold’ approach, yet midwives were merely fulfilling the prescriptive global and institutional criteria for breastfeeding support.

Global and national policy initiatives have put breastfeeding on the agenda as a priority for institutions and professional bodies, including the Australian College of Midwives. Breastfeeding initiation and exclusivity at discharge are now being used
by health services as evidence of a breastfeeding friendly hospital environment and are indicators of performance. Yet I would argue that despite antenatal promotion of breastfeeding and the provision of highly trained breastfeeding specialists, professional support is not always facilitative of breastfeeding. In fact, the interactions observed in this study sometimes involved midwives controlling or pressuring women to perform at breastfeeding or at least at breast milk extraction, which only served to alienate the woman from her body and her infant. At times, the woman seemed invisible in the pursuit of breastmilk for her infant. Indeed within global policy, women appear to have been positioned as simply the suppliers of nutrients, in need of protection if supplies are to be maintained. Global policy makers have not heeded feminist calls (Van Esterik, 1994) for representation from non-government breastfeeding representatives in the discussion and planning of global breastfeeding support strategies.

What has evolved instead, from lactation science, and breastfeeding medicine, is a focus on the supply of breastmilk rather than a prioritising of ‘at the breast’ feeding. The BFHI takes up this nutritional focus by similarly emphasising the importance of breastmilk feeding, by any means possible. The ‘protection’ of breastfeeding, articulated by BFHI, and global policy, translates in midwifery practice into the ‘protection’ of milk supply and the subordination of the ‘supplier’. If breastmilk supply is compromised, either by the faulty ‘equipment’ or the inexperienced ‘extractor’, then expert midwives step in to rectify the situation. Regrettably, the research findings presented in this thesis demonstrate how infants may be the ‘scapegoat’ at times, in the search for reasons for breastfeeding difficulties. I argue these difficulties can be traced back to spatial and discursive determinants which complicate and problematise breastfeeding. For example, the technomedical hospital environment employs highly specialised ‘expert’ practitioners to intervene and ‘fix’ impediments to breastfeeding. Communication exchanges between the ‘protected’ woman: the human ‘container’ for precious liquid gold and the midwife employed to manage her, become estranged in this setting.

The mechanisation of breastfeeding in the technomedical environment has led to the introduction of additional equipment, such as the electric breast pump, to enhance performance. The emergence of the breast pump as the ‘door to freedom’ (Morse & Bottorff, 1989) for women confirms Hausman’s (2003) argument that women are
continually forced to fit breastfeeding into contemporary constraints. For example, the provision of a space for breast expression in the workplace, negates the need for flexibility to enable ongoing ‘at the breast’ feeding. Women are thereby restricted to expressing and storing their product, rather than being facilitated to enjoy a return to the workforce, whilst maintaining a connected, embodied relationship with their infant (Hausman, 2003). The lack of feminist attention to breastfeeding, as a maternal practice, has been blamed for the proliferation of biomedical (Hausman, 2003), or, as this study has identified, ‘liquid gold’ discourses which direct attention away from the woman, and towards the ‘body as machine’.

8.2. The ‘Body as Machine’

Many of the midwifery practices observed, throughout this study, have confirmed the integration of a ‘body as object’ belief about breastfeeding. Simple examples, such as the widespread tendency by midwives to lean in and feel for fullness in the breast, without the perceived need to seek permission, reinforced a perception of the breasts as disconnected ‘equipment’. Hand expression of small amounts of colostrum, initiated by midwives without permission, provided the infant with a ‘taste’ of what the ‘equipment’ had to offer. Predictions about the timing of mature milk arrival ‘the magic 72 hours’, confirmed mechanistic perceptions of temporality. If breastmilk did not arrive as scheduled, the construction of an ‘inadequate milk syndrome’ (Dykes, 2002) began. The specialist midwife, became the qualified ‘mechanic’ or ‘technician’ employed to manage the ‘equipment’, by introducing stimulation measures to speed the process up.

These findings confirm Dykes (2005b:85 & 95) argument that women’s early experience of breastfeeding, in hospital settings, can lead to a conceptualisation of the body as separate, a ‘vessel’ or a ‘faulty machine’ engaged in a ‘production process’. This conceptualisation directly correlates with the midwifery language and practices emerging from the ‘liquid gold’ discourse reported in these findings. In her monograph Breastfeeding in Hospital Dykes (2006) questions the suitability of the hospital as the most appropriate place for women to establish breastfeeding. The findings from this study support Dykes (2006), call to encourage a return to one’s own community following birth, away from the ‘mechanistic’ hospital environment.
Recent feminist interest in the breastfeeding body, such as Alison Bartlett’s *Rethinking Breastfeeding*, have emphasised the importance of integrating embodied understanding into conceptualisations of breastfeeding. The link between bodily responses, and lived experiences are widely ignored by biomedicine, due to interpretations of the body according to Cartesian principles. Yet, as Bartlett argues, if breastfeeding was really about learning how to operate the ‘hired’ breastfeeding equipment, then the current abundance of professionals who teach such skills, would result in sustained breastfeeding (Bartlett, 2005). Clearly, breastfeeding is much more than a learned skill.

The findings reported in this thesis highlight the lack of integration of the mind and body into midwifery conceptualisations of breastfeeding. This is despite the fact that breastfeeding activity is at the interface between the internal mind and body experience, and the external cultural, historical and social experience (Bartlett, 2005). Yet much of the language and practice used by midwives continues to separate the mind and body and fails to tap into a woman’s own embodied knowledge and expertise, or her social and cultural circumstances. The spatial location of breastfeeding within the biomedical hospital environment appears to negatively impact on breastfeeding and inhibit relationality.

### 8.3. The Technomedical Setting

Midwives in this study were surrounded by discourses, which variously influenced breastfeeding support provision. The prioritisation of the technomedical model (dominant in institutional health care settings generally) influenced the technocratic style of midwifery practice observed. Expert midwives engaged with women in disconnected ways. Within the ‘not rocket science’ and ‘mining for liquid gold’ approaches, midwives adopted this expert stance and utilised authoritative communication styles to affect compliance. As identified by Dykes, adherence to institution-specific priorities revealed a midwifery alliance ‘with the institution’ rather than ‘with the woman’ (Dykes, 2006a). I would argue, as has Dykes (2006), that midwives steadfastly adhered to institution specific priorities and conceptualised breastfeeding according to linear time.

The objectification of the woman at both the participating hospitals, positioned her as a passive, malleable function of the organisation that midwives were employed to
manage. Acceptance of this passive position ensured women maintained their ‘good’ mother identity, whilst obediently deferring to the health professional for advice and guidance. In this environment, however, the woman was ‘under the microscope’ twenty-four hours per day. Her competency with breastfeeding was repeatedly assessed, as well as her interactions with her newborn. Chastised at times for having too many visitors, or for passing the infant around, she was also advised to restrict cuddling her infant too much in case it inhibited the demand for breastmilk. The hospital represented a spatial locality where there were ample opportunities to reinforce the woman’s position as subordinate ‘novice’.

Discourses attributable to BFHI featured prominently at both sites, such as the importance of skin-to-skin contact, demand feeding and rooming-in. Yet at the BFHI accredited hospital the combination of BFHI discourses, and associated practices, introduced a new level of intensity into breastfeeding interactions. Understandably, hospitals wishing to maintain their BFHI accreditation status have a vested interest in ensuring as many women as possible commence breastfeeding. However, in this context ongoing commitment to breastfeeding became an institutional and professional priority, rather than an individual concern. Institutional prioritising of exclusive ‘breastmilk feeding’, was reflected in midwifery practices which directed a woman’s decision making, and bodily performance. This again emphasised the midwife as ‘expert’, employed to manage and control the ‘novice’ breastfeeding woman.

Despite the focus on woman-centred care in midwifery discourse this was suppressed at both institutional settings. In its place the science of lactation and practices emerging from technomedicine dominated. For example, the health professional ‘knack’ of hand expression of the woman’s breast, getting the baby fed first, then showing the woman how to hand express herself, actually contradicts the principles of self determination, holistic care and building connection, which are reputedly integral to midwifery care. In fact, many of the practices prescribed by BFHI accreditation seemed to be incompatible with midwifery principles, such as ‘teaching all women’ rather than working in partnership with women. In this context, it is easy to see how breastfeeding became a competency upon which women were assessed, prior to discharge.
High staff to woman ratios and the hospital ‘churn’ of admissions and discharges hampered opportunities for connected midwife-woman relationships. Instead, midwives who genuinely connected with women in one single interaction had more flexible time arrangements than the majority. For example, midwives working in the caseload model of midwifery care had the capacity to provide flexibility around support provision. However, these study findings have highlighted that even within the technomedical hospital environment midwives were able to engage with women in a facilitative way when the mother and infant were conceptualised as one unit and breastfeeding prioritised as a relationship.

8.4. The Prioritisation of Relationship

Only eight of the interactions observed in this study reflected the prioritisation of the mother-infant relationship. Alternative models of care, which offered flexibility around allocation of time, seemed to enable this style of interacting with women. The communication style adopted by midwives who prioritised relationship included respectful listening, open-ended questions and the provision of options and suggestions. This type of facilitative communication reflects the principles of woman-centred care and is reflective of what Schmied and colleagues (2011) have termed an ‘authentic presence’. It was holistic, the woman was seen in the context of her life, her right to self-determination was respected, her infant’s needs were integral, and continuity of provider was important. Noticeably, difficulties with breastfeeding and infant behaviour were normalised within this support style rather than problematised. This is consistent with a philosophy of midwifery which recognises that pregnancy and childbirth are normal bodily processes for women, which can sometimes be complicated by pathology (Pairman & McAra-Couper, 2006).

Yet not all midwives in the alternative models of care, communicated with women in a facilitative way. For example, skin-to-skin contact, while prioritised by a majority of midwives for relationship formation at birth, became a tool for attachment, in the postnatal period. Assumptions around midwifery ‘right of access’ to the breasts, for infant nutrition purposes, led to both language and practices which interrupted mother-infant synchronicity. Negative descriptors of infant behaviour also disrupted the breastfeeding relationship, as the woman and infant were constructed as being in opposition to each other. Quotes from women at follow-up interview indicated the
long-term ramifications from this language. I would argue that midwives who viewed breastfeeding as an inherently complicated activity, requiring management and control, had integrated technomedical discourse into practice.

Individual women, who described the benefits of connecting with midwives in a relational way, described the importance of being seen as a unit, not as two individual people. I argue, on the basis of these study findings, that recognition of mother-infant connectivity is a significant aspect of postnatal support which is currently lacking in standard service provision models.

Prioritisation of the mother-infant dyad as one complete unit instead of two separate entities at an institutional level, might lead to improvements in midwifery language and practices. In addition, institutional recognition of the importance of relationship formation between woman and midwife may help to facilitate ‘woman centred care’ philosophy in these settings. Honouring the principles of continuity of care provider, and ensuring women can establish breastfeeding in a location of their choosing, may do much to ‘keep the process normal’. Further I argue that reframing breastfeeding as an extension of the symbiotic relationship formed during pregnancy, might have a similarly transformative effect on midwifery language and practices.

8.5. Keeping Breastfeeding Normal

In Chapter One, I outlined the philosophical underpinnings of midwifery practice in Australia. The midwifery profession has an international focus on keeping pregnancy and birth normal. However, the findings from this study indicate that paradoxically, during the postnatal period, there was a lack of commitment to keeping breastfeeding normal. This is an important finding with significant implications for midwifery practice and the education of midwives. In summing up the implications for practice from this study, I have focussed on four key areas: policy, practice, education and research.

8.5.1. Policy related to breastfeeding

The BFHI represents a set of global ‘best practice’ principles which aim to improve the culture and practices in hospital environments to ‘protect, promote and support’ breastfeeding. The BFHI is an important initiative, responsible for much needed change in health services and is arguably the most influential policy to impact upon midwifery practice, in the postnatal period, in recent history. The elevation of
breastfeeding to the status of a public health priority has ensured health administrators incorporate breastfeeding policy into service monitoring and planning. However, whilst the ‘ten steps’ were intended to be a set of guidelines for creating breastfeeding friendly environments, they appear to have become, in some settings, a prescription for what all women need or must have. Arbitrary numbers or percentages are attached to individual standards within the accreditation process in order to assess and confirm compliance with the global standard. Of note, indicators of maternal enjoyment or satisfaction seemed to be lacking, or are deemed irrelevant, in the accreditation process.

The findings from this study highlight that the implementation of the ‘ten steps’ template into practice has been aligned with performance measures which dictate midwifery practice. Requirements to comply with these measures seem to have led to many of the highly technical and rigid practices observed.

Breastfeeding seemed to be reduced to mere nutrient transfer and acquisition of ‘liquid gold’. These study findings signal the need to consider carefully the way in which the BFHI is implemented at the local level, and to review the accreditation performance measures. It is time to emphasise, on the basis of these findings, that the BFHI ‘ten steps’ are a set of practice guidelines which can be adapted to local circumstances, rather than a prescriptive template for ‘breastfeeding success’. There are, for example, a number of studies indicating improvements in breastfeeding initiation and duration when less than the full ten steps are implemented (Cattaneo & Buzzetti, 2001; DiGirolamo, Grummer-Strawn, & Fein, 2001; DiGirolamo, Grummer-Strawn, & Fein, 2008).

The current provision of postnatal care within fragmented hospital-based models also needs to be addressed at National and State policy levels. These findings highlight the value of the midwife-woman relationship, not just in facilitating optimal pregnancy and birth outcomes (Hatem, Sandall, Devane, Soltani, et al. 2008), but also in the period after birth during early mothering and the establishment of breastfeeding. The endorsement of midwifery models of care at a policy level, is necessary to generate a move away from the current trend to ‘problematicise’ breastfeeding, towards a more normalising approach. The midwifery role of supporter, rather than director, manager, teacher or technician can be realised, when
women are facilitated to remain with, or return quickly to, their own family and community, whilst receiving care from a known midwife.

Access to midwifery continuity of carer in NSW is set to increase as part of a recent State health department policy, entitled *Towards Normal Birth*. This NSW state maternity services policy has set a target for continuity of carer models at 35% for all women by 2015 (NSW Health, 2010). Recent changes to midwifery care provision at a National level, such as the provision of Medicare provider numbers to eligible midwives, indicates that access to a range of options for midwifery care may become increasingly available for women. It is anticipated therefore that the opportunity to develop a relationship with a midwife, or with a small group of midwives, will lead to improved outcomes and satisfaction for women.

### 8.5.2. Midwifery and lactation consultant practice

It is time for midwives and lactation consultants, who support women during the early establishment of breastfeeding, to take some responsibility for the dissatisfaction women describe. These study findings highlight the need for significant improvements in the practices adopted by a majority, in order to achieve genuine partnership approaches to midwifery care. The technocratic practices observed included: language which objectified the woman as ‘supplier’ of breastmilk, the breasts as ‘equipment’, and the infant as an ‘inefficient’ extractor. Yet midwives who spent time building a relationship with the woman were observed adopting communication styles that facilitated the mother-infant relationship and breastfeeding. These included: the use of open ended questions, listening to the woman, taking an interest in the woman’s previous experiences, offering suggestions rather than advice, eliciting the woman’s preferences for support (such as hands-off or on) and fostering the woman’s capacity to tune in to her infant. Yet many of these facilitative components of support were lacking in the standard hospital-based models of care. Reorientating postnatal care to achieve more flexible time arrangements, combined with relationship building, may be the first step towards maternal satisfaction with support and communication around breastfeeding.

**Giving women time in midwifery models of care**

Midwives and women identified ‘time’ as a crucial factor for building confidence with breastfeeding. Midwives working in standard hospital-based postnatal care
reported that they lacked the time to provide individualised assistance, guidance and emotional support to women. Observation of practice confirmed that a lack of time inhibited opportunities for facilitative support. In addition, the lack continuity of carer in the first five to six days hampered relationship formation. The analysis of interactions revealed that staff who spent time developing a supportive relationship with a breastfeeding women also kept the process normal. New models of care, that increase the provision of postnatal midwifery care in the home and community, facilitated better allocation of time according to need and greater opportunity for continuity. These findings support the move towards models of care which allow for more flexibility in organising time to individualise support for women who are establishing breastfeeding.

**Prioritising the relationship between mother and infant**

Whilst the ability to spend time with the woman was one component of facilitative support, not all midwives who had autonomous control over ‘time allocation’ engaged with women in a facilitative way. A crucial aspect of the facilitative support style was the prioritisation of the breastfeeding relationship. When the relationship between the mother and infant was prioritised, supportive language and practices followed. Within this approach, women were encouraged to ‘tune in’ to their infant and skin-to-skin contact was encouraged, but not forced. Midwives normalised infant behaviour, and reframed negative maternal conceptualisations, thus enhancing mother-infant synchronicity. Mother and infant were viewed as one unit and the woman’s embodied knowledge was respected. Tuning-in behaviours were reflected in the language adopted by midwives, as they simultaneously communicated confidence in the woman’s ability to breastfeed. Suggestions and options for breastfeeding challenges were offered, and the woman’s right to self-determination respected.

This analysis of midwifery practice suggests that midwives may be completely unaware of the crucial role they have in enhancing mother-infant synchronicity during this transitional period of life. For example, restricting parental intimacy with their infant for the purposes of increasing the demand for breastfeeding, effectively interfered with mother-infant synchronicity. In addition, the language used by midwives to describe unwanted infant ‘performance’ often resulted in negative ‘labelling’ of normal newborn behaviour. The widespread construction of infants as
‘thinking’ and ‘deciding’ whether to ‘cooperate’ or not, further exacerbated negative
depictions of the infant. The introduction of these language and practices by ‘expert’
clinicians often negatively influenced the woman’s own assessment of her newborn.
Yet midwives had the capacity to positively influence a woman’s assessment of her
infant, as was demonstrated in the relational approaches to breastfeeding support.

Respect for the woman’s role in the care of her infant should become standard
midwifery practice. The midwifery models of care, discussed above, which enable
authentic midwifery care, provided in partnership with women, might begin to
generate improvements in this component of communication around breastfeeding.

**Rethinking the role of the lactation consultant**

These findings also suggest it is time to reconsider the role of the lactation consultant
in post birth care. Women struggling to adjust to their new breastfeeding
corporeality, were often referred to specialist clinicians rather than offered ongoing
midwifery support. Time constraints appeared to result in this type of ‘passing the
buck’ practice. An assessment of breastfeeding performance by a technocratic
lactation specialist, seemed to lead to a diagnosis of the problem and a prescriptive
solution. Yet additional time with a midwife who adopted an affirming approach,
who listened and enhanced confidence through excellent communication, may have
been all that was required.

These study findings indicate that access to a highly specialised lactation consultant,
during the early establishment of breastfeeding, does not always facilitate ongoing
breastfeeding. Significantly, the absence of a ‘relationship discourse’ led to a ‘breast
centred’ focus on ‘product’ over ‘process’. The focus on breastmilk ‘the product’
was highlighted 20 years ago by lactation consultant Kathleen Auerbach (Auerbach,
1991) who suggested that the medical model favoured this focus because it is easier
to manage, and I would argue easier to control, than the more dynamic breastfeeding
relationship. In this study the majority of lactation consultants were observed
immediately ‘getting down to the business’ of breastmilk feeding without a period of
social interaction to ‘get to know’ the woman. Breastfeeding was ‘problematised’ in
this paradigm, and prescriptive expression plans and ‘hands on’ assistance became
the ‘tools of the trade’.
However, lactation consultants who did prioritise relationship practiced in a different way. Women described the benefits of this relational style of communicating especially when they were struggling to maintain a breastfeeding relationship with their infant in the neonatal intensive care unit. Lactation consultant support for women with a sick infant, or with a structural impediment restricting breastfeeding, was clearly vital and necessary. These study findings support the need for specialist lactation consultants to be available to support women with breastfeeding difficulties which deviate from the norm. On the basis of these findings however, I would suggest that casting the net beyond these ‘medical’ indications for specialist referral, risks the iatrogenesis described in this thesis.

8.5.3. The education of midwives and lactation consultants

The components of language and practices which reflect an ‘authentic’ presence during breastfeeding interactions have been speculated previously (Schmied, et al., 2011). The findings from this study provide an analysis of the actual facilitative and inhibitive components of professional support. Midwives who seek to provide ‘authentic’ midwifery care require a high level of communication skills and sufficient time to spend with women. Yet many of the interactions observed lacked even the basic principles of open communication. The WHO Infant and Young Child Feeding group have identified several essential principles for communication, which they recommend be used when engaging with women who are breastfeeding (WHO, 2009). These include listening and learning by asking open-ended questions, using non judging words, showing interest, demonstrating empathy and using non verbal communication. Building confidence incorporates accepting the woman’s view, providing positive reinforcement, offering practical help when necessary, making suggestions and using language devoid of professional jargon (WHO, 2009:38).

These components of effective communication should be incorporated into midwifery education, including when preparing for BFHI implementation. The inclusion of a component of critical self-reflection in education sessions for midwives, is also recommended to enable the exploration of the appropriate use of ‘self’ in interpersonal exchanges with women.

Important questions have been raised in this analysis regarding the current teaching of undergraduate midwives and graduate nurses. Curriculum review is necessary to highlight some of the gaps in the current teaching of breastfeeding support for
women. For example, the following questions could be asked of midwifery curricula: is breastfeeding presented in course content as merely a physical process, including anatomy and physiology, mechanics of the process and promotion of the micronutrient properties of the product? Or, are women’s embodied experiences of breastfeeding discussed with undergraduate midwives? and Is there critique of feminist and sociological knowledge integrated into course content? These study findings invite a review of these components of midwifery education.

This study also suggests the need for improvements in lactation consultant education. The influence of lactation science and the discoveries from breastfeeding medicine appear to have overshadowed the sociocultural and emotional aspects of breastfeeding for women. The findings from this study suggest that incorporation of a relationship discourse into lactation consultant education, as well as a ‘keeping breastfeeding normal’ discourse, might shift the lactation consultant focus away from the breast ‘product’ towards the interconnected mother-infant dyad.

Development of an educational package for midwives and lactation consultants, using the findings from this study, would ensure this research translates into practice-based improvements. The recorded and transcribed interactional data, represent a rich resource for the teaching of midwives. The de-identified ‘scripts’ from these midwife-woman exchanges could be adapted as ‘role-play’ exemplars. The use of these exemplars could supplement course content in this area. Interactive role-play scenarios provide the opportunity for midwives to gain insight into the nature and the impact of inhibitive and facilitative communication styles.

8.5.4. Midwifery research and dissemination of findings

As detailed above, this study into language and practice has important implication for health care policy, midwifery practice and education. Converting this research into effective change involves sharing the findings at professional fora. Aspects of this research have been presented at state, national and international conferences, and this will continue. In addition, these findings have also highlighted several areas for future research.

To date there has been very little recognition of the challenges faced by governments and service providers in the dissemination and implementation of a global strategy, such as the BFHI. Implementation of this strategy requires organisational change and
a shift in professional practice to align with strategic goals. One of the important things to ask from these findings is whether the way in which BFHI has been integrated into institutional culture influences the rigid and technical focus on the breastmilk ‘product’ observed in this study. Most midwives were undeniably ‘breast-centred’ during interactions with women around breastfeeding, reflecting the suppression of midwifery ‘woman-centred’ discourse. Further research, into the implementation of BFHI at a variety of institutional settings, might illuminate implementation strategies which facilitate the amalgamation of BFHI principles and midwifery concepts. In addition, further research into the effect of individual steps on midwifery practice might lead to improvements in BFHI implementation. Certain steps were genuinely facilitative of breastfeeding support and yet the rigid interpretation of others appeared to inhibit support.

In addition, the prolific use of breast pumps for ‘breast milk’ feeding was especially apparent within the BFHI accredited hospital. This seems to be an emerging social trend also as women seek to ‘fit’ breastfeeding ‘in’ to existing social constraints. Geraghty and Rasmussen (2010) suggest ‘breastmilk feeding’ behaviours may have implications for the health and wellbeing of mothers, which we are as yet unaware of (Geraghty & Rasmussen, 2010:135). This is an area currently lacking in research enquiry.

The influence of continuity of carer models on the duration of breastfeeding requires further investigation. Changes to midwifery models as a result of recent NSW state policy may provide an opportunity for further investigation. It is anticipated that developing a relationship with a midwife, or with a small group of midwives, will improve opportunities for both women and midwives to reap the benefits of relational communication. The systematic review by Hatem et al. (2008) indicates that improvements in breastfeeding initiation can be gained from midwife-led models of care, such as the continuity models described at both MUA and MUB. Due to the lack of data on breastfeeding duration however, the authors were unable to comment on the influence of these models on breastfeeding duration (Hatem, et al., 2008). This is a current gap in the literature and an area where further research could lead to practice-based improvements for the benefit of breastfeeding women. A larger study into the language and practice of midwives working in continuity of carer models may also illuminate additional areas for improvement. Overall more research is
needed into the practice implications for women who receive postnatal care in genuine community based midwifery partnership models of care.

8.6. Looking Forward

This research has provided an insight into midwifery communication at two maternity units in NSW. In Chapter Three, I discussed Foucault’s three modes of objectification: dividing practices, scientific classification and subjectification. These three modes highlight the influence of institutional and disciplinary discourses on the creation of ‘subjects’ and ‘subject identities’. The positions taken up by women and midwives, during the postnatal period, can be understood in the context of the ‘disciplines of power’ currently ‘objectifying’ individuals. These objectifying strategies created certain conditions for subjectivity, within the maternity health care system.

Critical discourse analysis has enabled the identification of the powerful discourses influencing midwifery practice. Insights gained from this analysis have revealed the subjectification inherent in the novice-expert positions taken up by participants. The implications for practice and suggested changes outlined above will begin the process of creating new forms of subjectivity and shift the focus of breastfeeding exchanges away from what the midwife can do for the woman and towards respect for what the woman can do for herself.

We know that alternative models of midwifery care can, and do, influence the provision of support which could be deemed ‘authentic’ or ‘genuine’ (Berg, 2005; Hatem, et al., 2008; Schmied, et al., 2011). The need for major reform of standard postnatal hospital midwifery support is obvious. This research adds to a body of knowledge calling for reform in the provision of postnatal care. The time has come to act, in partnership with women, for improvements in the support provided by midwives as women establish their breastfeeding relationship.
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APPENDICES
Appendix 1


A meta-ethnographic synthesis of women's experience of breastfeeding.

A meta-ethnographic synthesis of women’s experience of breastfeeding

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Abstract

Despite considerable evidence and effort, breastfeeding duration rates in resource-rich countries such as Australia remain below World Health Organization recommendations. The literature on the experience of breastfeeding indicates that women construct and experience breastfeeding differently depending upon their own personal circumstances and the culture within which they live. Breastfeeding has also been described as a deeply personal experience, which can be associated with ‘moral’ decision-making. The aim of this synthesis was to better understand the social phenomenon of breastfeeding by making the hidden obvious. Using a meta-ethnographic approach, we analysed the findings from 17 qualitative studies exploring women’s experience of breastfeeding. Commonly used metaphors, ideas and phrases across the national and international qualitative studies were identified. Two overarching themes emerged. Breastfeeding was described in terms of ‘expectation’ and ‘reality’, while the emotional aspects of breastfeeding were expressed in ‘connected’ or ‘disconnected’ terms. The prevalence of health professionals and public health discourses in the language women use to describe their experience, and the subsequent impact of this on maternal confidence and self-assessment of breastfeeding are discussed. This synthesis provides insight into some of the subtle ways health professionals can build maternal confidence and improve the experience of early mothering.

Keywords: breastfeeding, experiences, expectations, discourses, meta-ethnography, synthesis.

Introduction

Breastfeeding is recognized as the healthiest form of infant feeding providing significant benefits for both mothers and infants [World Health Organization (WHO) & United Nations Children’s Fund (UNICEF) 2003]. New mothers are encouraged to exclusively breastfeed their baby for the first 6 months of life and to continue to breastfeed until their infant is at least 2 years of age (National Health and Medical Research Council 2003; WHO & UNICEF 2003). Data from the Longitudinal Study of Australian Children recently revealed that while initiation rates in Australia are high, breastfeeding rates fall well below the WHO recommendations. Within a national cohort of 5000 children, only 14% of infants were exclusively breastfed at 6 months of age and approximately half were still receiving some breast milk at this age. A steady decline in breastfeeding was evident until at 12 months and 2 years, only 28% and 5% of infants, respectively, were receiving any breast milk (Australian Institute of Family Studies 2008,
Theses figures are consistent with previously documented national breastfeeding rates (Australian Bureau of Statistics 2003). International figures reveal that in other Western societies such as the United States of America (USA), Canada and the United Kingdom (UK), breastfeeding rates are similarly below the WHO recommendations (Clements et al. 1997; Callen & Pinelli 2004; Li et al. 2005; Bartington et al. 2006; Fein et al. 2008).

The variations in breastfeeding rates (Griffiths et al. 2005; Bartington et al. 2006; Kelly et al. 2006; Hawkins et al. 2008) attest to the fact that breastfeeding is more than the simple transfer of nutrients from mother to child; it is, we argue, a socially constructed practice (Blum 1993, p. 296; Hausman 2003). This assumption is supported by the extensive literature on breastfeeding that suggests it is a deeply personal experience embedded within a woman’s specific social and cultural circumstances (Maclean 1990; Schmied & Lupton 2001; Bartlett 2002; Nelson 2006; Marshall et al. 2007; Spencer 2007; Crossley 2009). Decision-making about infant feeding is thus a complex multifactorial process (Sheehan 2006) that is influenced by such things as family and social circumstances, the health of the baby and other dependants, return to work plans, the woman’s own health needs, her previous experiences and the culture in which she lives (Papinczak & Turner 2000; Kirkland & Fein 2003; Gatrell 2007; Miller 2007; O’Brien et al. 2009).

It is also well recognized that the early postnatal period, in which the first breastfeeding experience occurs, represents a time of ‘redefining’ the self. Maternal self-esteem and confidence can be especially vulnerable during this time (Mercer 1995; McVeigh & Smith 2000; Larsen et al. 2008). It is not surprising therefore, that how a woman experiences breastfeeding, at this time, has been found to impact upon her developing sense of herself as a mother (Maclean 1990; Hartrick 1997; Schmied & Lupton 2001; Sheehan 2006; Marshall et al. 2007). Nelson (2006) reports on this in her synthesis of 15 qualitative research papers on maternal breastfeeding experience. The synthesis yielded the universal translation of breastfeeding as an ‘engrossing personal journey’, and four underlying themes outlined the phases of the ‘journey’. Nelson concluded that improvements in clinician ‘sensitivity’ toward ‘the meaning and significance of breastfeeding to maternal self-esteem’ are necessary (2006, p. 19). This is particularly important in the context of recent qualitative synthesis findings which demonstrate that health-care services are currently ‘failing the new mother’ (McInnes & Chambers 2008, p. 423). Mc Innes & Chambers synthesized 47 qualitative research papers to ascertain maternal and health professional perceptions of breastfeeding support. The findings suggested a maternal preference for social or volunteer support networks and highlighted the need for ‘emotional’ support alongside ‘practical’ and ‘informational’ (McInnes & Chambers 2008, p. 422). In addition Britton et al. (2007) conducted a systematic review of 34 controlled trials to measure the effect of support interventions on the duration of breastfeeding. A combination of peer and professional support were identified as important factors in the maintenance of exclusive breastfeeding especially within the first 3 months (Britton et al. 2007).

Despite the extensive literature on breastfeeding and ongoing improvements in breastfeeding support, very few resource-rich countries have breastfeeding...
rates that meet WHO recommendations. In order for health professionals to contribute to improve breastfeeding longevity, and to ultimately meet national and international targets for maternal and infant health, further research into the barriers are necessary. This does not mean, however, that qualitative researchers have to continually ‘re-invent the wheel’ by finding new and different ways to research breastfeeding experience (Sandelowski et al. 1997, p. 366). As demonstrated above, undertaking meta-synthesis facilitates the gathering of new insights, through comparing and contrasting existing research findings, and has become a well-established practice in health-care research (Britten et al. 2002; Campbell et al. 2003; Pound et al. 2005; Nelson 2006; Downe 2008; Larsen et al. 2008). This approach ensures that individual research studies are not rendered ‘little islands of knowledge’ but rather, in combination, are contributing to the expansion of knowledge about the given area of interest (Sandelowski et al. 1997, p. 367).

The purpose of this meta-ethnographic synthesis was to conduct an interpretive enquiry into the descriptive phrases and metaphors used by women when explaining the experience of breastfeeding. By focusing on the language and discourses women used to describe their experience, the synthesis aimed to make explicit the events and interactions which shape breastfeeding experience, and to highlight ways for health professionals to better engage with breastfeeding women. Nelson (2006) presented her meta-synthesis findings using quotes from the women in the original studies. We became intrigued as to whether women use similar descriptive language across the national and international studies which focus on the experience of breastfeeding. While Nelson (2006, p. 15) translated the synthesis findings into ‘the embodied reality’, ‘becoming a breastfeeding mother’, ‘a need for support’ and ‘the journey must end’, we wondered if women’s own descriptive language might reveal more of the diversity of the experience for mothers. In particular, we were interested in building upon the implications for clinical practice, identified by Nelson (2006, p. 19) by examining in greater depth, the subjective experience of breastfeeding. It was hoped the focus on the language used to describe experience might offer greater insight into individual and group beliefs and practices, (Fairclough 1992, p. 63; Weedon 1997, p. 21) and highlight the dominant discourses impacting on breastfeeding mothers. We have used a Foucauldian understanding of discourses as ways of articulating and developing knowledge about a given topic which can be influenced by power and control (Foucault 1972, p. 22, 216). Women are exposed to various discourses about breastfeeding and infant feeding in general, and issues of power and control are often central to this endeavour. Some discourses seek to control behaviour and can be deemed important, or not, based on an assessment of the source (Foucault 1972; Fairclough 1992; Parker 1992; Lupton & Barclay 1997). In this way, professional discourses may be deemed more powerful than social discourses however, each influence the woman’s decision-making and actions in subtle ways. Subjective understandings and internalization of these various discourses and their powerful effects, will be revealed in the language used by women to describe their experiences. The study of language as discourse has gained increasing popularity in health research in recent times as language is understood to reflect, and simultaneously construct, our experience of the world (Weedon 1997). In this synthesis, we have used an analysis of language to gain insight into what motivates action, what restricts action and what influences thinking (Weedon 1997, p. 40).

**Method**

The synthesis presented in this paper replicated the approach to meta-ethnography advocated by Noblit & Hare (1988). These authors argue that meta-ethnographic enquiry is driven by the desire to develop interpretive explanations and understanding from multiple cases of a given study phenomenon by utilizing research which is ‘grounded’ in the experiences of participants (Noblit & Hare 1988, p. 12). Critically examining the literature by systematically undertaking cross-case comparison can facilitate new insights and has the potential to make the ‘hidden’ obvious (Noblit & Hare 1988, pp. 13, 17–18).

Noblit & Hare (1988, pp. 26–29) outlined seven phases of meta-ethnographic synthesis. These seven phases provided the framework for the synthesis pre-
sented in this paper. Phase one involved identifying the area of interest and formulating the synthesis question (Downe 2008, p. 5); ‘How do women describe breastfeeding and their experience of it?’

Phase two involved determining which research studies should be included in the synthesis. The literature search was conducted in May 2008 using the CINAHL, MEDLINE and PsycINFO databases with the key words: ‘breast feed’, ‘experience’ and ‘qualitative’. In addition, some key frequently cited qualitative research studies, which included women’s narratives on breastfeeding, were also obtained using the SCOPUS database. In total, the search yielded 236 possible research papers. The inclusion criteria were set at: peer-reviewed journal articles reporting research using qualitative methodology, published in English, reflecting participant’s experience of breastfeeding and presented with extensive quotes from women throughout the text. The quality criteria applied to the research papers was consistent with the summary score advocated by Downe et al. (2007). The included studies scored a ‘C’ or above which reflected an acceptable level of credibility, transferability, dependability and confirmability (Downe et al. 2007, p. 132) Saturation was apparent after 17 qualitative papers had been synthesized. Sixteen of the included studies utilized interviews or focus groups as the data collection method. One study reported the open-ended responses to a questionnaire and was included as it provided rich descriptive data for synthesis. A summary of the 17 research papers can be found in Table 1.

Phases three to six outlined the analysis process (Noblit & Hare 1988, p. 28). A period of reading and re-reading the papers commenced the process. The themes from each individual paper were identified, and quotes from women were grouped within each relevant theme. Initial gathering of ideas and concepts occurred across the texts and the relationships between the studies were identified. A process of unravelling the studies to determine similarities and differences was then commenced. This fifth phase involved identifying ‘key metaphors, phrases, ideas, and/or concepts’ which were similar across the studies (Noblit & Hare 1988, p. 28). Noblit and Hare described these as ‘reciprocal translations’. These translations represented more than simply a summary of all the similarities between the studies. Instead, as Noblit and Hare advocate, by finding the relationships between the translations we were able to uncover the links and in the process gain a deeper understanding of the phenomenon being reviewed. Noblit & Hare termed this process, of building inference, the ‘Line of Argument Synthesis’ (Noblit & Hare 1988, pp. 62–4; Thorne et al. 2004, p. 1349). Our ‘line of argument’ therefore, represented an interpretive reading of the identified translations. Phase seven, writing up and presentation of the findings, allowed for further clarification and consolidation of the synthesis.

In their original work, Noblit & Hare (1988) advocated the synthesis of researcher interpretations or what Schutz (see Schutz & Natanson 1990) termed ‘second order’ interpretations. This was said to yield, what Britten et al. (2002, p. 213) have named, ‘third order interpretations’ which represent the integrated interpretive findings of the synthesizer. In some cases, however, researchers using this method have found that the derived themes were too abstract to allow for comparison between studies. In these circumstances, using ‘first order constructs’ or the direct participant quotes/data for comparison, albeit within the context of the original researcher interpretations, was necessary (Pound et al. 2005; Atkins et al. 2008, pp. 11, 23; Garside et al. 2008). Researchers argue that this approach is appropriate when the expression of second order constructs is largely descriptive rather than interpretive which can limit the translations during synthesis (Walsh & Downe 2005; Garside et al. 2008). In addition, there is an expectation that interpretive synthesis will be ‘grounded in the data’ reported in original studies (Dixon-Woods et al. 2005, p. 46).

To answer the question posed for this meta-ethnographic synthesis, it was necessary to use the direct quotes/data from women in the included studies. Interpretations by the original author(s) were utilized to ensure that the quotes were examined in context. It was assumed that the quotes the authors used in presenting their findings represented examples of the opinions of other participants and were reflective of the broader interpretive theme.
Women’s experience of breastfeeding

Findings

The 17 studies included in this meta-ethnographic synthesis represent the experience of breastfeeding (including decision-making) from over 500 women in six Western countries. Although the question posed for this synthesis necessitated the inclusion of areas of similarities and differences across the studies, very few differences or ‘refutational translations’ were uncovered. Instead the synthesis generated metaphors, phrases and concepts which were predominantly consistent across all the studies.

This meta-ethnographic synthesis revealed two main themes. The first, labelled ‘Expectations and reality’, grouped together the phrases and metaphors that described women’s expectations of breastfeeding as a natural process which was best for the baby and was aligned with being a good mother. Subsequently, women perceived that it was important to get breastfeeding right. The description of reality however, reflected a sense that breastfeeding was not necessarily easy but was ‘demanding’ and required perseverance. Ceasing breastfeeding was often associated with guilt and failure.

The second overarching theme was labelled ‘Discourses of connection and of disconnected activity’. Women who articulated their enjoyment of breastfeeding referred to the special relationship it afforded them with their infant. Maternal confidence and appropriate support were key factors expressed by women who positively articulated the pleasures of breastfeeding. In contrast, women who experienced difficulties and described negative experiences with breastfeeding expressed a lack of confidence in their body and their baby. The level of appropriate support was also an area of critical reflection.

The themes from this analysis will be presented with the words women used to describe their experience. All participant quotes will be acknowledged within quotation marks. For readers’ ease, the studies will be referred to according to the number allocated to them in Table 1.

Expectations and reality

Breastfeeding is the ‘best’

The single most influential motivator women gave for choosing to breastfeed was their desire to give their baby the ‘best’ (1, 5, 8–11, 13–15). Women consistently acknowledged the benefits of breastfeeding for the baby (1, 2, 10, 14) including the nutritional or nourishing aspects (3, 7, 10) and the provision of immunity (2, 10, 11, 13). The dominant public health discourse, ‘breast is best’, had not been lost on those women who chose to bottle feed either. Research reporting interviews with women who either intended to bottle feed, or who were currently bottle feeding, identified their belief in the health benefits of breastfeeding for babies and mothers (10, 11). There were, however, some who questioned whether breastfeeding was always best for baby. In the most part, this was based on a belief that discomfort with breastfeeding can negatively impact upon the infant and that scientific advances have made infant formula an acceptable alternative (10, 11).

Breastfeeding is ‘natural’

The majority of women identified breastfeeding as ‘natural’ (2, 3, 8–11, 17) and important for ‘bonding’ (2, 3, 5, 8–11, 15, 17). A link between the expectation that breastfeeding would be easy because it is natural was apparent (1, 7, 8, 13). Many women expressed complete surprise at the realization that breastfeeding may not be problem-free (1, 2, 4–6, 8, 13). While the analysis suggests that for some, ‘natural’ equated to ‘automatic’ (8 p. 123), and therefore easy, there were women who identified breastfeeding as a learned skill (1, 4, 5, 8). Reading books, leaflets and attending classes were mentioned as strategies to enhance breastfeeding readiness (8, 12). These actions were, however, also acknowledged by one participant in Mozingo et al. (2000, p. 123) study as not protecting against having ‘trouble breastfeeding’ (8).
Table 1. Qualitative papers included in synthesis

<table>
<thead>
<tr>
<th>Number</th>
<th>Author</th>
<th>Country</th>
<th>Participants</th>
<th>Methodology</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bottorff (1990)</td>
<td>Canada</td>
<td>Three women, SES not provided</td>
<td>Phenomenology based on face-to-face interviews</td>
<td>1. Experience of persistence</td>
</tr>
<tr>
<td>2</td>
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SES, socioeconomic status; WIC, Women, Infants, and Children.
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<td>19 women, SES ranged from high to low</td>
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<td>Maternal and Child Nutrition: Phenomenology of Women's Experience of Breastfeeding</td>
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<td>24 women, SES ranged from high to low</td>
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<td>Interviews. Based on interviews, analysis based on in-depth, semi-structured interviews.</td>
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<td>Baker et al. (2005)</td>
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<td>USA</td>
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<td>26 women, SES ranged from high to low</td>
<td>Low to high</td>
<td>Interviews. Based on interviews, analysis based on in-depth, semi-structured interviews.</td>
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1. Idealized expectations
2. Clash with reality
3. Personal feelings of discomfort
4. Inadequate or inappropriate assistance
5. Incremental disillusionment and cessation of breastfeeding
6. Relief vs. guilt/hate/ sense of failure
7. Lingering self-doubt vs. resolution
8. Baby feeding: making decisions
9. 'Breast is best': knowledge of breastfeeding
10. Bottle feeding and the role of the father
11. Health system factors
12. Prenatal care
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15. Influence of the WIC
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18. Getting on with my life
19. The physical bond of breastfeeding
20. Modesty and physical exposure
21. Returning to work or school
‘Good’ mothers breastfeed

The notion or belief that breastfeeding was inextricably equated with being a ‘mother’, and more importantly to being a ‘good’ mother (1, 4, 8, 10–16), stood out in many of the women’s narrative. This was not only a powerful motivator in the decision to breastfeed but also to persevere with breastfeeding when experiencing difficulties (1, 8, 10, 12–14, 16). For example one woman stated, ‘What good mother wouldn’t want what’s best for her baby?’ (8 p. 122). Similarly, but from the reverse perspective, the data and interpretations presented by Sheehan et al. (2003) attested that women were also conscious that their decision not to breastfeed may prompt health professionals to view them as, ‘the worst mother in the world’ for not breastfeeding (10 p. 263). Participants articulated that professional discourses imposed considerable ‘pressure’ on them to breastfeed (10). As a result, women used words and phrases such as ‘bad’, ‘awful’, ‘horrible’ or ‘irresponsible mother’ if not breastfeeding (4, 11, 14, 16). In contrast, some women who ceased breastfeeding cited reasons related to being ‘more of a mother’ (8 p. 124) as motivating their desire to cease breastfeeding because they felt (or others suggested) their experience of pain and discomfort was inhibiting their ability to mother effectively (6, 8, 11).

It is important to get breastfeeding ‘right’

The expectation and/or desire to get breastfeeding ‘right’ was a dominant theme (4, 6, 7, 8, 11, 13). Women emphasized the importance of having a health-care professional check their attachment to see if they were ‘doing it right’ (3, 4, 6, 7, 13, 14) and expressed dissatisfaction if staff didn’t do this often (3). The desire to do it ‘right’ was related not only to women’s self esteem as a mother but also to the more tangible physical aspect of preventing nipple pain. Breast and nipple pain were repeatedly mentioned as negative aspects of breastfeeding (1, 2, 4–7, 9, 13, 15). One participant in the Kelleher (2006) study questioned the notion that the ‘right latch’ would protect against nipple pain stating, ‘right latch or not it is going to be sore’ (6 p. 2731). Nipple pain for a number of women was unexpected, and the descriptions of pain experienced ranged from ‘uncomfortable’ to ‘excruciating’ (4, 5, 6, 7, 8).

Breastfeeding is not as ‘easy’ as it looks

While there were women who expected and/or predicted that breastfeeding may not ‘be easy’ (4, 10), there were many accounts demonstrating women’s overwhelming surprise at the ‘scale’ of difficulties experienced (1, 2, 4–8, 13). The sense of having been disappointed by the reality of breastfeeding was a persistent theme in women’s stories. Women described a sense of ‘silence’ around what the experience would be like; ‘no-one really tells what the body will feel like’ (6 p. 2730). Many women reported reaching a breaking point from which some recovered and continued to breastfeed whereas, others saw the challenges as insurmountable and ceased (4, 5, 6, 8). In several studies, breastfeeding was described as an ‘awful’ or ‘horrible’ experience (6, 8, 9). In many instances, women described becoming ‘fearful’ and ‘dreading’ breastfeeding as a result of problems such as nipple pain (5, 6, 8, 13, 16, 17).

Breastfeeding is ‘demanding’

In a number of papers, breastfeeding was depicted as ‘demanding’ or ‘wearing’ (2, 3, 9, 13). A participant in the study by Shakespeare et al. (2004) stated ‘I didn’t find breastfeeding very easy . . . from time to time you give a bottle I mean it is, it’s so liberating, because you are free of this thing . . . your friend or your partner can take the baby and give it the milk . . . It’s just so demanding of you, you know’ (13 p. 258). The concept of a baby ‘demanding’ a feed was described as an ‘inconvenience’ by some. For example, one woman in the Baker et al. (2005) study said, ‘he wanted feeding no matter where you were and to me I didn’t feel like breastfeeding’ (16 p. 330). In Bottorff’s (1990) study, one woman described the baby as an abuser; for this mother, the experience was in direct contrast to the ‘beautiful pictures of a mother breastfeeding’ which she had imagined or seen (1 p. 205). Similarly, a participant in the more recent work of Kelleher (2006), described the breast pain she had experienced as causing her breasts to ‘tak(e) a beating’ (6 p. 2731).
For a small number of women in the Schmied & Barclay (1999) research, descriptions of breastfeeding included language such as a ‘battleground’, a ‘fight’ and ‘violent’ (9).

Breastfeeding requires ‘perseverance’

Persistence (4, 7) and perseverance (1, 2, 7, 13, 15) were recurrent themes throughout the literature. Commonly, women reported that in the first few weeks ‘it’s so easy to give up’ (I p. 202). Continuing to breastfeed was perceived by women to require strong levels of commitment and determination (1, 4, 5, 8, 10, 14). A participant in Hegney et al. (2008) anticipated difficulties with establishing breastfeeding and described it as a ‘real battle’ requiring commitment (5 p. 1185). A number of women were motivated to persevere due to a determination to achieve their preset breastfeeding targets (4, 5, 8, 13, 14). To do this, women used strategies such as, ‘express(ing)’ (5 p. 1188) to get through an uncomfortable period, and long term goal setting such as breastfeeding until baby is ‘12 months’ old (14 p. 71). Perseverance with breastfeeding despite difficulties was also influenced by a faith in the temporal improvements which accompany any newly learned skill (1, 3, 4, 5, 7).

I felt ‘guilty’ for stopping breastfeeding

Women described feeling ‘pressured’ to breastfeed (10, 11, 13, 16); or ‘forced’ to attach their baby to their breast (11, 16) and predicted feelings of guilt if breastfeeding didn’t ‘work’ (10 p. 262). Guilt associated with depriving the baby of ‘the best’ and resultant feelings of selfishness were persistent themes around breastfeeding cessation (1, 6, 8, 14). Feelings of having given up too easily or not tried ‘hard’ enough were apparent (4, 6, 8, 14). Concern that ceasing breastfeeding may have harmed the baby in some way, further exacerbated feelings of guilt (8). Shame and/or embarrassment associated with not breastfeeding was also apparent as women sought to hide the fact that they were bottle feeding, or, intended to bottle feed (8, 10, 11). Guilt associated with feelings of having let the baby, or others, down was evident (5, 13, 14, 16). Some women experienced a sense of ongoing guilt. For example, ‘I felt very, very guilty about not being able to breastfeed . . . every time R*** has a patch of eczema I attribute it to the fact that I didn’t breastfeed her’ (13 p. 258).

I felt a ‘failure’

Self-blame (2, 4, 7, 8, 13) and the use of the word ‘failure’ (5, 7, 8, 13, 14, 16) to describe unmet breastfeeding goals were consistent findings. The sadness and confusion women felt if breastfeeding had not proceeded as they anticipated was evidenced by quotes such as ‘Mentally I felt really let down; all I wanted to was to breastfeed and failed’ (7 p. 376) and ‘I just burst into tears. I felt like a real failure’ (5 p. 1186). A participant from Shakespeare et al. (2004) describes the intensity of the emotion around breastfeeding difficulties, ‘So I remember . . . sitting on the sofa . . . not having success and crying because I couldn’t do it and thinking “Oh God, I’m failing and I can’t do this” ’ (13 p. 256). The impact of these feelings on the developing relationship with the baby have also been highlighted (6, 13). In addition, some women described a sense of ‘rejection’ if their infant did not breastfeed as they had anticipated (8, 17).

Discourses of connection

‘I Love it’

For many women, the positive breastfeeding relationship experienced with their infant was expressed in terms of incredible ‘closeness’ (7, 9, 12, 17) and ‘connectedness’ (9). Words and phrases women used to describe what they loved about breastfeeding included ‘intimate’ (2), ‘bonding’ (7, 11) and ‘my favourite time’ (9). Many women disclosed their delight at the ‘special time’ (7, 9) breastfeeding afforded them with their infant, and the way it ensured they had ‘time out’ (7) to sit and just enjoy the baby. The feeling of ‘being needed’ (9) gave many women satisfaction as did the ‘privilege’ of sharing their body with their baby (9, 10). When, despite difficulties, breastfeeding had been established, maintained and goals had been met, women expressed an overwhelming sense of achievement, joy and pride.
Not surprisingly, when women experienced breastfeeding this way they often found it difficult to part with when it came to an end (1, 9).

\textit{'I feel confident'}

Antenatally, women could predict breastfeeding as dependent upon having confidence in one’s body and oneself; ‘… if you are confident then you’ll be able to breastfeed’ (10 p. 262). Postnatally, women reported feelings of confidence (2, 3, 17) or a desire to be confident (2) with breastfeeding. Women who expressed confidence with breastfeeding, identified various cues from the baby such as ‘settling between feeds’ (2 p. 2287), a baby who was ‘… happy and contented’ (3 p. 237) and had plenty of ‘wet nappies’ (5 p. 1188) as indicative that breastfeeding was progressing well.

Women also identified a faith in their body to provide all that was necessary for their baby’s needs, for example, ‘my body tells me what I want (to eat) really’ (3 p. 237) or ‘to me it doesn’t make sense that your body wouldn’t be able to make enough [milk]’ (5 p. 1187). These cues further enhanced the levels of assurance that breastfeeding was going well for themselves and their baby.

Strategies utilized by women to improve their confidence with breastfeeding included positive self-talk (1, 5), prioritizing breastfeeding (3), goal setting (5), ‘taking … cue[s] from the baby’ (2, 5 p. 1188), being flexible (3, 5), faith in improvements with time (4, 5, 7, 10), and support and assistance from family and staff (1, 3, 4, 5, 7).

\textit{'I just felt so supported'}

According to Botorff (1990), women relied on the ‘talk of others’ to persist with breastfeeding as the words from others brought ‘hope and comfort’ (1 pp. 206–7). Women acknowledged the positive impact of the support they received (3–8, 13, 14). Feelings of connectedness with other mothers who were experiencing the same emotions and challenges were apparent in quotes from women (5, 4). The quality of the relationship which developed between a peer-support worker and a breastfeeding woman was reported as resembling a friendship rather than a worker/client relationship which facilitated improved support (12). Breastfeeding clinics were reported by women as offering opportunities for supportive interactions with health professionals (4, 13). The communal nature of a breastfeeding clinic environment also brought advantages such as meeting other women in the same situation and normalizing the need for extra assistance (13). Women in the Kelleher (2006) study reported a ‘helpline’ service kept them connected to ‘information and guidance’ (6 p. 2734), while others found having a face to face consultation with a health professional extremely beneficial (4). The desire to actually develop a connection with the health professional was apparent in references to the importance of continuity of carer, individualized advice, and a warm and supportive interaction (4, 7, 13).

The importance of having a supportive partner was a recurring theme in women’s stories (4, 5, 6, 7, 11). Women sometimes referred to ‘we’ when reflecting on decisions made about infant feeding (7, 8). For some, breastfeeding was viewed as part of the broader relationship between mother, father and baby (4, 5). One participant in Manhire et al. (2007) summed up a consensus opinion about breastfeeding apparent in the literature saying ‘It takes perseverance, dedication and a supportive partner to get through the first weeks’ (7 p. 376). Having a mother who breastfed and was supportive also facilitated sustainable breastfeeding for women (3, 4).

\textbf{Discourses of disconnected activity}

\textit{'My body was out of control'}

This synthesis revealed that for some women, breastfeeding was experienced as a negative activity. Examples of women’s disconnected references to their own body, and/or to their baby, highlighted the lack of control which a number of women felt accompanied breastfeeding. Antenatally, a few women were ‘repulsed’ (10 p. 263) by the idea of breastfeeding. Women in the Schmied & Barclay (1999) study reported being amazed at their body’s ability to produce milk and yet, for some this was followed by a disgust at their lack of control over their body (8, 9,
References to ‘messy’ (8 p. 124), leaky, ‘sticky’ (9 p. 331) breast milk were given as evidence that the body was ‘out of control’ (8 p. 124, 9, 13). The desire to return to normal was a recurring theme in women’s stories (2, 9, 10, 13) with several women expressing a need to get their ‘body back’ (9 p. 331, 10 p. 263, 17 p. 102). Comparing oneself to a ‘machine’ (9 p. 330) or a ‘cow’ (9 p. 330, 10 p. 262, 17 p. 102) was a feature of some of the research findings from the USA and Australia.

A lack of faith in the capacity of the female body to adequately nourish an infant was a further perceptible theme in this synthesis. The concerns expressed by women about their own ability to produce ‘enough’ milk (1, 2, 3, 4, 6, 8) and milk of sufficient quality (3, 4, 7) were abundant. This lack of trust in the body extended to concerns about enough milk ‘leaving my body’ (2 p. 2287), worry about ability to ‘keep up with him’ (1 p. 204) and babies crying because they’re not ‘getting enough’ (2 p. 2287, 8 p. 123). Women questioned whether their diet was good enough to sustain their baby (3) and the notion that a breastfeeding mother has to continually ‘watch what you eat all the time’ (1 p. 206), seemed to be overwhelming for some (3). Weighing babies to ascertain how healthy they were further reinforced the fear women had of potentially not providing sufficiently for their infant (3, 4, 7). Similarly when women compared breast milk to artificial formula, it created a sense of uncertainty that breast milk was of equal quantity and quality (2, 3). A participant in the Dykes & Williams (1999) study highlighted this point: ‘My milk looked sort of blu[ey] grey and thin and watery. When you see the baby milk in bottles it’s white and frothy and it looks really thick and healthy. It made me think well my own is not much in comparison’ (3 p. 236).

My baby ‘didn’t know how to feed’

This analysis revealed that a number of women were keen to assert the reason breastfeeding did not establish was because the baby was not able to do it (8, 12, 16). One mother kept a bottle of breast milk in the fridge as ‘confirmation that . . . it wasn’t MY problem’ (8 p. 126). Comments regarding babies’ inability to feed or ‘latch on’ were apparent (8, 12, 16). Examples of the tendency to explain difficulties with establishing breastfeeding by referring to the baby include, ‘She didn’t know how to feed’ (8 p. 125), and ‘. . . she was always hungry and wasn’t putting on weight very well’ (7 p. 377).

The establishment of an enjoyable fulfilling breastfeeding relationship was, for a number of women, dependent upon the baby behaving in a socially acceptable, appropriate or ‘civilised’ manner (2, 5, 7–9, 13). Women reported feelings of being restricted (12) and expressed frustration when babies woke for a feed early (1), fed all the time (4, 12), ‘feed whenever they want to’ (2 p. 2288), were ‘always hungry’ (7 p. 377, 16 p. 103), ‘gorge[d]’ (2 p. 2287) themselves when they did feed, cried ‘for nothing really’ (2 p. 2288) or wanted to feed ‘. . . no matter where you were . . . ’ (16 p. 330). These behaviours seemed to be considered ‘uncivilised’ rather than normal infant behaviour. A few women linked feelings of disconnectedness to their baby with the suboptimal acquisition of a breastfeeding relationship (6, 9).

Potential support people were ‘very unhelpful’

Women reported that at times, their partner or family member recommended the time to wean (7, 14, 5, 12) or the time to supplement with formula (3) which inevitably influenced their decision-making, and/or, caused conflict. Breastfeeding in public was described by many women as restrictive and ‘embarrassing’ (10, 11, 12, 15), and avoidance of breastfeeding in public was often for fear of ‘offending’ others (4) or ‘. . . because of other people’s embarrassment . . . ’ (15 p. 34). A number of women predicted embarrassment if breastfeeding in front of particular people such as their father-in-law (10) or their partners’ male friends (15). In general, a lack of community support for breastfeeding in public influenced women’s comfort with this and in some instances women chose to bottle feed rather than compromise their modesty (12).

A recurring theme in this synthesis was that health professionals in Western hospitals had no time to spend supporting and educating women about infant feeding (4, 7, 8). Further, some health professionals
were reportedly intimidating (6), rude (7), gave
technical, inconsistent and conflicting advice (7, 8),
had an ‘unhelpful attitude’ (16 p. 331), and were
pushing breastfeeding even at the ‘. . . expense of the
mothers emotional health’ (7 p. 379, 13, 16). Women
reported health professionals touched and grabbed
at their breasts without permission (6, 8, 12). With
a number of women expressing a preference to be
assisted to breastfeed independently (6) and, to
have practical support from health professionals to
achieve this (8).

Health professionals reportedly advised some
women to cease breastfeeding and commence bottle
feeding for a variety of reasons (3, 4) or gave babies
bottles of formula or ‘sugar water’ without permission
from parents (8, 12). At times a lack of respect for
individual choice and decision-making was evident
(16) as a participant in the Raisler (2000) study indi-
cated ‘I said no bottles and they would like force
bottles on me . . . they gave her a bottle without even
waking me up to ask me . . . I had made it specifically
clear! . . . I want this baby completely breastfed’
(12 p. 256).

Discussion

This synthesis, which draws on the findings of 17
qualitative studies exploring the experience(s) of
breastfeeding for women, has revealed some of the
dominant discourses which are potentially impacting
on breastfeeding women’s experience. Historically,
breastfeeding knowledge had been passed down by
women from one generation to the next within com-
unities and within families (Dettwyler 1995; Fildes
1995; Ryan & Grace 2001). We argue, like Bartlett,
that there has been a ‘cultural shift in authority’ away
from women’s own shared embodied knowledge
towards a ‘biomedical narrative’ (Bartlett 2002,
p. 376). In Western societies, breastfeeding knowledge
is predominantly delivered by experts who often posi-
tion mothers as ‘novitiates in need of tuition on how
to breastfeed’ (Bartlett 2002, p. 376). In Western
societies, breastfeeding knowledge is easy. Antenatal
preparation tends to focus upon portraying all the
positive, natural aspects of breastfeeding in an effort
to ensure that as many women as possible commit to
breastfeeding (Schneider 2001; Wall 2001). Lavender
et al. (2005) speculated that an antenatal education
session aimed at informing women of the benefits of
breastfeeding actually contributed to the ‘clash with
reality’ which women subsequently experienced.

Nature discourse

It is evident that women have heard the ‘public
health’ message that ‘breast is best’ and all women
can and should do it. The desire to give one’s baby the
‘best’ clearly motivated the majority of women to
choose to breastfeed. However, for many, giving one’s
baby ‘the best’ unpredictably required the acquisition
of new skills, overcoming challenges and the need for
support from others. The sense of disillusionment
which some women experienced when establishing
breastfeeding was apparent. The expectation that
breastfeeding would be ‘easy’ has been linked to a
discourse of ‘nature’ where breastfeeding is repre-
sented as instinctive. Hall and Hauck report that
in Australia breastfeeding is still depicted as a
‘“natural” romanticized, problem-free experience’
(Hall & Hauck 2007, p. 794). Wall (2001) argues that
breastfeeding educational material aimed at pregnant
women emphasizes the natural aspects of breastfeed-
ing and implies that breastfeeding is easy. Antenatal
preparation tends to focus upon portraying all the
positive, natural aspects of breastfeeding in an effort
to ensure that as many women as possible commit to
breastfeeding (Schneider 2001; Wall 2001). Lavender
et al. (2005) speculated that an antenatal education
session aimed at informing women of the benefits of
breastfeeding actually contributed to the ‘clash with
reality’ which women subsequently experienced.

Lavender and colleagues concluded that the provi-
sion of a single antenatal breastfeeding education

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session overemphasized the positives of breastfeeding without also providing information on overcoming difficulties and challenging the ‘peer and societal pressure’ for short-term breastfeeding (Lavender et al. 2005, p. 1052). Research has shown women with realistic expectations during the early post-partum period breastfeed for longer when compared to women with unrealistic expectations (Whelan & Lupton 1998; Hauck & Irurita 2003; Hegney et al. 2008).

Scientific discourse

Advances in technology have enabled the viewing of the internal mechanism of breastfeeding (Henderson & Scobbie 2006, p. 515; Jacobs et al. 2007) to the extent where the minute detailing of every aspect of ‘correct’ attachment is defined. The discovery that ‘positioning and attachment play[s] a crucial role in the successful ejection and transfer of milk’ (Henderson & Scobbie 2006, p. 515) has meant that much professional discourse and practice is focused on the acquisition of optimum attachment. Some breastfeeding educators and lactation consultants advocate the teaching of the science and ‘physics’ of correct attachment to new mothers (Powers 2008). The use of this type of ‘scientific’ discourse implies that there is one ‘right’ way to breastfeed. Women have accepted these discourses and express a strong desire to get breastfeeding ‘right’ (Hall & Hauck 2007). Midwives inadvertently contribute to the preoccupation with the ‘right’ latch when they have a preference for physically attaching the baby, (Mozingo et al. 2000; Kelleheer 2006) and/or repeatedly checking and rechecking, detaching and reattaching the baby in their effort to achieve that picture perfect ‘latch’. In addition, the focus on the science of breastfeeding, results in an obsession with weighing babies to seek confirmation that optimum growth is being achieved (Dykes & Williams 1999; Sachs et al. 2005). Relatively little is written about women’s embodied knowledge and women’s explanatory language around the experience of breastfeeding; for example, the language used when breastfeeding feels ‘right’ or when it feels ‘wrong’ (Beasley 1991; Ryan & Grace 2001; Spencer 2007).

Success/failure and the good mother discourses

The ‘successful breastfeeding’ discourses in the public health and professional literature (Leff et al. 1994, pp. 99–104; WHO 1998; Dykes & Williams 1999, pp. 232–246; Hauck & Irurita 2003, pp. 62–78) are reflected in the tendency to describe breastfeeding experiences in terms of success or failure (Hawkins et al. 1987; Bottorff 1990, pp. 201–209; Driscoll 1992; Hoddinott & Pill 1999, p. 34; Mozingo et al. 2000, pp. 120–126; Hauck & Irurita 2003, pp. 62–78; Shakespeare et al. 2004, pp. 251–26; Baker et al. 2005, pp. 315–342; Hall & Hauck 2007, p. 791; Manhire et al. 2007, pp. 372–381; Hegney et al. 2008, pp. 1182–1192; Larsen et al. 2008). For example the WHO Baby-friendly Hospital Initiative statement on breastfeeding includes, ‘The ten steps to successful breastfeeding’ (WHO 1998). Research on breastfeeding ‘success’ has been measured by duration, by women’s own self-assessment, and by infant factors (Leff et al. 1994; Lothian 1995; Hauck & Reinbold 1996; Whelan & Lupton 1998). It can be argued that the use of a language of ‘success’ inadvertently alienates women who have not been deemed successful in this area. The use of this language is additionally problematic when authors unintentionally slip into the use of further alienating terms such as ‘successful breastfeeding’ (Leff et al. 1994, p. 102; McInnes & Chambers 2008) or ‘successful mothers’ and even ‘successful women’, when describing those who have established breastfeeding (Leff et al. 1994, pp. 315–342; Hall & Hauck 2007, p. 791; Manhire et al. 2007, pp. 372–381; Hegney et al. 2008, pp. 1182–1192; Larsen et al. 2008). If the ‘good’ and ‘successful’ mother breastfeeds in order to give her baby the ‘best’ (Blum 1999; Murphy 1999; Schmied & Lupton 2001), how does the mother who has not established breastfeeding assess herself? If the ‘good’ and ‘successful’ mother breastfeeds in order to give her baby the ‘best’ (Blum 1999; Murphy 1999; Schmied & Lupton 2001), how does the mother who has not established breastfeeding assess herself? The ‘moral baggage’ (Murphy 1999; Shaw 2004) associated with infant feeding, has the potential to result in the feelings of guilt and low self-esteem, and potential for depression reported by women whose breastfeeding experience has not progressed as anticipated (Cooke et al. 2007). While culturally, the ‘good
mother’ breastfeeds is contrasted by the fact that ‘good women’ do not expose their breasts in public (Maclean 1990; Henderson et al. 2000; Mahon-Daly & Andrews 2002). The confusion that these sociocultural mixed messages cause not only restricts the performance of breastfeeding (Hoddinott & Pill 1999; Shaw 2004) for some but for others is a sufficient deterrent for them to avoid breastfeeding all together (Earle 2000; Raisler 2000; Sheehan et al. 2003). The long-term impact of these discourses necessitates the health professional obligation to challenge the dominant ‘good mother’ parameters.

It has been speculated that feelings of having ‘failed’ impact upon maternal self-esteem (Papinczak & Turner 2000). Women who exclusively breastfeed have higher ‘self concept’ when compared with those who exclusively bottle feed (Britton & Britton 2008). Women who have been deemed to have ‘failed’ (or consider themselves failures) search for reasons to rationalize why this may have happened. From this synthesis, it is apparent that women attribute blame to either their own bodily malfunction, their infants’ inabilities and/or the inadequate support they received. The tendency for a number of mothers to ‘blame the baby’ when breastfeeding did not progress as planned was an interesting finding from this analysis.

Biomedical discourses and ‘demand’ feeding

Biomedical discourses are evident in the language some women used to describe their body. Mechanistic and disconnected descriptions are consistent with the techno medical ‘body-as-machine’ metaphor highlighted by Davis-Floyd (2001). The biomedical body is contained, controlled and stable and is prefaced on a male norm; in this context female bodily processes such as breastfeeding can tend to be pathologized (McDowell & Pringle 1992; Shildrick 1997, pp. 14–15; Davis-Floyd 2001:56). The use of disembodied language by women reveals the Cartesian dualist separation of mind and body which biomedical advocates (Beasley 1991; Spencer 2007). The cultural acceptance of the ‘techno medical’ model of health (Davis-Floyd 2001; Dykes 2006) is further evident when health professionals, family and community members espouse a lack of faith in the woman’s body to produce sufficient milk (Dykes & Williams 1999; Mozingo et al. 2000; Hauck & Irurita 2003). Similarly the tendency to focus research on when things go ‘wrong’ (Mozingo et al. 2000; Hauck et al. 2002; Shakespeare et al. 2004; Kelleher 2006; Hegney et al. 2008), rather than on a more solution-focused approach, is additional evidence of the influence of techno medicine on health professional practice (Davis-Floyd 2001, p. 57).

The description of breastfeeding as ‘demanding’ (Dykes & Williams 1999, p. 238; Schmied & Barclay 1999; Shakespeare et al. 2004) may be a reflection of the force of a ‘demand’ feeding discourse. Examples of the experience of ‘demanding’ breastfeeding include the sense of ‘being completely worn by it’ (Shakespeare et al. 2004, p. 255) or describing the baby as ‘always at me’ (Schmied & Barclay 1999). Dykes (2006) argued the use of the word ‘demand’ originated from the industrialization of Western societies where the focus was on supply/demand and production line output. Dykes identified that the demand-feeding discourse has resulted in women describing breastfeeding as ‘breaching temporal’ and ‘bodily boundaries’ (Dykes 2006). The etymology of the word includes definitions such as ‘a forceful request’ (Rooney 2004) or ‘to ask for with authority’ (Delbridge 1991) and prompts the questions – firstly, do some women interpret ‘demand feeding’ as involving the use of force? and, secondly, do health professional discourses set women up to view themselves as passively responding to the ‘demands’ of the infant with little or no regard for their own needs or wants? (Shaw 2004; Dykes 2006). MacLean concludes in her book on women’s experience of breastfeeding that ‘[W]omen, particularly first-time mothers, must learn to accept that life with a newborn is demanding’ (MacLean 1990, p. 205). The impact of this type of language may be that the breastfeeding relationship becomes viewed by women as a ‘battle’ between themselves and the ‘demanding’ baby (Bottorff 1990; Schmied & Barclay 1999; Hegney et al. 2008). References to feeling ‘ pressured’ (Sheehan et al. 2003) or ‘forced’ (Baker et al. 2005) to breastfeed may be further indications of the implications of this type of discourse.
Historically, research into maternal experience of breastfeeding has charted many similar findings as those revealed in this synthesis (MacLean 1990; Dignam 1995; Ryan & Grace 2001). MacLean (1990) documented women’s experiences from 756 interviews and found many similar themes as those revealed in this endeavour, such as what motivates women to breastfeed, and the expectations and realities of breastfeeding. However, this synthesis, which drew on the findings of qualitative studies exploring the experience(s) of breastfeeding since 1990, and across six Western countries, has revealed that despite the extensive qualitative research on women’s experience of breastfeeding many women are still reporting negative feelings about their body, their baby, themselves and about the quality of support they have received.

The public health and health professional messages such as breast is ‘best’, and ‘[The ten steps to] successful breastfeeding’, are reflected in the words women use to describe their experience. We would argue the highly technical, institutionalized healthcare environment potentially influences the discourses health professionals draw upon when supporting women who are establishing breastfeeding. The influence of biomedical discourses can also adversely influence how women view their own body and even how they view their baby. The findings from this synthesis are supported by two research papers published after May 2008. A Scandinavian meta-synthesis of seven qualitative studies on breastfeeding experience identified that a woman’s confidence with breastfeeding is influenced both by expectations, professional support and by the discourses of ‘nature’ and ‘body as machine’ (Larsen et al. 2008, p. 657) The authors concluded that breastfeeding should be viewed as a ‘competency to be attained’ rather than something which every woman can do ‘naturally’ (Larsen et al. 2008, p. 660) The second paper utilized women’s own descriptions of their breastfeeding experience to reveal the impact of ‘expectations’, ‘infant behaviour’ and ‘support’ on maternal confidence. Women in this study conveyed, through their language, the importance of infant satisfaction and connection, to breastfeeding longevity (Grassley & Nelms 2008).

Ryan & Grace (2001, p. 494) have highlighted that the health professional use of ‘medicoscientific language’ has effectively robbed women of the opportunity to establish their own discourses on the subjective experience of breastfeeding. Health professionals contribute to this ‘suppression of alternative discourses’ (Ryan & Grace 2001, p. 494) by the paucity of scholarly enquiry revealing the embodied reality of breastfeeding (Schmied et al. 2001). Dignam (1995) alluded to a resurgence of interest in valuing embodied descriptions of breastfeeding however, as revealed in this synthesis, the language used by women is so heavily peppered with techno medical descriptors that the intimacy and relational aspects of breastfeeding continue to be largely suppressed (Ryan & Grace 2001; Schmied et al. 2001). This synthesis reinforces the need for health professionals to move away from biomedical breastfeeding discourses towards more holistic language where the mind and body are viewed as ‘inseparably intertwined’ and the embodied reality of breastfeeding is more clearly articulated (Davis-Floyd 2001; Dykes 2002; Spencer 2007). These findings have prompted the research team to further investigate the influence of the discursive constructions of breastfeeding, and newborn infant behaviour, on women’s experience of breastfeeding and their reflexive recount of this.

**Limitations**

Sandelowski (2006) warns of the limitations of qualitative meta-syntheses. She encourages researchers to acknowledge that the interpretations presented are at least three times removed from the original data. Similarly, she reminds readers that the synthesis is only one ‘reading’ of the data where several alternative interpretations are likely to be possible.

Additional limitations from this meta-ethnographic synthesis include the retrospective nature of some of the studies; the lack of uniformity of methodology used and, in some instances, an inadequate description of methodological approach (6, 11, 13); one paper focused on women who were motivated to breastfeed only (3), five papers were focused on those experiencing significant difficulties only (4, 5, 6, 8, 13), two papers included data from women from low socioeco-
nomic groups only (12 & 15) and one paper was not solely about breastfeeding experience (or decision-making), however, it included valuable data on this (16). The papers predominantly articulated white Caucasian women’s experience of breastfeeding. Having said this, however, the meta-ethnographic synthesis does highlight both the diversity of the experience of breastfeeding for women as well as the similarities in experience across Western societies.

Conclusion

Much has been written about the disillusionment some women feel when faced with breastfeeding challenges. Clearly, being confident and well supported enables women to experience breastfeeding as a joyous, connected relationship. Social and cultural discourses are inevitably implicated in the reflective recount of subjective experience. The findings from this meta-ethnographic synthesis have highlighted the contribution of sociocultural discourses to the sense of disillusionment, and failure which many women express. It is also evident that the words and language health professionals and other support people use may be contributing to the lack of confidence, and sense of guilt and failure which some new mothers report. Health professional language and practices have the potential to enhance maternal self esteem, to transform societal discourses and to contribute to improvements in the experience of breastfeeding for women. Further research into the nature of health professional discourses during breastfeeding support, and the impact of these upon women, is necessary to gain a deeper of understanding of the micro and macro determinants of breastfeeding experience.

Acknowledgements

We would like to acknowledge the midwives and women who generously participated in this research study. We would also like to thank the two anonymous reviewers for their helpful comments on an earlier version of this paper.

Source of funding

This work has been funded by an Australian Research Council Linkage grant for the project: ‘Establishing Breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers’.

Conflicts of interest

No conflicts of interest have been declared.

References


Women’s experience of breastfeeding


Appendix 2

Invitation Statement for midwives;

Introduction poster for ward display; and

Invitation to Focus groups for midwives
Dear Midwifery Colleague,

You are invited to participate in the research project:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

This research seeks to capture what we, as midwives, do, and say, when interacting with women and their families about infant feeding. It is hoped this research will reveal what we do well, what factors influence our interactions with breastfeeding women, and where the areas for improvement are.

Your decision to participate is completely voluntary and you are under no obligation to be involved in this research.

If you agree to participate your interactions with consenting women, during the postnatal period, will be observed and (when possible) tape-recorded. You will be allocated a numerical code which will be used for all observation and interview data. All aspects of the study, including results, will be confidential and only the researcher will have access to information on participants (in coded form). You may also be invited to participate in a focus group (during work time) to discuss where midwives gain their own knowledge about breastfeeding. Individuals will not be identifiable from focus group data.

It is hoped this research will lead to improvements in women’s experiences with infant feeding and in advances in midwifery training and practice.

This research project is due to commence in late September and you may be approached during this time and personally invited to participate in the study. You will be offered a Participant Information Statement outlining what you would be asked to do and the risks and benefits of participating. If you agree to participate you will have the opportunity to have any questions answered before signing a consent form. If you have any questions (or need further clarification) about this project at this point, please do not hesitate to contact me on mobile 0431 731 160.

Thank you for considering this invitation.

........................................
Elaine Burns RM
University of Western Sydney
Research Project
Commencing Soon

“Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers”

Hi my name is Elaine Burns and I am a midwife researching the support we give to women who are establishing breastfeeding. This research is necessary to ensure continued improvements both in the early experience of breastfeeding for mothers and in midwifery practice.

This project is due to start at (Name of Hospital) in (Month). The research will involve observation and tape recording of interactions between midwives and mothers when breastfeeding is the focus. If you think you may like to participate please feel free to take an information sheet and also write down any questions you may have. I will be available to answer questions before recruitment commences.
HAVE YOUR SAY

The research project “Establishing Breastfeeding” has reached the final phase of data collection.

Thank you to everyone for the contributions you have made.

The final midwifery focus group is scheduled for

**Tuesday 24th February** (after handover)

Here is your opportunity to “tell it like it is” when providing support to women who are establishing breastfeeding on the postnatal ward?

What makes it easy and what makes it hard?

This focus group will be conducted according to strict ethical guidelines and individual participants will not be identifiable.

**AFTERNOON TEA WILL BE PROVIDED**
Appendix 3

Participant Information Statements;

Information Statement for postnatal mothers, partners and significant others;

Information statement for midwives and lactation consultants;

Information Statement for Antenatal Parenting Education Participants; and

Information Statement for Parenting Educator
Information statement for midwives and lactation consultants:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

Invitation
You are invited to take part in this research which is being conducted by Ms Elaine Burns as part of a Doctor of Philosophy degree at the University of Western Sydney under the supervision of Associate Professor Virginia Schmied, Associate Professor Jennifer Fenwick, and Dr Athena Sheehan. You are being invited as a participant because you are a midwife or lactation consultant who is interacting with women regarding infant feeding.

Why is this research being done?
The purpose of this study is to describe the language and practices used by midwives and lactation consultants when discussing infant feeding with women, or when assisting women with breastfeeding. We would also like to look at the impact of these interactions on women during pregnancy and in the immediate post-birth period. Through focus group sessions we would like to discover where midwives gain their own knowledge about breastfeeding and we will use interviews, with midwives and lactation consultants, to gain an understanding of the individual perspectives on what works well and on the factors which impact upon optimum infant feeding support. It is hoped this research will lead to improvements in women’s experiences with infant feeding and in advances in midwifery training and practice.

Who can participate in the research?
Midwives, and lactation consultants, who are interacting with pregnant women and new mothers about infant feeding, can participate in this study. Your decision to participate is completely voluntary. If you decide to participate you can withdraw at any time without having to give a reason. If you decide not to participate, or you wish to withdraw from the project at any time, your decision will not disadvantage you. If you choose to withdraw, and if it is possible to retrieve, your data will be returned to you.

What would you be asked to do?
If you agree to participate we will observe your interactions with consenting women during the postnatal period, and when possible tape-record the interaction. You will also be asked to participate in an interview or focus group which will last approximately one hour, and can be carried out during work time.

What are the risks and benefits of participating?
This study involves observation of interactions with postnatal women, and an interview or focus group session. It is not expected to cause you any discomfort. If you are uncomfortable being observed, or during the interview or focus group, remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences. You can also ask for the tape recording to be stopped at any time and you have the right to
review the transcripts of the recording. We are unable to promise you any individual benefits from participating in this research however it is hoped this research will shed light on ways to improve midwifery practice for the benefit of women and their families.

**How will your privacy be protected?**
You will be allocated a numerical code which will be used for all observation and interview data. All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants (in coded form). The consent form and the general information about you will be kept in a separate location from the observation and interview data. The data will be stored in a locked cabinet at the University of Western Sydney and destroyed 7 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project. If you agree to be included in a focus group or interview we ask that you do not identify yourself or anyone else during the interview or group. This is to protect your privacy and the privacy of others. The audio-recordings, hand-written and transcribed notes will be de-identified thus removing all reference to individuals and institutions.

**How will the information collected be used?**
The information collected will be analysed and reported in a thesis to be submitted for Ms Burns’ degree. We plan to write papers for publication in professional journals outlining the research and the findings and present the results at professional conferences. Confidentiality of individual participants and organisations will be assured. A report will be provided to all participants with opportunity for feedback before the report is finalised.

**What do you need to do to participate?**
Please read this Information Statement and be sure you understand its contents before you consent to participate. After you have read this information, Ms Burns will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Elaine Burns, PhD Candidate, Mobile 0431731160 or Associate Professor Virginia Schmied, Project Supervisor, Ph. 9685 9505.

**Thank you for considering this invitation**

**Signatures**

A/Prof Virginia Schmied  Ms Elaine Burns  
University of Western Sydney  University of Western Sydney

................................................... …………………………………………….

Signature  Signature

...../ ...../ ..........    ...../ ...../ ..........  
Date  Date

**Complaints about this research**
This research has been approved by the Human Research Ethics Committee of [Name of Health Service], Reference 08/06/18/5.03.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to … (Name Provided)
Information Statement For Antenatal Parenting Education Participants

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

Invitation
You are invited to take part in this research which is being conducted by Ms Elaine Burns as part of a Doctor of Philosophy degree at the University of Western Sydney under the supervision of Associate Professor Virginia Schmied, Associate Professor Jennifer Fenwick, and Dr Athena Sheehan. You are being invited as a participant because you are interacting with midwives and/or lactation consultants regarding infant feeding.

Why is this research being done?
The purpose of this study is to look at the language midwives and lactation consultants use when discussing infant feeding with women and families during pregnancy, or when assisting women with breastfeeding in the first week after birth. We are particularly interested in the language used during antenatal classes and the types of information given to women and families about infant feeding. It is hoped this research will lead to improvements in women’s experience of infant feeding and in advances in midwifery practice.

Who can participate in the research?
Pregnant women, and their partners or significant others, who are attending this parenting education session, and are aged 16 and over are able to participate. Your decision to participate is completely voluntary.

What would you be asked to do?
If you agree to participate this antenatal parenting education session on infant feeding will be observed and tape-recorded.

What are the risks and benefits of participating?
This study involves observation of this parenting education session and it is not expected that this should cause you any discomfort. If you are uncomfortable being observed remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences. You can also ask for the tape recording to be stopped at any time and you have the right to review the transcripts of the recording. We are unable to promise you any benefits from participating in this research however it is hoped this research will shed light on ways to improve practice for the benefit of women and their families. If you decide to participate you can withdraw at any time without having to give a reason. If you decide not to participate, or you wish to withdraw from the project at any time, your decision will not disadvantage you. Your access to services at this hospital will not be affected, in any way, whether you choose to participate or not. If you choose to withdraw, and if it is possible to retrieve, your data will be returned to you.
How will your privacy be protected?
We ask that during discussion in this session you not identify yourself by name or identify anyone else. This is to protect your privacy and the privacy of others. No identifying information about you or the service will be kept with the transcripts. The consent form will be kept in a separate location from the observation data. The data will be stored in a locked cabinet at the University of Western Sydney and destroyed 7 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project.

How will the information collected be used?
The information collected will be analysed and reported in a thesis to be submitted for Ms Burns’ degree. We plan to write papers for publication in professional journals outlining the research and the findings and present the results at professional conferences. Confidentiality of individual participants and organisations will be assured. A report will be provided to all participants with opportunity for feedback before the report is finalised.

What do you need to do to participate?
Please read this Information Statement and be sure you understand its contents before you consent to participate. After you have read this information, Ms Burns will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Elaine Burns, PhD Candidate, Mob 0431731160 or Associate Professor Virginia Schmied, Project Supervisor, Ph.9685 9505.

Thank you for considering this invitation

Signatures

A/Prof Virginia Schmied
University of Western Sydney

Ms Elaine Burns
University of Western Sydney

................................................... …………………………………………….
Signature  Signature

...../ ...../ ..........    ...../ ...../ ..........
Date  Date

Complaints about this research
This research has been approved by the Human Research Ethics Committee of [Name of Health Service], Reference 08/06/18/5.03.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to … (Name Provided)
Information Statement for Parenting Educator:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

Invitation
You are invited to take part in this research which is being conducted by Ms Elaine Burns as part of a Doctor of Philosophy degree at the University of Western Sydney under the supervision of Associate Professor Virginia Schmied, Associate Professor Jennifer Fenwick, and Dr Athena Sheehan. You are being invited as a participant because you are a midwife or lactation consultant who is interacting with women regarding infant feeding.

Why is this research being done?
The purpose of this study is to describe the language and practices used by midwives and lactation consultants when discussing infant feeding with women, or when assisting women with breastfeeding. We would also like to look at the impact of these interactions on women during pregnancy and in the immediate post-birth period. Through focus group sessions we would like to discover where midwives gain their own knowledge about breastfeeding and we will use interviews, with midwives and lactation consultants, to gain an understanding of the individual perspectives on what works well and the factors which impact upon optimum infant feeding support. It is hoped this research will lead to improvements in women’s experiences with infant feeding and in advances in midwifery training and practice.

Who can participate in the research?
Midwives, and lactation consultants, who are interacting with pregnant women and new mothers about infant feeding, can participate in this study. Your decision to participate is completely voluntary. If you decide to participate you can withdraw at any time without having to give a reason. If you decide not to participate, or you wish to withdraw from the project at any time, your decision will not disadvantage you. If you choose to withdraw, and if it is possible to retrieve, your data will be returned to you.

What would you be asked to do?
If you agree to participate we will observe and tape-record this antenatal parenting education session. You may also be asked to participate in a focus group which will last approximately one hour, and can be carried out during work time.

What are the risks and benefits of participating?
This study involves observation of an antenatal parenting education session on infant feeding, and, for some participants, focus group participation. It is not expected to cause you any discomfort. If you are uncomfortable being observed, or during the focus group, remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences. You can also ask for the tape recording to be stopped at any time and you have the right to review the transcripts of the recording. We are unable to promise you any individual benefits from participating in this research however it is hoped
this research will shed light on ways to improve practice for the benefit of women and their families.

How will your privacy be protected?
You will be allocated a numerical code which will be used for all observation data. All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants (in coded form). The consent form and any general information about you will be kept in a separate location from the observation and interview data. The data will be stored in a locked cabinet at the University of Western Sydney and destroyed 7 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project. If you agree to be included in a focus group or interview we ask that you do not identify yourself or anyone else during the interview or group. This is to protect your privacy and the privacy of others. The audio-recordings, handwritten and transcribed notes will be de-identified thus removing all reference to individuals and institutions.

How will the information collected be used?
The information collected will be analysed and reported in a thesis to be submitted for Ms Burns’ degree. We plan to write papers for publication in professional journals outlining the research and the findings and present the results at professional conferences. Confidentiality of individual participants and organisations will be assured. A report will be provided to all participants with opportunity for feedback before the report is finalised.

What do you need to do to participate?
Please read this Information Statement and be sure you understand its contents before you consent to participate. After you have read this information, Ms Burns will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Elaine Burns, PhD Candidate, Mobile 0431731160 or Associate Professor Virginia Schmied, Project Supervisor, Ph 9685 9505.

Thank you for considering this invitation

Signatures

A/Prof Virginia Schmied
University of Western Sydney

Ms Elaine Burns
University of Western Sydney

........................................................................................................................................
Signature                          Signature

...../...../..........
Date

Complaints about this research

This research has been approved by the Human Research Ethics Committee of [Name of Health Service], Reference 08/06/18/5.03.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to … (Name Provided)
Information Statement for postnatal mothers, partners and significant others:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

Invitation
You are invited to take part in this research which is being conducted by Ms Elaine Burns as part of a Doctor of Philosophy degree at the University of Western Sydney under the supervision of Associate Professor Virginia Schmied, Associate Professor Jennifer Fenwick, and Dr Athena Sheehan. You are being invited to be a participant because you will be talking with midwives and/or lactation consultants about feeding your baby, or you will be present during these discussions.

Why is this research being done?
The purpose of this study is to look at the language midwives and lactation consultants use when discussing infant feeding with women and families and when supporting women with breastfeeding in the first weeks after birth. We are interested in the way women and midwives interact during this time and in observing how midwives assist women with feeding their newborn. We also want to look at the effect of these interactions on women in the first few weeks after birth. It is hoped this research will lead to improvements in women’s experience of breastfeeding and in advances in midwifery practice.

Who can participate in the research?
Pregnant women, and new mothers, who are booked into this hospital, and are aged 16 and over, are able to participate. Partners and significant others, who are present during these interactions, are also able to participate. Your decision to be involved is completely voluntary.

What would you be asked to do?
If you agree to participate you will be asked to provide some general information about yourself, such as age, education background and previous postnatal experience. You will then be asked to have interactions about infant feeding, between yourself and a midwife (or lactation consultant), observed and tape recorded. Postnatal women will also be asked if you would be interested in participating in an individual interview about your experiences after you have returned home. This interview would last approximately one hour, and be carried out at a time and place convenient to yourself.

What are the risks and benefits of participating?
This study involves observation of interactions between you and the midwife or lactation consultant and it is not expected that this should cause you any discomfort. If you are uncomfortable being observed remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences. You can also ask for
the tape recording to be stopped at any time and you have the right to review the transcripts of the recording. We are unable to promise you any individual benefits from participating in this research. If you decide to participate you can withdraw at any time without having to give a reason. If you decide not to participate, or you wish to withdraw from the project at any time, your decision will not disadvantage you. Your access to services at this hospital will not be affected, in any way, whether you choose to participate or not. If you choose to withdraw, and if it is possible to retrieve, your data will be returned to you.

How will your privacy be protected?
All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants (in coded form). The consent form and the general information about you will be kept in a separate location from the observation and interview data. You will be allocated a numerical code which will be used for all observation and interview data. The data will be stored in a locked cabinet at the University of Western Sydney and destroyed 7 years after publication. Individual participants and institutions will not be identifiable in any publications arising from this project.

How will the information collected be used?
The information collected will be analysed and reported in a thesis to be submitted for Ms Burns’ degree. We plan to write papers for publication in professional journals outlining the research and the findings and present the results at professional conferences. Confidentiality of individual participants and organisations will be assured. A report will be provided to all participants with opportunity for feedback before the report is finalised.

What do you need to do to participate?
Please read this Information Statement and be sure you understand its contents before you consent to participate. After you have read this information, Ms Burns will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Elaine Burns, PhD Candidate, Mobile 0431731160 or Associate Professor Virginia Schmied, Project Supervisor, Ph 9685 9505.

Thank you for considering this invitation

Signatures
A/Prof Virginia Schmied
University of Western Sydney

Ms Elaine Burns
University of Western Sydney

................................................... …………………………………………….
Signature  Signature

...../ ...../ ..........    ...../ ...../ ..........
Date  Date

Complaints about this research
This research has been approved by the Human Research Ethics Committee of [Name of Health Service], Reference 08/06/18/5.03.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to … (Name Provided).
Appendix 4

Consent form for midwives and lactation consultants;

Consent form for participating women, and their partner or significant other;

Consent form for Parenting Educator; and

Consent form for Parenting Education Class Participants
Consent form for midwives and lactation consultants:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to having interactions about infant feeding, between myself and a pregnant woman or new mother, observed and audio recorded. Yes No

I consent to participate in an interview at a time convenient to myself. Yes No

I consent to participate in a focus group. Yes No

I understand that I can ask for the recording to be stopped at any time and can review the transcripts.

I understand that my personal information will remain confidential to the researchers.

I have the opportunity to have questions answered to my satisfaction.

Print Name:
Signature: Date:

Contact Details:

I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:
Signature: Date:
Consent form for Parenting Educator:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to having this parenting education session observed and audio recorded. Yes  No

I consent to participate in a focus group. Yes  No

I understand that I can ask for the recording to be stopped at any time and can review the transcripts.

I understand that my personal information will remain confidential to the researchers.

I have the opportunity to have questions answered to my satisfaction.

Print Name:
Signature: Date:
Contact Details:

I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:
Signature: Date:
Consent form for Parenting Education Class Participants:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to having this parenting education class observed and audio recorded. Yes No

I understand that I can ask for the recording to be stopped at any time and can review the transcripts.

I understand that my personal information will remain confidential to the researchers.

I have the opportunity to have questions answered to my satisfaction.

Print Name:
Signature: Date:

I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:
Signature: Date:
Consent form for participating women, and their partner or significant other:

Establishing breastfeeding: an analysis of the language and practices used by midwives and lactation consultants when interacting with new mothers.

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to having interactions about infant feeding, between myself and a midwife (or lactation consultant) observed and audio recorded. Yes  No

I consent to participate in an interview following discharge from hospital and at a time convenient to myself. Yes  No  N/A

I understand that I can ask for the recording to be stopped at any time and can review the transcripts.

I understand that my personal information will remain confidential to the researchers.

I have the opportunity to have questions answered to my satisfaction.

Print Name:

Signature: Date:

Contact Details:

I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:

Signature: Date:
Appendix 5

Field Observation Guide
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<td>Participant Code:</td>
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<td>Midwife Code:</td>
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<td>Postnatal Day:</td>
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<td>Date:</td>
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<td>Time:</td>
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<td>Bed Number:</td>
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<td>Ward Environment:</td>
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<td>Present in the Room:</td>
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<td>Curtains or other notable factors:</td>
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<td>Interaction initiated by:</td>
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<td>Midwife demeanour:</td>
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<td>Participant demeanour:</td>
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<td>Baby behaviour:</td>
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<td>Non-verbal interactions:</td>
<td></td>
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<td>Comments:</td>
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<td>Closure initiated by:</td>
<td></td>
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<td>Outcome of interaction:</td>
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Appendix 6

Reflexivity in midwifery research: The insider/outsider debate

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Abstract

Objective: to explore the challenges of conducting an observational study of postnatal interactions, between midwives and women, when the researcher was a midwife observing in familiar midwifery settings.

Background: participant observation conducted by researchers who are themselves midwives raises questions regarding the influence of ‘identity’ and ‘insider’ knowledge on the conduct of such projects. The insider/outsider status of researchers has been explored in other disciplines, yet this is an area which is underdeveloped in the midwifery literature where few attempts have been made to subject this issue to sustained analysis.

Design: a qualitative study (investigating the provision of breast-feeding support in the first week after birth) provided the opportunity for reflexive exploration of the tensions faced by midwife researchers.

Setting: two maternity units in New South Wales, Australia.

Participants: participants included 40 midwives and 78 breast-feeding women.

Findings: possessing ‘insider’ midwifery knowledge was advantageous in the ‘getting in’ and ‘fitting in’ phases of this research study however unanticipated role ambiguity, and moral and ethical challenges, arose as a result of this ‘insider’ knowledge and status. Prolonged periods of observation challenged the midwife researcher’s preconceived ideas and early decisions about the advantages and disadvantages of being an ‘insider’ or an ‘outsider’ in the research setting.

Key conclusions: reflexive analysis of insider/outsider experiences revealed the middle ground which participant observers tend to navigate. Whilst professional insider knowledge and status offered many advantages, especially at the first study setting, some of the inherent embodied, and socially constructed features of the ‘midwife’ observer role, were unanticipated. Cultural competence, in these observational study settings, translated into role ambiguity, and at times, culturally entrenched role expectations. Implications for practice: midwifery observation of clinical practice, for research, or practice development purposes, requires a degree of juggling of insider knowledge to facilitate observation and analysis. Prior to conducting observations midwives should consider how best to occupy the middle ground between insider and outsider. Within the middle ground the midwife can draw on those aspects of ‘self’ required to negotiate respectful relationships with colleagues, whilst also ensuring the maintenance of an analytical degree of distancing.

Introduction

Evidence based practice is fundamental to contemporary midwifery care and in recent years midwives have made increasing contributions to this research agenda. Observation of midwifery practice, for research purposes, spans the entire methodological spectrum, with ethnographic research methods gaining increasing popularity. Observational research, conducted by researchers who are themselves midwives (Hunt and Symonds, 1995; Stapleton et al., 2002; Hunter, 2005; Dykes, 2006), offers opportunities for reflexive consideration of the influence of professional ‘identity’ during data collection. Although the importance of identity, and the issues of ‘insider’ researcher status in ethnography have been explored in other disciplines, this is an area which is underdeveloped in the midwifery literature. In fact conspicuously few

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Attempts have been made to document the issues arising from sustained observation and analysis of midwifery colleagues. This paper aims to address this gap in the midwifery methodological debate by exploring the benefits, unanticipated challenges and insights gained from fluctuating ‘insider’ and ‘outsider’ experiences during an observational study of the interactions and practices of professional midwifery colleagues.

To orientate the reader a brief scholarly overview of the issues involved in undertaking participant observation is provided. The paper then presents two case studies drawing on data from 85 recorded interactions between midwives and women, where breast feeding was the focus, during the first week after birth. The two distinct maternity unit environments and professional communities had different cultural norms and mores. Attaining and maintaining a researcher presence at each site required different levels of midwife/researcher or insider/outsider positioning.

**Background**

The aim of observational research is to gain insight, from both an emic (insider) and etic (outsider) view of the culture and practices of a particular community or group (Spradley, 1980; Hammersley and Atkinson, 2007). In order to achieve this enhanced understanding, an authentic and holistic account of the group’s (participants') attitudes and behaviours needs to be observed and recorded (Fetterman, 1989). Undertaking this task requires the researcher to maintain a presence ‘within’ the social world they wish to observe. Making decisions around the level of engagement [for example, from complete observer to complete participant (Gold, 1958; Atkinson and Hammersley, 1994)], and getting the balance right, is often a challenging task (de Laine, 2000; Borbasi et al., 2005; Hammersley and Atkinson, 2007; Simmons, 2007).

Contemporary approaches to participant observation, particularly within the health-care context, include more participation than has been the case historically (de Laine, 2000; Borbasi et al., 2005). As a result over the last two decades there has been an increasing body of work focusing on the experience of conducting research as an ‘insider’ in health-care settings (Borbasi, 1994; Asselin, 2003; Allen, 2004; Lykkeslet and Gjengedal, 2007; Simmons, 2007; Condell, 2008).

Authors who have had prior or existing membership of the group being studied have reported benefits from ‘insider’ knowledge or status. Identified advantages include ease of access to the study setting and early rapport building (Lipson, 1989; Reid, 1991; Gerrish, 1997; Asselin, 2003; Simmons, 2007). For example nursing and midwifery researchers have commented on the ease with which they can enter hospital and, ‘blend in’ due to their knowledge of the culture and language and ‘degree of acceptance’ from other clinicians (Gerrish, 1997; Leslie and McAllister, 2002; Allen, 2004; Simmons, 2007; Santiano et al., 2008). Having an ‘insider’ perspective has been identified as advantageous when negotiating and maintaining access to the study setting as the insider is more readily accepted, has a better understanding of the culture and the language, and has less chance of affecting the flow of interactions (Bonner and Tolhurst, 2002; Leslie and McAllister, 2002; Toffoli and Rudge, 2006). The insider/outside status of the researcher can therefore influence synchronisation with the study setting and participant behaviour (Bonner and Tolhurst, 2002).

Predictably, conducting participant observation within one’s own professional group can produce challenges between being known as an ‘insider’ whilst endeavouring to observe with an ‘outsider’ lens (Leslie and McAllister, 2002; Allen, 2004). Role confusion and over-identification with participants are two examples of challenges regularly reported in the literature (Klein and Johnston, 1979; Lipson, 1989; Reid, 1991; Gerrish, 1997; Bonner and Tolhurst, 2002; Groenknjaer, 2002; Toffoli and Rudge, 2006). Adler and Adler (1987: 17) describe how over familiarity in an area might result in the loss of ‘analytical perspective’ and may risk the researcher ‘going native’.

Debates continue regarding whether the best research is conducted by external observers (outsiders), or by marginal/full members of the group being studied (insiders) (Kanuha, 2001; Morse, 2006; Hammersley and Atkinson, 2007; Zaman, 2008). Several authors have identified the need for more discussion on researcher experiences in managing and maintaining access to research participants within health-care settings and the potential for over-identification within familiar clinical settings (de Laine, 2000; Morse, 2006; Toffoli and Rudge, 2006). Less is written about the degree of familiarity researchers should have with participants, the research site and how researcher/clinicians position themselves during observational research (Lipson, 1989; Borbasi et al., 2005). These are also important considerations for strengthening approaches to practice development and practice review, both of which use observational techniques, and which have previously received limited consideration in midwifery literature.

**Methodological context**

This paper draws on the experiences of a novice researcher who is also an experienced midwife (first author EB), collecting research data, in hospital and community settings. Data collection was part of an Australian national competitive grant with an embedded doctoral scholarship supported by an academic group supervision model (second, third and fourth authors). A number of data collection techniques were employed during the study including audio recorded observations, face to face interviews with midwives and women, focus group interviews and field notations. Ethical approval for the study was obtained from both the University and participating Area Health Services in New South Wales, Australia (HREC 08/06/18/5.03).

The majority of the observed and recorded interactions were collected from postnatal wards at two maternity units, neither of which the midwife/researcher had previously worked at. Maternity unit (MU) A was situated within an Area Health Service with one of the highest birth-rates in NSW (CER, 2008). At the time of data collection the maternity unit was short staffed by eight full time equivalent midwives.

Maternity unit B was situated within a large tertiary referral centre within a different Area Health service in NSW and had approx. 1000 more births per annum than MUA. At the time of data collection midwifery staffing was at optimum levels. The staff mix at both settings included student and registered midwives, some of whom had additional qualifications as lactation consultants.

Data were collected over a 16-week period during 2008–9. The interactions were observed across the three different shift times (morning, afternoon, and night shifts). The 85 interactions recorded included 40 midwives and 78 different women. Detailed field notes, outlining researcher thoughts, feelings and the process undertaken, were collected at the end of each observation ‘shift’. Further reflection and field note recording occurred during and as a result of ongoing monthly research team meetings and group analysis sessions. The field notes form the data set for this paper.

To meet the aims of the study it was important to gather data which included the language and practices used by midwives when supporting breast-feeding women in the very first week after birth. As a research group we recognised and discussed at length that the collection of this data might be confronting for some of the participants. Asking women to allow a complete stranger to be intimate, and for some, profoundly private experiences, was...
considered potentially difficult and sensitive. In addition, midwives were asked to permit an unknown, external researcher to observe, audio record, and document their interactions with women. With this in mind the research team spent some time considering how best to approach the study settings. Our combined extensive work experience both as midwives and nurses, in a variety of maternity units and hospital, gave us insight into these environments and what might be required to ensure respectful field relationships were established. We considered the influence of professional insider, but organisational outsider (Simmons, 2007), status on access, recruitment and ongoing interaction with participants within the study environment.

At the outset it was agreed a ‘peripheral member’ status (Adler and Adler, 1987: 36) would facilitate inconspicuous observation and an emic perspective without the need to actually participate in core activities. In addition, we acknowledged the advantages of utilising professional insider knowledge to enhance accessibility, minimise researcher effect on the midwife/woman interactions, and facilitate ‘unobtrusiveness’ (Fetterman, 1989; Field, 1989; Hammersley and Atkinson, 2007; Condell, 2008). The following case studies will highlight the unanticipated challenges and fluctuating nature of insider and outsider positioning experienced within these health-care settings. The case studies reveal the first authors (E.B.) reflexive journey and for this reason the following section has been written in the first person using ‘I’ rather than ‘we’.

Case Study One: insider positioning

Approximately six months prior to commencement of participant observation at MU A, I was introduced to key gatekeepers and began attending midwifery staff meetings. These meetings provided an opportunity to meet potential participants and generally become a familiar face in the maternity unit. At the meetings I discussed my background and interest in the midwifery support given to women who are breast-feeding. I indicated a level of understanding of the resource constraints midwives were working within and was sympathetic to the fact the unit was short staffed and often very busy. Over the intervening months I also became increasingly aware of the impact this busy, under resourced working environment had on staff morale. I felt able to relate to the midwives’ frustrations and dissatisfaction having worked previously in very busy, understaffed hospital environments. As I listened to the stories of workload issues, feelings of discontent and helplessness I found myself relating in an empathic collegial way.

Overcoming suspicion

One month prior to planned commencement of data collection, I attended staff meetings to invite midwives to participate in the study and asked for expressions of interest. I provided a written invitation for each staff member and posted an expression of interest (EOI) form in the staff tea room. The EOI form hung on the staff room wall for two weeks without any names being listed. I sensed there was a certain level of suspicion amongst the staff as to what the study might involve and who the findings might be reported to. Researchers conducting studies within their own health-care settings have reported similar experiences (Asselin, 2003; Allen, 2004; Simmons, 2007). Staff at this hospital seemed ‘stressed’ at the outset and appeared not to have time to participate in any additional activities which were not directly related to providing care to women and newborns.

From the beginning I felt it important to breakdown any ‘hierarchies’ between myself as the researcher and potential participants (Leslie and McAllister, 2002; Karnieli-Miller et al., 2009). I also felt a strong desire to avoid adding additional tension, by assuring midwives that confidentiality was a high priority, and that the study was not about scrutinising individual practice but rather aimed to capture the broad spectrum of practice.

As a professional member of the group under study I had the added benefit of identifying a ‘commonality’ between myself, as the researcher, and participants (Dwyer and Buckle, 2009: 58). During an informal chat at an ‘afternoon tea get together’ several staff asked questions about the project and generally chatted about the importance of gaining insight into midwifery practice. Midwives seemed keen to ascertain the aspects of midwifery care which women find beneficial and to identify those areas where improvements could be made. During this informal discussion, several senior members added their names to the EOI and by the end of the ‘afternoon tea’ I had eight potential midwifery participants. My perception was that the midwives became more willing to contribute as a result of an increased level of shared understanding between us. Shared understanding of this nature has been found to be especially beneficial in health-care settings (Toffoli and Rudge, 2006; Dwyer and Buckle, 2009).

Getting in

Despite being an outsider in the ‘organisational’ sense, my professional midwifery insider status seemed to facilitate early acceptance of my regular presence on the ward (Simmons, 2007: 12). Strategies utilised to limit researcher obviousness included paying close attention to the mode of dress and deportment of the observer (Bonner and Tolhurst, 2002; Allen, 2004; Hammersley and Atkinson, 2007). Reid (1991: 547), a nurse conducting research on a hospital ward, reported feeling fearful of ‘flaunting’ her university status by dressing in her own clothes and wearing her hair down. I dressed in a subdued understated way, similar to the uniform style worn by the midwives. A concerted effort was made to avoid wearing red as this was the colour worn by managers and it was important to avoid being cast as a ‘management spy’ (Simmons, 2007: 13). As reported by other clinician researchers I found it beneficial to wear an identification tag in the same style of lanyard card holder as the staff wore and generally sought to present myself as more ‘like’ than ‘different’ to the larger group of potential participants (Reid, 1991; Gerrish, 1997; Groenkjaer, 2002). Staff questioned me on my midwifery background when meeting me for the first time and this represented a period of ‘sussing’ out my credentials and deciding if I was a suitable person to be observing clinical practice.

Fitting into the context

Gaining acceptance into the study setting involved approval for researcher presence from, not only the participants, but other non-participating team members. The physical layout of the ward included a central work station where an administrative clerk, midwives, and other health personnel, gathered to record notes and follow-up on clinical results on the ward computers. The desk area was a large square space in the centre of the ward, closed at two sides and open at two. The open sides were flanked by large bright signs warning that this area was for ‘authorised personnel only’. This space was strictly a staff only domain despite the fact that it represented a short cut from one side of the ward to the other. Women and their visitors were seldom permitted to take this short cut. My perception was that staff closely guarded this domain and continually reinforced to outsiders that this was their territory. Initially, I remained outside the midwives station whilst introducing myself and the research study to staff. However, being on the outside of this area seemed to highlight my outsider status, so to minimise outside observer effect I began positioning myself within
Fitting in with the midwives

Fitting into the setting represented not only a period of blending in, to minimise disruption of the day to day activities on the ward (Gerrish, 1997; Bonner and Tolhurst, 2002), but also becoming attuned to the individual needs of midwives who consented to participate (Reid, 1991; Borbasi, 1994). Midwives who had previously identified themselves as interested in participating in the study were approached at a later date to negotiate the most appropriate shift to schedule for observation. Throughout this process I sought to fit around the midwives own schedule. This involved availability across the three shifts: morning, evening and night shift, and included weekends. Initially I planned to attend the MU for 4-hour sessions of observation. Following my first few observation sessions, and after discussion with my supervisors, it became apparent that it was important to work an entire shift with the midwife as this seemed the least disruptive approach and facilitated my desire to obtain an emic perspective and to authentically represent the complexity of the postnatal midwifery role.

Once I began data collection it also became important to be 'in tune' with the day-to-day stressors on the ward. Midwives were often working short staffed and regularly seemed to be in 'distress' with the number of women they needed to care for on the ward. Invariably availability for the provision of breast-feeding support was compromised in this context as staff sought to direct their energy towards other priorities. This type of authentic reflection of restrictions on staff accessibility, for optimal breast-feeding support, was a central component of the research agenda. However, at times in the early stages of data collection, whilst staff were getting to know the researcher and there was still a degree of unease and unfamiliarity about the project, I felt that being present on the ward exacerbated staff stress and added to their feelings of being burdened. Vignette 2 from my field notes illustrates this situation.

Vignette 1:

Two afternoon staff went off to the tea room for handover whilst I stayed at the desk. The morning staff then asked if I also wanted to attend handover and I agreed this might be helpful. The afternoon staff accepted me into the room to sit in on handover. Initially I thought this was a useful way to firstly blend in, secondly, gain an idea of the number of potential breast-feeding participants and thirdly gain acceptance from the midwives. However, during the handover session it became obvious that it would not be appropriate for an 'organisational outsider' to continue to sit in on these sessions for three reasons. Confidential information was discussed about clients without their prior knowledge that a researcher might be present, secondly the researchers’ presence may have caused uneasiness for non-participating midwives who were giving or receiving handover, and thirdly information gained from this forum could not be utilised in the study in any case.

Vignette 2:

I arrived today (day 3) to collect observations with a midwife I had spoken to previously and who had expressed an interest in participating in the study. On arrival the midwife was obviously distressed and didn’t look very pleased to see me. She stated ‘I don’t know how much observing you will get today as it is so busy’. The ward was short staffed and she was frantically trying to get another staff member to cover… I could see that she was distressed and I offered to return on another shift when staffing was better. I felt that to proceed with the plan to observe this midwife’s interactions this shift would have added to her feelings of being burdened … she gladly accepted saying ‘today would not be such a good day’ to do observations. I agreed to return the following Friday.

This vignette highlights the influence of professional insider knowledge on decision making. A professional outsider may have proceeded with the planned observation shift regardless of the midwives' distress. This type of action could be considered exploitative, and had the potential to damage the rapport established thus far. Although an objective of the study was to observe breast-feeding support provision on busy understaffed shifts, at the time this vignette was documented I considered it important to prioritise the building of ongoing respectful and trusting relationships with participants in the study. This strategy was successful as there were numerous opportunities at subsequent visits to gather rich data on very busy, understaffed shifts with midwives who happily gave permission for me to stay and observe. This experience revealed that although professional insider knowledge influenced researcher decision making at certain times, ultimately it did not limit data collection and in fact may have enhanced opportunities via mutual respect and trust.

‘Fitting in’ also represented an uncomfortable period of identifying where best to position myself within the physical layout. As discussed previously I initially hovered around the perimeter of the midwives work station until I felt a level of acceptance to remain within this space. However, quite unexpectedly, once I had become comfortable interacting with midwifery participants within this ‘inner sanctum’ I found myself slipping into clinician ‘worker’ mode at times as indicated below, when the boundary between clinician and researcher became blurred. The nature of this particular ward environment, which was often short staffed and busy, meant that I often felt a strong desire to ‘help out’ (Morse, 1989; Reid, 1991; Gerrish, 1997; Lykkeslet and Gjengedal, 2007; Simmons, 2007).

Blurring of boundaries

As a midwife I was very comfortable relating to midwife participants within this environment. I could relate to their frustration when working shifts with insufficient staff. Whilst at times I felt it important to ‘help out’ whenever I could this was hampered by my limited capacity, due to ethical and legal requirements, associated with organisational outsider ‘researcher’ status. Vignette 3 highlights the dilemmas associated with this.

Scenarios such as these became common place whilst I maintained a presence within the midwives working station. As a pseudo-member of the team, within the boundaries of the midwives station, I also found staff would seek me out to ask advice on a particular clinical problem they were having. This resulted in further reflection on my position as researcher or midwifery colleague (see Vignette 4).

As the study drew to a close at MU A I began to feel a level of ‘protectiveness’ towards the midwife participants. Staff began to question me, during the last few weeks about ‘how bad’ the study
findings might be and there was an undeniable sense of dread from staff about the final analysis (see Vignette 5).

This trend towards over-identification with participants represented the commencement of a period of re-thinking the merits of insider positionality. Slowly I began to acknowledge some of the benefits of highlighting my organisational outsider status whilst in the field (see Vignette 6).

Case Study 2: outsider positioning

In the 12 months prior to commencement of data collection at MU B, I met key gatekeepers and attended several staff meetings, to introduce the study and provide information to staff about what the study would involve. Again, I introduced myself as a midwife conducting research, and was warmly received by staff who

Vignette 3:

When call alarms are activated, and at times go unanswered, my natural inclination (or perhaps conditioned response) is to go and answer them. I am finding it unsettling knowing that someone is needing assistance and yet staff are busy and cannot attend. Today I noted a buzzer ringing during a staff member’s whole tea break (20 minutes continuously) as none of the other midwives had answered it. I wanted to help out today by answering the call for assistance when staff were busy. However, due to my organisational outsider status, inevitably I needed to find a staff member to assist with the woman’s request. This is becoming very frustrating when, with my ‘clinician hat’ on, I could easily be of assistance to both the woman and the staff member.

Vignette 4:

Today the staff were tending to check what I thought about particular clinical decisions they were making. During these discussions I felt hesitant to participate as I normally would in a clinical setting as I felt I would be stepping outside of my role as a researcher to engage in clinical decision making discussions (on issues such as whether a particular medical recommendation was appropriate). I felt constantly in limbo between outsider ‘researcher’ and insider ‘clinician’.

Vignette 5:

I am beginning to feel like it is a breach of trust to report any negatives about the way midwives conduct their work. I feel that the midwives have generously offered to let me observe their practice and it subsequently feels wrong to highlight the areas of poor practice observed.

Vignette 6:

As an organisational ‘outsider’ it felt good to be removed from the interpersonal clashes which inevitably plague any workplace and I have felt a certain degree of freedom to be able to attend staff meetings and workshops without any of the ‘baggage’ that others seemed to bring to these meetings. This experience is highlighting for me the importance of maintaining a certain ‘outsider’ distance whilst in the field.

Vignette 7:

First shift on the ward today and I was warmly welcomed by the midwives. The midwife I was due to work with was keen to introduce me to other staff and was generally eager to help out. I felt an instant researcher acceptance and instant welcoming into midwifery areas. I felt that I had an ‘access all areas’ status and did not feel a need to gain acceptance as it was already implicitly offered.
Fluctuating insider/outsider positioning

As discussed previously the research team had agreed working the ‘shift’ with the midwife would be the most beneficial way to conduct observations. At times this was difficult, due to the location of the sites; however, it became clear that this was crucial to gaining staff respect and trust in my researcher role (see Vignette 8).

This encounter highlighted both my outsider and insider status. My outsider status was clear as I was a transient sporadic member of the group. However, my professional insider status was also in question here. This is the kind of reaction I would have anticipated had I been working clinically on the ward that day but as an observer midwife there was still valuable research data to be gathered on this day. Respecting participants and blending into the expected pattern of midwifery behaviour was important for maintaining access to the research site and for ensuring ongoing participation.

Midwifery staffing at MU B was optimal and midwives had access to additional personnel and resources to assist with their work throughout the day. Midwives seemed to spend most of their time with women and the ‘staff-call buzzers’ were mostly answered promptly. At times I helped out by fetching things for the midwife, however, while interacting with the midwives at this site, I maintained an ‘observer midwife’ status and seldom felt the need to engage in ‘hands on’ help whilst there. I believe this was partly due to my position at the outer perimeter of the work station. When call buzzers would alert I did not feel obligated to answer the call if the midwife was busy. The staffing levels at this site meant that another staff member would invariably leave the central work station to answer the call. I did notice, however, that on evening or night shifts, whilst I was sitting within the work station, I often helped out in more practical ways, such as settling babies.

Clinical discussions often occurred within the designated staff work station. Whilst midwives permitted me to observe these discussions they did not ask for my opinion or input into the discussion. Despite being accepted as a professional insider my outsider status was also acknowledged by the midwives (see Vignette 9).

Role ambiguity

The challenges to role boundaries experienced in this setting often occurred when the midwife left the room momentarily. There were a number of occasions when the woman and/or her partner would use this opportunity to ask what I thought about their situation. Having introduced myself to participants as an outsider midwife there followed a tendency to ‘check out’ what I thought about whether everything seemed ‘normal’ or not. This became especially uncomfortable when the practice being observed was causing distress to the woman. Remaining a silent observer when the midwife had left the room was especially challenging. For example, during an observation of a discussion about infant care with a first time mother the midwife continually spoke to the woman as though she was a novice at handling infants. When the midwife left the room (to get a nappy) the woman and I engaged in chit-chat. During this brief interchange the woman indicated that she had a professional background as an early childhood worker. When the midwife returned I was torn between telling the midwife this additional information or continuing to observe the conversation that ensued to determine how far into the interaction it would be before the midwife elicited this information herself. I found it agonising to observe the resultant interaction because the midwife continued to speak to the woman as a novice and did not engage in any ‘checking in’ with the woman about prior knowledge. Despite my maintenance of an outsider observer positionality the relationship formation, which inevitably occurs between researcher and (in this case midwife) participants, meant that observing this midwife without supplying her with the additional information I had gained felt like ‘spying’ or what some researchers describe as ‘exploitative interloper’ behaviour (Adler and Adler, 1987; Gerrish, 1997; Hammersley and Atkinson, 2007: 217; Simmons, 2007: 4).

As the study drew to a close the high morale, resilience, and sense of being ‘valued’ that I had observed within this group of midwives meant that they seemed keen to hear both the ‘good’ and the ‘bad’ stories and to learn new ways to improve their practice. Unlike MU A I did not experience any sense of betrayal in highlighting the negative practices observed.

Discussion

This paper has drawn on midwife researcher experiences and ongoing reflections to explore the dynamic nature of observational research conducted within maternity units. The changes in positionality across these two study sites challenged the binary insider/outsider dialectic. Whilst similar methods were used to gain entry into the maternity sites including approaching key gatekeepers, attending meetings prior to entry, paying attention to the presentation of ‘self’ and endeavouring to ‘fit in’ around participants schedules, different insider/outsider positioning was used. Several factors impacted on the decisions made regarding insider or outsider positioning including the culture within the maternity unit, spatial layout and level of staffing. These, combined with researcher reflexivity and sense of self in the field, created a greater awareness of insider–outsider, clinician–researcher, positionality. These nine vignettes provided insight into the complex nature of ‘professional insider’ participant observational work. The researcher experiences illuminated many of the ambiguous characteristics of observational research, conducted with midwifery colleagues, which should be considered prior to commencement of research studies, as well as when undertaking practice development and professional practice review.

Vignette 8:

Today I arrived half way through the morning shift. This was unavoidable because of a car accident on the way to the hospital this morning but on my arrival I sensed that the staff felt I had missed most of the shift. The midwife I was due to work with said ‘you have missed lots of potential interactions’. I had previously observed the regular pattern of caregiving which seemed to focus around the morning until about 12:30 p.m. when staff would be writing up notes or updating the computer or handing over to team leader. As I was just arriving at 11:30 the staff probably felt there was not much point in being there. After explaining the reason for my lateness and re-negotiating with the midwife whether to remain for the rest of the shift or not she agreed that it might be beneficial if I continue to observe for the rest of the shift (another 4 hours), which I did and in the end I gained valuable data today.

Vignette 9:

During a clinical decision making discussion about a client today I was included as an observer but was not asked for my opinion or to contribute my own clinical experience to the discussion. There was an obvious sense of confidence between the staff that even if they did not have the answer or solution to the problem their colleague would. I observed that additional opinions were gleaned from senior staff working on the ward today.

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Insider/outsider dialectic

Consistent with previous work, using a professional insider status, enhanced credibility, and facilitated researcher ease of access and initial acceptance at each site (Field, 1989; Reid, 1991; Groenkaer, 2002). Similar to Leslie and McAllister (2002: 701), naming oneself as a ‘midwife’ highlighted a commonality in cultural identity between researcher and participants and implied a level of ‘trustworthiness’. The socially constructed meaning of professional identity offered an expedient way of communicating certain positive researcher characteristics, such as caring, capacity to listen and empathy (Leslie and McAllister, 2002). In this study, highlighting a shared embodied understanding (Savage, 1995) of the nature of midwifery care, also contributed to the development of trusting and respectful ‘field’ relationships with midwifery participants. Identifying mutual desires, such as improving clinical practice, alleviated some of the suspicion toward the study purposes. In addition, professional acculturation and a level of ‘cultural competence’ facilitated ongoing acceptance of researcher presence (de Laine, 2000; Kanuha, 2001; Borbasi et al., 2005).

The desire to emphasise either insider or outsider status was however, contingent upon the reception from midwifery staff during preliminary engagement with staff. The presence of a research culture at MU B meant acceptance of an outsider researcher, observing practice, was rapid and welcomed. The high morale noted amongst the midwives at MU B conveyed a sense of openness to scrutiny, and staff seemed committed to improving practice. By contrast midwives at MU A had less familiarity with clinician researchers, low morale and an initial reluctance to participate. As a result negotiating and maintaining access to this site was much more delicate. Research suggests that midwives who have been working in understaffed areas for prolonged periods of time report high levels of stress, low morale and ‘diminishing competence and confidence’ in their role as a midwife (Brodie, 2002: 8; Curtis et al., 2006). Leslie and McAllister (2002) further point out that a heightened level of suspicion towards ‘outsider’ observation is often the result of participants perceiving themselves to be on the bottom of the hierarchy. In this context outsiders and their behaviour, whether belonging to the profession or not, might be interpreted pessimistically as ‘spying’ and/or an opportunity to exploit the negatives (Adler and Adler, 1987). Similarly, Clarke and Cochrane (1998: 31) argue that researchers entering the clinical field to observe practice can also be construed as disrupting the status quo and as such are at risk of being labelled ‘troublemakers’ or ‘agitators’. Attracting the label of ‘other’ can be problematic when conducting research in a setting where there is a clear distinction placed on insiders or outsiders (Adler and Adler, 1987: 43).

Although insider positioning was found to be advantageous for gaining entry and maintaining access to participants in this study, there were instances of blurred role boundaries, testing of authenticity and feelings of clinical incapacity. The vignettes served to highlight some of the moral and ethical dilemmas which peppered this research journey. The level of ‘participating’ and ‘observing’ the midwife researcher could engage in was often perceived as a ‘grey’ area which challenged the competing insider/outsider binary. At both study sites there were examples of over-identification with midwifery participants, and feelings of betrayal of participant trust, regardless of the level of insider or outsider positioning. Others have similarly reported feelings of guilt, exploitation and disloyalty when undertaking participant observational work (Baillie, 1995; Lykkeslet and Gjengedal, 2007: 701; Simmons, 2007).

The complex nature of negotiating ‘relational closeness’ whilst ensuring ‘analytical distance’ (Lykkeslet and Gjengedal, 2007: 701), represents a dilemma for participant observers. Maintaining what can be described as a ‘social and intellectual distance’ (Hammersley and Atkinson, 2007: 90) from participants seems at times incongruous with establishing open, honest, trusting research/participant relationships (Allen, 2004). Yet without the space created by ‘distancing’, authors such as Hammersley and Atkinson (2007) contend that analysis would be rendered impossible. In this study, clarity of researcher positioning emerged from the continual balancing of outsider ‘strangeness’ with insider ‘relationality’. What became crucial was the researchers’ ability to cast a backward critical gaze at their own subjective positioning and engage in ongoing reflexivity (Finlay and Gough, 2003).

The benefits of reflexivity

There is little doubt that the process of reflexivity facilitated awareness of the variability of the insider–outsider experience and the resultant fluctuating nature of peripheral and active membership roles (Adler and Adler, 1987). Undertaking what has been described as ‘methodological self-consciousness’ (Finlay and Gough, 2003: 4) has become an integral component of qualitative enquiry (Lipson, 1989; Baillie, 1995; Allen, 2004; Toffoli and Rudge, 2006). The ‘story behind the story’, which reflexivity provides, inevitably gives rise to greater insight into the relationships between participant–researcher and the co-produced nature of qualitative research (de Laine, 2000: 212; Finlay and Gough, 2003: x).

The choices qualitative researchers make between the ‘dispassionate’ observer or engaged participant observer have been characterised as constituting a ‘moral passage’ for the interpretive researcher involving questions of ‘self-identity’ and ‘moral’ decision making (de Laine, 2000: 18). As these vignettes attest, prolonged periods of observation forced ‘self-awareness’ through the moral and ethical questions, which unfolded during data collection, and the problems of identity, which were part of the research journey (de Laine, 2000). It was these very dilemmas that led to greater insight and understanding about the ‘self’ and the moral and ethical interplay between the researcher and participants (de Laine, 2000).

Self-awareness of prior socialisation as a midwife and nurse was prominent in both study sites. Whilst highlighting the researchers professional ‘insider-ness’ implied certain desirable ‘midwifery’ characteristics, it also, unintentionally, entailed some unwanted socially constructed meanings. The socially constructed nature of the identity of ‘nurse’, ‘midwife’ or ‘researcher’ (Allen, 2004) meant that potential participants brought their own preconceived notions about the researcher–clinician role independent of the desired positionality. The implicit understanding that the researcher/clinician could ‘pitch in’ if it was busy (Beale and Wilkes, 2001) and work the full shift was an unspoken feature of the clinician–researcher relationship. The balancing act between being a stereotypical ‘good’ clinician and/or a ‘good’ researcher seemed at times an impossible tight-rope to walk (Beale and Wilkes, 2001: 38). This was especially so when colleagues were working with minimal staffing and busy workloads. The tussle between roles experienced here, highlighted the importance of clinical practice to clinician identity and the confusion which arose when this identity was evoked (Allen, 2004).

The middle ground

The insider/outsider debate facing midwifery researchers cannot be prescriptively resolved (Acker, 2000: 198). We would argue that the process of discovering how to work creatively within a space will inevitably pose some tension. All qualitative researchers bring a combination of skills and a sense of belonging to a multitude of ‘in’ or ‘out’ groups when embarking on research studies. Professional affiliation within a group is just one aspect of commonality and does not denote ‘complete sameness’ within the group (Dwyer and
Buckle, 2009: 60). Members will consist of people with varying levels of commonality in experience, background and even subcultures, which might exist within larger participant groupings (Asselin, 2003; Seymour, 2007). Inevitably participant observers will ‘trade’ on any commonality between themselves and participants to facilitate early and ongoing access to the study setting (Hammersley and Atkinson, 2007). Midwives should acknowledge their own ‘multilayered identity’ and consider the implications of their personal and professional characteristics on their relationships with research participants and colleagues (Leslie and McAllister, 2002).

Throughout this observational study the first author, at times, felt closer to the ‘insider’ or ‘outsider’ perspective, however, this was as dynamic and evolving as the project itself. Discussions around being one thing or another, in this case one of two opposing ends of a spectrum (Bonner and Tolhurst, 2002), can be misleading for midwives entering health-care settings. Researcher experiences presented here corroborate the argument that the ‘fluidity’ of in/out positionality (Sonи-Sinha, 2008) means that we ‘cannot ever occupy one or other of these positions’ but rather must occupy the ‘space between’ (Dwyer and Buckle, 2009: 60–61). Kanuha (whose research focused on cultural insider experience) has termed this ‘researching at the hyphen’, traversing the ‘sometimes conflicting duality...of insider–outsider roles’ (2001: 443).

Participant observers, by their very visibility, engage in participation whilst observing, unaware of the implications of this. Whilst an impersonal, detached, observer might collect objective data devoid of intimacy, relationality and emotion, an engaged and participatory observer will obtain different perspectives (de Laine, 2000). The challenge for midwives using this approach to practice-based research is to balance their multilayered identity, while building rapport, obtaining ‘emic’ perspectives, maintaining their ethical integrity and preserving some ‘distance’ for analysis (Lipson, 1989; Hammersley and Atkinson, 2007).

Central to the set of researcher skills required for participant observation are empathy, caring, sharing, and understanding, without which the researcher will remain a detached observer (de Laine, 2000). Dwyer and Buckle (2009: 59) add, an ability to be ‘open, authentic, honest, and deeply interested’ in participants experiences and committed to ‘accurately represent’ their milieu. The researcher is ‘...the research instrument par excellence’ during observational research (Hammersley and Atkinson, 2007: 17) so enabling insider and outsider aspects to simultaneously coexist expands the range of the researcher’s ‘tool bag’. Awareness of the potential influence of embodied midwifery knowledge on participant observer performance, especially in busy understaffed environments, is a potent reminder of the importance of balancing these insider and outsider perspectives. The case studies presented here indicate a degree of juggling of the various characteristics of insider–outsider experience to achieve the desired level of familiarity with, and distance from, participants. It is only within this ‘middle ground’, between ‘insider’ and ‘outsider’, that ‘emic’ and ‘etic’ perspectives can be realised.

Conclusion

The binary positioning of insider or outsider denies the ‘middle ground’ which qualitative researchers typically navigate. Observational investigations fundamentally require the development of open, honest relationships with participants. Establishing research relationships with participants will inevitably include disclosure of various levels of insider–outsider belongings. This paper highlights the importance of avoiding the tendency to be one thing or another in favour of occupying a space in the middle where the researcher can draw on their multilayered identity to facilitate familiarity whilst maintaining an analytical degree of distance. The challenge for midwifery researchers observing practice is to balance their positionality within the middle ground with ethical integrity, authenticity and relationality. The moral and ethical challenges, which arise as part of the observational experience, should be viewed as opportunities for reflexivity and exploration of the subjective positioning of the midwife observer.

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Appendix 7

Case Study- Helen and Ethan
Helen was a 23 year old woman who was experiencing difficulties breastfeeding her first baby Ethan, whom she had birthed three days before. When recruiting Helen to the study she disclosed to me that she had previously had very little exposure to breastfeeding but had attended parenting education classes antenatally. She was first referred to Sonia, the lactation consultant, the day before due to the difficulties she was having with latching Ethan to the breast due to ‘flat nipples’. Sonia had provided assistance with ‘latching and attaching’ the day before. Overnight Helen, and the midwives, had experienced ongoing difficulties getting Ethan ‘on the breast’. The midwives had attempted to hand express colostrum but could not retrieve sufficient quantities, so Ethan had been ‘topped up’ with formula. It was 11:15 am before Sonia, the lactation consultant, was free to ‘check in’ on Helen again. Sonia was considered a ‘junior’ member of the consultancy team as she had recently been orientated to this extended clinical position, however she had been a midwife for the past 12 years experience.

Sonia commenced this interaction after a request from Helen to assist with latching Ethan to the breast. On arrival, the specialist was equipped to get ‘down to business’ wearing a fresh pair of gloves. Helen was also preparing for the ‘feed’ having woken Ethan up as he was ‘due’ for a feed. Helen had also removed Ethan’s clothes for some ‘skin to skin’ stimulation. Overnight and at the previous feed 3 hours earlier Ethan had been fed formula.

Interaction 67

Sonia: Okay. So we’re day three today aren’t we? Now are you feeling any breast changes this morning?
Helen: Yeah. This one especially is really firm.
Sonia: Okay, yep.
Helen: This one not so much, but yeah.
Sonia: That feels quite firm?
Helen: Yeah.
Sonia: Yeah, okay. So feel bigger?
Helen: Yeah.
Sonia: Are you feeling any tingling sensations in there or anything like that?
Helen: Not really. Just obviously like tender to touch.
Sonia: Okay. So that’s a good sign because it means that your milk might be starting to come in. So that’s a good thing.
Helen: Yep.
Sonia: Okay. Once that milk comes in we could start using the nipple sheild.
Helen: Yep.
Sonia: Get bub on and that might be easier for bub to get on.
Helen: Yep.
Sonia: We usually like to get your milk in first before we start using that. So we might try him on the breast now if that’s what you want to do?
Helen: Yep.
Sonia: See if we can get bub on the breast and then we might umm... yeah we’ll do that first and then see where we go from there.

The consultant use of the word ‘we’ to imply collective decision making was quickly followed by instructions, and commands. Interestingly the use of the nipple shield was positioned as assisting Ethan to get ‘on’ rather than assisting Helen. Despite the skin-to-skin contact Ethan did not look interested in feeding so Sonia proceeded to physically attach him to the breast several times using ‘hands on’ practice, and seemed to coach him through a feed:

Sonia: [to Helen] Do you want a hand? [hands on assistance]...(to Ethan) Come on. You can’t just go to sleep. Got to eat. Come on. Come on. You have to want to suck. Alright. Come on sweetheart. You’ve just gone to sleep. You can’t just go to sleep. You have to wake up and have something to eat. Come on. [hands on] (to Helen) I’m just expressing a little bit there just so that we can try and encourage bub to wake up a little bit.(to baby) You’re either one or the other aren’t you this morning? Asleep or awake [unclear]. Come on sweetie....Come on, you need to wake up. You can’t just sleep like that [name]. You’ve got to wake up. Do you want a feed? Are you ready for a feed? (to mum) When was the last feed sweetie?

Helen: 8:30. (it is now 1120)


Helen: You can’t do it if you’re sleeping mate.


Helen: Come on bubba.

Sonia: You can do it. You can’t do it if you’re sleeping. You need to help us. We can’t do it for you. We can’t make [you suck] sweetie. Come on. Come on [name]. Come on. Yeah. Yeah that’s it. That’s it. You come over to the breast now and do

Helen: [unclear] sleep don’t you?

Sonia: Come on. Try and wake up. Don’t go back to sleep again. What you doing? Are you going to sleep [unclear]? what are you doing? are you going to start to wake up. Are you going to play with mummy’s nipples? Come on. It’s just there. Sweetheart, now we don’t want you crying. We just wanted to wake you up. [unclear]. You’re hungry [unclear] breakfast. Come on sweetheart. Come on.

Helen: [baby crying] It’s okay. It’s okay bubby.

After a few more attempts at getting baby ‘on’ the consultant suggested expressing using the electric pump:

Sonia: Now Helen what we can do to try and bring your milk in a little bit quicker is get you on one of our pumps and that can sometimes help the milk to come on a bit quicker. If you’re already feeling that your breasts are feeling a little bit bigger, we might find that on the pump you might start to get some milk. Once we get you know, 10-15 mls we can maybe put bub on with the shield. How does that sound to you?

Helen: Yeah that sounds good, yep.

Sonia: Okay. At this stage bub’s mouth looks pretty good.

Helen: Yep.

Sonia: It’s just he’s finding it difficult to get onto the nipple and to breast feed. So, we might try with the expressing pump and then once we start getting him – see a bit of volume there, then we could maybe try the shield and see if bub will get on that way.

Helen: Yep.

Sonia: How does that sound to you?

Helen: That sounds good.

Sonia ostensibly went to gather the necessary equipment and also place a nipple shield in the steriliser ready for use when the milk was flowing. The consultant explained what she was doing to Helen including an explanation around the importance of using the pump 3rd hourly to keep the nipples stimulated and to ‘speed up’ the process of milk coming ‘in’. The junior consultant conferred with her senior
colleague to ‘check’ her plan of ‘attack’ was suitable. She returned to Helen to convey this information:

Sonia: I have just spoken with (senior LC) and she agrees as soon as you start getting five to 10 mls then if we get five to 10 mls this time, then we can put the shield on for a feed. Okay? It doesn’t have to be with one of us.

Helen: Yep.

Sonia: With one of the lactation consultants. The midwives can initiate nipple shields so that you find once you start getting that volume then you can go home.

Helen: Okay.

Sonia: Once we try putting the nipple shield on and if bub takes the shield and does really well and has one or two feeds, if you’re feeling confident you can then go home.

Helen: that would be good

Sonia: (interrupts) I think at this stage it probably will be a good idea just to stay until we get those volumes and until we can initiate that shield [unclear]. Because I know we’ve got – I will get the pump…

Helen: Okay. Thank you.

Unfortunately the breast pump was not available when the consultant went to fetch it and Helen had to wait for a further half an hour until it was free. When the consultant returned with the pump she instructed Helen to dress baby (as she had been having skin to skin time). Helen proceeded to talk to Ethan as she dressed him while the consultant watched on and joined in:

Helen: Want to help mummy dress you?

Sonia: No not really mum.

Helen: Because you’re lazy aren’t you?

Sonia: That’s a nice suit mum. So dress him up and wrap him up. Oh dear sweetie. Come on. As soon as mummy gets some milk you can have some food.

This brief interchange clearly placed blame for the difficult circumstances with Helen and her inability to supply sufficient ‘gold’ for Ethan. Sonia proceeded to set up the pump and instruct Helen in how to do this also:

Sonia: Does that feel alright? Okay. Now I’ll just put bubba down there for the moment. I’m just going to get this [unclear]. So, there’s five parts to the pump. There’s your bottle that your milk goes into. There’s this little thing that helps with [unclear]. Dear.

Helen: Pick you up.

Sonia: Hang on. There’s this little white thing that this little dooverlackie here goes onto that little dooverlackie there. Fancy that. Now on that one there sits in there okay. Now the girls can show you… Then there’s this little [unclear]. It doesn’t matter
which way the lead goes in. This just goes into the back where there’s a little hole there. Okay? Which side you want to pump on first it doesn’t matter.

Helen: Doesn’t matter.

Sonia: Okay. So you can try that side first [unclear]. Yep, just clip it on. Just make sure that the nipple area is sort of in the middle of this area here because [unclear] out. Okay. So just hang on. Okay, so we’ll start off with the quick sucks and then it goes into some long drawing sucks okay?... What’s wrong Ethan? You’re awake now. (baby crying and mouthing around looking for nipple) So to settle him down [LC picks up baby and rocks him] do you want me to try that a little bit of formula ...do you want them to [unclear] about it? Just so he can settle down [unclear]. Have you got a watch or something? Ten minutes on that side.

Helen: Yep.

Sonia: Ten minutes on the other side. Then five minutes on each side.

Helen: Okay. [unclear]?

Sonia: Yeah. Just turn it off first then. Drop it [unclear]. I’ll be back in a few minutes. I’ll just go and grab a little bit of formula. Depending on how much milk we get this time I’ll see how we go.

Helen: Okay.

The consultant took Ethan with her as she left to prepare the formula. Instead of getting the formula though, she consulted with the senior lactation consultant and received confirmation that her ‘prescription’ to express the breasts every three hours was correct. When she returned to see Helen she informed her that she had not given the baby formula as he had settled. Helen was continuing to express using the electric pump. The consultant proceeded to give her a lot of advice about ensuring her own fluid intake was sufficient to ‘bring the milk in’ and that she was eating 3 meals per day and resting. The general tone of this interchange was the positioning of Helen as at ‘fault’ for the lack of milk supply. The consultant assisted Helen to switch the pump over to the other breast after 10 minutes of ‘pumping’. Nil ‘liquid gold’ had been expressed over the 10 minute period. Whilst Helen began pumping the other breast the consultant sat nearby and fed Ethan the formula from a bottle. Helen completed her prescribed 10 minutes on each side, followed by 5 minutes on each side. At the end of this Helen looked into the bottle attached to the pump to check for ‘gold’ but the bottle was empty:

Sonia: That’s okay. We’ll do a little bit of hand expressing and we’ll get just as much. Get a bit more for him [unclear]. Sweetie. I’ll put that up [unclear]. Go and get a little cup and we’ll do some hand expressing, okay?
The consultant returned and encouraged Helen to hand express into the cup. Helen proceeded to do this and collected the small droplets of colostrum into the cup. Helen increasingly looked sad as her attempts to express ‘liquid gold’ yielded such small amounts. The consultant endeavoured to reassure her following a particularly long silence whilst she observed Helen’s technique:

Sonia: That’s pretty good. You’ve done a great job. Okay. It will come, okay. So just a matter of persevering and it will come. Bubba will [unclear] hopefully you can breast feed, okay. But we’ll [unclear]. Like you’re just not [unclear]. But we’ve got some great signs, okay? We’ve got some great signs,[unclear] your breasts feel a bit bigger [unclear]. That’s really good, okay, and if we can get you pumping and things like that, that will help to increase your milk as well.

Helen: Yep.
Sonia: Okay? We’ll just keep doing that every three hours and keep trying bub every three hours. (Helen starts crying)

Helen: Yep.
Sonia: But it can be very frustrating when you’re having problems like this, okay? and you can get a bit down and depressed and it’s a good sign that you’re teary sweetie because that means you’re [unclear] becoming a nice mum, okay? So perhaps you will go as well. Okay? I’ll get you some tissues.

Helen: It’s alright.
Sonia: …come out. Okay.
Helen: Alright.
Sonia: I’ll go and label that for you, okay? Keep going. Okay, and we’ll try again next time. I might [unclear]. what time are you due for the next feed I think it will be about – it’s 3:00 o’clock.

Helen: Yep.
Sonia: Okay. So the midwives will be able to help you with [unclear].
Helen: Okay.
Sonia: …you’re expressing fine, okay? Okay. It’s not easy is it sweetie Okay. I’ll go and label this for you and you can give this to bub next time okay?

Helen: Yep.
Sonia: Look, you got a couple of drops so that’s fantastic. Okay? Okay. I’ll wash all this up for you sweetie. Then you can just buzz next time and the girls will get it for you.

Helen: Okay.
Sonia: Then they can show you how to wash it up next time.
Helen: Okay. Thank you.
Sonia: That’s okay. (Sonia leaves and Helen is crying and upset)
Clearly the labelling of the ‘liquid gold’ and cleaning up of the equipment was prioritised by this clinician over and above the comforting of Helen whose own bodily ‘equipment’ had been deemed faulty, whose infant was deemed an ‘inefficient extractor’, and for whom specialist intervention had failed. Instead, distressingly, this woman was left to pick up the pieces of what had transpired over the past hour, alone as the specialist consultant moved on to the next referral. Two and a half hours later Helen buzzed for Sonia to return to assist with latching the baby ‘on’ as he had woken up hungry for a feed and she was having difficulty getting him to stay ‘on’.

The consultant put on her gloves immediately and got straight to the business of offering to help Helen ‘attach’ Ethan:


Helen: I know you can do it.


Helen: It’s alright bubba. It’s all good. Just need to keep going.

Sonia: Come on. The one suck wonder again hey? That’s what you did last time. [unclear]. Keep going. You both seem relaxed this time at least.

Ethan attempted to latch to the breast several times but was unable. The consultant then suggested using the pump to pull the nipple out further and then try attaching Ethan. The pump was duly brought to Helen and she did as she was asked. Ethan still did not ‘latch’ effectively. The consultant was keen to use the nipple shield however, her senior colleague had given instructions not to use a nipple shield until the milk had ‘come’ in. The junior consultant lamented the fact that another senior consultant was not on today as she felt this situation could be improved by the use of the nipple shield. Instead what she said to Helen was:

Sonia: So if you want to what we can do [unclear] that while we’ve got the pump here we can put you on the pump say for 10 minutes and then we can try bub again if you like?

Helen: Okay.

Sonia: How does that sound because bub seems fairly…

Helen: I don’t think he [unclear].

Sonia: …there.

Helen: No. You don’t want any, do you?

Sonia: Okay.
Helen: We’ll [unclear].
Sonia: So we’ll wrap bubba up and give bubba the colostrum. Okay? Okay.
Partner: Come on mate.
Sonia: So the other thing we can do Helen, to actually help your milk come in sooner
Helen: Yep.
Sonia: Is actually put you on two pumps at one time, okay?
Helen: Yep.
Sonia: That tells your brain or your brain thinks then that you’ve actually got twins.
Helen: Okay.
Sonia: Okay, and it helps increase the supply a bit quicker. Do you want to try that this
time?
Helen: yep
Sonia: Yeah, okay. So I’ll go and get the other pump. Usually I don’t like to try the
mums on that the first time that they go on the pump because they don’t know
what the pump’s like.
Helen: Yeah.
Sonia: So I don’t tend to try them on the two pumps at the one time because sometimes it
can be a bit overwhelming. But if you’re happy to try that, we can definitely try
that.
Helen: Yep.
Sonia: Okay. I’ll go and get the other one…
Helen: Okay.
Sonia: …and see how we go.
Helen indicated to me that she was happy to try ‘anything’ as she had wanted to go
home as soon as possible but thought she had to remain in hospital until the milk
came in.
Helen’s journey over this one four-hour period highlighted the consultant desire to
use technology to enhance the performance of faulty ‘equipment’. The possibility
that Ethan might be so full from the formula top ups, that he was no longer behaving
as a hungry day 3 breastfed baby, was not even considered by this consultant.
Instead, the lack of colostrum derived from electric pump use led to further
pathologising of Helen’s body. The appliance was ‘revered’ as a wondrous machine
with the power to ‘trick’ Helen’s body into producing gold. The consultant regularly
gave Helen options to solve the problem of the faulty ‘equipment’ and the ‘sleepy’
baby not wanting to suck. However, each time there appeared to be a choice between
different options, it was the consultant, Sonia, who decided which course of action to
take. The following excerpt further highlights these points:
Sonia: It mimics the baby, okay. So the baby actually gets on and does really slow sucks and really fast sucks.

Helen: Yep.

Sonia: Then once the milk starts to let down it goes into the slow sucks. This pump does that automatically for you, like a baby would. (silence) Then the other option Helen you’ve got is just to pump until we get another five to 10 mls of breast milk. Then try bub back on the breast then. So it’s really up to you, whichever way you want to go. If you want to keep trying bub on the breast each feed, you can. Or you can just go the pump and try it just by the pump. Okay? So we might stop that now and try bub because I can actually see some breast milk on the end there as well which is good.

The case study revealed the overarching lactation consultant desire to gain control over the breastfeeding woman’s body for the benefit of the infant. The ‘down to business’ approach adopted by lactation specialists, conveyed the need to optimise all available time effectively to ensure continued breastfeeding.