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ADVOCACY WITH CONTEXT:
THE ROLE OF PEDIATRICIANS
IN BREASTFEEDING SUCCESS

by

SANYA BANSAL

A thesis submitted in partial fulfillment of the requirements
for the Honors Undergraduate Thesis program in Sociology
in the College of Sciences
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ABSTRACT

Although the importance of breastfeeding is almost universally accepted, the rates of breastfeeding are increasing at a decreasing rate. The current literature provides much insight as to how medical professionals such as obstetricians and lactation specialists could improve the rates of breastfeeding. The pediatrician, in particular, could encourage breastfeeding at a prime opportunity: during postnatal visits. Unfortunately, there is limited research on what role the pediatrician plays in breastfeeding success. This study used in-depth, qualitative interviews from four pediatricians to gather data on the true role of the pediatrician in breastfeeding. These pediatricians were selected based on the diverse patient population they serve, considering factors such as race, socioeconomic status, and geographic density. It is believed that pediatricians have a strong positive impact on the culture around breastfeeding but may not be fulfilling their duties to promote breastfeeding to the fullest extent, as compared to the June 2022 recommendation set forth by the American Academy of Pediatrics. Through this study, we can see that pediatricians follow the AAP recommendations in some areas and some recommendations are simply unrealistic for their patients. We also understand how some disparities, specifically the socioeconomic disparity, manifests in mothers and how that affects pediatric practice. This information can be used to improve these AAP guidelines for pediatricians and help improve pediatric practice.

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INTRODUCTION

Breastfeeding is almost universally touted as being the healthiest feeding choice for the infant and the mother. According to the Center for Disease Control (CDC), breastfeeding can reduce an infant's risk of asthma, obesity, Type 1 diabetes, respiratory disease, ear infections, sudden infant death syndrome (SIDS), gastrointestinal infections, and necrotizing enterocolitis in preterm babies. For mothers, breastfeeding reduces their risk of high blood pressure, Type 2 diabetes, ovarian cancer, and breast cancer (Why It Matters 2022). For this reason, most health professionals and many health agencies work to promote breastfeeding over the alternative: formula-feeding. The American Academy of Pediatrics (AAP) recommends that mothers exclusively breastfeed for the first six months. After six months, breastfeeding should be continued with the implementation of outside food sources as well (American Academy of Pediatrics 2022).

One such health professional that works to promote breastfeeding is the pediatrician. About three to five days after birth, a new mother will take her newborn to visit the pediatrician. The purpose of this visit is to check that the newborn is progressing properly in its first few days of life, and to suggest anything the mother can do to make sure the child thrives. As one of seven critical roles of the pediatrician in terms of breastfeeding, the AAP recommends that the pediatrician provide support for the mother to breastfeed and provide any information that might lead to her successful breastfeeding (Eidleman et al., 2012).

However, despite a massive push for increased breastfeeding rates beginning the 1990's, the rates do not seem to be improving. According to a recent CDC study, "Among infants born in 2019, most (83.2%) started out receiving some breast milk... At 6 months, 55.8% of infants received any breast milk and 24.9% received breast milk exclusively," (Breastfeeding Report

Card 2022). There exists a large disparity between the AAP recommendation and the actual rates of breastfeeding, and this disparity only increases if we look at certain demographics of breastfeeding mothers, such as African-American/Black mothers and Hispanic mothers or low socioeconomic mothers and high socioeconomic mothers.

There are many reasons for this disparity to exist, and one such reason might be due to the role that pediatricians play in maintaining the culture around breastfeeding. It is possible that the pediatrician affects the success rate of breastfeeding among mothers.

The current literature contains minimal in-depth analysis on the role of the pediatrician in regards to breastfeeding support. Previous research has chosen to focus on other medical professionals, especially in-hospital medical professionals. For this reason, there is much knowledge about how positions like the obstetrician and lactation specialist are able to improve breastfeeding rates. This study hopes to part from the current state of the literature by investigating the role of the pediatrician specifically. There is also minimal research on the impact of medical professionals (especially pediatricians) on the culture of breastfeeding. This study aims to answer the questions: What role does the pediatrician play in breastfeeding support, especially in comparison to the AAP's June 2022 breastfeeding policy ?, and What role does the pediatrician play in maintaining a culture around breastfeeding?

Maternal Medical Support

There are three main points of focus when it comes to medical breastfeeding support: pre-birth, birth, and post-birth. A woman might see many different medical specialists in all three of these stages, including (but not limited to) an obstetrician, a labor nurse, a midwife, a lactation specialist, and a pediatrician. Because it is much harder to maintain a level of

interaction and support with health care providers once the mother and baby leave the hospital, the role of providers before and during the hospital stay is a vital aspect of providing information regarding breastfeeding. In fact, one study found that “if the woman’s clinician supported breastfeeding only, then a woman was 1.95 times more likely to initiate breastfeeding compared to those women whose clinician encouraged the use of formula only or both formula and breastfeeding,” (Kornides & Kitsantas, 2013).

Starting from the beginning, once a woman has found out that she is pregnant, her next steps include setting up an appointment with an obstetrician. The obstetrician is the health care provider that the soon-to-be mother is interacting with the most when she makes the decision to breastfeed or not. Usually, the obstetrician will also be the one the mother contacts if she has breast-related difficulties with breastfeeding, such as mastitis, engorgement, or cracked nipples (Nichols-Johnson, 2004). The obstetrician can have a huge impact on whether a woman even chooses to start breastfeeding in the first place. Yet, one study found that only 29% of prenatal visits included a conversation about breastfeeding, and the average length of this conversation was 39 seconds (Demirci et al., 2013). As seen previously, mothers who are properly educated about breastfeeding will have higher breastfeeding success rates. When obstetricians are failing to provide that knowledge, then, it can be argued that these health care professionals could be playing a role in low breastfeeding rates.

However, there are still two more checkpoints that might encourage a new mother breastfeed. The next people that could guide the mother are the physicians and medical specialists she sees in the hospital when giving birth. This can include a wide variety of people who are available to help, including midwives and nurses, the obstetrician and in-hospital pediatrician, and occasionally a lactation specialist.

A midwife is a person who provides specialized and individualized maternal and neonatal care. The job of a midwife might include assisting with a home birth, helping come up with an in-hospital birth plan, helping advocate for the mother during her birth, caring for the mother right during and after the birth, and so on. In a 2010 study regarding the role of midwives in breastfeeding support, Bäckström et al. concluded that, “If health care professionals responded to the woman’s unique needs, the woman felt that the breastfeeding support was good and was based on her as an individual, otherwise a feeling of uncertainty emerged,” (Bäckström et al., 2010). By providing one-on-one support, a midwife has the potential to encourage a new mother to initiate and continue breastfeeding by increasing her self-confidence.

Nurses, with larger caseloads, cannot provide such individualized care. However, the nurse is the medical professional that a mother will have the most interaction with if she does not have a doula. The nurse monitors dilation and fetal condition, and the nurse also provides pain medications and an epidural if needed. A 2003 study investigated how nurses could impact a mother’s perceived support from the healthcare system. This study found that nurses play a huge role in the successful initiation and continuation of breastfeeding and provide mothers with the confidence to breastfeed (Hong et al., 2003).

Sometimes, a few hours after a baby is born and it is time for the baby’s first feeding, a lactation specialist will visit the mother and baby and provide support on how to breastfeed. This might include teaching the mother how to angle her breast to get her child to latch, how to switch the baby to the other nipple, nipple care for the mother, and other information that might be useful for a breastfeeding mother. One study found that using lactation consultants improves the rate of initiation of breastfeeding (Patel & Patel, 2015). Another study found that an experimental group of mothers, in which the mothers were discharged early post-birth but then

provided lactation specialists at home, were exclusively breastfeeding at a higher rate than mothers who were discharged at a regular time but provided no lactation help (McKeever et al., 2002).

The obstetrician can help the soon-to-be-mother decide to breastfeed exclusively for the first six months of her child's life, and the midwife/lactation specialist in the hospital can teach her how to breastfeed. After this mother leaves the hospital, however, she no longer has the support to get to the six months of exclusive breastfeeding that the AAP recommends. This is where the pediatrician comes in. A new mother will see the pediatrician upwards of six times when she brings her baby in for "well-baby visits" during the first year of her baby's life (Make the Most of Your Baby's Visit to the Doctor Ages 0 to 11 Months), and even more if the baby is not making adequate weight gain. In fact, the AAP provides specific recommendations for pediatricians to help them support mothers in their breastfeeding journey. The AAP states that most breastfeeding issues arise four to seven days after birth and so pediatricians are able to fulfill their "critical role" at the health supervision visit recommended at three to five days of age of a newborn (Meek et al., 2022). New mothers also view their pediatrician as the primary source of information about breastfeeding, but one study showed that one-third of the mothers in the sample group did not discuss feeding in their visits (Cross-Barnet et al., 2012).

The pediatrician has arguably the most important role in breastfeeding success. While the obstetrician provides support prenatally and the lactation specialist provides in-hospital support, the largest gap between "needed support for the mother" and "provided support from the health care provider" exists primarily at the level of the pediatrician after the mother leaves the hospital and is no longer surrounded by professional support. The timing of the pediatric visits provides pediatricians the opportunity to give the most support, which is why there needs to be focused

research on how pediatricians are providing support to mothers. Unfortunately, there is minimal research available regarding this specific topic currently, but this study aims to fix that.

Disparities in Breastfeeding

Within breastfeeding, there exist many disparities between certain demographics regarding breastfeeding rates. The racial disparity is most often discussed, but a disparity exists between socioeconomic classes and even urban versus rural demographics.

Starting with the racial disparity, according to a 2015 study, 83% of Asian/Pacific Islander mothers ever breastfed, 81% of Hispanic mothers breastfed ever, 77% of white mothers breastfed ever, and 59% of African American/Black mothers ever breastfed (Jones et al., 2015). We see these rates go up in the recent years. In a 2021 study, it was found that 90.3% of Asian mothers, 87.4% of Hispanic mothers, 85.5% of white mothers, and 73.6% of African American/Black mothers initiate breastfeeding (Chiang et al., 2021). However, the rate of breastfeeding amongst African American and Black mothers is still considerably lower than the other demographics, and it gets worse when the rates of breastfeeding at six months and at 12 months is evaluated.

As for socioeconomic status, one study regarding mothers in California found that “Women with higher family incomes, those who had or whose partners had higher education levels, and women who had or whose partners had professional or executive occupations were more likely than their counterparts to breastfeed” (Heck et al., 2006). Another study conducted in 2021 surveyed 239 mothers, and found that there is “an overall lower prevalence of exclusive breastfeeding among low-income families,” (Moran-Lev et al., 2021). However, even at all socioeconomic statuses, Black babies are still breastfed less as compared to their white

counterparts (Racial and Socioeconomic Disparities in Breastfeeding—United States, 2004 2006). The rates of breastfeeding amongst low socioeconomic Hispanic/Latina women are also higher at any amount of breastfeeding than their non-Hispanic Black counterparts (Fryer et al., 2018).

In terms of geographic disparities, a 2009 study found that women living in rural areas had a disadvantage in breastfeeding initiation, but again, this data exists as an intersection between socioeconomic status and race in that rural Black/African American mothers are less likely to breastfeed than rural white mothers (Sparks, 2009). Another study from 2019 states that “rural and low-income mothers [are] less likely to initiate and maintain breastfeeding,” (Kapinos et al., 2019)

There are many reasons why these disparities exist. There are barriers to breastfeeding that are present for Black, lower-socioeconomic mothers that do not exist for white, upper-class mothers, such as a lack of cultural acceptance, lack of knowledge regarding breastfeeding practices, and lack of access to health care providers for breastfeeding support (Jones et al., 2015). We can also look to a historic point of view, in which “Black women [were] forced to breast feed the white infants first for their slave masters and continuing through the Jim Crow era,” (Hemingway et al., 2021). While many barriers to breastfeeding are systemic (for example, lower-paying jobs that lower-income women rely on provide less support for breastfeeding mothers than high-paying jobs), health care professionals can work to bridge the gap by providing knowledge and support that minority women do not often receive.

Pediatricians may play an especially important role in this. “Primary care is recognized as the most important form of healthcare for maintaining population health because it is relatively inexpensive, can be more easily delivered than specialty and inpatient care,” (Guagliardo, 2004).

In fact, the AAP recommendation for pediatricians in regards to breastfeeding (Meek et. al, 2022), as of June 2022, states,

The AAP is cognizant that for women to be successful in achieving the recommended breastfeeding goals, significant societal changes are required. Pediatricians can play an important role in leading and advocating for the societal changes that permit continued exclusive and direct breastfeeding, such as guaranteed paid maternity leave, flexible work schedules, including working from home, and on-site child care. Additionally, public health interventions such as WIC incentives and environmental policies may provide opportunities to overcome structural barriers to breastfeeding.

The field of pediatrics is considered primary care health, and so because of its relatively high accessibility for most demographics, pediatricians should be able to work to bridge that disparity in breastfeeding.

Current Breastfeeding Culture

Culture around breastfeeding is a large factor in why a mother may initiate breastfeeding and/or continue breastfeeding. This culture can be impacted by many factors, including family, friends, local values, and health care providers.

One study explored the attitudes of breast-feeding women who lived in communities in which breastfeeding was not common. The study found that breastfeeding mothers were “particularly susceptible to early weaning,” (Rossman, 2007). Another study found that in an area of Louisiana that has historically low breastfeeding rates, the health care providers had positive attitudes regarding breastfeeding but little knowledge on how to support breastfeeding practices. In fact, the health care providers felt like they held no influence on the mother’s

success rate regarding breastfeeding (Lucas et al., 2013). A 2007 study showed that a mother's perceived family and partner support and positive attitude regarding breastfeeding were likely to influence her to breastfeed (Persad & Mensinger, 2007).

A positive breastfeeding culture can also have a huge impact on the success of breastfeeding amongst mothers. In *Sharing Milk: Intimacy, Materiality and Bio-Communities of Practice*, Dr. Shannon Carter and Dr. Beatriz Reyes-Foster (2020) explore the positive culture around breastfeeding communities where mothers will share their breastmilk. By implementing practices of hosting weekly breastfeeding support meetings, online support groups and interaction, and regular events, this community was able to create a supportive network of women who breastfeed and helped each other to continue breastfeeding. Another study found that if the people supporting the mother (father, family members, friends, etc.) have a positive attitude about breastfeeding, then breastfeeding rates would increase (Clifford & McIntyre, 2008).

As previously demonstrated, pediatricians play an extremely important role in helping mothers to breastfeed and perhaps even bridge the disparity in breastfeeding between certain demographics. This can only happen, however, if the pediatrician works to promote a positive culture around breastfeeding. This study examines the personal opinions that pediatricians hold in regards to breastfeeding and how this might affect said pediatricians' practice of medicine in regards to breastfeeding. Through this study, the contribution of pediatricians in creating and maintaining disparities, and bridging those disparities will also be evaluated. These issues will be analyzed in comparison to the recommendations for pediatricians in regards to breastfeeding as set by the AAP. Based on previous evidence regarding the impact of pediatricians and current breastfeeding rates, it is believed that pediatricians have a strong positive impact on the culture

around breastfeeding but may not be fulfilling their duties to promote breastfeeding to the fullest extent.

METHODOLOGY

This study collected data through qualitative interviews from pediatricians located in different geographic areas (urban versus rural) of United States. Pediatricians were also selected based on the diverse population they serve. This study collected four interviews from pediatricians.

After selection of a pediatrician based on background research of the demographics of the area in which the pediatrician serves, the pediatrician was contacted through email and telephone (if available). Approximately 40 pediatric offices were reached out to in order to recruit participants for this study. Six pediatricians replied. Two of the recruited pediatricians decided not to continue with the study after reading the Interview Guide (Appendix A) because they believed they would not be able to answer to the full extent of the questions based on their scope of practice. Four of the pediatricians recruited decided to go ahead with the study. These pediatricians were randomly assigned a number 1-4 to protect their anonymity, and referred to using this number from here on forward.

These interviews were over a 30-minute period at the convenience of the pediatrician. The physician was asked a series of questions (see Appendix A: Interview Guide) to gather information about personal opinions on breastfeeding, breastfeeding successes and failures witnessed during their practice, population demographics, local breastfeeding culture, and the role the pediatrician may play in the culture. The pediatrician was also asked about specifics of their medical practice. An audio recording of each meeting was saved and used for transcription.

These interviews were then transcribed using an online transcribing software. The transcripts were manually edited to confirm that they were accurate to the audio recording. These transcripts used to qualitatively analyze the data gathered. Common themes were coded and

quotations were pulled from the transcripts for each theme that were then used to write the Results section.

RESULTS

The interviews conducted revealed a few common themes in the beliefs of pediatricians, despite a difference in patient population served. Pediatrician 1 primarily saw upper-class, suburban, educated, and white patients. Pediatrician 2 works as an acute pediatric hospitalist, so her patients were mainly sick babies and children “from all walks of life.” Pediatrician 3 explained that since she works in a metropolitan hospital, she sees a large variety patients, from inner-city, lower-socioeconomic patients to a middle-class population, to a population she needs to use language interpreters with often. Pediatrician 4 patient population is about “70% Medicaid,” with a higher African American population. This data is summarized in Figure 1, located in the Appendix section. This variety in patient population helps ensure that any common themes we see will likely be more representative of the general population of pediatricians than if all the pediatricians sampled served the same patient population.

The audio recordings from the interviews were transcribed. When reviewing these transcriptions, three themes emerged. First, the pediatricians interviewed all agreed that breastfeeding was the best with the condition that breastfeeding was possible for the mother. The pediatricians also seemed to agree that the main role of the pediatrician is to educate families, but this conversation must be conducted tactfully. The four interviewees further concur on some of the main barriers to breastfeeding: work for mothers, the support surrounding a mother, and the mother’s stress level. In terms of the AAP recommendation of exclusively breastfeeding until the baby is six months of age, although three pediatricians stated that this was an achievable goal for some of their patients, it seems that a very small percentage of patients are actually getting to six months of breastfeeding. In Pediatrician 1’s office, about 80-90% of mothers reach this goal.

Pediatrician 2 says maybe about 50% of the mother she sees are breastfeeding. Pediatrician 3 and 4 describe about 70% of their mothers breastfeeding.

Conditionally Pro-Breastfeeding

The pediatricians interviewed seemed to be in agreement that breastfeeding is the best option for most mothers. Pediatrician 1 describes, “My personal opinions very much line up with, you know, all the AAP recommendations and things like that. But it’s really the best possible thing you could give for your baby.” Pediatrician 2 concurs, stating, “I think breastfeeding is, breast milk is liquid gold. And I think every baby should have the opportunity to get that if possible.” Pediatricians 3 and 4 echo this sentiment, asserting, “I think breastfeeding is amazing. I think it’s something that everyone who can do it, should do it. And there’s a lot of benefits for both babies and moms,” and, “I think [breastfeeding is] wonderful. I mean definitely, it’s the best way to go.”

Despite their positive personal opinions towards breastfeeding, some of the pediatricians recount that they do not try to advocate for it at times. Pediatrician 4 mentions,

I see a lot of single moms, a lot of, you know, families where they have like five kids and stuff, like sometimes it’s not feasible, right. So for those parents, yeah, so I don’t push it as much... I’m definitely pro-breastfeeding. But it just depends on the patient where I really push it and where I don’t.

Pediatrician 2, who works in a hospital setting, raises a similar concern. She affirms, “Typically, in the acute care setting, it’s not always appropriate to advise in one way or the other...”

Pediatrician 1 also contests her previous pro-breastfeeding statement by expressing,

But also, having breastfed two kids of my own, it's hard, especially with your first baby, you don't know what to expect, you know, you don't know how much volume they're getting with each feed. As a mom, you know, you may have had a difficult delivery or you might be recuperating from a C-section. And now you're asking your body to be this factory of milk production. And that takes a lot of calories, it takes rest, it takes, you know, your stress level, you have to be calm, drinking a lot, eating. So it, it does have its challenges.

From these answers, it is easy to see that though pediatricians have personal opinions on breastfeeding which indicate that these pediatricians are knowledgeable on the benefits of breastfeeding for both mother and baby, these pediatricians understand that there are certain situations in which it is not appropriate for them to advocate for breastfeeding. These exceptions might be caused by a mother's family situation or her medical state. Another reason could simply be the reason why a mother is meeting with a pediatrician. Like Pediatrician 2 expresses, if a child is in the hospital for an acute issue, then it might not make much sense to start a conversation about if the mother is breastfeeding.

Education and a Challenging Conversation

However, while the AAP recommendation might not have realistic applications in all pediatric practices, the pediatricians unanimously agreed that their role in breastfeeding success is to educate. Pediatrician 3 raises the point that,

I think by having, pediatricians are the ones who are most, I think, accessible and see moms and babies the most, especially in those first few weeks of life. So having those open conversations, open dialogue with families, I think we are able to set them up for

success, and not being afraid to offer up those resources and ask those tough questions early on about what barriers may come up down the line, and knowing that moms have access to you before the problems happen, I think that makes a big difference.

Pediatrician 1, who had her own children who she breastfed, says, “I try to give them personal opinion, you know, personal opinion and personal experience to encourage them and let them know like, ‘Hey, I get it.’ You know, it is hard. It can be a challenge... I try to relate to them personally.” Pediatrician 2 agrees, stating,

I think a pediatrician's role is more to educate the mom and provide her with educational knowledge. Pediatricians, remember, see this patient for 30 minutes at max, that's the only time you have to examine the baby, talk to mom and dad about all the anticipatory guidance... I think, encouraging [breastfeeding] and letting the families know about the importance of it, and what resources there are available...

However, these pediatricians all mentioned something interesting: educating a mother involves a tricky conversation that requires tact and skill from the pediatrician. As mentioned in the previous section, it might not always be appropriate to start a conversation about breastfeeding. When this conversation *is* initiated by pediatricians, the pediatricians interviewed mentioned how they work to avoid pressuring a mother or making her feel like a failure.

When asked about how she advocates for breastfeeding during patient interactions, Pediatrician 1 replied, “You have to be careful, you have to have a non-judgmental way of asking if they're formula feeding... You have to be very careful that you're encouraging and not pushing for not making a mom feel like a failure, you know.” Replying to the same question, Pediatrician 3 asserts that, “I never want to put a family in a place where they feel judged if

they're not thinking about breastfeeding." She also goes on to discuss situations in which she has felt that her fellow providers might be creating pressure on their patients, stating,

I think that for a while, and unfortunately in some areas, we work in a couple of different hospital settings. So in some of our nursery settings, I certainly have felt that pressure, and I felt like parents have felt that pressure from certain providers or members of our staff, that they have to breastfeed, and if they're not successful, then they're failing their babies.

Pediatrician 4 agrees, stating, "I hate to put this pressure on these parents and then they can't [breastfeed], and then they get stressed, and then it just affects everything at home." In advising future pediatricians, Pediatrician 2 declares, "I think the big important thing as an aspiring pediatrician is we all get caught up in our little rabbit holes and ivory towers of being judgmental, 'You didn't breastfeed your child, you're not a good mom.' Being open and accepting in whatever situation..."

To ensure that they are creating a safe for their patients that is void of any pressure to breastfeed, two pediatricians have a similar script they follow. Pediatricians 1 and 3 both start the conversation by first looking at the baby's weight. When the weight is headed in a good direction, these pediatricians make sure to emphasize that her baby is healthy before asking the mother how she is feeding the baby. Pediatrician 1 says, "I want to try to reassure them right off the bat that to me, the baby looks super great. So now we can have this conversation."

Pediatrician 3 says that during an exam, "It's a good opportunity, I'll bring up the growth curve, 'Their weight looks great, this is awesome. Whatever you're doing is working.' Really encourage what they're doing."

The pressure that parents might feel from providers to breastfeed is so common that these two pediatricians, despite practicing in completely different states with completely different patient populations, have almost the same script when discussing breastfeeding with their patients.

Barriers to Breastfeeding

The pediatricians interviewed mentioned a few common barriers that their patients encountered most often when trying to breastfeed. The three most common barriers mentioned were work, support, and stress levels for moms.

Three of the four pediatricians interviewed mentioned how a mother's work acts as a barrier to breastfeeding. Pediatrician 1 specifies,

I think it's harder for a mom that say, maybe doesn't have such a high level of education, works a job that isn't as conducive to 'Oh sure, take a break and go breastfeed,' you know, 'Here's a room for you to take your pump and relax.' And you know, not everybody has those kind of jobs.

Pediatrician 4 agrees, stating, "It depends on which workplace you have. I mean, a lot of my patients maybe worked in restaurants or stuff like that. Sometimes it's harder to find a place to go ahead and pump and breastfeed." Pediatrician 3 helps her patients advocate for breastfeeding by letting them know what they are allowed to have. She states, "And if they're going back to work, [reminding them] what they're allowed to ask for. They're allowed to have a place that they're supposed to be able to go breastfeed. They're allowed to take those breaks to breastfeed."

Interestingly, Pediatrician 1 connects how a workplace might treat breastfeeding to the socioeconomic status of the mother working the job. She talked about how her private practice

recently got bought out by a bigger group that is spread out throughout the city she works in. This has diversified her patient population in the past few months, and the new patient population is lower in socioeconomic class than her regular patient population. She has seen how it has been harder for this lower socioeconomic population to breastfeed because their jobs are less lenient.

Another barrier that is mentioned often is how much support the mother receives. Pediatrician 3 makes sure to include this as a question in her evaluation, asking

How much support are they getting?... There's a lot of support often for families up front so I usually like to actually ask in those next couple of visits like, what support are you having? Are their in-laws around or their spouses waking up in the middle of the night for feeds with them?

Pediatrician 1 says, "When you don't have additional hands around and helping, it's hard, I think it would be hard for a mom to sit there and successfully breastfeed an infant exclusively for six months." Pediatrician 2 describes something similar, mentioning that,

Breastfeeding is not just the mom's responsibility. It's the responsibility of everybody that supports that mom. Because if that mom has no support, and she's a single mom, who's waking up every two hours, doesn't have time to go get her meals or even that glass of water, when she's sitting down to nurse that baby, she's not going to make the breast milk and then it's going to be a frustrating process.

Without support, these pediatricians understand that a mother is much less likely to breastfeed.

Stress level of the mother is also brought up in numerous interviews. Pediatrician 4 articulates, "Moms who come in and who are extremely stressed out about [breastfeeding] because 'Oh my gosh, I just can't produce enough milk,' and then they can't sleep, they can't,

you know, and it just affects the relationship between the mother and the baby.” Pediatrician 1 affirms,

I think maternal stress level is a big [barrier to breastfeeding]. I think when moms are stressed out, and that can be physically because maybe they had a C-section and they’re hurting and they don’t feel, you know, they can’t, it’s hard to produce milk when you’re hurting, you know, you have pain from an incision or whatever. So I think maternal stress and health level, it can be a big factor.

Obviously, if a mother is very stressed, her milk production might decrease, which would only further act as a stressor. A mother must keep herself healthy to breastfeed, which can get hard if she is working or does not receive any external support.

DISCUSSION

The results, as ascertained from four qualitative interviews of pediatricians, show that there is overlap in some pediatricians' beliefs and medical practice. All four pediatricians interviewed agreed that breastfeeding is the best choice for both mother and baby, but choose to advocate for it only when appropriate. The pediatricians also agree that their role in breastfeeding success is to educate their patients and families, and some barriers to breastfeeding that they have observed during their practice include working conditions, a mother's support system, and her stress level.

These results both affirm and contradict the AAP recommendation for a pediatrician's role in breastfeeding. Some of the practices that the AAP recommends are feasible and actually carried out by pediatricians in their practice. Other recommendations, however, are much more difficult according to the pediatricians interviewed and are unrealistic standards.

The AAP recommendation, as of June 2022, states, "Pediatricians can play an important role in leading and advocating for the societal changes that permit continued exclusive and direct breastfeeding, such as guaranteed paid maternity leave, flexible work schedules, including working from home, and on-site child care," (Meek et. al, 2022). We see that Pediatrician 3 advocates for this "societal change" in her practice. She states,

I think the other piece that we can do a better job of, that I think we're starting to really incorporate, those pieces to families that are going back to work... if they're going back to work, [reminding them] what they're allowed to ask for. They're allowed to have a place that they're supposed to be able to go to breastfeed. They're allowed to take those breaks to breastfeed.

In this way, Pediatrician 3 is advocating for social change that allows for breastfeeding in her medical practice by encouraging her patients who are going back to work to advocate for equal access for themselves.

Pediatrician 3 is also working to bridge the disparity that might exist between lower-class mothers and higher-class mothers. Since mothers from a lower-socioeconomic background might not have access to jobs that allow them to take breaks to breastfeed or provide places to breastfeed (Pediatrician 4 mentions “restaurant jobs” when discussing this issue), these mothers might think this is the norm for how they should be treated as working mothers. By reminding them that there are laws that protect working mothers that allow them to have a time and place to breastfeed, this pediatrician can help her patients advocate for themselves, enact that societal change, and bridge the disparity between lower-class mothers and higher-class mothers in terms of breastfeeding success.

The AAP recommendation also asserts that, “Additionally, public health interventions such as WIC incentives and environmental policies may provide opportunities to overcome structural barriers to breastfeeding.” Pediatrician 4, who works with a majority Medicaid patient population, stated,

There’s lactation in here, but a lot of people don’t have even the conveyance to go. So I do, obviously, I do tell them, you know, if you can’t, don’t want to ride the bus or you know, and all that. Actually a lot of Medicaid insurances will provide taxis and services, but they have to book it a week ahead. So it’s just, I try to provide those resources.

Pediatrician 4 helps to connect her patients and educate them about the resources available to her lower-socioeconomic patients, just as AAP recommends for her to do. In working to educate her

patients about these resources, Pediatrician 4's work can contribute to bridging the socioeconomic gap in breastfeeding success outcomes.

A contention point between the AAP's recommendation and what actual pediatric practice looks like rises from the results gathered from the "Conditionally Pro-Breastfeeding" subsection. In their updated 2022 policy for breastfeeding, AAP generally mentions that "Pediatricians are ideally positioned to serve as breastfeeding educators and not solely delegate this role to staff or nonmedical or lay volunteers. Pediatricians' direct communication with families that breastfeeding is a medical and health priority can increase initiation, duration, and exclusivity," (Meek et. al, 2022). However, this policy provides no information for how pediatricians who practice acute pediatrics (like Pediatrician 2) should advocate for breastfeeding. This policy does not seek to create exceptions for which it might be inappropriate for a pediatrician to educate about breastfeeding. In this way, this policy feels out-of-touch and unrealistic for most practicing pediatricians, as we see reflected in our pediatrician's responses.

The results from the "Education" subsection indicate two things. Firstly, these answers show how there is a culture around breastfeeding in which health care providers might be making mothers uncomfortable and pressured into breastfeeding. The origins of this culture are hard to pinpoint to exactly one cause. However, we can infer that perhaps health organizations like the AAP and CDC that have increased the push towards breastfeeding in the recent decades might have created guidelines and a resulting culture for providers to push for breastfeeding without taking into consideration the effect on their patients. If providers felt pressured by the recommendations set by AAP and CDC that their patients should be reaching this minimum amount of breastfeeding, then these providers might offset this pressure onto their patients.

This, then, has made it harder for current providers to start a conversation about breastfeeding without scaring off their patients who have had negative experiences discussing breastfeeding with their providers in the past. As we see in these results, the pediatricians interviewed are cautious about that negative impression they might leave if the conversation about breastfeeding makes their patient feel judged. Pediatrician 3 even voices that she takes extra care to avoid putting pressure on a family “because I don’t think that that’s healthy for your provider-patient relationship.”

Although it was expected that pediatricians have a strong positive influence on the culture around breastfeeding, our results show that the opposite might be true. Whatever the reason for pediatricians to create this pressure on their patients and their parents that they should be breastfeeding, this mindset from the pediatrician has worked to actually push parents away from breastfeeding and make them wary about having this conversation with their providers, as is alluded to by the pediatricians interviewed. The pediatricians that were interviewed for this study also mentioned in their interviews techniques to avoid contributing to the negative culture, and in doing so, are working to dismantle said negative culture. As we have seen, pediatricians obviously have a strong impact on the culture of breastfeeding, in both a negative way and a positive way.

I also expected that pediatricians may not be fulfilling their duties to promote breastfeeding fully. Although we see that none of the four pediatricians interviewed have a patient population where 100% of their mothers initiate and continue to breastfeed, this might not be because of the work of the pediatricians themselves. As mentioned, the pediatricians interviewed were pro-breastfeeding, but only conditionally. They list barriers to breastfeeding

that might be holding mothers back from breastfeeding, and also how appropriateness of the conversation about breastfeeding varies at times.

These pediatricians also might not have the means to educate their patients. According to the CDC, “Research shows that physicians generally lack adequate breastfeeding education and training. Better training in this area can help them gain the appropriate knowledge, skills, and confidence to support families and advocate for breastfeeding-friendly practices where they work,” (Physician Education and Training to Support Breastfeeding, 2022). The AAP is currently conducting a project called the “Physician Engagement and Training Focused on Breastfeeding,” which would work to increase integration of the breastfeeding education into medical school curriculum (Physician Education and Training to Support Breastfeeding, 2021). Further research would need to be done to understand the impacts of this initiative and the resulting state of medical education in regards to breastfeeding.

A limitation of this study is the small sample size. With a greater sample size, we would be able to generalize these results further. The sample is also not evenly spread across the population of pediatricians. Two of the pediatricians interviewed are from Florida, which would skew our results. Furthermore, out of the four pediatricians that were interviewed, only one was not a general practitioner. This prevents this data being applied to all pediatricians, which includes more than just general practitioners. Because of the lack of representation within our sample, we cannot appropriately generalize these results.

With this study, we have added to the current state of literature. Previously, there lacked substantive research on the role that pediatricians play in breastfeeding. The AAP releases guidelines for pediatricians to promote breastfeeding, but we did not know if these protocols were being followed. Through this study, we can see that pediatricians follow the AAP

recommendations in some areas and some recommendations are simply unrealistic for their patients. We also understood how some disparities, specifically the socioeconomic disparity, manifests in mothers and how that affects pediatric practice. However, my study did not provide information in regards to how other disparities in breastfeeding affect pediatric practice. A future study could push the literature further by investigating the racial disparity and how pediatricians manipulate their practice to the advantage or disadvantage of that racial minority.

This information in this study can be used by other pediatricians to improve how they practice medicine to benefit lower-socioeconomic mothers. The AAP could also take advantage of the information in this study to expand their guidelines for pediatricians in regards to breastfeeding. As seen previously, these guidelines do not account for many scenarios in which it might be hard for a pediatrician to promote breastfeeding. These recommendations also lack guidance for general pediatricians whose scope of practice falls outside of general pediatrics. With this information, the AAP could set guidelines that cover these deficiencies, which would also give pediatricians better information on how to practice medicine to promote breastfeeding. The overall implication of this study could be to eventually decrease the disparity in breastfeeding and promote breastfeeding to a greater extent.

Appendix A: Interview Guide

Appendix A: Interview Guide

1. How long have you been a practicing pediatrician? How long have you been at your current practice?
2. What are your personal opinions on breastfeeding?
 - a. Are you for/against/neutral?
 - i. If for, how do you advocate for breastfeeding during your patient interactions?
3. What does a conversation about breastfeeding typically look like with a new mother?
 - a. Walk me through a script or a checklist of things you like to talk about during the patient interaction
4. How many new mothers and newborns do you typically see per month?
5. How many of those mothers breastfeed?
 - a. How many initiated breastfeeding versus how many continued to breastfeed?
6. Are you familiar with the American Association of Pediatrics' recommendation for mothers to exclusively breastfeed up to six months?
 - a. Do you feel like this is a realistic goal for most of your patients?
 - i. If no, then where do you see gaps and how do you think they could be fixed?
 - ii. If yes, then what are some things you and your practice do to help your patients reach this goal?
7. In the area surrounding your practice, how would you describe the general population in terms of race and socioeconomic status?

- a. White, Black, Hispanic, Asian, minorities, urban, rural, lower socioeconomic background, etc.
8. How would you describe the general population of patients you see at your clinic, in specific, new mothers and babies?
9. How would you describe the breastfeeding culture in the surrounding area?
 - a. Does it seem like most mothers are breastfeeding, or does it seem like majority use alternative forms of feeding?
 - b. What about among your patients? Is the breastfeeding culture among your patients similar to the culture in the surrounding area, or is it different in some way?
10. What is your personal opinion on the state of the culture regarding breastfeeding?
11. What do you see as the most significant barriers to breastfeeding?
12. Do you think there are things pediatricians can do to increase breastfeeding success, or do you see this as the responsibility of other healthcare professionals or a different entity altogether?
13. My last question is what advice do you have for me as an aspiring pediatrician with regard to breastfeeding?

Those are all my questions today. Thank you so much for participating. Is there anything you would like to add?

Appendix B: Table 1

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Table 1: Interviewed Pediatrician Demographics

Pediatrician	State	Years Practicing	Pediatrician Race	Approx. # of Babies Seen per Month	Patient Population	% of Mothers Breastfeeding	% of Mothers Breastfeeding in Practicing State
1	FL	26.5	White	2-3	Upper-class, suburban, educated, White	80-90	87.2
2	FL	20	Asian	15	Sick babies and children from "all walks of life"	50	87.2
3	DE	3	Asian	30-60	Large variety, some inner-city, low socioeconomic to middle-class, needed to use language interpreters often	70	80.5
4	OH	17	Asian	16-20	70% Medicaid, with higher African-American population	60-70	76

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