CHAPTER 4

DOUBLE ENTITY, DOUBLE JEOPARDY

Introduction

Because of the unique health care responsibility the midwife has to a double entity (the mother and baby) the midwife has to balance or maximise what is in the interests of both. In the following pages the midwife's professional obligations to this double entity, in particular about infant nutrition, will be described.

In order to fulfil these obligations and achieve what is morally right the midwife needs to act to provide benefits and prevent harms to both mother and baby. Benefits include giving accurate advice to the mother about establishing and maintaining breastfeeding. Preventing harms includes explaining about the harmful effects on breastfeeding and the potential to harm the baby if the mother chooses to feed her newborn baby with artificial formulae. Because the harms of artificial formulae are so demonstrably bad, I believe the midwife should use persuasion and offer positive alternatives to artificial formulae such as **wetnursing** or **human milk banking**.

This chapter will also focus on autonomy and paternalism which may be in conflict when there are competing claims between benefits to the woman and the prevention of harms to the baby. Some women choose to exclusively artificially feed their newborn. The following extract from an Australian Women's news weekly lists some of the reasons one woman gave for choosing artificial formulae:

> A new father can feel rejected because of the time the mother spends breastfeeding... one drawback was having to watch what I ate as some food tainted the milk ...some women find large heavy breasts uncomfortable and unattractive and consequently are unable to exercise.[163]

Some breastfeeding women may ask the midwife to give the baby artificial formulae during the night so that the woman can have an uninterrupted or **good night's sleep**. A moral dilemma for the midwife is created between the duty to prevent harm to the baby and the duty to respect the wishes of the mother.

James McKenna, an American Anthropologist posits the theory that separation of infants from parents is abnormal and that co-sleeping improves sleeping patterns of infants and mothers.[164] He also suggests a link between co-sleeping and prevention of Sudden Infant Death Syndrome [SIDS] so that removal of babies to the nursery may be another harm to the newborn.

An attempt will be made to make a reasoned case for persuading the woman who does not wish to breastfeed, to change her mind about her choice of infant nutrition. Because there is a need to provide an atmosphere of freedom of choice, specific methods of communication will be described. The ways in which the midwife can persuade the woman to change her decision may be limited by the woman's depth of knowledge and beliefs. The importance of examining these limits will be explored.

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[163] Stewart, D. 1992. 'Why I'm a bottle-feeding mum.' *The Australian Women's Weekly*. Sydney: ACP Publish- ing Ltd. February Soapbox

[164] McKenna, J. 1993. 'Rethinking "Healthy" Infant Sleep.' *MIDRS: Midwifery Digest*.(Sep 1993) 3:3

Also, some midwives are limited by their lack of current knowledge and mistaken beliefs.[165] Some believe that they are acting in the breastfeeding woman's best interests by feeding the baby with artificial formulae while the woman sleeps. Some out of date midwives do not act to prevent the giving of formulae and some knowingly give formulae without informing the woman of the harms of artificial formula.

Questions will be raised about the parents' rights to freely choose artificial feeding as a method of infant feeding or whether the parents should be coerced by the state [government] to breastfeed in order to prevent harm to the baby. Preventing harm to the baby when the newborn baby is not in a position to argue against harms nor to claim rights to be exclusively breastfed identifies the moral dilemma examined in this chapter.

In addition to persuasion of the woman, acting to enable midwives, colleagues, the community, public and other health agency policies to reflect the World Health Organisation's Code, would assist in enhancing the moral integrity of the midwife.

The following extracts from the Code help to substantiate some of the claims raised in the following pages of this chapter.

> ...Affirming the right of every child and every pregnant and lactating woman to be adequately nourished as a means of attaining and maintaining health;

[165] Lewinski, C. 1992. 'Nurses' knowledge of breast-feeding in a clinical setting.' *J. Hum Lact.*,_8 (3) 142-148 cited in *Update.* 11:10 p 9

> Recognising that infant malnutrition is part of the wider problems of lack of education, poverty and social injustice;... Conscious that breast-feeding is an unequalled way of providing ideal food for the healthy growth and development of infants; that it forms a unique biological and emotional basis for the health of both mother and child; that the anti-infective properties of breastmilk help to protect infants against disease; and that there is an important relationship between breast-feeding and child-spacing;
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> ... Recognising further that inappropriate feeding practices lead to infant malnutrition, morbidity and mortality in all countries, and that improper practices in the marketing of breast-milk substitutes and related products can contribute to these major public health problems;
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> ... Appreciating that there are a number of social and economic factors affecting breast-feeding, and that, accordingly, governments should develop social support systems to protect, facilitate and encourage it, and that they should create an environment that fosters breast-feeding, provide appropriate family and community support, and protects mothers from factors that inhibit breastfeeding.[166]

How the midwife can act to enhance professional, public, local and national bodies to promote breastfeeding will be included later in this chapter.

1. The Midwife And Her Professional Obligations

The professional autonomy of the midwife, as the primary carer for most women and their newborn babies in this country, rests with the midwife maintaining credibility as the expert designated to give the best advice to women in regard to infant nutrition. Professional autonomy entails

[166] [WHO]World Health Organization. l981. International Code of Marketing of Breast-milk Substitutes. WHO/MCH/90.1 (Annex 2 p.47)

increased reliance on one's own judgment, and correspondingly the midwife is morally responsible for the consequences of her practice.

If the midwife believes that she is acting in the woman's best interests by enabling her to have a good night's sleep then she may consider her action [giving the baby artificial formulae] to be morally defensible. The benefit of a good night's sleep should not, however, have sufficient precedence over the known harmful consequences of a baby receiving artificial formulae. When the midwife gave a formula to the baby of a breastfeeding woman without her consent, then she was acting paternalistically. Paternalism and its implications will be discussed in the next section.

The midwife was also unprofessional because her judgement was marred by a lack of current knowledge. As Tom Beauchamp and James Childress put it:

> In professional relationships the argument is that a professional has superior training, knowledge and insight and is in an authoritative position to determine what is in the patient's best interests. The professional is like a parent when dealing with dependent and often ignorant patients.[167]

In this case the midwife has mistakenly used her authority and consequently abused the dependent status of the woman to whom she has a duty of care.

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[167] Beauchamp, T.L. & Childress, J.F. 1989. *Principles of Biomedical Ethics.* New York: Oxford University Press. pp 212-213

When the midwife gives artificial formulae to the baby without the consent of the woman who has chosen to exclusively breastfeed her baby, the midwife not only harms the process of breastfeeding, but may cause short and long term harm to the newborn baby. Her knowledge is inadequate and may even border on culpable ignorance. The confusion between what is beneficial for the mother and what is beneficial to the baby is complicated by the midwife's lack of knowledge about the benefit of breastfeeding in relation to sleep, and patterns of breastfeeding in the newborn. McKenna demonstrates on film that babies left co-sleeping with their breastfeeding mother will actually knock on the breasts when seeking a feed and mimic the mother's movements during her sleep[168].

In 1994 Jan Edwards recent President of the Board of the Australian Lactation Consultants Association [ALCA] in a personal communication re-affirmed that the practice of giving artificial formulae to babies of breastfeeding mothers, still continues.

Placing the baby in the nursery limits easy access of the mother to her baby and consequently her ability to control what is fed to her baby. Commisso, referred to in Chapter One stated that:

> it is usually women having their first baby who are unable to resist the persuasion to place their baby in the nursery overnight.[169]

The failure of the woman to sleep through the night may be seen to reflect poorly on the midwife's perception of what a **good** midwife does

[168] Harris, H. 1994 President of ALCA Melbourne:

[169] Commisso, *loc. cit.*

in caring for the women in her care. The woman also may have unreal expectations about a good night's sleep. The need to prove that the woman had a good night's sleep may be a more powerful influence on the way the woman and the baby are managed, than whether the woman was assisted in her desire to establish breastfeeding.

It is true that the woman who has recently given birth to a baby is tired. However, for the newborn the urge to be fed (having recently been removed from a continuous supply of nutrients in utero) usually requires a range of frequency of feeds from one or even up to ten or more feeds (commonly referred to as **cluster feeds**) in the next twenty four hours, with a similar pattern for some weeks.

Most up to date midwives recognise this factor as being different from what was traditionally thought and accommodate the difference. Provided there is no maternal impediment, such as rare congenital lack of breast tissue, most healthy normal women can provide human milk for their newborn. As a leading textbook on the subject of breastfeeding states:

> It is advisable for numerous reasons to feed young infants whenever they indicate a need... In general young infants, especially newborns, have very irregular feeding intervals. They may feed at unevenly spaced intervals from 6 to 12, or as many as 18 times in a 24-hour period ...Mothers, [midwives, the general public and close relatives], may need reassurance that this early phase of very frequent feeding is likely to settle into more predictable routines as lactation is established.[170]

[170] Royal College of Midwives [RCM] 1991. *Successful Breastfeeding.* New York: Churchill Livingstone. p 33

The quality of sleep of the newly delivered mother may also be improved by breastfeeding at night.

> ...There is a suggestion that dopamine receptors in the brain mediate sedation. ...this may account for the often reported and observed sleepiness that women experience when they breastfeed. [171]

The midwife is also lacking in knowledge about the effects of giving a bottle of artificial formulae, including its harmful effects on the baby as well as its interference with the process of breastfeeding. This interference with drainage, the *sine qua non* of successful breastfeeding sometimes results in painful blockage, engorgement, inflammation and abscesses of the breasts.

2. <u>The Obligations Of A Professional Not To Harm</u>.

The midwife has a professional obligation to prevent harm to the baby, and to do so, she must be up to date in her field of expertise.

Peter Singer and Helga Kuhse give an instructive parallel example of responsibility for preventing harm:

> ...If I am standing on the beach while someone drowns in the surf fifty metres

[171] *ibid.*

> away, I will not be morally responsible for the death if, concentrating on a game of beach cricket, I fail to notice the person signalling for help. Even if I did notice the signal, but was unable to help because I cannot swim a stroke and there was no one else who could be summoned in time, I will not be responsible. If, however, I noticed the signal and could easily have carried out the rescue, but refrained from doing so because I didn't wish to interrupt my sunbathing, I bear considerable moral responsibility for the death. If I happen also to be a lifeguard and was on duty at the time, my moral responsibility for refraining from rescuing the drowning person is greater still. Moral responsibility arises only when we have some control over our actions in a situation, and it is strengthened when we have a specific duty that is relevant to what is happening.[172]

An analogy can be drawn with the mother who wishes to artificially feed her baby but **knows nothing about the harms** of artificial formulae. Her baby is the drowning person and the mother is the person who cannot swim. The motive or intent of the **mother** who is **lacking knowledge,** is morally different however, from the **midwife** who **lacks knowledge**. This midwife is a professional who ought to have current knowledge, and who has not bothered to update her knowledge. Her position is similar to the lifeguard who was on duty but refrained from rescuing the drowning swimmer. However, this midwife is even more irresponsible because she has not maintained her skills.

The lifesaver, who is able to swim but makes no attempt to save the drowning person is also similar to the midwife **who has the knowledge** and fails to prevent the baby from receiving formulae. But there is a difference between

[172] Kuhse, H. & Singer, P. 1985. *Should the Baby Live?* Oxford: Oxford University Press. p 84

those midwives who know about the harms of giving formulae and do nothing to prevent the giving of the bottle and those who do not know about the harms of giving formulae and still give a bottle of formula to the baby. The result in each case is that the baby receives a bottle of formula. Both of the midwives are wrong but in different ways.

Neither of these midwives, however, should be excused from the moral obligation to have current knowledge about breast feeding and the moral obligation to avoid harming those in her care.

The midwife has, a similar professional responsibility to the lifeguard, not only to have knowledge, but to use that knowledge in preventing harm. The midwife has as stated later in Kuhse and Singer[173] 'some control over her actions and has a specific duty that is relevant to what is happening'.

The midwife who knows the harms and still gives formulae to the baby, may have weighed up harms to herself. In practice it can be difficult to persuade colleagues that giving formulae is harmful. The resistance to the idea may make the midwife extremely uncomfortable. The knowledge-able midwife will often be faced with the decision whether to act in the face of risks to herself. Her career may suffer if she attempts to carry out practices which are in conflict with a superior who is not as knowledgeable.

For example a student will begin to give information to a woman about the benefits of

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[173] *ibid.*

breastfeeding and the harms of artificial formulae. A midwife who is out of date may challenge the student and change the student's management in front of the woman. The student becomes distressed for two reasons, firstly the knowledge imparted by the midwife is wrong and even damaging, and secondly the student's credibility is diminished.

As the student's clinical supervisor I usually debrief the student and the midwife (separately) in order to bridge the gap between current knowledge and out of date practice. On occasions following this debriefing the out of date midwife may victimise the student. Student midwives who are powerless and often in a vulnerable position, become distressed because they are stopped by intransigent, out of date midwives, from teaching the mother about correct breastfeeding practices.

I also experienced moral distress when the out of date midwife projected her anger at me. A result of what this midwife perceived as interference with her practice or agency protocols, included (as the midwife happened to be in a position of authority) threatening the placement of university students. The attempt to prevent the giving of formulae or promoting successful breastfeeding may result in too great a harm to the student, the clinical supervisor and the university. If in order to avoid conflict or victimisation, compliance with the out of date midwife follows, then intolerable guilt leading to moral distress may occur.

Kuhse and Singer's example, outlined above, could be extended to include a situation where the lifesaver may resist saving a life because she might drown in rough seas. If the midwife or the

lifesaver does not act, in the face of rough seas or risks, are they morally culpable? Singer (as cited in Beauchamp and Childress) contends that:

> ...we have an obligation to assist ...if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it.[174]

While some actions can be taken and ought to be taken there may be cumulative effects if carried out too often. That is the person undertaking the action may need to conserve energy so as not to be incapable of acting at other times. Benefits accrue from the judicious use of bravery rather than constantly setting unrealistically high standards.

The student or midwife who takes risks on a daily basis may eventually resign due to cumulative stress or **burn-out,** as a result of conflict. Alternatively, a midwife may remain in the health system, but become fearful of change and resist efforts to introduce new knowledge or practices. But sometimes by persisting she may find that there are times when the power of others to cause harm has diminished. The previously mentioned threat to student placement was negated three months later when complaints from women to a higher authority resulted in the re-education and subsequent re-deployment of the out of date midwife.

Sometimes the conflict itself brings about a change in attitude and the risk of harm

[174] Singer, P. 1979. *Practical Ethics.* Cambridge: Cambridge University Press pp 168 ff cited in Beauchamp and Childress *Principles of Biomedical Ethics* New York Oxford University Press p 198.

disappears. As stated by John Stuart Mill in On Liberty:

> Truth, in the great practical concerns of life, is so much a question of the reconciling and combining of opposites, that very few have minds sufficiently capacious and impartial to make the adjustment with an approach to correctness, and it has to be made by the rough process of a struggle between combatants fighting under hostile banners. [175]

The first step in a process of bringing about change described by Kurt Lewin included a concept similar to Mill's description of a **rough process.** Lewin described promoting situations which 'unsettle the established modes of behaviour' and he termed this **unfreezing.** If in response to this unfreezing, change occurs, then Lewin suggests locking the new behaviour into place by means of providing benefits such as praise and rewards. This latter process he termed **refreezing**.[176]

If the knowledgeable midwife is unable to persuade the woman or her colleagues then she may need to use alternative strategies such as Lewin's model for overcoming resistance to new knowledge or practice. In order to improve the knowledge or correctness of the out of date midwife the student or midwife may have to accept the lack of minds '**sufficiently capacious** or **impartial** to make adjustments'.

Moral distress may be an outcome for the student but the conflict itself may bring about a change in attitude of the out of date midwife. By

[175] Mill, J.S. 1948. *On Liberty and Considerations on Representative Government.* McCallum R.B. (Ed.) Oxford: Basil Blackwell p 42

[176] Stoner, J.A. Collins, R.R. and Yetton, 1985. *Management in Australia.* New Jersey: Prentice-Hall

accepting the **rough process of a struggle** then the student midwife may avoid intolerable guilt and pursue correct practice.

It should be possible to carry out our **obligation to assist** without sacrificing anything of **comparable moral importance** as Singer, cited earlier, contends. If the student midwife or clinical supervisor are prepared to endure uncomfortable feelings then moral distress may not necessarily be an outcome.

The intransigence of her colleagues, let alone the resistance of the mother to knowledge about the harms of artificial formulae to the baby, and the powerful force of industrial marketing, place at times, seemingly insurmountable barriers in the way of enhancing correct breastfeeding practices.
But if the midwife gives the woman up to date information and prevents exposure to misinformation from intransigent midwives she enhances successful breastfeeding. By educating the woman about the harms of artificial formulae the midwife also improves the woman's' decision making ability and as a result may avoid harms to the baby. By avoiding harms the midwife has also respected the woman's autonomy.

3. Autonomy And Paternalism

Autonomy, (the literal meaning of which is self-rule), or the idea of personal autonomy as an extension of self determination by the individual is, as described in Beauchamp and Childress;

> a personal rule of the self while remaining free from both controlling interferences by others and personal limitations such as

pp 452-453

> inadequate understanding that prevent meaningful choice.[177]

Respect for autonomy requires that the midwife acts to support the mother in her choice of nutrition for the baby. The principle of respect for autonomy, as described in Beauchamp and Childress [178] involves treating agents [the woman] so as to allow or to enable them to act autonomously. That is, 'true respect includes acting to respect'.

Most women by the time they become pregnant have already made a choice about the method of infant feeding. Melbourne figures for breastfeeding ranged from 80-85% of women breastfeeding when they leave hospital, reduced to 57% of those women breastfeeding at three months.[179] The figures give some credence to the view that most women choose to at least initiate breastfeeding.

Usually the decision is made by the mother about the method of infant feeding but many factors play a part in influencing that decision. Attitudes, beliefs, knowledge and experience of either partner, relatives, doctors, midwives and friends, may contribute to whether the choice is a strongly held desire of others or the autonomous wish of the mother.

If the woman chooses to breast feed, then the midwife should act to respect that woman's wishes and prevent harm to that process. The midwife is not acting to respect the woman's autonomy when she gives artificial formulae to the baby without the consent of the woman who has chosen to

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[177] Beauchamp, *op. cit.*, p 72

[178] *ibid.*, p 71

[179] HDV *op. cit.*, p 127

exclusively breastfeed her baby. A midwife who does this is acting paternalistically if she does it because she thinks it will be in the woman's best interests.

> The root meaning of paternalism (after the writings of Immanuel Kant and Mill) is; `the principle and practice of paternal administration; government as by a father; ...in the same way a father does for those of his children'.[180]

According to some definitions, a paternalistic action, whatever its form, necessarily infringes autonomous choice and on that basis is not usually morally justifiable. Alternatively, some proponents of paternalism state that paternalism may be morally justified when it involves overriding a person's wishes in order to provide benefits or to avoid harms.

For example, a person who has a severe infection may object strongly to being injected with life saving antibiotics in spite of being adequately informed. The objections based on fear of pain ought to be considered of lesser importance than actions to prevent death. In order to act in the patient's best interests a judgement about competence may need to be made. This may involve appeals to a higher authority (Medical Director or the Law) which may then rule the patient incompetent on the basis of, as argued by Beauchamp and Childress, 'the harms preventing from occurring outweigh the loss of independence'. [181]. **Weak paternalism** would be justified if this person was suffering from an

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[180] Beauchamp, *op. cit.*, p 212

illness likely to cause death, for example meningitis. It is likely that such a patient would be disorientated from fever and therefore has a degree of compromised ability to make a judgment. With an involuntary patient some form of restraint would need to be used in order to give the injection.

Paternalism is sometimes described as Weak paternalism if it is carried out in the interests of someone (in this case, the woman) who is non-autonomous. Included in a description by Beauchamp and Childress of a non-autonomous person is one whose consent is 'not adequately informed or has compromised ability'.[182]

In weak paternalism one has the right to prevent self-regarding conduct only when it is substantially non-voluntary or temporary intervention is necessary to establish whether it is voluntary or not.[183]

The autonomy of the woman who does not know about benefits of breastfeeding or harms of artificial feeding would be compromised to some extent. Any decision about infant nutrition by this woman would be described as substantially non-autonomous. When the midwife enhances this woman's knowledge she empowers her to make an informed decision which restores to her an increased degree of autonomy.

The midwife who acts to avoid harms to a woman when there is a degree of compromised ability (because the woman is not adequately informed

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[181] ibid.,p 219
[182] loc cit p 218

[183] *ibid*

about the choice of nutrition of her baby) is using a weak paternalistic intervention. Making an uninformed decision which could harm her baby, may cause emotional distress to the woman.

In order to justify the argument that the woman's autonomy is being jeopardised, it is useful to realise that there is a potential to emotionally harm the woman. If the woman values her newborn baby's health, finding out about the harmful consequences of artificial formulae, after the event, may result in outrage. Her distress may be even greater if she discovered that the knowledge about harmful consequences had been negligently withheld. Hence the midwife's beneficent intervention to enhance the woman's knowledge, and prevent psychological harm to the uninformed woman is justified weak paternalism.

.31 *Information Giving & Informed Consent*

> The most relevant meaning of consent includes a voluntary uncoerced decision, made by an autonomous person on the basis of adequate information and deliberation, so that they are able to reject or accept a course of action that will affect him or her[184]

Establishing whether the woman has made an authentic decision `free of coercion or controlling influence of others' would be ascertained by the midwife during the decision making or interview process. If the woman is to choose autonomously about the method of feeding her baby, she has to act in accordance with an informed plan.

[184] Gillon, R. 1986. *Philosophical Medical Ethics* Brisbane: John Wiley & Sons p 113.

The notion of informed consent is congruent with the concept of an informed plan.

The midwife should give accurate and complete information about the benefits of breastmilk and the harms of artificial formulae and encourage the woman to make a choice based on material information. Material information is what the woman regards as worth knowing about, even if it will not causally affect her decision about whether to choose breastfeeding or artificial feeding. For example, if there is a family history of asthma, then the allergenic properties of cow's milk formula would be material.

A sample consent form listing the harms of artificial formula was included in the 1994 Victorian Government Health and Community Services Promoting Breastfeeding Guidelines.[185]

In the case of the woman who chooses to artificially feed her baby, the midwife may suspect that she is not adequately informed. The midwife should be justified in informing her of the benefits of breastfeeding and the harms of artificial feeding. Some women who are not adequately informed may already have another child or children with asthma, diabetes or heart disease, or a strong family history of disease. This history is a still more conclusive justification for persuading the woman to breastfeed. A secondary effect of this persuasion if

[185] Health and Community Services 1994. *Promoting Breastfeeding Victorian Breastfeeding Guidelines* Melbourne: Victorian Government Publication. Appendix 1

successful, would be prevention of harm to the baby, who is entirely non-autonomous.

As the following recommendation from the Ministerial Review of Birthing Services in Victoria demonstrates, women have recently expressed the need to take control of their own birthing experience (which may include breastfeeding):

> All hospitals and care givers in private practice should consider developing birth plan forms, to be used as a standard part of antenatal care to record the pattern of care agreed to in discussion with women and their partners. [186]

The emphasis should therefore be on respecting the woman's autonomy and not on the midwife's traditional practice of making independent judgements about the woman's care.

Collection of relevant data and consultation with the persons in her care, peers and other health carers are an inherent part of maintaining standards of midwifery care. By consulting the woman about her care, the midwife not only respects the woman's autonomy, but enhances the achievement of the best consequences overall. This includes consequences which are in the best interests not only of those in her care, but also of her profession, her employer and the wider community.

.32 *Self-determination in Midwifery Practice*

[186] HDV *op_cit* p 55

Apart from the standard of midwifery practice which urges the midwife to maintain knowledge and the skills required to achieve excellence in midwifery practice, the midwife is instructed to: 'use a problem solving approach to provide health education on an individual basis'.[187]

One particular problem solving approach which has been universally used in nursing practice, is named the Nursing Process.

> The Nursing Process consists of five steps - assessment, analysis/nursing diagnosis, planning implementation and evaluation, and is analogous to the [informal] problem solving process used by nurses since Florence Nightingale [188]

By using the Nursing Process in a birth plan format recommended by the HDV Study Group mentioned earlier, the midwife incorporates one of the basic tenets of autonomy, that is self determination. The midwife involves the woman in planning the care of herself and her baby.

While Birth Care Plans have been taken up by many women and some agencies in the last decade, the content is mainly focussed on conduct of labour and pain relief methods. It is my contention that this plan should dedicate a large proportion of the content to

[187]Olds, S. London, M.L. Ladewig, P.W. 1992. *Maternal Newborn Nursing*. 4th Edition Sydney: Addison-Wesley p 23,

[188] *ibid.*, p 25

breastfeeding. A nine page, predominantly check list style lactation plan by Wellstart International can be found in Riordan Appendix H [189]. This broadly based plan encourages the midwife and the woman to examine and record a history of medical, family, nutrition, lifestyle habits and a past and present breastfeeding history of the woman. Early decisions about infant nutrition feeding and preferences of the mother are established. While nine pages may seem time consuming for the mother the principle of autonomy is met particularly if the woman enters the data.

If an interview for the purpose of taking a lactation history is followed by and coincides with visits to the midwife in the antenatal period, then the opportunity for the introduction to a valuable education program can be initiated.

In the analysis phase of the nursing process the midwife determines the entry knowledge of the woman and then makes a diagnosis. One example of a midwifery diagnosis is **knowledge deficit** which could be used to describe the status of the woman who has insufficient knowledge about infant nutrition. The midwife then proceeds to implement an education program which should involve a formative, cumulative and summative evaluation of the woman's understanding. The midwife uses a series of balances and checks to ensure substantial understanding.

[189] Riordan, *op cit.*, pp 657-666

.33 *Substantial Understanding and Weak Paternalism*

Substantial understanding according to Faden and Beauchamp is:

> somewhere between adequate and full understanding ...effective communication needs to be used to facilitate this understanding.[190]

Successful communication usually results from the use of a variety of communication techniques such as open ended questions, active listening (clarifying, focusing, and paraphrasing) and passive listening (eye contact, open stance and congruent facial expression).[191]

When the midwife provides the woman with up to date and accurate knowledge as well as ensuring substantial understanding then the midwife maintains optimal standards of midwifery practice. The midwife is able to act in the woman's and baby's best interests, because the midwife has provided the woman with the opportunity to make the best choice for her baby. The midwife has disclosed information, assisted the woman to comprehend the information about the risks and outcomes of infant nutrition, and ensured voluntariness, that is she has not coerced or unduly influenced the decision. She has respected the woman's autonomy and

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[190] Faden, R.R. & Beauchamp, T.L. 1986. *A History and Theory of Informed Consent.* New York: Oxford University Press. p 305

[191] Bolton, R. 1991. *People Skills: How to Assert Yourself, Listen to Others, and Resolve Conflicts.* Australia: Simon Schuster Parts One and Two

empowered her to give informed consent or to make an informed choice.

> Justified weak paternalistic interventions involve respect for autonomy, and yet may initially mean disregarding consent.[192]

Consent may be given, however, following a full explanation of benefits or harms. In other words decision making capacities are enhanced.

> Weak paternalism is justifiable in so far as consent to the interference would be forthcoming were the subject's decision-making capacities restored.[193]

An example of improved decision making capacities and the relationship to justified weak paternalism was explicated in the preceding pages.

.34 Strong Paternalism

As stated earlier 80% of women in Victorian Hospitals choose to initiate breastfeeding.[194] Described in the first Chapter of this thesis were some of the factors which may contribute towards the decline of women maintaining breastfeeding at three months to 57%. One of these factors was giving of artificial formulae to babies of breastfeeding women which resulted in interference with prolactin release and drainage of the breasts. The subsequent

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[192] Beauchamp, *op. cit.*, p 247

[193] Young, R. 1986. *Personal Autonomy: Beyond Negative and Positive Liberty*. London: Croom Helm. p 64

[194] HDV, *op. cit.*, p 127

outcome of this effect usually is a poor milk supply leading to the abandonment of breastfeeding.

Similar figures in a Canadian study demonstrated a breastfeeding initiation rate of 80%, but in spite of the WHO recommendation to breastfeed at least for 6 months, exclusive breastfeeding rates at 6 months were 25%.[195]

A claim of justified paternalism, that is, acting in the breastfeeding woman's best interest to provide a good night's sleep, can be negated by anecdotal evidence that breastfeeding women generally sleep equally well when access to their babies is unrestricted at night and rooming-in is increased. [196] [197]

The conflict then, is between perceived beneficence (one ought to do good and ensure a good night's sleep) and failing to respect the woman's wishes to exclusively breastfeed, (overriding respect for autonomy) by giving the baby of a breastfeeding woman artificial formulae without consent.

The action-guiding moral principle, respect for autonomy, has here been wrongly overridden by the principle of beneficence.

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[195] Ellis, *op. cit.*, p 626.

[196] Walker, B. 1986. Survey of antenatal women's expectations, and postnatal women's actual patterns of sleep in the postnatal period. Melbourne: Mercy Hospital for Women. Unpublished

[197] Waldenstrom, U. & Swenson, A. 1992. 'Rooming-in at night in the Postpartum Ward.' *Midwifery.* UK: Longman Ltd. 7:82-89

Paternalistic action by the midwife is unjustified when it is based on mistaken beneficence.

Any action which overrides a substantially autonomous or voluntary decision, would be defined as strong paternalism. Advocates or defenders of **Strong paternalism,** hold that 'it is sometimes proper to intervene in order to benefit a person even if that person's risky choices are informed and voluntary'.[198]

The woman, who has had a substantial degree of autonomy restored through good communication and education, may persist in her decision to artificially feed her baby because it prevents distress to herself. In spite of warnings about harms to the baby the woman may choose to ignore the risks.

In spite of the availability of alternatives such as human milk banking or wet nursing the woman may still wish to artificially feed her baby. Is the harm to the baby serious enough to warrant limiting the woman's freedom? Does the baby have a right to the woman's body or at least to correct nutrition in the form of human milk? Can the woman be incarcerated and forced to give her baby breastmilk?

In an often quoted example John Stuart Mill states:

> If either a public officer or any one else saw a person attempting

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[198] Beauchamp, *op. cit.*, pp 218-219

> to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of his danger, they might seize him and turn him back without any real infringement of his liberty: for liberty consists in doing what one desires, and he does not desire to fall into the river.[199]

In the situation described earlier on page 119 the patient refused an injection to save his life. On the basis of compromised ability to make a judgment and the avoidance of harms, his autonomy was overridden and using restraint a life-saving injection may be forcefully given. This situation could be analogous to, as quoted in Mill 'seizing him and turning him back' because if he was competent he may prefer to have the injection or be prevented from dying. Overriding his autonomy may have been infringing liberty, but in the end the saving of his life may have been what the patient genuinely desired.

But if the condition for the patient was not life threatening then a case could be put for respecting his autonomy by warning of danger but not forcing him to have the injection. I agree with Mill when he goes on to say;

> Nevertheless, when there is not a certainty, but only a danger of mischief, no one but the person himself can judge of the sufficiency of the motive which may prompt him to incur the risk, ... he ought, I conceive, to be only warned of the

[199] Spitz D.(Ed.) 1975. *On Liberty John Stuart Mill Annotated Text Sources and Background Criticism* New York: W.W. Norton & Company P 89

> danger; not forcibly prevented from exposing himself to it.[200]

The woman who persists in giving her baby artificial formulae may have very strong inner compulsions or fears which in spite of substantial explanations, cannot be overcome. She may also be compelled to return to work and be unable to breastfeed for this reason unless of course the work situation was conducive to breastfeeding. The importance of her reasons is known only to herself.

The woman should be warned of the dangers of artificial formulae. Coercing her to breastfeed would not only be impractical, but may be viewed as strong paternalism, at least in so far as it relates to her own interests. It would be difficult to justify paternalism on these grounds. There is, however, another issue: that of harm to the baby.

4. Prevention Of Harm To The Baby

Mair, a nurse-lawyer drew attention to the obligations of the health care professionals to prevent harm to a child when she wrote about a successful Victorian damages claim of a child, against his mother while a fetus:

> ...as well as giving consideration to the likely effect upon the pregnant woman, they [the Health Care Professionals] need to consider the possible effect on her existing unborn child and to others who may be subsequently born to her. The duty of care will arise if it is reasonably foreseeable that **acts or**

[200] *ibid* p 89

> **omissions** of the health professional will expose a prospective plaintiff to an unreasonable risk of harm.[201]

The claim of a fetus while a prospective claimant may be analogous to that of the newborn baby. A child may make claims about forseen damages, as a consequence of receiving artificial formulae while a newborn baby.

It could be argued that the midwife needs to consider the forseeability of possible harms to the newborn baby when advising the mother about infant nutrition.

The defendants argued in the Victorian case that the plaintiff was not a legal person and that the fetus and her mother were essentially one personality. The judge disagreed and the child was awarded damages against the negligent driving of its mother. D. Brahams adds in a paper about this issue that: 'in Britain concerns about pregnant women who engage in hazardous activities eg. smoking, drinking have not had much practical impact'.[202] Brahams elaborates further that:

> In England at least a fetus must take its mother as it finds her ...it is the mother's rights and interests that will prevail in law if the mother wishes. ...Different attitudes have been expressed in the USA, where women have been constrained and confined with a view to protecting their unborn child from their mother's unsatisfactory lifestyle.[203]

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[201] Mair, J. 1991. 'Foetal Life and a Legal Duty of Care.' *ACMI Journal.* Dec P 13

[202] Brahams, D. 1991. 'Australian mother sued by child in utero.' *The Lancet* vol 338 no 8766 14 September pp 687-688 in *MIDRS.* Midwifery Digest. (Mar 1992) 2:1

[203] Brahams *loc. cit.*.

The fetus exists only because of the nourishment of the woman's body. The obligation of the woman to continuously nourish the fetus is absolute; that is, the mother is unable to withdraw fetal access to the maternal circulation until the pregnancy is terminated or **at term** [ranging from 37 weeks to 42 weeks gestation]. The newborn baby is, however, exposed at birth to alternative methods of nourishment. The woman **is** able to withdraw the baby's access to breastmilk, and due to the industrial adaptation of cow's milk, give the baby artificial formulae.

The obligation of the woman to provide correct nourishment (uncontaminated by drugs such as narcotics, alcohol or cigarettes), to the fetus, has been argued for by many writers [204] [205] [206] and is expanded on briefly later in this Chapter.

Whether the nourishment is beneficial or harmful, the fetus, like the newborn baby is unable to prevent harms or make a claim for correct nourishment. In the case of the fetus the best results would be obtained if the mother avoided drugs. In the case of the newborn baby the best results would be obtained if the mother chose breastfeeding.

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[204] Tanne, J.H. 1991. 'Jail for pregnant cocaine users in the US'. *British Medical Journal.* 303;6807 10:12 p 873.

[205] Peacock, J.M., Bland, J.M., & Anderson, H.R. 1991. 'Cigarette smoking and birthweight: type of cigarette smoked and special threshold effect'. *International Journal of Epidemiology.* 20:2 June pp 405-412

[206] Martin, T.R., Bracken, H.R. & Sloan, M. 1992. 'Cigarette, Alcohol and Coffee consumption and prematurity'. *American Journal of Public Health.* 82: 87-90

.41 Beneficence and non-maleficence

Because the midwife has to act to meet the best interests of the baby and the mother, the use of the principles of beneficence and non-maleficence may sometimes provide sufficient justification for overriding the principle of respect for autonomy.

Beauchamp and Childress distinguish the principles of beneficence and nonmaleficence in the following way:

> **Non-maleficence**;
> 1. One ought not to inflict evil or harm;.
>
> **Beneficence**;
> 2. One ought to prevent evil or harm 3. One ought to remove evil or harm 4. One ought to do or promote good.[207]

Balancing these principles while respecting autonomy in order to achieve the best outcome becomes complex when the mother chooses to artificially feed her baby.

The midwife, when endeavouring to respect the woman's autonomy, but wanting to avoid the harms of giving artificial formulae to the baby, must decide which of the these action guiding principles, on balance, is best. If the sum total of benefits falls on the side of non-maleficence (avoiding harms) then attempts to change the woman's mind would be justified.

The principle of beneficence dictates that one ought to promote or do good, but also

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[207] Beauchamp and Childress, *op. cit.*, p 122-123

act to prevent harm. By successfully persuading the woman to breastfeed and not give formulae to the baby the midwife not only promotes good but more importantly removes harm from the baby. There is no conflict.

The principle of non-maleficence (one ought not to inflict harm) allows for inaction. The midwife who refrains from feeding the baby artificial formulae (in spite of a request from the breastfeeding mother) is refusing to inflict harm on the baby. However, the mother then has to breastfeed and may resent the baby for depriving her of what she perceives to be a benefit ie. good night's sleep.

If the midwife considered that refusal (to give the baby formulae) would inflict emotional harm on the mother, then she may feed the baby the formula, justifying her action on the basis of avoiding emotional harm to the woman. There would be no point in suggesting that the mother give the formula to the baby, as it would defeat the purpose of the woman's desire to achieve a good night's sleep.

Balancing benefits or harms against alternative benefits or harms occurs when the benefit to the mother does not coincide with the benefit to the baby. This balancing requires more than relying on principles of beneficence, nonmaleficence or autonomy to decide what is in the best interests of both mother and baby.

.42 Utilitarianism

A Utilitarian or consequential view may lead the midwife to consider that on balance emotional harm to the mother is a lesser harm than the potential physical harms to the baby. The better action would be to try to persuade the woman to breastfeed or for the midwife to suggest the provision of positive alternatives such as wet nursing or human milk banking.

By using a consequentialist approach or Utilitarian framework or doing what on balance leads to the greatest benefits, an argument for not harming the baby may be put. It is difficult to say however, what would produce the most benefit or happiness for the baby in the long term, or alternatively what, in the short term the baby would prefer. Irrespective of what the baby and parents want, it may be that, what the baby in the long term would intrinsically value, or subsequently consent to, is the more important measure. In order to objectively measure what the baby might value in the long term, it is probably better to choose values of health, or freedom from pain, when minimising harms.

In a description about what values should be considered as most desirable, most utilitarians include health and freedom from pain.[208] Because, as I have already stated, in determining utility for a baby, preferences cannot be measured, I have chosen health as a value which any reasonable person would value.

[208] Beauchamp and Childress, *op. cit.*, pp 27-28

Before exploring some of the issues related to contemporary baby nutrition, we should note that left to nature, most babies would be breast fed. Leaving babies to nature means that (as a Swedish film demonstrates) if a naked unwashed baby is placed on the mother's naked body, it will instinctively seek out the breast.[209]

The normal full-term human infant at birth is equipped to breast-feed successfully. Left to their own devices human infants will follow an innate programme of pre-feeding behaviour in the first hours after birth that can include crawling from the mother's abdomen to her breast. The baby has co-ordinated hand-mouth activity and actively searches for the nipple. The nipple has a special odour [and deeper colour] and has been measured to be 0.5 degrees centigrade cooler than the skin around it.[210] Finally the mouth gapes widely and finally, latches well to the breasts and feeds vigorously before falling asleep. This latching on may take from 5 minutes to 120-150 minutes after delivery.[211] [212] Witnessing the behaviour of this newborn baby might lead the observer to assume that this baby could indicate a preference, at least for breastmilk!

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[209] ALCA Source, (Personal Communication) Maureen Minchin

[210] Odent, 1992 *op. cit.,* p 72

[211] Widstrom, A.M. et. al. 1987. 'Gastric Suction in healthy newborn infants; effects on circulation and feeding behaviour.' *Acta Paediatr. Scand.* 76: 566-572

[212] Harris, H. 1994 President of ALCA Personal Contact and video.

It would be difficult to envisage how, in a busy obstetric hospital (where midwifery and obstetric interventions are common) the baby would have the opportunity to gain access to the breast in order to satisfy this preference. In the more serene atmosphere of homebirth or some Melbourne birthing centres this event has been observed. [213]

Midwifery interventions include washing the mother and baby which possibly interfere with body odours, skin temperature differences and natural instincts. Obstetric interventions include giving narcotic injections which evidence suggests may depress the infant's respiratory centre and result in poor breast latching[214]. Other interventions include chemical or mechanical inductions of labour and episiotomies (a cut to the perineum) the efficacy of which has been disputed and which commonly raise anxiety levels in the mother. [215]

A recent South African study demonstrated that reduced anxiety levels of the woman in labour improved the rates of breastfeeding. Newton, cited in Hofmeyr [216] noted that syntocinon (the hormone responsible for milk ejection or let-down) is inhibited by

[213] Thompson Robyn 1994 Melbourne Midwifery Services Personal contact

[214] Lawrence, *op. cit.*, pp 222,223

[215] Kitzinger S & Simkin, P. 1988. *Episiotomy and the 2nd Stage of Labour.* 2nd Ed. USA: Pennypress

[216] Hofmeyr, G.J. et al. 1991. 'Companionship to modify the clinical birth environment: effects on progress and perceptions of labour and breastfeeding.' *British Journal of Obstetrics and Gynaecology* 98: pp 756-764 cited in Kroeger M. 1993. 'Labour and Delivery practices: The 11th Step to Successful Breastfeeding.' MIC *op cit* Vol II May 9-14 p 1023 -1037

adrenaline released when fear is present. Fear was significantly reduced in the presence of a midwife and the absence of intervention. Newton hypothesises that this inhibition is present in mammals to prevent **milk stealing**.[217]

In spite of what is thought to be natural or what in the long term a child might value some women may choose to give a bottle of infant formula to a baby even when there is a strong family history of asthma, diabetes or other potentially fatal diseases. Despite the woman's autonomous state, the midwife should act to prevent harm to the baby. The woman's own good physical or mental, may not be sufficient reason to harm the baby.

However, the mother may consider that loss of income is a greater loss than harm to the baby. The future harms to the baby may not be easy to imagine while immediate loss of for example income is concrete. Unless employers can be persuaded to provide facilities for breastfeeding women then in current circumstances her decision is justifiable.

It would be wrong if the mother, having been informed about the harms of artificial formulae and there was no other obstruction, still persisted in giving the baby artificial formulae. The baby is of equal worth when considering our obligations not to harm. Are the harms reasonably foreseeable and if they are, what is the

[217] Hofmeyr, *loc cit.*

moral responsibility of the woman in avoiding harms to her baby?

.43 *Parental Rights*

The right of parents to make decisions for their children is discussed at length by Carson Strong in a paper about the rights of deformed babies and their rights to live or die. The arguments put in his discussion about parental rights can be transferred to the discussion about artificial feeding when he claims:

> This [parent's] right to decision making has limits, of course. When parental decisions are likely to result in harm to a child, the state may intervene, as in cases of treatment refusal on religious grounds.[218]

If the harms of artificial formulae are sufficient to override the parents wishes, state [government] intervention, in this case would require a beneficent act to prevent harm, rather than promote a treatment.

Strong suggests `...that the interests of the infant should take priority in these treatment decisions'. [219]

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[218] Strong C. 1986. 'The Principle `Patients Come First' and Its Implications for Parent Participation in Decisions'. in Weil W.B. and Benjamin, M.(Eds.). 1986. *Contemporary Issues in Fetal and Neonatal Medicine Ethical Issues at the Outset of Life.* Melbourne: Blackwell Scientific Publications. p 189-190

[219] Strong, *op. cit.*, p 189

The woman is not just free to choose for herself, as has already been stated, she has a fundamental obligation not to harm the baby. In one of Mill's well known position statements about liberty, he suggests that the only time a person can be forced to do something against their will, is to prevent harm to others.

> ... the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to *others* [my italics] His own good either physical or moral, is not a sufficient warrant.[220]

As the moral dilemma is created by the conflict between the woman's desire to feed her baby artificial formulae and prevention of harm to the baby, then who should decide when power can be exercised over this woman? When we return to John Stuart Mill's classic statement about power over the autonomy of others above, it supports Strong's view that there are limits to family autonomy.

Mill would surely have included children in these *others.* While Mill excluded children from the benefits of liberty he did not exclude them from protection against harm.

> We are not speaking of children, ...Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury[221]

[220] Mill, *op. cit* p 8

[221] Mill, *loc. cit.*

O'Neill further reinforces the view that children should be protected from harm when she states that;

> ... although they [children] (unlike many other oppressed groups) cannot claim their rights for themselves, this is no reason for denying them their rights.[222]

As already outlined in Chapter One there is ample evidence to support a position that artificial formulae may contribute to the high prevalence of life-shortening disease in our society.[223] [224] [225] There is, therefore, a good case for the state acting to persuade parents to support breastfeeding and prevent harm to babies from artificial formulae.

It is for reasons of justice that the state may need to intervene. That is, the harm to a future population, resulting from thousands of babies being given artificial formulae, has broader implications for society. Immeasurable costs to the health of society from diseases such as eczema, asthma and diabetes is one implication. Economic costs to the National Health Scheme in the UK are estimated at 68 million English pounds per year due to gastro-enteritis.

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[222] O'Neill, O. 1988. Children's Rights and Children's Lives. *Ethics.* 98:4 pp 445-446

[223] Cunningham, *loc. cit.*

[224] Akre, (Ed.) 1989. 'Physiological Development of the Infant'. in Supplement to the Volume 67, 1989, of the *Bulletin* of The World Health Organisation. 'Infant Feeding the Physiological Basis'. Geneva: WHO p 63 Chapter 4

Pollution effects on the environment from the equipment used to market formulae are not usually included in the equation (883 million l6 ounce cans for milk powder were sold in the USA in 1992) but is one hidden factor worthy of note.[226]

The moral question is whether it is right for the midwife to intervene when there is likely to be emotional harm to the mother. Are these emotional harms greater than the potential for ill health? It could be argued that although emotional harms are significant, there are methods of overcoming these harms, whereas potentially fatal diseases are not so easily overcome.

Article 3 (1) of the U.N. Convention on the Rights of the Child expresses the rights of the child in the following way:-

> in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.[227]

Article 24 recognises the right of the child to the enjoyment of the highest attainable standard of health. One of the provisions for the implementation of this right is:

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[225]Minchin ,M. l987. *Food for Thought.* Sydney: Unwin Paperbacks

[226]Bird, L. l993. 'TV Ads Boost Nestle's Infant Formulas. Market Scan' *The Wall Street Journal.* Mar 30 pp B1-B4 cited in 'Baby Milk Action' *Update* l994. 11(7) 13

[227] United Nations l989. 'The Convention on the Rights of the Child'. General Assembly of the United Nations. 20th November l989.

> 'to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of ...the advantages of breastfeeding,...'

This section of the Convention could be interpreted as meaning that state intervention to support a benefit such as breastfeeding would be justified.

.44 *Limits of coercion/Parental Rights*

When a woman has been fully informed about the risks of harm to her baby, but nevertheless chooses to use formulae, what should the midwife do?

The midwife could take steps to persuade the woman to breastfeed such as arranging for an expert lactation consultant [IBLC] or a doctor who is a breastfeeding enthusiast, to visit the woman to reinforce the credibility of the midwife's advice. Presuming that the woman does not wish to knowingly harm her baby, it may be reasonable to suggest positive alternatives to artificial formulae such as wetnursing or human milk from the banking of other women's milk, on the grounds of minimising harms to the baby. These alternatives are less harmful and may be cheaper than artificial formula and could be a means of enabling the woman to pursue a career or relieve her of breastfeeding if deep psychological problems are the cause of her reluctance to breastfeed.

.45 *Justifying Interference with Liberty*

Now the woman to whom I refer may not desire to feed her baby with breastmilk (her own or any other woman's). It would not be

appropriate to intervene as there is no way you can force this woman to breastfeed unless you tie her down. Seizing or tying this woman up would be a serious infringement of her liberty. Tying the woman down would also be impractical as surveillance alone would require a great deal of time and money.

In Charleston, South Carolina, pregnant women using cocaine are forced into treatment and may even be jailed. If the woman does not present for a programme of treatment before 27 weeks gestation, she will be indicted. The programme consists of completing treatment for addiction and antenatal care while incarcerated. The cost (in the USA) of treating a baby addicted to cocaine is $5,200 American. The American Civil Liberties Union argues that this forced treatment is:

> paternalistic and strips pregnant women of their rights to bodily integrity and privacy and to refuse medical treatment.[228]

Arresting the woman in order to provide the baby with breastmilk may be extreme, but it is at least conceivable that a judge might be convinced to jail women to prevent harm to the newborn, in a similar way to the previously mentioned South Carolina judiciary.

Nevertheless the argument put by the American Civil Liberties Union, on anti-

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[228]Tanne, *op. cit.*, p 873.

paternalistic grounds against incarcerating women for cocaine addiction is strong.

If. as Brahams cited earlier (page 135) states, the fetus must 'take its mother as if finds her' then it may follow that the newborn should take mother as it finds her.

It would, in my view be both wrong and impossible to force a woman to breastfeed her baby. The interference with liberty is too drastic to be outweighed by possible, but uncertain life-shortening harms to the baby.

Pregnant women are strongly advised to avoid socially acceptable drugs such as alcohol and nicotine, but are not jailed if they imbibe. The fetus who is exposed to parents who drink excessive alcohol is likely to be born mentally and physically retarded. Fetal Alcohol Syndrome [FAS] is a well recognised phenomenon of newborn babies whose mothers drink excessively especially in the first trimester. The baby is characterised by microcephaly (small head with limited ability for the brain to expand) and lower than average development of facial features. The baby suffers from alcohol withdrawal at birth if the mother continues to drink during the pregnancy and is treated with sedation until delirium tremens (commonly known as D T's) cease.[229]

In order to prevent this effect (in women at risk for conceiving while overusing alcohol) incarceration would be required before

[229] Olds, *op. cit.,* Glossary

conception or at least during the first trimester before the brain develops!
A woman who is forced against her wishes to breastfeed is more likely to be angry, and resent those who restrict her freedom. The extent of the power of the jailers is out of proportion to the good achieved if the woman breastfeeds. Also as the WHO recommends at least six months exclusive breastfeeding the cost of supervision and lodging would make custodial breastfeeding impractical. The woman may project her anger towards the child.

It would be better if the woman was swayed by reasons put by an expert. It is possible to sway women or people generally, by applying pressure through enlightened peer groups or by the method described as the Theory of Reasoned Action.

Icek Ajzen and Martin Fishbein, two American professors of communication and psychology, profer a theory of reasoned action which they state:

> can be applied to the problem of changing behaviour through persuasive communication... the ultimate determinants of any behaviour are behavioural beliefs concerning consequences and normative beliefs concerning the prescriptions of relevant others. To influence a persons behaviour ...it is necessary to change their primary beliefs.[230]

The primary belief may be that artificial formulae is as good as breastmilk.

[230] Ajzen, I., Fishbein, M. 1980. *Understanding Attitudes and Predicting Social Behaviour*. New Jersey: Prentice-Hall pp 239-242.

While yielding to persuasion may not occur and acceptance of the information may have little impact it was Azjen and Fishbein's finding that the discomfort created by a message was sufficient for example, to promote changes in the behaviour of alcoholics.

The message about positive feedback when alcoholics joined a recovery program had less impact than giving negative impact for failing to join a program. Similarly then in the case of breastfeeding, giving information about its benefits may have little impact, but providing discomfort about the negative effects of formulae feeding might.

Frowning by midwives at women (as described on page 9 of the first chapter) who chose artificial formulae, may be justified on the basis of causing discomfort.

The use of influence by high prestige, powerful figures may result in easier ways of enhancing breastfeeding practices or it may just result in strong paternalistic instruction. The influence of peer groups may be stronger especially if that group is met with frequently. If the peer group or family, have a strongly held belief about artificial feeding then their influence may be greater than any paternalistic instruction from a professional. Discomfort created by being different may be a more powerful factor in changing beliefs about infant feeding.

The Baby Friendly Hospital Initiative brochure published by UNICEF and WHO in August l991 includes over thirty actions or ideas to influence the community about breastfeeding. These ideas include posting and distributing the Ten Steps to Successful Breastfeeding in schools churches companies and places of employment.[231] The **unfreezing** process is included by suggesting women ask prospective health carers or agencies if they are baby friendly and to communicate disapproval of marketing strategies to formulae companies. The use of *positive reinforcement* (praising those who follow the Ten Steps) included in these ideas, incorporates the precepts of **refreezing.**

Another question is whether parental rights are greater than those of the newborn baby. Can the woman who gives the artificial formulae to her baby, (in spite of knowing about foreseeable harms to her baby) be

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[231] **The Ten Steps to Successful Breastfeeding.**

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding [sic]policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless *medically* indicated.
7. Practice (sic) rooming-in allow mothers and infants to remain together 24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

World Alliance for Breastfeeding Action [WABA] 1989 From: Protecting and Supporting Breast-feeding. The special Role of Maternity Services. A joint WHO/-UNICEF Statement, Published by the World Health Organization, 1211 Geneva 27, Switzerland, l989. Geneva UNICEF

compared with those women who smoke or drink alcohol during pregnancy? Can the woman's wishes to artificially feed be overridden in the best interests of the baby?

Strong states that:

> care and nurture of their children which includes basic needs such as food ....Parents are also given a great deal of discretion in proper ways of caring for their children, even though there is a great deal of diversity of opinion on what is the in our culture parents have a moral responsibility to provide for the best approach ...the autonomy of individuals is a value of great importance, and respect for autonomy requires that we respect the decisions of parents concerning family life...[232]

When the mother makes a decision about feeding her baby artificial formula, she probably believes she is acting beneficently, that is, she is nourishing her child. The decision to artificially feed the baby however, is more likely to be based on benefits to or avoiding harm to herself than unknown perceived harms to the baby.

These benefits may include meeting work commitments for monetary reward. While Bundrock indicated that their were cost benefits (approximately $500 to the woman who breastfeeds) this amount would be insufficient inducement to remain at home. However the cost savings to the health budget of a nation may be sufficient inducement for a Government to provide

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[232] Strong, *loc cit.*

facilities for breastfeeding mothers in the workplace.[233]

Avoiding harms may include emotional harms such as embarrassment or deep psychological harm. Physical harms such as mastitis or breast abscess experienced in a previous pregnancy are often cited by women as a deterrent to repeating breastfeeding. Because counsell-ing may improve the former and better management of breastfeeding prevent a repetition of the latter the midwife should try to dissuade the woman from artificially feeding her baby.

.45 Justifying Interference with Liberty

While Strong, in an earlier statement about the priority of infants in treatment decisions, is referring to a decision about providing life prolonging treatment, he goes on to argue that parents (and physicians) are the best decision makers. The conflict between what is right for the parents and what is in the best interests of the infant, identifies the need for some overriding decision to be made when there is likely to be evil produced to someone else.[234]

The example of giving or not giving artificial formulae is not as extreme as the life prolonging or life ceasing decisions in Strong's example of a deformed child, but is close to the issue of the brain damage related to the boy in

[233] Bundrock, *loc. cit.*
[234] Strong, *loc. cit.*

a Jehovah's witness example describe further on in this chapter.

The midwife should be able to intervene, when the mother makes a decision to artificially feed her baby, if there is significant likelihood of damage or harm to the baby.

If the woman values acting on the basis of well-informed reasoning, then the midwife is morally justified in intervening by persuading her to breast feed because formulae is likely to irreparably harm her baby's development.

Compelling this woman to breastfeed may be justified on the basis of preventing harms to the baby. However, as the action required to place this baby's health above the woman's autonomy may involve disproportionate action such as incarceration or tying the woman down, then her decision to artificially feed the baby would have to be respected.

Mill [235] describes three kinds of objections to the interference of the state. In the first he suggests that it is better for individuals to carry out something in which they are personally interested. This suggestion is congruent with the principles of respecting autonomy in decision making. This woman is not personally interested in breastfeeding, and although the state may

[235] Mill, *op. cit.*, p 98-99

wish it, incarceration is not a suitable or just solution.

The second objection relates to a notion which is congruent with the principles of adult learning theory. Performing something which even if not done well will enhance **their knowledge of subjects**. The woman may learn more if she artificially feeds her baby and then discovers that the baby is allergic to the formulae. It might be through this experiential learning that she is finally convinced to try breastfeeding in order to avoid harm even if only for future children.

The third objection relates to the subject of power. Mill suggests that the most 'cogent reasons for restricting interference of government is the great evil of adding unnecessarily to its power'.[236] Tying women down to breastfeed or forcing them to breastfeed will lead to an abuse of that power.

Paternalistic actions can be beneficial in particular or unusual cases, such as giving blood to save the life of the child of a Jehovah's Witness. Strong goes on to state that parents have a right to make decisions, but with that right comes responsibility. The right to decision making has limits especially when parental decisions are likely to result in harm to a child. The state has intervened, in cases of treatment refusal on religious grounds such as occurs

[236] Mill, *loc. cit.*

in patients who are Jehovah's Witnesses and who require a blood transfusion to avoid brain damage or death.

Jehovah's Witnesses believe that taking blood into one's body through the mouth or veins is a violation of God's Law. Their belief is so strong that, as they state: 'if we try to save our life, our soul, by breaking God's law we will lose it [our soul] everlastingly'.[237]

In a New Jersey case, Muhlenberg Hospital v Patterson,

> ...a blood transfusion was ordered for a minor, (a Jehovah's Witness), because of the risk of permanent brain damage rather than death. ...The court ordered the operation and a transfusion stating that to delay the operation until the boy was old enough to decide, would cause harm. •

The outcome of this decision for the child may be exclusion from the family and religion. The emotional harms to the child and the family may be so great that death may have been preferred. 'Death due to a refusal to accept a blood transfusion is ultimately equated with dying for one's beliefs'.[238] If the boy had not been given a transfusion then the harm in his eyes may have been less than being excluded from his family.

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[237] Anderson, G.R. l983. 'Medicine Vs. Religion: The case of Jehovah's Witnesses'. *Health and Social Work. Vol No* p 32

[238] Anderson, *loc. cit.*

• [320 A 2d 918 (N.Y. l971) *See North Eastern Reporter* Vol 278 N.E. 2d [St. Paul Minn: West Publishing Co.] 41. in Anderson G.R. l983 Medicine Vs. Religion The case of Jehovah's Witnesses. *Health and Social Work.* pp 31-38

It could be said that women will suffer severe emotional distress or depression as a result of being made to feel inadequate for artificially feeding the baby. As referred to earlier women were frowned upon.

Ostracising women in this way would be one form of coercion which could lead to depression. What could be worse than feeling ostracised however, may be an unsettled crying baby suffering allergic reactions from exposure to artificial formulae. The unsettled crying of a distressed baby may also lead to depression. The subsequent sleepless nights, for many months may outweigh the short term gain of sleep in hospital when a midwife gave a bottle of formula to the baby.

A woman who is forced to breastfeed may also feel depressed. All three situations (a) being ostracised, (b) a crying baby suffering allergy and (c) being forced to breastfeed, could lead to rejection of the baby.

An analogy can be drawn here with the emotional harm felt by the Jehovah's Witness parents who were directed by law to surrender their child to the direction of the medical profession. The belief that if they receive blood they will risk eternal damnation may affect their attitude towards their son. It may be hard for some parents to rationalise the involuntary nature of this transfusion and may spiritually reject the child.

5. Persuasion And Its Limits

Some beliefs are demonstrably false. If the midwife or the woman believes that artificial formulae is **just as good as breast milk** then there may be a need for management strategies or an approach which will help to change their false belief. There may be justification on the basis of beneficence or non-maleficence to ensure that the non-autonomous (or ignorant) woman is exposed to current information.

The midwife who educates the woman about artificial formulae and breastfeeding has a moral obligation to have current knowledge, and be skilled in communicating this knowledge. The midwife is in a position, because of her close proximity with the birthing process, to exert an influence over the vulnerable woman's choice of infant nutrition. That is, the midwife may use persuasive catch phrases such as **breast is best** to persuade the woman to initiate breastfeeding following delivery.

On the other hand the midwife is in a position to coerce the woman not to breastfeed. She may use other persuasive phrases such as a **good night's sleep**, to influence the woman to leave her baby in the nursery to be fed with formulae. Also, some midwives avoid their obligations by withholding or omitting information about the harms of artificial formulae.

Choosing someone who has charisma and credibility, may help to influence a woman to change her mind about feeding her baby with infant formula, but as an experiment by J. McCroskey demonstrated, the credibility of the

source had less bearing on outcome than strong supportive evidence.[239] The midwife (with or without charisma) should be equipped with up to date research-based knowledge. According to Beauchamp and Childress `a person needs to be convinced to believe in something through the merit of reasons advanced by another person'. [240]

According to Ajzen and Fishbein it was only when there was minimal supportive evidence that communicator credibility had any influence. Ajzen and Fishbein also commented that receivers with low self esteem yielded more to forceful statements. But they gave an explanation that these latter two conditions did not influence a permanent change in attitude.

It would be easy to understand then why paternalistic instruction appears at least superficially to work in the hospital setting. The low breastfeeding rates at three months referred to earlier could be a result of paternalistic instruction forcefully given to women of low self esteem. These instructions may not have been supported by research-based evidence and therefore failed to influence a change in belief about the harms of artificial formulae.

As described earlier by Ajzen and Fishbein feelings of discomfort are more likely to produce a change in beliefs. The pressure from peer groups with whom they are in constant contact may be a greater influence than the occasional encounter with a professional.

[239] Ajzen & Fishbein *op cit* p 223
[240] Beauchamp and Childress *op cit* p 108

Persuasion is the weaker form of influence according to Beauchamp and Childress. There may be varying degrees of persuasion used. For example when taking the history of a pregnant woman who revealed (a) the death of a baby due to Sudden Infant Death Syndrome (which has links to formulae feeding) [241] [242] or (b) a family history of asthma,[243] the midwife could use evidence of an increased risk of harm to persuade a reluctant woman to breastfeed.

But as Beauchamp & Childress state;

> professionals are sometimes morally blameworthy if they do not attempt to persuade resistant patients to pursue treatments if they are medically essential[244]

Freedom to choose is limited when there is a lack of knowledge about both methods of infant nutrition. In order to explain the intricate nature of the breast feeding mechanism and the risks of artificial formulae the midwife needs to ensure that the woman has **substantial understanding.**

.51 Cultural forces and hormones.

If the woman has substantial understanding, but still persists in giving her baby

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[241] Wood, C.B.S. & Walker-Smith, J.A. 1981. *MacKeith's infant-feeding and feeding difficulties.* 6th Edn. Edinburgh: Churchill Livingstone. p 105 in Cunningham *op. cit.,* 1985 p 15

[242] Sudden Infant Death Foundation. Melbourne

[243] Miskelly, F.G., Burr, M.L., Vaughan-Williams, E., Fehily, A.M., Butland, B.K., Merrett, T.G. 1988 Infant feeding allergy *Arch Dis Child.* 63:388-93 in Cunningham, *op. cit.,* 1990. p 20

[244] Beauchamp, *op. cit.,* p 109

artificial formulae, because she considers that the risks to her own mental or physical health are greater than harms to the baby, should the midwife continue to seek to persuade her to breast feed her baby?

I argue that the harms of artificial formulae are so great that the midwife should attempt to persuade the woman to use other women's breastmilk for her infant's nutrition. If a woman felt obliged to use this method, to avoid harms to her baby, there may be a risk that her self esteem would be lowered. Her adequacy as a mother may be challenged by partners, close relatives and friends. The cost and inconvenience of this option may be prohibitive, and if it is, the woman may be challenged to change her mind for the sake of the baby. The discomfort felt may be worse for the woman than the option of breastfeeding her baby.

The extent to which the woman values health, or the degree to which both physical and mental health are prized, needs to be considered before arguing on utilitarian grounds. The potential for the baby to suffer disease leading to early death (for example from gastro-enteritis), is probably a greater harm than the emotional harms to the mother.

Also those women who successfully use breastfeeding as a method of contraception may be better off both in financial and health status (as a result of not having to purchase or imbibe synthetic chemicals). There is also a reduced risk of cancer for

breastfeeding women and the potential to improve other diseases such as diabetes referred to in Chapter One.

In an example given in Chapter One, the breastfeeding woman woke during the night and asked to breastfeed her baby; the midwife told the woman to go back to sleep, and the midwife continued to artificially feed the baby. The midwife overrode the woman's autonomous wish to breastfeed.

The woman seemed powerless to prevent the midwife from overriding the breastfeeding woman's autonomous wish to exclusively breastfeed thus causing harm to the baby.

Michel Odent a French obstetrician (well known guru to most members of the International Confederation of Midwives) is in favour of non-intervention in the birthing process. Odent profers an explanation for the subservience of breastfeeding women.

He suggests that the hormones oxytocin and prolactin which are present in the breast milk and in her system have a calming effect on women making them sufficiently docile to attend their babies needs. [245] The influence of these hormones may explain the inability to self-advocate of those distressed women described in the Ministerial report.

Odent speculated on what might be the cultural characteristics of a society where

[245] Odent, M. 1993. 'A critique of The Anthropology of Breast-feeding'. *Midwives Chronicle and Nursing Notes.* November, p 456.

prolactin (the hormone responsible for milk production) is in short supply. He states:

> If the characteristics of a culture are shaped by the population's hormonal imbalance, my guess was that such a society would be highly aggressive and destructive, with little respect for the environment. This has been exactly the case in Icelandic society.[246]

Hastrup, a leading Danish anthropologist made a detailed study of Icelandic women who did not breastfeed their babies from sometime in the 16th century to well into the 19th century. The basic diet of these infants was cow's milk or butterfat mixed with fish. Hastrup proposed that one of the reasons for not breastfeeding was tied in with values about wealth related to milk producing cows. The measure of wealth was farm produce; cream and butter were tokens of success.[247]

The reasons why a whole race would abandon breastfeeding are obscure and seem irrational. Eventually Icelandic women returned to breastfeeding through the educative influence of a physician. It would seem that given rational reasons these women were persuaded to return to breastfeeding. So that education should be one of the rational reasoned ways to influence change.

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[246] Odent, M. 1992 *The Nature of Birth & Breast-feeding.* New York Greenwood Publishing Group

[247] Hastrup, K. 1992 'A Question of Reason: Breast-Feeding Patterns in Seventeenth-and Eighteenth-Century Iceland'. in Maher, V.(Ed.) 1992. *The Anthropology of Breast-feeding* Oxford: Berg. pp 91 - 108

If the forces in a culture about profit are enough to influence women to abandon breastfeeding, then it could be postulated that culturally induced embarrassment in Australia (where women can be evicted from public places for indecent exposure when breastfeeding) is a major cause of women abandoning breastfeeding.

.52 Embarrassment and Convenience

Embarrassment may be the outcome of a cultural practice which leads many women to prefer artificial feeding rather than any other easily explained cause such as having to work. Large numbers of women in the workforce following childbearing have been increasing only in the last 20 years. So that return to the workforce does not easily explain the high use of formulae immediately following the second World War.

Embarrassment as a causal factor in women abandoning breastfeeding at three months needs further investigation but has been cited as a reason in two studies.[248] [249] In nearly all societies parts of a woman's body are hidden by clothing or restricted posture. In some it is concealed in its entirety and even threatened with death. In Nigeria Posters denounce short skirts: 'Long Leg is evil... kill corruption'. [250]

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[248] Allison, L. 1992. 'Breastfeeding trends in New Zealand'. *Nursing Newsline.* 9:2-3 cited in Jackson, H. J. 1994. 'Promoting, Protecting and Supporting Breastfeeding in a bottle feeding culture; Do Women really have a choice'? in *Proceedings Midwifery and the Community 3rd National Research Forum* Abbotsford: LaTrobe University.

[249] Tupling, H. 1988. *Breastfeeding: a new mother's handbook.* Sydney: Watermark Press p 31

[250] Kitzinger, 1987 *op. cit.*, p 188

Evidence that Victorian hotel owners and a West Australian bus driver and a New South Wales magistrate are offended by breastfeeding may be extrapolated to and reflective of public attitudes. [251] [252]. Although as Kitzinger suggests (Chapter One page 19) it is about invasion of male territory; **a threat that woman is coming out of her hidden place**.

A deeply ingrained cultural belief in the general population may be transposed to those midwives who do not appear to actively promote breastfeeding. Midwives are recruited from the community and community attitudes are probably reflected in the attitudes of a majority of midwives.

In a previously cited work by Ellis, a study done in Canada, by M. Beaudry and L. Aucoine-Larade on 780 women, revealed that women who chose artificial feeding perceived convenience or compatability with maternal lifestyle as the primary reason for choice of infant nutrition.[253] It appears then, that it is the wishes or preferences of the parents which are paramount.

If the mother makes a decision to artificially feed, in order to go to work it may be considered interference with family

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[251] Jinman,R and Scott, J. 1993. 'Breast-feeders take protest to court'. *The Australian.* May 20 1994 p 9

[252] Wells, M. 1994 'Cover those Breasts' in Letters to the Editor *The Australian.* May 25 p 13

[253] Beaudry, M & Aucoine-Larade,L. 1989. 'Who Breastfeeds in New Brunswick, When and Why?' *Canadian Journal of Public Health*. 80 (May/June), 166-172

life to attempt to overturn this decision. Some women may need to return to work, and as our society rarely caters for breastfeeding women in the work place, the woman who has to give up work to breastfeed may perceive this as an interruption to family life. So that interferences with parental decision making, which may cause harm to families, should be avoided.

Unpaid maternity leave is supported by predominantly male Trade Unions. Some male Trade Unions members may have preferred women to stay at home to breastfeed if, as Kitzinger suggests, the invasion of the work place reflects that woman is coming out of her hidden place. Providing breastfeeding facilities at work may be a beginning to the, albeit sub-conscious, giving up of power.

Kitzinger describes an incident in Ireland when a union member breastfed her baby at a Chapter meeting. At a subsequent meeting male colleagues many of them fathers of large families criticised her. Ribald comments about the size of her '*you know whats'*, Kitzinger comments, reflected the tendency of these men to move the *mother* category in to the category of *tart.*[254]

In a statement in June, l993, Hiroshi Nakajima, Director General of WHO said 'working outside the home and breastfeeding are compatible when a mother has the support of her family and her employer'. He also suggests that employers should promote

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[254] Kitzinger, *op. cit.*, p 189

better facilities for breastfeeding mothers in the workplace and that there needs to be a change in attitude by colleagues in the work place.[255]

There would be no need to interfere with family life if these structures, such as time out to breastfeed and creches for the children of breastfeeding women, were available. The harms would need to bad enough not only to the baby, but to a wider society if society were to agree to having these support systems.

Mill includes in his discussion about objections to government interference the idea of;

> taking them out of the narrow circle of personal and family selfishness, and accustoming them to the comprehension of joint interests...the management of joint concerns - habituating them to act from public or semi-public notices and their conduct by aims which unite...[256]'

Involving the community or taking them out of the narrow circle of personal and family selfishness and accustoming them to joint interests is outlined in the following pages in a discussion about the Baby Friendly Hospital Initiative. [BFHI].

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[255] Uniting Church of Australia 1993. 'Mother-Friendly Workplaces' *Baby Milk Action: Update.* St James, NSW: Social Responsibility and Justice Committee for the Assembly 11:7 p 10

[256] Mill, *op. cit.,* p.98,99

The BFHI operates by first of all challenging the way in which current practice occurs. In the BFHI brochure an outline of longer-term strategies for achieving a baby friendly world is described.

The Ten Steps to Successful Breastfeeding are the criteria by which hospitals are judged. Ensuring the maternity centres practise all of these is the role of an accreditation team invited in by interested hospitals.

When some out of date midwives first hear these instructions there may be a great deal of anger and confusion. Some of these criteria challenge deeply held beliefs of some midwives particularly in relation to complementary feedings, nursery care and scheduled feeding.

The involvement of women in completing a questionnaire which asks them to answer the question 'How does your Neighbourhood Hospital/Health Facility Measure Up?' may help to preserve a degree of autonomy for the woman. The questionnaire involves the woman in answering l7 prescribed questions related to successful breastfeeding. These completed forms are returned directly to the hospital administration, by the woman. A double-barrelled effect is that the hospital and the staff's roles are reversed and are now accountable to the women in their care for breastfeeding management. Previous quality assurance evaluations primarily related to the bland questions about noise, warmth of the room and the quality of meals. The employer and the midwives may receive negative feedback from these women if they do not adapt to the ten steps.

Mitcham and District Hospital was the first Victorian private hospital to receive Baby Friendly status in Victoria The Royal Womens Hospital, a major Melbourne teaching hospital failed on the first attempt in l993. The discomfort created because its prestige was dented caused a change in its behaviour. After a year of hard work in November l994 its prestige in relation to breastfeeding had been restored. The Royal Womens Hospital, a major Melbourne Teaching Hospital is now the first teaching hospital in Australia to be granted this status.

Both of these hospitals had employed a lactation consultant midwife (IBLC) for a number of years. The Board of Mitcham and District Hospital replied positively to an invitation by me on behalf of the Midwives Action Group to apply for accreditation with UNICEF as a BFHI in l991. This hospital had already established a reputation at the forefront of breastfeeding so that there was very little need to change their practice. The current number of applications for accreditation is increasing according to the midwife convenor of the Victorian Branch of UNICEF Lisa Donahue.

Conclusion

Throughout this Chapter an attempt has been made to address the midwives' obligations to the mother and baby - a double entity. The midwife and her obligations to act in the interests of both mother and baby involved arguing a case on utilitarian grounds to provide what on balance would be in their best interests. In order for the midwife to be able

to carry out her professional role it is imperative that her knowledge is current.

Because it could be demonstrated that breastmilk is the most beneficial nutrition for the baby and has health benefits for the mother the midwife is obliged for professional and moral reasons to persuade the woman to breastfeed her baby.

The midwife is also obliged to support those women who choose to breastfeed and provide her with up to date information. Because the up to date midwife is aware of the harms to breastfeeding of giving any supplementary or complementary feeding, the midwife is obliged to prevent and refrain from giving these to the baby of any woman who wishes to exclusively breastfeed. This midwife also is obliged to promote change in her out of date colleagues.

The case to support this contention was easy to present using the swimmer example given by Kuhse and Singer.

Changing out of date midwives involves using many strategies and some of those have been included in this chapter. Change agents included Azjen and Fishbein's Theory of Reasoned Action or Lewin's unfreezing, freezing model. The use of a Lactation plan introduces the idea of women being involved in determining and controlling, what happens to them and may assist in circumventing the paternalistic mistaken views of some midwives..

The more difficult case was arguing that a woman who chose to artificially feed her baby

should be dissuaded from doing so and persuaded to breastfeed.

The result of acting to respect this woman's autonomy is that the midwife needs to support that woman's decision to feed her newborn baby with artificial formulae. But I argued that in order to respect that woman's autonomy the midwife must ensure that the woman has substantial understanding of the harms of artificial formulae. Unless the woman receives this information and has a substantial understanding of this information then the woman's decision is based on limited knowledge.

In order to avoid foreseeable harms to the baby I have argued that the midwife is obliged to inform the woman of these harms. Some would argue that this would make the woman feel guilty, but I believe that to withhold this information on the basis of what after all is an assumption by the midwife is not justifiable. Withholding information because someone may feel guilty is making a decision for someone else and may reflect a personality trait on the midwives' part that could affect objectivity.[257] In order to avoid paternalistic assumptions the midwife should ask the woman how she feels.

These guilt feelings while they may lead to depression can be resolved through counselling, while the demonstrable harms of giving artificial formulae are not so easily reversed. Lewin's model of change or Azjen and Fishbein's theory of reasoned action supports my view that

[257] Walker, B. 1994. 'Double Entity/Double Jeopardy' in the *Proceedings Midwifery and the Community 3rd National Research Forum* Abbotsford Campus: LaTrobe University .October, 1994 p 187

before a change in beliefs can be achieved a sense of discomfort should be felt. If change can be achieved based on negative appeal the harms of artificial formulae should be clearly described.

An argument on Utilitarian grounds was given that on balance the harms to the baby from artificial formulae are greater than any guilt driven emotional harms to the woman. If this sense of discomfort can be perceived to have worse negative consequences than the discomfort of breastfeeding then a change in behaviour may be achieved by perceptions about preferred consequences.

Regardless of any explanation about the harms to the baby of artificial formulae, some women for reasons known only to themselves still prefer to artificially feed. I have endeavoured to profer various explanations for this preference which included notions of deeply held beliefs influenced by religion cultural beliefs, men, power, sexuality and industrial formulae companies.

The limitations of parents to make decisions was also explored and it was demonstrated by the use of the example of Jehovah's witnesses that the wishes of parents could be overridden by a higher authority (the law) if it meant harm (brain damage or death) to the child. A case of justified paternalism. Although some women have been incarcerated to protect the rights of the fetus from injury due to cocaine, this action has been labelled unjustified strong paternalism. The incarceration of a breastfeeding woman to protect a baby from the harms of artificial formulae (which are not

immediately life threatening) is not only impractical but also unjustified strong paternalism.

In order to justify persuading the woman to breastfeed an argument was put, about the baby's right to be exclusively breastfed based on the principles of beneficence and non-maleficence. That is the benefits of breastmilk and avoiding the harms of giving artificial formulae to the baby. To satisfy these principles means overriding the autonomy of the woman if she persists in wishing to breastfeed.

If the woman believed that the harms of, for example not being able to work, precluded her from breastfeeding then in the interest of avoiding harms to the baby alternatives such as human milk banking and wet nursing were suggested. Although both of these options are currently becoming more readily available they may not yet be practical. The woman however, has a choice which does not involve tying her down. Longer term solutions to options in the workplace require intense lobbying and a commitment from the community.

Even if the woman's decision making abilities were improved by giving her substantial understanding about the harms of artificial feeding, and she still persisted in her wish to artificially feed her baby then there is very little more can be done. Tying this woman down would be impractical and unjustified as the baby is not at risk of death. The situation where the patient refused an injection was different, restraining this person down to give an injection is justified on the basis of his

reduced ability to reason and the consequences of death.

The idea of a Lactation Care Plan as outlined in this chapter assists the midwife in assessing the woman's health status and her beliefs. Such a plan not only allows the woman choices but should enhance the woman's autonomy by giving her the opportunity to record her preferences and explain her beliefs.

According to Ajzen and Fishbein, in order to influence a person's behaviour it is necessary to identify and change if necessary, these primary beliefs. The primary belief may be that artificial formulae is as good as breastmilk.

The idea of signing a consent form which outlines the harms of artificial formulae prior to giving consent for the baby to receive formulae not only protects the health worker from future liability but may result in producing a sense of discomfort in the woman.

So by creating discomfort or unfreezing the behaviour a previously reluctant woman may be persuaded to breastfeed. Because the health of future babies and women can be improved by exclusive breastfeeding I believe that it is important to try to improve the understanding of a larger population through democratic means.

As recommended by the NH & MRC in Chapter one these democratic means included formal and informal education in schools and the community. By encouraging more women to breastfeed in the workplace, in public and even

in the media, better role models are provided. Desensitisation to embarrassment may result.

I am confident also that the Baby Friendly Hospital Initiative will provide some of that means for midwives and hospitals to change their out of date practices.

Other means of persuading women to breastfeed, as the WHO/UNICEF joint statement suggests, should be through an approach aimed at the community. I believe Mill made this same suggestion when he urged 'society to take them out of the narrow circle of personal and family selfishness'. The health and the baby and the woman and society are the *joint interests* when he states 'accustom them to the comprehension of joint interests' and the BFHI is encapsulated in the statement 'habituating them to act from public or semi-public notices and their conduct by aims which unite'.

The next step in the change theory approach is that of freezing the behaviour. This includes praising and affirming positive behaviours once they are achieved. The reward of a contented baby free from persistent illness is one such reward. The awarding of the Baby Friendly Hospital Initiative [BFHI] approval to the two previously mentioned hospitals is likely to prevent a return to habits which compromised the autonomy of women as described in the Ministerial Report of Birthing Services.

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