Breastfeeding in Medicine: Time to Practice What We Preach

Phoebe Danziger, MD

At first, breastfeeding was not at all what I had imagined. To this day, I wince when I recall the toe-curling pain that coursed through my body each time my daughter's tiny newborn mouth latched onto my breast, a sensation that stood in stark contrast to the exhilarating magic of her existence. Despite prenatal preparation, supportive family, and knowledgeable physicians, nurses, and lactation consultants, the early days of breastfeeding were more challenging than I had ever imagined. The physical and emotional intensity of serving as this small human's primary source of fluid, nutrition, and comfort was simply overwhelming. More than once, with nipples cracked and bleeding, I sat and cried. How could something so simple, so fundamental, so primal, be so hard?

More than 70 months of breastfeeding later, nursing my 4 daughters is one of my proudest, most precious accomplishments. The hard work and tears paid off; by the time my youngest infants were born, they latched like champions, and breastfeeding was second nature. At many points along the way, however, achieving this goal seemed in irreconcilable conflict with a career in medicine. To be clear, as a pediatrician I support parents feeding their infants in whatever way is best for their family without judgment. The history and politics of what (and by whom) infants are fed is long and storied, rife with deep racial, ethnic, and socioeconomic inequities that persist in a variety of forms to this day. Some contend that, driven by ideology, the benefits of breast milk and breastfeeding have been overstated. Although additional research is needed to explore the nuances of the topic, there is a strong body of evidence in which the many unequivocal advantages of breastfeeding for mothers and infants is described.[1–5]

For me, as for so many others, breastfeeding has been an extraordinary and profound experience: the feeling of a nursling's warm body nestled into one's own and the sense of connection that comes from being able to provide wholly individualized milk for an infant, even when apart. One can parse the numbers, too: researchers estimate that if 90% of families in the United States were to adhere to the medical recommendation of 6 months of exclusive breastfeeding, 13 billion dollars would be saved annually. But for many, the experience and meaning of breastfeeding amount to far more than can be captured in a bottom line.[6]

However, breastfeeding in America (and in medicine) has a long way to go. Despite rising interest and acceptance in recent years, breastfeeding rates in America remain low. Although >80% of infants are breastfed at birth, by 3 months, fewer than half are

Division of General Pediatrics, Department of Pediatrics, University of Michigan, Ann Arbor, Michigan

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Address correspondence to Phoebe Danziger, MD, Division of General Pediatrics, Department of Pediatrics, University of Michigan, 1540 E Hospital Dr, Ann Arbor, MI 48109. E-mail: phoebed@med.umich.edu

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exclusively breastfed, and by 6 months, slightly more than half are receiving any breast milk at all.[7,8] Enormous structural and cultural barriers, including suboptimal postpartum support, inadequate parental leave, and lack of deep and genuine societal support of breastfeeding, deter many women from breastfeeding for their desired duration.

Physicians who breastfeed are no strangers to these challenges. Authors of several studies indicate that the majority of physician mothers cease breastfeeding earlier than they wish because of work-related factors.[9–11] When I reflect on some of the experiences shared by myself and my colleagues, it is no wonder why this is. My colleagues and I have been asked not to pump in staff break rooms or team workrooms. We have been offered pumping locations in supply closets or bathrooms, despite federal law (section 4207 of the Patient Protection and Affordable Care Act of 2010 [PL 111-148]) requiring employers to provide "reasonable break time" for employees to express milk for a child up to 12 months of age in a private nonbathroom location.[12] As trainees, pumping time must often be taken at the expense of educational conferences. My peers and I have received disparaging comments about how frequently we pump, how long it takes to pump, and how old the infants are for whom we pump. We have been asked not to store breast milk in shared refrigerators, or there have been no refrigerators available for storage use. We have felt explicit pressure to go inappropriately long intervals between pumping sessions, which has resulted in pain, decreased milk supply, clogged ducts, and mastitis. At the end of the day, we have received evaluations specifically referencing the ways in which our breast pumping was considered inconvenient, caused others to feel uncomfortable, or was perceived to hinder our performance.

Many in medicine are genuinely committed to supporting breastfeeding trainees and physicians, but good intentions alone cannot overcome such entrenched and pervasive barriers and beliefs. Departmental lactation policies and increased access to hospital-grade pumps should be lauded, but individual- and department-level solutions alone are not enough. In fact, when we rely solely on this category of intervention, we paradoxically run the risk of creating and deepening an unintended disconnect. Individuals who support such solutions may perceive themselves as adequately supportive of breastfeeding. Their breastfeeding colleagues, however, are often left to wonder why, if they are surrounded by such satisfactory support, breastfeeding in medicine continues to feel so impossibly and invisibly hard.

There are concrete steps we can take to meaningfully address the current barriers and provide benefits not only to physicians who breastfeed but to society more broadly. Personal breastfeeding experience among physicians has been associated with increased breastfeeding advocacy.[11] These findings underscore the notion that as physicians, our unique and privileged position within society confers not only the opportunity but also the obligation to be leaders and standard-bearers. Although the obstacles may be complex and daunting, it is time to practice what we preach and work to enact meaningful change. We can start by implementing humane parental leave policies in all medical training programs. This includes offering comparable opportunities and expectations for fathers, who can play a critical role in the early establishment of successful breastfeeding relationships and deserve to be treated as equal partners in parenting. We can advocate for guaranteed access to on-site and/or employer-affiliated child care. We can implement real and meaningful exposure to the practicalities of breastfeeding for all medical professionals, and we can ensure that this education illuminates why the topic of breastfeeding encompasses far more than a casual choice between breast milk and formula.

When I reflect on my own experience as a breastfeeding mother in medicine, I am struck by the intensity of the physical and emotional journey. Although some may be able to seamlessly transition into the parental role, the reality for many is that breastfeeding (mirroring parenting in general) is a complicated, profound, messy, and all-consuming undertaking, with a steep learning curve but unimaginable rewards. If my daughters had never been breastfed, would they be just as happy and healthy and secure? I do not doubt it for a moment. Countless factors contribute more to a child's quality of life than what type of milk is provided. The argument for supporting breastfeeding is not, then, a militant argument of breast milk versus formula, or a simplistic narrative of devoted versus neglectful mothers. It is, rather, an argument for supporting all families and children, and for showing that we as a profession and as a society have the courage and vision to champion what is right, what is possible, and what is good.

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