

This essay explains, reflects and analyses a critical incident which occurred on a postnatal ward during my first clinical placement as a student midwife. The incident relates to breastfeeding practices on the ward and is classed as critical because it triggered an instinctual response in me which made me feel it was not right or helpful. My response and feelings at the time were not grounded in theoretical knowledge but rather an instinctual feeling. As a result of this instinctual feeling, the incident was explored. This exploration opened up a flood gate of information regarding what could be learned from this incident and ways to improve practice. What was learnt from this incident will be discussed with the use of relevant literature. Discussion of the following topics will facilitate reflection and evaluation of the critical incident, maternal (breastfeeding) instinct, the use of skin-to-skin contact, using baby slings, co-sleeping, baby-led attachment and use of the hands-off technique (HOT), ways to empower mothers, positive reinforcement, the Baby Friendly Hospital Initiative (BFHI) and ethical, legal and competency aspects of this critical incident.

The incident unfolded as follows. Ellen was a twenty-seven year old primipara who had been on the postnatal ward for five days. It was handed over that she was having difficulty breastfeeding due to large breasts and flat nipples and as a result the baby (Harry) wouldn't attach and was very unsettled. My first contact with Ellen was when she requested assistance to breastfeed. The hands-off technique was used but Harry would not open his mouth to attach to Ellen's nipple and was crying throughout. I enlisted the help of a senior midwife who had assisted Ellen previously. She settled Harry by placing her finger in his mouth and rubbing his soft pallet. She placed a rolled hand towel under Ellen's breast and pushed Harry onto her breast. This 'hands-on' approach was successful in attaching Harry and he fed for thirty minutes.

Approximately three hours later Ellen requested I watch her attach Harry. I watched as she anxiously hurried to attach him and Harry soon became frustrated and began to cry. I could not see fault in her technique and had reached the limits of my breastfeeding understanding so enlisted the help of a second midwife. She attempted a hands-on approach, which was unsuccessful. She changed her approach and hand expressed milk from Ellen and feed it to Harry using a syringe with her finger in his mouth. The rationale for this, she

explained, was that he was sucking and being rewarded with milk which should train him for breastfeeding. Two hours after this Ellen wished to breastfeed again. The second midwife attempted to assist the frustrated and tired Ellen feed the screaming Harry using a hands-off approach, which was unsuccessful. She then attempted a hands-on approach which was also unsuccessful. The story ends with Ellen behind the nursery curtain attached to a breast pump and crying loudly at her perceived failure. Harry's dad nursed him while I did as the midwife suggested and syringed expressed breast milk into Harry's mouth while he sucked my finger. I felt horrible about doing this, for a reason unknown to me, but felt compelled to continue as I had no other solution for Ellen and Harry. The night's events left me exhausted and confused.

The next day I came onto a morning shift and Ellen's sixth day on the ward to notice Ellen attached to a 'supply-line'. When I questioned the midwife about the rationale for the supply line she stated that it was Ellen's sixth day here and she needs someone to teach her some independence with breastfeeding and the supply-line would allow Ellen to breastfeed when she went home. Ellen, Harry and her husband went home that day with enough supply-line equipment to last two weeks. I was confused as to how a supply-line provided Ellen and Harry with breastfeeding independence.

It was not until I spoke to the Antenatal educator and a casual midwife did I realise why I had uneasy feelings about what we had done to (not for) Ellen. The antenatal educator highlighted to me that the postnatal ward is not baby friendly and not to participate in the breastfeeding practices they promote. She encouraged me to allow extended skin-to-skin time and use a hands-off approach. A casual midwife further validated and labelled my bad feelings when she mentioned that she has never seen so many mothers with breastfeeding troubles then at our hospital and if we were a baby friendly hospital we would not be able to practice the way that we do. She also stated that in all her years as a midwife in the Northern territory she had not seen a baby that 'couldn't' suck. These two women verbalised what I could not, and made me realise that we had done the wrong thing and that there is a better way to assist women to breastfeed than constant hurried intervention. What follows is a critical reflection and analysis on what could have been done better in regards to this incident and in the future for women who experience breastfeeding difficulties.

'It is beyond doubt that lactation and breastfeeding continues to suffer from cultural barriers as western medical advice implies that the mother is inadequate to breastfeed her own infant' (Lennart, 2008, p.2). Due to western society women have come to distrust nature, yet successful infant feeding relies upon the mother following her own instincts and intuition. Relying on nature and avoiding intervention will prevent breastfeeding difficulties (Lennart, 2008, p.2). The more infant feeding has become supervised by the medical profession the more mothers decide they are incapable of breastfeeding their children. Breastfeeding is mishandled and has become medicalised (Walker, 2007, p.549). Medical and Western society has led women to believe that breastfeeding is not instinctual and is a skill which must be learned (Naish & Roberts, 2002, p.2; OMG, 2005, p.1). While this in some respects is true, in that traditionally women would 'learn' to breastfeed through a lifetime of watching other women do it, medical society does not recognise a mothers innate ability to feed her child (OMG, 2005, p.1). This has resulted in the Medicalisation of breastfeeding and taken it out of the domain of the family and community and into the hospital. The westernisation of society has led to the separation of families and independence from others which has resulted in women having little or no contact with babies before their own (Naish & Roberts, 2002, p.3). Without contact with family and subsequently babies, maternal instinct has faded by the way side, leaving women to learn the skills of mothering from the medical profession and midwives (Naish & Roberts, 2002, p.6).

The scientific and medical approach to breastfeeding advocates the use of scheduled feeding and solitary sleeping which is opposite to traditional methods of child rearing where the baby would be carried close to the mother throughout the day (Lennart, 2008, p.2; Moore, Anderson & Bergman, 2007, p.2), feed on demand and nurse through the night while sleeping in the family bed with its mother (Naish & Roberts, 2002, p.9). Assisting Women and babies who have difficulty breastfeeding becomes a fight against western and medical society itself as the solutions to breastfeeding difficulties are rarely found from them, but rather, by revisiting and advocating traditional styles of mothering. This approach to assisting women to breastfeed will be discussed further and is the core of the conclusions reached in response to the critical incident explained.

The western and medical idea of the daily separation of mother and infant has contributed to mothers and babies not forming a strong bond and thus, having a less successful breastfeeding experience (Moore, Anderson & Bergman, 2007, p.1, Naish & Roberts, 2002, p.3). The use of prams and cots has encouraged maternal and infant separation and can cause difficulty with breastfeeding. Similarly, the hospital at which I work promotes babies being kept separate from their mothers. Mothers are encouraged to keep their baby in the cot if they wish to walk around and not to hold their baby in bed, through fear that they may trip and fall with their baby or drop their baby if they fall asleep with it in bed. As a result, the only close contact the babies have with their mothers can often be when breastfeeding. This exact scenario was played out with Ellen the shift before I met her. The midwife caring for her in the morning scolded her repeatedly for holding her baby in the bed and instructed her that it was important that she keep the baby in the cot because she could fall asleep in bed and drop the baby. This was after Ellen had been told by a different midwife that it is important to hold Harry to settle him. This highlights the Medicalisation of breastfeeding and the denial of maternal instinct on the ward and reiterates to Ellen the western way of child rearing. It is suggested that industrialised societies and hospital routines significantly disrupt mother infant interactions and have harmful effects (Moore, Anderson & Bergman, 2007, p.2). I feel the encouragement on the ward to keep babies separate contributed significantly to Ellen and Harry's breastfeeding problems.

The UNICEF/WHO Baby friendly hospital initiative endorses co-sleeping or bed-sharing because it promotes more stable vital signs in the baby, allows the mother to have a more restful sleep and promotes more effective breastfeeding (Buswell & Spatz, 2007, p.22; Hormann, 2007, p.355-356). Currently, our hospital does not meet the BFHI criteria and does not encourage co-sleeping based on the sudden-infant-death-syndrome sleeping guidelines. A study by McCoy, Hunt, Lesko, Vezina, Corwin, Willinger, Hoffman & Mitchell (2004) found a strong relationship between bed-sharing and breastfeeding and found that it facilitated breastfeeding by providing closer contact between mother and infant and therefore greater opportunity to breastfeed. While there is a fear that co-sleeping increases the risk of SIDS, this is a contentious issue as literature also exists that gives weight to the argument that co-sleeping actually reduces the risk of SIDS when practiced appropriately (Buswell & Spatz, 2007, p.23; Naish & Roberts, 2002, p.56). The idea that co-sleeping

encourages breastfeeding should be adapted and the hospital should encourage mothers to maintain closeness between themselves and their babies as much as possible to assist them with breastfeeding. I feel that this would have been helpful to Ellen and Harry.

Another practice which promotes closeness, instinctual behaviour, breastfeeding and bonding, is the use of a carry pouch or sling. Mothers who carry their babies in a sling, close to them throughout the day are much more in tune with their babies eating and sleeping rhythms which allows them to breastfeed more effectively and they have more settled babies (ACNM, 2007, p.644, Lennart, 2008, p.2; Naish & Roberts, 2002, p.44). Encouraging Ellen to use a sling to encourage closeness and breastfeeding would have been an effective way of settling Harry throughout the day and assisting Ellen to be more aware of his feeding needs. Furthermore, allowing Ellen and Harry to have regular skin-to-skin contact throughout the day would have encouraged more bonding and allowed Harry to properly attach to Ellen's nipple. He would have been more settled and in a better behavioural state to latch on and breastfeed (Feldman, 2004, p.150; Karl, 2004, p.292; Moore, Anderson & Bergman, 2007, p.2; Naish & Roberts, 2002, p.36). Skin-to-skin contact is an important part of the instinctive process of breastfeeding for both mother and baby (<http://www.breastfeeding.asn.au/bfinfo/bla.html>).

Allowing mother and babies to live in close proximity by encouraging co-sleeping, baby-wearing and skin to skin contact can facilitate breastfeeding by promoting baby-led attachment. This method of encouraging attachment involves placing the baby on the mother chest and allowing the baby to discover the nipple and attach themselves with minimal support from the mother (Lennart, 2008, p.1; Naish & Roberts, 2002, p.3). The baby follows a pattern of instinctive behaviours to get to the breast (<http://www.breastfeeding.asn.au/bfinfo/bla.html>). Infant-led attachment almost always leads to correct attachment to the nipple due to it being less forced and hurried; the baby attaches in its own time (Naish & Roberts, 2002, p.36). This form of attachment is only successful provided the mother and baby are healthy and allowed sufficient skin-to-skin contact. The baby must be allowed to go through its pre-feeding rituals of licking, smelling, touching and mouthing the breast before attaching to get acquainted with the nipple (Lennart, 2008, p.1; Naish & Roberts, 2002, p.36). Ellen and Harry's breastfeeding practices

were frantic, hurried and filled with anxiety, allowing skin-to-skin and employing practices which promoted calmness and patience may have encouraged Harry to attach better to Ellen's nipple and prevented the interventions that occurred resulting in a more positive breastfeeding experience for both Ellen and Harry.

A practice frequently used on the post-natal ward and with Ellen and Harry was a 'Hands-on' approach to breastfeeding. The government of Western Australia and The Department of Health have a written policy regarding the use of a 'hands-off technique' (HOT) as opposed to a hands-on technique. One of the goals of this policy is to achieve successful breastfeeding by standardising teaching and eliminating contradictory advice (OMG, 2005, p.1). A major part of Ellen's situation was that depending on which midwife was caring for her, her care, advice and strategies were different which was confusing for Ellen and did not allow her to independently breastfeed. The rationale behind HOT is to nurture a mother's confidence in her ability to breastfeed, which Ellen did not have. HOT encourages the use of positioning and attachment posters, pictures and a model breast and doll to demonstrate and coach the mother. This enables her to gain confidence in attaching the baby to her breast independently; midwives are encouraged not to touch the mother or baby at all (OMG, 2005, p.1). Ingram, Johnson & Greenwood, (2002) aimed to determine whether a hands-off breastfeeding technique, if taught to mothers in the immediate postnatal period improves their chances of breastfeeding successfully and reduces the incidence of problems. They found that the use of a hands off technique, which enables mothers to position and attach their baby for themselves, increases breastfeeding rates and reduces the incidence of perceived milk insufficiency.

A hands-off technique is more empowering to women because when they successfully attach their baby, they feel as if they did it for themselves which gives them confidence and empowers them to independently care for their baby without the need of medical assistance. The importance of maternal confidence and knowledge in the success of breast feeding is well recognised. A hands on approach is thought negatively affect a mother's self confidence when initiating breastfeeding. (Weimers, Svensson, Dumas, Naver, & Wahlberg, 2007, p.6). Furthermore, Weimers et al (2006) performed a qualitative study and discovered that women did not appreciate hands-on breastfeeding assistance; they found

it unpleasant and felt objectified. Not only this but, mothers who were visually instructed in breastfeeding technique with an artificial breast and doll experienced fewer breastfeeding problems. The results of this study found that women found hands-on breastfeeding assistance as brutal, unpleasant and that it violated their integrity. Mothers were angry at midwives who did not ask permission to touch their baby or their breast. Mothers said they would have preferred a discussion about breastfeeding and practical education. This highlights the importance of providing women with hands-off breast feeding assistance to empower them and increase their confidence. This will result in greater breastfeeding success and would have been more helpful to Ellen and Harry than syringe feeding and using a supply line to manage their breastfeeding problems.

A striking aspect of Ellen and Harry's breastfeeding experience was the language which was used by the midwives to describe their situation. No-one said anything positive to Ellen regarding her ability to breastfeeding and the discourse was resoundingly negative. Statements including 'no, he's not sucking', 'he won't attach', 'I don't know what's wrong', 'he won't settle', 'you're not holding him right' continued throughout the shift and abounded in negative connotations. It is well documented that healthcare providers have an influence on a women's choice of infant feeding (Miracle & Fredland, 2007, p.546; Hong, Callister & Schwartz, 2003, p.10). Walker (2007) found that inadequate, insensitive or apathetic approaches to breastfeeding by health care providers results in early weaning due to maternal frustration. Women who receive encouragement from health care providers are four times more likely to breastfeed than those who receive no encouragement. Therefore midwives have a special responsibility to promote breastfeeding and provide encouragement to mothers who wish to do so (Hollander, 2001, p.184). Midwives practice has the potential to be more harmful than good, I feel that the suggestions given to Ellen were more harmful to her breastfeeding experience than helpful and I fear that as a result of our actions Ellen gave up breastfeeding. In the future, being encouraging and using positive language to support the mother will be used.

Ultimately, the critical incident could have been avoided if the hospital at which I am employed was BFHI accredited. The BFHI was released in 1991 by the World Health Organisation and the United Nations Children's Fund (UNICEF) to pave the way for all

maternity services to become centres of breastfeeding excellence. Maternity facilities become accredited when they meet the BFHI criteria. Included in the BFHI are the 'Ten steps to Successful Breastfeeding' which aim to avoid maternity care practices which interfere with breastfeeding (Forster & McLachlan, 2007, p.274). The most important aspect of the BFHI for my hospital would be the focus on education of health care providers in maternity and neonatal services (Walker, 2007, p.552). A major focus of the BFHI is to promote consistency among staff training to avoid conflicting information being given to the mother and family regarding breastfeeding practices (Hollander, 2001, p.185; Walker, 2007, p.552). In a study by Tiedje et al, 2002, participants sighted that hospital policies and procedures and people in the health care system who gave advice about breastfeeding were not particularly helpful in establishing breastfeeding and rather derived support from particular individuals within the system, not from the uniformly applied policies and procedures. Mothers also identified a lack of consistency in hospital policies and procedures. These same ideas are identified by Mozingo, Davis, Droppleman and Merideth (2000). Thus the BFHI provides a way to promote more consistent breastfeeding protocols in hospitals and has been shown to improve rates of breastfeeding in accredited hospitals (Bartington, Griffiths, Tate & Dezateux, 2006, p.1178; Perez-Escamilla, 2007, p.484).

The Australian nursing and midwifery council's competency standards that were utilised during this incident include the following. Element 2.1 was used by myself and states that a competent midwife 'recognises and acts within own knowledge base and scope of practice'. This was employed when I collaborated with other midwives after analysing my own skill and ability to deal with the situation. At this point I recognised that Ellen and Harry required assistance outside of my knowledge base and scope of practice. This ties into competency 2.3, 'consults with and refers to another midwife or appropriate health care provider when the needs of the women and her baby fall out of the scope of practice' (ANMC, 2006, p.4). Throughout the critical incident, element 3.2 of the ANMC national competency standards was utilised, this states that the midwife 'provides learning opportunities appropriate to the women's needs' (ANMC, 2006, p.5). This was achieved during hands-off breastfeeding assistance when I taught Ellen the physiology of breastfeeding and gave education regarding attachment. Throughout the incident I subconsciously utilised element 5.6 of the competency standards which states that the

midwife 'evaluates the midwifery care provided to the women and baby' (ANMC, 2006, p.5). This was done also following the incident when I sought clarity for my negative feelings toward the incident and discussed the incident with educators which further assisted my evaluation. As part of my evaluation of the incident I was forced to look at my own beliefs about the provision of midwifery care and feel that my response to this incident was a result of my strong grounding in a holistic model of health care and a midwifery model of health care stemming from my training as a Naturopath. As such I utilised element 12.1 which states that a midwife 'address the impact of personal beliefs and experiences on the provision of midwifery care' (ANMC, 2006, p.7). My negative response to the critical incident most likely stemmed from the medicalised approach taken to assisting Ellen and Harry, which I did not feel comfortable with due to my healthcare philosophy. Evaluation of this critical incident has allowed me to utilise element 13.1 of the competency standards which states that a competent midwife 'assesses and acts upon own professional development needs' (ANMC, 2006, p.7), this was achieved by discussing the incident with educators and pursuing alternative methods of breastfeeding assistance, an endeavour which has been culminated in this essay. The research employed to assess this incident will allow me to utilise element 14.1 which states that the midwife 'ensures research evidence is incorporated into practice' (ANMC, 2006, p.7). As a result of this incident my understanding of breastfeeding practice has been enriched through the process of evaluation, assessment and research. This process will allow me to incorporate this knowledge into my practice which will encourage evidence based practice and translate into more positive outcomes for the women and babies I care for.

It is the midwives ethical obligation to support and enhance the women's breastfeeding experience. The midwife is in a position of power and knowledge and has a responsibility to educate women regarding breastfeeding (Miracle & Fredland, 2007, p.545). as part of this responsibility the midwife should be well educated and up to date with the latest evidence to ensure she is practicing in an evidence based manner. A midwife is ethically and legally required to fulfil her role and responsibilities as a midwife which includes encouraging a natural approach to maternity care and promoting breastfeeding using appropriate practices (Miracle & Fredland, 2007, p.545). Furthermore, ' a mother is not able to exercise her right to autonomy and a self-determined decision about breastfeeding if her

health care provider does not ensure that she has the relevant information (Miracle & Fredland, 2007, p.546), this raises the issue of informed consent. Informed consent is a process by which the midwife shares with the mother all relevant risk and benefit information on all treatment alternatives and the patient shares with the provider personal information which may alter their treatment decisions (Miracle & Fredland, 2007, p.545; Thompaon, 2004, p.109). In order to obtain informed consent for breastfeeding intervention the midwife is legally required to obtain consent from the mother, which implies that the mother is fully informed about all treatment options, this did not occur for Ellen and Harry.

In conclusion, Ellen and Harry's experience with breastfeeding was characterised by rapid, inconsistent intervention which was ultimately unhelpful in her attaining breastfeeding confidence and independence. I would consider this a midwifery failure. It is the role and responsibility of the midwife to practice in an evidence-based manner and equip the women to breastfeed her child independently with the use of strategic education and encouragement. Western and medical culture promotes practices which are detrimental to breastfeeding, it is a midwives responsibility to offset these barriers and assist mothers to tap into their maternal instinct to promote breastfeeding. Wearing babies close to the skin and co-sleeping can encourage mothers to be more intuitive and promotes breastfeeding. Midwives can also encourage mothers to develop breastfeeding independence by employing a hands-off technique and using encouraging and positive language. Ultimately, accreditation as a baby-friendly hospital may prevent this scenario being repeated. A focus on education of staff and consistency of hospital policy and practice would also assist midwives to fulfil their responsibility to practice in an evidence based manner.

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