Submission no. 122
AUTHORISED: 28/3/07

Submission to the House Standing Committee on Health and Ageing Inquiry into Breastfeeding

Dr Fiona H Clements MBBS Grad Cert Health Informatics

26/02/07

I am writing a personal submission as a doctor and a mother. I am writing mostly about the inadequate knowledge base of and inconsistent information given by doctors, and the importance of addressing this through education. I will also briefly mention the WHO Code and some other issues that are of concern to me.

MEDICAL EDUCATION

My own experience is that I was taught little about breastfeeding in my medical training. I can remember being taught about formula feeding and how much when, but I have no memory of any specific teaching about breastfeeding. So when practising I had to say to Mums, "I know we do this if they are on formula, but I don't know if it's the same for breastfed children." And at least I made the distinction, whereas I have heard of other doctors giving advice which is basically treating breastmilk and artificial infant milk as the same. Which I have now learnt they very clearly are not.

When pregnant I was planning to breastfeed, knowing it was better than artificial infant milk, but not really knowing what the differences were. Once my daughter was born, I started reading specifically the research done on breastmilk, and was astounded at the health difference between breastmilk and artificial infant milk being so huge. I almost couldn't believe it, so read more on the constituents of breastmilk as to what could be making such a difference. It was only then for the first time I discovered that fresh human milk is full of immunoglobulins, white blood cells and so much more. I'm a doctor and yet I didn't know all this, and when I went back to my textbooks nothing was there either. All I read led me to the conclusion that promoting and supporting breastfeeding was the best preventative health care I could practise, and feeling absolutely flabbergasted that I had been taught nothing about this as a medical student. I was reassured when my interpretation was confirmed by the current Australian Infant Feeding Guidelines for Health Workers which states "The total value of breastfeeding to the community makes it one the most cost effective primary

prevention measures available." (p.14) The ongoing health differences may be even more important in the light of recent research suggesting that kids who are healthier when they are young grow up to be healthier adults, through the role of inflammation on ageing. I heard this on the ABC Health Report, I can't remember the exact episode to find the reference, sorry.

My experience is reflected in a number of studies which find that many doctors have little knowledge about breastfeeding or even confidence in dealing with breastfeeding problems, and find doctors mostly learn about breastfeeding from their own personal experience.(Brodribb 2005) I think the lack of knowledge is also reflected in a paper from Victoria, Australia; James (2004) found that when mothers did report doctors as a source of breastfeeding information, this was negatively correlated with prolonged breastfeeding. And in Australia doctors are well-utilised by mothers as a breastfeeding support. (Hegney 2003) So women go see a doctor for breastfeeding support, and come away more likely to wean. Yet our first duty of care is do no harm, and here we are, increasing the likelihood of disease through early weaning. Not intentionally, but through lack of knowledge.

And many doctors, while they say they are supportive of breastfeeding, really only pay lip-service to it. One GP friend of mine offered the best available learning experience, a small group workshop for GP registrars on breastfeeding, and no one turned up. Another GP ran a workshop aimed at GPs and 3 people turned up. I've heard of other doctors who laugh and think there is nothing new to learn about breastfeeding. I've talked with other doctors and watched their eyes glaze over and head turn away when I start talking abut the importance of breastfeeding. I was on the Children and Young People's Curriculum Review Committee for the Royal Australian College of General Practitioners (RACGP), looking at the paediatrics section, and all the material I put in about breastfeeding was edited out. They left in all 3 points in the learning objectives about immunisation, but world wide, breastfeeding prevents more deaths than immunisation. (Labbok et al 2004) That really felt like hitting my head against a brick wall.

The National Institute of Clinical Studies (NICS) "Evidence–Practice Gaps Report Volume 2" 2005 acknowledges the gap between evidence and practice with breastfeeding, and states "Information given to women about breastfeeding needs to be consistent and based on the best available evidence." One big step towards doing this is to improve medical education about breastfeeding. Given the hierarchical nature of the health system I would anticipate that if the doctors take it seriously everyone else will follow, with no disrespect to nurses and the many other health professionals who work with mothers and babies.

One prong of this is to include breastfeeding in the Australian Medical Council's (AMC) Guidelines defining the goals and objectives of basic medical education, so future doctors will be knowledgeable about breastfeeding. Currently the guidelines state:

"Graduates completing basic medical education should have knowledge and understanding of: 6. Normal pregnancy and childbirth, the more common obstetrical emergencies, the principles of antenatal and postnatal care, and medical aspects of family planning." I argue that breastfeeding needs to be included in this 6th point. "Normal pregnancy, childbirth and breastfeeding....." It does need to be taught to all doctors as breastfeeding, as a part of life, can intersect with many medical specialities, e.g. surgery, anaesthetics, psychiatry, radiology, as well as general practise, obstetrics and paediatrics.

Another prong is to educate doctors currently practising about breastfeeding. There have been attempts to do this, as I mentioned before, although none seem to achieve much. I think that may come back to the fact that breastfeeding is not valued, and the importance in preventative health is not appreciated. Putting value on it often means creating financial incentives, as the successful immunisation rebate program shows. Another issue for GPs when practising is that consultations dealing with breastfeeding problems are often long to prolonged i.e. over 20 or 40 minutes, and with medicare rebates, the longer you spend with a patient the less you get paid.
An idea I've had that would help is to recognise the extra training required to become an International Board Certified Lactation Consultant (IBCLC) and provide specific Medicare rebates like Mental Health rebates on Focussed psychological strategies (FPS), items 2721, 2723, 2725, 2727. I have done an FPS course and am eligible for these rebates, and I am also studying to become an IBCLC, and there is definitely less work involved in the FPS course, yet I judge in my practice I am using my IBCLC study knowledge more often.

Items to include are:

- initial visit (standard and long)
- complex problem
- home visit
- review visit
- tongue tie snip (not just to cover the procedure but the explanation and consent process)
- needle aspiration of breast abscess

I think this would encourage more doctors to do the IBCLC training, and this would then create a peer group who could educate other doctors about the basics. An NICS study (2003) found that peer to peer learning is the most effective form of ongoing medical education.
Having these item also available to IBCLCs as allied health professional rebates would enable non-IBCLC GPs to refer to IBCLCs more readily, and so improve the support network for mothers who encounter difficulties with breastfeeding.

THE WHO CODE

Another area where I found recently that only lip-service was being paid to supporting breastfeeding was in an advertisement run in the September 2006 Australian Family Physician, the journal of the RACGP. The RACGP in its position statement on breastfeeding says "The RACGP supports the WHO Code and will not accept practices that undermine the Code." The Who Code on the Marketing of Breastmilk Substitutes section 7.2 states "Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters." Yet the AFP ran an advertisement for artificial infant milk which was not at all scientific or factual. I wrote a letter of complaint, and when the editor wrote back, he could not see that there was a problem with the ad, or that it contravened the RACGP's position statement, and did not even acknowledge that it had. Again I think the doctor's lack of concern reflects the community attitude, that "breastfeeding is better but not much and feeding artificial infant milk is normal so it doesn't really matter". Which is the heart of the issues around breastfeeding. I have sent in a complaint to APMAIF, which has been acknowledged. However I think at the time the company was entering the market and had not signed the voluntary MAIF agreement. To me this shows up the inadequacies of the MAIF agreement, and I urge you to implement the entire WHO Code and make compliance mandatory with significant penalties for breaches. I am sure there will be enormous resistance to this by the industry, as there was to the introduction of mandatory restrictions on the advertising of tobacco and alcohol by their related industries. However when there are very clear health risks related to a product, and it is clear there are significant health risks with artificial infant milk, governments are capable of taking a leadership role and legislating these restrictions.

OTHER ISSUES

Rotavirus Vaccine

I believe the government is contemplating spending many millions of dollars on a vaccine against one of the five strains of rotavirus. Given that artificially fed infants are perhaps six times more likely to get gastroenteritis, I would urge you to include breastfeeding in the cost/benefit equation when making this decision. The current information may be based on studies that do not differentiate infant feeding methods. According to the last national statistics from the Australian Bureau of Statistics, which are not actually easy to interpret, it looks like that for children under the age of 12 months, under half the children are receiving breastmilk, so any studies that do not differentiate infant feeding methods would give no indication of the difference in risk between exclusively breastfed infants, partially breastfed infants and artificially fed infants. I would urge you to find such studies, and evaluate the cost/benefit of promoting and supporting breastfeeding, which may reduce morbidity of all 5 rotavirus strains, as compared to universal immunisation against one rotavirus strain.

This also brings out the point of lack of good and reliable statistics on breastfeeding in Australia. We really need to know what is actually happening to best assess the impact of any outcomes of this inquiry.

Milk Banks

I recently heard Professor Karen Simmer speak about the establishment of a human milk bank in Perth for the Neonatal Intensive Care Unit (NICU). They had to get Rotary help to get established, and there is now another pilot human milk bank in the Queensland Gold Coast that is struggling to get established. The NICU is a point where there are very clear and substantial cost benefits if human milk is routinely used. I understand hospitals are state based and funded, but ultimately that is federal money. A strategy for funding human milk banks in all NICUs around the country would surely save us money by reducing morbidity and mortality in these high risk low birth weight babies, as well as reducing the anguish of their parents.

Australian Breastfeeding Association

Last year, 2006, the Federal Labour Party promised 2 million dollars to the Australian Breastfeeding Association, specifically to support their helpline. This is an invaluable service given the conflicting information mothers often receive from health professionals, and government recognition and financial support are long overdue.

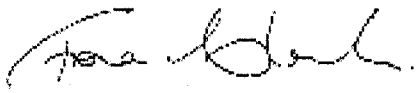
6 Months of Regular Maternity Payment

I hear from mothers feeling they have to wean when returning to work, or their work is not flexible or accommodating enough to support continued breastfeeding. I am not at all surprised that Norway, with 48 weeks of paid maternity leave, has very high breastfeeding rates. Again this acknowledges the importance of parenting and breastfeeding in the most important stage of a child's development, and sets up future physical and emotional health. The current maternity payment arriving in a lump sum is often seen as a bonus and I hear is often used to buy things totally unrelated to the new child, let alone being used to support the family over the time of maternity leave. An ongoing fortnightly maternity payment, like the Family Tax Benefit, for the first 6 months would be far more appropriate. The one aspect of the current maternity payment I do agree with is it being for all mothers; the argument against paid maternity leave was that it only would then apply to mothers who had been employed.

SUMMARY

Physiologically and historically, breastfeeding is the normal way to feed a child. At the

minute we live in a culture which thinks it is normal for the sole food of an infant to be a product based on cows milk that has been dried, modified, added to with other products, occasionally contaminated with bacteria and metal pieces (FDA report, March 2006), then reconstituted and sometimes stored in unhygienic conditions, which creates an immunocompromised child, more prone to acute infections and autoimmune diseases. For the health of our community, we need to change that thinking. I have suggested 2 actions that will contribute to that change - the education of medical practitioners and the adoption of the WHO Code on the Marketing of Breastmilk Substitutes in full with mandatory restrictions. Once people think of breastfeeding as normal, then the ground shifts for making decisions, like funding human milk banks, whether universal rotavirus vaccine is cost effective and also for mothers in their own infant feeding choices.



Dr. Fiona Clements MBBS Grad Cert HI

References

Australian Bureau of Statistics "Breastfeeding in Australia, electronic delivery" 17 September 2003

Brodribb W, Fallon T. "Health professionals and breastfeeding - knowledge, attitudes and beliefs" Topic In Breastfeeding, Lactation Resource Centre Nov 2005

James J "An analysis of the breastfeeding practices of a group of mothers living in Victoria, Australia" Breastfeeding Review 2004; 12(2):19-27

Labbok MH, Clark D, Goldman AS, "Breastfeeding: maintaining an irreplaceable immunological resource" Nature Reviews Immunology 2004, 4: 565-572

Hegney D et al "A Longitudinal Needs Analysis of Breastfeeding Behaviours and Supports in the Toowoomba Region" 2003 http://www.usq.edu.au/resources/bf+phase+1.pdf

National Health and Medical Research Council "Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers" Endorsed 10 April 2003

National Institute of Clinical Studies 2003. Information finding & assessment methods that different groups of clinicians find most useful. Prepared by the Centre for Clinical Effectiveness. NICS, Melbourne.

The FDA Enforcement Report. March 1, 2006
http://www.fda.gov/bbs/topics/enforce/2006/ENF00941.html