

**Working at the interface between the art and  
science of breastfeeding: A qualitative study of  
International Board Certified Lactation Consultants'  
experiences.**

Sarah Jane Brown

A thesis submitted in fulfilment of the requirements of  
Bournemouth University for the degree of

Doctor of Philosophy

September 2012

Bournemouth University

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# **Sarah Jane Brown: Working at the interface between the art and science of breastfeeding: A qualitative study of International Board Certified Lactation Consultants' experiences.**

## **Abstract**

Since 1985 a specialist breastfeeding practitioner, an International Board Certified Lactation Consultant (IBCLC), has been in existence. European and global recommendations propose that IBCLCs are employed within health services to support breastfeeding initiatives, however, the research-based evidence is restricted and did not include any description of the experiences of practitioners. The aim of this study was to describe the experiences of IBCLCs in England and in the process understand some of the enablers and barriers of their role.

Data was collected through narrative accounts from twelve IBCLCs who worked in the north of England. The first interview asked practitioners to narrate accounts of how they became and practiced as IBCLCs and the second interview, six months later, sought further elucidation on topics that were found to be common experiences to all practitioners.

The narrative accounts were analysed through a social constructionist framework where descriptions were drawn into categories, then themes. The four themes were identified as; centred on breastfeeding; developing a breastfeeding practice; chip, chipping away at the breastfeeding practice coalface and maintaining a balance within a professional practice. The IBCLCs described seeking a niche in practice from which they could work with the necessary freedom and autonomy to meet the needs of the breastfeeding dyad.

The IBCLCs demonstrated a passion and a woman-centred expertise which led them to being seen as breastfeeding champions. All of the participants extended their role into teaching and managing change in breastfeeding practice but the participants felt underprepared and not well

supported for such a role. While the IBCLC qualification provided the professional qualification the participants' sought, the study identified issues that needed further consideration.

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## **Acknowledgements**

I am very grateful for the encouragement and guidance that I received from my supervisors Dr Jen Leamon and Dr Kath Ryan while undertaking this study. Their patience and wisdom helped to keep me focused when diversions tempted me away from the main objectives of the study.

I would also like to thank Dr Moira Walker and Dr Kate Galvin, who both offered their supervisory support to me at different times during the research.

This research would not have been possible without the IBCLC practitioners who gave their time and energy in retelling their often emotional accounts of practice. I thank them for their commitment, fortitude and generosity in sharing their narratives with me. I would also like to acknowledge all the IBCLCs I have encountered prior to and during the course of this study who have encouraged me to undertake and complete the research.

A special acknowledgement is also due to Dr Irene Ridgers who reviewed all the data and analysis as an academic IBCLC practitioner. Her review gave me the perspective I needed and the time and energy she contributed to the study was very much appreciated.

Finally I need to recognise the support of my husband Terry, who has supported me to reach this and many goals in my life

## Abbreviations and definitions

ABM	Association of Breastfeeding Mothers.  <i>A UK based mother-to-mother breastfeeding support group.</i>
BeSST	Breastfeeding Support Skill Tool  <i>An oral practice-based assessment of breastfeeding practice.</i>
BFHI	Baby Friendly Hospital Initiative  <i>The Baby Friendly Hospital Initiative is a worldwide programme established by WHO and UNICEF to encourage maternity hospitals to implement and seek accreditation through a ten step programme. Part of the implementation is that practise has to fully implement the WHO International Code of Marketing Breast-milk Substitutes.</i>  <i>The UNICEF UK Baby Friendly Initiative was launched in the UK in 1994. Its principles were extended to cover the work of community health-care services with a seven step programme in 1998. In 2005, it launched an accreditation programme for universities that run midwifery and health visiting courses.</i>
BfN	Breastfeeding Network  <i>A UK based mother-to-mother breastfeeding support group.</i>
DOH	Department of Health  <i>National government department that provides leadership for public health in the NHS and for social care in England.</i>

EC	European Commission  <i>The Commission represents and upholds the interests of the European Union by drafting proposals and managing the day-to-day business of implementing policies.</i>
ELACTA	European Association of Lactation Consultants  <i>The European affiliate group of ILCA.</i>
GP	General Practitioner  <i>A medical practitioner who works in primary care.</i>
HV	Health Visitor  <i>A community based nurse who mainly works with mothers once postpartum care is handed over from the midwife.</i>
IBCLC	International Board Certified Lactation Consultant  <i>A practitioner who has passed the International Board Certified Lactation Consultant examination and works as a health care professional who specializes in the clinical management of breastfeeding.</i>
IBLCE	International Board of Lactation Consultant Examiners  <i>IBLCE is the global authority that determines the competence through examination and maintenance of register of IBCLC practitioners.</i>
IFA	Infant Feeding Adviser  <i>A role usually defined by an organisation which sets any formal qualifications required by the practitioner.</i>
ILCA	International Lactation Consultants Association  <i>The international professional association of IBCLCs.</i>
JHL	Journal of Human Lactation  <i>The official journal of ILCA.</i>

JBI	<p>Joint Breastfeeding Initiative</p> <p><i>A four year project (1988 -1992) supported by the DOH which set up local and a national working group to promote breastfeeding.</i></p>
LLLI	<p>La Leche League International</p> <p><i>An international mother-to-mother breastfeeding support group.</i></p>
LCGB	<p>Lactation Consultants Great Britain</p> <p><i>The UK affiliate group of IBCLCs.</i></p>
MRI	<p>Magnetic Resonance Imaging</p>
MRSA	<p>Methicillin-resistant Staphylococcus aureus</p>
MW	<p>Midwife</p> <p><i>A health professional who offers care to women during their pregnancy, birth and post natal period.</i></p>
NBAW	<p>National Breastfeeding Awareness Week</p> <p><i>A UK based week used to promote breastfeeding which started in 1992. The Welsh, Scottish and Northern Ireland government office continue to support the week but similar support stopped in England in 2010.</i></p>
NBWG	<p>National Breastfeeding Working Group</p> <p><i>The National Breastfeeding Working Group consisted of the national co-ordinator and national representatives from organisations who had an interest in promoting breastfeeding. The national group linked with a regional co-ordinator and group. The framework was disbanded in 2011 when government funding was withdrawn.</i></p>

NCT	National Childbirth Trust  <i>A UK based mother-to-mother parenting support group.</i>
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PCT	Primary Care Trust  <i>The NHS trust commissions primary, community and secondary care from providers. The structure is due to change in March 2013 when commissioning services become GP driven.</i>
RCT	Randomised Controlled Trials
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund United Kingdom
USA	United States of America
WHO	World Health Organisation

## **Chapter One: Rational and introduction.**

*An unexamined life is not worth living* (Socrates 469 - 399 BC cited Xenophon 2007, p.218).

### **1.1. Rationale for the study**

When I commenced my midwifery training in 1986, I soon realised that not all health professionals shared the same interest in breastfeeding that I did. Even as a student midwife I was asked to help and support breastfeeding women although my knowledge and skills were based on little more than personal experience. It was not until I began to specialise, and became an Infant Feeding Advisor and an International Board Certified Lactation Consultant (IBCLC) in the 1990s, that I began to fully understand what I and probably other health professionals might not know about breastfeeding.

My skills and knowledge in breastfeeding practice have developed over the years, alongside an appreciation that I now work very differently from how I worked when I first qualified (Brown 2004). In 2002 I became a lecturer practitioner, as I did not want to continue to meet newly qualified midwives who knew so little about breastfeeding, and women who felt unsupported by health professionals when choosing to breastfeed their baby (Brown 2006a). When I retired from clinical and academic practice both the hospital and university had gained the initial step of United Nations International Children's Emergency Fund United Kingdom (UNICEF UK) Baby Friendly Initiative accreditation for their breastfeeding practice (UNICEF UK BFI 2008). The accreditation is part of a global scheme which was initially launched by the World Health Organisation (WHO) and UNICEF (WHO and UNICEF BFHI 1991) with amendments in 2009.

Alongside my paid work, I have always been actively involved with Lactation Consultants Great Britain (LCGB), the affiliated British group for

IBCLCs. Part of my involvement was in organising national conferences for LCGB as well as attending the International Lactation Consultants Association (ILCA) conferences, which were mostly held in the USA. Meeting international delegates and speakers opened my eyes to different ways of working as an IBCLC, but also challenged my understanding of working as a practitioner in the UK (Brown 2003).

As I came near to retirement and to stepping aside from my professional breastfeeding practice, I began to reflect on my experiences. I decided to examine my understanding of being an IBCLC in England alongside those of other practitioners and discover if my experiences were just personal to me.

## **1.2. Introduction**

Throughout evolution, the mother and infant's health and wellbeing have been supported and sustained through breastfeeding (Stuart-Macadam 1995; Elliot and Gunaratnam 2009). Breastfeeding, described in such circumstances, is considered to be exclusive breastfeeding<sup>1</sup> with the introduction of complementary feeding when breastfeeding alone is not sufficient to meet the infant's nutritional needs which usually occurs when the infant is about six months old (WHO 2003). The infant continues to be fed by the mother until either of the dyad indicates a readiness to stop, which usually occurs beyond the second year (WHO 2001; WHO 2003; Kramer and Kakuma 2009).

Since the 1980s the evidence-base for breastfeeding has grown exponentially and stimulated international (WHO and UNICEF 1989; EC 2004; AAP 2005; WHO 2007) and national initiatives (DOH 2004b; Renfrew et al. 2005; Demott et al. 2006) to promote, support and enable breastfeeding. The long-term breastfeeding rate in the UK, though, has

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<sup>1</sup> Exclusive breastfeeding is defined as no other liquids or solids with the exception of drops of syrup consisting of vitamins, mineral supplements, or medicines (WHO 2001)

been very slow to respond (Bolling et al. 2007) and the UK has been placed sixteenth out of seventeen European countries in the length of time infants are breastfed (EC 2004; Euphix 2009).

The UK, especially England, has recorded breastfeeding rates in infants up to nine months of age at five yearly intervals, since 1975 (White et al. 1992). While a gradual rise in the number of women who initiate breastfeeding has been recorded from 51% in 1975 to 83% in 2010 in England (White et al. 1992; The NHS Information Centre 2011), the overall pattern of early cessation of breastfeeding has demonstrated little improvement (Bolling et al. 2007). In the UK, the National Infant Feeding Survey for 2010 showed that 83% of babies are “put to the breast”<sup>2</sup> at least once (The NHS Information Centre 2011) but an earlier survey found that only 45% of women exclusively breastfed their baby at one week, 21% at six weeks and at six months the proportion was negligible (<1%) (Bolling et al. 2007). Bolling et al. (2007) also recorded that nine out of ten women who had stopped breastfeeding before six months had wanted to feed their baby for longer.

There are regional as well as national differences in the breastfeeding rate, which are recorded quarterly by the Department of Health (DOH 2011a). The statistics demonstrate lower initiation rates for the North-East (56.9%) and the North-West (64%) against the national average for England (73.7%) for January to March 2011 (DOH 2011a). The level of breastfeeding cessation measured at 6-8 weeks for the same period, though, demonstrates an overall similar decline in the North-East to 28.9% (28.8% decrease) to the North-West 32.9% (30.3% decrease) against the overall reduction of 46.2% (27.2% decrease) for England (DOH 2011a).

In cultures where breastfeeding is the norm, breasts have retained their primary biological function as infant feeding appears to be part of everyday

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<sup>2</sup> The UK definition of any breastfeeding for the survey might also include bottle feeding with artificial milk (Bolling et al. 2007).

life and instinctively evident (Gunther 1973; Carter 1995; Dettwyler 1995). Described in this context, breastfeeding appears simple and easy to manage and is often described as instinctive or naturalistic based on evolutionary mammalian development (Dettwyler 1995; Odent 2002; Hausman 2003; Mohrbacker and Kendall-Tackett 2010). The breastfeeding woman and her baby are seen in this context as an interactive dyad, who are supported within their community (Dettwyler 1995; Odent 2002).

Hartmann (2007, p.8) illustrated the normality of breastfeeding in a picture of aboriginal children in Australia, learning through play by making clay breasts whenever a baby was born within their community. Hartmann (2007) found that nipple trauma and mastitis were rarely encountered in Aboriginal communities but these issues remain the most common problems encountered in England where breastfeeding is usually not considered the norm (Bolling et al. 2007). Learning to breastfeed at such an early age appeared to enable women when they became mothers. In contrast, a study in the UK of primary-age school children, who were asked to draw and talk about infant feeding, found that feeding bottles, rather than breasts, were linked to baby feeding (Angell 2009).

During most of the 20th century in the UK, breastfeeding has become seriously undermined by a combination of pseudo-science, political manoeuvring and the marketing pressure of breast-milk substitute manufacturers (Fildes 1995; McConville 1994; Yalom 1997; Minchin 1998; Ryan 1998; Hausman 2003; Palmer 2009). An infatuation seemingly appeared that modern science could improve on a way of feeding that was often seen as out-dated and primitive (Baumslag and Michels 1995). Medical intervention that regulated artificial infant feeding attempted to regulate breastfeeding and “free” women from the restriction and demands of their baby (Baumslag and Michels 1995; Minchin 1998; Ryan 1998; Boswell-Penc 2006; Palmer 2009). The mixture of cultural, social, political and medical pressures undermined lactation and often led to an infant being deprived of optimum nutrition (Ryan 1998; AAP 2005; Dykes 2006a;

Kramer 2010). Meanwhile, the number of women who understand how to breastfeed is lost to communities (Baumslag and Michels 1995; Carter 1995; Woolridge 1995). The overall outcome is that breastfeeding becomes a culturally mediated bio-psychosocial activity, where control is transferred to health professionals, alongside its promotion (Woolridge 1995; Allison 1996; Ryan 1998; Dykes 2006a; Boswell-Penc 2006; Gripsrud 2006).

In most of the western world there are clear boundaries between what is inside and outside the body and how intimate body fluids, such as breast milk, are exchanged (Carter 1995; Giles 2003). A UK focus group study reflected some of these conflicts, when some women reported that even family and friends found breastfeeding “repulsive” and could not be in the same room when they breastfed (McFadden and Toole 2006, p.165). It appeared that even in the privacy of people’s homes, breastfeeding is not always perceived as a neutral activity (Carter 1995, Ryan et al. 2010). Some feminist accounts have also illustrated an uneasy relationship with breastfeeding where the interactive breastfeeding dyad were described as clashing with the concepts of socially imagined independent bodies (Giles 2003; McCarter-Spaulding 2008).

When scientific, medical and governmental interests become involved in the development and promotion of infant feeding practice, a biomedical model of support was described (Ryan 1998; Dykes 2006a; McInnes and Chambers 2008; Burns et al. 2010). The biomedical discourse describes the monitoring of feeding practices through close observation and regulation, which in the late nineteenth century was developed, initially to regulate bottle feeding (Palmer 2009). Palmer (2009) observed that some breastfeeding women instinctively did not follow such regulations but the movement of childbirth into a hospital environment, in the mid-twentieth century, made such routines and practices easier to enforce (Dyball 1992; Frampton 2005; Dykes 2006a).

The resultant cultural shift from women to health professional control has not appeared to improve breastfeeding practices. Renfrew et al. (2000, p.88) found that “a large proportion of problems were a result of mismanagement” by health professionals who maintained a level of ignorance by “not utilising the evidence-based knowledge that was available to them.” Breastfeeding women are also often dismissed by health professionals as ignorant about how to feed their infants (Ryan 1998; Hausman 2003; Frampton 2005; Palmer 2009). A possible explanation might be that while health professionals are identified as having a role in promoting breastfeeding, many had similar experiences of socialisation to infant feeding as the families they care for and therefore do not challenge their understanding of what they know (Clarke-Jones 2004; Spear 2004; Battersby 2002).

Battersby (2002) found that midwives who worked in England felt the same conflict and emotional experiences as other women who chose to breastfeed. The difference was that the midwives also described a dissonance between practice and personal experiences after returning to work following breastfeeding their own children. This dissonance was partially explained by Dykes (2006a) who argued that some health professionals adopted a constructed authoritative knowledge within health settings about breastfeeding that might conflict with their personal experiences of nurturing their children. The constructed authoritative knowledge has been described by others as a way of managing breastfeeding where breasts were considered as well ordered machinery, which functioned independently of their owner and any stimulation by the baby (Carter 1995; Greer 1999; Frampton 2005; Bartlett 2006). The descriptor of authoritative knowledge reflected the biomedical breastfeeding discourse adopted within this study to describe the paradigm of clinical lactation support often observed and described in UK organisations such as in the NHS (van Teijlingen 2005; Bolling et al. 2007; Renfrew et al. 2005; Dykes 2006a; Health Commission 2007; Bhavnani and Newburn 2010). The biomedical discourse reflects the resolution of

any breastfeeding issue through simplistic solutions, such as supplementation with artificial milk,<sup>3</sup> rather than in-depth observation of why a physiological process was failing (Cadwell and Turner-Maffei 2004; Bolling et al. 2007; Beake et al. 2010).

Burns et al. (2010) found in their meta-ethnographic synthesis of women's experiences of breastfeeding that making a choice to breastfeed was a very personal experience, which was described in terms of the mother's expectation and their perceived reality of the experience. While there is a greater understanding of the reasons to breastfeed, choosing to breastfeed is not made in rational circumstances (Schmied and Barclay 1999; Schmied and Lupton 2001; Marshall et al. 2007; Ryan et al. 2011a). McKenna and Volpe (2007) illustrated a similar emotional response from parents when they had to choose where their baby would sleep, either with them or in a cot in the early postnatal period. When women choose to breastfeed they need positive role models and sources of good support (Ryan 1998; Schmied and Lupton 2001; Marshall et al. 2007; Ryan et al. 2011a). A community containing confident breastfeeding practitioners therefore is important to enabling women's choice as in many families, generations of mothers have only known bottle-feeding (Stuart-Macadam 1995; Marshall et al. 2007; Ryan et al. 2010).

Women have also complained that health professionals do not share what knowledge they have with them (Hoddinott and Pill 1999; Dyball 1992; McFadden and Toole 2006; Amir and Ingram 2008). The lack of sharing reflected Paulo Freire's (1996) work as an educationalist among disenfranchised communities, where he described a culture of silence within some societies. When women are kept "submerged" and ignorant about what they want to know then they are denied the opportunity to consider, grasp and come to know and express a deeper understanding of

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<sup>3</sup> In the 2005 National Infant Feeding Survey (Bolling et al. 2007), one third of breastfeeding infants had received supplementary feeds while in hospital which matched the same number of women who had experienced breastfeeding problems.

breastfeeding (Freire 1996, p.82). Through not sharing such vital information with and between women, “a powerful force for breastfeeding promotion” is at risk of not being returned to and embedded within communities (Brown 1998, p.21).

When women can access and harness the scientific, experimental and experiential knowledge of feeding their baby the resultant empowerment discourse frames breastfeeding as a liberating force for women (Locklin and Naber 1993; Van Esterick 1995). Belenky et al. (1997) recognised that such inspiration can become a trigger for further learning and an enabler for sharing such knowledge and skills with others. Learning to successfully breastfeed therefore can illustrate a life enhancing skill that enables women to become role models and encourage others to consider breastfeeding their baby.

In the 1950s the development of childbirth and breastfeeding support groups such as the National Childbirth Trust (NCT 2009) and LLLI (LLLI 2009), recognised that woman-to-woman peer initiatives were needed by their members as mothers were not able to access the support they needed from health professionals. Both organisations, alongside two further groups which were formed in the UK in the 1990s (ABM 2010; BfN 2010), educate their own breastfeeding practitioners (NCT 2009; LLLI 2009). In the 1980s a group of experienced breastfeeding support volunteers from LLLI in the USA and Australia sought to formalise their knowledge and skills and become recognised as professional practitioners through the development of the IBCLC qualification (Lauwers and Swisher 2005). The first IBCLC practitioners, who were voluntary breastfeeding LLL Leaders in the USA and Australia, qualified in 1985 (Lauwers & Swisher 2005). A year after the first IBCLC qualifying examination was held, health professionals were encouraged to seek the same accreditation (Lauwers & Swisher 2005). From 1993 prospective IBCLC practitioners were able to undertake the qualifying examination in England (Scott 1994).

In 2007, four IBCLCs in England wrote accounts on "Lacthelpers", an Internet forum for breastfeeding practitioners, about experiences of feeling "burnt out" while working in the National Health Service (NHS) (Blenkinsop 2007; English 2007). The possibility of IBCLC "burn out" had been raised by Heinig (2002), in an editorial, but the practitioner's accounts appeared to be the first recorded experiences. The IBCLCs' accounts described a dissonance between the expectations of their managers who questioned why specialist practitioners were needed, and what they felt they could achieve in promoting improvements in breastfeeding practice. Workplace adversity or "burn out," had been recorded in other roles within the NHS and resilience for surviving and thriving in such circumstances has been observed in some practitioners (Glasberg et al. 2007; Jackson et al. 2008). Resilience appeared to be related to emotional stamina, the ability of practitioners to have autonomy in practice and to be able to problem solve (Jackson et al. 2008). What was known about IBCLCs and an understanding of their experiences in practice therefore became the starting point for this study.

This study consists of nine chapters. In the following chapter I discuss the professionalisation of breastfeeding practice and the development of the IBCLC role. The discussion broadens out to examine differences between the UK and USA. The chapter illustrates the context for the study and identifies the study's aims and objectives.

In chapter three I discuss how my personal clinical experiences of working as an IBCLC informed the research framework. The stages of the research are described alongside reflections at each step of data collection and analysis.

The following four chapters were originally identified as themes. Reflection and reflexivity enabled a deeper understanding of what was described within the themes whereupon they became chapters in the thesis. Throughout the four chapters quotes from the participants, from

the research log and my personal reflective account are used to ground, illustrate and aid the analysis.

In chapter four, centred on breastfeeding, the IBCLCs describe how becoming a breastfeeding mother focused their professional practice into supporting other women who wanted to breastfeed. Breastfeeding is described as more than a way of feeding a baby and more as an interactive process between the mother and baby in learning to understand each other. The description of professional servant is ascribed to the participants as it illustrated the way the IBCLCs worked with the mother and baby.

Chapter five describes how the participants' developed their professional breastfeeding role within the NHS, in private practice and as a volunteer. The chapter title, developing a professional practice, reflects how the IBCLCs enhanced their practice and their perceptions of self through addressing a gap in their understanding of human lactation and breastfeeding.

In chapter six, chip, chipping away at the breastfeeding practice coalface, the participants change their focus to illustrate how they work with other health professionals in the clinical workplace. The descriptor of the IBCLCs role was extended from working as a professional servant to one of becoming a servant leader. The IBCLCs described how they worked as change agents and educators in their clinical workplace.

Chapter seven examines how the IBCLCs work differently to many of the health professionals around them. The opportunity to work in breastfeeding practice was seen as essential especially if extra stressors, such as lack of management support, were present which could destabilise the participant's role.

Chapter eight, follows the main analytical chapters and considers the enables and barriers illustrated by the participants. The chapter includes

some recommendations for the promotion and support of IBCLCs in the UK.

The final ninth chapter, concludes the thesis with an examination of the strengths and limitations of the study and proposal for further research.

## **Chapter Two: The development of a professional role in breastfeeding practice**

*We believe that it is the right of every woman to breastfeed her children and the right of every child to receive human milk (LCGB 2006).*

### **2.1. Introduction**

The focus of this study was on the experiences of IBCLCs in England. The areas reviewed in this chapter are therefore linked to the context of breastfeeding practice mainly set within the UK and the development of a professional role within the field of lactation support. The literature was reviewed throughout the course of the study and was undertaken with historical limits set from 1985 when the first IBCLC qualified until the final search on 15<sup>th</sup> December 2011. The literature search comprised of a global exploration of relevant papers, which were sought using Academic Search Complete, ASSIA, CINAHL, MIDIRS, British Nursing Index, Cochrane, EMBASE, Ingenta Connect, Global Health, Health Information Resources, NHS Evidence, PubMed, ResearchGATE, Web of Knowledge, WHO Reproductive Health, Google Scholar, and the web sites of the international and affiliated membership groups of IBCLCs. The A – Z of electronic journals and Electronic Thesis Online Services (ETHOS) were also searched using combinations and phrases of IBCLC, lactation consultant, breastfeeding specialist, infant feeding advisor/specialist, breastfeeding counsellor/practitioner, breastfeeding professional and breastfeeding clinical practice. The search included the term breastfeeding used as one word and separated into breast and feeding.

### **2.2. The IBCLC role**

Anyone can engage in breastfeeding practice and call themselves a breastfeeding counsellor, lactation consultant or infant feeding specialist. The title of IBCLC is different as it is legally protected under global registered trademark regulations and only practitioners who have successfully passed the entrance examination and maintain their qualification can use it (Lauwers & Swisher 2005; IBLCE 2006). The role

of an IBCLC is described as an allied health professional where practitioners have the skills, knowledge and attitudes required to assist women to breastfeed (IBLCE 2006; ILCA 2010). Smith (2011, p.417) suggested an IBCLC role definition of; “clinical/practical management of breastfeeding and lactation,” which is promoted by ILCA (2010) as the only international professional qualification in breastfeeding practice.

Prospective practitioners who want to become an IBCLC have to meet the entry criteria of at least 1000 hours of supporting breastfeeding women in practice and 90<sup>4</sup> hours in academic study before sitting a qualifying examination (Wilson-Clay 2000; Lauwers & Swisher 2005; IBLCE 2009a; Riordan & Wambach 2010). Successful practitioners also have to demonstrate, at five yearly intervals, their ability to stay in practice through either resitting the examination or through the accrual of at least 45 hours of post-qualification education hours related to breastfeeding practice (IBLCE 2009a).

### **2.3. Professionalising breastfeeding practice**

Since the twentieth century society has changed and moved away from traditional sources of help to a “service delivery system” where advice from professionally qualified practitioners appears valued (Cherniss 1995, p.189). The change, in breastfeeding support, has attempted to fill an apparent gap in the unmet needs of women who want to breastfeed but find that their community and often health professionals lack the knowledge and skills to support them (Palmer 2009). In entering a helping, caring role, such as supporting breastfeeding women, practitioners have been regarded as having a vocation or a “calling,” where a strong sense of moral dedication is needed and where financial gain is subordinated to serving the public interest (Cherniss 1995, p.4; Sullivan 2000; Liaschenko and Peter 2003; Martimianakis et al. 2008). Becoming an IBCLC, though, might reflect a more secular framework of practice where being able to seek monetary reimbursement and

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<sup>4</sup> The educational hours were increased from 45 to 90 hours for candidates from 2012 (IBLCE Europe 2011).

professional recognition for the role might become a motivating force for practitioners. Sullivan (2000) observed changes and tensions in other health practitioner's practice when they moved from a vocational to a more secular framework of practice. Such descriptors were not found in the personal accounts of IBCLC practitioners but such findings cannot be discounted as the descriptions were about working with breastfeeding women not about a broader framework of practice (Brown 2000; Cook 2002; Anon 2004; Glen 2004; Lee 2006). The development of a professional role in breastfeeding practice has raised questions about the possible risk of "medicalising" the way practitioners work and presenting it as a specialist position, which only a few women can access (Aldana 1990; Wilson-Clay 2000, p.58). Concerns have also been raised about some women thinking that a specialist, such as an IBCLC, is essential to ensure successful breastfeeding (Oakley 1992; Schmied and Lupton 2001).

MacDonald (1995, p.1) suggested that professional practice should be referred to as an "occupation based on advanced, complex, esoteric, or arcane knowledge." The original model of a profession was one where knowledge was closely guarded providing a specialist status on the practitioner and an assumed ignorance on behalf of the client. The imbalance between the specialist and the client was maintained to provide the profession with control through its knowledge and an ability to advocate on behalf of its practitioners (MacDonald 1995). The ability of professions to practice in this way acted as a "closed shop" in resolving any issues and practitioners risked developing services that suited their needs rather than those of the people they served ( Abbott and Meerabau 1998, p.8). This description does not sit easily for IBCLCs who articulate a framework of enablement through sharing, facilitation and service to others but how practitioners apply this concept in practice remains evidentially underexplored (Auerbach and Riordan 2000; Wilson-Clay 2000; Smith 2003a).

MacIntyre (2007, 2009) drew on many historical concepts and philosophic works to open up a dialogue that offers a different examination of modern society and how professional practice functions. Heavily influenced by Aristotelian considerations, MacIntyre offered a dialogue drawn on “practices” which were used in a specifically defined way as:

Any coherent and complex form of socially established co-operative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods are systematically extended (MacIntyre 2007, p.187)

This definition might appear over long but the essence of the description of professional practice was one that was enabled through personal development which was recognised by others. MacIntyre (2007) attempted to illustrate the difference between a work orientated task and a professional role. He described practice as having internal and external goods. A professional practitioner, according to MacIntyre, continually strove within an Aristotelian framework to set standards of excellence in practice, by doing good and working co-operatively with others. Only the practitioner could specify internal goods and only practitioners who had obtained the relevant knowledge and experience were considered competent to judge the internal goods within the role. External goods appeared when others began to recognise and validate the practitioners’ work (MacIntyre 2007). This concept resonates with the aspirations of the IBCLC practice framework and the development of a professional practice (Wambach et al. 2005; IBLCE 2006). Some IBCLCs have received international recognition and external validation for their level of expertise in human lactation and in resolving breastfeeding problems but drawing attention to a few practitioners does not illustrate how other practitioners practice (Ballard et al. 2002; Walker 2006; Watson-Genna 2008; Riordan and Wambach 2010).

#### **2.4. The development and possible issues with the IBCLC role**

The short history of becoming an IBCLC described the emergence of an allied health professional who initially worked as a volunteer with breastfeeding women to one where health professionals and their practice were also included. The number of practitioners and the international aspect of the qualification developed rapidly and by December 2011 there were “over 25,000 IBCLCs in 90 countries” (IBLCE 2011b).

Initially the development of the IBCLC credential moved volunteer breastfeeding practitioners from working within their own woman-to-woman support organisation to an international professional consultant framework. The change in practice was initially described by Wilson-Clay (2003, p.xxii) as; “a lonely business, often frightening . . . often living in a state of terror” as she described how working without the support framework of the voluntary organisation left her exposed to the stresses and strains of independent practice. The situation was resolved when Wilson-Clay (2003) formed a partnership with another IBCLC and began to articulate and share her experiences in practice with another practitioner.

From 1986 qualified health practitioners were invited to seek IBCLC accreditation to enhance their professional support for breastfeeding women (Lauwers and Swisher 2005; Riordan and Wambach 2010; ILCA 2010). The dual role was promoted in articles in the USA and Australia (Newbold and Endacott 1988; Drew and Escott 1997; Riordan and Wambach 2010) and promoted by Riordan and Wambach (2010) as providing better job security for the practitioner. No evidence was presented to support Riordan and Wambach’s (2010) claim. Some UK-based health professionals, though, have articulated an improved use of evidence-based breastfeeding practice when they became IBCLCs (Blenkinsop 2002; Richards 2005; Timms 2007).

An Australian study identified some issues with health professionals who worked in dual roles as IBCLCs. In an exploratory study about infant feeding attitudes and behaviours, Osborne et al. (2009) described a small group of IBCLCs as motivated practitioners who undertook the qualification at their own expense and studied in their own time. The study did not identify why the health professionals became IBCLCs but did find that some dual qualified practitioners had become disillusioned about their practice role and were contemplating not maintaining their IBCLC registration (Osborne et al. 2009). Unfortunately there were no further indications, apart from a lack of any financial incentive from their employers, as to why the IBCLCs would not maintain their qualification.

The entry criteria to become an IBCLC are less restrictive if the practitioner is already a health professional. Applicants who are not health professionals are required to undertake extensive education on 14 further topics, which medical practitioners are already considered to have covered in their training (Riordan and Wambach 2010; IBLCE Europe 2011). The apparent shift, from the original concept of the IBCLC accreditation to provide experienced breastfeeding volunteers with a professional qualification, to making it more difficult and expensive to become an IBCLC if a volunteer, is not without its critics and might have lost sight of the original concept of the role (Bono 1989; Riordan 1989; Aldana 1990; Bernshaw 1990; Powell 2011). An added risk is that health professionals might also bring a more bio-medicalised approach into their practice which does not reflect the language of the founding lay IBCLC concept of working with women (Edwards 1985; Ryan 1998; Wiessinger 2000).

The involvement of doctors within what was seen as a holistic woman-centred midwifery practice might illustrate the described concern about health professionals becoming IBCLCs. Wagner (2007) described birth, like breastfeeding, as a normal physiological process. The involvement of medical practitioners meant that birth became redefined which enabled a shift of power which pathologised birthing and marginalised the psychological and social aspects of care (Davis-Floyd 1994; Savage

2007). The professionalisation of breastfeeding practice especially the inclusion of clinicians into the IBCLC role may or may not reflect a similar change but a level of scepticism should exist until there is an examination of how health professionals articulate their practice. Certainly a change in focus to a more specialist practice and a greater medicalised vocabulary was observed in articles published by IBCLCs towards the end of the twentieth century especially in the *Journal of Human Lactation* (JHL) (Gibbons et al. 2000; Hinson 2000; Ballard et al. 2002; Willis 2003).

Other concerns about the IBCLC role have emerged (Paul 2008). An article in the *New York Times* recognised that there had been an increased demand for IBCLCs mostly in the USA, Canada and Australia and suggested that this sudden increase had led to some practitioners qualifying without the depth of knowledge or understanding the role required (Paul 2008). In an on-line role delineation survey of 8,974 IBCLCs in 2007, some practitioners mentioned a similar concern and identified a lack of practical experience before sitting the examination (McIntyre 2007). The survey was only completed by 2,191 (24.4%) practitioners so the overall report has to be treated with some caution but 1370 (62.6%) of the respondents had qualified within the five years prior to publication therefore their recall of commencing in practice was fairly recent (McIntyre 2007). The response by the IBLCE was interesting as the organisation doubled the number of accounted academic study hours,<sup>5</sup> from 45 to 90 hours, prior to undertaking the qualification, while the hours in clinical practice remained the same at 1,000 hours (IBLCE Europe 2011). The survey was presented as a brief report and has since been removed from the IBLCE website, although some of the comments and recommendations remain on-line (McIntyre 2007). A further survey is due in 2012 (IBLCE 2011d).

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<sup>5</sup> When applying to sit the IBCLC qualification for the first time, candidates have to provide evidence of attending either physically or on-line, conferences, study-days or educational workshops related to lactation and breastfeeding (IBLCE Europe 2011).

How practitioners prepare and develop their role has received little attention in IBCLCs literature. Auerbach et al. (2000) suggested a linear development similar to that ascribed to nurses by Benner (1984) although no evidence was produced to support the theory. Benner's (1984) descriptions were based on Dreyfus and Dreyfus's (1980) work on skill acquisition, where practitioners passed through five progressive linear stages, from novice to mastery of their practice. A more fluid model, though, originally ascribed to the assessment of supporting breastfeeding women might be illustrative of IBCLC practice (Cadwell and Turner-Maffei 2004). The Cadwell and Turner-Maffei (2004) model described a forward, backward and circular movement, weaving strands of practitioner's logic, wisdom and theory into a deeper understanding of practice.

Wallace and Kosmala-Anderson (2006) found that as health professionals became more exposed to breastfeeding knowledge and practice, practitioners began to seek a greater understanding of human lactation. The self-motivation to develop personal practice, which D'Antonio (2006, p.245) called a change process "from below," reflected an Aristotelian approach to learning, which will be further explored in the methodology chapter related to praxis (Aristotle 1999). A Swiss study, found that health professionals developed their breastfeeding knowledge and skill when their hospital gained BFHI accreditation when some practitioners continued to advance their practice and became IBCLCs (Merten et al. 2005).

Schôn (1983) described clinical work as a swampy ground where practitioners could not rely on one solution to resolve any problems. The admission of uncertainty is considered necessary as a way of understanding practice (Cadwell and Turner-Maffei 2004). Benner (1984) observed much of nursing knowledge embedded in practice and stated that to progress any professional understanding a dialogue was necessary between clinical work and any relevant source of knowing. Schôn (1987) was the first to conclude that professional practice was an artistic endeavour that he called a form of intelligence, a kind of knowing, which

Hinchliff (1999) described as competent practice. Both ILCA and IBLCE describe IBCLCs as competent practitioners but how a one-day multiple-choice examination with a pass or fail outcome can assess the intricacies of IBCLC practice has not really been explored. What is missing from the literature is how a practitioner's knowledge and skill is used in managing tasks within the role and how this is communicated to others to illustrate their professional practice (Fry et al. 1999).

An understanding of how IBCLCs develop their practice may also help address the respondents' question in the 2007 role delineation study of the need to repeat the entry-line examination which practitioners need to undertake every five to ten years to maintain the IBCLC qualification (McIntyre 2007). The IBLCE (2008b) response to continue with the present re-certification framework might have been better understood if based on research findings. A different framework exists in nursing and midwifery in the UK, where a reflective competency framework is used to record the development of a practitioner (Lewis 2003; McGee and Castledine 2003). Ensuring IBCLCs re-sit an examination every five to ten years to maintain levels of practice knowledge may be appropriate for some practitioners but it also risks some candidates using pattern recognition, based on their acquired practice, to answer the questions (McGee and Castledine 2003). Asking experienced practitioners to re-sit a baseline entry examination might also be problematic if the practitioner's theoretical and experiential knowledge has developed to a more advanced level, where the practitioner may be generating their own clinical theories, which might conflict and challenge the examination format (McGee and Castledine 2003).

When IBCLCs first qualify they are not "finished products" but this was also not discussed in the role delineation study (Cherniss 1995, p.7; McIntyre 2007). Two guest editorials in the JHL suggested that mentorship or preceptors for IBCLCs should be considered for newly qualified practitioners but the articles remain as proposals not as possible

frameworks to implement such an initiative (Lauwers 1997; Mannell; 2008).

The evidence of how IBCLCs work in practice is limited to brief personal accounts from the UK and the USA (Blenkinsop 2002; Hoover & Weissinger 2003; Cadwell & Turner-Maffei 2004; Lee 2006; Timms 2007). Personal accounts provide a starting point for understanding the experiences of practitioners but they offer little exploration or reflection on IBCLCs' experiences in practice and do not present the depth of knowing that is needed to inform future practice.

### **2.5. Assessing the impact of the IBCLC role.**

The lack of understanding of how IBCLCs practice has not hampered ILCA proposing that practitioners can enable change in breastfeeding practice. The promotion of the IBCLC role as agents of change, though, appears to be based mainly on research examining the impact practitioners make in practice and not on their experiences (Appendix 1; ILCA 2011d). The evidence on IBCLC practitioner's impact is also limited as Thurman and Allen (2008) discovered when they wanted to evaluate research on the relevance of an IBCLC in an outpatient setting. Thurman and Allen (2008, p.423) found that although preliminary findings indicated some positive correlations between IBCLC use and improvements in breastfeeding duration, the reliability and validity of the reviewed studies could not be ascertained.

Other research related to IBCLC practice and practitioners was identified during the literature review and placed in a separate appendix. The search used the words as well as the IBCLC initials and the phrase lactation consultant, which were checked to ensure that the participants were qualified practitioners. Forty studies were found between 1989 and 2009 (Appendix 1).

Out of the 40 identified studies, 29 were from the USA, 4 from Australia and Canada and one each from Brazil, Ghana and Holland. Thirty-four of the studies used quantitative research methods, one used mixed methods (Stefiuk et al. 2002) and five used qualitative methodology. The qualitative research included a case review study (Wohlberg and Geary 1994) and four studies which interviewed participants. Three studies interviewed mothers (Pastore and Nelson 1997; Mammott and Bonuk 2006; Lamontagne et al. 2008) and one asked IBCLCs about their use of breast pumps (Buckley 2009). The women who were interviewed described how IBCLCs increased their perseverance to breastfeed (Mammott and Bonuck 2006) and provided the specialist support they sometimes needed to feed their baby (Pastore and Nelson 1997; Lamontagne et al. 2008).

Twenty-two of the 34 quantitative studies examined any changes in breastfeeding outcome with the employment of IBCLC practitioners. The remaining 12 quantitative studies provided descriptive accounts of IBCLC practice such as manning a telephone support line (Lee 1997) or working in a breastfeeding centre (Stefiuk et al. 2002). None of the intervention studies proposed the null hypothesis that IBCLCs did not make a difference, which suggests the researchers undertaking the work might have had a vested interest in promoting the role (Patton 2002). Nine intervention studies were described as Randomised Controlled Trials (RCT) and this is where the remaining focus of the review was placed.

The nine RCTs had differing rationales for undertaking the research therefore the total number in the control/intervention groups were not the same. All of the studies justified their sample size related to the RCT except for Brent et al. (1995). The sample size ranged from under 120 (Brent et al. 1995; McKeever et al. 2002; Stevens et al. 2006; Gill et al. 2007; Petrova et al. 2009), to 338 (Bonuck et al. 2005) and 683 (Kools et al. 2005). The RCT studies ranged from short interventions by IBCLCs who focused on the antenatal and early postnatal period (McKeever et al. 2002; Stevens et al. 2006; Gill et al. 2007), until three months (Petrova et

al. 2009), or a year of continuing support provided by the practitioner (Brent et al. 1995; Kools et al. 2005; Bonuck et al. 2006). Brent et al. (1995) and Gill et al. (2007) reported a significant increase in the incidence and duration of breastfeeding in the IBCLC supported group but McKeever et al. (2002), Kools et al. (2005), Stevens et al. (2005) and Petrova et al. (2009) did not. Bonuck et al. (2005) reported a significant difference in the duration of breastfeeding until 20 weeks in the IBCLC supported group but this was not observed after this time although data was collected for one year. Bonuck et al. (2005) is the only RCT referenced in the ILCA documents and only until the twentieth week (ILCA 2011a and d).

The two remaining RCTs were studies where the IBCLCs educated the health practitioners in the intervention group and the outcome of the training was assessed in the length women continued to breastfeed (Albernaz et al. 2003; Aidam et al. 2005). In both of these studies there was a significant improvement in the duration of breastfeeding in the groups the IBCLC trained. Neither of these studies is referenced by ILCA although the WHO (2003), the European Commission (EC 2004) and the USA Surgeon General (USA Department of Health Services 2011) described the need for health professionals to gain greater specialist knowledge from experienced practitioners.

The World Health Organisation (WHO 2003), the European Commission (EC 2004), the Australian Government (Osborne et al. 2009) and the USA Surgeon General (USA Department of Health Services 2011) have all recommended that IBCLCs have a role to play in providing specialised breastfeeding practice and promotion of breastfeeding. In fact the EC (2004) has recommended an increase in the number of IBCLCs to enable the development of their promotional role. The evidence these recommendations are based on, though, is less than mentioned in Appendix 1 (Bolam et al. 1998; Gonzalez et al 2003; Bonuck et al. 2005; Castrucci et al. 2006; Mannel and Mannel 2006; Dweck et al. 2008; Thurman and Allen 2008) and none of the studies described the experiences and needs of practitioners to fulfil such roles. All the

referenced studies are included in the Appendix 1 except Bolam et al. (1998) research.

The inclusion of Bolam et al. (1998) in the WHO (2003) and EC (2004) reference list is difficult to understand and it is noted that it is not included in later documents. The research took place in Nepal without any reference to IBCLC practitioners although experienced health professionals were used to promote breastfeeding and family planning in three intervention groups alongside a control group (n=540). The study concluded that there was not any difference between the groups in the duration of exclusive breastfeeding as the result of any of the interventions undertaken although the health professionals did have an impact on family planning outcomes.

In June 2011 ILCA approved the first publication of a position paper on the role and impact of the IBCLC practitioner (ILCA 2011d). The document referenced some of the research already described in Appendix 1 (Bonuck et al. 2005; Castrucci et al. 2006; Thurman and Allen 2008) but did not reference any other studies. While ILCA promotes the work of IBCLC practitioners the organisation has not undertaken any research on the role although the position paper reference list did identify gaps in professional understanding. One of the main areas of missing research is in how practitioners work and their experiences in practice.

## **2.6. Working within an international qualification**

In the first fourteen years of the accreditation (1985 – 1992) just 10% of the candidates were from countries outside the USA, Canada or Australia. By 2010, the number of candidates had increased to 40% from 46 countries other than the USA, Canada and Australia (Gross 2010). In 2011 practitioners were registered in 90 countries (IBLCE 2011b). Germany and France have the most IBCLCs in Europe (1340 and 468 respectively), while the UK is third with 430 practitioners, the same number as the Netherlands (IBLCE 2011b). The greatest number of IBCLC

practitioners (11,056) globally, though, remains in the USA (IBLCE 2011b).

The USA influence on IBCLC practitioner development and practice remains strong. The main organisational framework for IBCLCs consists of the examination board (IBLCE)<sup>6</sup> and the professional association (ILCA)<sup>7</sup> both based in the USA. Europe has a regional link, European Lactation Consultants Alliance (ELACTA),<sup>8</sup> but presently there are not any UK based IBCLCs within any of the representative organisations. Many of the roles within the organisations are honorary posts. Financial constraint may therefore influence a practitioner's decision to become involved with IBCLC international organisational issues. The same considerations may also reduce the number of practitioners who attend the ILCA international conference that has only once been held outside North or South America (Australia 2003) in the past twenty-six years. A smaller European conference in association with ELACTA have been held in Vienna and Basle but again cost might have restricted some UK IBCLCs attending and meeting at a European level (ELACTA 2011).

The historical differences in how the health services are constructed and function in the USA and the UK also mean that how IBCLCs work in practice varies. Sullivan (2000) wrote that historically most professions in the UK and USA have enjoyed similar outcomes but in the USA there appears to be greater opportunities for IBCLCs to work in private practice, either as a single practitioner or in a group practice (Smith 2003a). One of the possible reasons for the development of private practice in the USA is that many private health insurance policies cover the costs of breastfeeding women seeking help from an IBCLC (Saks 1995; Smith 2003a). If a woman sought similar support of an IBCLC practitioner in private practice in the UK, reimbursement of fees would be very unusual

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<sup>6</sup> <http://www.iblce.org/>

<sup>7</sup> <http://www.ilca.org>

<sup>8</sup> <http://www.velb.org/english/conferences/congress-2010.html>

(Pemberton 2008). The outcome is that the opportunities for UK IBCLCs to develop a full-time private practice are very limited (Pemberton 2008).

In the public sector IBCLCs in the UK and USA were found to work in a variety of roles in public health, maternity hospitals, neonatal units, community health initiatives and within voluntary support groups (McIntyre 2007). Smith (1994) in a Masters dissertation used a questionnaire with IBCLC participants at a USA-based ILCA conference in an attempt to understand where the practitioners worked. Out of the 545 questionnaires handed out, 319 (63%) were returned which identified that 66% practiced in a hospital setting and 50% had dual health qualifications. From Smith's small study it is possible to see that some practitioners worked within the USA health service with just the IBCLC qualification. In England just one practitioner has written about her experience of being employed within the NHS with her IBCLC as the only qualification for the job (Saunders 2007). The experience was quite short lived as the Infant Feeding role was one of the first to be cut when financial restraints were introduced into the workplace (Saunders 2007).

The proposed USA model of IBCLC hospital-based practice recommends that a unit employ approximately 8.6 practitioners per 1,000 live births to provide antenatal education, in-hospital and postnatal community support (Mannel and Mannel 2006). In the UK there are just 430 IBCLCs but maternity services are very different to those of the USA (IBLCE 2011b). Comparisons are therefore difficult to draw and while the EC (2004) calls for more IBCLCs in practice, the lack of research on the role especially in the UK, hampers any understanding of the most effective role for practitioners and what they might need to support them in practice.

## **2.7. Global frameworks that support and protect breastfeeding and enable IBCLC practice.**

The WHO and UNICEF have been instrumental in developing global strategies and initiatives that enable, protect and promote breastfeeding.

The frameworks also inform and enable practitioners in their breastfeeding practice. The three frameworks relevant for IBCLC practitioners are the WHO International Code of Marketing Breast Milk Substitutes (1981), The Innocenti Declaration (1990-2005) and WHO and UNICEF Baby Friendly Hospital Initiative (BFHI 1991).

### **2.7.1. WHO International Code of Marketing Breast Milk Substitutes (1981)**

The aim of the WHO Code<sup>9</sup> (1981, p.8) and its subsequent Resolutions is to:

provide safe and adequate nutrition for infants . . . by ensuring the proper use of breast milk substitutes, when they were necessary.

The scope of the WHO Code (1981) framework applies to the marketing of breast milk substitutes, any complementary foods, feeding bottles and teats. One of the expected outcomes of the WHO Code is that people who choose not to breastfeed would be provided, by health professionals, with appropriate information and support that was not influenced by the market place. All IBCLC practitioners have to practice within the WHO Code (IBLCE 2011f).

Apart from personal and international frames of reference, England has a legal framework<sup>10</sup> that reflects European regulations which differ to the WHO global recommendations on marketing breast milk substitutes (HM Government 2007; Palmer 2009). The Infant Formula and Follow-on Formula (England) Regulation (HM Government 2007) allows health services and practitioners to receive manufacturers' sponsorship, branded literature and other promotional material from infant formula manufacturers which can be used in practice. Clinical practice areas in the UK working towards or are already BFI accredited as well as IBCLCs cannot use such promotional materials (WHO and UNICEF 1991; Noel-Weiss and Walters

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<sup>9</sup> The title of the publication has been abbreviated.

<sup>10</sup> <http://www.food.gov.uk/multimedia/pdfs/guidancenotes2008amendmar09.pdf>  
[http://www.legislation.gov.uk/uksi/2007/3521/pdfs/uksi\\_20073521\\_en.pdf](http://www.legislation.gov.uk/uksi/2007/3521/pdfs/uksi_20073521_en.pdf)

2006; Smith 2011). Lactation consultants, therefore, might experience conflicting interests from other health professionals or organisations accessing such sponsorship or using manufacturers promotional material if they work outside the WHO and UNICEF Baby Friendly Hospital Initiative (BFHI 1991).

Palmer (2009) described a “naivety” in some health professionals about comprehending marketing techniques in their practice with regard to infant feeding but ILCA has also been challenged by its members on occasions about how it receives sponsorship from various companies (Brooks 2009a and b; Powers 2009; Vanderveen-Kolkem 2009). The ILCA website, conferences and JHL all receive funding from breast-pump companies, manufacturers of breast creams and breastfeeding aids (Brown 2006b). The sponsorship does not contravene the WHO Code (1981) but the reliance on such sources of funding might challenge those accessing ILCA of the normality of breastfeeding and places the organisation on a business rather than a practice-based footing with manufacturers. A different approach has been taken by the UK ILCA affiliated group, LCGB, as it has decided not have any business links, sponsorships or advertisements in its journal, on its website, or at any conference or study day (Brown 2006b).

### **2.7.2. The Innocenti Declaration (1990-2005)**

The Innocenti Declaration originally set out four goals; the establishment of national breastfeeding co-ordinators and national breastfeeding committees; the adoption of the Baby Friendly Hospital Initiative (BFHI); the full implementation of the WHO Code (1981) and its subsequent resolutions and the enactment of a legal framework that protected the rights of employed breastfeeding women (UNICEF 1990). The original recommendations have been built on and strengthened since its inception but remain patchy in their implementation in the UK (UNICEF 2005; UNICEF Innocenti Research Centre 2005). As the BFHI and the WHO Code (1981) are discussed elsewhere (2.7.1 and 2.7.3) and employment

issues are not relevant to the study, the national and regional framework are considered related to IBCLC practice.

In England the UK Joint Breastfeeding Initiative (JBI) pre-empted the Innocenti Declaration (1990) by two years and formed a national framework for breastfeeding practice (Henshel and Inch 1996). In 1993 the Department of Health formally recognised the work of the JBI and the organisation became the National Breastfeeding Working Group (NBWG) (Henshel and Inch 1996). The NBWG enabled IBCLCs, to develop a greater involvement with breastfeeding initiatives at local, regional and at a national levels until 2011 when government support was withdrawn and the National and Regional Co-ordinators posts were disbanded (Fyle 2011).

While the WHO Code (1981) and the Innocenti Declaration (1990) offer global frameworks that can inform and support IBCLCs practice a lack of national recognition, though, presently hampers the help these initiatives can provide to practitioners (Palmer 2009; Brady 2010).

### **2.7.3. The WHO and UNICEF Baby Friendly Hospital Initiative (1991)**

The global Baby Friendly Hospital Initiative (BFHI) was launched in 1991 (WHO and UNICEF 1991) as an approach to reverse the medicalisation of infant feeding within hospitals. The ten steps of the initiative provided research-based evidence that challenged health professionals to change their practice and adopt ways of working that supported breastfeeding women to feed their infants (Murray 1996; Broadfoot et al. 2005). The steps recognised that policies, protocols and guidelines were needed for practice but also that health professionals required education and practical support to enable the changes to be fully implemented (Bruce et al. 1991; Murray 1996).

The initial maternity hospital-based initiative was launched in the UK in 1994 (UNICEF/UK BFI 2011a). The UK initiative changed to the UNICEF/UK BFI when it extended accreditations into the community,

neonatal units and universities who educate health professionals (UNICEF/UK BFI 2011c). While limited research in the UK has shown that the implementation of the programme has had a positive impact on breastfeeding rates, there remain continuing challenges in achieving the full award in many practice areas. One of the challenges is to gain management commitment to undertaking the necessary changes in practice to fully implement the initiative (Broadfoot et al. 2005; Dykes and Flacking 2010).

Initially the Department of Health only recommended the adoption of the principals of the BFHI into UK maternity units (DOH 1995) but in a more recent report the full implementation of the award, or a similar externally evaluated framework, became a core recommendation for all maternity care providers in England (Demott et al. 2006). The accreditation, though, does require practitioners who can lead on the initiative with an understanding of why the changes are necessary, otherwise old ritualised practices could be at risk of being replaced by new ones (Schmied and Lupton 2001; Palmer 2009).

Price (2006), a midwife, found that implementing the necessary changes for a maternity unit in England, was problematic. In an action research thesis, in which the implementation of step four<sup>11</sup> of the BFI was described, Price (2006) found that adherence to routines and institutional practices supported health professionals who wanted to maintain the status quo and did not want to change their practice.

While the UNICEF/UK BFI, has been promoted to challenge institutionalised breastfeeding practice there remain risks and stressors with its implementation. Price (2006) concluded in her study that to enable any such change in practice, health professionals needed education, support and role modelling, which might suggest a key role for experienced breastfeeding practitioners such as IBCLCs.

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<sup>11</sup> Step Four is to help the mothers initiate breastfeeding soon after birth (UNICEF/UK BFI 2011c).

## **2.8. Implementing change in breastfeeding practice**

Health professionals have been encouraged to implement change in breastfeeding practice through working with frameworks such as the BFI (Murray 1996; Cadwell and Turner-Maffei 2009; Riordan and Wambach 2010). Dykes and Flacking (2010), though, have suggested that interventions and changes should not be considered until the socio-cultural context and constraints of practice are also understood. Cadwell and Turner-Maffei (2009) recognised the complexity of managing change in breastfeeding practice when they suggested that day-to-day leadership should be facilitated by others than the IBCLC. The rationale for the IBCLC not to lead on managing the changes was to enable the practitioner to concentrate on working in practice and champion and role-model optimum infant feeding practice in the workplace. How IBCLCs experienced, navigated and managed any changes in practice is poorly explored within the literature, which could indicate a lack of understanding of what practitioners need to know and how best to support them.

## **2.9. Defining the role of IBCLCs**

Traditionally, sociology defined a profession as that which matched certain traits. Colyer (2004) described professionalisation as a process that consisted of five stages: training, the formation of a professional association, an ethical code and political activity to establish recognition and protection of the professional role. Lactation consultant practice is guided by the Code of Ethics (IBLCE 2011f), the Scope of Practice (IBLCE 2008a), Standards of Practice (ILCA 2006), Clinical Competencies (IBLCE 2010c) and Documentation Guidelines IBLCE (2010b) as well as a disciplinary framework and a recording system for complaints against practitioners (IBLCE 2011c). Standards and Scope of Practice ensure quality of care and define the core responsibilities of the IBCLC practitioner (ILCA 2006; IBLCE 2008a) while the public are afforded some protection by ensuring that practitioners work in an appropriate way. The framework meets the developmental stages of a profession (Abbott and

Meerabau 1998) but the trait approach does not describe the essence of being a breastfeeding practitioner. The idea of professional development is not a static concept but a constantly evolving process where IBCLCs negotiate their role within their practice environment.

Historically doctors have received recognition as a legally and socially privileged group within health services both, within the UK and USA (Saks 1995; Sullivan 2000; Wagner 2007). Such recognition has enabled medical practitioners to exert direct and indirect control over other affiliated health practitioners which could affect how IBCLCs practice (Saks 1995). Williams (1995a, p.4), a medical practitioner in the USA, suggested that as a new profession, IBCLCs needed to take the initiative and educate others about their role but even she suggested that “some physicians may never accept you as a colleague.”

Lactation consultants might have circumnavigated some of the impediments experienced by other alternative practitioners such as herbalists, by defining themselves as an allied, as opposed to autonomous, health profession, but IBCLCs need to remain aware of the risks of medical dominance within the role (Saks 1995). The rationale for IBCLCs to become an allied health profession might have been serendipitous or might have reflected a neo-Weberian<sup>12</sup> approach. The choice, though, could have been pragmatic as hierarchical status is subordinated to the realities of developing a professional role for practitioners.

Sullivan (2000) described how each profession has different cognitive maps which develop through their value systems instilled during the training process, socialisation into the role and educational experiences. Becoming an IBCLC in the UK, though, is different as most prospective candidates prepare and develop for their role in isolation or with minimal

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<sup>12</sup> Max Weber described social structures and class based on status, economics, politics, honour and prestige. The medical professional reflected within such a framework has a higher social setting than professional breastfeeding practice (Saunders 1990; Barker 2005).

contact with other practitioners (IBLCE 2009a). The consequence of a lack of socialisation into the profession appears unknown but as the attraction into the qualification is a regard for developing a breastfeeding practice then this aspect might be easier to articulate than the role

The IBLCE ascribes control over who enters and stays in the profession by its regulatory frameworks (IBLCE Europe 2011). Witz (1992) considered that such exclusionary closure was a strategy of occupational control over a specialised area of practice and a way of protecting its niche in the market place. The rationale IBLCE adopts is that through the employment of such frameworks the public are protected (IBLCE Europe 2011). The way ILCA and IBLCE promote the qualification, though, as the only available global recognition for breastfeeding practitioners might link into Witz's (1992) concern of establishing and protecting a particular professional stance. The stance though, might attract prospective candidates to consider a career in breastfeeding practice although what the role entails is not always clearly defined.

One central function of any profession is that it ensures the acquisition and recording of expertise (Larson 1990). Practice-based professions have, in the past, not always found the articulation and recording of their expertise an easy accomplishment (MacDonald 1999). One of the first initiatives, which followed the development of the IBCLC qualification, was the publication of the JHL, which became the official publication of ILCA (ILCA 2010). The stated aim of the JHL is to maintain a "professional excellence in lactation management." and provide a place to "voice a professional practice". A search of the JHL archives, though, provided just one reflective account which described being an IBCLC and that was about working in private practice in the USA (Wiessinger 2002). The article was noticeably different from other journal articles in its use of emotional language, suggesting that the profession has so far avoided this type of exploration of its practice.

Professional practice for IBCLCs requires practitioners to develop a body of knowledge that is distinctive in its own right (Higgs et al. 2001; Bartlett 2005). According to Higgs et al. (2001), practitioners need to be very self-aware to be able to reflect on their own values, goals and personal frames of reference to enable them to share their descriptions with others (Rogers 1974; Belenky et al. 1997). This reflective understanding was under-represented in the official ILCA journal and may or may not be missing from IBCLCs practice

### **2.10. Conclusions on being an IBCLC**

The IBCLC qualification is relatively recent in its formation and while it was originally pioneered as a professional development for voluntary breastfeeding counsellors, health professionals now form the largest cohort of practitioners (Bailey 2005). How or if this has changed the way practitioners practice is presently unknown. Why practitioners undertake the qualification and how they practice also remains largely unclear. Both ILCA and IBLCE describe IBCLCs as competent but the research to back up such a statement is missing. Alongside the missing descriptors of practice the experiences of IBCLCs go unrecorded and possibly unrecognised. The lack of such research means that any problems or issues in practice are not identified and if possible, addressed. Some IBCLCs have described working in stressful situations but the lack of any understanding of practice means that the development of appropriate ways to support them is presently missing.

Practitioners need to articulate their practice to enable an understanding and a sharing of their professional practice. The lack of researched descriptions of IBCLC practice meant that the articulated framework of enablement through sharing, facilitation and service to others could not be confirmed or illustrated in the available literature (Auerbach et al. 2000; Wilson-Clay 2000). The personal accounts by IBCLCs provided a narrow window onto their practice but by the very nature of such recall the findings can be very selective and limited. Any profession requires a deep

understanding of its practice (Abbott and Meerabau 1998; Colyer 2004) and how that practice sets that role apart. In not examining the experiences of being an IBCLC an essential part of any understanding of the role is missing.

Professional practice has been described as a journey where a constant framing and reframing of professional identity is required by the practitioners (Radovich and Higgs 2001). On local, national and global levels there are pressures to implement change in how breastfeeding women are supported. As IBCLCs have been considered suitable practitioners to enable such developments it is timely to examine how IBCLCs work in practice and what their needs might be.

### **2.11. Aims and objectives of the study**

The primary aim of the study was a descriptive exploration of the experiences of IBCLCs who work in England.

The objectives were:

- To help IBCLCs produce reflective narratives about their practice and experiences.
- To provide a reflective analysis of the narratives focused on the context within which the IBCLCs practiced, including enablers and barriers to their role
- To produce an account that reflected the experiences of a group of IBCLCs who worked in England so that others might understand the role, which could enable any partnership work with other practitioners
- If found necessary, to produce some recommendations to facilitate the optimal development of the IBCLC role in England.

In the following chapter I discuss how my personal clinical experiences of working as an IBCLC informed the research framework. The stages of the research are described alongside reflections at each step of data collection and analysis.

## **Chapter Three: Finding a way to explore IBCLCs experiences**

*Human beings are not built in silence, but in word, in work, in action reflection (Freire 1996, p.69)*

### **3.1. Introduction**

Having set out the thesis objectives at the end of the previous chapter, this section describes my theoretical stance, methodology and specific strategy of analysis adopted for the study. Ethical issues are described and discussed and lastly I address the issues of assessing the quality of the evidence as it applies to the trustworthiness of the findings from the study.

### **3.2. My standpoint as the researcher**

I accept that individuals have different ways of knowing. Before I embarked on the research, I examined and reflected on my practice as an IBCLC by completing a personal narrative to understand my stance within the study. I found that my account illustrated a *praxis* that enabled the way I worked in practice.

Aristotle's description of *praxis* has been interpreted as the integration of theory, practice skill and embodied or realised practice (Holloway and Freshwater 2007; MacIntyre 2007). Knowledge, according to Aristotle, translated from the original treatise, consisted of three principles; theory, known as *theoria*; *poietics*, known as production and practice, observed as action (Aristotle 1999). Through the integration of the three aspects of knowledge, *praxis* became exemplary (MacIntyre 2007 and 2009). The understanding of Aristotle's *praxis* drew me to identify Schön's (1983, 1987) and Friere's (1996) work as the way I integrated the aspects of my practice knowledge into a whole. Friere's (1996) work especially had resonance in my work as an educationalist and a clinician, as his understanding of the transformative action of reflection provided me with the hope that practice can change when appropriately supported.

Praxis<sup>13</sup> motivated me to continually improve and develop expertise in my practice. Reflective practice was invaluable in understanding the tacit knowledge embedded in my clinical experiences (Schôn1983 and1987). As both praxis and reflection were central to how I worked they became the starting point for understanding how I could approach the research and frame the study. The chosen reflective framework for the study was Daudelin's (1996) who described reflection as;

a stepping back from the experience to ponder, carefully and persistently, its meaning to the self through the development of inferences (p.39)

My clinical background had everything to do with driving my interest in the research that would, to some degree, affect aspects of how I undertook the study. As the researcher I felt compelled not only to reflect on my practice but also to engage in a high degree of reflexivity throughout the research process (Burr 1995; Mason 1996; Guillemin and Gillam 2004). Mason (1996) considered that reflexive research;

means that the researcher should constantly take stock of their actions and their role in the research process and subject these to the same critical scrutiny as the rest of the data (p.6).

The challenge was to actively engage and develop as a reflexive researcher. Patton's (2002, p.66) model of reflexive questioning was adopted into the study to enable my development and achieve a greater level of "self-questioning and self-understanding."<sup>14</sup> Employing a reflexive approach recognised how I interacted with the research process throughout the course of the study which also meant I was writing myself into the process. Alvesson and Sköldberg (2000, p. 246) described how such an approach can avoid a "narcissistic self-centredness" in the

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<sup>13</sup> Praxis within the study is defined as an integration of the senses through "thought, action and meaning" (Holloway and Freshwater 2007, p.30)

<sup>14</sup> Appendix 2

researcher as it provides an opportunity to go beyond any preconceived ideas and open up myself to consider new ideas which might not have been previously considered. The reflexive stance also enabled the analysis of the data within the social constructionist framework of the study as it maintained an attentiveness and consciousness to my personal influences as well as those affecting the participants (Potter 1996; Alvesson and Sköldberg 2000; Patton 2002). The use of a research log<sup>15</sup> provided the evidence of my engagement within the study and placed the experiences and reflections and reflexive practice within the context of the research process (Silverman 2001).

### **3.2.1. Understanding the tensions of becoming a researcher**

In undertaking the role of practitioner turned researcher, I was drawn into a position that had tensions of being an insider, an outsider and being on the boundary between the two roles. The tensions between the roles required me to challenge assumptions about myself but also opened me up to a deeper understanding of practice as an IBCLC. In acknowledging my practice interest I recognised that I had “insider knowledge”, which enabled me to pose questions that others might not think to ask but might also risk a lack of questioning with assumed familiarity with the subject (Ewing and Smith 2001; D’Antonia 2006; Adams 2007). I found that the wide reading for the literature review alongside the reflections on my practice brought a deeper conceptual clarity of my understanding and place within the research which provided a wider perspective for the study (Wainwright and Forbes 2000).

### **3.3. Setting the research framework**

Health practice-based disciplines have relied heavily on positivist approaches to scientific inquiry in the past (Holloway and Wheeler 1996; Silverman 2001; Parton 2003), which was considered problematic in illustrating the experiences of IBCLC practitioners (Flyvbjerg 2001; Gergen and Gergen 2008). A qualitative approach was therefore chosen for the

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<sup>15</sup> Appendix 3

study as it orientated the research towards collecting complex experiences of professional practice (Robson 1993; Holloway and Wheeler 1996; Parton 2003). One of the defining traits of a professional practitioner has been described as an ability to articulate a knowledgeable or *phronetic praxis* (Bernstein 1982; Flyvbjerg 2001; Svenaeus 2003; MacIntyre 2007). Phronesis has been viewed as a practical wisdom based on mediations between reasoning and knowledge, where the ability to articulate practice has been described (Friere 1996; Fish and Coles 1998; Svenaeus 2003). Frank (2004) described phronesis as functioning beyond the basic understanding of work but with a practical wisdom.

### **3.3.1. Choosing Narratives to hear IBCLCs accounts of practice**

Working with breastfeeding women is an intimate interaction between the IBCLC and the woman, which a third person, such as a researcher, could easily disturb. An observational approach, therefore, did not seem appropriate to the study and might have missed how the practitioners reflected on and articulated their phronetic praxis.<sup>16</sup> I had observed, while attending study days and conferences where IBCLCs were present how practitioners actively listened and shared stories from practice when there was time to share their experiences. The interactive participation by IBCLCs came to mind when I attended a study day facilitated by Arthur Frank (Frank 2008) where I had the opportunity to listen and discuss with other researchers how narratives were used to collect data. The ability of IBCLCs to share their experiences with their peers also appeared to reflect the way practitioners worked with breastfeeding women. The familiarity with the approach in practice for the IBCLCs I felt was transferable to the research framework.

Fish and Coles (1998) illustrated professional practice as an iceberg where only the practitioner's action was visible while the knowledge, feelings, expectations, assumptions, attitudes, beliefs and values were

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<sup>16</sup> Aristotle (1999) describes phronetic praxis as a practice wisdom achieved through utilisation of the integration of knowledge and skill.

hidden below the water line. Asking IBCLCs to narrate their experiences of practice meant asking practitioners to access these submerged areas of practice (Garro and Mattingly 2000; Holstein and Gubrium 2003; Bolton 2006).

Harnett (2010, p.164) described how narratives illuminate the interplay of “social, historical and spatial contexts”, which construct lives and perceptions of who we are. In describing narratives in this way the practitioner’s account could be seen as a series of connected events which illuminated intersections between the biographical, historical, social and culture influences within the narrated experience (Burdell and Swadener 1999; Holstein and Gubrium 2003; Hogan 2006).

In recalling practice in this way, practitioners have been described as “talking themselves into existence” (Horsfall et al. 2001, p.91), which is apposite for an initial study illustrating IBCLCs experiences. The ability to articulate practice is a core competency for an IBCLC (IBLCE 2010c), and has been utilised by other professional groups to illustrate their development as a profession (Jeffrey and Woods 1996; Parton 2003; Chanfrault-Duchet 2004; Decker & Iphofen 2005).

Within the study, narratives were considered subjective accounts that captured the artistic and evocative data that reflected an essence of IBCLCs’ practice. The risk in choosing this approach was that the accounts would open up individual practitioner’s practice to scrutiny and might recall emotional experiences which might not have been fully addressed (Mattingly 2000; Holloway and Freshwater 2007). The pressure for me, as the researcher, was that I had to collect what Flyvberg (2006, p.237) described as “good narratives” that collected the complexities and contradiction of real life.

Polkinghorne (1988) described narratives as a basic way of interlinking human actions and events into an interrelated understanding. In collecting narrative accounts of practice from practitioners I felt the study retained the “noise” of real life, which other research approaches might

have missed (Halse 2010, p.28). Personal narratives appear to matter, especially in professions, which have previously been unexamined, as they show how peoples' lives are lived and there is a powerful moral idea of authenticity within such accounts (Frank 2002).

### **3.3.2. The use of a Social Constructionism Framework**

A social constructionism framework was chosen for the study as it acknowledges how the practice environment, through its social and cultural structures, can impact on how the IBCLCs narrated their accounts and reflected on their experiences in practice (Berger & Luckman 1967; Burr 1995; Potter 1996; Nightingale and Cromby 1999; Parton 2003; Bolton 2005). Burr (1995) considered that social constructionism has a looseness in structure that encourages the examination of such cultural and social influences while leaving space for the researcher to define the study framework further, if necessary.

A central premise of social constructionism is that it offers a chance to explore and explain the environment of IBCLC practice and recognises that the human world is different to the natural, physical world and must therefore be studied differently (Patton 2002; Bolton 2005).

A risk in using a constructionist approach is that the participants might be seen only as social actors not as practitioners, which could miss the emotional "natural, impulsive and passionate" aspects of practice (Bolton 2005, p.71). Social constructionism approaches have tended to ignore embodied experiences in the past, which Burr (1999) suggested has led to disembodiment of participant's accounts and a "uniform plasticity" of descriptions of practitioners' encounters in practice (Cromby and Nightingale 1999, p.11). My approach was to inter-weave storied accounts from the practitioners alongside my own reflections, when appropriate, to contextualise, anchor and illustrate the embodied experiences of practitioners. The utilisation of a social constructionist framework in such a way was felt to illuminate the emotional as well as the

social and cultural context of IBCLC professional practice (Cherniss 1995; Chanfrault-Duchet 2004; Bolton 2005).

### **3.3.3. Questioning the need for a woman-centred perspective for the study**

Breastfeeding is seen as a womanly experience practiced within the social and cultural context of the communities in which women live (Palmer 2004; Boswell-Penc 2006). The adoption of a social constructionist framework acknowledged the social and cultural context of breastfeeding but an orientation towards a feminist stance within the study was not taken. I acknowledge that the participants and the researcher in the study are female and that breastfeeding is often described as taking place within a woman-focused environment but that alone should not frame the study within a feminist stance (Alvesson and Sköldbberg 2000).

From a researcher position I considered Harding's (1991 p.2) stance reflected my own in that when women research women they view what they see as "part of life" and not part of a movement. Using a feminist perspective within the study would have argued that there was a socially constructed difference between the sexes in relation to breastfeeding (Oakley 2000). I did not find the case for a feminist stance on gender difference well argued. Becoming and being an IBCLC did not appear to be a gender based activity, as a minority of IBCLCs are male. Within feminism itself there also appeared to be an ambivalence and contradiction about breasts and breastfeeding (Carter 1995), which might not have led to any clarity or supported the idea of a gender sensitive approach in the research. The use of a feminist stance within the study, therefore, was not chosen as it did not bring any clarity to the role of an IBCLC.

### **3.3.4. Practice and power**

Knowledge and power are interwoven into any position where practitioners' work within a hierarchal system of employment, such as working within the NHS (Kirkham 2010). There are also issues with relationships between a newly developed profession and other health professionals, especially as to how the new practice is viewed (Horsfall et

al. 2001; Dykes 2006a; Brine 2010). Alvesson and Sköldbberg (2000) argued in favour of using a reflective approach when describing such influences. My personal account illustrated how I had chosen to seek a particular role or niche in practice, where my Aristotelian approach did not clash too often with the utilitarian outlook mainly espoused within the NHS (Balaban 1990; MacIntyre 2007). Kirkham (2010) and Dykes (2006a) found that midwives who practiced within hospital settings usually adapted to the power structures within the workplace. Deery et al. 2010b, though, also found some midwives who sought a niche to enable them to practice the way they wanted (similar to my own experiences), which could reflect other IBCLC practitioners' experiences.

Foucault (1980) believed that through narrative accounts the mechanism by which individuals develop within social structures could be revealed. The concept of narrative used by Foucault (1982), though, was different as he employed narratives as a framework to illustrate how objects and subjects were described through the use of language. Foucault (1980) did not delimit or define power but describes it as existing within relationships. By analysing statements or single units which constitute a discursive formation, Foucault (1980) described how the speaker illustrated their constraints and where they were situated. Deetz and Kersten (1983) pointed out how with Foucault, attention was focused on power where individual practitioners could choose to create their own subjectivity in how they lived their own lives as long as they had the autonomy to do so. Foucault (1982) described practitioners achieving these outcomes through resistance or acceptance to present practice discourses which narrative accounts could capture.

Listening only to narrative accounts, though, was considered to be too restrictive, especially at times when words fail to describe the participant's experience. Burr (1999) described how the body has expressive powers that can be accessed through the senses to frame occasions when words are not enough. Field notes were therefore used at the completion of each interview to identify and collect the sensory elements of body

language and other factors that, as the researcher, I recalled from being with the participant, factors which could inform the analysis further.

### **3.4. Data collection**

Frank (1995, p.25) thought that collecting narratives was a “hard, but also a fundamental moral act”, which asked much from the researcher. I considered that the statement also held true for the participants, as they would have to narrate and reflect on areas of practice, which could revive strong emotional memories (Wengraf 2001).

#### **3.4.1. Sample and Recruitment**

A purposeful sample of twelve IBCLC practitioners who worked in the north of England was recruited to the study. The rationale for choosing participants who lived over a hundred and fifty miles was that they and their practice were unknown to me and the lack of familiarity could assist me in “opening up to seeing their situation” (Walters 1995, p.796).

Accessing information on IBCLC practitioners in the UK and the recruitment of practitioners to the study, though, was problematic. I formally approached the European office of IBLCE, which maintains the register of all IBCLCs in the UK, to ask for their assistance with recruitment to the study. The request was turned down on the basis of the IBLCE Privacy Policy, which only allows contact with practitioners on matters of their qualification (IBLCE 2009). The same policy was also cited when I asked for statistical details about IBCLCs in the UK. These details might have built up a better picture of practitioners and practice in England (IBLCE 2009b). The only other national records of IBCLC practitioners in the UK are maintained through ILCA and its affiliate group LCGB. Only a third of IBCLCs in the UK are members of LCGB and even fewer of ILCA, so any recruitment through such organisations risked limiting the number of practitioners I contacted.

Fortunately a breastfeeding co-ordinator agreed to act as a local recruiter for the study. She maintained the contact details of all of the twenty-three

IBCLCs who worked in the north of England. Unfortunately, further details on the twenty-three practitioners were not available as the recruiter was unable to provide them. All that can be stated is that out of the 234 registered IBCLCs in Britain in 2008 (IBLCE 2008b), 23 practitioners in the north of England were contacted by letter by the recruiter and of these 12 responded to the recruitment letter and contacted me and became the sample for the study. Out of the 12, 10 were members of LCGB and 5 were members of ILCA which further illustrated that recruitment through these affiliate organisations might have been problematic.

The local recruiter sent an invitation to participate in the study to the twenty-three IBCLCs in her area.<sup>17</sup> Prospective participants were asked to contact me if they required further information or wanted to participate in the research. The recruitment of participants was designed so that the practitioners who took part in the study would be known only to me to help protect their identity. The recruitment method had an inbuilt risk that, in the case of a poor response, IBCLCs could not be re-contacted but the risk did not materialise.

The 12 IBCLCs recruited to the study represented just over half of the practitioners in the locality. If more practitioners had responded then they would have been included in the study, as the framework was flexible enough to accommodate further narratives. The number of IBCLCs who were recruited to the study was relatively small but was considered appropriate for the qualitative framework of the study, which called for two in-depth interviews.

Of the 12 practitioners who participated in the study, 11 were interviewed twice. One participant had emigrated to Australia after the first interview and although she was contacted twice following the move, she decided not to participate further and so was lost to follow up (Participant 6). Further details about the participant sample are in Table 1.

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<sup>17</sup> Appendix 4

<b>Table 1: IBCLCs recruited to the study</b>						
Participant	IBCLC	Work in NHS	Private practice	Voluntary work	Interview One	Interview Two
1	1-5 years	IFA	No	No	Yes	Yes
2	1-5 years	BF lead/HV	No	No	Yes	Yes
3	1-5 years	BF lead/HV	No	Yes	Yes	Yes
4	1-5 years	MW/IFA	No	Yes	Yes	Yes
5	6-10 years	IFA	No	No	Yes	Yes
6	1-5 years	IFA	No	No	Yes	No
7	11-15 years	No	No	Yes	Yes	Yes
8	6-10 years	MW/IFA	Yes	Yes	Yes	Yes
9	6-10 years	MW	No	Yes	Yes	Yes
10	11-15 years	MW manager	Yes	No	Yes	Yes
11	6-10 years	IFA/Nurse	Yes	Yes	Yes	Yes
12	1-5 years	BF lead/HV	Yes	No	Yes	Yes
IFA = Infant Feeding Adviser, MW = Midwife, HV = Health Visitor						

### 3.4.2. Interviewing IBCLCs

The first interviews took place during October and November, 2008. The second interviews took place during April and May, 2009. Prior to each interview the participants were provided with information about the study. Before the second interview each practitioner was sent a copy of their transcribed first interview and a brief overview of the initial findings from all the participants.<sup>18</sup> The second interview was based on questions sent alongside the initial findings. Written consent was obtained from each participant prior to data collection

Participants were asked where and when, within a two-week period, they would like to be interviewed.<sup>19</sup> Five of the interviews took place in the workplace and the remaining eighteen interviews were carried out in the participant's home. When interviews were conducted in the workplace research governance was obtained from the site where the participant worked (Fife and Forth Valley Research Ethics Service 2008<sup>20</sup>).

Participants were asked, when possible, to provide a storied account of their experiences so a greater correspondence between how life was lived and how it was illustrated in the narrative could be drawn (Bruner 1990; Mattingly 2000). Interruptions to the participant's narrative were kept to a minimum, to encourage full narrative disclosure and to provide time for reflection on what was said. Further questions or clarification, if necessary, was sought after the participant had stopped speaking. Checking through clarification enabled the narrative to become more context sensitive, in that what I heard, I also understood (Cohen et al. 2000; Silverman 2001; Patton 2002).

The initial interviews started with the opening question:

*Can you tell me how you became an IBCLC and your experiences in practice?*

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<sup>18</sup> Appendix 5

<sup>19</sup> Appendix 5

<sup>20</sup> Appendix 9

The research log, after completion of the first three interviews, recorded concern around the uncertainty in two participants of knowing how to start their narrative. After the initial hesitation the participants did not illustrate any further difficulties. The confusion, for the participants, appeared to be related to the opening statement asking two questions and its brevity. The opening prompt was therefore adjusted to become longer, clearer and provide information about how the participant might like to respond and how I would facilitate the interview (Wengraf 2001).

The opening question for participants became:

*Can you tell me about your experiences of being an IBCLC, about the events and experiences which are important to you. You can start around the time you decided to become an IBCLC and you can begin whenever you like. Please take your time and I will listen. I will not interrupt. I will take some notes and after you have finished telling me about your experiences I will come back to some things that might be important to you.*

The change improved the initial flow of the narrative and was adopted for the final nine interviews. The adjustment was still considered to maintain the integrity of the interview, which consisted of a narrated personal account of how the participant became an IBCLC and their experiences in practice (Gaydos 2005).

The second interview, six months later, was based on questions identified from the initial analysis of the first interview. The questions were on three topics; support for participant's practice, teaching others and managing change. The rationale in questioning on these topics was to provide further elucidation on how each subject affected the practitioner.

All the interviews were digitally recorded. Contemporised field notes, which formed part of a research log, were completed as soon as possible following each interview. Interviews varied from 35 to 95 minutes in length. Transcripts of the first and second interviews were completed and sent to participants in March and November, 2009.

### **3.4.3. Reflections on using research interviews**

Although I had undertaken some research interviewing prior to this study the approach was different to my previous experiences (Brown 2006a; Brown et al. 2008). I did consider undertaking a pilot study prior to undertaking data collection which would have tested my ability as a researcher, the recording equipment and the data collection questions (Frankel and Devers 2000; van Teijlingen and Hundley 2000; Kim 2010). In choosing not to undertake a pilot study I was not rejecting the feedback such a review could provide but questioning how relevant it was to the study. The approach in the study, although described as interviewing, relied on asking an opening question and then listening (Mishler 1991). I acknowledge the opening question was adapted during the course of the interviews but on reflection I wondered if the need to adjust the opening question would have been identified any earlier if just one or two pilot studies had taken place.

I was aware that research interviewing would be different from hearing accounts in clinical practice but I also believed that the same general principles I used in my clinical work of active listening, facilitation, reflection and clarification were an appropriate and transferable skill into the study (Kvale 1996; Lauwers and Swisher 2005). The collection of very detailed, in-depth data validated the transfer of this skill. The final rationale for a pilot study, familiarisation with equipment, I did act upon and I made sure I was adept in collecting recordings before I embarked on data collection.

One of my concerns in interviewing other IBCLCs was that I might assume commonalities of experiences when a participant narrated an account that I considered reflected my own. The anxiety was that the participant's meaning might be lost if I assumed a prior understanding. On listening to the recordings I found that in practice, the regional differences in participants' accents and the phrasing was different to my own. The differences enabled me to seek clarification about what was being described.

The practice of active listening, which had been honed in my clinical practice, I found was the way I stayed open, questioning and alert to any subtle changes in the narrative accounts. Active listening required me to demonstrate to the participants that I was hearing their account through appropriate body-language, eye-contact, and verbal sounds of encouragement which enabled me to stay listening even when the narrative had stopped (Crotty 2003; Wengraf 2001; Lauwers and Swisher 2005). On transcription of the recording I realised how staying silent at the end of a participant's narrative enabled practitioners to reflect and often bring further thoughts into their accounts. Silence, I found, informed the interview.

The expectation in collecting in-depth narratives was that participants in the study would adopt a reflective frame of reference. Reflective practice had received little attention in IBCLC literature as a search of the JHL confirmed. An Eight Level Lactation Consulting Process, designed by IBCLC practitioners, used a reconciliation framework between the different levels of understanding practice (Cadwell and Turner-Maffei's 2004). The framework was different and more contained than reflective practice in that any questions asked had to be based on observable facts and compatible with these findings in any outcome.

Eleven of the twelve participants had other health related qualifications where reflective practice formed part of their professional framework (NMC 2008). Bolton (2005) described how professional practitioners engage in effective reflection on their practice although it might not always be made explicit in their practice framework. Reflective practice, Bolton (2005, p.211) suggested, was evident in the proficiencies of professional practice such as the maintenance of written records, which is part of the core competencies of IBCLC practice (Smith 2003a; IBLCE 2010c). Why reflective accounts are missing from IBCLC literature is impossible to explain but all the participants narrated their accounts through a reflective lens.

I found that in undertaking the research each aspect of the study had to be very carefully considered. One detail I did not fully explore was how I presented the transcription of their interviews to the participants. While all the participants had agreed that they wanted transcriptions sent to them and stated that they had previously seen such data, I did not clarify what type of narratives the practitioners had previously observed. Sikes (2010) discussed how any research procedure might not fully address how the practitioner feels when confronted with a transcription that represents a personal story. For the participants it was not what they had said but the way it was reflected in the transcripts that was problematic. When I returned for the second interview, I found three participants had not seen a fully transcribed narrative before and were only familiar with the smoothed out texts in published research. The three participants were concerned about the pauses, repeated words or phrases that they had used within the narrative. I realised, too late, this anxiety could have affected how the participants narrated their following accounts. In my research log I discussed how I could have addressed the issue at an earlier stage by showing participants a sample of a transcription, alongside an offer of a more simplified account. The lapse in checking out such a detail, though, did not evidence itself in the way the participants narrated their second accounts.

The purpose of returning the interview data to the participants was not for them to validate what they had narrated but to consider and reflect on what was said. The participants were offered a full or simplified transcript of their second interview. All of the participants asked for the full transcript.

I found the variety of ways the participants prepared for the second interview interesting as some read the transcripts, some the feedback I had sent and others a combination of both. Comments from Ruth who had read the transcript and Susan, who used the feedback, are included.<sup>21</sup>

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<sup>21</sup> I named each participant to enable a separate voice for each practitioner. As the researcher I am the only person who can link a name to a participant. Transcription nomenclature in Appendix 6.

*Reading the transcript . . . made me think of things . . . I had not asked myself before . . . so sometimes somebody else asking the questions gave me a chance to think about it as to why I undertook those things . . . but giving me a chance to think about it . . . it does make you reflect about your practice (Ruth/2/8 -13<sup>22</sup>).*

*and it's quite reassuring in a way . . . that there are other lactation consultants out there . . . who . . . are making the same comments (Susan/2/9 -11)*

Providing feedback to the participants prior to the second interview appeared to help them feel part of the research and to reflect further on their practice. I recorded in my research log that the second interviews, with regard to the organisation and the collection of data, were not as problematic. This may have been because of familiarity with me, the study, the feedback and the framing of the questions. I also found that some participants, who had presented an uncritical narrative in the first interview, were more open about their experiences and the issues they encountered in practice during the second meeting.

### **3.5. Data management and analysis**

The following section describes how the data was transcribed and analysed to illustrate the experiences of IBCLCs in practice. A reflection on the research process is provided at the end of this section.

#### **3.5.1. The analytical framework**

The analysis was a continuous process that began with the initial hearing of the narratives. The field notes recorded my initial reactions and reflections which together with the research log documented the progress of the research (Patton 2002; Crotty 2003; Chanfrault-Duchet 2004).

The interviews were transcribed using Silverman's (2001)<sup>23</sup> framework for interpretation, which ensured details such as pauses, non-lexical

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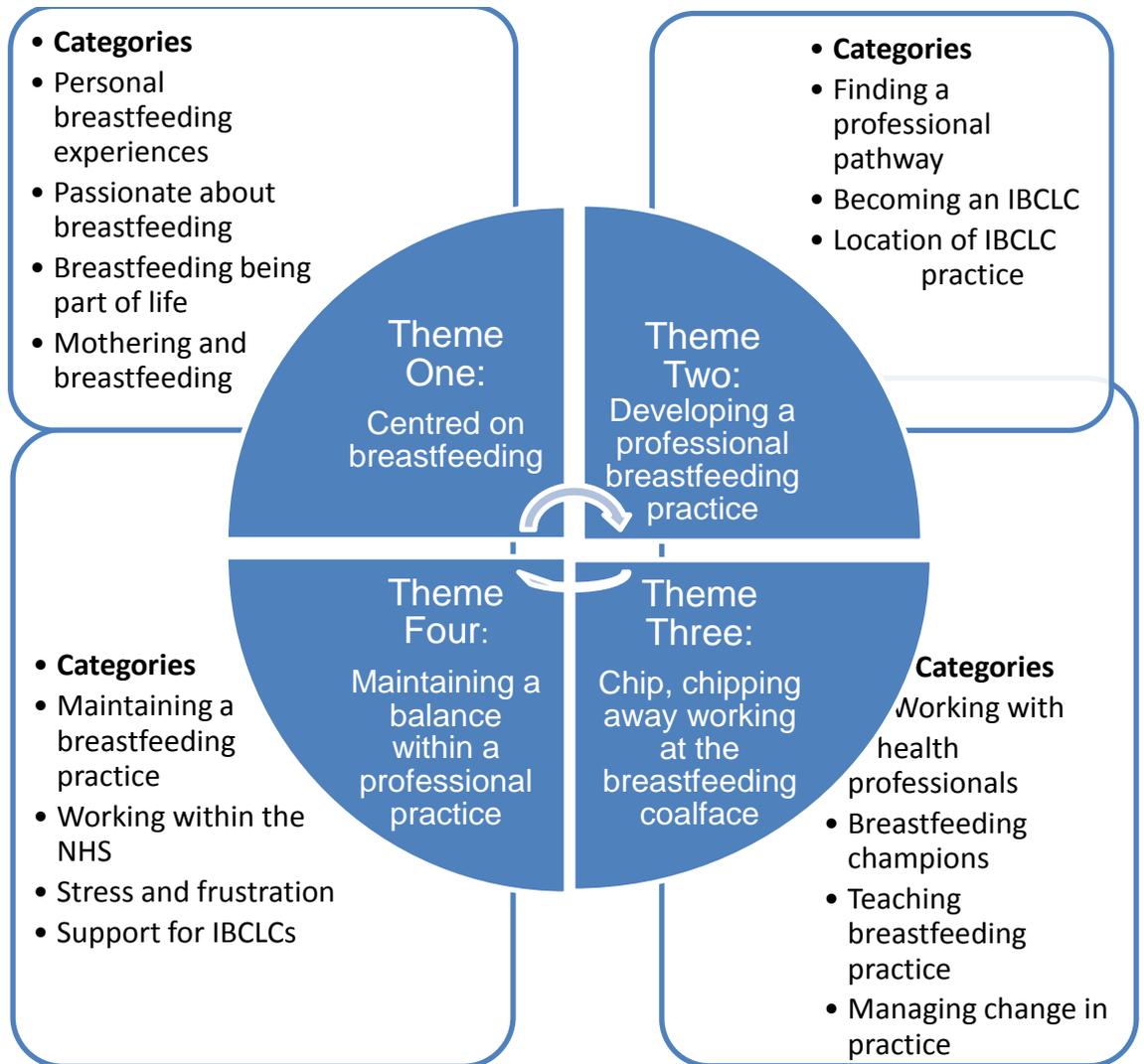
<sup>22</sup> The information at the end of the narrative indicates the name of the participant, the 2, that it was the second interview and the final numbers related to the numbered lines in the transcript.

<sup>23</sup> Appendix 6

expressions and speakers interruptions and overlaps were noted within the text. Although time consuming, the transcription of the narratives enabled me to become sensitised to the accounts and gain a deeper understanding of what and how accounts were shared. Listening to the participant's narrative was important in the analysis, as through hearing the practitioner's voice, the "emotional heat" of the moment was linked to my memory of that account (Holloway and Freshwater 2007, p.45).

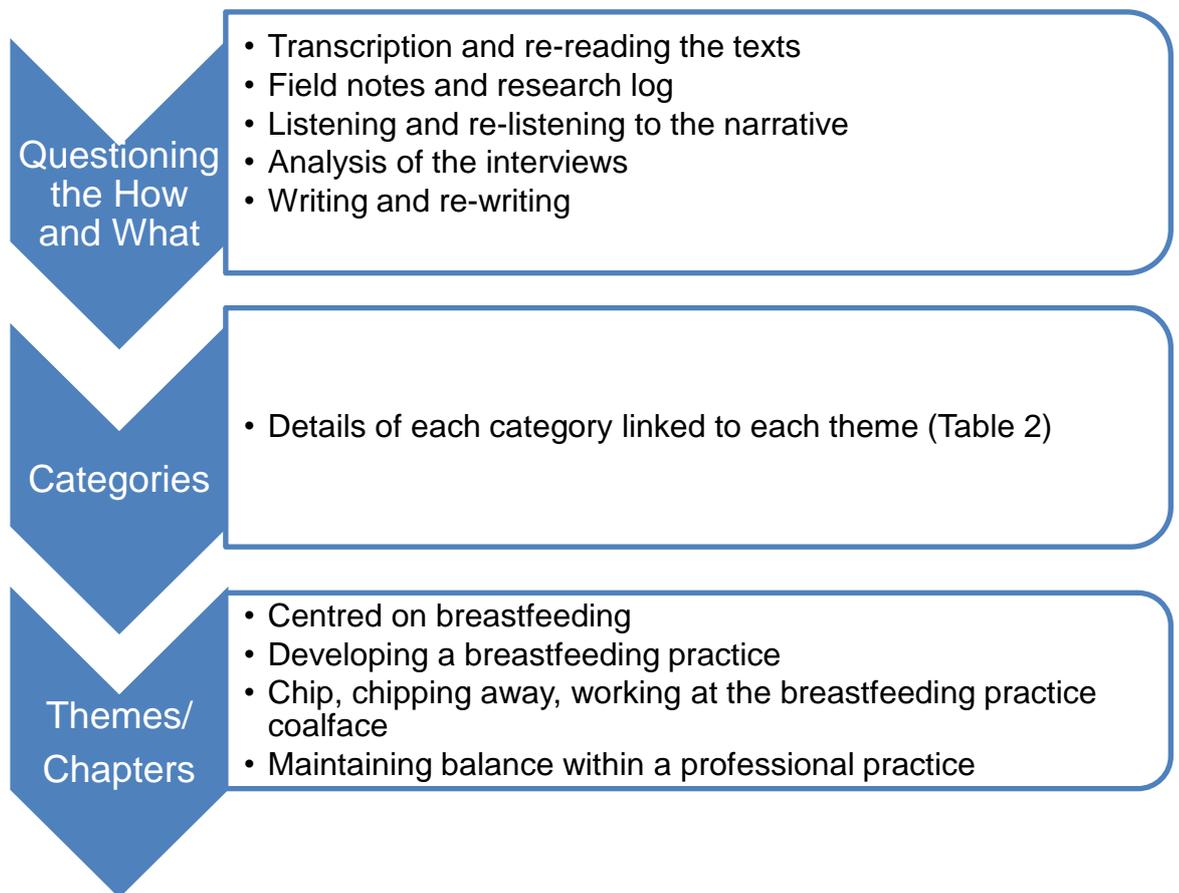
In each narrative there was a weaving of core descriptors of "how they do it" (Butler et al. 2001, p.205), or how each IBCLC worked in practice. The descriptors also illustrated what occurred as the result of the actions. In choosing to analyse the accounts through the action descriptors, the narratives became intimately bound up with one another, as there were commonalities in the nature and environment of social action and interaction between many or all of the participants (Bruner 1990; Ricoeur 1992 and 2004; Mattingly 2000; Smith 2000). The approach initially appeared too simple to be an analytical framework for the whole study but on drawing the descriptors together under categories, themes were generated which described particular situations, meanings and experiences which illustrated the practice of an IBCLC. Initially the narratives were treated as context-independent text which were inductive or data-driven, providing "raw information" for analysis (Althiede and Johnson 1998; Boyatzis 1998, p.30; Smith 2000). The inductive approach placed the data into categories. Within each category there was a process of regularly comparing data to ensure the contextual setting was understood (Althiede and Johnson 1998; Smith 2000). From the categories themes began to emerge (Table 2).

**Table 2: The arrangement of categories into themes**



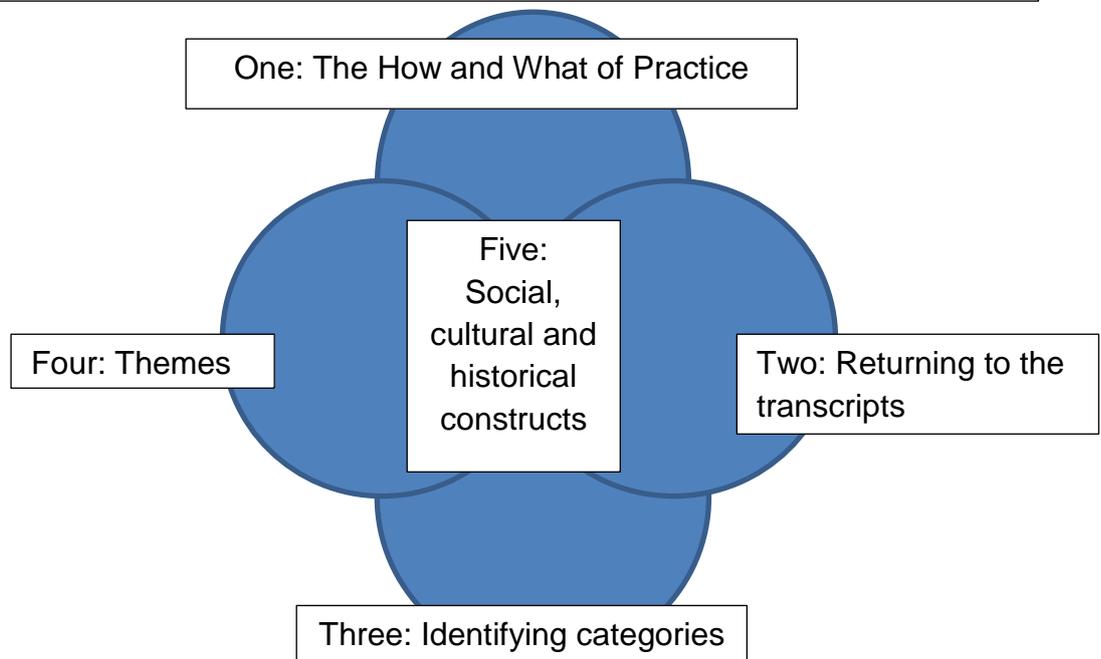
The constant cycle of listening to the interviews, reading the transcripts, considering the categories and thematic understandings meant that the analytical process was slow but founded on a deep understanding of the data (Boyatzis 1998)(Table 2,3 and 4).

**Table 3: The analytical framework of the narrative accounts that was set within a social constructionist framework**



The analysis represented movement, from the individual context-independent descriptor, to the thematic group of contextual understanding of IBCLC practice. The interpretation was my own which used my insider-outsider knowledge as an IBCLC but primarily as a researcher. Through this approach individual participants' experiences were duly given recognition, alongside commonalities of practice the other practitioners encountered. The aim was to render the day-to-day as well as the diverse experiences of practitioners legible and dialogical (Table 2, 3 and 4).

**Table 4: Circles of reflection and reflexivity, illustrating the interaction between the questioning of one to five in enabling the analysis of the IBCLCs narratives.**



The analysis brought action and experience together by asking the “how” and “what,” of the participants’ experiences, which were embedded within the narratives (Table 4). An emergent dialogue arose from the experiences that also recognised and drew on the social constructs of practice (Polkinghorne 1995; Mattingly 1998; Crotty 2003). This led to further exploration of meaning for IBCLC practitioners and their professional role. Where participants narrated an alternative account to other practitioners then this was also included to illustrate the range of the presented experiences. The analytical framework enabled descriptions of how IBCLCs worked, identifying similarities as well as any differences in practice as well as providing opportunities for their individual voices to be heard.

### **3.5.2. Reflection on the methodology and analysis**

Patton (2002) and Crotty (2003) described one of the strengths of using a qualitative approach within a study framework was the flexibility it produced to make adjustments to ensure the aim of the research was met. When the study was planned the proposal was to use Fischer and Goblirsch (2006) narrative biographical structuring for data analysis. The analytical framework assigned data into three life frameworks of the lived, experienced and presented life which at the research planning stage appeared relevant to understanding IBCLCs' experiences in practice. In application, following the analysis of four narratives, I realised that biographical structuring presented some problems in the study. The main issues were that the analytical approach did not fully address the stated aims of the study and that individual biographical analysis of each participant risked their anonymity. The use of Fischer and Goblirsch (2006) narrative biographical structuring for data analysis resulted in-deep focusing on each practitioner which reduced the opportunities, through lack of space within the thesis, to explore and reflect on any emergent themes of IBCLC practice.

The described analytical framework for the study (3.5.1.) was developed through my returning to the data, re-reading relevant texts and examining other qualitative studies where professional practice was described. The framework took shape very slowly and initially I was quite tentative in expressing any confidence in the analytical process. As a researcher, I felt I struggled at times to illustrate the focus of the tensions within the role the participants narrated. It was not until I read Adam's (2007) research on nurses' experiences where similar concerns were expressed that I realised I was not alone in expressing my anxiety.

The progress of the analysis was very slow. Holloway and Freshwater (2007, p. 81) aptly named the process a "period of incubation." At times I appeared to do nothing but write and rewrite, and then delete most of what I had written. What I did not realise at the time was each account brought

me closer to an understanding of the narratives. Reissman (2006) described narratives as a series of sequences and consequences where events are selected, organised, connected and evaluated. My analytical writing reflected a similar process and progress.

### **3.6. Consideration of reliability, validity and trustworthiness in the study's findings**

Silverman (2001) placed the onus on the researcher to demonstrate that the completed research is trustworthy. The subjectivity within the research framework was openly acknowledged throughout the research and my stance within the discussions clearly stated. Choosing the correct research approach was essential in framing the study (Mays and Pope 1995). The explicit details of the development of the study, the process and the reflexivity embedded within that understanding recorded in my research log demonstrate a clear audit trail and a transparency within the research.

The use of a social constructionist framework took into account that IBCLC practice does not take part in isolation but needed to be understood within the contextual world in which the participants' worked. Looking at, capturing, and respecting multiple perspectives of practice provided depth to the study's findings and challenged and offered different ways of understanding the way the participants worked (Mays and Pope 2000). Trustworthiness in the research was demonstrated through transparency in the process and how the framework was referenced to other relevant approaches to data collection and analysis (Psathos 1995).

Holloway and Freshwater (2007), Halse (2010) and Brine (2010) suggested that the essence of any narrative research is reflected in the ability of the study to provide an authentic voice for participants about their experiences. Apart from my research supervisors, who have been involved throughout the process, an IBCLC colleague, who had completed her doctoral studies, and was not involved in the research, agreed to read the transcripts and comment on my analysis. The rationale for the

alternative reading was to enable me to consider other possible interpretations of the data and reflect on any underexplored areas within the transcripts (Mattingly 1998; Benwell & Stokoe 2006).

*I have just spent the day with the person who has read the transcripts and the analysis of my study as a second reader. I was incredibly anxious before meeting up as sharing my findings at this stage when I still have so many doubts and questions myself felt almost premature within the study framework.*

*How wrong I was as the day debating and justifying the research was just what I needed. The discussions clarified my thoughts and I found I could articulate and defend my findings. We also found that we reflected similar feedback from the data, which gave me confidence in what I was writing. We ended the day spending time discussing our practice. Suddenly we looked at each other and laughed in recognition that that was one of the findings from the study. In fact, the reviewer felt the work needed to be heard by other IBCLCs and asked if she could contact the LCGB Conference organiser and suggest me as a speaker.*

*Research Log 24.9.11.*

The feedback from IBCLCs on the research findings is limited to the participants and the reviewer at this stage but they have reflected similar feelings of compatibility with what was found. The final test of the research in reflecting aspects of the IBCLCs role will not be realised until the research can be shared with a greater number of practitioners (Lincoln and Guba 1985; Silverman 2001; Patton 2002).

### **3.7. Ethical Considerations**

The ethical dimensions of the research were integral in the planning and management of the study and placed the responsibility on me to reflect this in the work (Sikes 2010). A qualitative framework can pose its own problems in maintaining an ethical stance and for me the main challenge was in staying true to the aims of the study while ensuring the potential

risks to the participants were anticipated minimised and prevented when possible (Richards and Schwartz 2002; Guillemin and Gillam 2004).

The outcome of the research was linked to the Aristotelian virtue of advancing general good in bringing an understanding to IBCLCs about their practice (Berstein 1982; Aristotle 1999). The ethical intention was *“aiming at the “good life” with and for others in just institutions”* (Ricoeur 1992, p.172). Ricoeur (1992) argued that each one of us has a responsibility and indebtedness to care for each other. The ethical framework should therefore balance my concerns as the researcher in pursuing the study against the rights of the IBCLCs who decided to participate in the research (Cohen et al. 2000).

Some researchers have expressed concerns that ethics and narrative research can become a contradiction in terms (Smythe and Murray 2000; Ellis 2007; Downs 2009; Rice 2009). To enable a full discussion of the issues, the procedural ethics in practice and relational ethics framework was adopted, as it appeared to match the demands of the study.

### **3.7.1. Procedural ethics**

Procedural ethics are governed by the Helsinki Declaration (2008), which ensures that medical researchers always work within ethical frameworks (Guillemin and Gillam 2004). The procedural framework was uppermost in my considerations at the start of the study when I paid particular attention to meeting the needs of the participants. The needs of each IBCLC were met through respect for the individual which was supported by a framework that consisted of informed consent, minimizing harm, trust, truthfulness and sensitivity. My practice-based ethical framework, as a midwife and IBCLC, had codes based on the four principles of biomedical ethics: respect for autonomy (the right to choose); beneficence (do good); non-maleficence (do no harm); and justice (fairness and equality) (Beauchamp and Childress 2001). Many of the principles of biomedical ethics were transferable to my practice as a researcher but the focus

changed to a participant- centred one (Smythe and Murray 2000; Holloway and Freshwater 2007).

The study asked IBCLCs to narrate descriptions of their practice, a topic they were considered to be familiar with and with which they should have been able to engage (Freedman & Combs 1996, Patton 2002). The articulation of practice was a form of reasoning, that yielded a type of ethical know-how, which reflected practical experience in the broad Aristotelian sense of wisdom and holistic development of self (Bernstein 1982; MacIntyre 2007).

By virtue of their professional competence, I considered that IBCLC practitioners were capable of making an informed decision to participate if they were given sufficient information on the study (Silverman 2000). The exact nature of informed consent continues to be debated (Holman 1991; Downs 2009) but the expectation, within the study, was that participants would understand the scope, the rationale and the framework of the research and balance this against any considered risk they perceived in becoming a participant.

The collection of personal narrative, through in-depth interviews, encouraged participants to explore their experiences in practice. The exploration provided a powerful moral idea of authenticity within the account but there was a possibility that the recall could bring to the fore unresolved issues from practice (Kvale 1996; Frank 2002; Guillemin and Gillam 2004). The anticipatory framework of procedural ethics took account of the emergent nature of the narratives (Smythe and Murray 2000; Guillemin and Gillam 2004) but could only provide information to participants on where they could seek further support if required, following the interview. The “ethics in practice” of actually being present during the interview is addressed in the following section (3.7.2) (Guillemin and Gillam 2004).

The participant’s written consent was requested prior to each interview (NRES 2008; Bournemouth University 2009). A signed consent form did

not recognise the act as constituting informed consent but was a formal acknowledgement of what was to follow and it provided the documented evidence that procedural ethics usually required (Guillemin and Gillam 2004). Participants were informed about the procedure for making any complaints about the process or management of the study and were made aware that they could withdraw from the study at any time (Bournemouth University 2009). Participants were also made aware that the recordings would be stored for a two-year period on completion of the research and copies of the transcripts and analysis for a period of five years according to the university guidelines (Bournemouth University 2009).

The study framework respected the confidentiality of the participants but could not guarantee the right to privacy and anonymity of practitioners who participated (Smythe and Murray 2000). An acknowledged risk within the study was that other practitioners might deduce who the participants were as IBCLCs constituted a small group of specialised practitioners who worked in a clinical role where practice was visible and known to others (Sikes 2010). The study framework attempted to reduce the risk of identification of participants by the use of the generic term of IBCLC and practice areas identified as the north of England. The participant's narrated quotes were given a name but only I, as the researcher, could directly draw a link between a practitioner and a narrative. I also took care to avoid any reference that could easily identify a participant within any quoted text. Anonymity was not possible in data collection as there were face-to-face interviews between myself and the participants (Kvale 1996) and formal ethical approval required line managers to be notified if data collection occurred on an NHS site (Fife, Forth Valley and Tayside Research Ethics Service 2008).

Procedural ethics recognized that participants require a "specific atmosphere" when asked to participate in such an intimate activity, such as sharing a personal narrative (Kazmierska 2004, p. 181). Asking participants to choose the venue for data collection countered some of the power imbalance between me and the participant and enabled the

practitioner to feel more comfortable in their chosen environment (Kvale 1996). Procedural ethics was also concerned with the safety of the researcher. Before embarking on data collection I completed a risk assessment for interviewing at home and in the workplace so that I was fully cognisant of any possible issues (Bournemouth University 2009).

Formal approval for the study was also sought and given.

1 Bournemouth University School Ethics Committee. According to Bournemouth University Research Ethics Code of Practice (2009) ethical approval could be sought directly from NHS Research Ethics Service (NRES 2008). A copy of the ethical submission was sent to the committee June 2008.<sup>24</sup>

2 NHS Regional Ethics Committee (REC)

The research required REC approval as some participants worked within the NHS and were interviewed at work. Regional approval was sought as the locality of participants covered more than one Local Research Ethics Committee (LREC).

The appropriate forms were submitted 28th June 2008 and reviewed 5th August 2008 by the Fife and Forth Valley Research Ethics Committee. I did not attend the hearing because of the distance involved in travelling but I was in contact with the committee secretary in case any further clarification was necessary. A reply was received on 18th August 2008 stating that the committee would be content to give a favorable ethical opinion of the research, subject to receiving a complete response to a request for further information on seven points, as set out in the letter.<sup>25</sup>

A full response, which covered the seven points was sent 28<sup>th</sup> August 2008 and full ethical opinion was confirmed for the study in a letter dated 18<sup>th</sup> September 2008. The single ethical opinion given applied to all sites

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<sup>24</sup> Appendix 7

<sup>25</sup> Appendix 8

but research governance approval was needed from each site where participants who worked for the NHS were interviewed in that workplace (Fife and Forth Valley Research Ethics Service 2008). Ethical approval was reviewed and extended for the duration of the research in November 2010 (Fife and Forth Valley Research Ethics Service 2010).<sup>26</sup>

### **3.7.2. Ethics in practice**

The recollection of experiences through sensory pathways, such as recalling a practice narrative, can initiate strong emotions in their retelling and reproduce the events that occurred in an “experience-near” way (Mattingly 1998, p.26). Through narrating accounts about practice, the IBCLCs were also revealing and sharing their identity as a practitioner. Viewed in this way, a narrative could have the potential to become a transformational experience for the practitioner, or pose a risk, as the accounts could open participants to revisit issues that could make them vulnerable (Smythe and Murray 2000; Corbin and Morse 2003). As the researcher, the onus was on me to ensure that the participants felt they could exercise choice and control during data collection. The use of open questions and time for reflection during the interview supported that framework.

The collection of data through in-depth interviews often touched on the emotional aspect of practice (Holloway and Freshwater 2007) where participants described tensions and conflicts as well as celebrated successful outcomes in their work. Procedural ethics only considered the possibility that emotional exchanges might take place; ethics in practice encountered the reality of what this meant (Guillemin and Gillam 2004).

My research log demonstrated that as a researcher, the emotional context of listening to participant’s narrative accounts was the one aspect of the role I had not prepared well for (Brown 2009). Guillemin and Gillam (2004) described an important role for reflection and reflexivity in ethical practice where it forms a bridge between procedural and practice-based

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<sup>26</sup> Appendix 8

ethics. While I had a theoretical understanding of data collection I did not appreciate the emotional environment until I was in it. Carter and Delamont (1996, p.10) suggest that through experiencing qualitative data collection, the researcher will “never be the same again.” In listening to each account my understanding of the IBCLCs deepened.

*Here I sit in a bubble of time and space transcribing the data. Time is marked with the level of light outside the window; space is the area around me, my books, pictures and mementoes of other things. It is peaceful outside this bubble whilst I listen to the recorded voices of the participants talking about their experiences in practice. In the research proposals it seemed so easy to write that the recordings will be transcribed but how can you ever reflect the experiences the participants recount?*

*It is over a month since I collected the data and as I listen again it is like listening to the narratives for the first time. At times the story is so involving I want to listen to the next part and forget to write it down. I then have to return to the tape, re-listen and write. This, for me, is also an emotional experience as they talk about their experiences in practice, which often have resonances with my previous work. The emotion is also expressed through the rhythm and tone of the voice. The faster voice appears to describe times that went well, the slow reflective voice mulls over the experiences and then there are the trembling, faltering accounts of the challenges and issues found in practice. There is laughter and in one case tears. It is an emotional roller coaster and I ask myself should I be doing this?*

Research Log 21.11.08.

Following the completion of the first round of data collection I took time out to revisit my understanding of the process of listening to narrative accounts which enabled me to write a reflective account of what I had experienced (Brown 2009). The process of writing the reflective account was cathartic as I realised that, while there were emotional moments for both the participant and myself, the practitioner “talked themselves through” the experience in the narrative and had formed some further ideas for practice by the end of the interview. The research log and

supervision also supported my development of a reflexive stand throughout the data collection.

Encountering narratives that stirred up my memories of practice, and on one occasion having a practitioner cry during her account, made me, at times reconsider if what I was undertaking was too difficult for the participants. The emotional context of clinical practice, I decided, was one of the reasons I was drawn into qualitative research and was a way of illustrating the complexities of working as an IBCLC practitioner. I recognised that using an emotional lens when researching carried some risks, but I also felt that the passions we hold within our practice makes us not just human but humane and are an essential part of practice that requires illumination.

### **3.7.3. Relational ethics**

Relational ethics were linked to issues of care and taking responsibility as a researcher in the way the study was facilitated (Ellis 2007). Hunt and Symonds (1995) reflected initial difficulty in separating professional judgement from clinical practice when observing practice as a researcher. I recognised and empathised with Hunt and Symonds (1995) dilemma as I understood that my ethical responsibilities as a practitioner were different to those as a researcher.

I needed a readjustment of ethical focus in becoming a researcher and I found that many aspects of practice were transferrable from my professional roles (NMC 2008; IBLCE 2010c). Ethical frameworks are embedded into professional practice and while Mason (1996) actually questioned the usefulness of professional ethical frameworks when involved in research, I found the basic premise of respect for the individual central to the study. Ryan et al. (2011b), when deliberating on five ethical case accounts where midwives were also researchers, found that the change to becoming a researcher was not that easy and that there are occasions when a professional ethical framework might take precedence, such as when a researcher is confronted with a duty of care. I was not

confronted with such a situation but I did revisit the IBLCE complaints procedures before listening to practitioners' accounts of practice. The IBLCE ethical framework states that it is the duty of practitioners to report breaches of practice by other IBCLCs but as violations should be first-hand witnessed accounts, narrated accounts are not included (IBLCE 2011d).

Elliott (2005) suggested that a researcher and participant develop a personal and moral relationship when involved in research. As a researcher, I found the relationship with the participants was different to a friendship and was based on a depth of appreciation and respect for their practice. I found the process quite humbling as participants shared and entrusted me with their very personal accounts of practice.

### **3.8. Conclusion to the chapter**

I likened the experience in designing and taking part in the research to a description by Potter and Wetherell (1987 p.168), where they described the process as similar to riding a bicycle; it is not easy to convey, until you actually engage in the process and then have to describe it. The study framework needed to reflect and explore the experiences of IBCLC practitioners. The lack of previous research hampered as well as offered opportunities for the research and adjustments were necessary as the study progressed.

Encouraging practitioners to narrate their experiences has enabled descriptive accounts to be drawn, accounts which could inform future research. I recognise that the collection of participants' narratives has limitations but through such descriptions there was anticipation that practice could be made visible for others (Freire 1996; MacIntyre 2009).

In the following four chapters the findings from the accounts by the participants are described. In the next chapter the descriptions of the participants' embodied experiences of breastfeeding are explored.

## **Chapter Four – Centred on breastfeeding**

*Nor is it any accident that I desire this relationship so deeply. Your body out of mine. From my body into yours. First blood. Then milk. These are the living threads that weave mother and child together (Steingraber 2001, p.209).*

### **4.1. Introduction**

All of the participants described a close affinity to breastfeeding that, to them, appeared instinctive and natural. The theme centred on breastfeeding was chosen to describe how the narratives reflected a focus for each practitioner, which arose from the participant's personal experiences, a passion for breastfeeding and an emotional link between mothering and infant feeding. The links centred the participant's view on breastfeeding as well as informed a professional practice that challenged the work/life balance that other work might entail.

### **4.2. Personal experiences of breastfeeding**

Although personal breastfeeding experience is not a prerequisite of becoming an IBCLC, all of the participants in the study were or had been breastfeeding women. The participants' personal breastfeeding accounts covered events 3 - 32 years prior to the interview but the events were recalled with clarity, even with reference to what health professionals had said. For some participants, breastfeeding was not a choice but an instinctive part of being a mother.

*I mean it wasn't even a choice . it was just something that you just thought about doing (Wendy/1/27 -29.)*

*I knew breastfeeding was possible because the things my mum said about it and I believed in that (Mary/1/234 -236).*

One participant appeared to immerse herself in the topic while breastfeeding her baby and subsequently thought that became the turning point in her practice.

*I was reading Gabrielle Palmer's Politics of Breastfeeding in one hand and writing my breastfeeding diary in the other and breastfeeding my child and trying to do my research on breastfeeding by writing my dissertation. Gabrielle Palmer changed my world really, I think that was the beginning (Carol /1/57 – 62).*

Another participant found that working in a different culture opened her eyes to looking at breastfeeding differently.

*I then went to work in the Middle East, which made me wonder, made me look at it (breastfeeding) and made me reflect on what happened here (Kate/1/22 – 28).*

Not all of the personal breastfeeding experiences were positive accounts as five participants had experienced a lack of support from health professionals when they felt they needed it. The accounts about poor health professional support were narrated in the first part of the first interview and two participants started their narrative with their experiences.

*I'm starting here because apart from being aware it was the very best for babies but not thinking about it as a great deal . . until I had my own (children) . . . it was quite a struggle at first . . it really took me by surprise . . I didn't have a lot of support. A colleague came and did my postnatal visits . . . I think she was embarrassed and just sort of said "Oh well you know what you are doing and just get on with it" (Wendy/1/30 – 40).*

*and I said he needs feeding . . there's no skin-to-skin at birth . . there was no breastfeeding at birth. I had him at nine o'clock at night and this was one o'clock in the morning and I was thinking I must feed him ( . . .) so . she picks him up and she lifted up my nighty and she plugged him (on) . . and she put my arm around him and she pulled the curtains and she went . and that was it. Well that was my bubble popped for a start and I thought if this is the way it's going to be then I'll just have to manage (Jane/1/ 41 – 55)*

*I was not surprised to have the problems other women had of very sore bleeding nipples and how people go in and say . give her five minutes either side and then give her a bottle (Ruth/1/392 - 395).*

The participants who experienced problems with breastfeeding were already health professionals when they became mothers but not IBCLCs. A similar problem with a lack of professional support and knowledge was identified by other health professionals in the UK when they became mothers (McMulkin and Malone 1994). The breastfeeding experiences of the participants and other health professionals also appeared analogous to the women they care for (Battersby 2002). The issues around personal breastfeeding experiences, though, did not appear to surprise the participants, just saddened them as the problems appeared similar to what they had already observed in practice (Dykes 2006a). The experience of poor support and a lack of health professional's understanding appeared to drive the participants on to navigate their own way and persist in becoming breastfeeding mothers. A similar outcome was found by Locklin and Naber (1993) in a grounded theory approach to understand the experiences of ten women who required high levels of motivation to continue breastfeeding. The same motivation to breastfeed sustained a confidence in the participants that they would succeed (Avery et al. 2009).

*I had quite severe engorgement and cracked nipples . and . . . anyway struggled for quite a while and it was just sort of through sheer determination that I wasn't going to do anything else that I got through it (Wendy/1/52 - 55).*

All the participants wanted other women to experience successful breastfeeding. The IBCLCs who had experienced a lack of professional support also narrated a commitment to improving practice so that other women might not have the same negative experiences that they had had. In one account Jane experienced eighteen months of personal anxiety and isolation from the health professionals she had previously worked alongside when she persisted in continuing to breastfeed, even when they expressed concerns about her baby not gaining enough weight.

*and all I got was, you'll have to give him a bottle in the evening, he's not gaining weight . . . but he looks alright and I just thought, no I'm not going to clinic ( . . . ) so I just became a health practitioner dodger . and they caught up with me in the end and sent me to "failure to thrive" clinic . . . but I still ignored them and (breast) fed him . and this consultant . . . said "there's nothing wrong with him, what are you doing here?" (for) eighteen months that anxiety had weighed on my mind all the time (Jane/1/100 – 137).*

In choosing to breastfeed, three other participants reflected a lack of knowledgeable support and a feeling of isolation and being different in a culture that was more familiar with bottle-feeding.

*when I had my first baby . . . breastfeeding in this area was appalling . it was 28% initiation rate . . . I was the only woman on the ward breastfeeding ( . . . ) in the end I breastfed for three and a half years because I was too idle to stop . . . and towards the end I felt like a complete pervert . . . it was the secrecy . I couldn't tell anyone else (Ruth/1/403 – 409).*

*I was the only one there that had a sling (laughs) . I was probably the only one still breastfeeding at nine months or so or a year . . . so I never sort of fitted in there (Wendy/1/141 - 146).*

*there were no children's centres, there were no groups to go to and there was just me and my baby breastfeeding (Carol/1/294 – 296).*

In recounting their personal breastfeeding experiences, the participants' stories were of challenging the "status quo". As Ruth and Wendy explained, they had chosen to breastfeed in parts of England where the breastfeeding rate is demonstrably low (Bolling et al. 2007). The breastfeeding initiation rate for the North of England has risen slowly from 55% (1990) to 62.5% (2005) but there are individual pockets of very low initiation rates, such as the one mentioned of 28% by one participant (Foster et al. 1997: Bolling et al. 2007). Overall the breastfeeding rate in England declines at a similar rate but when the initiation rate is low it

means that by six months just 15% (1990) to 17% (2005) of women are providing any breast milk for their baby in the participants' area of practice (Foster et al. 1997; Bolling et al. 2007). Against this background, the participants described their personal experiences of breastfeeding and of supporting other women to do the same.

Wagner et al. (2006) found in their research that a certain personality trait often led women to breastfeed.

In cultures in which breastfeeding is not the norm, women who possess personality traits of openness and extraversion are more likely to initiate breastfeeding (Wagner et al. 2006, p.24).

Such traits were observable in the participants and might well have assisted them in their roles, as well as in choosing to breastfeed.

*When re-reading Wagner et al.'s (2006) research I recalled my initial response when asked by one of my research supervisors what I felt about the participants I had interviewed. At the time I thought I responded rather limply that "I liked them" but now I have had time to reflect on why. During data collection the participants impressed me with the amount of energy and enthusiasm they had invested in their practice, their openness to new ideas, the way others sought them out but also how extraordinarily ordinary they thought the work they were undertaking was.*

Research Log 22<sup>nd</sup> November 2009.

Breastfeeding, like childbirth, is a significant human experience, but its social meaning is shaped by the society in which women live (Dettwyler 1995; Stuart-Macadam 1995; Blum 1999; Dykes 2006a; Hausman 2008). Some of the participants had experienced the negative side of social and health professional support while breastfeeding but that had not deterred them from continuing to breastfeed, in fact, in some cases it had spurred them on. Through their experiences of breastfeeding the participants recognised that other women who choose to breastfeed might require practitioners who believe that they can breastfeed.

*I wished there had been a me around 13 years ago that could have come and sorted out my breastfeeding problem (Ruth/1/429 -430)*

*I became an IBCLC mainly from my own experience of breastfeeding . I had very little help . . (Jane/1/24-2).*

*I had inconsistent advice and I had a lot of pressure put on me . . when I came back to work within the NHS I felt I needed to do something about this (Ann/1/22-26).*

Stockdale et al. (2008 and 2010) explained that for women to achieve a successful breastfeeding outcome, a balance between valuing the behaviour and the expectancy of success was necessary. All the participants reflected both these positive attributes towards breastfeeding. An intrinsic motivation to succeed at breastfeeding was central to each participant's experience of motherhood (Schmied and Barclay 1999). Theorists such as Deci and Ryan (1985) found that intrinsic motivation to succeed at anything requires a sense of competency as well as a sense of self-determination. While the participants illustrated high levels of self-determination to breastfeed, a lack of understanding and personal breastfeeding competency might have led to the breastfeeding problems five of the practitioners experienced.

Sharing personal breastfeeding narratives can be difficult and only half of the participants chose to talk about their own breastfeeding (Schmied and Barclay 1999). Health professionals, though, do need to acknowledge their own breastfeeding experiences before they begin supporting other women, as a lack of separation between the personal and the professional can risk the personal informing the professional (Bruce et al. 1991; Sanderson 1991; Battersby 2002; Tennent et al. 2006). The preparation of voluntary lay breastfeeding counsellors in the UK encourages and allows time for practitioners to reflect on their breastfeeding experiences before progressing on to work in practice (ABM 2010; BfN 2010; LLL 2010; NCT 2010). The IBCLC qualification, though, alongside most other health professionals' training in the UK, does not formally facilitate an

exploration and reflection on prior breastfeeding experiences unless the prospective candidate has previously trained as a volunteer counsellor.

On hearing the participants' personal breastfeeding accounts I initially considered that they might reflect Cox's (2006) description of how women put aside their personal story of mothering and breastfeeding until they find someone who will listen to an uninterrupted story of their experience. I felt that in collecting the narratives I might have been that listener. Further listening, reading and reflection on the narratives, though, made me reconsider that the accounts did not appear to be told as a way of personal debriefing, but as an illustration of why the participant became an IBCLC. The storied accounts of personal breastfeeding experiences were an emotional explanation of why they were IBCLCs which they may have had little opportunity to share in their day-to-day lives (Nelson 2007; Grassley and Nelms 2009). The storied accounts became a starting for explaining why they became an IBCLC.

### **4.3. A passion for breastfeeding**

All the participants couched their narratives in emotional terms, especially related to their attachment and passion for breastfeeding. The passion for breastfeeding focused the participants on what they wanted to achieve in their practice and reflected an idealism without which "professionals become less caring and compassionate" (Cherniss 1995, p.4).

*that's what makes me passionate . . . I think feeding from my first-hand experience is what impacts successful breastfeeding can have and what impact it has when it's . . . miserable (Ruth/1/437 – 441).*

*the thing is . they do say . that if you are passionate about something you will do it . . . that is how I feel about breastfeeding . and that's why I just love it . because I will do it no matter what (Linda/1/568 -575).*

*it's my passion, my husband will tell you the difference between me coming in from an ordinary shift and coming in where I've been with breastfeeding women (Gail/1/131 – 135).*

Some other IBCLCs in the USA, in private practice, have described their personal drive and passion (Locklin 1993; Wilson-Clay 2003; Smith 2003a). Timms (2007) also alluded to her passion in her description of working in the health services as a lactation consultant in the UK. A search of JHL, using the words passion, passionate, emotional and practice, found just five articles using any of these descriptors related to IBCLCs. Four of the articles were editorials (Wiessinger 2002; Heinig 2002 and 2008; Mannel 2008) and one was a tribute to an IBCLC (Neely 2003). Wiessinger (2002), in her editorial, proposed that a passion for the role was one of the five facets of IBCLC practice.

In considering the Latin root of passion, to suffer or endure, there appeared little relationship to the participants' descriptions, which were dominated by strong emotions and strong enthusiasms for breastfeeding (Oxford English Dictionary 2011). The passion illustrated by the participants appeared more closely connected to the philosophical context of being passionate, which is linked to the possession of an "intense love, devotion, warmth, fervour" or even "anger" and "frustration" (Oxford English Dictionary 2011).

*this (breastfeeding) is a passion and I suppose frustration for me as well because of the way things are at the hospital (Gail/1/326 -328).*

Vallerand et al. (2003) proposed a Dualistic Model of Passion, where the emotion is defined as a strong inclination or desire towards a self-defining activity, in which a person invests time and energy. For the participants in the study who valued breastfeeding and found it meaningful, there appeared to be a strong desire to internalise the passion and make it part of who they were (Deci and Ryan 1985). Vallerand (2003) considered that such internalisation formed a harmonious passion where practitioners have freely adopted the activity without attaching any contingencies to how they would carry it out. The way a practitioner gains satisfaction from

such a passion, though, can be affected by outside influences, such as working within a non-supportive culture, where a participant's enthusiasm and commitment to breastfeeding might not be viewed in quite the same way.

The second concept of passion identified by Vallerand (2008) described an obsessive passion, where the strong desire to engage in an endeavour such as breastfeeding still exists but the practitioner does not have any control over the activity. In working with an obsessive passion the practitioner works under pressure to carry out the activity often with many personal regulations attached as to how it will be undertaken. The practitioner, because they hold such a deep seated passion, might feel under pressure and feel compelled to engage in providing a professional practice for breastfeeding women but their altered focus controls them.

I felt uncomfortable to think that any of the participants might demonstrate an obsessive passion in their work as the emotive words are often used in a negative context within breastfeeding practice. Breastfeeding women and practitioners who support breastfeeding practice have been labelled in a pejorative way, as obsessive or as Lactavists, breastfeeding Nazis or the breastapo (Schmied and Barclay 1999; Giles 2003; Martin 2009; Maxted 2011) and such negative connotations made me cautious in undertaking any further analysis. Returning to Vallerand et al's. (2003) original study, though, I found I could adapt a framework for each concept that could be related to breastfeeding practice and used to interrogate each participant's narrative (Table 5).

<b>Table 5: The Harmonious and Obsessive Passion for Breastfeeding Scale</b>	
<b>Harmonious</b>	<b>Obsessive</b>
1a. Open to a variety of breastfeeding experiences	1b. Cannot live without undertaking a breastfeeding activity
2a. New experiences make the practitioner appreciate breastfeeding even more	2b. Cannot help oneself undertaking a breastfeeding activity
3a. Breastfeeding reflects the things liked about oneself	3b. Have difficulties in imaging life without breastfeeding
4a. Breastfeeding is in harmony with other activities	4b. Emotionally dependent on breastfeeding
5a. Ability to control work within breastfeeding activities	5b. Experiences problems controlling personal needs in undertaking breastfeeding activities
6a. Breastfeeding enables the practitioner to live memorable experiences	6b. Practitioner experiences an obsessive feeling towards breastfeeding
7a. Completely at one with breastfeeding	7b. Practitioner's need depends on being able to undertake a breastfeeding activity
Adapted from: Vallerand et al. 2003.	

On returning to the data and the field notes I found that all the narrative accounts illustrated a passion towards breastfeeding that reflected a tendency to the harmonious concept of practice rather than the obsessive. Four participants demonstrated a greater tendency to move towards the obsessive concept in not being able to live their life without breastfeeding (3b) and being drawn into breastfeeding activities (2b) but I considered the problem might lie with how the IBCLCs phrased their descriptions and my interpretation of them, rather than the practitioner's attitude. The field

notes I recorded following each interview also illustrated participants who engaged enthusiastically in working with breastfeeding women without any outward signs of being controlled by their professional practice.

*As soon as breastfeeding was mentioned she leaned forward and smiled (Field notes / 1 / 12 / 12<sup>th</sup> November 2008<sup>27</sup>)*

*I was bowled over by her personal passion for breastfeeding, her face lit up (Field note / 1 / 3 / 8<sup>th</sup> October 2008)*

There were illustrations of tensions and stressors within the participants' narratives about working in a professional role but these appeared to be linked to the environment of practice, rather than the fundamental ontological concept of being an IBCLC. The context of the participant's practice is explored further in this and the following two chapters.

The participants appeared to internalise their passion for breastfeeding and in so doing make it become part of themselves (Moyles 2001; Vallerand 2008) and of their professional practice (Barnett 2009). Through choosing to work in supporting breastfeeding women, the participants were following their passion, which appeared to heighten the possibility of them finding an enjoyable, stimulating and rewarding career (Moyles 2001). In choosing to support breastfeeding through personally selecting to become an IBCLC, all the participants reflected a more vocational calling than a secular one (Sullivan 2000; Martimianakis et al. 2008; Vallerand 2008).

*and obviously I have the passion to want to do something or I would have walked out twelve months ago (Mary/2/ 128 – 139).*

The description by Moyles (2001, p.84), of a role where “passion is never mindless but rather very mindful,” appeared a good description of the participants as they indulged their enthusiasm to enhance their practice with breastfeeding women.

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<sup>27</sup> My field notes record the comments after the first interview with the twelfth participant and the date.

*it's my passion. I think that breastfeeding is so important that you would support anyone in any way to enable them to be a successful breastfeeding mother (Jane/2/24 -26).*

#### **4.4. Working with breastfeeding women: a continuum of life.**

Throughout the narrative accounts there was very little separation between the participant's personal and practiced-based self. For the participants, although a work/life balance was mentioned on three occasions, professionally supporting breastfeeding women appeared to form a part of their life that was integral to who they were. Land and Taylor (2010) in their research on work/life balance offered a view of professional practice as a continuum of life. In focusing on work as part of life, rather than the negative aspects of how labour dominates life, Land and Taylor (2010) described how the motivation to work can form new ways of working, which otherwise could be missed.

Ruth's narrative evidenced a weighing-up, negotiation and recognition about how she worked, which was reflected in the way she laughed at the end of the account.

*Work life balance can be a bit of an issue but if it is something you are passionate about it is easy to let it take over your life ( . . . ) I think it is really important not to take work home with me or I end up working more hours than I should be ( . . . ) but . . you go home and do work (laughs) (Ruth/2/47–82).*

Lewis and Cooper (2005) found that many professional practitioners experience enjoyment in their work, which often makes them choose to work longer hours and use practice-time as a non-work activity. The way all the participants narrated their approach to working matched Lewis and Cooper's (2005) description of practitioners who do not recognise the work/life balance the same way as some other people do. While the participants recognised the risks of taking on too much work and how a management structure could abuse the way they worked, the emotional attachment to breastfeeding tempted most of the participants to take on a

greater level of work than perhaps other health professionals might consider. There was not any noticeable difference between participants who worked in the NHS, the voluntary sector or in private practice in approaching work in this way. The seeking out of practice experiences might be partially explained by Benner et al.'s (2009) work, which found that practitioners, when they first qualify, look for a range of work that meets their needs in developing a professional role. The important factor was that the practitioner had the passion and the freedom to choose when and where they undertook the extra work.

*Initially . . . all you felt was you had to utilise your skills and that you would constantly work over your hours . . . I think now I'm older and I'm wiser and I'm in a different game and I'm looking to be able to continue until I choose to retire, I do less (Ann/2/41 – 45)*

Ann, an experienced IBCLC, had learnt to adjust as she developed her professional practice but that might not have been possible for all practitioners unless they had the autonomy and knowledge of practice to make that decision. Cherniss (1995, p.9) and Ruotsalainen et al. (2009) illustrated how practitioners, when starting out in a profession, risk becoming “victims of their own idealism.” Practitioners need to recognise and understand when to adjust their workload, as Ann had done. Perhaps sharing between IBCLCs of the issues around finding a balance in their own life and practice would help newly qualified practitioners reflect on the issues in a more realistic way.

#### **4.5. Responsive mothering through breastfeeding**

For some participants breastfeeding was described as part of mothering which reflected the early La Leche League (LLL) philosophy of “mothering through breastfeeding” (Shepherd 2005, p.27). While four of the participants were or had been LLL Leaders, the other practitioners did not have links with the voluntary organisation but expressed similar thoughts on breastfeeding.

*I don't know where the passion came from, but I think it is something to do with mothering (Susan/1/569 -570).*

*I stayed with breastfeeding because of the mothering support (Denise/1/302).*

One participant also went on to consider that becoming a mother could change other practitioners as well.

*and I always say to colleagues, when you've had your own baby you will think differently and they always come back and say you were right, you were right (Susan/1/671 – 674).*

Wendy recorded how she had changed when she became a mother.

*because I had had a child ( . . ) my whole outlook on care and emotional experiences . just changed . . once I had my own child . I could no longer do the things you have to do (in her clinical work) (laughs) (Wendy/1/56 – 61)*

In Wendy's case she felt unable to work in the highly charged medical environment she had previously worked in as she found the emotional demands were too high now she was a mother.

The link to mothering through breastfeeding returned infant feeding to a naturalistic or instinctive course, where the woman is supported to reciprocate the early biological behaviour of the baby and feed her infant (Klaue et al. 1995; Bergman 2003; Avishai 2007; Colson et al. 2008). All the participants observed the needs of the mother and infant partly in biological terms as enabling the baby to feed but also as a sensitisation period where, around the time of birth, women open themselves to meet their infant's needs and begin to learn to mother their infant (Brazelton 1981; Winnicott 1987; Klaus et al. 1995).

*just let your baby come round in skin-to-skin contact ( . . . ) you can assess the baby is well and give the mum confidence (Jane/2/95 – 98).*

*baby just needs time and skin-to-skin contact to get things established (Linda/2/251 – 252)*

Brazelton (1981) considered that emotional turmoil was a necessary adaptive process to becoming parents, where the focus of care is drawn through the infant, thereby enabling the woman to feel in control and gain confidence in responding to her baby's needs. The anthropologists LeVine et al.(1994, p.132) described the breastfeeding mothers and babies observed in Africa as:

Interdependent and exclusive in their relation, to a degree that is unique in postnatal life and exceeded only by the relations between a pregnant woman and her unborn child.

Uvnäs-Moberg (2003), when she became a breastfeeding woman, described a state diametrically opposed to the stress she was familiar with in her day-to-day life as a scientist. Curiosity about her emotional experiences as a breastfeeding woman drove her to investigate the role of the hormone oxytocin. Uvnäs-Moberg (2003) discovered that, apart from enabling the milk ejection reflex and uterine contractions previously linked to the release of oxytocin, the hormone also provided the calming and connected response, which enables parents, especially the mother, to focus on and care for her baby. The degree of self-sufficiency in a mother breastfeeding her baby might make others feel excluded from the relationship and challenge practitioners on how they work and support the dyad (Jackson 2002; Avishai 2007) but the subtle processes were what the participants were looking for.

The way all the participant's described the breastfeeding mother and baby illustrated how they observed a "uniqueness in the dyad" (Smith 2003a, p.4). The participant's narratives of linking motherhood and breastfeeding appeared to be based on observations in practice and reflection on a range of resources which included anthropological studies that inform many of the textbooks IBCLCs use (Lauwers and Swisher 2005; Stuart-Macadam and Dettwyler 1995; Riordan and Wambach 2010).

*we've kind of lost that instinctive nurturing unquestioning kind of world that we used to live in (Carol/1 580 – 582)*

The six participants' who described their own breastfeeding experiences reflected the intensity of feeling Steingraber's (2001) account demonstrated at the beginning of this chapter. The participants provided an emotional context in their accounts of the mother, baby breastfeeding relationship that biomedical ways of examination of any evidence did not. (Jensen et al. 2008). Jensen et al.'s (2008) review recommended that only proven scientific facts about the health outcomes of breastfeeding a baby should be shared with women as any conclusive evidence about the quality of breastfeeding relationships was missing. The participant's account told a different story as they observed the relationship and recognised and responded to the woman and infant's needs to understand each other (Klaue et al. 1995; Woolridge 1995; Bergman 2003; Meyer and Oliveira 2003; Colson et al. 2008). The topic is returned to in greater depth through a discussion on how participants adopted a right-sided hemispheric<sup>28</sup> approach to support maternal understanding of caring for her baby, in chapter seven (7.2.2.).

Breastfeeding, as envisioned by all the participants, was viewed as a normal transition to motherhood. Schmied and Lupton (2001), Marshall et al (2007) and Knaak (2010) challenged such an assumption and considered mothering through breastfeeding as a bio-medical discourse, which is shaped partly by health professionals to describe and frame women conforming to a stereotypical image of being a good mother. The present UK health promotional message of "breast is best" does not help, as rather than normalising lactation, it places pressure on women to choose to breastfeed to match an ideal that is rarely achieved (Schmied and Lupton 2001; Bolling et al. 2007; Berry and Gribble 2008; Ryan et al. 2010). When women consider that their mothering is not good enough, through either not breastfeeding or prematurely stopping, then life-long

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<sup>28</sup> Right-sided hemispheric approach to understanding is used within the thesis to describe a holistic approach to learning rather than a task-orientated way such as holding the baby in a certain way to breastfeed.

feelings of personal disappointment and often guilt might accompany the decision (Ryan 1998; Marshall et al. 2007; Bhavnani and Newburn 2010; Burns et al. 2010; Hauk et al. 2010). The participants brought a different perspective to breastfeeding as they recognised that the outcome for many women choosing to breastfeed in the UK remains uncertain. In working with women the participants demonstrated how their professional practice can support breastfeeding outcomes and enable women to feel positive about their feeding experience (Locklin and Naber 1993; Ryan et al. 2010). From such a perspective, nurturing and mothering were interchangeable.

*and about why babies sometimes won't attach for 5-6 days and it's about being patient and keeping the baby fed and hydrated with breast milk and encouraging mum and supporting mum saying you're alright . . he is alright . we will nourish your baby . . just let your baby come round in skin-to-skin contact (Jane/2/91 – 96).*

Altaweli and Roberts (2010) attempted to define, in a concept analysis, aspects of maternal-infant bonding. The concept was described as a complex phenomenon, which was recognised as a unique relationship that developed during the pregnancy and continued through breastfeeding (Altaweli and Roberts 2010). While bonding between a mother and her baby is considered by many people as the only essential part of mothering, Brazelton (1981, p.98) observed that “bonding is not enough, bonding is like falling in love,” and only forms an initial stage of attachment between the mother and her baby. The participants recognised that breastfeeding women needed some perspective and continuing support when choosing to breastfeed and nurture their baby. In their narrative illustrations, some participants provided an understanding of what women might need through reflecting Wiessinger’s (2002, p.114) description of “hanging tough” and staying strong for mothering.

*so I started in a way as a philosopher by saying that . that's very hard but keep going and then went through a period of ( . .) applying more management and techniques because we'd heard*

*the speakers and we'd seen the things but I have to say now . back to being a philosopher again because I know that I can give a mum a couple of tips but the best help I can give her is to say look you'll get there and give her perspective . so I've gone full circle really (Denise/1 311 – 323).*

Hausman (2003) reflected on the paradox of promoting mothering through breastfeeding when many women lack the practical support and might be exposed to the social constraints that can hamper successful feeding outcomes. The participants' descriptors of practice demonstrated how they met women's needs through being physically and emotionally present, with the necessary knowledgeable support that women needed to remain strong to breastfeed. The participants illustrated how other health professionals risked not meeting a woman's needs by just focusing on a baby's nutritional needs and not considering the maternal infant relationship. One example of this was Jane's description of how she became a "health practitioner dodger" when her breastfeeding child was slow to gain weight.

The participants' narratives illustrated an essential understanding of the breastfeeding dyad, which required a sensitivity that remained open to both the mother and baby's needs. Because the approach was focused on the mother and baby's needs and supported through the participant's expertise, a way of describing the participant's role was sought. Cronk's (2010, p.56) described midwifery practice as a model of professional service where midwives who provide a woman-centred practice should consider themselves a "professional servant." The servant role, within such a context, was not considered as one of subjugation and loss of autonomy but the provider of a professional service (Oxford English Dictionary 2011). The professional servant role also recognises the social and cultural context of "trying" to breastfeed in the UK and that women required practitioners who worked with them. The descriptor also recognises that professional practice does not have to set itself apart from breastfeeding women but works in partnership with them. Cronk (2010), Deery et al. 2010 and Wilkins (2010) suggest that many health

professionals have moved away from a historic model of providing a service in partnership with women and have adjusted their roles to fit the business of the workplace. In explaining IBCLCs as professional knowledgeable practitioners who provide a service, the descriptor “professional servant” evokes a model of working with breastfeeding women who, when possible, provide continuity of carer which enhances the development of trust between the woman and practitioner (Huber and Sandall 2006).

The professional aspect of the service role applied to the knowledge base the participants held in being IBCLCs and applied in the course of their practice. I also considered the descriptor of professional doula but the etymology and descriptions of females attending women during parturition used for doulas, did not encompass the full lactation cycle or include the role of men as IBCLCs (Raphel-Leff 1991; Carter 1995; Lauwers and Swisher 2005; Palmer 2009; Oxford English Dictionary 2011).

The participants, through their passion for breastfeeding, brought a vocational approach to the role and maybe a different perspective to professional practice. While the participants narrated accounts of mothering through breastfeeding, I would suggest a more appropriate descriptor was mothering through understanding a baby’s needs. The rationale for the adjustment is that while the participants narrated accounts of supporting breastfeeding women, breastfeeding did not always continue, but learning to mother did.

*with a mum that actually decides at some point , then no it’s (breastfeeding) not for her we’ve had the input. I can walk away from that experience feeling that we supported her, in the end it was her decision (Gail/1/180 -185).*

*one size fits all approach to breastfeeding isn’t true and doesn’t really support people. You’ve got to treat mothers and their babies as individuals ( . . . ) whatever their (woman’s) definition of successful is . . . I think we in the NHS are driven by target, initiation*

*rates and all these sorts of things, but I don't think that is breastfeeding support (Ruth/2/32 -41).*

In meeting women's needs in this way, the anticipation is that even if breastfeeding did not continue, women will remain confident in their mothering ability to care for their infant and to reconsider breastfeeding in the future.

#### **4.6. Considering centeredness on breastfeeding**

The participants appeared to draw on their personal experiences, emotional attachment and their concept of mothering and breastfeeding to describe their centeredness on breastfeeding. Some of the participants had experienced the negative side of social support in learning to breastfeed but that had not deterred them, in fact, in some cases it had spurred them on and had illustrated a persistence to succeed. The centeredness on breastfeeding provided a passionate vocational calling for the participants to provide a professional practice for other women who choose to feed their baby. Through the participants' experiences of breastfeeding they recognised that other women might require practitioners who believed that they could also become breastfeeding mothers. The essence of the participant's practice was described as working as a professional servant, which enabled women to mother their baby in the way that met their needs.

The centeredness on breastfeeding gave the participants a different perspective when working in a professional role. In supporting women to breastfeed their baby, the participants reflected a practice that was part of their everyday life. The lack of separation between work and life was satisfactory as long as the participants had autonomy and freedom in their practice to work the way they needed to.

In the following chapter how the participants developed their professional role and worked in practice is described.

## **Chapter Five: Developing a professional breastfeeding practice**

*The milk flowing back to the breast may without offence be dissipated, you must use this ointment: Take pure wax, linseed; when the wax is melted, let the liniment be made, wherein linen clothes must be dipped, and, according to their largeness, be laid upon the breasts (Aristotle 1933, p.282).*

### **5.1. Introduction**

The quote at the start of this chapter illustrates that professional advice about breastfeeding is not a recent phenomenon but how practitioners utilise such knowledge and skill and work with women is less well described. The participants' centeredness on breastfeeding (Chapter Four) provided the motivation for the practitioners to develop a professional practice that brought its own personal rewards and recognition. Developing a professional breastfeeding practice, though, highlighted that the participants had gaps in their knowledge and understanding of lactation and of practice. To help address the gap, the participants continually sought opportunities to work and learn about breastfeeding. When the prospects of clinical work were very limited then the participants sought alternative opportunities to practice, which ranged from working as a volunteer for an organisation or in their own time or working in private practice.

### **5.2. Finding a professional pathway**

Half of the participants narrated accounts of seeking a way of developing a clinical practice that enabled them to focus on breastfeeding within their present health professional role. Finding a professional pathway that developed, recognised and validated their breastfeeding practice, though, did not always appear easy.

### 5.2.1. Finding out about becoming an IBCLC.

All the participants said that once they found out about the IBCLC qualification, they realised that was what they wanted to become.

*and at last there was some sort of qualification (Susan/1/217).*

*you're on the internet looking and . . . and ended up finding out about lactation consultants. . . and I felt that's what I want to be . I want to be one of them (Carol/1/ 73 – 82).*

Eleven of the participants had heard about the qualification from other IBCLCs who they had met at work, on study-days or while on holiday. Six of the participants were encouraged and supported by IBCLC practitioners to undertake the qualification.

*the best thing I ever did was . we had a holiday in Vancouver . . . I spoke to the lactation consultants that were there in post (Ann/1/34 – 37)*

*at every session she was telling us about being a lactation consultant which made us look at it further (Ruth/1/79 - 81).*

*I thought it was for other people, I really didn't think it was for me and I thought it was to do with private practice and I thought it was to do with international specialists but I was encouraged by a colleague (Susan/1/13 - 143)*

Accessing information about becoming an IBCLC in the UK proved to be quite difficult for the participants. I undertook a similar Internet search using phrases such as lactation consultant, specialist breastfeeding practitioner and professional breastfeeding practitioner or counsellor. The only phrase that produced any results was lactation consultant, where links were found to organisations such as LCGB, an affiliate group to ILCA or IBLCE the international based examination board and professional association. A web-based search of UK health professional sites for NHS careers (NHS 2011b), for midwives (RCM 2011), health visitors (CPHVA 2011), nurses (RCN 2011) and speech and language therapists (RCSLT

2011), using similar descriptors, did not produce any links or information about the IBCLC role. I found out about becoming an IBCLC when the RCM initially promoted the qualification but the endorsement has since stopped (Cullen 1999; Scott 1994). The only voluntary lay-breastfeeding support group that provides further information on becoming an IBCLC is LLL, while the UNICEF/UK Baby Friendly Initiative (2011a) website has links to LCGB.

The use of the approach of “each one to reach one” that ILCA (2011e) promotes to stimulate its IBCLC membership appears relevant to how eleven of the participants became IBCLCs. Three of the participants had supported other practitioners to become IBCLCs.

*there were four others (. . .) I helped them through (. . .) I felt able to move on in my role because I brought them up . I taught them as much as I can . I supported them as much as I can . and they are now lactation consultants (Ann/2/111 - 123).*

The way Ann described how she “brought them up” illustrated a nurturing, almost a mothering role, in developing future IBCLCs. Listening to the account returned me to my experiences in my personal narrative and the aspect of nurturing by lactation consultants who supervised my first qualifying examination.

The lasting memory of undertaking the examination for the first time was one of acute nervousness sitting in a cool school classroom on a hot July day with the sound of the animals on the attached school farm coming through the open windows. It was also memories of nurturing care from the examination proctors who were IBCLCs. They handed out tea, home-made cakes and empathy.

*(Personal narrative of becoming and being an IBCLC, February 2007)*

### **5.2.2. Finding gaps in breastfeeding knowledge**

My rationale for becoming an IBCLC was that I retained uncertainty about how well founded my knowledge on breastfeeding was and I wanted to “test” myself on what I knew especially as I was teaching other health

practitioners. Preparation for the qualification made two other prospective practitioners realise that they did not know as much as they thought about human lactation and breastfeeding.

*we kept ringing each other and saying . . ."we don't know anything do we? Here we are teaching people about breastfeeding and we don't know anything" (Carol/1/109 - 113).*

All the participants described how they prepared to become IBCLCs and everyone talked about gaps in their knowledge, which were partially filled by undertaking the qualification. There was a difference, though, in the amount and approach to learning some of them had to undertake. Three participants, who were experienced lay volunteer breastfeeding counsellors or Leaders, two of whom were also health professionals, reflected a straight-forward developmental progress to an advanced level of practice (Dreyfus and Dreyfus 1980; Benner 1984; Auerbach and Riordan 2000). The experience of working as a voluntary lay breastfeeding counsellor or Leader appeared to have provided the foundational breadth and depth of knowledge on which to build in preparing for the IBCLC qualification. A national review reported a similar finding. Voluntary lay organisations were reported as often providing more competent practitioners than many health professional courses (Renfrew et al. 2006).

The remaining nine participants, all of whom were health professionals, experienced more gaps in their underpinning knowledge when preparing to become an IBCLC. They had gained their health professional qualifications between five and twenty years prior to interview and all appeared to have initially relied on their professional training, further post-registration courses such as health visiting and a degree to provide their breastfeeding knowledge. Two participants had also attended a two-day workshop facilitated by an IBCLC, while five participants had attended a three-day UK/UNICEF Baby Friendly Initiative course (2011b) prior to undertaking the examination.

*and then . help with breastfeeding . . I found myself (with) a huge gap in my knowledge (Wendy/1/73-74).*

*so I had the passion but did not have enough knowledge . . I met women who struggled (Mary/1/371 -373).*

*I had the same knowledge that most health professional have . which isn't enough to support breastfeeding women (Kate/1/56 – 57).*

The developmental progress of the nine health practitioners reflected a fluid model of personal development, which contained a backwards as well as a forwards movement of learning. The impression gained from the narrative accounts was that, while initially the nine participants considered that becoming an IBCLC was a progressive developmental step, which built on previous knowledge (Benner 1984), in preparing for the qualification, the practitioners had to reconsider the depth and breadth of their previous understanding.

The lack of breadth in breastfeeding knowledge in practice might be easy to understand in a health professional role such as midwifery, where the focus is on antenatal, intra-partum and initial post-partum care of the woman and her child (NMC 2008). Thomson (2008), though, has also suggested that midwives' breastfeeding knowledge might also be limited in depth.

My literature review identified concern about health professionals' understanding of supporting breastfeeding practice since 1988 with shortcomings in the academic and practice-based education of health practitioners noted until fairly recently (DOH 1995; Henschel and Inch 1996; Porteous et al. 2000; Abbott et al. 2006; Renfrew et al. 2006; McFadden et al. 2007). Three participants, who were health professionals as well as IBCLCs, had completed further educational courses within one to three years of data collection and were very aware of the lack of information on breastfeeding on more recent health professional courses.

*I've just done my ( name of post-registration course) training and we had nothing on breastfeeding and a lot of the others on the course had come from the acute sector and there wasn't . .there wasn't anything on it there wasn't anything at all . . (Kate/1/141 - 146).*

The post-registration qualification brought health professionals into contact with breastfeeding women and Kate recognised that some of the students on the course had had very limited exposure and experience in lactation. While the reason for no breastfeeding input on the course became apparent later in her narrative, through a visiting IBCLC having to cancel the teaching sessions, Kate remained conscious that the practitioners might not be aware of what they did not know.

In an attempt to ensure newly qualified midwives and health visitors are equipped with basic breastfeeding knowledge and skills to support breastfeeding effectively the UNICEF/UK Baby Friendly Initiative developed an externally validated accreditation award for British universities in 2008 (UNICEF/UK BFI 2011d). Of the 46 universities (NHS 2011d) who offer midwifery, health visiting and public health pre-registration courses in England, by November 2011, ten had attained the full accreditation, three had attained Stage One and seventeen had been awarded a Certificate of Commitment, which demonstrates an interest in the award (UNICEF/UK BFI 2011c). The response to an external validation process such as the UNICEF/UK BFI does not reflect a complete picture of pre-registration breastfeeding education for health professionals in the UK, though, as each university requires professional and educational validation of a professional training curriculum (NMC 2011; The Higher Education Academy 2011). The nine health professional participants in the study mentioned underpinning gaps in their health education on human lactation and breastfeeding which the lay volunteer trained practitioners did not narrate. While the nine health professionals addressed the lack of knowledge with further study, other

health professionals might not seek such learning and rely on their personal experiences to support their practice (McFadden et al. 2007; Furber and Thomson 2008).

*if you are looking after women you need to give them the best care you possibly can which means you've got to increase your knowledge base (Linda/1/ 56 – 59).*

### **5.3. Becoming an IBCLC**

Feelings of elation and pride were described by a third of the practitioners on becoming an IBCLC but there was also an undercurrent of wariness on sharing the news or gaining any recognition of the qualification from others.

*it's a matter of pride to call myself a lactation consultant . . you've got to have done the work . you've got to understand . and you just learn all the time (Jane/1/ 209 – 214)*

*yes I was quite proud of myself, yes I was quite pleased . . but I suppose I just got on with it and did not make a big song and dance about it really and perhaps I should have done (Mary2/1/ 995 -999).*

Being an IBCLC, though, made a real difference in how the participants practiced.

*without the lactation consultants' knowledge support . . I wouldn't be the person I am today (Ann/1/155 – 158).*

*I found with working as an IBCLC is that's extended my practice ( . . . ) which has been quite challenging (Linda/1 83 – 93)*

*It's given me a greater confidence ( . . . ) I found if you demonstrate that confidence people have confidence in you (Ruth/1/655 – 706).*

*I just thought I was somebody with an extra interest but actually it did reinforce my knowledge and skills (Susan/1/164 – 166).*

Every participant's general demeanour changed when they talked about being an IBCLC. The change was difficult to capture in a narrative, but in my field notes I attempted to portray my impressions following the interviews.

*Eager to talk and smiling and leaning forward as she talked especially about being an IBCLC (Field notes 23.10.08)*

*Very quiet and thoughtful but face relaxed when talking about using her qualification (Field notes 13.11.08)*

One participant found that being an IBCLC was;

*like the concrete and it's sort of really underpinned all my knowledge and skills (Susan/1/305 -306)*

The drawing of an analogy between IBCLC practice and manufactured building material initially appeared a dubious illustration of how a practitioner worked but the passive participle of concrete is *concreresco*, to come together, and *cresco*, to grow (Oxford English Dictionary 2011). The binding action of water, essential in the making of concrete, reflected how the participants became catalysts in their profession, working at and drawing together aspects of the art and science of breastfeeding, to form a breastfeeding practice (Bolton 2006; Higgs and Titchen 2001).

The participant's narrative accounts focused on why they had become IBCLCs and how they felt they had benefited from the qualification. All the accounts were narrated in quite a self-effacing way. The rationale for this approach was not easy to understand.

*it wasn't done with the view that . . .you know . . . I'm a lactation consultant . I'm a superior being or anything like that, in fact it was to increase my own knowledge base and to give it a focus (Helen/1/61 – 64).*

In articulating professional breastfeeding practice in England, the participants had learnt to be circumspect in how they spoke about their role. The explanation of a self-effacing culture within the IBCLC

participants appeared to be based on the cultural response towards breastfeeding within the country, rather than one held within the group.

### **5.3.1. Developing a Breastfeeding Practice.**

The main part of preparation to become an IBCLC is based on a large element of self-study and practice (Smith 2011). A deep approach to learning was illustrated in the narrative accounts as participants demonstrated a strong motivation to learn and wanted to acquire the depth of knowledge that could inform their practice (Fry et al. 1999). The process of learning they used was an integration of practice and theory, where one complemented the other. Benner et al. (2009, p.15) describe clinical practice as a “complex, varied and undetermined” environment, which is constantly changing and shifting. Health professionals try and make sense of what they see through drawing on what they know (Higgs et al. 2001). Working in a clinical role therefore became critical in integrating any theoretical learning.

*I'm learning all the time (Susan/1/308)*

*I'm really keen to keep on learning (Ann/1/396).*

*trying to extend my knowledge with regard to that . . I have used the Health E-Learning site . the one from Australia<sup>29</sup> . and have used that for special things (Gail/1/125 - 128).*

Each participant adopted a way of learning that suited her needs, which was especially well illustrated by one participant describing how she prepared for the IBCLC examination.

*I am quite a visual learner. It was sort of reading a chapter of Riordan<sup>30</sup> every night and making notes on it ( . . . ) doing the work beforehand is the important bit, it made me read stuff ( . . . ) it help me understand (Ruth/1/91 - 141).*

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<sup>29</sup> Health E-Learning which offers distance learning on breastfeeding. Available from <http://www.health-e-learning.com/> [Accessed 22<sup>nd</sup> February 2011].

<sup>30</sup> Riordan, J. 2005. Breastfeeding and Human Lactation (3<sup>rd</sup> Ed), London: Jones and Bartlett, one of the recommended texts for IBCLC candidates.

All the participants reflected an Aristotelian approach to praxis, where they continually challenged themselves in what they knew, through adopting a readiness to learn through observations and their understanding of practice (Bernstein 1982; MacIntyre 2007). The participants' accounts provided evocative images of how learning was part of their lives.

*and even now by the side of my bed it's all breastfeeding books . . . and I'm just fascinated (Jane/1/217 – 222).*

*and I've just read the leaflet in the bath last night and I thought what a lovely way to write about breastfeeding (Carol/1/ 604 – 606)*

*I try and get in about two conferences a year and admittedly they're always breastfeeding ones . . . because you learn so much ( . . . ) it's not the same as reading an article, reading a book . you can talk to them . you're hearing it first hand and why and it just makes such a difference and it keeps you going (Helen/1/347 – 365).*

The participants described a continuous learning experience while working in practice, which one participant described as building up layers of knowledge and skills.

*it's quite hard to know at what point you got this knowledge and skills and started using them . . . (laughs) because it keeps adding on, it's like layers and layers (laughs)(Mary/1/ 745 – 749).*

Benner et al. (2009) wrote that any skilled practitioner learns to hold a background understanding of practice in a fluid-like way so that they are able to recognise the unexpected. While working as a professional practitioner is not always about working as a specialist but understanding all aspects of practice is essential to enable recognition of the unexpected. Benner (1984) saw much of nursing knowledge embedded in practice itself when she acknowledged the importance of “know how,” when working in a clinical role.

The following research log account, although it does not relate to the data, is included as I began to collect accounts from my teaching experience to

illustrate how health professionals developed their knowledge in supporting breastfeeding women. The account illustrates how health professionals often limit their focus to how the baby is positioned and attaches at the breast rather than considering other aspects of breastfeeding such as understanding the inter-relationship of anatomy and physiology between the mother and baby.

*Today I was told the following story by one of the health practitioners who attended the previous session on neonatal oral anatomy I facilitated.*

*Following the workshop, the practitioner contacted a mother who was experiencing breastfeeding problems that nobody could resolve. The practitioner asked the mother if she could review the case as she had learnt something that might help.*

*The practitioner explained that as soon as I started describing how breastfeeding could be affected by any deviation from what would be expected as a “normal” neonatal palate she realised that she had to, if possible, examine this particular baby’s mouth. On checking the baby’s mouth she found a bubble palate (Snyder 2000; Riordan and Wambach 2010).*

Research Log 11<sup>th</sup> December 2010.

I turned to local voluntary breastfeeding counsellors when I was developing my professional practice. Three-quarters of the participants also narrated how they had sought out and worked alongside other practitioners recognised for their expertise in supporting breastfeeding women. When Abbott et al. (2006) asked senior managers in three English health areas about opportunities for health professionals to learn about breastfeeding, they were informed about “breastfeeding champions” in each locality. The described breastfeeding champions were a mixture of health professionals and voluntary lay breastfeeding counsellors and the participants illustrated a similar role when they became IBCLCs.

Apart from learning about breastfeeding, I observed a different approach to practice by working alongside local volunteer practitioners who worked outside the NHS.

On reflection I think becoming an IBCLC was the challenge I needed to make me start working differently. My support network came not from health professionals but from the voluntary breastfeeding counsellors who nurtured me through these developmental stages. On reflection I can see much of my practice at that time was based on a biomedical model, which limited the way I worked with women. Through working with the voluntary counsellors I found I had to unlearn many of the practices I had taken on as a health professional and learn new skills and knowledge.

*Personal narrative on becoming and being an IBCLC, February 2007.*

Although the participants did not narrate any similar adjustments in the way they practiced, they did reflect a similar approach to that which I first observed in lay breastfeeding counsellors. What I was unable to answer was if they had always worked with such a focus on practice or if, like me, had changed while working in the role.

### **5.3.2. Lactation consultant or IBCLC: using a title**

Most of the participants use the title of Lactation Consultant as a way of describing who they were. As the title Lactation Consultant is unregulated, the IBLCE Code of Professional Conduct (2011f) recommends that practitioners use the regulated title of International Board Certified Lactation Consultant or the acronym IBCLC when in practice. A mixture of role titles was used in the NHS circumscribed by the job description when a participant was employed in a specialist role. None of the role titles included the qualification title. They were:

- Infant Feeding Advisor
- Breastfeeding Specialist
- Breastfeeding Lead.

Two participants provided two differing accounts of what the title IBCLC meant to them.

*I assume that most GPs see the word “Lactation Consultant” and assume that I am a doctor, that’s absolutely fine, if it helps them see me as what they were asking for . . . (laughs) . . . in a more professional light then I’m not going to get rid of their delusion that I am a doctor. No most people do not have an idea what it is, but it sounds good (Ruth1/42 -52).*

*Sometimes I get asked, what do you mean consultant? Sometimes I’ll sort of dampen it down a little bit and I sometimes don’t use the words lactation consultant, I’ll use lactation specialist or infant feeding specialist or breastfeeding specialist because consultant is a word that gets misinterpreted ( . . . ) and I’m not really sure why because I knew that it was credible but I wasn’t sure but I didn’t want to push myself too much (laughs) (Susan 1/731 -748).*

Susan was ambivalent about how she viewed and articulated her qualification, especially when questioned by other health professionals. Ruth found the word “consultant” assisted her practice, especially when dealing with medical practitioners. Professional titles frame a practitioner’s practice, especially within large organisations such as the NHS. A title can inform others, on a superficial level, where a person fits within a hierarchical organisation, although it cannot illustrate the personal competency or practice of that practitioner (Kirkham 1999; Wilkins 2010). A title, though, should also enable practitioners to express a mutual interest in who and how they are with each other (Wilson-Clay 2000).

The rationale for the IBCLC title appears unrecorded but the words, “lactation” and “consultant,” utilise the language of a medical vocabulary. The word *consultant*, derived from Latin roots to consult or discuss with experts, is firmly embedded and often framed within medical practice in the UK (Savage 2007; Oxford English Dictionary 2011). The DOH (2004a) Agenda for Change framework has extended the concept of consultant practice and practice-based roles, though, in the NHS into other health professional work such as nursing and midwifery practice. The first Infant Feeding Consultant role was appointed in October 2011 (McKeegan

2011). The reporting of the appointment does not record the practitioner as an IBCLC, which she is, only as a midwife (McKeegan 2011). Within the NHS there appears to be a disjuncture between an appointment of a health professional to specialist or lead breastfeeding or infant feeding role and acknowledgement of the IBCLC qualification either in the job title or in related information about the practitioner.

The concept of a consultant practitioner within the NHS is different from that expressed in the title of an IBCLC but that does not mean the qualification cannot be acknowledged. While the NHS prescribes and defines the role, an IBCLC automatically gains the title on qualification (Partlow and Graham 2000; DOH 2004a). The NHS might not yet be ready for practitioners to self-appoint themselves with such a title which might explain the differing accounts by the participants.

### **5.3. Location of IBCLC practice**

The participants worked in three distinct practice areas, within the NHS, in private practice and as a volunteer either within a voluntary lay breastfeeding organisation or independently in their own time.

#### **5.3.1. Working in the NHS.**

Eleven of the participants had worked or were working in the NHS when interviewed. When the study commenced, four participants worked in the NHS as infant feeding/ breastfeeding advisors; six months later two further practitioners had commenced in similar roles. Two participants experienced a great deal of freedom in how they developed the particular role within the job descriptors but four practitioners were provided with very long, detailed job descriptions against which their activities were matched.

*because my job was a public health job really and I had to create the job . . . because people hadn't done it before . . . so I had to grow the job . . . it allowed me an enormous amount of time I'd never had before to investigate what works (Carol/1/327 – 332).*

*the actual job description is completely and utterly . . . ridiculous (laughs) . because it involves such an awful lot (Gail/2/93 -95/ 7).*

The remaining five participants employed in the NHS, held a leadership role for breastfeeding practice, while working within their primary health professional employment, such as a registered nurse, health visitor or midwife. Leadership roles were different for each participant and the amount of time provided for the extra responsibility ranged from nothing to five days a month.

Half of all the participants had funded themselves to become an IBCLC<sup>31</sup>. Five of the remaining six were successful in obtaining funding from their NHS employer and one had won a monetary award.

*I remember my manager at the time saying to me “Right we are prepared to support this but what are we going to get out of it?” . . so at that point I had to think what is anybody going to get out of it and I just said I’ll be much better at supporting breastfeeding women and I’ll be much better at my job, if I have this qualification because I will have to study in great depth . . . and didn’t give it much thought really until I started studying (Carol/1/92 -104)*

The dearth of evidence about being an IBCLC might well have affected how the role was proposed as she reflected:

*if I’d only known what a difference it would have made to the women . .I would have told them (Carol/1/415).*

The participants narrated differing experiences of how other health professional and NHS management did or did not recognise the IBCLC role.

*Once I qualified my managers congratulated me when I actually passed but beyond that I don’t think really it made any major difference (Linda/1/33 – 35)*

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<sup>31</sup> The examination fees are set every year. The cost in 2011 was 400 Euros. Extra costs are books, conferences, on-line learning, workshops which candidates have to attend to accrue the necessary 90 hours of registered learning.

*Well for the job I went for . . . in fact when I told them (that I was an IBCLC) they didn't even know what it was . . .they just said . . ."Oh is that the big exam?" . . . . (laughs) (Wendy/1/385 – 388/7c).*

*The lactation consultant (qualification) was probably the one thing that actually helped me get the job (Ann/1/314 – 315).*

*I have to say it's probably not made any difference to my professional status because I do believe people don't know . . don't really know what a lactation consultant is . . however I have the qualification written into my job description (Susan/1/286 - 294).*

Ann's employers were aware of what the qualification might offer their service but the three remaining responses ranged from indifference to inertia in finding out about the title.

The balance between being an IBCLC and working as a health professional employed with a wider remit, such as a nursing role, often appeared difficult to maintain. All the participants who worked in this way held a leadership role in breastfeeding practice. The participants were drawn to developing their breastfeeding role while trying to complete the work entailed in their other job.

*I would have my own caseload to look after and very often I would be pulled off by another member of staff, if there was a (breastfeeding) problem with her, the mother or her baby ( . . ) but nobody would cover me when I sorted out her mother and so it became very difficult and I just struggled on for a while because I was so passionate about the things that needed to be done ( . . . . ) I went to see my manager and put my cards on the table and I said "Look you can't have it both ways . thank you very much you've paid for my training but now it's just becoming so overwhelming ( . . . ) to my surprise, very soon afterwards she gave me a dedicated day and I was able to build on that (Susan/1/86 – 111).*

Susan's request for support from her line management met an appropriate response but Gail's experience was more negative.

*I feel probably like every other lactation consultant it is a non-supported environment despite the government's targets ( . . . ) in this role you feel like you're banging your head against a brick wall, or you know, little voice in the darkness .shout . shout . shout . it (breastfeeding) is valued by the woman which is where at the ground level that's where you want to be but it's not, as a rule, within a hospital environment, it is not valued at all (Gail/1/ 392 – 406).*

Gail recognised the value that breastfeeding mothers placed on what she provided but there appeared to be a chasm between the women's acknowledgement and how her employers listened or responded to her needs. The act of listening and reciprocity is considered fundamental practice within well-managed organisations (Huczynski and Buchanan 1991). Bolton (2000b, p.584) found that for a group of nurses working within the NHS, one of the few ways the practitioners could express how they felt about their "invisibility" within the service, was to offer "gifts" of extra time and emotional support to patients. Gail appeared to work in a similar way, as the idea of a gift of her practice, evaded organisational prescription of her role. In meeting women's needs in this way, Gail could express her individuality and autonomy as a practitioner. The extra level of time and energy Gail invested to maintain her practice through such gifting, though, can pose a risk of her becoming exhausted, stressed and demoralised through a continuing lack of professional recognition. The risk in Gail continuing not to address the issue is that management might expect her to continue to work in a similar way while her motivation to continue to practice might be lost.

While most of the participants managed to see breastfeeding women whenever they could, there were two accounts where there was a significant delay.

*I see them . but . it can they can be . .you know . ten days down the line before I see them . .and if they've been having problems with breastfeeding .well . . . it gets quite difficult (Jane/1/195 -200).*

*because many have given up and by the time I get to see them . they have reached that point emotionally where they don't want to go back . . the door might have been ajar but they don't want to open it (Kate/2/30 -33).*

The participants explained the delay in terms that their health professional role, which was the reason they were employed within the NHS, had a service agreement that prevented them from meeting post-natal mothers at an earlier stage. Both the participants had a lead role for their practice area to develop support for breastfeeding women but they described how they were hampered by the service agreement in using their IBCLC qualification, when women really needed them. Another participant, though, had circumnavigated the service agreement by using her breastfeeding lead role to forge links, which enabled earlier referrals from other health professionals.

*our manager doesn't want us to visit children less than ten days old . so I get around that ( . . . ) last week I visited a baby that was three days old ( . . . ) the midwife there whom I've got a good relationship with and we do the antenatal classes . and she asked me if I could go because purely she was off and . because she wanted this mum to have a bit more support . so I did a two hour visit and we used that biological nurturing and stuff and it was the first time this woman had a had a pain free feed . but in the night before because the pain was so bad she had given three lots of formula ( . . . ) she was thinking of giving up and the baby has put on 8 ounces in weight over the weekend . . and that's what I say . . and that's what keeps you going isn't it ? . .and that's what justifies the . . better use of my time (Mary/1/692 – 714).*

In all three accounts, the participant's manager was not supportive of them using their IBCLC qualification at an earlier stage to meet women's needs, although 15% of breastfeeding women in the UK stop feeding their baby within the first two weeks (Bolling et al. 2007). The UK National Infant Feeding Survey (Bolling et al. 2005) also found that 90% of the 40% of

women who weaned prematurely had wanted to continue to breastfeed but a lack of appropriate support had prevented this outcome. The three most common reasons women stopped breastfeeding at this time were insufficient milk (42%), painful breastfeeding (30%) and a baby that does not latch to the breast (24%), all feeding issues that IBCLCs are qualified to provide the necessary skills and expertise to address (Smith 2003a; Bolling et al. 2007). While managers used the framework of service agreements to stop the dual qualified participants in the study from extending their practice, there were ways to circumnavigate the problem, such as developing inter-service working between the different professions. The narratives illustrated that it is time to find a way in meeting the needs of women rather than service needs to enable breastfeeding to continue.

### **5.3.2. Working in Private Practice**

Four of the participants had worked or were working in private practice at the time of data collection. While two participants fitted in their private practice around a part or full-time role in the NHS, the remaining two participants had left the health service and started a full-time practice as an IBCLC. Both the participants who entered full-time private practice found it offered an alternative way of working with breastfeeding women, one that had not been possible within their existing NHS roles.

*so I made the positive decision to actually leave the Trust and . . . I . . . decided to set up a lactation consultancy (Ann/1/86 – 88).*

*I actually left the NHS . . . that was to do with the fact that . . . there was a lot of change in management taking place . . . and . . . I actually decided that I . . . no longer wanted to . . . fight the battles I had been fighting within the NHS . . . and I was given the opportunity to . . . really look at having a change of career . . . it was shortly after that I decided to go into private practice (Linda/1/48 – 56).*

The two participants who had entered full-time private practice had both returned to the NHS but in changed roles and to work for different

organisations. All the participants who worked in private practice spoke of personal conflict about charging for a service, which they considered needed to be freely available for all breastfeeding women.

*I did have moral concerns about this because I felt the service should be available for all women regardless of their actual financial status (Ann/1/89 -92).*

The participants' concerns about charging for a private service were partially ameliorated by three of the IBCLCs who offered their services on a voluntary basis, or negotiated a service that was charged to the local NHS.

*they tend to be telephone contacts because I'm on . . . several of the websites . for breastfeeding support . . and I've had phone calls from abroad . and I've had phone calls from all over the UK (Kate/1/97 -100).*

*the main part of my consultancy was . . providing education to NHS organisations . and actually seeing private patients . initially . and then . the hospital that I worked in actually saw that there was a big gap there and they started to refer women ( . . .) one of the managers had to approve this . prior to me contacting . the women . and that's what I did . . and so . for the next six months I worked partly . . for private . but partly for the NHS (Ann/1/97 – 110).*

*one of the things I have felt very strongly because now I've been working in private practice and . . obviously (women) had to pay me if I am going out to see them . I have always said that telephone and e-mail contact I would always do as a volunteer and I am involved in . . two particular breastfeeding support groups . . which run once a month (Linda/1/97 -104)*

The risk of offering a service, where women have to pay, meant that participants often saw breastfeeding women in extremis.

*a lot of the women when I go out and see them . . . I can tend to be the last port of call before they stop breastfeeding because they've been really . really struggling (Linda/1/178 – 181).*

Other IBCLCs, who work in private practice in the USA, have also described themselves as practitioners of last resort and how there is always the possibility of encountering “scary situations,” because of that (Hoover and Wiessinger 2003; Wilson-Clay 2003). Linda found that women were seeking practitioners who believed in their ability to breastfeed, while some of the feeding problems were probably caused by “small failures in NHS practice.”

*it's simple things that can be put into place in the very early days and . . . for example unlimited skin-to-skin contact and . . . allowing the baby to self-attach at the breast . that frequently they wouldn't have come to the problems they've actually . hit against . or if someone had actually simply explained to them . . . how to tell the baby is well attached to the breast and really listened and . . . believed in breastfeeding (Linda/1/70 -80).*

Working in private practice, apart from developing business skills, also provided the participants with opportunities to work in different ways.

*I think one of the differences actually with . my work in private practice and my work . in the NHS is I have much more long term contact with people and . so people still keep in touch with me and . . . send me a bit of an update . several . even years down the line . and that has been something really . . really enjoyable and very rewarding (Linda/1/138 -145).*

*you have to learn how to sell yourself and that's something we don't do within the NHS (Ann/1/370 -372).*

*so a lot of telephone advice .and it's amazing . .how much information you can get . . just by talking to someone over the phone . . and then how much information you can give them or at*

*least put them in the right direction if you can't see them for an assessment (Kate/1/100 – 114).*

*I just felt more confident when I started doing some private Lactation Consultant work (Wendy/1/255 – 256).*

The independence that working in private practice provided, though, was also recognised by one participant as a possible cause of some friction when returning to work in the NHS.

*but I suppose having been independent it is quite difficult . to go back into . . . bureaucracy . . . and . having to make sure you're having to adhere to guidelines . even if you don't necessarily agree with those guidelines . you have to challenge them through the right channels . . it's not actually been a bad discipline for me . but . it's . . quite an interesting tension (Linda/2/66 – 72).*

Women might choose to pay for private breastfeeding support, just as some women choose to employ a midwife in independent practice, but the participants' accounts illustrated that women were often paying for help to resolve basic breastfeeding problems that should have been resolved within a health service. The participants in private practice were meeting the needs of women wanting to breastfeed but at a financial cost to women. The impression of IBCLCs working in private practice in this way was of practitioners providing a safety net for breastfeeding women, not a complementary service to the NHS.

#### **5.4.3. Working as a volunteer**

As participants related their accounts of practice, they described volunteering outside paid work. While three participants were involved with voluntary breastfeeding support groups, six IBCLCs were working in unpaid and often unrecognised practice in their own time. Through working as a volunteer, the participants described finding “a balance between giving and getting” in their lives, which has been described as essential in developing a professional role (Cherniss 1995, p.121). Deery

and Hunter (2010a) described the motivation to become a volunteer as usually altruistic but, from the participants descriptions, it was also observed as self-serving, as it provided the opportunity to work with breastfeeding women and enhance their practice.

Many of the participants narrated working as a volunteer as a choice, which offered them an opportunity to work differently from their day-to-day role and fulfil their ambition of becoming a complete practitioner (Barnett 2009).

*I've been able to, as a volunteer, see them (women) over a three month period and watch things develop ( . . . ) I think the biggest amount of experience I gained was as a volunteer (Gail/1/281 – 313).*

*if I wasn't in my current role, I would still want to be a breastfeeding supporter and I do see people on a voluntary basis, people who need breastfeeding support (Jane /2 /27 -30).*

*in my local area in fact I used to visit them (women with breastfeeding problems) all on my days off because I'd say "Oh she only lives round the corner I'll nip round" (Carol/1/ 443 – 446).*

A recent, fairly controversial, government initiative is for a greater number of volunteers to work with organisations as part of developing a Big Society (Cameron 2011) but when Wendy offered to become a volunteer within the NHS as an IBCLC, the response was not welcoming.

*and I asked, do you need any volunteers, I've got these qualifications is there anything I can do . .no . . those doors were shut, I think I tried (named three hospitals), I didn't get very far (Wendy/1/206 – 212).*

In a study of 530 senior Canadian managers and professionals, Burke and Fiksenbaum (2009) found that the participants who scored highest in passion for their work willingly undertook extra work. The risk for the participants was that in working as volunteers their enthusiasm and

dedication to working in their own time could become an expectation from their employers rather than a considered activity they undertook of their own volition (Freudenberger and Richelson 1980; Cherniss 1995; Burke and Fiksenbaum 2009). Working as a volunteer is linked to many earlier discussions especially to work/life balance (4.4).

*I choose to do that in my own time because it doesn't fall on a (dedicated) breastfeeding day (Gail /1/552 – 554).*

*unless you work over your hours you don't actually get any visits done (Helen /1/ 173 -174).*

The difference between Gail's and Helen's account was the ability to choose when to work as a volunteer. If working in a participant's own time was not freely volunteered and therefore not under their control, issues of working under pressure appeared in the narrative. Ann had tried to take a firm line on this by choosing not to work outside her working hours.

*I haven't volunteered, but I think, sometimes you have to deal with what you have in front of you and you're also trying to juggle family life (Ann/1/241 - 244).*

## **5.5. Considering the development of a professional breastfeeding practice.**

This chapter continued to build on the previous theme of centeredness on breastfeeding and described the personal development of the participant's professional practice. The participants illustrated a strong dedication and self-motivation to develop as a competent practitioner and utilise every opportunity that presented itself to work with breastfeeding women. In practising as an IBCLC, the participants reflected a life-long or Aristotelian approach to developing a praxis, which exemplified an expert practitioner.

The participants discovered that finding out about becoming an IBCLC was not always easy and most had relied on other practitioners to encourage and inform them about the role. Health professional organisations did not provide any information about the role, although

initially the RCM had. The participants, once they were qualified, took on the role of informing and supporting other health professionals to become IBCLCs.

Working in practice was an essential element of being an IBCLC. If the present role did not provide the opportunities to work in breastfeeding practice or limited the participant's experience in any way, then the practitioner actively sought a way to fill the gap of working with the breastfeeding mother and baby. The participants found that working in private practice or as a volunteer, offered them opportunities for developing their practice that were not always available in the NHS. Working in NHS, private practice or as a volunteer, though, raised issues for the participants. Working in the NHS often raised concerns about lack of recognition and managerial support, not being listened to and limitations on how they practiced which often reduced opportunities to work with breastfeeding women. Participants who worked as volunteers and in private practice chose to work within these frameworks as they provided the freedom and autonomy to work the way they needed to. Both frameworks offered the opportunity for participants to work differently but from the practitioners' accounts they often supported breastfeeding women who were failed by the NHS. Working with breastfeeding women was the touchstone for all the participants whereby their needs were met, as were those of the mother and baby.

In the following chapter how the participants worked with other health professionals is described.

## **Chapter Six: Chip, chipping away, working at the breastfeeding coalface.**

*To keep our faces towards change and behave like free spirits in the presence of fate is strength undefeatable (Keller 2009, p.13)*

### **6.1. Introduction**

The personal development of the participants, described in chapters four and five, enabled the IBCLCs to assert authority and expertise in breastfeeding practice, which made their work visible and recognised by other health professionals (Belenky et al. 1997). By raising the profile for breastfeeding, the participants were also drawn into teaching other health professionals and into managing changes in infant feeding practices within the health service. The participants' narratives reflected a similar developmental pathway to my own but a review of IBLCE practice information and frameworks illustrated mixed messages about the involvement of lactation consultants in either education or the development and management of change.

The documentation for IBCLC practice in developing any education skills lacks clarity. The Examination Blueprint (IBLCE Europe 2011) mentions a commitment by prospective practitioners to breastfeeding promotion and community education. The Scope of Practice (IBCLE 2008a, p.1) describes a practitioner who, by educating women, families, health professionals and communities, protects, supports and promotes breastfeeding. The Standards of Practice for an IBCLC (ILCA 2006) describe practitioners with an ability to educate parents (4.1.) and share "evidence-based information and clinical skills" with other health professionals (4.5). The Clinical Competencies for the Practice of IBCLCs (IBLCE 2010c, p.1) describes a practitioner who can provide "evidence-based education," which includes curriculum development. All of the descriptors lack clarity and lead to a confused picture of what role an IBCLC plays in educating other health professionals. The McIntyre Delineation Study on the IBCLC role (McIntyre 2007) found that

practitioners were concerned about a lack of educational preparation in teaching other health professionals. The IBLCE response was to increase the number of questions on the topic 10 -16, to 14 -20, which is not well illustrated in the examination blueprint (IBLCE Europe 2011).

A search of the forty books on the recommended reading list for prospective IBCLC practitioners found two books that had chapters on education and one on managing change (Riordan and Wamback 2010; Lauwers and Swisher 2011). Practitioners, of course, can search in other relevant texts to gain further knowledge and skills on teaching and managing change but the lack of clarity about the role of IBCLCs in either activity might mean that practitioners enter the profession with very little preparation for such roles.

This chapter explores and describes the experiences of the participants in attempting to develop other health professionals' understanding of breastfeeding practice. The participants focused on sharing what they knew through role-modelling their work and in drawing other health professionals into really seeing and understanding practice. For the participants who worked in the NHS, there was also an expectation that they would teach in a classroom setting away from the practice area. The participants described a process of learning to teach. In managing change, the participants illustrated an ability to access opportunities as they presented themselves.

## **6.2. Working with health professionals, noticing the gaps**

While the participants had addressed their lack of breastfeeding knowledge and skills, they realised that for many other health professionals, practice had not changed.

*I think it can be issues that some practitioners do not know they are giving the wrong information and that some do not have much confidence in their practice (Ruth/2/176 -179).*

*and it was blatantly obvious to me the gaps that were there with respect to practitioners in the unit. So I sort of took things in hand (Susan/1/41 – 44).*

Through working at the practice coalface, the participants encountered situations where they had to deal with the consequences of inappropriate breastfeeding support provided by other health professionals. The description of the practice coalface is used to illustrate the participants encountering and reacting to a situation, rather than planning what needed to be done.

*of the visits I do it's down to either positioning or attachment (Jane/1/650 -655).*

*and it's that frustration . . . it's almost the frustration that we haven't sorted the basics out yet (Susan/1/870 -871).*

*quite frequently when mums come out (of the hospital) with sore nipples . . .well they say . . .the (named health professional) checked and they said it (the baby) was on right . and then they get quite defensive because . . . they've been told everything is right . which obviously it isn't . and . . . you actually have to be actually quite tactful . . .to try and alter things a little bit (Helen/1/326 – 329)*

The participants did not want to undermine the woman's confidence in their health professional's practice but recognised that some breastfeeding women were not receiving the support that they needed. The breastfeeding problems that women encountered had to be addressed by the participant or there was a risk that a cascade of negative breastfeeding events would follow.<sup>32</sup> The IBCLCs also recognised that there was a need to reduce or, if possible, prevent the recurrence of such incidents in the future.

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<sup>32</sup> The breastfeeding cascade starts with poor positioning at the breast, which for the mother might lead to nipple trauma, poor milk drainage, mastitis, breast abscess alongside a risk of localised infection of the nipple and areola. For the baby, poor positioning might lead to underfeeding as milk transfer is restricted leading to the risk of supplementation with artificial milk. Such feeding might also undermine the mother's confidence to breastfeed for subsequent babies (Walker 2006; Riordan and Wambach 2010).

*The voices of the participants, as they narrated such accounts brought me back to remembering how I initially felt when working day-to-day with breastfeeding women who were referred to me by health professionals. On many of these occasions I wondered why health professionals appeared not to be seeing what I observed in practice, as simple adjustment in feeding positioning usually was all that was needed. McKinlay (1979) suggested that many aspects of health service practice are short-term, problem specific, individual-based interventions. The frustration in dealing with the day-to-day problems meant that the real problems, such as challenging the underpinning knowledge of health professionals did not always get addressed. My description of working in practice at that time reflected similarities with the USA story of the Dutch boy, Hans Brinker, who held back the flood waters in Holland by keeping his finger in a crack of a crumbling dyke (Mapes-Dodge 2007). My role was keeping the flood from becoming a reality.*

Research log 22<sup>nd</sup> March 2009.

The participants realised that health professionals did not always observe the mother and baby as an interconnected partnership but used a more task-orientated approach towards breastfeeding (Renfrew and Hall 2008). Jane and I illustrated a tacit understanding of our experiences of other health professionals practice when we both laughed after the following statement.

*sometimes midwives will say I've got the baby on (both laugh with mutual recognition of similar experience) (Jane/1/767 – 769)*

The laughter shared a mutual embarrassment at recognition of the possible risk of inappropriate health professional practice. Working as an IBCLC exposed the participants to different realities of health professionals' clinical work in supporting the breastfeeding mother and baby, as well as their perceptions of practice.

*and then you could go to the other degree where you have people with no interest . they think . that people who are interested (in breastfeeding) are bizarre (Ann/1/187 -109).*

*and a lot of health professionals do not like breastfeeding (Helen/1/89).*

*some people are darn right hostile about it and Baby Friendly and breastfeeding . . all together . . I have got one person in my office . in our team .who really . . our computers back onto one another and she's got two little cows with Cow and Gate<sup>33</sup> tails . .and they are pointing straight at me (laughs) . . . .and I just think .ummmmmm . . (Kate/2/173 – 179).*

The participants did not excuse or explain other health professionals' approach towards breastfeeding but their descriptions reflected Ekström et al.'s (2005) work on midwives' and nurses' attitudes towards infant feeding. Ekström et al. (2005) found that health professionals fell within four descriptive groups: regulating, facilitating, disempowering or expressing an antipathy towards breastfeeding. The descriptors show that the three accounts by Ann, Helen and Kate reflect health professionals who fall within the breastfeeding antipathy or aversive group. Furber and Thompson (2006 and 2010) also reflected how a group of midwives worked within a disempowering framework when they considered what was in the woman's "best" interest and directed the language they used away from the woman-centred care that the breastfeeding mother needed. The participants encountered health professionals who held entrenched views about breastfeeding and were reluctant to change how they worked. Studies in the UK that reflect health professionals' negative attitudes towards breastfeeding are mainly quite old, but the participants' narrative accounts indicate that similar opinions might still exist in practice (Chalmers 1991; Beeken and Waterston 1992; Freed and Clark 1995).

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<sup>33</sup> Cow and Gate is an artificial baby milk product

*I am involved with the Baby Friendly (Initiative) and . . . involved with . . . teaching . . . . you meet an awful lot of . . . opposition . . . its . . . cross your arms and . . . “I know all about this . . . we used to do that years ago” (Helen/1/67 -72).*

*They (health professionals) often do not like what I say (laughs) . . . and they sometimes say “That can’t be right . . . well there’s no point in expressing when the breasts are empty . what’s the point in that?” . . . but I don’t know how much of this influences practice . . . as people like to think whatever they have been practising in the last twenty years . . . is right (Kate/2/138 -144).*

Participants who worked outside the health service, in private and voluntary practice, also encountered different experiences when they met or worked with other health professionals.

*as an example I visited one of my daughter’s friends fairly recently in hospital . and I went as a mother of a friend . .and . this lady .had a baby very early and the hospital . they were trying to get this tiny baby to feed a lot of milk three hourly . and it needed . .two hourly feeding ( . . .) she was in and out of hospital for . seven weeks which was ridiculous . .they finally said what you need is a lactation consultant , . . and I thought . .well I was there (Denise/1/74 – 90).*

*once a week . . a toddler group . takes place at the local church . . and again .as a volunteer . .I’ve become part of the staff . . I .am really just to be there for mums if they come along with a new baby or older baby that wants to breastfeed . and need some support . .the (named health professionals) already started doing outreach clinics . so I . decided to . go along at the same time and it helped me make links with other health professionals (Linda/1/123 – 133).*

These two accounts illustrate that the context of practice is important when IBCLCs work with health professionals. In the first account, Denise did not share her IBCLC qualification with the health professionals, perhaps

because the contact was fleeting and not in a professional context. Linda, however, worked alongside health practitioners over a period of time and there was a chance for everyone to observe each other's practice. Linda's account of a partnership model of working with health professionals could be followed up with further research as a way of promoting breastfeeding support within communities. Such evidence might be required in the future if IBCLCs are to work with other health professionals, as suggested in the government's proposed changes to the NHS<sup>34</sup> and the launch of the Big Society.<sup>35</sup>

### **6.3. IBCLCs as local breastfeeding champions**

Abbott et al. (2006) and Bate (2007) found that, within health service settings, opportunities for learning about breastfeeding were often dependent on a small band of enthusiastic practitioners. The term informal learning was applied to learning situations that were not part of a recognised academic or professional training course and often relate to opportunities when formal organisational support might be missing (Abbott et al. 2006). All the participants illustrated the role of "breastfeeding champions" when they described working alongside health professionals at the clinical coalface and acting as role models for breastfeeding practice.

*I feel that I am a role model for others (Ann/1/391).*

*some things that work is .people . . . catch good practice from you . if you can actually get people to come into groups and work alongside you . . if you can do visits together . I think that can help if they can actually see . what we do (Ruth/2/131 -135).*

By role modelling and articulating a professional practice, the participants were seen as breastfeeding champions and became a reference point for other health professionals.

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<sup>34</sup> DOH proposal on creating social enterprise initiatives (DOH 2011b and c).

<sup>35</sup> David Cameron's Big Society speech (Cameron 2011)

*And usually in this area people come to me and ask “where can I find this out?” . . . and sometimes .someone has told them a bit of research and could I find out about that (Ruth/1/265 – 268).*

*They’ll say . look can you go and see Mrs so and so . . . she’s having a problem (Helen/1/596 -598).*

The reaction of the health professionals who worked with the participants illustrated a dual approach to the IBCLCs’ role. Some of the participants’ narratives illustrated how some health professionals wanted to work with them to gain a greater understanding of breastfeeding practice, while others considered the availability of an IBCLC as an opportunity to refer women on and so reduce their workload. Jane addressed the risk of the off-loading of breastfeeding care by health professionals by inviting a practitioner to join her in her practice.

*if a midwife or a health visitor has got a breastfeeding problem I’ll come and do a joint visit with them . . .and we’ll go through it together and we’ve got a . . . consultation check list so . . .I get them to go through the check list of the consultation . . do a proper consultation before they ring me and then I can ask them lots of questions (Jane/1/188 – 194).*

The act of referral presented Jane with an opportunity to work with health professionals and observe their practice. The use of a check-list also acted as a tool for health professionals to fully engage in breastfeeding practice and share what they knew with the mother and the IBCLC. In the following account, Mary talked about the underpinning basics of breastfeeding that needed to be observed before moving onto more specialised care.

*a baby had been discharged with some heart conditions and three weeks old and still not back to birthweight ( . . .) so nobody had seen this baby feed and were blaming the weight loss on the baby’s heart condition . and the mother went home and was seen by the dietician and told to express her milk and to give this baby*

*expressed breast milk . and she did. She had breastfed her first child for two years ( . . . ) when the (named health professional) rang me yesterday to sort of sound me out about this advice, I said well we've got to look at the whole breastfeeding situation haven't we? We've got to go back to basics and see if this baby is feeding effectively. I need to see what this baby is doing ( . . . ) I'd never met the mother before she didn't really want to use the pump and when we looked at positioning and attachment it was awful (Mary/1/614 -640)*

Mary was not drawn into any speculative care but needed to listen to the mother and observe the dyad breastfeeding. Within the story she described how she drew the health practitioner into observing what she was seeing. The process of thinking aloud together can form a dialogue where the roles of individuals merge and information is shared (Friere 1996). From such a vantage point, issues related to practice are observed and a framework of care can begin to be described.

Cadwell and Turner-Maffei (2004) found that each IBCLC went about the process of consulting in different ways but what concerned them was that many of the lactation consultants they observed in practice did not apply or articulate assessment and critical thinking skills. Mary reflected professional practice in recognising the complexity of the situation but also in articulating a need to return to a basic understanding of what was needed before practice could move on. By reflecting practice in this way, a simple one fix solution, such as bottle-feeding expressed breast milk suggested by the dietician, would not resolve the underlying problems.

Mary did not identify any particular framework of practice in her account but described a multifaceted cycle of care, which required reflection and reconciliation (Schön 1983; Cadwell and Turner-Maffei 2004; Jasper 2004; Benner et al. 2009). In working in this way, Mary, along with seven other participants described how she modelled, listening, articulated reflective professional practice, which employed counselling skills that enabled women to work towards an outcome that met their needs.

#### 6.4. Working with health professionals

Working with health professionals provided the participants with a window onto other peoples' practice that they might not have been able to access in any other way.

*if someone asks me to do a visit . . . I am quite forceful in insisting that the health professional comes along . . . because . . . it's no good me going on and tweaking it . . . because . . . they've not learnt anything. We went in fact . . . to see a lady who had . . . the most horrendously sore nipples . . . and I had not seen her feed . . . but as soon as she showed me her nipples . . . I knew the baby was not close enough . . . I could just tell by the trauma to the nipple how she was actually feeding the baby ( . . . ) she had been feeding like that for ten days . . . (sighs) . . . and the practitioner could see immediately when I showed her . . . and the sad thing was . . . she's one of the really good practitioners . . . and she's been on the training . . . and she's been on the updates (Jane/2/211 – 238).*

The story illustrates how health professionals apart from needing theoretical knowledge to underpin what they observe in practice also require interpreters, such as the participants, to enable an understanding of breastfeeding. Kessels and Korthagen (1996) describe how such learning through observation can focus on the development of practical wisdom or phronesis. Facilitating practice development through encouraging practitioners to deeply observe or really see practice is considered a particular skill, which nine of the participants described using in their clinical work (Kvernbekk 2000; Jacob and Jeannerod 2003).

Kvernbekk (2000, p.362) demonstrated how teaching someone to observe a change in practice, though, without the underpinning knowledge means they only see "formless stuff," which is not helpful to either the teacher or the learner. The nine participants described how they provided the foundational theoretical underpinning learning often in classroom settings

away from clinical practice. Teaching away from the clinical coalface is described in greater detail later in this chapter (6.5). The theoretical underpinning of practice was stimulated and drawn upon by all nine participants when they asked health professional to organise a visual experiences in a way that held meaning for them when working in clinical practice (Titchen and Higgs 2001; Jacob and Jeannerod 2003).

Kvernbekk (2000) described “seeing-that” in practice as a most persuasive way of developing novice practitioner’s into really seeing practice. Kvernbekk (2000) also acknowledged that the greater the theoretical knowledge held by the learner, the better flexibility they have in deeply observing or of “seeing that” in practice. While Jane sounded exasperated that the practitioner had not implemented any changes in her practice, the previous learning was quickly acknowledged in a moment of gestalt,<sup>36</sup> or through an understanding and integration of the whole in “seeing that” when working with the participant in practice (Ogier 1989).

Dual aspects of articulation and visual acuity were essential to the participants in integrating and developing the practice of other health professionals. The context of “seeing-that” in practice, used within this study, is linked to the sense of gaining insight through perception, knowledge and reflection of what is known and what needs to be known to support a professional breastfeeding practice (Soltis 1966; Berger 1972 and 1991; Kvernbekk 2000; Jacob and Jeannerod 2003). Higgs et al. (2001) described how artistry and creativity were needed for practice development and competent practice which the participants recognised was needed by health professionals to develop their practice. Grossberg (1997) described how there has to be a match between a top-down expectation of wanting to understand and the baseline amount of knowledge a person has before active learning can occur. The nine participants illustrated how they informed but also enthused health professionals into developing their own breastfeeding practice not only by

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<sup>36</sup> Gestalt is often considered right hemispheric learning (Springer and Deutsch 2003)

providing the underpinning knowledge but also by inviting others in to examining the art of breastfeeding.

The articulation of phronetic praxis integrated practice and theory whereby participants shared through “seeing that” what was seen and what was known with others. The approach all the participants used is reflected in the title of the thesis of working at the interface between the art and science of breastfeeding. Rolfe (1996) described that the promotion of a technical science within nursing has made practitioners lose sight of what they need to really observe in caring about people and instead have learned to care for them. The subtle difference in prepositions reflected how the participants attempted to move health professionals into caring about the dyad and thereby utilising both theoretical and practical knowledge. In asking health professionals into a “seeing that” state the participants were “reconceptualising and problematizing the familiar, looking for the “unasked questions” and “renovating” existing patterns of thought and practice “(Holmes 2002, p.80).

By drawing health professionals into verbalising what they saw, the participants encouraged each practitioner to construct a detailed view of what they were observing. Seeing practice in this way might elicit a more emotional response towards the breastfeeding mother and child, where the health professional and IBCLC could maintain a dialogue between multiple sources of sensory perception, knowledge and practice experience, which can become integrated into a craft knowledge (Benner 1984; Berger 1991; Titchen and Higgs 2001; Jacob and Jeannerod 2003). Ericsson et al. (2007) noted that, when practitioners with expert knowledge shared such practice with others, a transfer of understanding was possible.

By working in clinical practice and stimulating such sensory perception, the participants were beginning to address emotional, esteem and practical breastfeeding support, that has been seen to be lacking from health professional support in the past (Ryan 1998, 2010, 2011; Shaw et al. 2004; Dykes 2006a; Burt et al. 2006; Renfrew et al. 2006; Tennent et

al. 2006; Fuber and Thomson 2008). Working with IBCLCs enabled the health professionals to observe practice through an experienced practitioner's lens, helping the integration of the art with the science of breastfeeding practice. The approach the nine participants illustrated could not be described as an apprenticeship, as the contact was only fleeting but Collins et al. (1989) described a Cognitive Apprenticeship Model, where learning in practice was influenced and enhanced by social processes that engage practitioners. The model had six main components that supported and organised learning, all of which the participants used in their role teaching other health professionals. The six components were:

- Modelling Practice
- Coaching
- Articulation of Practice
- Reflection
- Exploration - prompting problem solving by practitioner
- Scaffolding - support for learning

The development of a supportive work-based learning environment is not a new concept but as other studies have found, there are difficulties and challenges in facilitating optimum breastfeeding practice in the clinical workplace (Fretwell 1980; Brown 2002; Furber and Thomson 2008; Brodribb 2011; Schmied et al. 2011). The day-to-day business of the clinical workplace means that health practitioners are often 'overworked' and 'stressed' and breastfeeding practice is not always given the priority it requires (Thomson et al. 2011, p.167). In an era where economic efficiency in maternity services is required, post-natal care, often described as the Cinderella service, is usually considered at greatest risk of cut-backs and therefore reduced levels of staffing to provide any care (Demott et al. 2006; Magill-Cuerden 2006; Bhavnani and Newburn 2010; Kirkham 2010). The participants recognised that an investment in developing a supportive breastfeeding practice pays dividends for the

mother and baby's feeding future but getting others to appreciate and recognise the priority did not always appear straightforward.

*I was really naive and just thought it was about time really . . . in that once you became a lactation consultant you just trotted off and have a bit more time to sit with women and change the world (Mary/1/102 – 106).*

From the participants' accounts, their presence in the clinical workplace was making a difference as they stimulated other health professionals to reflect on the way they worked.

*for example like a conversation I had on the ward yesterday . . . it wasn't formal teaching at all . . . but it was talking about this incident about neonatal hypoglycaemia<sup>37</sup> . . . and the health professionals were saying should we be challenging these doctors? (Linda/2/287 – 292).*

The participants, who worked at the clinical coalface, acted as a bridge between the art and science of practice, where they invited health professionals to observe, reflect on and really see how they worked with the breastfeeding dyad.

## **6.5. Learning to teach away from the clinical coalface**

All the participants talked about teaching health professionals away from the clinical workplace. At the second interview, participants were asked to expand further on their experiences of teaching.

*In order to teach other health professionals we do a short university course . . . just four and a half days ( . . . ) but you don't do full teaching . . . and then suddenly in this role it's like well . . . you can help that woman attach her baby so you can teach someone else how to do it . . . and probably that's not good enough preparation (Ruth/2/221 -231).*

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<sup>37</sup> Hypoglycaemia is a recording of blood sugar below the norm. There are risks for the infant if prolonged hypoglycaemia is not treated. <http://www.uptodate.com/contents/neonatal-hypoglycemia>

Most of the participants had limited experience of teaching adults prior to taking on their IBCLC commitments and this mainly involved facilitating ante-natal birth preparation sessions. When the participants were asked about what preparation they had to teach, seven of the IBCLCs recalled attending a short post-professional development course on teaching and learning in practice, two had accessed teaching modules on Masters-level degree courses, one was a qualified children's teacher; one had undertaken a teaching and learning module in her professional training and one could not recall undertaking any teaching course at any time. Nine of the participants had also attended UNICEF/UK BFI courses, which are described in greater detail in section 6.5. All but one of the participants had undertaken some further education on learning to teach but four spoke of their concerns about their ability to undertake the role of teaching their peers.

*Just because I have given birth . does not make me a midwife . just because I have managed to breastfeed and somehow muddled through . doesn't mean I can teach someone else (Ruth/1/416 -419)*

*I didn't come into the job to be a teacher I just got a basic . .ENB<sup>38</sup> teaching certificate . . . but there is nobody else in the Trust . . with the breastfeeding skills . . . to be able to do it . .and . .I'm not saying that I'm in any way an expert (Jane/2/278 – 282)*

*Terrified . .(short, sharp laugh) . yes . and almost . . am I qualified to do this? We are qualified because we know a lot about the subject . but I still question . . are we qualified enough as a teacher? (Susan/2/172 -177/6f).*

*teaching my peers was one of my fears . . fear is probably a strong word to use .but . . . I would happily teach mothers but I was not so keen on teaching my peers . but it is now I have gained an enormous amount of confidence in it . . and I really enjoy it . I really*

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<sup>38</sup> The English National Board (ENB) pre-dated the Nursing and Midwifery Council (NMC) and was an awarding body for post-qualification courses.

*do . . . I think it is because I have been gaining experience over the years (Linda/2/278 – 284)*

While the participants' narratives illustrated their anxieties about learning to teach, their personal motivation to share their breastfeeding knowledge with others drove them on to educate other health professionals.

*If you have a skill that you can share with other people then teaching is the way to go about it (Denise/2/108 -110).*

In teaching other health professionals, some of the participants realised that their understanding of breastfeeding practice had also deepened. The accounts by the participants of learning to teach drew me back to a personal reflection at the beginning of my Masters dissertation, which appeared appropriate for the participants in this study as well.

*It had been a wonderful evening; a relaxing time with colleagues who were also IBCLCs. An unwritten rule was not to discuss any issues around our work but as most of us felt we "lived" the role it was difficult not to be tempted. The conversation started innocently enough when I described my reactions and reflections on reading the phrase "if you would thoroughly know anything, teach it to others" (Edwards 1959, p.32). I was just beginning to fully understand what it meant as my role as clinical educator developed. A ripple of interest stirred in the group, which soon rose to an animated discussion on the interaction between practice and teaching and gaining from both. This simple phrase had meaning for us (Brown 2002).*

The link between becoming an IBCLC and sharing knowledge about human lactation and breastfeeding practice was a natural progression in professional development. Belenky et al. (1997, p.134) described how most of the women in their study reached a level of constructed knowledge when they "jumped outside," the frames and systems that authority provided and found their own way to share what they knew with others. The participants reflected a similar outcome.

To enable their professional development, participants articulated the need for support to enhance their teaching skills and the freedom to

choose how they would obtain such educational support. Five of the participants, who worked in the NHS, described a service expectation that they would teach. They had received organisational funding to undertake their IBCLC qualification but not any accompanying support for learning to teach.

Although all the participants in my study had little preparation in education, the challenge of learning to teach provided a way for the practitioners to step away from day-to-day practice and develop skills that enabled them to provide a different perspective on breastfeeding practice. They recognised that they had the necessary knowledge base on breastfeeding practice and human lactation but questioned their ability to teach.

*I think there is very little preparation ( . . . ) I think having the confidence to stand up . is really part of that . . and again . it's trial and error . . in the early days (Ann/2/211 -229)*

*The teaching preparation we had there was nil . . we made it up as we went along . . and what worked we kept in and what didn't work we tended to lose . I haven't really had any kind of formal training (Gail/2/331 – 342).*

*I quite like teaching so I sort of go out and find out different things people have done and then go to other peoples' workshops and steal other's ideas (Ruth/2/210 -212).*

There are frameworks and strategies within the NHS, which staff can access to support them in their personal development to matching the service needs (DOH 2004a and c; Renfrew et al. 2006). One participant, though, described her lack of success in gaining such management support for her developing interest in education.

*but I did ask . . two years ago . . to go on the postgraduate teaching certificate course and my immediate boss said yes . . but my . . next boss up said no it wasn't appropriate . . and I just found that really . . well why is it not appropriate? . . I spend . probably . . a third of my role now in teaching (Jane/2/333 -339).*

Jane's account illustrates how decisions can vary within the different layers of any hierarchical organisation but what was concerning was a lack of explanation of the rationale for the change. The managerial response, from Jane's perspective, almost disregards the service and her needs to meet a growing demand for practitioner-based education in stating such a development is inappropriate.

Research that describes the experiences of practitioner-based health professionals teaching other practitioners away from an academic setting was difficult to find. MacDougall and Drummond (2005) used semi-structured interviews with ten experienced doctors who taught other, more junior, medical practitioners. The research found that the doctors had undertaken very little formal learning on educational theory, which led to them teaching as they had been taught. The outcome was that the majority did not like lecturing and felt more comfortable in clinical teaching. The doctors, though, did reflect my previous description by Edwards (1959) when the researchers found that, as the doctor's teaching developed, so did their articulation of clinical knowledge (MacDougall and Drummond 2005).

The participants described a range of teaching styles they used in their classroom teaching, which might have reflected how they were taught or as Ruth had done, observed in other workshops they had attended. When the participants talked about their teaching, they illustrated that a great deal of thought and preparation had gone into ensuring that they held the attention of the attending health professionals and that the session was informative.

*I have collected together a whole load of photographs . . . of mums and babies . . . with different problems and you've got to look at the picture and say . . . what do you think . . . what kind of problem is this . . . going to cause . . . is it going to cause a problem . . . and sometime it's . . . just simple things (Jane/2/284 – 296).*

Jane also combined stories and pictures from her practice to illustrate how women's breastfeeding needs were met.

*I had a mum recently who was using a supplementer<sup>39</sup> and . . . she'd stopped breastfeeding . . . and then she wanted to restart . . . and I asked if I could take some photographs . . . oh she said as long as you don't take my face and she signed the consent form . . . and I had some fabulous photographs . . . . really lovely . . . I took them over the top . . . coming onto the breast . . . and then through the feed . . . and then she flicked the tube out of his mouth and he was just suckling without it . . . and nobody told her to do it . . . she just did it . . . instinctive . . . and then he was asleep (both laugh). He was a local baby . . . so they (health professionals) know it's happening here . . . on our own patch (Jane/2/300 – 315)*

The joint laughter Jane and I shared indicated our understanding of how women can act instinctively when focused on the needs of their baby. The laughter also celebrated the power of the story and pictures in enabling other health professionals to reflect on practice when such resources are shared with them (van der Hulst and vanTeijlingen 2001; Leamon et al. 2009). Jane was bringing the aspect, previously described in a clinical setting within this study, of “seeing-that” into an educational setting (Soltis 1966; Berger 1972; Kvernberkk 2000; Jacob and Jeannerod 2003). In choosing this approach, Jane was stepping back from a situation she had encountered in practice, opening up a dialogue with other practitioners and exposing them to concepts of practice and reflections that illustrated her professional practice.

Entwistle (2000) observed that teachers often select and interpret what they are going to teach, based on their experiences and understanding of a subject. Jane reflected a similar approach as she wanted other health professionals to understand breastfeeding, not only from a professional viewpoint but from the perspective of what it meant for women who sometimes struggled to feed their baby. Freire (1996, p.75) described such educators as “humanist” and “authentic,” as the objective in

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<sup>39</sup> A supplementer is a container which holds either expressed breast milk or artificial milk which the mother wears level with her breasts. A tube exits the container to either breast so that when the baby attaches at the breast they can access milk. A supplementer meets the nutritional needs of the baby while keeping the baby at the breast.

undertaking such teaching was to transform the understanding of those present. By teaching in this way there was also a greater possibility of holding health professionals attention to enable them to reflect of their practice (Rolfe 1996; Fry et al. 1999; Entwistle 2000).

In a similar approach, where change was needed in the way a company functioned, managers used stories to develop work-based adjustments to the way they worked (Cortese 2005). Cortese (2005) found that each person identified with and felt that they were contributing towards a common goal by opening up through stories, accounts of what was possible within the workplace. Consequently resistance to change was reduced (Cortese 2005). In undertaking a similar approach Jane and three other participants, who described using storied accounts in their teaching, might also have been preparing the health professionals for the changes needed in practice.

#### **6.5.1. Education or training: A confusion in descriptions.**

Eleven of the participants referred to teaching as training. In retrospect I wish I had clarified their understanding and use of the word within the context of their accounts. The use of the word might have related to the UNICEF/UK BFI framework that refers to all of its teaching activities as training, where it might be an appropriate descriptor in meeting the initiative's objectives of providing off-the-job teaching to enable on-the-job application of knowledge and skills. The teaching illustrated by the IBCLCs, however, was more in line with facilitated learning, which attempts to bridge the practice theory divide (Rolfe 1996; Fry et al. 1999).

When I applied the Latin roots for education, '*educare*,' to bring up and '*educere*,' to lead (Oxford University Dictionary 2011), I found that all the participants reflected both aspects in the way they described their teaching. The participants evoked the science-based research that informs human lactation and breastfeeding but also the empathetic experiential understanding that stimulates caring and intuitive practice that is necessary in any professional practice (Kolb 1984; Knowles 1990; Bernstein 1982).

*Just open your eyes and look at this with fresh eyes and look at this (Jane/1/670 -672).*

### **6.5.2. Facilitating learning to support the Baby Friendly Initiative**

Ten participants were involved in teaching other health professionals to meet the requirements of Step Two<sup>40</sup> of the UNICEF/UK BFI (2011b). In the UK, UNICEF provides training courses for health professionals. There are, however, financial implications for health services in purchasing staff training and the participants were nominated to attend the nationally run courses and to cascade the information down to the rest of the staff.

Nine of the participants had attended the UNICEF/UK BFI three-day breastfeeding management course, which covered the basic principles of breastfeeding practice. Seven had attended the three-day, “Train the Trainers” course, which enabled them to teach other health professionals (UNICEF/UK BFI 2011b) and one participant was waiting to attend. All health professionals have to attend the basic management course before that can attend any other BFI courses, regardless of any other qualification. One participant had not attended any of the BFI courses but nevertheless was involved in service-based training sessions related to the initiative. Ten participants, apart from undertaking the teaching for the BFI, were also involved in auditing clinical practice to identify health professional’s learning needs.

*I have quite a bit of influence as to what goes on the course . like at the moment . I did an audit and not many people were teaching women to hand express so we’ve more of a focus on hand expression (Jane/2/182 -185).*

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<sup>40</sup> Step Two of the BFI is to train all healthcare staff in the skills necessary to implement the breastfeeding policy (UNICEF/UK BFI 2011a).

*I am at the moment delivering the three day UNICEF training . but . definitely . I think the course we are delivering is better than the one we were given<sup>41</sup> in terms of attachment and bonding and I think it gives the practitioners the other stuff they need . . in terms of baby wearing (the use of body hugging baby slings) and bed-sharing (Mary/2/581 -591)*

The participants wanted to be involved with the BFI but they realised that informing health professionals about breastfeeding was not enough and that learning that demonstrated change in practice was what was really needed.

*The three day training just raises awareness . . raises people's knowledge . yes they should be doing more but they actually need one-to-one supervision because some people work out there where there are only a few breastfeeding women . so there are issues around confidence (Mary/2/167 -175).*

*The health professionals could reel it out . . . cross the T's and dot the I's and all the rest of it but . . when you actually took them to a woman with a baby and asked them to go through attachment and all the rest of it . it was a very different kettle of fish (Helen/2/ 328 – 336).*

*So most of them have had some really good training . . but they have not had the follow up from that (Linda/2/244 -245)*

When they encountered health professionals who had attended the BFI training, some of the participants found that the learning was not being applied in practice.

*you can train people and you can do . like the UNICEF . because its fantastic because it has . . a set standard . . so you can say to staff . tell me the signs of good attachment . .you know . . tick tick tick tick tick and they will list them for me . and you say show me .*

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<sup>41</sup> Participants on the UNICEF/UK BFI Train the Trainers course are provided with teaching resources (UNICEF/UK BFI 2011b).

*.and they show you . and then next week they'll phone you up and they'll say I've got this lady and the . baby is three weeks old and she's still got sore nipples and I've checked positioning and attachment and its absolutely fine . . .but it isn't fine (Jane/1/665 – 680).*

The four previous accounts reflected that the participants realised that many health professionals had problems integrating what they learnt into practice and the participants realised that any teaching needed to be followed through into the clinical workplace. The apparent lack of change in practice, though, challenged the participants' understanding of the UNICEF/UK BFI framework, where improvements in practice have been recorded without any of the apparent issues they were observing (Martens 2000; Broadfoot et al. 2005).

Globally the BFI has been associated with an increase or at least a stabilisation of breastfeeding rates and improvement in health professionals' knowledge and skills (Prasad and Costello 1995; Cattaneo and Buzzetti 2001; Kramer et al. 2001; Philipp et al. 2001; Alan et al. 2002; Broadfoot et al. 2005; Martens et al. 2005; Caldeira and Goncalves 2007). In a Scottish study the breastfeeding rate increased significantly in five years in hospitals with BFI accreditation (11.39%) compared to non-accredited units (7.97%) (Broadfoot et al. 2005). A UK study demonstrated that teaching breastfeeding skill acquisition to health professionals on a 20-hour WHO and UNICEF breastfeeding management course significantly improved the participants' skills in practice (Moran et al. 2000). Further reading of the UK study, though, showed practice-based skills were not observed but were calculated using the Breastfeeding Support Skills Tool (BeSST), an oral not a practice-based assessment (Moran et al. 2000). As Jane and Helen described in the previous quotations, health professionals were able to articulate the necessary observations but the internalisation of that knowledge and application in a clinical setting might be missing.

*I think we put the practitioners (midwives) on a pedestal because they were deemed to be able to know . whereas the care assistants were not ( . . . ) and we found that the care assistants were just so much better . . because they'd had a practical assessment and faults had been picked up (Helen/1/76 -88).*

The UNICEF/UK BFI (2011a) accreditation process recommends that an experienced practitioner assesses health professionals' as well as ancillary staffs' <sup>42</sup>practice prior to an official audit for the award. If this practice-based assessment is not undertaken, Step Two of the BFI award can still be passed as the assessment is made solely on the recall of a practitioner's knowledge but gaps in a practitioner's practice might still exist.

Several participants recognised that other health professionals viewed the UNICEF/UK BFI framework as a task-oriented, technical, superficially learnt process.

*I think some people come at it (breastfeeding) quite superficially and do not think about it (Ruth/1/254).*

The biomedical model of breastfeeding breaks practice down to its component parts and has for many health professionals been their only experience of learning about breastfeeding practice (Ryan and Grace 2000; Gaskin 2010; Schmied et al. 2011). Schmied et al. (2011), in a study of health professionals' perceptions of implementing the Baby Friendly Health Initiative (BFHI) in Australia, found that many practitioners looked upon the steps in the Initiative as a set of tasks rather than a supportive process. The gap between the two perceptions of practice, Schmied et al. (2011) thought, might reflect why the breastfeeding outcomes were not as good as they could have been, as task-orientated working does not meet women's needs. All of the participants realised that health professionals needed more than a surface approach to learning and understanding of breastfeeding practice and offered a more

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<sup>42</sup> Any member of staff who assists breastfeeding women can be assessed in Step Two of the UNICEF/UK BFI assessment (UNICEF/UK BFI 2100a).

challenging, deeper holistic interpretation of supporting breastfeeding women and their children. Thomson et al. (2011) called for a “hearts and minds” approach when implementing the BFI framework within an English community setting. The approach involved emotional and rational engagement, leadership, engagement of key partners and changing attitudes and practice, all the abilities and aptitudes the participants illustrated in their practice.

*we can do it ourselves as we have paid UNICEF thousands of pounds over the years to come and do it for us and we do not need it anymore . . .we've grown up (Ruth/1/185 -190).*

### **6.5.3. IBCLC involvement in teaching medical staff**

Williams (1995a) suggested that IBCLCs should take the initiative and educate doctors about their role and about breastfeeding. Four participants had taken up the challenge although the outcome reflected Abbott et al.'s (2006) research that very few doctors took advantage of such learning. The four participants undertook the educational sessions to enable medical staff to become congruent with the UNICEF/UK BFI framework and to try to reduce conflicting care and advice provided to breastfeeding women.

*training for the medical team and having run-ins with them about policies . . when they suggested supplements for babies . . . on the wards (Linda/1/43 -45).*

*despite doing the training we are still getting GPs who are telling mums to stop breastfeeding and put the baby on the bottle if the baby fails to gain weight (Jane/1/360 -366).*

The accounts by the participants, illustrated a greater impatience with the doctors than with other health professionals that they had not adjusted their practice when presented with information on breastfeeding. None of the participants described working in clinical practice with doctors. Ruth appeared to adjust her approach in facilitating the sessions and, rather

than informing the doctors, she posed questions about situations that they might encounter in practice.

*It is related to practice . . . you're an A and E doctor<sup>43</sup> and a woman comes in with a broken leg and a breastfeeding baby . . .the issues around separation .medication . baby being admitted to a hospital full of MRSA <sup>44</sup> they have to think about things like that (Ruth/1/629 – 634).*

The approach might have been more pertinent to the doctors needs, as Burt et al. (2006) found that medical practitioners wanted more interaction and sharing of implications of practice in breastfeeding teaching. The persistence of the participants was also illustrated when Jane described how she continued to work at adjusting GPs practice to meet women's needs.

*But you know chip .chip .chip .we're still on with that and if I see a mum with her baby who's failed to gain weight I always write to the GP say what the action plan is and what guidance we have given and what the results were (Jane/1/380 -385).*

#### **6.5.4. Teaching breastfeeding peer supporters**

Six of the participants described how they were involved in local peer support initiatives. A peer-supporter is described as a woman who provides woman-to-woman breastfeeding support, either paid or on a voluntary basis, following some initial training under the auspices of a voluntary lay breastfeeding group or a health professional (NICE 2008; Rossman 2010). The focus of peer work is on support not in providing breastfeeding advice.

*we've got breastfeeding peer support groups as well so we've got 14 peer support groups around the district . so we are training and updating those and they're purely voluntary . .and . . we just set those up within children's centres and they are like local groups for*

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<sup>43</sup> Accident and Emergency Department

<sup>44</sup> Methicillin-resistant *Staphylococcus aureus*

*local mums . . . some work very very well some not so well and it all depends on whether the midwife or the health visitor . . . gives them the respect they deserve and contacts them and goes to see them and keeps the groups going . . . and if they do . . . they are fab but if they don't . . . they sort of drift away (Jane/1/616 -634)*

*we've a great . . . a really good motivated team of well-trained peer supporters ( . . . ) but we are now down to two supporters . out of four training courses . .there are only two left . because . . we haven't got . the structure there (Gail/1/565 -585).*

The National Institute for Health and Clinical Excellence (NICE 2009) commissioning guide for peer support suggests that an experienced person, with relevant qualifications, leads on such local initiatives but as Gail described, often the structure is not there or if it is it has to be fitted around other roles. The one exemption amongst the participants was a practitioner who had a full-time post as an Infant Feeding Advisor and allocated time for peer support work.

Two participants had obtained government urban renewal funding<sup>45</sup> through their local Health Authority, to provide paid peer supporters in their practice area. Jane seized an unexpected opportunity, when her manager was on leave, to attend a breastfeeding strategy meeting and had successfully advocated for funding for a social enterprise business<sup>46</sup> to run the local peer initiative.

*but I know for a fact . . . if she'd been there we wouldn't . it would not even have got on the agenda of the strategy meeting (Jane/1/481 - 492).*

Jane did not explain further why her manager was reluctant to seek the funding, which she successfully obtained. Health professionals were seen

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<sup>45</sup> Social initiatives to improve the physical, social and economic environment between 1997 and 2010 were often funded through urban renewal funds (Thompson 2008). England was the first European country to pursue this initiative, which failed to reach its own target of 10% reduction in inequalities in life expectancy and infant mortality (Machenbach 2009).

<sup>46</sup> There is not one definition of a social enterprise business but the term is usually applied to businesses where a proportion of the profits are invested into social causes (Teesdale 2010).

not as uncaring but as often too busy to provide the breastfeeding support the women wanted.

*but ultimately maybe we need somebody different and it isn't just taking the midwives role away from them but I know it can be perceived as being that . . . in many cases it was the role that they weren't doing anyway (Ruth/1/530 -535).*

The participants described through their accounts how they were open to new ways of supporting breastfeeding women, seeking the necessary funding and facilitating the development of resources.

*We developed a course which trained local (health professionals as) administrators so they could train the local women ( . . . ) and it was quite empowering (for them) . a lot of them said it's like having a light bulb switched on (Denise/1/138 – 145).*

Apart from working differently, the participants described how peer supporters and health professionals should be working towards a common outcome of supporting breastfeeding women. Freire (1996, p.73) considered that “without dialogue there is no communication, and without communication there can be no true education.” An important way of achieving that outcome was seen by one participant as sharing learning between peer supporters and health professionals.

*Any training is joint training between health professionals and peer supporters . and it's gone well . and it's about appreciating the health professional . they are the lead in lots of cases . but you also have to actually respect other people's expertise (Ann/2/158 -163).*

The six participants reflected openness and dialogue as fundamental in their peer support work. Not all the health professionals the participants worked with saw the joint development of breastfeeding practice in quite the same way. Ruth experienced problems from health professionals when the breastfeeding peer supporters started being paid for their work.

*having said that it's . certain of the health professionals have said they are plebs because they haven't got a degree in the health professions . but . one has a degree in sociology and one a qualified art teacher . one of them is a single mother of two who is 21 and lives on a council estate . . fab .(Ruth/1/542 -546).*

Ruth's reply is interesting as the focus of peer support work is very different and enables distinctive relationships with women separate to that provided by health professionals (Williams 1995b). Bourdieu (1993) described lay knowledge often invoked within groups such as peer supporters where their experiences enable them to act according to their social background. By working in this way peer supporters enable other women to breastfeed within their community. Health professionals provide a different framework of support, which Ruth recognised to a degree but might not have fully understood when she described the academic qualification of the peer supporters.

The development of breastfeeding peer-support initiatives is backed by (NICE) guidelines and commissioning documents (NICE 2006, 2008 and 2009), which provided a supportive framework for the participants similar to the UNICEF /UK BFI.

## **6.6. Supporting IBCLCs to teach**

Teaching, for the participants who worked in the NHS, presented a large commitment in time, even if the load could be shared with other IBCLC colleagues.

*We are on Stage Two of the UNICEF Baby Friendly<sup>47</sup> . .so we do all the training<sup>48</sup> and I share it with the Infant Feeding Co-ordinator at the local hospital( . . .) two days every other month . and then we do peer support training as well . . and then I do updates on a rolling programme of six and then we'll have a short break and we start again (Jane/1/306 -320).*

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<sup>47</sup> The UNICEF /UK BFI consists of three stages before reaching full accreditation (UNICEF/UK BFI 2011a).

<sup>48</sup> The use of the descriptors, training and education are discussed in 6.7.

Abbott et al. (2006) found that practitioners' who champion breastfeeding practice are often isolated and unsupported. There are no formal educational forums available for IBCLCs in the UK, although ILCA does provide a dedicated part of its website to education, with some teaching tips and presentations available for practitioners to use. A letter in JHL, from IBCLCs in the USA, suggested that a workshop they had attended, which provided opportunities for educational sharing and support, was something that they found very useful and requested that it be repeated in the future (Brittner et al. 2009). I could not find any follow-up action to this request. Apart from a lack of IBCLC educator-to-educator peer support, there is a dearth of accounts about the teaching experiences of practitioners. There are, though, many articles by practitioners about what they teach (Montgomery 1999; Riordan 2000; Bunick et al. 2006; Howett et al. 2006).

I reflected back to my experiences of teaching and how my understanding of the integration of the art and science of education was not apparent until I became a lecturer practitioner.<sup>49</sup> Other lecturer practitioners have experienced similar issues of being appointed for their clinical skills into teaching roles but only gained the necessary educational skills when they became university employees (Lessing-Turner 1997; Jackson 1999; Evans 2000). The participants spoke of a similar predicament. While they stayed in clinical practice, the developmental framework that could enable them to be supported and progress in learning to teach was apparently missing.

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<sup>49</sup> Hollingsworth (1997) statement to the NHS Executive defined a Lecturer Practitioner as an employee who is accountable to the Trust for service provision and to a university for education provision.

## 6.7. Managing change in breastfeeding practice

When I first became an Infant Feeding Advisor I anticipated that the major changes in breastfeeding practice could be integrated into how we worked within a few years. Fifteen years later I am still waiting for many of the changes to be fully adopted into practice. Sadly, managing change within the clinical environment is difficult. Often practitioners develop routines and practices, which keep physical and mental demands at a reasonable level where they feel they can cope. The coping mechanism limits how health professionals open themselves up to learning or developing further in practice, which adds to my frustration in seeing only gradual changes in how we work.

(Personal narrative of becoming and being an IBCLC, February 2007).

Managing change in practice was part of the role for all the participants. There were differences between the participants who worked in the voluntary sector, in private practice and in the NHS. The participants who worked in the NHS had mixed experiences of managing change and were exposed to levels of greater frustration at not being able to achieve what they felt was relevant and needed in breastfeeding practice. The participants who worked in the voluntary sector or private practice were less constrained but were limited in what they undertook by the time and level of commitment they could provide to support the change.

*I think one of the differences actually with . my work in (private practice) and my work . in the NHS is I have much more long term contact with people in private practice ( . . . ) actually within the toddler group I have noticed a real change in culture that's taken place . . because . . when I first went along I found . . it was very much a bottle-feeding culture there were very few people who would be seen to be breastfeeding there . and I have to admit I had to question why I was going . . but I would go and just chat to people then who had a young baby . or when I could tell they had a bump and they were pregnant and talk about things . and then the local (named health professionals) cottoned on to the fact that I was there . and we started to get quite a queue on occasions . . . . .*

*and now . . . they've recently trained their own peer supporters  
(Linda/1/138 -160)*

This account, I consider, illustrates a very potent example of managing change, where the participant almost dared not anticipate the transformation she observed in practice. Moss-Kanter (1983, p. 279) described “architects of change” who are involved in the construction, or reconstruction, of actions to make new patterns of work possible. Apart from Linda, Carol had also observed changes in the way other health professionals worked.

*and some of the practitioners I've been working with for the last .  
three or four years are brilliant now and they kind of ring me less  
and less (Carol/1/433 – 438).*

Not all the narratives illustrated incremental developments in changes in practice. Gail observed how quickly practice reverted to previous ways of working in her NHS area when a key IBCLC left her role and before she, was appointed to the vacated post.

*it just seemed like my predecessor had never been there (Gail/1/60  
-65).*

Working in change management requires a constant and relentless driving enthusiasm, which can be difficult to maintain if progress is blocked or very slow (Moss-Kanter 1983). The following narrative with Susan is included as it so closely reflected other participants' experiences in developing practice within the NHS.

*Interviewer (I): Yes . . . any change . . . you've just woken up and you  
thought . . . that would be a good something to do [both laugh].*

*Susan (S): I used to wake up with a lot of those thoughts . . . I used  
to get a lot of those thoughts . . . they've been suppressed over the  
years . . .*

*(I): So why might they have been suppressed?*

*(S): I think that is to do with . the organisation ( . . . ) it's much more difficult . . . working in the health service now . . . everything . has to go through . . committees now . and those . committees might consist of people who don't know anything about . . what you are trying to change ( . . . ) so it's all very . . red tape now . . . you can't do anything very easily now . . and in some respects . it's a good thing . as we want it to be right . but it takes so long . . . these days . . and sometimes you just pull out half way through as you just don't have the time . . . and things get left (Susan/2/65 -110/140).*

Susan was not the only one to describe the amount of time needed for organisational ratification of changes in the NHS, which appeared to be measured in months and years rather than days.

*each Trust . . has their own systems of doing things . . . which makes it really quite laborious . . . we are in the process of looking at a Breastfeeding Policy for the county ( . . . ) for the hospitals and for . the city . . . . and now . . . we've actually written the core we know it has to go through all the different processes in each Trust (Linda/2/35 – 42).*

Maintaining the motivation for change illustrated a high level of commitment and persistence from the participants. Peter Drucker (1999) considered a complete change within any organisation could never be managed but that alterations in the way it functioned might be made. To enable such movement, the forces for the alteration in practice, though, must be greater than those resisting the change, as practice has to move away from maintaining the status quo (Lewin 1951). If the forces remain even or against the change then allies need to be sought that alter the balance in favour of adjustments in practice (Lewin 1951).

The process initially appears quite simple but any adjustments challenge health professionals' understanding of the practice and their attitude and perception of the necessity for change (Price 2006; Schmied et al. 2011). Linda and Carol, at the commencement of this section, described their observations of changes in practice but each mentioned how change had

occurred over a long time. Their persistence in role modelling and challenging others to work differently enabled health professionals to become allies for practice change, which maintained the adjustment. Gail's experience was different in that the health professionals had not internalised the change when the previous IBCLC left her post, so practice quickly reverted to the prior status quo (Huczynski and Buchanan 1991). The adoption of national initiatives, such as the UNICEF/UK BFI and peer initiative programmes (Demott et al. 2006; NICE 2001; NICE 2008), provided opportunities for the participants to gain management support and to push against the status quo in breastfeeding practice.

A very early study, albeit on repetitive factory-based work, found that performance was improved and changes were possible when someone took an interest in what the workers were doing (Vernon et al. 1924). The participants illustrated a similar interest in what occurred in the clinical workplace. While Vernon et al.'s (1924) research took place in a factory there are descriptions of some maternity units being described as units of production (Hunt and Symonds 1995; Dykes 2006a; Deery et al. 2010). When practice environments relate to production, rather than focused on what women need, a myopia in practice can develop (Prosser 2010, p82). Practitioners who can see practice differently are needed in such circumstances. The participants were interested in how other health professional's worked and wanted them to view their practice from a different perspective. The participant's presence in practice enabled them to champion the needs of the breastfeeding dyad and when possible challenge practitioners to reflect and reconsider their practice.

*I think it is to do with the system and the organisation that we are in and . . . pressure and . . .there's just no time to stand back and see and review and prioritise . . .you're always . . . fire fighting (Susan/1/884 -888).*

*time doesn't afford you that luxury when you're working clinically (Carol/1/342 -344).*

*The hospital it's a baby factory . . . and the postnatal wards are . . . just . . . awash with mums and babies and . . . very few people to help them . . . so . . . the support there is very poor (Kate/1/351 – 354).*

Kirkham (2010) described an industrial model of maternity service being developed in the UK with the introduction of market values and articulated economies of scale. The risk for breastfeeding women might be that in such circumstances woman-centred care becomes submerged in an input/output model of production (Dykes 2006a; Kirkham 2010). If staff become isolated, uninformed and undervalued in trying to meet the set outcomes of the unit, then the humanness of a practice that meets women's needs is also lost (Huczynski and Buchanan 1991; Handy 1993; Iles and Cranfield 2004).

McKinlay (1979), when describing a lack of health promotion that relate to individual needs, wrote about inabilities in very busy work situation to focus upstream. The outcome of not looking upstream is that practitioners only focus on rescuing the people who are drowning and so become exhausted in the process. At the beginning of the chapter I described my initial role as feeling like Hans Brinke (6.2.) holding back the floodwaters of poor breastfeeding practice. It was not until I undertook a module in my first degree in managing change that I had the time and developed the skills to understand where my focus in practice should be which often involved looking upstream and responding to the practice needs identified there. The lack of time all of the participants who worked in the health service described might affect the ability of practitioners to look beyond the immediacy of their present role.

I would describe all the participants as practice leaders in the clinical workplace. They wanted to serve breastfeeding women through enabling professional practice that they shared with other health professionals (Greenleaf and Spears 2002; Prosser 2010). Greenleaf and Spears (2002) described such leaders who protect and develop particular areas of practice, as servant leaders. The development of this idea follows on from the description of the participants working as professional servants (Cronk

2010). Greenleaf's (1977, p.22) concept of the servant leader is, "a servant first. It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead."

Greenleaf (1977) was very explicit in his description of a servant leader as a professional practitioner who did not actively seek power through leadership but developed the ability to lead through their expertise in practice. The descriptor of servant leader illustrated a lack of managerial power attached to the role, but the ability to lead, inspire others and change practice through the recognition by people of their levels of expertise in practice. A practitioner, according to Greenleaf (1977), who sought leadership first had different priorities in seeking power and acquiring the status of leader. The description of servant leader described the way all but one of the participants worked. The exception was the participant who had sought a senior management position to enable change through her position.

The participants who worked as servant leaders had to adopt a different approach to managing change than someone with the powers invested through organisational management would adopt. The approaches were exemplified by the participants role modeling the necessary changes and providing clinical support and education for other health professionals. Pollitt (1993) and Dawson (1999) suggested that the complexities of a professional role have in the past produced many of the leaders that have advanced healthcare but for the participants it was not an easy task. The NHS has produced an Internet resource about managing change but none of the participants described using it or accessing any other learning on the topic to enable their personal development (Iles and Sutherland 2004). While the NHS describes managing change as an essential element of developing clinical practice (DOH 2004c), the participants found that enabling such development, while working in clinical practice, required a particular commitment and persistence. The outcome was that some participants narrated high levels of frustration when the supportive framework for such changes was missing.

The IBCLC curriculum does not provide any tools or identify any frameworks for change management that could help prepare a practitioner when working in stressful conditions (Cadwell 2002). Asking a practitioner to work with little understanding of managing change could place the IBCLC at risk of experiencing disappointment, stress and reluctance to develop breastfeeding practice further. While Glasberg et al. (2007) and Jackson et al. (2008) found that some practitioners had resilience for thriving and surviving in such stressful circumstances the risk should not be taken unless totally unavoidable.

## **6.8. Conclusion to the chapter**

The increased visibility of the participants in the workplace was a mixed blessing. Some health professionals sought the participants out to question them further on lactation and practice, while others referred breastfeeding women on, suggesting that the mother and baby required specialist support. The participants observed, through such referrals, that there were gaps in many health professionals' understanding of practice, as well as a lack of confidence in managing successful breastfeeding outcomes. Through acting as role models and articulating their professional breastfeeding practice, the participants attempted to draw other health professionals into developing their own practice. The participants recognised that not all health professionals were ready to change but by sharing with them the emotional context of seeing the interconnectedness of the mother and baby, the IBCLCs anticipated that practitioners might begin to view breastfeeding differently.

All the participants were involved in teaching professional breastfeeding practice. None of the participants felt fully prepared to facilitate learning for other health professionals, as the IBCLC curriculum had only touched on the topic of education. While the participants' narratives illustrated their anxieties about learning to teach, their personal motivation to share their breastfeeding knowledge with others drove them on to educate other health professionals. The participants described the process of learning to teach as developed through trial and error. The challenge of developing

as a teacher, though, provided the participants with an opportunity to step away from day-to-day practice and develop skills that enabled them to offer a different perspective on breastfeeding practice. The link between becoming an IBCLC and sharing knowledge about professional practice appeared to be a natural progression in an IBCLC's development.

Through bringing aspects of clinical work into the learning environment, the participants used stories of what was possible in practice. Consequently resistance to change was reduced. The participants who worked in the NHS, though, had mixed experiences of managing change and were exposed to levels of greater frustration than practitioners who worked in the voluntary sector or in private practice. The IBCLC qualification had not provided the participants with any preparation in change management but they soon learnt that articulating practice development through the BFI framework enabled them to gain some management support. Working to develop breastfeeding practice within the NHS, though, often exposed participants to stressful situations.

By working between management structures that often wanted constant change, and health practitioners who often resisted any proposed developments, the participants performed a role of stewardship in protecting and developing breastfeeding practice, which exemplified the role of servant leader. The participants illustrated the range of working as servant leader that Greenleaf (1977) originally described. Some participants were rather reluctant to describe themselves as leaders or felt they had had the role thrust upon them through the demands of the service, while others developed a natural leadership stance in developing changes in breastfeeding practice.

Lack of research and accounts by other IBCLCs might have previously hampered understanding of the experiences of practitioners in practice. This study, though, found that the participants needed greater understanding about education and managing change practice. While all the participants demonstrated high levels of resilience for thriving and surviving stressful situations particular aspects of teaching and managing

change could have been avoided if the IBCLCs had been better prepared. The participants did not lack determination in their goal to improve professional support for breastfeeding practice but their persistence was linked to trial and error and learning while in practice rather than preparation prior to becoming an IBCLC. Now a descriptive understanding has been gained of the experiences of the participants further research and practice development can be undertaken.

## **Chapter Seven: Maintaining a balance within professional practice**

*A dynamic balance between doing and being is central to healthy living and wellness, and how becoming whatever as a person is dependent on both (Wilcock 2002, p.9).*

### **7.1. Introduction**

The participants described trying to maintain a balance between their professional and other life interests as well as within their role. The emotional pull of practice was difficult for the participants to ignore. Kirkham (2010, p.258) described how practitioners need to learn to “balance engagement and detachment” for their own emotional well-being but at times this appeared impossible for the participants to achieve.

The participants described their professional practice within a paradigm that often reflected differences from other health professionals approaches and clashed at times with the target-driven outcomes of the NHS. The participants who worked in the NHS often spoke of encountering and navigating their way through either levels of indifference about breastfeeding or a tendency by others to observe practice as a task-orientated outcome. Challenging such indifference and approach required a high level of commitment to articulate a breastfeeding practice that met breastfeeding women’s needs and enabled a balanced woman-centred care.

While all the participants narrated accounts of how becoming an IBCLC made a difference to how they practiced, maintaining a balance in their day-to-day professional life was easier if they only worked in private-practice or as a volunteer.

### **7.2. Staying in a meaningful professional breastfeeding practice.**

Working in practice with breastfeeding women was a central need for all the participants. Even the participant who was employed as a senior

manager allocated time to meet breastfeeding women. One participant, Susan, described how practice rewarded her with a personal “buzz” of satisfaction. My interpretation of a “buzz” within the context of the narrated account was linked to receiving positive feedback, pleasure and satisfaction from a job well done.

*because that's where I feel most satisfied, you get a buzz, when you've helped a mother (Susan/1/540 -543).*

Finding fulfilment by working with breastfeeding women was a strong motivator for all the participants. In some participants' accounts, such feedback appeared as the only recognition the practitioner received in their role.

*that's what makes me passionate . . . I think feeding from my first hand experience is (knowing) what impacts on successful breastfeeding (Ruth/1/437 – 440).*

*the thing is . they do say . that if you are passionate about something you will do it . . . that is how I feel about breastfeeding . and that's why I just love it . because I will do it no matter what (Linda/1/568 -575).*

An ability to provide woman-centred practice provided the necessary feedback the participants needed on their practice (Titchen and Higgs 2001; Benner et al. 2009).

### **7.2.1. Illustrating a sensitive practice**

During the interview the participant could choose to include accounts from practice if they wanted to. Half of the participants shared at least one account of their experiences, which were narrated quite spontaneously during the interview.

*I don't remember if I told you before . . . of one lady . . . oh and she's just had the most awful delivery . . . and she could only feed lying on one side . so it was fine when she was lying down . that was no problem . but she couldn't lie on the other side to use the other*

*breast . . so I went in . . this baby was slung over her shoulder . and I thought . I don't believe this . . but then you look at the baby . . and the baby is putting on weight . . it's doing everything it should be . you look at its mouth action . you look at the way it's behaving and you think . . don't interfere . . because I think . . often we are a little bit rigid . . the baby has to be so . but then you look at biological nursing<sup>50</sup> and you think . it doesn't have to be like that . . and it's a question of them both being comfortable (Helen/2/292 – 310).*

The narrative illustrates a high level of sensitivity by the participant towards the needs of the mother and baby. Helen described, with deep observational powers on the dyad, how she integrated known research and clinical practice into her care. An initial reflection on the account drew my thoughts to the “awful” delivery and the feeding position of the baby, which could illustrate some birth trauma in the infant (Smith 2008). My observation, though, only reflected part of an entire picture, where Helen realised that comfort through breastfeeding might be healing after such a birth experience and not to interfere.

The development of practice knowledge within the account is different to a traditional academic approach, where propositional knowledge is used (Higgs et al 2001). Titchen and Higgs (2001, p.215) presented practice knowledge as “a phenomenon, which is multifaceted, living, changeable, evolving and constructed.” Practice knowledge within Helen’s account reflected Higgs and Andresen’s (2001) description of weaving of propositional knowledge, professional craft knowledge and personal knowledge into a personal professional framework or tapestry. Ann reflected her focus within her professional framework was very different to most NHS care when she described how she supported other health professionals to become IBCLCs.

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<sup>50</sup> Biological nursing, was named by Colson et al. (2008) who observed babies adjusting to their own way of attaching and feeding from the breast if supported appropriately.

*I always feel that I need to say to them whatever you've learnt . . . just throw it out of the window 'cause it's probably not going to be helpful and . . . we view things quite differently . . . and the way we support women . . . is quite different to the routine NHS care (Ann/1/269 – 293).*

The descriptors of how the participants' worked reflected a practice paradigm centred on the needs of the breastfeeding woman and child, which often conflicted with the way large organisations, such as the NHS, work (Deery et al. 2010). The way the participants' work should be core to any caring organisation but the essence of such practice appears often to have been lost (Kirkham 1997; Dykes 2006a; Deery et al 2010; Schmied et al. 2011). A similar dichotomy has been ascribed to midwifery care, where the service is articulated as woman-centred but where there are noticeable differences between the ways practitioners work within different practice areas (Shallow 2003; Deery et al. 2010; Devan et al. 2010). Deery et al. (2010, p. 26) found that many midwives were attracted to working in smaller non-medical units or in specialist roles because they could create a "niche" for themselves and work instinctively in the way they needed to. Walsh (2007) described a "niche" midwifery practitioner as one based on Friere's (1996) concept of praxis, where the practitioner wanted other health professionals to adopt their approach to practice. Ann's account reflected aspects of both the descriptors. The term "niche practice" was adopted as a descriptor, to illustrate an IBCLC who instinctively sought a role that provided the freedom and autonomy to practice in a woman-centred holistic way that influenced other health professionals to adopt similar practices. Walsh (2007) and Deery et al.'s (2010) research into how some midwives wanted to practice did not only illustrate how the participants in my study wanted to work but also identified how limited the opportunities to gain such niche working are. Perhaps it is time the NHS reconsidered the worth of these practitioners and how the health service can retain and support them, as they acted as role-models, educators and change agents within the clinical workplace.

The participants' accounts of seeking a role is easier to understand when the descriptor of finding a niche is used. Business models demonstrate that placing a person in the wrong job causes high levels of stress and often chronic illness, so the participants' persistence was important for their personal welfare (McCrae and Costa 1989; Benziger 1996). Benziger's (1996) work, built on Carl Jung's (1933) work on four areas of brain function, identified workers who worked outside their dominant area of practice, became exhausted through constantly trying to re-adjust the way they worked. The participants were trying to avoid too much friction in their lives by seeking a role that could enable them to maintain a balance within their practice.

### **7.2.2. Exploring an empathic understanding of right-brain learning**

I felt very drawn to narratives of breastfeeding practice as, although now retired from clinical work, the accounts returned me to working with women and their infants. Within my appreciation of the context of breastfeeding practice is an understanding of a relationship between the mother and infant, which reflects Winnicott's (1987, p.64) description, "there is no such thing as a baby. A baby cannot exist alone, but is essentially part of a relationship."

Since Winnicott's (1987) work, there is a better understanding of the inter-relationship between the mother and baby, where women learn to trust their own instinctive actions in meeting their baby's expressed needs (Klaus et al. 1995; Odent 2002; Bergman 2003; Bergman et al. 2004). The participants' narratives revealed a similar understanding which reflected the IBCLCs practice framework based on WHO and UNICEF (2003) statement that the mother and baby are an inseparable biological and social unit (WHO and UNICEF 2003). The framework not only invites women to return to a more instinctive response in becoming a mother but challenges health professionals to adopt practices to reflect a sensitivity and an understanding of the process.

Anderson (2010) described how women in the second stage of labour respond and react in an instinctive way if they feel they can trust those

around them and feel confident in the ability of practitioners to understand and support them in an appropriate way. A similar framework appears relevant to enable breastfeeding where women need to maintain or return to a state of primary preoccupation to fully understand their infant's needs (Winnicott 1987). While there were accounts within the study of how the IBCLCs worked with women as professional servants there were also observations by the participants that they felt they worked differently to many other health professionals. In trying to understand how the participants worked I remembered descriptions by other IBCLCs that practitioners either used or needed to develop a way of practice that met a woman's need for right-sided learning when breastfeeding their baby<sup>51</sup> (Lauwers and Swisher 2005; Mohrbacher and Kendall-Tackett 2005; Watson-Genna 2008; Riordan and Wamburg 2010). My initial understanding from reading such statements was that the participants might have adopted similar empathetic practices to meet the needs of breastfeeding women without realising that their approach was different to other health professionals. The difference was only observed by the participants when they began to work alongside health professionals and tried to enable other practitioner's breastfeeding practice.

Lauwers and Swisher (2011) has suggested that practitioners who work with breastfeeding women bring a balanced approach which favours neither right or left-sided learning to their practice. Other IBCLCs have suggested that they use a right-sided approach but in each case the rationale for such statements is not referenced or linked to any research (Dickens 2010).

The examination of how women adapt to their infant's needs may appear to step aside from the social constructionist framework of the study but McGilchrist (2009) has described an apparent shift and dominance of left-

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<sup>51</sup> The term right-sided learning is used to describe an approach that appeals to an emotional, non-verbal emphasis an understanding is drawn through observation of the dyad and not on breastfeeding. Left-sided learning describes a task-orientated focus on breastfeeding with little reference to the relationship. In both cases learning occurs but within these simplified descriptors the suitability of frameworks are considered in relationship to supporting the mother in the most appropriate way.

hemispheric learning in Western society which might conflict with the needs of the individual such as those of breastfeeding women. Ornstein (1977) has suggested that the Western emphasis on language and logical thought has meant that there has been a move away from a balanced approach to learning to a greater weight given to left-sided education. The outcome is that left-sided dominance is well exercised within large organisations such as the NHS with the result that the holistic, emotional adjustment that women need to become mothers is often not met because of an emphasis on “scientific materialism” (McGilchrist 2009, p.82). Oakley (2007) described how, as human beings, our whole bodies are organically asymmetrical but usually little notice is taken of the difference until the harmony is disturbed. The balance is altered and adjustments are necessary with the birth of a baby when hormonal priming changes the harmony within women to enable an adjustment to motherhood (Kennell and McGrath 2001; Uväs Moberg 2003; Winberg 1995 and 2005; Prime et al. 2007). The way the NHS and most health practitioners practice therefore might be out of kilter with the needs of breastfeeding women and explaining the experiences of IBCLCs through a lens of how they adjust their practice to meet the needs of breastfeeding women therefore appears relevant to the study.

Hormonal priming, mainly based on the action of oxytocin and prolactin, has been linked to a right-sided dominance in the postpartum period to enable women to focus on the needs of her breastfeeding baby (Nissen et al. 1998; Czank et al. 2007; Prime et al. 2007). Both hormones are initially released at high levels in all women who give birth but in breastfeeding women, prolactin levels slowly reduce to just above pre-pregnancy levels by about eight to ten weeks post-partum, while pulses of oxytocin are always released as long as women breastfeed (Czank et al. 2007; Prime et al. 2007).

Oxytocin has been described as having a dual mechanism of action, one via the circulation, which causes the breast milk ejection reflex and the other as a neurotransmitter, which is stimulated by the baby through

physical touch (Winberg 1995; Nissen et al. 1998; Uväs Moberg 2003; Bergman et al. 2004; Winberg 2005; Prime et al. 2007; Gordon et al. 2010). Biological human studies have found that oxytocin is released directly into the brain structures, where it has been observed to modulate human social cognition (Uväs-Moberg 2003; Feldman et al. 2007; Prime et al. 2007). The participants made use of this understanding of oxytocin release by encouraging skin-to-skin contact and baby massage when the baby was not breastfeeding. In animal studies, oxytocin has been found to have a positive effect on social memory and in priming the neural pathways, which command innate behaviours in both the mother and baby (Winberg 1995; Uväs-Moberg 2003; Feldman et al. 2007; Prime et al. 2007). Feldman et al. (2007) evidenced levels of oxytocin in pregnancy and the post-partum period as predictors of infant-mother bonding. The precise way oxytocin works in birthing and breastfeeding women is poorly understood but it is known to play a role in stimulating the amygdala of the brain, which is the centre for non-verbal communications and interaction and is essential in the process of women understanding their baby's expressed needs (Kirsch et al. 2005; McGilchrist 2009).

The level of circulating prolactin is interdependent of levels of dopamine (Czank et al. 2007). Nipple stimulation during breastfeeding stimulates the hypothalamus to inhibit the release of dopamine and increase the level of prolactin (Chao 1987). Neurochemically, the left hemisphere of the brain is described as more sensitive to dopamine levels than the right hemisphere so that the higher levels of prolactin in breastfeeding women illustrates an enhancement of right-sided dominance (Chao 1987; McGilchrist 2009).

Kim et al. (2011) reported in a small research study, with 17 post-natal women who were either breastfeeding (n=9) or bottle-feeding with artificial milk (n=8) that breastfeeding mothers demonstrated a greater sensitivity and empathy to their baby's needs. At 2-4 weeks Magnetic Resonance Imaging (MRI) scanning was used to investigate maternal brain activation in response to the mother's own baby's cry versus a control baby-cry. At 3-4 months mother and baby interactions were also videotaped in their

own home. The MRI scans showed that the right superior frontal gyrus and right lateral amygdala of breastfeeding women demonstrated greater activity when stimulated by their baby's cry. The degree of brain sensitivity was related to any breastfeeding taking place and not to exclusivity (Kim et al. 2011). The researchers did not further explain the findings, except to speculate that hormonal priming might have had an effect on such maternal responses.

My understanding of hormonal priming presented some persuasive evidence that breastfeeding women are more receptive to a right-sided approach from practitioners in learning how to breastfeed. The right hemisphere of the brain is described as having a breadth and flexibility of attention that helps us as humans to bring emotion and empathy to our understanding of others which appears appropriate when learning to nurture a baby (Springer and Deutsch 2003; McGilchrist 2009). Winberg (1995) argued that maternal care of a baby through neural and hormonal control showed a remarkable stability as long as the harmony of the interaction was not interrupted. If Winberg's (1995) understanding is correct then a practitioner's sensitivity to the particular needs of the mother and baby appears essential with such a fragile interaction.

Linda's account illustrated how she enabled the mother to understand her baby's needs.

*I went to see a mum . . . a couple of week ago . . . and when I pointed out to her that her baby was rooting at the fist . . . and that was one of the early signs of being interested in feeding, she said "Oh I just thought that was a sign that my baby was just . . . alert and interested . . . and I would probably be using a dummy at that point rather than offering the breast again" . . . that baby was slow to gain weight (Linda/1/228 – 237).*

Describing our actions and practice in terms of right or left-sided brain dominance could be seen to be reductionist if just explained through brain function alone. The link between hemispheric dominance and a temporary change in hormonal activity, which enables women to breastfeed their

baby, appears, to make sense and returns feeding to an understanding of our mammalian roots. The participants appeared to understand the context of supporting breastfeeding through such right-sided adjustment, which might have improved the outcome in the following narrative.

*One (case) in particular that comes to mind which brings me great pleasure is a girl who was on anti-psychotic drugs and had to pump and dump basically for three months and we got her through that . . . (laughs) . . . by just really . . . I suppose the biggest thing was keeping her motivated and keeping her positive about the fact that this baby was going to go back on the breast afterwards . . . which she did . . . a dream you know and you just think wow what we were doing . . . skin-to-skin . . . we were doing co-bathing . . . you know we were doing so much to keep that baby near the breast without actually being on the breast for that time . . . so actually seeing that work was (an) enormous satisfaction . . . (laughs) . . . if it hadn't worked then we would probably have revisited it in another way (Gail/1/285 – 304).*

In observing the mother and baby in this way, a completeness within the relationship is seen when the infant breastfeeds. The change of focus appears to alter the way the practitioner practices, from “doing and supervising,” to becoming a “resource and facilitator” (Dykes and Flacking 2010, p.734). The participants’ accounts, through displaying sensitivity towards the dyad, illustrated that breastfeeding was best learned by watching and following with “one’s eyes, one’s hands and ultimately one’s whole being” (Chuang 1964, p.44) which enabled a responsive understanding.

*you know it's not a thing to be got through it's something . . . just the first few days . . . you can get people through it by just helping and assisting . . . in a positive way more than anything I think so . . . yes you've got to be skilled in order to do that . . . but . . . attitude is so important . . . that is probably . . . I would say . . . for me . . . the difference between success and failure (Gail/1/149 – 158).*

Meeting women's needs this way might make the experience memorable for the mothers, even if the IBCLC may not be fully aware of the impact they had.

*I meet mothers who I helped years ago and they remember you don't they? I may not remember them but they remember me (5/1/547 – 550).*

### **7.3. Practising within the NHS**

All eleven participants, who had worked or were still working in the NHS, expressed problematic accounts of working within a large organisation. The following section explores the issues in greater depth.

#### **7.3.1. Perceptions of other health professionals**

Throughout the participant's accounts there were reflections on working with other health professionals within the NHS. The accounts demonstrated that attitudes towards breastfeeding and supporting breastfeeding women were never neutral. One participant recounted how she was told she was being too forceful or "bullying" women to keep them breastfeeding.

*you have to be so careful that whatever you are doing is not seen as bullying .when you are doing something . so it doesn't seem to matter how you gauge it . how you try and express it . . you can still be criticised for it . (Kate/2/34 – 38).*

Kate described how the comments had the effect of modulating how she articulated her practice. Within any professional practice there should be room for constructive criticism but what Kate was experiencing went beyond that as it affected how she worked.

#### **7.3.2. Keeping the breastfeeding practice plate spinning.**

Within organisations, such as the NHS, a linear concept of time has been described, where people speak of breaking work down in a sequential way to meet set targets (Hunt and Symonds 1995; Dykes 2006a; McGilchrist

2009). The description fits left hemispheric action, which is framed within a rational system of managing practice (McGilchrist 2009). In articulating their practice of working with breastfeeding women, the participants narrated a more fluid, circular concept of time, which was spent on focusing on the dyad rather than the clock (Lauwers and Swisher 2005; Dykes 2006a; McGilchrist 2009; Riordan and Wambach 2010). Time working with breastfeeding women was not marked in a linear way, while other clinical work was.

The eleven participants who had worked or were still working in the NHS described how time pressures impinged upon their role.

*it feels like I'm spinning plates, I've got so many targets to reach (. . .) I'm not doing it for the targets I'm doing it because I want to make things better (Jane/1/642 -648)*

*so busy in the NHS now they're so overworked, so much pressure so many targets, so many boxes to tick, everything has to be risk assessed and the politics are just huge and they get in the way of quality (Susan/1/ 510 – 515).*

While working in the NHS, participants spoke of how they tried to maintain balance between their “other work” and what was to them, their practice “niche” of working with breastfeeding women. Maintaining balance was usually impossible to achieve, as breastfeeding practice always came first and other work had to be fitted in around it.

*when I've got my diary and the phone rings I have to make a decision, do I spend this afternoon writing this report or do I go and see this woman who's in tears, that's the bit I'm really struggling with (Mary/2/ 79 – 81).*

An added stressor for the participants was that the health service was reducing the level of post-natal support provided by health professionals, which often affected breastfeeding women. The reduction affected how the participants' worked as they talked about trying to continue to meet the needs of breastfeeding women within the reduced framework. The

outcome for the six participants who worked in the community in a dual role as a health professional and IBCLC was frustration that they could not fully meet the needs of breastfeeding women and were seen by some health professionals as providing more than the allotted care.

*So I find it very frustrating . because I know what I would like to do . I know the time I would like to spend with these women and certainly you do get some comments passed . why is this woman still on the books . . . because she still has a breastfeeding problem (Helen/1/219 – 224).*

*we have . very little . . time . unfortunately . for going back and doing follow ups . we will do a follow up but literally it's just one . . they've got to be having mega (breastfeeding) problems to get to see us more than that (Kate/1/318 -323).*

Helen worked full-time as a health professional with an IBCLC qualification. During the interviews she described how she could only manage to provide the support breastfeeding women needed at weekends.

*but you can't beat going into a woman's house and having the time to sit with her and help her with attachment . .and explain why she needs a good feed ( . . . ) Fridays and the weekends I thoroughly enjoy for the simple reason we don't have a clinic and you have time and you can go and you can see these women . you can help them and make sure everything is OK (Helen/1/258 – 274).*

The description of working at weekends acts as a counterbalance to the demands of Helen's role for the rest of the week. Kate also described attempting to meet the demands of a dual role within one job.

*I have the breastfeeding lead but I don't get any hours for it at all . . and here we are in National Breastfeeding Awareness Week and I have one two hour slot in the local leisure centre . . . to try and promote breastfeeding (Kate/2/47 -50)*

Kirkham (2010) found that when midwives felt that they were controlled they also felt they were not trusted and were reluctant to commit to developing their role any further. This was not found within the participants' accounts but they needed to maintain a high level of passion and motivation to counteract some of the obstacles they encountered in their practice.

### **7.3.3. Protecting breastfeeding practice.**

Seven of the participants described incidents when health professional practice could affect breastfeeding outcome. All of the incidents occurred in the NHS. Jane narrated how extra feeds were given out to bottle-fed infants, so that women did not have to ask for them when the clinical workplace became very busy. The practice ignored a previously agreed policy.

*but that was not quite the right time to sort of kick up a fuss . . with two midwives . . and the place was hell on earth . . but . . . I brought it to the attention . . of the ward manager . . and the senior management the next day . . . I was . . just fed up . . because we do have policies . . and I feel that if you had to take that action because you were too busy, then you have to put an incident form<sup>52</sup> in . . . and say because there was too few staff on the ward . . we could not follow our own guidelines and our own policy . . we . . . let our standards slip . . we had to give bottles out . . and . . . we were unhappy about doing that . and it's a staffing issue (Jane/1/135 - 146).*

Jane bided her time in addressing the issue but the essence of her action was in protecting infant feeding. The account illustrates her concern for women who choose to bottle-feed their baby who apparently, within this account, were assumed to be feeding without any problems. One of the myths often perpetuated by health practitioners is that bottle-feeding is

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<sup>52</sup> A clinical incident form is used within the NHS to report any unintended or unexpected incidents that could lead to or have led to harm for one or more women or infants. This reporting mechanism demonstrates the intention that everything possible should be done to prevent a re-occurrence (NHS 2011a).

easy and does not carry risks (Martin 2009; Mitchell 2009; Crawley and Westland 2011).<sup>53</sup> Hoff (2003) and Deery et al. (2010) also described how some health practitioners, who profess to work in a professional woman-centred framework, were manipulated by the subjective and socially constructed experiences of their day-to-day work not to question how they were asked to work.

Shaw et al. (2004, p. 20) found that one of the four attitudinal themes midwives described when experiencing a heavy workload was, “breast is best but not when we’re busy”. The risk was that, when the practice workload increased, infant feeding, especially breastfeeding, was no longer viewed as an essential service and practice levels slipped.

Hoff (2003) described how some practitioners, after initially trying to cope with similar situations, articulated what needed to change and used policies and reporting systems to make sure practice did change and did not revert. Jane’s previous narrative reflected an example of such a practitioner.

There were occasions when the participants encountered health professional practice that was risky.

*people are saying . . . give the baby a rusk in the bottle so it sleeps through . that at some point there’s got to be stick (a ruling) that says that is not acceptable practice (Ruth/2/139 -142).*

*there is quite a tendency to lead fairly quickly . . . to reaching for formula milk (when a baby was not breastfeeding) . . .and they say well we are only just giving a small amount (Linda/2/256 – 259).*

Ruth and Linda’s accounts illustrated their frustration that apart from the inappropriate practice, health professionals’ knowledge often remained poor on understanding the rationale for some practices in supporting

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<sup>53</sup> Apart from missing out on many of the constituents in breast milk or being exposed to foreign components in artificial milk, bottle-fed babies are at risk of contaminants in the milk product, being burnt from too hot a feed, overfed, incorrect reconstitution and oral malformation (Riordan and Wambach 2010; Crawley and Westland 2011).

breastfeeding. In both cases the participants were attempting to get health professionals to recognise the risks and change their practice but as Ruth reflected sometimes it is easier when there are clear rules for practitioners as not all practitioners are prepared to gain a deeper understanding of the topic.

While working in such pressurised clinical environments, some health professionals can remain silent (Liaschenko and Peter 2003; Deery et al. 2010). The seven participants were different and were not silent bystanders but advocated the need for ethical professional practice.

#### **7.4. Listening to narratives of stress and frustration**

While most of the participants found that being an IBCLC provided a great deal of personal satisfaction, like any professional role, it had its stressors. Mary narrated an interesting concept of how she viewed being an IBCLC.

*I can remember going to one conference where somebody described this gingerbread effect that on the outside it looks all sugary and sweet but on the inside it isn't (Mary/1/1142 -147).*

Mary and four other participants, described experiences of feeling “burnt-out” by working in a dual role.

*I do feel it's burn-out definitely, and some days . I just . I'm so almost . well I have been tearful at times , some days I have been tearful, but they are not uncommon ( . . . ) I think it is to do with the organisation that we are in and pressure and there is just no time to stand back and see and review and prioritise, you're always fire fighting ( . . . ) and I never used to feel like that, when I first started to be interested in this speciality but I think it is across the board I don't think it is infant feeding, it's sad . . .(Susan/1/876 -898).*

Listening to such accounts was at times harrowing. When I started on the study I was hoping not to hear any further examples, other than those previously mentioned, but five participants provided further accounts (Blenkinsop 2007; English 2007).

Not all the accounts described negative stressful experiences. Two participants had become quite strategic and left the NHS and started up their own private practice because of the high levels of emotional stress. Ann realised her work situation had to change but the decision had not been easy.

Interviewer : *How did you come to terms with those choices?*

Ann : . . . . . forced . . (laughs) . .I had to make a decision . I always think when you get to a point in your life and things aren't working . you have to find a solution . you are responsible for your own life ( . . . ) I literally had to . . change my values . . and say this has been forced upon me (Ann/1/331 – 350).

Ann's laughter also appeared forced as she described how she had to re-think and re-adjust the way she worked because the NHS could not provide the niche practice she was seeking. Belenky et al. (1997, p.231) recognised that women who work at the level of constructed knowledge "balance and honour the needs of self as well as the needs of others." In many ways, Ann's account illustrated the persistence and tenacious attitude that other participants demonstrated to stay in a clinical role but in this particular narrative, the action was related to personal awareness and valuing of self to be able to adapt to continue in practice.

*you could become burnt out . I haven't got near that because at the end of the day I actually value myself (Ann/2/46 – 48).*

Two other participants were also contemplating leaving the NHS.

*it's partly a bit of burnout perhaps but there is still this desire to go out there and do some private practice (Susan/1/794 – 796).*

Being an IBCLC offered an opportunity to move outside the NHS but changing to work in private practice meant some uncertainty, which involved financial concerns. Cherniss (1995) found that when she interviewed twenty-six teachers and health professionals on qualification and again ten years later, some had made radical career changes from

the original role they had taken on. The difference between Cherniss's (1995) research and this study is that the two IBCLCs who left the NHS did choose to return to the organisation at a later date with much clearer ideas of how they wanted to work.

*and actually I went into the role as a job share because . . . I knew what it was like from previous experience . and being able to bounce ideas off somebody is really, really helpful (Linda/2/161 – 164)*

Five participants felt there was a lack of recognition of what they wanted to achieve and felt they were employed to *tick the boxes*, (Susan/1/165), *to go and sort out problems* (Helen/1/553) and *firefight* (Susan/1/887), rather than develop a breastfeeding service that reflected the needs of the women. The mismatch between how employer and practitioner viewed practice outcomes made the participants feel that they were often *banging (their) head against a brick wall* (Gail/1/392), being a *little or lone voice* for breastfeeding (Ruth/2/60, Gail/1/394) and not actively being listened to. The lack of progress and managerial support left many participants emotionally drained, so that they *no longer wanted to fight the battles* (Linda/1/50) that appeared to be necessary when developing a breastfeeding service, with minimal support. Maslach (2003) claimed that such emotional stressors are often linked to emotional exhaustion, depersonalisation and a feeling of personal devaluation. This was described in some of the participants' narratives. The participants wanted to feel valued, trusted and respected within their organisation (Attridge 2009).

All of the participants, whether they worked in the NHS or not, exemplified self-orientated workers, who held internalised beliefs that made them strive for perfection in what they attempted to undertake. Childs and Stoeker (2010) examined orientation to work with practitioners who were considered to be perfectionist. Although the perfectionist groups were initially considered to be at higher risk of burn-out, Childs and Stoeker (2010) found that the self-orientated group were actually at a lower risk.

The rationale for the low risk was found that the self-orientated group achieved high levels of engagement in their work, which often encouraged them to stay and persevere in their present role. While Childs and Stoeker (2010) described work engagement as a role retainer, the reciprocity of breastfeeding women still appeared to be the strongest indicator of the participants staying in their present role.

The Boorman Report (2009, p.3), which reviewed NHS employee's health and wellbeing, recognised that staff needed to "receive the same level of support for their health and well-being that they deliver to their patients." Seven participants described how they found such support missing from their workplace.

The report indicated that savings of over £555 million could be made with improvements in the working environment, to reduce stress-related sickness (Boorman 2009). Research into the causes of work-related burnout found that it can be the result of the work environment where there appears to be a pervasive interconnectedness between emotional work, emotional wellbeing, professional practice, the busyness of the workplace and lack of appropriate support (Cherniss 1995; Hoops 1999; Sandall 1999; Demeronti et al. 2001; Maslach 2003; Sheward et al. 2005; Bogaert et al. 2009; Maslach et al. 2009; Ruotsalainen et al. 2009; Rose and Glass 2010).

Practitioners who work within emotional frameworks, such as IBCLCs, identify a need for organisational recognition and support to validate their practice (Sandall 1999; Bogaert et al. 2009; Ruotsalainen et al. 2009). Two further studies also found that health service managers were often slow to embrace appropriate strategies to support practitioners who worked in specialist or niche practice (Bolton 2005; Deery et al. 2010). Emotional wellbeing within professional practice has been viewed as very fluid and feelings of being "balanced" or "out of balance" are two distinct ways of describing how practitioners cope (Rose and Glass 2010). The participants in my study spoke of maintaining emotional equilibrium as long as they had autonomy and freedom to practice with breastfeeding

women. I concluded that to achieve the necessary level of support managers must acknowledge and understand the practitioners' needs.

Concerns have been previously expressed in editorials in the JHL that IBCLCs might be at risk of burn out (Heinig 2002; 2009). The risk, Heinig (2009, p.135) identified, was in a "do it all" IBCLC who in many ways was responsible for her own exhaustion by taking on too great a workload. In this study, the participants' narratives, while confirming that there are stressors inherent in employment, illustrate that the issues were not fundamental to the personal traits of the practitioner but to the framework of practice. In understanding how the participants' experienced their role, a starting point for other IBCLC research has been drawn but further work needs to be undertaken to identify and quantify the stressors and determine the best way to ameliorate them.

## **7.5. Sources of support**

Throughout the interviews the participants described differing levels of support and the range of people and practices that supported their role. All the participants described how fellow IBCLCs, family and friends provided support but there was a lack of mention of other support frameworks. The participants, therefore, were purposely asked about support for their practice at their second interview.

### **7.5.1. Support from family and friends**

All the participants narrated accounts of seeking and receiving support from family and friends.

*Fortunately I had a very supportive family . very supportive husband (Ann/1/49 – 51).*

*I have a very supportive family who will say you are doing too much (Denise/2/76 -77).*

*I've got a few friends who are passionate about breastfeeding ( . . . ) sometimes we really lift each other up and sometimes we drive each other down (Mary/2/639 -645).*

Stevanovic and Rupert (2009) found that there is an increasing interdependence between work and family life and that work experiences are likely to affect close relationships. In a survey asking professional psychologists about their work/life satisfaction and family support, Stevanovic and Rupert (2009) found that a positive accomplishment at work was associated with enhanced family communication, which led to greater family support. On the negative side, emotional exhaustion at work was associated with family stressors and less support.

The participants' accounts, viewed against Stevanovic and Rupert's (2009) findings, show how the emotional thread of being an IBCLC can impact on family life. One of the issues that immediately came to mind was how precarious were the seven participants who lacked management support, as described in the previous section. The participants' reliance on practice and feedback from breastfeeding women demonstrated a risk that any issues or negative outcomes from practice could have profound outcomes on the practitioners' family and friends.

#### **7.5.2. Managerial support**

There were four accounts where the participant reflected good managerial support. Each manager was described as easily accessible, provided relevant feedback and enabled and supported changes in breastfeeding practice.

*I feel very well supported within my organisation and I've got senior people who are champions . so this is the first time that I've come into an organisation where whatever you come up with . it's not blocked . it's . .well how do we achieve it and that's extremely refreshing (Ann/1/218 – 224).*

The pro-active form of management support that Ann experienced was appreciated and also enabling. Ann responded to the recognition of her own knowledge and skills and the freedom to express and follow-up ideas in practice.

The remaining seven participants who worked in the NHS narrated accounts that illustrated a lack of managerial encouragement and assistance.

*I absolutely have no support . . . the role is not resourced at all (Kate/2/53).*

*I've got all the knowledge . they ask you stuff . but then it all dies a death because I don't have the time to follow it up and keep banging on people's desks . and then I do get frustrated because I've told them four times (Mary/2/494 -497).*

*I find it a little bit frustrating in the fact that you're an IBCLC and it's . . . not regarded with any respect at all . but . on the other hand they're quite happy to sort of wheel you out to go and sort out the problems (Helen/1/550 – 553).*

Hochschild (1983, p.137) used the phrase “emotional labour” to illustrate how professional practitioners’ work does not always just lie with attainment of technical skills but also in creating the correct environment for practice. Rose and Glass (2010) found that among the main stressor for nurse practitioners, over which they have no or very little control, were lack of resources and lack of support at work. In this study seven of the eleven participants working in the NHS spoke of lack of managerial support or resources or both, in their role. The stressors of working in professional practice with such impediments, hindered the participants’ effectiveness in practice, as well as undermined their sense of feeling valued or respected as practitioners.

The Agenda for Change (DOH 2004a) framework was developed to provide support for NHS health practitioners in developing their clinical roles. None of the participants described using this framework.

*the last two applications for study days with regard to breastfeeding have been refused ( . . . ) I'd asked for the funding for the Baby Friendly Conference and I'd only wanted the money for the conference . .I was going to take it in my annual leave (faltering*

*voice) ( . . ) putting it politely it isn't fair (laughs) ( . . ) and why bother paying me one day a week if not going to invest in the role at all (Gail/1/417 – 451/7f).*

While three participants described how they had approached their manager for “support,” they were not specific about what they had asked for as they used generic terms in their narratives. I realise that this term should have been clarified in the interview, to gain a fuller description. I should also have asked if their role had been fully evaluated against the Agenda for Change framework (NHS 2010). Further work is needed to define effective management support for IBCLCs.

### **7.5.3. Support for professional practice**

In the narrative accounts the participants did not dwell on explaining a lack of management support but quickly moved onto what they perceived as more positive aspects of their role, of ways of developing a professional practice. The participants described using other IBCLCs, web-based resources and colleagues. One practitioner had accessed the supervisory framework provided through her midwifery qualification as one of her clinical supports in practice.

The ability of the participants to access support from sources other than work was important. While family and friends were a source of day-to-day listening and reassurance, essential to their role, for all participants, was communicating with other IBCLCs who understood their professional practice. The ancient Greeks called time out of practice “*kairos*” (Lynch 2002, p.184). The articulation and sharing of practice between like-minded practitioners has been observed to engender a sense of professional belonging and knowing (Lynch 2002).

*I am part of a group. I'm not an isolated part of infant feeding (Ruth/1/290 -291)*

*I have a close group of colleagues who are also lactation consultants and we do meet regularly . . and although we don't call it official clinical supervision, it is clinical supervision ( . . .) we will*

*talk it through and sometimes she (another IBCLC) will ask if I will come along with her to just observe because sometimes a fresh pair of eyes helps (Jane/2/71 -79).*

*I work very much in isolation . . . the others aren't so much working in isolation . . but they are actually experiencing more hostility than I was . so . . it was sort of . . in fact in the end we had a couple of meetings and then looked at one another and said . . . this is counselling one another. . but it was important (Kate/1/410 – 426).*

Meeting up with other IBCLCs was recognised by the participants as important for their mutual support, as well as maintenance of their professional identity.

*in fact there were so few of us at one time . .we used to have a Christmas dinner together (laughs) and we used to meet . unfortunately or fortunately . there are more lactation consultants now and too many for us to sort of meet up . so we don't meet up any more which is a bit sad really (Susan/1/772 – 776)*

Editorials in the JHL have also espoused the need for IBCLCs to develop supportive networks but presently the responsibility lies with the practitioners to achieve this on their own (Glover and Lauwers 2005; Heinig 2007). From the participants' accounts, some supportive groups were already in place but they did not appear to be known or recognised outside that group membership.

One of the changes I introduced as National Co-ordinator for LCGB was a move from a one-day to a one and a half-day conference so that practitioners could meet up and socialise for one evening. At the time I did not realise how helpful that was, until one participant shared her thoughts about how important the meetings with other IBCLC on such occasions were to her.

*It keeps you going (attending conferences) . . talking to other IBCLCs and you realise the problems that you have are not unique*

*to me or the area . . . they are just such a help to keep you motivated . . . to keep you going (Helen/1/366 -372)*

Meeting other breastfeeding practitioners was also possible through regional meetings. The development, function and disbandment of the regional groups was described earlier (2.6.2.) but when data was collected for this study the groups were still functioning. All the participants, who worked within the NHS were involved in regional breastfeeding groups and relied on them to keep informed about local and national initiatives.

*Yes plugging into them . . . like regional network meetings has been . . . really helpful (Wendy/1/561 – 563).*

*I do think there are links, there is a feeding down and obviously we feed up to the regional government ( . . . ) you feel you are being listened to and there is some communication going upwards and downwards ( . . . ) and although I am employed locally I can feel part of a bigger impact (Ruth/1/342 -366)*

The effect of the withdrawal of the national and regional framework is presently unknown but from the participants' comments, the outcome could lead to further isolation of practice and practitioners. The real outcome of the disbandment of the framework might never be fully recognised as, apart from the participants' comments in this study, I could not find any other reports or research about how practitioners might be affected by the loss of such an initiative.

All the participants mentioned the use of un-moderated, web-based, discussion forums for lactation professionals, such as Lacthelpers and Lactnet (Blackburn 2009) and the LCGB members' site. Wiessinger (2002) described Lactnet and e-mail as a union invented for professionals and from the beginning practitioners have embraced the use of these forms of communication. The forums provide access to many other practitioners where, with permission from the women, the issues around a particular case can be discussed, while maintaining the anonymity of the mother. Wiessinger (2002) was aware that some IBCLCs were

embarrassed to ask what to other practitioners might appear to be simple questions. They do, however, read what others write and learn in that way. Sharing of information enables other members of a group to also sustain and improve their powers of observation, to stay informed of practice development and to feel part of a wider community (Glover and Lauwers 2005; Benner et al. 2009).

*but there are things that people get over the years you can't write in a book (laughs) you really can't write them in a book and if you pick up any book it's all very general (Gail/1/360 – 365/7g).*

Sites such as Lacthelpers and Lactnet also provide access to archived material and discussion forums for topical issues that are often highlighted in the press. While access to such resources was deemed to be very supportive by all the participants, the level of knowledge of each contributor to the site is unknown, except in the case of the LCGB site. Furthermore, personal practice issues are difficult to address on such open forums, although members can contact each other “off-line” in some situations.

## **7.6. Considering balancing breastfeeding practice.**

The essence of being an IBCLC for each participant was the freedom to work in breastfeeding practice. Finding a niche, especially within the NHS, where the role fitted their needs, enabled the practitioners to express autonomy and freedom to practice that matched their needs. Working with breastfeeding women acted as a counterbalance to the stressors encountered within the health service, where practice took place in a different time frame.

The participants illustrated instinctive sensitive practice when describing their experiences of working with breastfeeding women. The participants' holistic empathetic practice reflected an openness to the possible right-brain approach women might adopt to learning to breastfeed and mother their baby. Exploration of hormonal priming during birth and in the post-partum period and adjustment in learning suggested that there were

possibilities that such a right-sided link exists. This understanding returns breastfeeding and mothering to its mammalian roots where women focus on their infant's needs to enable the child's survival. In appealing to right-sided learning within breastfeeding women, the participants reflected a different approach to most Western style learning, which is dominated by left-brain activity.

The participants worked not only to protect breastfeeding within their own practice but in every day encounters. The participants took action when they observed other practitioners placing infant feeding at risk. The examples illustrate the participants were not silent by-standers but advocated the need for ethical professional infant feeding practices.

The participants were described as self-orientated practitioners for whom maintaining balance within their role was difficult, especially when they worked within the NHS. The majority of the participants who worked in the NHS, described a lack of managerial support for breastfeeding and their practice, which left them exposed to avoidable high levels of stress. The busyness of the NHS also meant that participants experienced other stressors such as increased volume and pressure of work, lack of resources and lack of listening to and understanding of their needs.

Five participants who worked in the NHS stated that they had experienced feelings of burnout at some time in their practice-based work. Because of the pressures within the NHS, two participants had moved temporarily into private practice and then returned to the health services when working conditions suited their professional needs. The option of working in private practice as an IBCLC provided another way of working for some motivated practitioners but did not address the issue of how to ameliorate the stressors of working within the NHS where practitioners wanted to feel valued, trusted and respected.

Seeking practice support from other IBCLCs was important to the participants. Family and friends provided day-to-day emotional support but other IBCLCs provided clinical support. The participants accessed clinical support through meeting with other IBCLCs or using Internet

support groups. The recent cessation of the national and regional breastfeeding co-ordinator network occurred during the course of the research and how the withdrawal of this facility will impinge on IBCLCs is presently unknown.

In the following chapter the role of the IBCLCs is described in relationship to the enablers and barriers of practice.

## **Chapter Eight: Enablers, barriers and recommendations identified from the study's findings**

*Never measure the height of a mountain until you have reached the top.  
Then you can see how low it was (Hammarskyöld 1964).*

### **8.1. Introduction**

The analysis of the twelve participant's narrative accounts presented in the previous four chapters provides an illustration of their experiences of practice. The descriptive illustrations meet the primary aim of the study but do not fully elucidate one of the study's objectives which was to examine the enablers and barriers of IBCLCs practice. This chapter will examine such aspects of the participants' practice, explore opportunities for future professional development and offer some recommendations to support the IBCLC role.

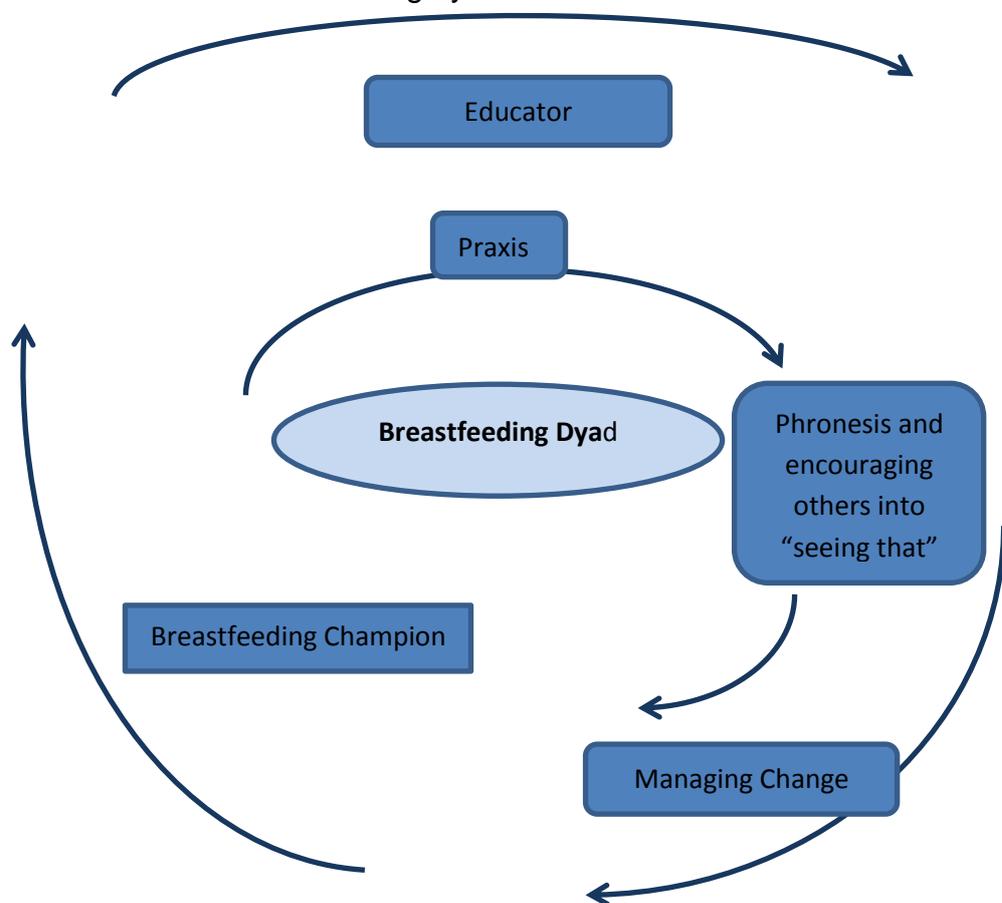
Before the description of the enablers and barriers identified by the participants are discussed, a return to how the IBCLCs practised is illustrated to set the context for this chapter. Table Six illustrates how all the participants centred their practice on the breastfeeding mother and child, which was described throughout the analysis (Chapters Four to Seven). The focus enabled the participants to develop and articulate a phronetic praxis, which they used to enable others, especially health professionals, into the "seeing-that" state of understanding the needs of the breastfeeding dyad (Chapter Six). Through practising in this way, the participants became educators and change agents who challenged others into observing the interrelationship of the breastfeeding mother and baby. The integration of the art and science through the observations of the breastfeeding relationship reflected an empathetic right-brain approach when working in practice (Chapter Seven). The participants described how they were recognised for their knowledge and skills as breastfeeding champions but not always as IBCLCs (Chapters Six and Seven). The lack of professional recognition for the IBCLC role, especially within the NHS, engendered some uncertainty within the participants as to who they were.

The uncertainty led to some difficulty in articulating their needs as practitioners (Chapter Seven).

The participants' approach to supporting breastfeeding women did not always match the utilitarian outlook of the health service. In working differently within the NHS the participants described seeking a niche for their praxis within the organisation. The niche was recognised as a place where they had the freedom and autonomy to work with breastfeeding women and influence other health professionals (Chapter Seven).

Descriptors of professional servants and leaders were also apportioned to the participants as their centeredness on breastfeeding motivated them to demonstrate and demand a service that met not only women's needs but also health professional's practice development (Chapters Four and Six).

Table 6: Diagram illustrating how the IBCLCs practised centring their care around the breastfeeding dyad.



## **8.2. Participants articulating for breastfeeding but not their IBCLC role**

The participants' accounts demonstrate how becoming an IBCLC enhanced their professional practice (Chapter Four and Five) which enabled them to promote a breastfeeding praxis with other health professionals (Chapter Six). Both findings are relevant to any organisation where health professionals support breastfeeding women. The paradoxical finding was that while participants promoted and supported breastfeeding they did not always endorse or advance their IBCLC role.

One participant mentioned that she had the IBCLC qualification written into her job description and five others had received payment of their examination fees, but the impression I gained from the data was that there was no active promotion beyond these described activities. Rather than articulate a professional practice the participants appeared to want their praxis to speak for itself. Gaining professional recognition through the development of a specialist clinical practice is laudable but within the work-based pressures of large organisations like the NHS, the link between expertise and a qualification, unless actively promoted, can be lost.

Finding a practice framework that suited the participants and enabled them to work with breastfeeding women was important for the participants. As becoming an IBCLC was possible, that is what they became. Working with breastfeeding women is what drew the participants to become IBCLCs, not the concept of being a Lactation Consultant. The working title of the thesis *Becoming and Being an IBCLC* was chosen as I thought the participants would want to narrate their professional role as a Lactation Consultant, what I found was practitioners who talked about working with breastfeeding women and enabling other health professionals to do the same. The title of the thesis was therefore changed prior to submission as I needed to describe how the participants worked who happened to be

IBCLCs. The IBCLC qualification provided professional recognition which matched the participants' needs. Becoming an IBCLC was only relevant as it enabled the participants to work with breastfeeding women in a professional capacity. A different qualification that offered the same professional recognition could well have had a similar outcome. The realisation that any formal recognition of the practitioner's knowledge and skill of human lactation and supporting breastfeeding practice could have been substituted for the IBCLC qualification could explain why the participants remained passionate and centred on their practice and more reticent about their role.

My interpretation does not mean that becoming an IBCLC was not important to the participants but the lack of role definitions and of UK practice-based research has hampered ownership and full articulation of their role. The most recent position paper on the IBCLC qualification (ILCA 2011d) provides nine descriptors for the role, all referenced to IBLCE professional standards, none to research-based evidence. The listing of nine descriptors by IBLCE, apart from leaving practitioners exposed to undue stressors through lack of understanding and preparation for the role, might also leave them confused as to what the essence of how they might practice might be (ILCA 2011d). This study provides an insight into how some IBCLCs practiced which might provoke a dialogue between other practitioners about their role and a greater transparency for the role. Wilson-Clay (2000) found that a lack of role clarity risked the ability of IBCLCs to share a common identity, which in turn risked isolation within their role. The lack of clarity might also explain the multiple role titles for the participants and a lack of confidence by practitioners to describe their qualification.

Dykes and Hall-Moran (2006) warn that all aspects of maternal and infant nutrition and nurture need to be viewed within a political framework. If IBCLCs want to find the niche in practice that suits their knowledge and skills then they will have to understand and be able to advocate what their work-based role might be. In 1992, ILCA founded the International Day of the IBCLC, to raise the profile of practitioners and to celebrate the success

of the role (ILCA 2011c). None of the participants mentioned supporting the day, although they did recall how they promoted the UK National Breastfeeding Awareness Week (NBAW). In the USA a “grass roots movement” has been described, where IBCLCs annually promote their practice within the wider community (Bailey 2005, p.239). Perhaps it is time practitioners in the UK developed their own vision and practice framework that will enable others to understand who they are.

### **8.2.1. Promoting the IBCLC role**

The participants described looking for promotional material to describe the IBCLC role. When searching the international (IBLCE<sup>54</sup> ILCA<sup>55</sup>) and UK (LCGB<sup>56</sup>) websites in November 2011 related to IBCLC practice, I was struck by the different ways breastfeeding and practitioners were portrayed through photographic images. The IBLCE, European and Middle East website has pictures of male as well as female practitioners. There is only one picture of a mother and baby, where the baby is held in its mother’s arms but is not breastfeeding. The ILCA web-site has changing pictures on its home page of groups of women sitting around a table, a conference presentation or bookstall, or of six men and women practitioners. On the LCGB site, the pictures are of mothers and babies, many of them breastfeeding, with no obvious portrayal of a practitioner. The difference between the sites and the visual impact they provide is quite marked. On the international sites, practitioners are usually portrayed distanced from women, wearing an unofficial medical style “uniform” of white coat or theatre scrubs,<sup>57</sup> qualification badge and sometimes a stethoscope draped around a neck. On the LCGB website practitioners lack visibility altogether. Uniforms have been described as a way of instilling a sense of power, superiority, separateness and professionalism but a lack of visibility and knowing who the practitioner is

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<sup>54</sup> <http://europe.iblce.org/>

<sup>55</sup> <http://www.ilca.org>

<sup>56</sup> <http://www.lcgb.org/>

<sup>57</sup> Clothes usually made of thin material that is easily laundered which at one time were only worn by operating theatre staff but now often worn by other hospital staff.

does not help in understanding the role either (Pearson et al. 2001; Spragley and Francis 2006; Cronk 2010).

In examining the international resources available for IBCLCs, I found two ILCA leaflets “*How IBCLCs make a difference*” and “*IBCLC: Experience you can trust*” (ILCA 2011a and b). The leaflets are available for anyone to download and were produced after I had completed data collection. The leaflet “*How IBCLCs make a difference*” references studies using positive outcomes from IBCLC work, none from the UK. I took a dialogical approach to reviewing the leaflet “*IBCLC: Experience you can trust*” which compared the information with the findings from this study (ILCA 2011b). The review was an attempt to see if the leaflet was a useful resource for practitioners in the UK. The ILCA (2010b) leaflet listed six points of being an IBCLC (Column A, Table 7). Alternative descriptors are offered from the data collected from this study (Column B, Table 7).

While the study’s findings do not represent the work of all IBCLCs in the UK, they do present a window into practice, which illustrates differences from the medical wording and format of the ILCA leaflet. The points in Table 7 were adjusted from the descriptors in the leaflet but it still does not represent all the aspects of IBCLC practice that were found in the study. The missing descriptors are:

- Working as a professional servant and leader
- Working with high visibility in practice, modelling the role
- A facilitator of learning about human lactation and breastfeeding through sharing their knowledge
- Managing change to optimise support for breastfeeding women
- Working at the interface between breastfeeding mothers and babies and their health professionals.

**Table 7: A comparison between the six descriptive aspects of being an IBCLC in the ILCA (2010) leaflet (A) and from this study (B).**

International Board Certified Lactation Consultants are:	
(A)	(B)
<p>Recognized the world over as possessing the only standardized, board certified lactation credential available.</p> <p>Knowledgeable about up-to-date evidence-based practices in lactation as demonstrated through rigorous exam process.</p> <p>Experienced in a wide variety of complex breastfeeding situations.</p> <p>Competent to assist mothers with establishing and sustaining breastfeeding, even in the midst of difficulties and high-risk situations that can arise.</p> <p>Sensitive to the needs of both mothers and children as they work to help mothers meet their breastfeeding goals.</p> <p>Ethical in their practice, abiding by Standards of Practice, a Code of Ethics and Scope of Practice.</p>	<p>Internationally qualified practitioners whose main focus is on maintaining and developing a professional practice that supports breastfeeding women.</p> <p>Practitioners who have qualified by examination after working in practice and undertaking further studying on lactation and breastfeeding over a period of years. After qualification the practitioner continues to study and develop a breastfeeding practice as an IBCLC.</p> <p>Experienced in developing a professional breastfeeding practice that meets women's needs in feeding her baby.</p> <p>Competent practitioner who works with women enabling them to understand how their baby breastfeeds.</p> <p>Works as part of a team in situations where breastfeeding may require extra support such as with premature babies or through mother/infant illnesses.</p> <p>Works within a professional and ethical framework which includes a formal complaints procedure</p>

The idea of developing a leaflet for UK use based on the MIDIRS Informed Choice<sup>58</sup> model is proposed. The model splits the leaflet in half with research-based information on the IBCLC role on one side and illustrations of how the practitioners work on the other. Further ideas on the promotion of the role are in the recommendations.

<sup>58</sup> <http://www.patient.co.uk/support/MIDIRS-Informed-Choice-Leaflets.htm>

Evetts (2003) argues that any professional organisation that raises an awareness of its own practitioners and the service they provide not only progresses its own registrants but can provide a way of promoting and protecting the public interest as well. In raising the profile for breastfeeding and the level of professional practice in England the participants might in the future find that they are in a stronger position to solicit and advocate for improved, appropriate, woman-centred support.

### **8.2.2. Developing skills associated with being an IBCLC**

Most of the participants described a lack of preparation in education and in managing change within their practice role. The participants who worked in the NHS did not describe any awareness or using supportive frameworks, such as the Agenda for Change (DOH 2004a), to seek any personal development as educators or in managing change. Instead, there was an acceptance that any preparation or short courses they had attended were either enough or all that was available. Perhaps this sounds like a harsh criticism of participants who demonstrated an ability to adjust, learn and develop their own teaching style but the approach also exposed some practitioners to extreme emotions, such as feeling terrified and to learning by trial and error, when a more supportive framework might have been less stressful.

Some of the participants taught in pairs with other IBCLCs. In these examples, neither practitioner was experienced in teaching but the mutual support was found to be reassuring. MacDougal and Drummond (2005), when they examined how medical consultants learnt to teach in clinical practice, found that working with experienced teachers was the most supportive and therefore highly valued approach. The pairing of an experienced IBCLC with a similarly knowledgeable teacher could provide an example of joint development, as each could learn through observing the other's practice. This example reflects how the participants encouraged health professionals into the "seeing-that" state of breastfeeding practice, which appeared to fit the way they learned.

Walsh et al. (2011), when examining the implementation of the Baby Friendly Health Initiative (BFHI) in Australia, identified the need for more IBCLCs to work in practice and teach other health professionals without any recognition of the particular practitioner's needs. The participants who worked in the NHS had similar experiences, where there appeared to be a misconception that the IBCLC qualification enables practitioners to teach. While all the participants recognised that learning to teach was an appropriate skill for an IBCLC, serious consideration is required as to how that is supported and enabled within the qualification. The chance to explore and initiate changes in how that occurs could provide further opportunities for research.

Similar issues were identified when participants were involved in managing change, especially in implementing the UNICEF/UK BFI. The participants welcomed the implementation of the initiative as it presented opportunities to realise changes in practice but without understanding the process of change management they were exposed to unnecessary stressors.

The original concept of the WHO and UNICEF BFHI (1991) was that accreditation was a foundation from which to develop a supportive breastfeeding service and therefore the start of a change process. A common misconception in the UK is that the award is the end objective. None of the participants were in a position where their institution had gained the full UNICEF/UK BFI accreditation but from their accounts they appeared to realise that they were building the foundations for change in breastfeeding practice. Through focusing on inviting other health professionals to also become IBCLCs, they were developing a core of knowledgeable practitioners who could continue to influence practice. Two of the participants took the suggestion of IBCLC practice a stage further and wanted to replicate a model they had heard about in some Australian maternity units, where most of the health professionals had dual qualifications. The described service model, though, did not reflect this study's findings, where self-motivation was the driver to become an IBCLC not a condition of employment.

### **8.2.3. Working with other organisations that support breastfeeding women.**

In Chapter Four I identified how most organisations in the UK that work with breastfeeding women do not provide information or links to IBCLC practitioners. A lack of information about becoming an IBCLC appears especially puzzling with regard to the Royal College of Midwives (RCM), as the organisation helped launch the qualification in the UK (Scott 1994). The RCM has previously held the midwifery representative position on the IBCLC Examination Board and invigilates the examination in London.

Some of the participants interviewed for this study were members of the RCM, other health professional organisations and lay breastfeeding organisations. Being a member provides further opportunity for IBCLCs to articulate their practice within those organisations. While Blenkinsop (2002) and Timms (2007) achieved this in writing about their role within their relevant journals, a more recent article about a day in the life of a midwife who works as an Infant Feeding Advisor (Barker 2011) did not mention her IBCLC qualification, except as one of the author's qualifications. Promoting the role within different relevant organisations appears possible but there are only a few published examples.

### **8.3. Support for IBCLCs**

Apart from promotion of the role, the study found that the participants experienced differing levels of support (Chapter Seven). Some participants had created their own supportive environment away from the workplace but such arrangements were ad hoc and dependent on knowing other practitioners or limited in how practitioners could share experiences through group e-mail sites.

The disbandment of regional breastfeeding practitioner's network groups in 2011, which all the participants had found informative and supportive, will reduce even further the opportunities for IBCLCs to meet. An annual LCGB conference and associated workshops, while found useful by some participants, was not frequent enough to offer the on-going support many

of the participants wanted. From the participants' described experiences, I consider a more pro-active approach to developing a support network for IBCLCs in England is probably necessary, ensuring that there is at least one group in each region of the UK. Lactation Consultants GB, as the affiliate body of ILCA and the organisation that represents IBCLCs in the UK, is ideally situated to take the lead.

One of the problems in proposing such a framework is in accessing IBCLCs who are not members of LCGB or ILCA. At the moment this represents just over half of the practitioners in the UK (IBLCE 2011b). Non-members, however, could be reached by IBLCE. The Privacy Policy of IBLCE presently prohibits any communication with IBCLCs, unless it relates to maintaining their qualification (IBLCE 2009b). The present position might have to be challenged in light of this study's findings, as the way the IBLCE works has to be weighed against the benefits of providing a supportive framework for practitioners and the protection and development of professional practice. I will share my research findings with IBLCE and, as an initial step, request that information about LCGB is sent to practitioners on qualification, so at least they are aware of what support is locally available. A similar request has previously not received a favourable response but research-based evidence might be more persuasive.

How each IBCLC support group functions would be dependent on the members of the group. The study findings, though, found that while IBLCE or ILCA do not use reflective practice as a framework for developing professional practice all the participants did. Cadwell and Turner-Maffei (2004) Lactation Consulting Process could be adapted as a reflective tool to use in the support groups as it utilises active listening skills and questions what is known and what needs to be known. The utilisation of such a framework could offer IBCLCs, who are unfamiliar with reflective practice a tool which could be supportive in their day-to-day work and when discussing clinical issues with their peers. The constructed knowledge, using such a reflective tool, should enable practitioners to

become confident in articulating their practice and their needs as professional practitioners (Tuckman 1965; Belenky et al. 1997).

Apart from support for a professional development of practice, practitioners who worked within the NHS had mixed experiences of support for their roles. While four participants said they had good management backing for their role or used a local Supervisor of Midwives to provide practice support, the other participants were exposed and isolated in their professional practice. Kirkham (1999, p.737) found that the practice culture of working in the NHS was one of “helplessness”, “low expectations,” “acceptance of the status quo” and “muteness.” The participants did not reflect any of these descriptors except a muteness about being an IBCLC which might be addressed in developing a more cohesive articulate group of professional practitioners to present to the public and future employers.

#### **8.4. IBCLC professional recognition and accountability**

International Board Certified Lactation Consultants are certified by the IBLCE under the direction of the United States National Commission for Certifying Agencies (IBLCE 2011d). While the certifying process formalises the qualification and enables IBCLCs to access insurance cover when working outside the NHS, formal recognition as an independent health practitioner within the UK was missing in the study findings.

Lactation Consultants GB have attempted to seek formal professional recognition of the IBCLC qualification through the Health Professions Council (HPC 2011) in an attempt to raise the profile of the role, especially within health-based organisations such as the NHS. Unfortunately, the application was halted in March 2011, when the inclusion of and the regulation for any new groups within the authority ceased (Myers 2011). A White Paper, “Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff” (DOH 2011b), proposed that the Health Professions Council is not necessary and that the present regulatory

system should be reformed and simplified. The White Paper encourages self-regulation and employers to take a greater responsibility for ensuring allied health professional staff are suitably qualified and trustworthy (DOH 2011b). The proposal, if it comes into force, might enable the recognition of IBCLCs, as long as a professional practice self-regulation framework can be articulated by practitioners.

Presently the requirements of the proposed legislation are quite vague about what is meant by self-regulation and what evidence would be required if it was enacted. Currently employers can check that an IBCLC is qualified with the IBLCE site as a registered practitioner. Each practitioner has a unique registration number and an identity card that records the date for re-registration. The present system informs employers that the practitioner has passed a written-based examination but does not identify that practice has not been assessed. If IBCLCs want to meet the professional framework of Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff (DOH 2011b), they might have to demonstrate a system that reflects a more vigorous approach to monitoring and enabling a practitioner's practice.

Presently the only way IBCLC practice is monitored is by anyone who has received or observed IBCLC practice that does not comply with professional standards (IBLCE 2010c) or the ethical framework (IBLCE 2004) making a formal complaint to the IBLCE Board. Apart from medical and criminal issues common to most professional organisations, under section D of the IBLCE Disciplinary Procedure (IBLCE 2011c), violations of practice are considered under the headings in column A of Table 8. The proposed changes to the Code of Professional Conduct for IBCLCs are listed in column B (IBLCE 2011f).

In essence the proposed changes of the professional code remains the same but in the up-dated framework practitioners are asked to identify their practice as an IBCLC rather than as a lactation consultant (IBLCE 2011c).

<b>Table 8: IBCLC Code of Professional Conduct Principles (A/IBLCE 2011c) and proposed changes (B/IBLCE 2011f)</b>	
<b>A</b>	<b>B</b>
Duty to preserve client's confidences	Preserve the confidentiality of clients
Duty to act with reasonable diligence	Act with due diligence
Duty to provide competent care	Provide services that protect, promote and support breastfeeding
Duty to maintain personal integrity	Maintain personal integrity
Duty to report truthfully and fully to the health care system	Report accurately and completely to other members of the healthcare team
Duty to uphold the standards of the lactation consultant profession	Uphold the professional standards expected of an IBCLC
Duty to exercise independent professional judgement and to avoid conflicts of interest	Exercise independent judgement and avoid conflicts of interest
Duty to follow IBCLC Disciplinary Procedures	Comply with IBLCE Disciplinary Procedures

## **8.5. Looking at different practice frameworks for IBCLCs**

Practice and approaches to practice are constantly evolving and IBCLCs need to be aware of the changes. The purpose of this section is to consider what alternatives might present themselves for IBCLC practice in the future, which could provide opportunities for working differently. The three main areas reviewed are working within public health, developing social enterprise initiatives and working as an IBCLC within the health service.

### **8.5.1. Moving into Public Health**

Following the UK general election in 2010, there have been many proposed changes in the health service and alterations to breastfeeding promotion in England. The government White Paper "Healthy Lives, Healthy People" (DOH 2010d) proposed that public health be transferred from local NHS control to the Local Authorities. Under the proposed

changes, Health and Wellbeing Boards will be established to oversee the health and social care services for each local authority area (DOH 2010d). If this occurs then IBCLCs are well situated to advocate that breastfeeding becomes a local public health priority. By moving breastfeeding to the public health agenda at a local level all the relevant groups, including lay supporters and interests, could be brought together. In many ways it would be similar to the Joint Breastfeeding Initiative (JBI) groups initially formed in the 1980's but this time with the formal backing of the local authority (Henschel and Inch 1996).

### **8.5.2. IBCLCs and Social Enterprise Initiatives**

A different framework is for IBCLCs to set up a social enterprise initiative and become self-employed while still working within the NHS (DOH 2011d). The UK Government has stated it is committed to giving public sector workers new rights to provide services through an employee-owned mutual enterprise (DOH 2011c). A staff-led enterprise is described as a mutual, co-operative, co-owned business or a social enterprise (Teesdale 2010; DOH 2011c). The emphasis in the development of social enterprises is that social or environmental objectives are central to what they do, which, for IBCLCs, would be in meeting government set breastfeeding targets. The identified advantages for practitioners are that the enterprise would be self-reliant, independent of NHS control and able to generate its own income through trading. Surpluses would have to be reinvested within the enterprise, which for IBCLCs might mean the employment of other practitioners or the provision of further training.

Employees working in the NHS from 2011 have the “right to provide” a social enterprise but there is no automatic guarantee that they will be successful (DOH 2011c). Community-based social enterprises for peer supporters who work with breastfeeding women are already in place<sup>59 60</sup> and for IBCLCs working in the NHS it might be a useful framework to explore further. As some of the participants identified within the study,

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<sup>59</sup> Little Angels <http://www.gos.gov.uk/497648/docs/289820/Theconceptionoflittleangels>

<sup>60</sup> Real Baby Milk <http://www.realbabymilk.org/faqs>

working with other IBCLCs enabled and supported their practice and forming a small group enterprise initiative may provide the independence in practice that some practitioners were seeking. Working in a social enterprise framework would enable practitioners to meet their agreed objectives in a manner they felt appropriate, which satisfied the descriptor of niche practice.

In choosing to work in a social enterprise initiative there is no guaranteed employment following completion of the contract and the practitioners would have to develop further skills, such as in marketing and writing business plans.

### **8.5.3. Working with other health professionals as an IBCLC in the health service**

My articulated outcome on becoming an IBCLC reflects Auerbach's (1989) statement, that through our practice of sharing knowledge and developing other practitioners' skills, we should make ourselves redundant. The opposite, though, is also possible, where the health service becomes dependent on IBCLCs or similar practitioners to support breastfeeding women while other health professionals withdraw from the practice.

The participants described throughout the study how they were trying to draw other health professionals into developing their practice with breastfeeding women. The findings, though, also demonstrated the tensions within the service that lay with the busyness of the clinical workplace and the reluctance by some health professionals to engage in developing their support for breastfeeding women. The risk for IBCLCs is that they are drawn into day-to-day support for breastfeeding women even when they observe the need for inter-professional working.

The data illustrates that there is a place for IBCLCs to provide a specialist service for breastfeeding women when required. The IBCLCs' narratives illustrated their practice of journeying with women when they experienced breastfeeding problems and how they enabled them to meet their feeding outcome. A role described within the study as a professional servant. The

participants were also described as servant leaders as they acted as role models sharing their knowledge and skills with other health professionals. Working alongside other health professionals, developing their understanding to a point where they know how to provide direct care and recognise when to refer for more specialist support, appears the most appropriate way forward. Leaving support for breastfeeding women only to IBCLCs risks further de-skilling of health professionals and marginalising breastfeeding even further. The art of looking up-stream is relevant for all IBCLCs, as they need to be aware of the risks of rushing in to meet service needs, which might not, in the long-term, meet breastfeeding women's needs.

## **8.6. Recommendations for the promotion and support of IBCLCs in England**

This research has provided a number of new insights into the experiences of a group of IBCLCs in England, which have led to recommendations for promoting and supporting the role. The thesis provides an opportunity to share the findings with the IBLCE and ILCA, as well as LCGB, to consider particular recommendations apart from ensuring the research findings are published and promoted. The recommendations are divided between LCGB, the international bodies ILCA and IBLCE and for individual practitioners.

### **Recommendation 1**

That ILCA and IBLCE are made aware of the research findings and asked to consider how they can support IBCLCs on the identified issues of developing teaching skills, managing change and practitioners seeking support for their clinical practice.

Rationale: Practitioners felt unsupported on the identified issues. The finding could inform the questions for the 2012 IBLCE Delineation Study as well as future publications on the role of IBCLCs in how the international organisations could help practitioners address some of these possible disparities in the role.

## **Recommendation 2**

That ILCA and IBLCE consider if there can be a clear single definition of being an IBCLC.

Rationale: Practitioners found it difficult to articulate their IBCLC qualification which led to mixed messages for IBCLCs, employers and women who sought lactation consultant's service.

## **Recommendation 3**

That LCGB liaise with ILCA and IBLCE to establish if it is possible to agree a explicit regulatory framework for IBCLCs in the UK that could meet Government requirement for independent health professional practice (DOH 2011c).

Rational: While IBLCE provides an international framework for professional practice for IBCLCs a national framework does not exist.

## **Recommendation 4**

That LCGB consider how they could implement a regional IBCLC peer to IBCLC peer support network which is built on reflective developing and review of practice.

Rationale: Practitioners identified a need for continuing professional as well as social support, to enable them to reflect on their practice, provide professional progression and be able articulate their role with peer IBCLCs, other health professionals and health service managers.

## **Recommendation 5**

That LCGB considers if further support such as workshops or on-line resources, can be provided for IBCLCs on education, managing change and up-dates on national initiatives, such as developing a public health remit or social enterprise initiatives.

Rationale: Practitioners have very little preparation on education or managing change when becoming an IBCLC. The busyness of the

workplace means that opportunities for further development of IBCLC practice can be missed.

**Recommendation 6**

That LCGB needs to consider how they can visually present the IBCLC practitioner as a teacher, working with other health professionals as well as with breastfeeding women.

Rationale: The present LCGB website does not illustrate the various roles of IBCLC practice.

**Recommendation 7**

That LCGB develops a promotional framework for the role of IBCLCs in the UK that includes the research from this study.

Rationale: Participants were seeking written information to help promote their role. Promotional material produced by ILCA was found not to reflect the study's findings but promotional material was still needed to help IBCLCs in the UK. Lactation Consultants GB agreed to finance the production of a leaflet about being an IBCLC in the UK until 2014. Evaluation of the leaflet by users and IBCLCs is recommended.

**Recommendation 8**

That LCGB establish links with other health professions, voluntary organisations and parental websites that support breastfeeding women.

Rationale: Contact with other organisations would raise the profile of IBCLC within the UK, as well as possibly establish web-based links for people seeking further information on the role.

**Recommendation 9**

That UK IBCLCs take responsibility for promoting their IBCLC role through initiatives such as ILCA Day of the IBCLC.

Rationale: Participants need to articulate their IBCLC qualification.

### **Recommendation 10**

That IBCLCs use their full qualification title of IBCLC in practice and on documents, and they use their personal identification badge to demonstrate they are qualified

Rationale: Practitioners need to raise their profile as professional practitioners.

### **Recommendations 11**

That IBCLCs write accounts of their practice to share and inform others.

Rationale: There is a lack of publication by UK IBCLCs of their practice and therefore, a lack of understanding and articulation of their role.

### **Recommendations 12**

That experienced IBCLCs offer mentoring to newly qualified practitioners.

Rationale: Newly qualified IBCLCs, are not fully formed practitioners and mentoring by a skilled knowledgeable practitioner would provide modelling of the role.

## **8.7. Conclusion on the experiences of participant IBCLCs**

In undertaking this research I found a commonality of approach to practice from all the participants that I was not expecting. In the literature review I raised concerns that health professionals entering a profession founded on the ethos of voluntary lay practitioners may change the focus of practice with breastfeeding women. The study found that my original concerns had no foundation related to the participants. The IBCLCs shared a common driver to improve the knowledgeable support available to breastfeeding women and work with women and other health professionals to achieve this outcome.

The participants focus on their practice, though, was at the expense of not promoting their role as an IBCLC. Working with breastfeeding women with a professional qualification drew the participants to become IBCLCs, not

the concept of being a Lactation Consultant. The participant's focus on developing a professional clinical role enabled the participants to promote a practice that was sensitive to the needs of the breastfeeding dyad but the promotion of being an IBCLC was limited to how they worked. I concluded that becoming an IBCLC enabled the participants to state that they were professionally qualified but a different professional qualification which offered the same recognition might have been undertaken instead. Becoming an IBCLC was relevant as it enabled the participants to continue to work with breastfeeding women in a professional capacity. The realisation that the participants were seeking a professional identity might explain why the participants remained passionate about their practice but more reticent about their role.

The participant's way of working as a professional servant and a servant leader illustrated practitioners who worked alongside women and health professionals sharing their knowledge and skills to develop breastfeeding outcomes. The strength of such a work-based role was that the participants became recognised as breastfeeding champions. The way the participants practiced met the WHO (2003) and EC (2004) description for specialised practitioners who can promote and develop breastfeeding practice within the workplace but it was their passion for practice that was recognised not their professional qualification.

The participants' passion for developing breastfeeding practice illustrated practitioners who were motivated to lead on implementation of initiatives such as the UNICEF/UK BHI (2011a) within the NHS. The participants, though, found that when they undertook the leadership role, they did not have the necessary skills and knowledge to implement the changes apart from their understanding of breastfeeding practice. The participants described acquiring the skills through trial and error which was a stressful experience. A lack of previous research on the experiences of IBCLCs may have hampered an understanding that practitioners need to identify their needs and acquire the necessary skills and knowledge within the practice framework prior to working in roles that demand such leadership.

The combination of trying to develop a professional breastfeeding practice, further skills to enhance the role and working in the NHS provoked a level of stress that made some practitioners contemplate or temporarily leave the health service and work in private practice. Private practice provided an opportunity for IBCLCs to work within a personal framework which brought some control back into their role. Leaving the NHS, though, was a temporary respite as the two participants who left did return to the health service when circumstances which enabled their breastfeeding practice, changed. The ideal role the participants sought within the NHS was a niche practice where they could work with autonomy assisting breastfeeding women and encouraging other health professionals to develop their practice.

The research demonstrates how politically aware practitioners need to be to the changing frameworks of practice, at local, national and international levels as risks and opportunities are presented to IBCLCs. The focus on breastfeeding and the flexibility in adapting to differing circumstances described by the participants, provided opportunities for IBCLCs which the practitioners did not discuss or appear aware of. The research findings proposed that practitioners consider moving into the local public health agenda or in establishing social enterprise initiatives where a niche practice might be easier to establish. A considered risk in remaining within the NHS is that IBCLC practitioners might become solely responsible for supporting breastfeeding practice, while other health professionals withdraw their support.

To enable any promotion of the IBCLC role practitioners need to articulate their practice. The lack of articulation and promotion of a professional IBCLC practice found in the study risked practitioners becoming exposed and isolated from other health professionals as they lacked an understanding of who or what they were. The research proposed that aspects of IBCLC practice, such as the role of professional servant and leader from the study, could form the basis of a British framework of

practice. The British framework would have the clarity the international structure lacks.

Part of the developmental dialogue needs to be set around how IBCLCs support each other, mentor future practitioners, share and develop their practice and promote the role. The suggested framework in the proposals in this study is that IBCLCs work through their affiliate professional organisation, LCGB, in the development of future initiatives. By enabling and supporting the personal development of practitioners and the promotion of the IBCLC role, LCGB could become the mouth-piece for a UK professional breastfeeding practice.

The quote used at the start of this chapter was chosen as it reflects the constant striving for excellence within any profession and professional practice. As we begin to understand what being an IBCLC might mean for practitioners then further challenges will present themselves.

## **Chapter Nine: Reflections and recommendations**

*There are in our existence spots of time, Which with distinct pre-eminence retain, A vivifying Virtue, whence . . . our minds, Are nourished and invisibly repair'd . . . (Wordsworth, 1805, Prelude XI. 258 -263, cited Radar 1967).*

### **9.1. Introduction**

This chapter completes the thesis. It has described the experiences of twelve IBCLCs who work in the north of England. The completion, though, does not mark a conclusion but a pause where further issues related to the role can be considered.

Ricoeur (2001) wrote that any research commences with some self-understanding and interpretation of the self. On completion of this study I realise what little I knew when I first started out on this thesis and now, how much more I still have to understand. This chapter undertakes a reflexive and reflective account of the research and its strengths and limitations.

### **9.2. My reflective description of the participants**

The study was timely in the respect that IBCLCs have been in practice in England since 1993 without any evident research on the experiences of practitioners. I now feel confident if asked to précis the way the IBCLC participants practice, to describe a group of highly motivated professionals who work with breastfeeding women enabling them to meet their and their infants' needs and enable other health professionals to do the same. The description is simple and while not elucidating how they practice, illustrates who they are.

The study is also timely because there is a continuing debate in the UK about why health professionals are not always placing the person at the centre of their care (Savage 2007; Deery et al. 2010; Kirkham 2010). As an example a recent report by the Quality Care Commission (NHS 2011c) illustrated how the elderly are ignored within many hospitals by the carers who should be listening and responding to their needs. In maternity care,

the voluntary bodies such as the NCT (2009) and governmental reports have called for re-focusing of service provision on the mother and baby since the Changing Childbirth Report (DOH 1993). While some groups of health professionals have adapted and developed the way they work (Savage 2007; Kirkham 2010) the changes have never been fully implemented in maternity services (Cumberledge 2003; Kirkham 2010). The participants' accounts provide descriptors of the tensions experienced when working in a woman-centred framework within the NHS. The study could help other health professionals gain some understanding of the issues around centring care.

### **9.3. Strengths, limitations and conclusions on the study**

I recognise that each person brings a different focus and attributes to any research undertaken. This section addresses the strengths, limitations and conclusions of the study except the rationale for the choice of the research framework which was discussed in Chapter Three.

Before I completed the study I remained tentative in suggesting others should pursue a profession in which the only experience I partially understood was my own. The completion of the thesis has changed my approach and I now feel able to promote the IBCLC role with an insight into what prospective practitioners need to consider with regard to learning, personal development and clinical support. By utilising the findings in such a way I consider the research has reached the aim and objectives set for the study.

My aim in undertaking the research was not to validate the role of an IBCLC but to provide an understanding of practitioners' experience in practice and if necessary to develop recommendations for practitioners. I could have undertaken the exploration without the academic rigour of a thesis but I found the supervisory framework enabled me to propose, debate and defend each stage of the research which provided me with a certain confidence in the process and the findings. As a researcher with minimal research experience, the structure of undertaking the thesis,

although frustrating at times, did enable me to maintain a focus on what I needed to do to complete the work.

A possible limitation in the study was that while I was primarily working as a researcher, I was also an IBCLC. Throughout the thesis I have attempted to make my position and the processes by which I have gained any understanding within the research framework as clear as possible. I found Daudelin's (1996) reflective framework enabled a way within the research for me to both monitor my actions and reactions and explore the data. Describing reflective practice as a way of self-monitoring could appear to be seen as restrictive and linked to a more reflexive action but I found it presented an opportunity to "open-up" and use my experiences as an IBCLC to challenge myself and the data. Alvesson and Sköldberg (2000) and Gadamer (1997, p.104) described a "fusion of horizons" between the researcher and the data when seeking an understanding through reflection. My aim was not to find a resolution to the descriptions of the participants' experiences but to ask inductive questions of practitioners. I described my action as more of a searching and exploration of the horizons of what is known about IBCLC practice within a reflective framework. Through searching I had to keep myself grounded in the data. The way each participant described and framed their accounts helped me in really listening to each narrative. The process enabled me to maintain some separation from my experiences from those expressed by the participants. The act of self-monitoring enabled me to reflect on how I handled the narrative but I do acknowledge the underlying limitation that while acting as the researcher I was also an IBCLC.

I found that working within reflective and reflexive approaches enabled me to think creatively about the research and also to take stock of my thoughts in a critical way (Mason 1996; Alvesson and Sköldberg 2000; Arber 2006; Crossley 2006). The strength of choosing such a framework was that I felt it challenged me to gain a deeper interpretation of the participants' narratives. By opening me up to consider what I knew about the role and professional practice I considered the completed thesis to be thoroughly examined and considered.

Alvesson and Sköldberg (2000) described how the use of reflexive practice in research could be difficult to separate from reflective practice. While I did not always consciously define when each approach was used within the study, I was aware there was a difference. Reflexivity provided a dimension to the study in the “way of seeing” the participants (Clegg and Hardy 1996, p.4). Using Patton’s (2002) questioning I could examine relationships the participants described between the social, cultural and political aspects of their practice. Bourdieu (1993) described that in examining such relationships a particular “habitus” or pattern of action among participants can often be described. The participants’ passion as a driver for developing a breastfeeding practice exemplified this.

Reflection built on these descriptors which enabled further examination of the context of professional practice (Alvesson and Sköldberg 2000). I found reflective practice shifted the analysis to a more interpretative stage where critical awareness of self within the process was essential. The process of reflection raised my awareness of how my values and interests could influence the course of the research (Lewis 2008). The use of Daudelin’s (1996, p.39) reflective framework, which described “stepping back,” helped me to pause, explore and make adjustment to the way the research was considered. The reflexive and reflective framework provided a perspective within the study which otherwise would have been difficult to achieve. The descriptions, though, remain my own.

I recognise that it was an emotional response to other IBCLCs about why they left the NHS that made me take the initial step and consider undertaking this study (Blenkinsop 2007; English 2007). While emotional issues are often reflected in practice (Schmied and Barclay 1999; Ryan et al. 2011a) similar responses in research are often under recorded (Hubbard et al. 2000; Holland 2007; Lewis 2008; Nicolson 2009). I felt that the research afforded the opportunity for IBCLCs to articulate and reflect on their practice and by including excerpts from a participant’s narrative the voice of the practitioner was heard which could also make

their experience feel “real” to other readers (Polkinghorne 1988; Potter 1996; Benwell and Stokoe 2006). The inclusion of excerpts from my research log and personal account of being an IBCLC were also used within the thesis as a way to illustrate how my understanding of the participants’ experiences developed throughout the study (Mark 2005). I felt that the inclusion of such dialogues within the thesis strengthened the understanding of the research process and provided a deeper meaning to the descriptions of IBCLCs’ experiences.

One of the limitations during the study was time. On commencing the research I felt what a luxury it was to devote years rather than months to a topic that I was passionate about. I was soon disabused of that notion. The time I had when trying to juggle a practice role, lecturing and research alongside family life was never enough. Fortunately, since my retirement from paid work I was able to devote the time I needed to the study, which aided the reflection and reflexivity I needed to undertake when analysing my data and writing up my findings. In Chapter Six I wrote about a practitioner’s time being spent with a breastfeeding dyad as different from that spent in day-to-day work. Undertaking this study has highlighted similarities in that researching a subject I still feel passionate about meant I did not count the time I spent undertaking the thesis in quite the same way as spent on other tasks.

Any understanding of the participant’s role within this study does not mean the descriptors are generalisable for all IBCLC practitioners which can be seen as a limitation but many of the findings are transferable to other IBCLCs in the UK working in similar situations. While the issue of generalisability might appear limiting and problematic for some practitioners the articulation of a professional role remains important for all IBCLCs and is a start in understanding the role. A similar understanding of the research findings needs to be applied when IBCLCs consider the recommendations for the promotion and support of the role.

## **9.4. Recommendations for further research on the role of IBCLCs**

At the commencement of this chapter I described the completion of this thesis as a pause before other research needs to be undertaken about IBCLC practice. This study provides a foundation from which to explore further aspects of the IBCLC role and suggestions for further research are included by way of conclusion.

### **Recommendation 1**

That research is conducted by IBLCE to address the following questions:

- What learning to teach is undertaken by IBCLCs?
- What are the needs of IBCLCs in developing teaching skills and resources?
- If working within a health service or other organisation, what changes, if any, in practice are the IBCLCs expected to implement?
- What resources or skills do the IBCLCs need to implement these changes?
- What role, if any, do IBCLCs have in implementing the WHO and UNICEF BFHI?
- What are the needs of IBCLCs in implementing the WHO and UNICEF BFHI?

Rationale: The IBLCE is responsible for the management of the qualification. The next IBLCE Delineation Study is due in 2012 and these questions could inform the survey. The information from the survey informs practice frameworks as well as the qualifying examination.

### **Recommendation 2**

That research is conducted by ILCA to address the following questions:

- What support frameworks are IBCLCs looking for in their IBCLC role?

- How and when reflective development is used by IBCLCs and how it can be enhanced?
- What ways would they like to see the IBCLC role promoted?
- How do IBCLCs cope in stressful situations?
- How are IBCLCs able to articulate their needs in developing a professional practice?
- How confident do IBCLCs feel to support their peers?
- How confident do IBCLCs feel to support other health professionals?

Rationale: Promotional material and support frameworks, provided and promoted by ILCA did not meet the needs of the practitioners in this study. Establishing IBCLCs needs could enable improved initiatives and uptake.

### **Recommendation 3**

That further research be undertaken to explore infant feeding outcomes between comparable obstetric and birth units in the UK which do and do not have an IBCLC in a specialist role.

Rational: There is one Randomised Controlled trail (RCT) carried out in the USA where standard or IBCLC interventions were made in the antenatal and postnatal period (Bonack et al. 2005). This study is promoted as one of the rationales for employing IBCLCs within a health service. The research is not relevant in the UK as service provision is different but health services still tend to be more receptive to quantitative than qualitative research when considering changes in practice.

### **Recommendation 4**

That further research is undertaken to examine how IBCLCs manage change in clinical practice. Ankyloglossia<sup>61</sup> detection and treatment could be used as an example of monitoring a change in practice.

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<sup>61</sup> Ankyloglossia or tongue-tie can be classified according to the site of attachment of the lingual frenulum on the tongue and the floor of the infant's mouth. A breastfeeding baby requires well-coordinated tongue action to enable optimum breastfeeding and the lingual frenulum may hamper such action (Watson-Genna 2008).

Rationale: NICE (2005) recommended treatment for babies if ankyoglossia is interfering with breastfeeding and six of the participants articulated accounts of attempting to develop a local support framework where treatment was possible. Researching how IBCLCs manage such change would be useful for understanding the enablers and barriers they face in practice.

#### **Recommendation 5**

That further research is undertaken to understand how IBCLCs develop a specialist role within the NHS and work within inter-professional teams.

Rationale: Narrowing the sample down to IBCLC practitioners who only work in a specialist role within the NHS could illustrate a framework for future practice as well as describe the present roles. The recent appointment of an IBCLC to a consultant role within the NHS suggests that there are more experiences to explore.

#### **Recommendations 6**

That further research on support initiatives that enable IBCLCs' practice is conducted.

Rationale: If the recommendations for regional groups, preceptorship or mentoring programmes for IBCLCs are initiated and followed within the UK then full evaluation will be needed to ensure these programmes are meeting the needs of practitioners.

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Appendix 1: Research involving IBCLCs.		The method of the literature search is described 2.1. and 2.5. with historical limits set from 1985 to December 2009.			
Authors	Title	Place	Method	Intervention	Key Points
Wambach, K. 1989.	<i>The effect of lactation consultant contact on early breastfeeding problems.</i> Dissertation, (Nursing). The University of Arizona.	USA	A group of 16 first time mothers. Group one (9) control with usual care and support. Group two (7) provided with extra education and support based on Oram's Nursing System by an IBCLC.	IBCLC intervention	Very small study. No significant difference noted between the groups except that the women in the experimental group did not give as many supplementary feeds.
Wilton, J. 1989.	Development of a hospital breastfeeding centre. <i>Journal of Human Lactation</i> , 5(3), 132 – 134.	USA	A descriptive survey based on retrospective chart review enabled the researcher an IBCLC to propose the development of a breastfeeding service.	Development of IBCLC led breastfeeding service in a maternity unit	Breastfeeding rate on hospital discharge prior to intervention 59% (N=349) and after 75%. Descriptions of how the service was implement and how it continues to develop. Women had to pay for the service which was reinvested in employing another IBCLC.

Wohlberg, L. Geary, B. 1994.	Team approach to breastfeeding the Low-birth weight infant: a case report. <i>Journal of Human Lactation</i> ,10(3), 181 – 183.	USA	Case report study on how the NICU feeding specialist (IBCLC) and a neonatal nutritionist worked together to support a mother in expressing and then breastfeeding her 24/40 baby	IBCLC collaborative working	Exclusive breastfeeding was not possible Both health professionals learned while working together.
Williams, C. Hoyle, D. Brimeyer, M. Williams, A, 1994.	Mothers' intention, age and education and the duration and management of breastfeeding, <i>Maternal Child Nursing</i> , 22(3), 102 -108.	USA	Comparison of outcomes between two breastfeeding groups. One group had IBCLC support (n=46) the other did not (n=115).	IBCLC intervention	The women who had IBCLC support breastfed for significantly longer (3.1 months, p=0.2) compared to the control group (2.4 months).
Brent, N. Redd, B. Dworetz, A. D'Amico, F. Greenburg, J. 1995.	Breastfeeding in a low-income population; programme to increase incidence and duration. <i>Archives of Pediatrics and Adolescent Medicine</i> 149: 798 – 803,	USA	Randomised non-blinded control trial. The intervention group (n=51) saw an IBCLC antenatally and up to a year if needed. The control group (n=57) had usual care.	IBCLC intervention	The intervention group had significantly higher incidence of breastfeeding (p =0.002, 61% v 32%). The duration was also longer in the intervention group (p=0.05)

Lawlor-Smith, C. McIntyre, E. Bruce, J. 1997	Effective breastfeeding support in general practice. <i>Australia Family Physician</i> , 26(5), 573-580.	Australia	Pre and post intervention evaluation study. The intervention group (n =119) and baseline group (n = 168) were predominately middle-class mothers. The intervention consisted of two prenatal and regular postnatal contacts with IBCLC until six months.	IBCLC intervention	Breastfeeding initiation rate was high in both groups. Breastfeeding rates were significantly higher in the intervention rate at 24 and 26 weeks (p=0.015 and p=0.018 respectively).
Lee, N. 1997.	Observation based upon multiple telephone contacts with new breastfeeding mothers. <i>Journal of Human Lactation</i> , 13: 147 – 150.	USA	Observational report based on the support provided to 600 women in the previous 6 years. Women received daily telephone contacts for 5-7 days, 1-3 calls over the next two weeks then the calls decreased.	IBCLC run hospital telephone support line	The breastfeeding rate was 85% of women who received calls breastfed at one week, 46% at three months and 23% at six months. The IBCLC called the mother. Just 12-16 % of calls were from the women.

<p>Pastore, M. and Nelson, A. 1997.</p>	<p>A breastfeeding drop-in centre survey evaluation. <i>Journal of Human Lactation</i>, 13(2), 291 – 298.</p>	<p>USA</p>	<p>Evaluation of a breastfeeding drop-in group using telephone interviews with 57 clients using open and closed questions. The most common problems were crying/fussing baby, difficulties with the latch.</p>	<p>IBCLC facilitated group run by two nurses with IBCLC qualification</p>	<p>Students and other health professionals attended the group for educational and observation support. At 4 months 81% breastfeeding with 50% breastfeeding until or beyond their intended duration. Ninety five per cent of the women stated the clinic had completely or partially resolved any problems.</p>
<p>Peitschnig, B. Siklossy, H. Gottling, A. Posch, M. Kafer, A. Lischka, A. 2000.</p>	<p>Breastfeeding rates of Very Low Birth Weight babies (LBW) - influence of professionals support. <i>Advanced Experiences in Medical Biology</i>, 478, 429 - 430.</p>	<p>USA</p>	<p>Measurement of breastfeeding rate in Very Low Birthweight infants before and after the introduction of an IBCLC into the care service.</p>	<p>IBCLC intervention</p>	<p>Before the intervention the breastfeeding rate was 21.5%. After the intervention it was 62.5%.</p>

Vari, P. Camburn, J. Henly, S. 2000.	Professional mediated peer support and early breastfeeding success. <i>Journal of Perinatal Education</i> , 9(1), 22-30.	USA	Quasi-experimental study using questionnaires to collect breastfeeding outcome at six weeks from an intervention group with an IBCLC and a group without.	IBCLC intervention	The intervention group had a higher mean at 5.42 weeks of exclusive breastfeeding (p=0.5) with younger women (under 25 years) but no difference was otherwise observed between the groups.
McKeever, P. Stevens, B. Miller, K. MacDonald, J. Gibbons, S. Guerriere, D. Dunn, M. Coyte, P. 2002.	Home versus hospital breastfeeding support for newborns: a randomised controlled trial. <i>Birth</i> , (29(4), 258 – 265.	Canada	A RCT of 138 women. The experimental group had standard hospital care with earlier discharge and home support from an IBCLC. The control group received standard hospital care and discharge. Data was collected at 5 and 12 days.	IBCLC intervention	The women in the intervention group appeared to feel more positive about breastfeeding but no difference in breastfeeding rate was observed.

<p>Stefiuk, W. Green, K. Turnell, R. Smith, B. 2002.</p>	<p>Process evaluation of the Saskatoon Breastfeeding Centre. <i>Journal of Human Lactation</i> 18(1), 29 -37.</p>	<p>Canada</p>	<p>A process evaluation was conducted to assess clients' characteristics and satisfaction with an IBCLC run breastfeeding clinic. Fifty women completed questionnaires and a telephone interview, 25 women who attended the clinic were telephoned and four visits were observed.</p>	<p>Description of IBCLC clinic</p>	<p>All observed visits took longer than expected Clients said they would use the centre again and recommend it to others.</p>
<p>Albernaz, E. Victoria, C. Haisman, H. Wright, A. Coward, W. 2003.</p>	<p>Lactation counselling increases breastfeeding duration but not breast milk intake as measured by isotopic methods. <i>The Journal of Nutrition</i>, 133, 205 - 209.</p>	<p>Brazil</p>	<p>Randomised intervention trial where 2 IBCLCs provided 40 hours of training for staff in the intervention group</p>	<p>IBCLCs training other health professionals</p>	<p>Mothers in the control group were twice as likely to stop breastfeeding by 4 month as those in the intervention group (p =0.04). Breast milk intake did not differ between the groups.</p>

Cantrill, R. Creedy, D. Cooke, M. 2003.	An Australian study of midwives breastfeeding knowledge. <i>Midwifery</i> , 19(4), 310 -317.	Australia	Postal questionnaire were sent to 9500 midwives who were members of the Australian College of Midwives.	Midwives some with IBCLC qualification.	Out of the 1105 relies participants who were over 30 years old, or had the IBCLC qualification, or had personal breastfeeding experience achieved a higher score.
Eichmann, K. 2003.	<i>The effect of routine follow-up with a Certified Lactation Consultant (CLC) or Certified Lactation Educator (CLE) on the duration of breastfeeding.</i> Thesis, (MSc). California State University.	USA	A total of 94 women, 50 in the control group and 44 in the experimental group received nine follow-up telephone calls from the IBCLC or CLE. A questionnaire was used to identify any breastfeeding problems.	IBCLC and CLE intervention	The qualifications of CLE were not explained so the study was not clear if they were different roles. No significant increase in duration of breastfeeding in the intervention group but the IBCLC and CLE considered they helped to reduce any breastfeeding problems.

<p>Gonzalez, K. Mainzen-Derr, J. Burke, B. Hibler, A. Kavinsky, B. Hess, S. Pickering, L. Morrow, A. 2003.</p>	<p>Evaluation of a lactation support service in a children's hospital neonatal intensive care unit. <i>Journal of Human Lactation</i>, 19(3), 286 -292.</p>	<p>USA</p>	<p>Charts of 350 babies randomly selected the year before and the year after an IBCLC was employed.</p>	<p>IBCLC intervention</p>	<p>The number of babies given their mother's milk increased from 31% to 47% (p=0.002). This increase differed significantly in relation to infant's clinical status and management. (apgars.gestational age) but not in maternal factors.</p>
<p>Ortiz, J. McGilligan, K. Kelly, P. 2004.</p>	<p>Duration of breastmilk expression among working mothers enrolled in an employer sponsored lactation program, <i>Pediatric Nursing</i>, 30(2), 111 - 119.</p>	<p>USA</p>	<p>Descriptive retrospective study on breastfeeding women who worked in one of five corporations were an IBCLC was employed to support them.</p>	<p>IBCLC employed by to support breastfeeding in the workplace</p>	<p>Breastfeeding was initiated by 97.5% of the group (435) and 57.8% continued breastfeeding and/or pumping for 6 months. The mean age when women stopped pumping at work was 9.1 months. The mean maternity leave was 2.8 months.</p>

Aidam, B. Perez-Escamilla, Lartey, A. 2005.	Lactation counselling increases exclusive breastfeeding rates in Ghana. <i>The Journal of Nutrition</i> , 135, 1691 -1695.	Ghana	Randomised trial. Group 1 the control group (n=85), Group 2 pre and post extra breastfeeding support (n=43) Group 3 extra breastfeeding help(n=49).	IBCLC trained the breastfeeding support team in Groups 2 and 3.	At 6 months 90 % in group 2 and 74.4%in group 3 were exclusively breastfeeding compared to 47.7% in the control group (p=0.002).
Chamberlain, L. Merewood, A. Malone, K. Cimo, S. Philipp, B. 2005.	Calls to an inner-city hospital breastfeeding telephone support line. <i>Journal of Human Lactation</i> 21(1), 53 – 58.	USA	Review of 5 years of records to an IBCLC run breastfeeding help line in a maternity unit.	IBCLC run help-line	The results indicated a substantial demand for breast pumps from women and a demand for the support line.
Fallon, T. Hegney, D. O'Brien, M. Brodribb, W. Crepinsek, M. Doolan, J. 2005.	An evaluation of a telephone-based postnatal support intervention for infant feeding in a regional Australian city, <i>Birth</i> , 32(4), 291 -298.	Australia	A prospective cohort study collected data from two hospitals( one private, one public) prior to (696 women)and after (625 women) the introduction of an IBCLC telephone support service. Women followed up for 3 months.	IBCLC intervention	For the women in the private hospital the intervention improved exclusive breastfeeding at 4.5 weeks but not at 3 months. No effects were observed in the public hospital. The women were very satisfied with the support

Kools, E. Thys, C. Kester, A. 2005.	A breastfeeding promotion and support programme a randomised trial in the Netherlands. <i>Preventive Medicine</i> , 40(1), 60 -70.	Holland	Cluster randomised intervention of 10 child health care centre allocated usual care or intervention of extra counselling by IBCLCs. Women recruited n=683 and follow up for 6 months	Extra IBCLC intervention	After 3 months there was no difference between the groups. After six months fewer women were breastfeeding in the intervention group (32%) than the control group (38%)
Rishel, P. and Sweeney, P. 2005.	Comparison of breastfeeding rates among women delivering infants in military treatment facilities with and without Lactation Consultants. <i>Military Medicine</i> ,170 (5), 435 – 438.	USA	Retrospective study of charts of babies in three military bases. One did not have an IBCLC the other two did.	Do units with IBCLCs on the staff make a difference?	A total of 507 birth were accessed. Women visited by an IBCLC were significantly more likely to breastfeed (p+0.001). At follow up at 4-6 months this difference had disappeared.

<p>Stevens, B. Guerriere, D. McKeever, P. Croxford, R. Miller, KL. Watson- MacDonell, J. Gibbins, S. Dunn, M. Ohlsson, A. Ray, K. Coyte, P., 2006.</p>	<p>Economics of home vs. hospital breastfeeding support for newborns, <i>Nursing and Health Care Management and Policy, Journal of Advanced Nursing</i> 53(2), 233 -243.</p>	<p>Canada</p>	<p>Two groups of term and near babies were randomly allocated to either early discharge and continuing breastfeeding support at home (intervention n=48) or usual care with breastfeeding support in hospital (n=40)</p>	<p>IBCLC support in the hospital and at home</p>	<p>There was no statistical difference in breastfeeding outcome between the two groups with similar costs for both groups</p>
<p>Bonuck, K. Trombley, M. Freeman, K. McKee, D. 2005. Bonuck, K. Freeman, K. Trombley, M. 2006.</p>	<p>Randomised controlled trial of a prenatal and postnatal lactation consultant intervention on infant health care use. <i>Pediatrics</i>, 166 (6), 1413 – 1426. <i>Archives of Pediatrics Adolescent Medicine</i>, 160(9), 953-960.</p>	<p>USA</p>	<p>Randomised, unmasked controlled prospective study which collected data from one month to a year. The intervention was the use of IBCLCs to provide support.</p>	<p>IBCLC intervention</p>	<p>The intervention group (n=163) received more breastmilk but exclusive breastfeeding rates were low and did not differ according to the group. The intervention group was more likely to breastfeed until week 20 (53.0% vs 39.3%) but there was no significant difference after that. The control group n=175.</p>

Castrucci, B. Hoover, K. Lim, S. Maus, K. 2006.	A comparison of breastfeeding rates in an urban birth cohort amongst women delivering infants in hospitals that employ and do not employ lactation consultants. <i>Journal of Public Health Management and Practice</i> , 12(6), 576 – 585.	USA	Cross sectional study where data from 11,525 births in one city were examined to see if an infant was breastfeeding on discharge from a maternity unit.	Breastfeeding outcomes related to the employment of an IBCLC in a maternity unit.	Women who gave birth in a maternity unit where IBCLCs were employed had a 2.28 (95% confidence interval) increased chance of breastfeeding on unit discharge,
Haas, D. Howard, C. Christopher, M. Rowan, K. Broga, M. Corey, T. 2006.	Assessment of breastfeeding practices and reasons for success in a military community hospital. <i>Journal of Human Lactation</i> , 11 (22), 439 – 445.	USA	Baseline measurement on infant feeding was taken in 2002. A lactation service was then established with 5 IBCLCs offering 24 hour service. A cross-sectional survey was collected in 2004 of 934 women who self-completed questionnaires. No record of non-returned forms or % of births.	Five IBCLC offering 24 hour cover intervention.	Breastfeeding rates increased after the establishment of the service. Prior to the intervention 80% (2002) breastfed and 92% (2004) after. Of those who initiated breastfeeding, 85% breastfeeding at one week, 67% at six weeks and 61.7% at 6 months post intervention. Longer term breastfeeding was not recorded in the first survey.

Lukac, , M. Riley, J. Humphrey, A. 2006.	How to integrate a lactation consultant in an outpatient clinic environment. <i>Journal of Human Lactation</i> , 22(1), 99 – 103.	USA	A retrospective chart review comparing the breastfeeding rates at 4 and 6 months for women who had seen an IBCLC (n=30) and not (n=30)	IBCLC providing support	In the control group, 23% were breastfeeding for 4-6 months compared to 53% in the intervention group.
Mannel, R. Mannel, R. 2006.	Staffing for hospital lactation programs: recommendations from a tertiary care teaching hospital, <i>Journal of Human Lactation</i> , 22(4), 409 – 417.	USA	A retrospective review of data from IBCLCs activity reports at a large hospital over a two year period.	Workload of IBCLC	Optimal IBCLC staffing calculated at one full-time IBCLC per 783 breastfeeding dyads, NICU per 235 breastfeeding dyads.
Memmott, M. and Bonuk, K. 2006.	Mother's reaction to a skills-based breastfeeding promotion invention. <i>Maternal and Child Nutrition</i> , 2(1), 40 -50.	USA	21 women were interviewed about their experiences of IBCLC support.	IBCLC intervention feedback from women	The women described that the IBCLCs increased their confidence and perseverance to breastfeed.
Betzold, C. Laughlin, K. Shi, C. 2007.	A family practice breastfeeding education pilot program: an observational, descriptive study. <i>International Breastfeeding Journal</i> , 2(4), 102 -108.	USA	A family practice employed an IBCLC. A questionnaire was used with 33 women to describe any impact.	IBCLC intervention and breastfeeding support program.	Women described how they had doubled the time they expected to breastfeed their baby and 75% of women reported that they felt successful.

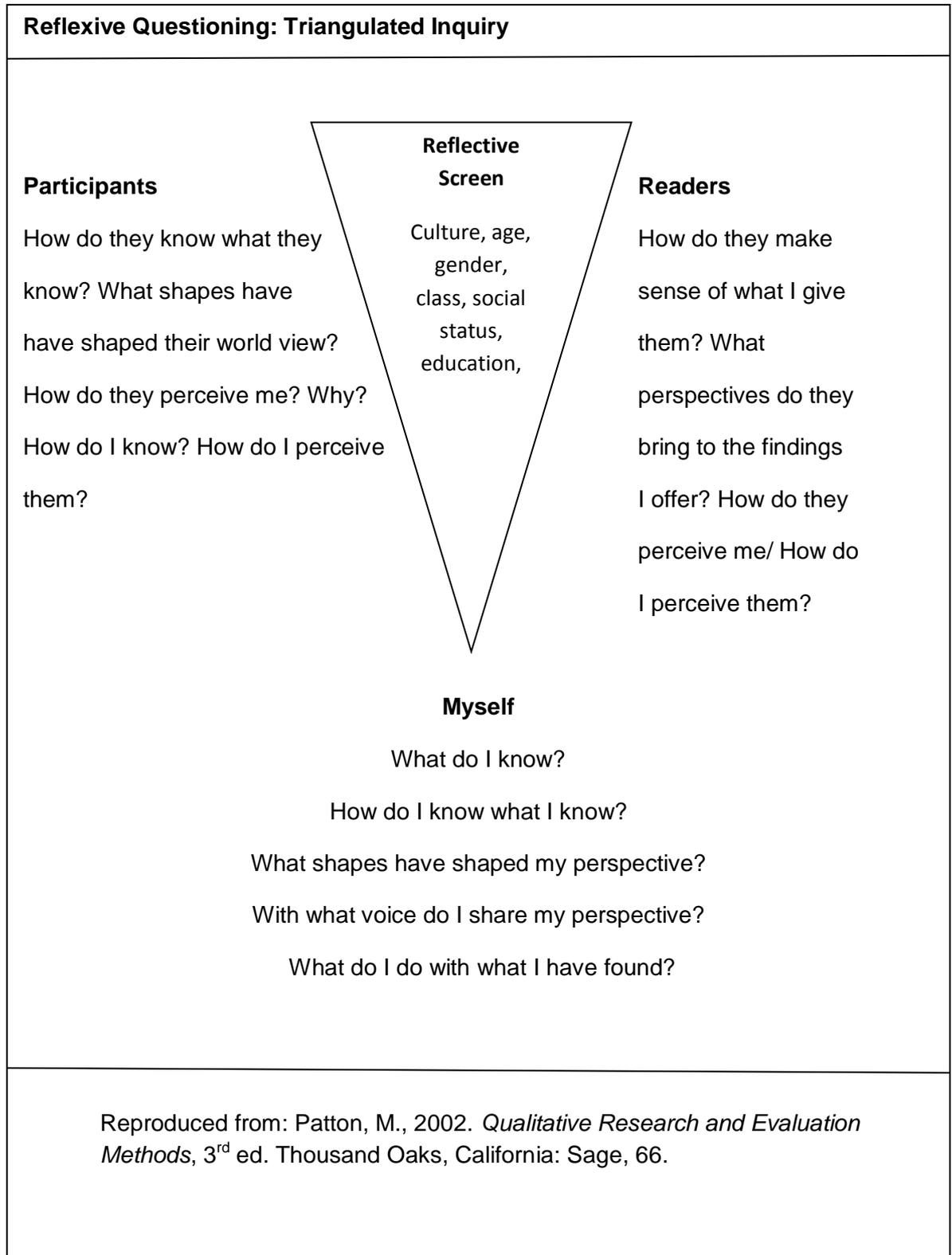
Castrucci, B. Hoover, K. Lim, S. Maus, K. 2007.	Availability of lactation counselling services influences breastfeeding among infants admitted to neonatal intensive care units. <i>American Journal of Health Promotion</i> , 21(5), 410 - 415.	USA	Cross-sectional study using population-level data (2132 infants). Breastfeeding at discharge and the presence of an IBCLC at the maternity unit	The presence of an IBCLC in the maternity unit where there was a neonatal unit.	The breastfeeding rates of mothers who delivered in a unit with an IBCLC where nearly 50% compared to 36.9% in units without an IBCLC. (Adjusted odds of breastfeeding were 1.34 - 95% confidence interval).
Gill, S. Reifsnider, E. Lucke, F. 2007.	Effects of support on the initiation and duration of breastfeeding. <i>Western Journal of Nurse Research</i> , 29, 708 – 723.	USA	Randomised controlled trail of 100 women with the intervention group meeting an IBCLC twice in the antenatal period and receive four postnatal phone calls. Control group standard care	IBCLC intervention	The intervention group had twice the odds of starting to breastfeed and of continuing to breastfeed for 6 months.
Chin, L. Amir, L. 2008.	Survey of Patients satisfaction with the Breastfeeding Education and Support Services of The Royal Women’s Hospital, Melbourne. <i>BMC Health Services Researc,h</i> 14(8), 83 - 92.	Australia	A survey of the women who had attended BESS clinic run by IBCLCs within a two month period. The response rate was 60.5%.	Response to IBCLC care.	Overall 56% stated that the quality of BESS was better than they expected.

<p>Lamontagne, C. Hamelin, A, St-Pierre, M., 2008.</p>	<p>The breastfeeding experience of women with major difficulties who use the services of a breastfeeding clinic: a descriptive study. <i>International Breastfeeding Journal</i>, 3(17) Available from: <a href="http://www.internationalbreastfeedingjournal.com">http://www.internationalbreastfeedingjournal.com</a> [Accessed 20 May 2008).</p>	<p>Canada</p>	<p>Descriptive study of the experiences of women with breastfeeding problems referred to a specialist clinic.</p>	<p>Specialist breastfeeding clinic run by an IBCLC and a physician.</p>	<p>Women who were referred to the breastfeeding clinic found that the support offered provided a positive influence on feeding outcome. The study suggests that specialist breastfeeding clinics might have a critical role in improving feeding outcome.</p>
<p>Rosen, I. Krueger, M. Carney, L. Graham, J. 2008.</p>	<p>Prenatal breastfeeding education and breastfeeding outcomes. <i>American Journal of Maternal Child Nursing</i>, Sept/Oct, 315 -319.</p>	<p>USA</p>	<p>Retrospective cohort design. One hundred and ninety four antenatal women at an army medical centre. Group one had an IBCLC who taught breastfeeding. Group two had one-to-one breastfeeding teaching by an IBCLC Group three educated the health professionals.</p>	<p>IBCLC teaching in two of the intervention groups</p>	<p>Women who attended one-to-one IBCLC support (Group 2) had significantly increased breastfeeding at 6 months (<math>p = 0.01</math>) when compared to the groups 1 and 3 which were facilitated by health professionals or IBCLCs. There was no significant difference between group 1 and 3.</p>

<p>Thurman, S. Allen, P. 2008.</p>	<p>Integrating Lactation Consultants into primary health care services: are Lactation Consultants affecting breastfeeding success? <i>Pediatric Nursing</i>, 34(5), 419 – 425.</p>	<p>Five studies. Four USA and one Australia</p>	<p>Search on Medline, PsychInfo, CINAHL, Google Scholar found five studies to compare the use or non-use of IBCLCs in an outpatient settings. Studies (Lawlor-Smith et al 2008, Vari et al 2000, Bonuck et al 2005 and 2006 and Lucak et al 2006).</p>	<p>IBCLC intervention</p>	<p>Reliability and validity of the outcomes of these studies could not be ascertained due to small sample sizes and other limitation on study designs.</p>
<p>Dweck, N. Augustine, M. Pandya, D. Valdes-Greene, R. Visintainer, P. Brumberg, H. 2008.</p>	<p>NICU lactation consultant increases percentage of outborn versus inborn babies receiving human milk. <i>Journal of Perinatology</i>, 28, 136 -140.</p>	<p>USA</p>	<p>Retrospective chart review of three time periods of three months each. One – before hiring an IBCLC, two –after the IBCLC arrived and three the subsequent period.</p>	<p>IBCLC intervention</p>	<p>The intervention of an IBCLC increased the time infants received breastmilk. The greatest impact was 4-6 months after her employment when she had implemented in-service educational programmes for staff.</p>

Buckley, K. 2009.	A double-edged sword: lactation consultants' perceptions on the impact of breast pumps on the practice of breastfeeding. <i>Journal of Perinatal Education</i> , 18(2), 13-22.	USA	A qualitative descriptive study which interviewed 12 IBCLCs ( 1-20 years qualified) .	IBCLCs perceptions about the use of breastpumps	Reported increased use of breastpumps over last 10 -20 years. Observed IBCLC change in use and considered a necessity in practice
Gross, S. Resnik, M Cross-Barnet, C. Nanda, J. Augustyn, M. 2009.	The differential impact of WIC peer Counselling programs on breastfeeding initiation across the State of Maryland, <i>Journal of Human Lactation</i> , 25(4), 435 – 443.	USA	A cross-sectional study which used self-reported data from a peer counselling group, an IBCLC run group and a standard care group of health professionals. Working in socially deprived area.	Peer group outcomes compared to an IBCLC and a health professional group. IBCLCs had trained and developed the framework for the peers	Breastfeeding initiation was significantly higher in the peer group. There was not a significant difference between the IBCLC group and the Health Professionals group The peer group had allocated time to talk to women,
Petrova, A. Ayers, C. Stechna, S. 2009.	Effectiveness of exclusive breastfeeding promotion in low-income mothers: a randomised controlled study, <i>Breastfeeding Medicine</i> 4(2), 63 -69.	USA	A RCT of 104 women. The intervention group (52) received one-to-one pre and postnatal breastfeeding support from an IBCLC.	IBCLC intervention	There was no significant difference between the groups in the exclusive breastfeeding rate after the three months. Intervention group (13.9%) Control group (10.5%).

## Appendix 2: Reflexive questioning framework.



### Appendix 3. Examples of research diary entries

Writing my research log provided an audit trail of activities related to the research especially related to capturing ideas and insights as the study progressed.

There were many examples that recorded my experiences in collecting the data, initial reflections, discussion on the methodology and on the analysis. Interviewing other IBCLCs had a profound effect on me which I shared in the research log.

Research log 16<sup>th</sup> November 2008.

*It made me reflect what an honour it is to carry out these interviews. To have the time to really listen to their accounts and hear how they perceive their practice is really amazing. Many accounts mention similar experiences such as lack of knowledge as a midwife, health visitor, paediatric nurse before undertaking the qualification, while most mention the issue of time but the way they work and how they describe how they work is beginning to demonstrate subtle differences which need teasing out from the data. I just have to make sure that when I get in the car after an interview, apart from writing up some notes, I try not to dwell on the interview but concentrate on the driving.*

Research log 3<sup>rd</sup> November 2008.

*The other aspect of this emotional journey is the content of the interviews. So far I have only interviewed IBCLCs employed in the NHS but already one has cried and another mentioned, "burn-out." I do feel emotionally drawn to them during the interview because so often their story was mine. I do not tell them this and I am glad I have written my own account of practice to help form some separation. These are wonderful strong women but some of them appear to be bending under the strain and I am cross with myself I did not start this research earlier. I need to write this down as I need to remember how I feel at the time as I find when I am transcribing the emotions recede and the analysis kicks in.*

This example illustrates how the voices of the participants stayed with me.

Research log 14<sup>th</sup> July 2009.

*I had not really considered in the research proposal I really would start the process of analysis from the first time I heard the recordings but I did and the participants' voices really resonated and stayed with me. These voices have stayed with me throughout the transcription and alongside a mental picture of when and where I collected the data.*

This example demonstrated the importance of returning to collect further data. Not only were the participant eager to share their experiences but they were beginning to use the interview to meet their needs. The illustration, to me, demonstrated a need for a more formalised/ informal support structure for IBCLCs.

Research log 3<sup>rd</sup> March 2009.

*What surprised me is how quickly the participant opened up and once the recording was switched off how much each one of them wanted to talk "off tape." What they wanted to talk about was different issues in each case.*

Other entries in the research log related to methodological issues such as writing to remind myself about how I should write.

Research log 22<sup>nd</sup> March 2010

*I am doing it again, not acknowledging that I am embedded in the study. My voice feels so frail against other researcher who articulate their competences and confidence in their findings.*

Entries also illustrated my struggles in what to leave out of the study so the analysis was deeper.

Research log 20<sup>th</sup> June 2010

*I am writing about how the participants managed change in their workplace, I so want to include the narratives about babies tongue-tie division but the accounts are so diverse it would take pages to discuss. The role of IBCLC and tongue-tie division is really a research project in its own right. I will just have to put the narratives to one side and address it separately.*

Research log 15<sup>th</sup> August 2011

*There is so much discussion around infant's tongue-tie division on Lact-helpers and here I am sitting on participant's narrative and not contributing. My priority is completing the thesis but then I must consider how I use the narratives the six participants shared with me about babies with tongue-ties.*

The appendix reflects some of the ways I recorded activities throughout the thesis.

## **Appendix 4: Letter to the local recruiter of IBCLCs in the North of England**



Date

Dear

### **Becoming and Being an International Board Certified Lactation Consultant (IBCLC) in England.**

Thank you for offering your help in recruiting IBCLCs to this study.

The study is about the experiences in practice of IBCLC's and what led them to seek this qualification. There appears to be little evidence about how IBCLCs work in practice and as it is a developing profession there is a need to know how to support practitioners and inform others about the role. The participants for the study therefore need to be IBCLCs who work with breastfeeding women and their infants in any setting.

The data for the study will be collected through two in-depth interviews with twelve practitioners reflecting on their practice. The researcher will be the interviewer as well as the transcriber for the study. Once the data is collected, a number will identify each participant. Practice areas will be broadly identified as being in the north of England. An independent researcher will be used to check the analysis

I am therefore looking for IBCLCs who work in clinical practice in the health service, privately or in the voluntary sector. The length of time they have been in practice as an IBCLC is not important. I have sent you thirty recruitment packs which I would like you to address and post to the IBCLC practitioners in your area when I contact you to give you the go ahead. Please could you let me know how many of these

packs have been sent and when they are sent by posting the enclosed letter addressed to me at the same time.

The prospective participants will have up to three weeks in which to contact me with their details. I will only know the practitioners who contact me. Four weeks after I have received the letter from you confirming that you have sent out the recruitment information I will select twelve participants for the study. I am looking for IBCLCs who work in different clinical areas so if more practitioners have responded than are needed for the study the difference in practice areas will inform the selection. I will contact all practitioners who respond whether they will be taking part in the study or not.

As you can see in the recruitment letter, practitioners can contact me for further information about the study. I will seek their consent before collecting data and they can withdraw from the study at any time.

I would like to interview participants in a venue and at a time of their choosing. I hope to start in October 2008 with the second interview about six months later dependent on obtaining ethical approval for the study.

I have enclosed a letter with a stamped addressed envelope asking you to confirm that you are willing to go ahead with the role of local recruiter for this study.

I really am very grateful for your interest and your help and I will keep in touch with you so you remain aware of how the study is progressing.

Yours sincerely

Sarah Brown

Registered Midwife, Midwifery Lecturer, IBCLC.

**Appendix 4: Reply letter for local recruiter.**



Date

**Becoming and Being an International Board Certified  
Lactation Consultant (IBCLC) in England**

I have received your letter about being a recruiter to the above study.

I agree /do not agree (*cross out as needed*) to act as a local recruiter of IBCLCs to this study.

I have sent out                      (number of packs) on                      (date).

Yours sincerely

Please return to

Sarah Brown

Registered Midwife, Midwifery Lecturer, IBCLC.

School of Health and Social Care

Bournemouth University

Finchdean House

St Mary's Hospital

Milton Road

**Appendix 4: Letter sent to prospective participants with four page information pack about the study and a contact letter to return to me.**



St Mary's Hospital

Milton Road

Date

Portsmouth PO3 6AD

Hants

Dear

I am undertaking a MPhil/PhD study on the experiences of IBCLC's and would like to invite you to be the local recruiter for the research.

Information about the study is in the local recruiter sheet, which is enclosed with this letter. Please read this and consider if you are able to take part.

If you are interested in taking part or require further information then please contact me using the contact details in this and the participant's letter. If you do not respond within three weeks of receiving this information I will understand that you do not want to take part and you will not be contacted again.

Yours faithfully

Sarah Brown 02392 286000 Ext 3926. [sabrown@bournemouth.ac.uk](mailto:sabrown@bournemouth.ac.uk)

Midwifery Lecturer

School of Health and Social Care

02392 286000 x3926 (Work)

[sabrown@bournemouth.ac.uk](mailto:sabrown@bournemouth.ac.uk)



## **Information for IBCLCs recruited to the study**

### **PARTICIPANT Information Sheet (version 2: 20<sup>th</sup> August 2008)**

**You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or you would like more information about (please see contact details at the end of this information). Take time to decide whether you wish to take part.**

#### **Study Title**

Becoming and Being an International Board Certified Lactation Consultant (IBCLC) in England.

#### **What is the purpose of the study?**

I am undertaking a MPhil/PhD study at Bournemouth University looking at your day-to-day experiences of working as an IBCLC and why you undertook the qualification..

#### **Why is this study necessary?**

The qualification of IBCLC is a fairly recent introduction and while there have been practitioners in the United Kingdom since 1993 there appears to be very little evidence on what your experiences in practice are. It is anticipated that this study will contribute to a body of knowledge about the role, which might in the future help other practitioners who either work or are considering undertaking the qualification and enable others to understand and support practitioners in their work.

**Why have I been chosen?**

As an IBCLC it is anticipated that you have experiences in working in this role.

**Do I have to take part?**

This is an entirely voluntary process and you are free to withdraw from the study at any stage.

**What will happen if I take part?**

You will be invited to take part in two interviews, which will last about 45 minutes to an hour each and are held about six months apart. The interviews will be held in a place of your choosing, however to safeguard your confidentiality it is anticipated that they will be held in a private environment. The interviews will be digitally recorded. At each interview you will be asked to talk about your experiences as working as an IBCLC.

After each interview you will be sent a transcript of the interview and you will be offered the opportunity to discuss these with the interviewer either via the telephone, by e-mail or at the second interview. Before the second interview you will also be sent information on the topics raised by all the IBCLCs in the first interview. You might want to consider and reflect on this information during the second interview.

**What do I have to do?**

If you decide to take part please fill in and return the attached letter and I will contact you as soon as possible to arrange a mutually convenient time and venue for the first interview. I require 12 participants for the study. If more than twelve practitioners respond to this invitation then I will select participants so that a variety of clinical practice is covered in the study.

### **What are the possible disadvantages?**

There is a possibility that when retelling past experiences you might encounter an upsetting episode that causes emotional upset. If such an incident occurs it is suggested you seek support from your clinical supervisor if you are a midwife or work in the voluntary sector or through a counseling services either run in your workplace or through your general practitioner (GP).

### **What are the possible benefits of taking part?**

The study will offer you an opportunity to talk about your work as an IBCLC. It is also a chance to take part in a study that will begin to illustrate and highlight the practice of IBCLC's, which will begin to build a body of knowledge about the role.

### **Will my taking part in this study be kept confidential?**

The taped interviews will be given a number after collection and will be known by this number from then on. All excerpts of the taped interviews given in the final study will be identified by this number and work areas will be known as the "north of England." The numbered transcripts will not be shared with anyone other than the researcher, the researcher's supervisor and a researcher asked to assess the research process.

The researcher will retain the taped interviews for two years and the transcripts for 5 years on completion of the study when they will be destroyed in accordance with Bournemouth University guidelines. A copy of the study will be stored in the library at Bournemouth University.

### **What will happen to the results of the research study?**

It is anticipated that the research will be published in the Journal of Human Lactation and possibly other peer reviewed health professional related journals. It is also anticipated that it will be presented at a national/international IBCLC conference.

### **Who has reviewed the study?**

This study has been reviewed by a NHS Research Ethics Committee, which has responsibility for scrutinizing proposals for medical research on humans. In this case, the reviewing Committee was the Fife & Forth Valley Research Ethics Committee, who have raised no objections from the point of view of medical ethics.

### **Contact for further information.**

If you require any further information please contact;

Sarah Brown on 02392 286000 Ext 3926; [sabrown@bournemouth.ac.uk](mailto:sabrown@bournemouth.ac.uk)

School of Health and Social Care

Bournemouth University

Finchdean House

St Mary's Hospital

Milton Road

Portsmouth PO3 6AD

Or Dr Jen Leamon (research supervisor) on 01202 967273;  
[jleamon@bournemouth.ac.uk](mailto:jleamon@bournemouth.ac.uk)

Thank you for taking the time to read this information sheet and for considering taking part.





**Becoming and Being an International Board Certified Lactation Consultant in England.**

**Participant Consent Form**

Please initial box

1. I confirm that I have read and understood the information about this study and have had the opportunity ask questions and have these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I understand that my involvement will be to participate in two audio taped interviews in a setting of my choice.

4. I agree that any comments I make might be quoted in the study but that these quotes will be anonymous

5. I agree to take part in the study

Name of participant \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of researcher \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

One copy for participant: One copy for researcher with Bournemouth University

**Appendix 5: Further information to participants about arranging the second interview and feedback from the first interview.**



Bournemouth University  
Finchdean House  
St Mary's Hospital  
Milton Road  
Portsmouth PO3 6AD  
Hants

Date

Dear

Thank you for participating in the first part of my study on Becoming and Being an International Board Certified Lactation Consultant in England. Enclosed is a transcription of the interview you participated in. To enable the process of interpreting the interview I have used some symbols, which are explained, in the enclosed chart. All references to your place of work or the role you undertake such as midwifery or health visiting have been removed from the text and will not be used in any quotes.

If you have any questions about the transcription or anything you would like to discuss further then please do not hesitate to contact me. I am planning to undertake the second and final interview in April and May 2009. I will contact you before then to seek your agreement and to arrange a suitable date and venue for the interview. Prior to this interview I will send you further information on topics that have been raised in the first interviews, as you may want to consider these during the second interview along with anything raised in this transcript

I look forward to meeting you again.



Bournemouth University  
Finchdean House  
St Mary's Hospital  
Milton Road  
Portsmouth PO3 6AD  
Hants  
02392 28600 3926

[sabrown@bournemouth.ac.uk](mailto:sabrown@bournemouth.ac.uk)

7<sup>th</sup> April 2009

### **Becoming and Being an IBCLC in England**

Dear

Thank you for taking part in the first part of the study. I am now planning the second and final interview for the above study. I sent the transcripts out in January 2009 so I hope you received your copy. Please contact me if you have not received one yet.

Enclosed with this letter is feedback from the first data collection and the questions for the second interview. I hope you will agree to take part in this follow up session which should provide some depth to some of the themes I have found. I would very much like to hold this second interview in May 2009 at a day, venue, and time convenient to you.

Please contact me by phone, e-mail at either address or return the enclosed letter saying if you wish to continue and details of when we can meet. The second interview will be audio taped as the first one was.

I look forward to hearing from you.

Yours sincerely

Sarah Brown  
Registered Midwife, Midwifery Lecturer, IBCLC.  
School of Health and Social Care  
Bournemouth University  
Finchdean House  
St Mary's Hospital

## **Feedback from First Analysis: Becoming and Being an IBCLC in England.**

There were various experiences leading to becoming and being an IBCLC and for many

- A gap in previous practice was addressed by undertaking the qualification
- Some had experienced poor support to breastfeed and were looking to improve this.
- Many had undertaken the preparation and examination with supportive peers and this had continued afterwards in supporting others to consider the qualification.
- Some had undertaken the qualification as it would validate their knowledge with others.
- All mentioned receiving referrals from other health professionals or from women.
- All mentioned that they undertook teaching
- Many mentioned writing guidelines, policies, information packages, completing audits.
- Some mentioned choosing to work in their own time
- Lack of time was an issue for many along with continuing changes in the workplace and in meeting targets
- There was mixed feedback on how managers did or did not support the practitioner and how other health professionals viewed the role.
- It appeared that working in the NHS is different from working elsewhere
- There were reflections of what breastfeeding means and its link to parenting and becoming a mother.

The questions which I would like you to consider for the second interview are:

- Any thoughts on your transcript or the above points?
- Could you tell me what supporting breastfeeding means to you?
- How do you take care of your own needs when working as an IBCLC?
- How do you go about changing things in breastfeeding practice?
- How prepared do you think you were to teach others about breastfeeding?
- How would you like to see the role of IBCLCs develop in England?



Bournemouth University  
Finchdean House  
St Mary's Hospital  
Milton Road  
Portsmouth PO3 6AD  
Hants  
02392 28600 3926

[sabrown@bournemouth.ac.uk](mailto:sabrown@bournemouth.ac.uk)

7<sup>th</sup> April 2009

### **Becoming and Being an IBCLC in England**

Dear Sarah

My Name

The day

Time

Venue

For our second interview.

I know you will get back to me to confirm this and/or if there any problems.

Yours sincerely

Sarah Brown  
12 Ash Close  
Cowplain  
Portsmouth PO8 8TU  
02392 782481

sarah@lcsouthuk.biz



Bournemouth University

Finchdean House

St Mary's Hospital

Milton Road

Portsmouth PO3 6AD

Hants

Date

Dear

Thank you for participating in the first part of my study on Becoming and Being an International Board Certified Lactation Consultant in England. Enclosed is a transcription of the second interview you participated in. To enable the process of interpreting the interview I have used some symbols, which are explained, in the enclosed chart. All references to your place of work or the role you undertake such as midwifery or health visiting have been removed from the text and will not be used in the study.

If you have any questions about the transcription or anything you would like to discuss further then please do not hesitate to contact me.

Yours faithfully

## Appendix 6: Transcription Symbols based on Silverman (1993, p.118)

Symbol	Example	Explanation
=	(A) However you want to do it (B) = However	No gaps between the speakers
. . . .	(B) I was the only one . . and	Each full stop is equal to 0.25 second
–	(B) it gave <u>me</u>	Underscoring indicates some form of stress via pitch and/or amplitude
:	W:ell	Colons indicate prolongation of the immediate prior sound, roughly proportional to the length of the prolongation
( )	(B) There were ( )	Empty parentheses indicate the transcriber's ability to hear what was said
( word)	(B) There were (practitioners)	Parenthesized words are possible hearings
,?	(B) What was I thinking,?	Indicates speaker's intonation , = rising intonation
-	(B) Becau-	Hyphen indicates an abrupt cut-off of the sound
{	(A) What did {you (B) {while	Left brackets indicate a point at which a current speaker's talk is overlapped by the other

Silverman, D. 1993. *Interpreting Qualitative Data: methods for analysing talk, text and interaction*. London:Sage.

## **Appendix 7: Bournemouth University ethical review**



### **Research Governance Review Group**

#### **Ethical review on behalf of the School research Committee**

Student: Sarah Brown

Title: International Board Certified Lactation Consultant's (IBCLC) experiences of their work in England

Reviewers: Martin Hind

Report prepared by: Martin Hind

Date: 2.06.08

This study is currently undergoing a NHS REC ethical review and this report is an evaluation of the proposed ethical considerations. The submitted proposal was used as the basis for this evaluation. In view of the comprehensiveness of the submitted proposal I did not review the online NHS REC form and so this report contains no feedback relevant to the online form. These comments are made on the assumption that the same quality of information in the proposal seen is the same as the content of the NHS REC application form

### **Comments**

Throughout the supplied proposal document the main ethical considerations all appear to be fully thought through, in particular;

- Consent is appropriately addressed in a considered way throughout recruitment and as the study progresses. The participant information sheet is detailed and

thorough and the intended procedures will achieve a satisfactory informed consent for all potential and actual participants. Securing written consent is indeed relevant for a study of this nature.

- Issues around confidentiality and data protection are both competently and thoroughly considered.
- All foreseeable risks are appropriately considered, in particular issues around personal safety with such data collection procedures (i.e. conducting one to one interviews in a setting determined by the participant).
- The risk/benefit tensions appear to have been considered.

There are no obvious ethical issues that have not been thought through and so in my opinion there are no concerns at this stage of the process. However there is one observation which will be relevant for the main write-up to this study and that is the distinct lack of ethical references in the reading. Codes governing research on human subjects as well as key texts really ought to have been acknowledged in the proposal document and certainly will need to be present in the final study write-up.

My recommendation is that the School Research committees approve this study to proceed subject to full NHS REC approval. This recommendation is in respect of only the ethical aspects to this study.

Martin Hind

Appendix 8: NHS Research Ethical Committee review



**Fife, Forth Valley & Tayside Research Ethics Service**

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Fife & Forth Valley Research Ethics Committee

Research Ethics Office

Level 9

Ninewells Hospital & Medical School

DUNDEE

DD1 9SY

Ms Sarah Jane Brown  
Infant Feeding Advisor/Lecturer Practitioner  
Bournemouth University  
Portsmouth Campus, Finchdean House,  
St Mary's Hospital, Milton Road  
PORTSMOUTH  
PO3 6AD

Date: 18 August 2008  
Your Ref:  
Our Ref: **FB/08/S0501/55**  
Enquiries to: Miss Fiona Bain  
Extension: Ninewells extension 32701  
Direct Line: 01382 632701  
Email: [fionabain@nhs.net](mailto:fionabain@nhs.net)

Dear Ms Brown

**Full title of study:** **Becoming and Being an International Board Certified  
Lactation Consultant (IBCLC) in England**

**REC reference number:** **08/S0501/55**

The Research Ethics Committee reviewed the above application at the meeting held on 05 August 2008.

### **Documents reviewed**

The documents reviewed at the meeting were:

<b>Document</b>	<b>Version</b>	<b>Date</b>
Application		04 July 2008
Investigator CV		08 July 2008
Protocol	3	01 July 2008
Covering Letter		04 July 2008
Research Proposal	1	01 July 2008
Supervisor CV - Dr Jen Leamon		

### **Provisional opinion**

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Vice-Chair.

### **Further information or clarification required**

1. The fact that you are undertaking a PhD needs to be mentioned earlier, ie, within the first paragraph.
2. In respect of A20, the Committee felt that you will know who is taking part, when the information sheet is resent where there is no reply. You should not re-send the information to non-responders, since they have already decided not to take part.
3. At question A44, it is unclear for how long the data will be kept. The Committee advises that data should be kept for 5 years, tapes for 2 years.
4. You clarified that you are inviting 23 participants to achieve 12 recruits.

5. The Committee felt that the letters were confusing and need to be reformatted
6. How will you be assured that remote recruiters, over whom you have no direct control, do not coerce potential participants in the study?
7. Regarding the PIS:-
  - The date for the first interviews should be changed from July 2008
  - You should refer to this Research Ethics Committee as follows: 'This study has been reviewed by a NHS Research Ethics Committee, which has responsibility for scrutinising proposals for medical research on humans. In this case, the reviewing Committee was the Fife & Forth Valley Research Ethics Committee, who have raised no objections from the point of view of medical ethics.'
  - You should to remove the statement about self funding - the Committee felt that this could be seen to be coercion.
  - You should include the following at the end: 'Thank you for taking the time to read this information sheet and for considering taking part.'

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 16 December 2008.

#### **Ethical review of research sites**

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. However, all researchers and local research collaborators who intend to participate in this study at NHS sites should seek approval from the R&D office for the relevant care organisation.

#### **Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**08/S0501/55****Please quote this number on all correspondence**



Fife



Forth Valley



Tayside

**East of Scotland Research Ethics Service**

Fife & Forth Valley Research Ethics Committee  
Research Ethics Office  
Tayside Academic Health Sciences Centre  
Ninewells Hospital & Medical School  
Residency Block, Level 3  
George Pirie Way  
Dundee  
DD1 9SY

Ms Sarah Jane Brown  
Infant Feeding Advisor/Lecturer Practitioner  
Portsmouth Campus, Finchdean House,  
St Mary's Hospital, Milton Road  
Portsmouth  
PO3 8AD

Date: 7 October 2010  
Your Ref:  
Our Ref: FB/AG/08/S0501/55  
Enquiries to: Miss Fiona Bain  
Extensions: Ninewells extn 8 on 32701  
Direct Line: 01392 632701  
Email: [jsr@hain@nhs.net](mailto:jsr@hain@nhs.net)

Dear Ms Brown

**Study title:** Becoming and Being an International Board Certified Lactation Consultant (IBCLC) in England  
**REC reference:** 08/S0501/55  
**Protocol number:** N/A

This study was given a favourable ethical opinion by the Committee on 18 September 2008.

It is a condition of approval by the Research Ethics Committee that the Chief Investigator should submit a progress report for the study 12 months after the date on which the favourable opinion was given, and then annually thereafter. To date, the Committee has not yet received the annual progress report for the study, which was due on 17 September 2010. It would be appreciated if you could complete and submit the report by no later than 17 October 2010.

Guidance on progress reports and a copy of the standard NRES progress report form is available from the National Research Ethics Service website.

The NRES website also provides guidance on declaring the end of the study.

[Failure to submit progress reports may lead to the REC reviewing its opinion on the study.]

**08/S0501/55: Please quote this number on all correspondence**

Yours sincerely

**Mrs Arlene Grubb  
Administrative Assistant**

Copy to: Dr Jen Leamon  
University of Bournemouth, R & D Office



**East of Scotland Research Ethics Service**

**Fife & Forth Valley Research Ethics Committee**  
Research Ethics Office  
Tayside Academic Health Sciences Centre  
Ninewells Hospital & Medical School  
Residency Block, Level 3  
George Pirie Way  
Dundee  
DD1 9SY

Ms Sarah Jane Brown  
Infant Feeding Advisor/Lecturer Practitioner  
Portsmouth Campus, Finchcree House,  
St Mary's Hospital, Milton Road  
Portsmouth  
PO3 6AD

Date: 4 November 2010  
Your Ref: LR/AG/08/S0501/55  
Our Ref: Mrs Lorraine Reilly  
Enquiries to: Ninewells exters on 40099  
Extension: 01382 640096  
Direct Line:  
Email: Lorraine.reilly@nhs.net

Dear Ms Brown

**Study title:** **Becoming and Being an International Board Certified Lactation Consultant (IBCLC) in England**  
**REC reference:** **08/S0501/55**  
**Protocol number:** **N/A**

Thank you for sending the progress report for the above study dated 14 October 2010. The report will be reviewed by the Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

The favourable ethical opinion for the study continues to apply for the duration of the research.

**08/S0501/55: Please quote this number on all correspondence**

Yours sincerely



**Arlene Grubb**  
**Administrative Assistant**

Copy to: Dr Jen Leamon  
School of health & Social Care  
Royal London House  
BOURNEMOUTH BH1 3LT

University of Bournemouth  
R & D Office  
BOURNEMOUTH BH1 3LT



## Appendix 9: NHS Local Governance Ethical Approval

The Mid Yorkshire Hospitals **NHS**

NHS Trust

Trust Headquarters  
Rowan House  
Aberford Road  
Wakefield  
West Yorkshire  
WF1 4EE

Our Ref: JS/sa/R&D/Letters/Nov.06/Brown.5

13 November 2008

Ext. 3821  
Direct Line: 01924 213821

Fax: 01924 214929

E-mail: jane.shewan@midyorks.nhs.uk

Ms Sarah J Brown  
Midwifery Lecturer  
School of Health & Social Care  
Bournemouth University  
Frichdean House  
St Mary's Hospital  
Milton Road  
Portsmouth  
PO3 6AD

Dear Sarah

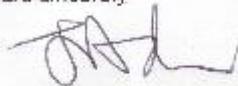
**Becoming and Being an International Board Certified Lactation Consultant (IBCLC) in England**  
R&D Ref: 08/597

Thank you for forwarding documents relating to the above study, together with a copy of the approval letter from Fife, Forth Valley & Tayside Research Ethics Service dated 18 September 2008.

On behalf of The Mid Yorkshire Hospitals NHS Trust's R&D Committee I am pleased to confirm approval for the study by Chair's action.

Kind regards.

Yours sincerely



**Jane Shewan**  
HEAD OF RESEARCH & EFFECTIVENESS

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DIRECTORATE OF NURSING, GOVERNANCE & PATIENT EXPERIENCE  
Ms T L McErlain-Burns  
Chief Nurse/Director of Patient Experience