

COMPLEMENTARY AND COMPETING ROLES OF VOLUNTEERS AND PROFESSIONALS IN THE BREASTFEEDING FIELD

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ABSTRACT

The roles of professionals in the breastfeeding field, particularly the relatively new profession of lactation consultant, may seem to compete with that of voluntary counselors. This article examines past areas of misunderstanding and suggests that the roles of the volunteer and professional are, in fact, complementary. Good communication is increasingly enabling both parties to work together for the benefit of all, especially the mother and baby.

INTRODUCTION

Breastfeeding has been described as the gold standard for infant feeding, providing first-class nourishment and protective factors for optimal infant health (Cunningham, Jelliffe, & Jelliffe, 1991; Dewey, Heinig, & Nommsen-Rivers, 1995). Indeed, Walker (1993), Riordan (1997), and Drane (1997) provide evidence that there may be physical and financial costs associated with *not* breastfeeding. A recent literature review by Kunz, Rodrigues-Palmero, and Koletzko (1999) documents the evidence that breastfeeding protects against major infectious diseases such as diarrhea, respiratory infections, middle ear infection, urinary infections, and reduces the incidence and severity of a number of other conditions. Additionally, these authors demonstrate that some forty-five or more types of bioactive factors contribute to the infant's growth and well-being (Kunz et al., 1999). The American Academy of Pediatrics (AAP) has endorsed the practice of exclusive (i.e., unsupplemented) breastfeeding for the first six months of life with iron-rich solid foods to supplement breastfeeding in the second six months (American Academy of Pediatrics, 1997).

If breastfeeding is so good for babies, why then do so many mothers begin breastfeeding and then quickly give up? Breastfeeding women today commonly require special support, especially in the early weeks, to give them confidence to continue and to correct or prevent initial problems. This is because of a lack of role models in the family, popular misconceptions about infant feeding in communities where breastfeeding had become rare a generation or so ago, incorrect information, and commercial pressures.

The mother may be isolated at home with the baby after early discharge from the hospital or, if she has support persons, they may be ignorant of the need for frequent feeding to establish and increase the milk supply. The newborn's normal pattern of frequent feeds is commonly misinterpreted as due to a lack of breastmilk, when the reality is that breastfeeding is going well. Well-meaning attempts to restrict the newborn's feeding frequency and reduce the number of feedings commonly lead to faltering milk supply, with the result that breastfeeding may be abandoned before the first appointment with a pediatrician or well-baby clinic. With support at this crucial time, many mothers can continue breastfeeding successfully.

As for commercial pressures, consumer advocate Ralph Nader (1999) has recently addressed the issue of free promotional materials and product samples given to new mother in maternity hospitals. He pointed out that these gifts from companies that manufacture infant formula have the effect of turning women into bottle-feeders when they encounter an initial breastfeeding problem. According to Nader (1999), these strategies are so successful that they are covered in marketing courses.

For these reasons, breastfeeding women may need the support of either a lay breastfeeding counselor or the professional lactation consultant, or both. In an ideal world, it would not matter a great deal which one the mother first contacts, as these two services complement each other and should therefore refer callers where appropriate. However, it has not always been an ideal world and, in the past, lack of clarity about the roles of volunteers and professionals in the same field sometimes led to a reluctance by both parties to refer mothers.

THE LAY BREASTFEEDING COUNSELOR

Volunteer breastfeeding counselors (BFCs) in self-help groups such as La Leche League International (LLLI) and the Nursing Mothers' Association of Australia (NMAA) are members of those peer groups who have been accepted for counselor training. These groups were established by mothers who had successfully breastfed one or more babies and saw the need to provide support to other women who wanted to breastfeed but were having difficulty because of lack of role models and practical support in the community. The long-serving counselor may no longer be perceived by group members as a true peer, having outgrown the life-stage of breastfeeding, but may be valued for her experience and hard-won

expertise. She may also choose to continue her commitment by contributing in administrative or educational roles, at regional, state, or national level. According to Phillips (1990), moving into a professional role in the breastfeeding field is another logical progression.

BACKGROUND TO THE NEW PROFESSION

By the early 1980s, a number of persons of varied levels of expertise were working as paid “lactation consultants” or breastfeeding advisers in the United States and elsewhere. A need was seen for professional standards in this emerging profession, for the protection of mothers and their babies. Consequently, the Chicago-based lay organization, La Leche League International, sponsored the formation of an independent body, the International Board of Lactation Consultant Examiners (IBLCE), to set up and oversee certification (Auerbach, 1989). Section 9 of the LLLI By-Laws (1999) specifically stresses the independence of the IBLCE in all policy matters related to certification and its financial separation from LLLI. That it was a voluntary organization which was instrumental in establishing a certifying body for the new lactation consultant profession indicates that the volunteer sector saw a need for a professional specialty in the breastfeeding area. A specialist field was thus created to which BFCs could confidently refer mothers, knowing that those certified had met the necessary standards. The Nursing Mothers’ Association of Australia was involved from an early stage. Consequently, the first examination to assess candidates’ competency was held in July 1985 in Melbourne, Australia, as well as Washington, D.C.

Candidates for the IBLCE examination are required to document considerable experience as breastfeeding facilitators and hold a degree (or an acceptable alternative, such as a nursing certificate), and need to be well versed in the competencies contained in the examination blueprint. Escott (1997) reported that in 1986, 47 percent of Australian candidates were BFCs, declining to 3 to 6 percent in 1997. She noted that those identifying themselves as nurses or midwives rose from 64 percent in 1985 (with very small numbers) to 94 percent in 1996/97, though it must be noted there was overlap between groups. As of January 1999, of 1004 successful candidates in the database of the IBLCE’s Regional Office in Australia, 942 were nurses (midwives, maternal-child health nurses, or other nurses). Of the rest, twenty-four were medical practitioners, fifteen were enrolled or mothercraft nurses, sixteen came from “non-health professional backgrounds” (mostly NMAA or LLLI), while the remaining seven were made up of other allied health professionals, including dietitians (Escott, 1999). In the United States, much of the first cohort of examination candidates in 1985 had received training through LLLI accreditation, but Riordan and Auerbach (1998) have noted a similar decline in this affiliation and most candidates today have a hospital or other clinical affiliation.

Persons who are certified as International Board Certified Lactation Consultants (IBCLCs) by the IBLCE, gain a postgraduate certification *specifically* in breastfeeding. As a 1990 article pointed out:

For other health professionals, breastfeeding is only a part of their studies, and training and expertise as a breastfeeding facilitator has often had to be acquired through personal interest and individual effort. The ranks of both lactation consultants and “lay” breastfeeding counsellors [sic] are swelled by persons from the traditional health professions . . . who have seen these are worthy avenues for improving their training and skills in supporting breastfeeding (Phillips, 1990).

Passing the examination is a beginning, not an end, to professional growth and recertification fifth yearly is mandatory for those continuing in the profession.

Work options for IBCLCs with nurse training, which are not usually open to those who are not RNs, include designated lactation consultant positions in maternity hospitals, employment by physicians in private medical practices, and employment on domiciliary midwifery programs following early discharge or government-funded programs for disadvantaged families. Some nurse-IBCLCs may use their lactation management skills part of the time in employment as midwives, child health nurses, or pediatric nurses. As already mentioned, private practice is the main work option for IBCLCs who are not RNs.

Breastfeeding education may develop as the main work for some IBCLCs, whatever their backgrounds; others may provide this education simply as part of their employment (Phillips, 1990). This educational role may consist of conducting courses or hospital in-services, speaking at conferences and workshops, or antenatal education for parents. Occasionally, there may be resentment of IBCLCs by BFCs for charging professional fees for these services. On the other hand, lactation consultants may believe that free or low-cost seminars conducted by voluntary groups are undercutting their business (Phillips, 1990), which they need to earn an income. Communication is important for maintaining good relations.

Establishing a private practice involves an initial financial outlay for essentials such as business cards, stationery, office equipment, furniture, and an answering machine; there are the additional expenses of suitable premises and telephone installation if a home office is not used (Leach, 1990). “It takes years to break even,” warn Riordan and Auerbach (1998, p. 742). Initial costs of establishing the lactation consultancy practice are lower for those running a practice based on home visits, but running costs include car mileage. Lack of uniform reimbursement from third-party insurers, or no reimbursement at all, is still an area of concern. In the United States, some lactation consultants derive the bulk of their income from managing breast pump rental stations, an area of concern to some because of encroaching commercialization. Otherwise, most private practice lactation consultants work only part-time in their chosen profession, and they commonly need to work at other jobs to support themselves. Such jobs include nursing

shifts in hospitals, freelance writing, teaching (outside the field), and interviewing for statistical surveys.

AREAS OF TENSION AND MISUNDERSTANDING

As the IBCLC in private practice may *appear* to be doing similar work, for pay, to that done by a voluntary BFC for no charge, misunderstandings have arisen in the past. Phillips (1990) pointed out a decade ago that the lay counselors were unaware of the financial outlay in setting up a private practice, prior costs of expensive textbooks and examinations fees, ongoing education, and re-certification. However, now that this new profession has become established, BFCs have increasingly become aware of the value of the lactation consultant as a resource person for referral of women needing more specialized, clinical input than they can offer. It also makes sense for the lactation consultant to refer her clients to La Leche League or NMAA for the ongoing support which many breastfeeding women need. Like the BFC, the private practice IBCLC is a referral point for mothers and babies needing medical care, as she recognizes when a situation is beyond her expertise and training.

The health professional who has become a breastfeeding counselor during her childbearing years commonly returns to the paid workforce after this period as an unpaid volunteer. In the voluntary sector she has gained expertise in helping breastfeeding women, which she might well not have learned through her professional training. She has also gained or refined counseling skills. Many prominent lactation consultants with health professional backgrounds initially gained their expertise in LLLI or NMAA before studying for IBCLC certification. The peer group usually sees their move back into professional work as a normal progression.

However, in the early years of this new profession when a volunteer from a background other than medicine, nursing, or allied fields took on a professional role as a lactation consultant, a certain amount of resentment among her former peers was apparent. These were the very persons from whom the new IBCLC, especially one entering private practice, expected support and understanding. Private practice remains the main option for lactation consultants without medical or nursing background, few of whom obtain employment in the health system in any country.

Although existing IBCLCs have generally been supportive of colleagues who are preparing for the examination, lactation consultants already in the field have sometimes been less than encouraging of breastfeeding counselors aspiring to become lactation consultants (Auerbach, 1989). Similar resentment was reported in Australia some years ago by Leach (1990), including where the lactation consultant entering private practice was also a trained nurse, as well as in the United States and Europe. This may explain why some new lactation consultants have tried to boost their professional status by distancing themselves from their

BFC roots. Brodribb (1993) reported that some health professionals feel threatened by the arrival of an IBCLC on staff. Phillips (1990) identified a further source of misunderstanding which may trigger feelings of resentment toward lay BFCs on the part of the lactation consultant. This is “the client expectation of a free service,” because the community has become accustomed to a free service from LLLI or NMAA. She suggested lactation consultants in private practice need to clarify, in the initial moments of a telephone inquiry, what the service entails, including charges and what these entitle the client to.

If they are continuing voluntary work as well as a professional role, there are also ethical considerations in ascertaining, at the outset, the nature of the call, that is, whether it is support-group counseling or a professional booking. Not everyone can afford separate telephone lines. As Wendy Brodribb, former NMAA president, medical practitioner (GP), and IBCLC, acknowledges, “There will continue to be problems when people attempt to wear more than one hat” (Brodribb, 1993, p. 311), but she believes that the development of better guidelines by self-help groups will alleviate this. Many IBCLCs find it easier to resign from the voluntary counselor role, though a minority have successfully managed to continue both, some for many years.

HOW THE TWO ROLES DIFFER—AND COMPLEMENT EACH OTHER

Short-Term Clinical Troubleshooting vs. Long-Term Support

According to Riordan and Auerbach (1998, p. 725), the main differences between the voluntary counselor and the IBCLC lie in where the service is provided, the clinical nature of the IBCLC consultation, and the short-term, sporadic care offered by the IBCLC compared with the sometimes long-term follow-up provided by the BFC. Marsha Walker, Past President of the International Lactation Consultant Association and a registered nurse and IBCLC, points out that the IBCLC’s expertise requires “a background of didactic education and clinical experience to troubleshoot the problems which so many mothers experience” (personal communication, August 28, 1999). This role thus goes beyond that of a BFC whose skills and credibility are essentially built on her situation as a peer. Long-time LLLI Leader and IBCLC Betty Crase (personal communication, August 23, 1999) sees the IBCLC as being mainly involved in breastfeeding initiation and specific trouble-shooting, usually in the first few days and weeks of lactation. In Australia NMAA BFCs are not obliged to counsel the mother who is not receiving professional care in the five days after delivery (NMAA Manual, B.30.1), and usually recommend she contact a health professional. Crase sees the LLLI Leader (BFC) as providing “ongoing support in the more normal course of breastfeeding and mothering” (Crase, personal communication, August 1999). She adds, “Neither can be pigeon-holed, however; there will always be overlap” (Crase, personal communication, 1999).

The Issue of Touching

BFCs seldom touch the mother and baby while assisting and guiding her to get breastfeeding right. LLLI emphasizes the need to ask the mother's permission before touching her, in an atmosphere of courtesy and respect (LLLI, 1998, p. 37), and some LLLI leaders never touch mothers at all. NMAA does not allow any physical contact between counselors and mothers and babies, such as handling the breasts or evaluating the baby's suck with a finger (NMAA Manual, 1992, B.90). The IBCLC who sees the mother and baby in a clinical setting makes the appropriate judgment as to whether it is necessary to touch the mother and baby and should do so with the mother's permission and with courtesy and respect. Some IBCLCs, because of their work situation or other professional background, may need to use physical contact regularly, while others may find they seldom do so.

The roles of BFC and IBCLC should be seen as complementary, not competitive. Brodribb (1993) has pointed out that the mother and her baby are best served when those caring for her respect each other and refer her to others where appropriate.

COOPERATION AND UNDERSTANDING BETWEEN SELF-HELP GROUPS AND IBCLCs

The lactation consultant profession should not supplant the volunteer BFC or the self-help groups, and *vice versa*. The latter "provide a peer group, and retain within the group those resources of experience which previously each individual had to find for herself" (Phillips, p. 93). A report from Europe (Trajan, 1980) found that participants in self-help groups received the sorts of help which could not normally be provided by professionals, while a report from the New Jersey Self-Help Clearinghouse (1985) noted that the point most often mentioned by participants was the ability to share and interact with a peer group whose members had experienced similar stressful situations. Thus, lay groups provide a resource which, if properly utilized, "can *complement* rather than replace the professional resources in the community" (Phillips, 1992, p. 267).

The lactation consultant, wherever she works, can be a liaison person between the mother and lay support group where she will hopefully turn for positive reinforcement. Further Phillips wrote,

This positive reinforcement can balance the negative attitudes towards breastfeeding and its successful management encountered in the wider community. Attendance at group meetings can bring a lessening of isolation for the breastfeeding mother, as well as on-going help and encouragement (1990, p. 94).

which may be preventive of problems. Riordan and Auerbach (1998) have pointed out that it is support groups and BFCs, rather than IBCLCs, which provide women with longer term support. These authors suggested that mothers who have needed

the specialized clinical skills of a lactation consultant can be encouraged to join a mother-support group to provide the sort of on-going caring and reassurance which these groups provide so well, and which ideally complement the usually short-term assistance of the professional.

As both lay and professional workers in the field need to remember: “No one owns breastfeeding; except, properly, the mother/baby dyad” (Phillips, 1990, p. 94). As Brodribb (1993) wrote, “It is a positive move for mothers and babies when GPs, LCs, and BFCs respect each other’s expertise and work together cooperatively” (p. 308). It would be regrettable if those who assist and support nursing mothers were to damage the image of the breastfeeding movement by allowing petty grievances to undermine what each party should focus on—working together to assist mothers to provide their babies with the best and safest way of feeding their babies. Where there is ongoing communication, it is a simple matter to establish and maintain amicable relations between IBCLCs and BFCs. Lactation consultants can refer their clients to La Leche League or NMAA meetings for peer group support and ongoing assistance. Breastfeeding counselors, in turn, can refer mothers who need the more specialized hands-on skills of the lactation consultant.

CONCLUSION

So it can be seen that the relatively new profession of lactation consultant has the potential to work in a complementary way with voluntary counselors and other health workers, in no way supplanting them. The beneficiaries of such an approach are the mothers and their babes we all serve.

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