Section 1

Historical and Work Perspectives

Just as the course of breastfeeding flows and ebbs in a woman's life, so breastfeeding has experienced flows and ebbs through many millennia. It takes a village to return to breastfeeding, and community-based programs that promote breastfeeding are working to increase the rate of breastfeeding around the world.

Until breastfeeding is again the unremarkable norm, increasing numbers of mothers who begin breastfeeding prompt a need for increasing numbers of specialists who can help those mothers continue breastfeeding. The visibility and acceptance of lactation consulting as an allied health profession offers opportunities for practice in hospitals, the community, and in private practice. Randomized clinical trials conducted around the globe during the past 20 years consistently demonstrate that lactation consultant services lengthen a mother's breastfeeding course and result in healthier mothers and babies.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Chapter 1

The Lactation Specialist: Roles and Responsibilities

Jan Riordan

A LACTATION CONSULTANT (LC) is a specialist trained to focus on the needs and concerns of the breastfeeding mother-baby pair and to prevent, recognize, and solve breastfeeding difficulties. LC services do not replace those of other healthcare workers; instead, the LC is an extender of maternal–child services. Lactation consultants work with the public in many settings: hospitals, clinics, private medical practices, community health departments, home health agencies, and private practices. Almost all lactation specialists are women; many have educational and clinical backgrounds in the health professions. The majority are registered nurses, although physicians, dietitians, speech therapists, and other health professionals practice as lactation specialists.

Lactation consulting is a rapidly growing new healthcare specialty. Prior to recognition of the LC as a paid specialist in 1985, individuals serving breastfeeding women did so as volunteers or as unrecognized practitioners. The lack of standardization of skills and minimal competencies led to formal development of the specialty practice. This occurred in part through a certification examination, and through the establishment of the International Lactation Consultant Association (ILCA), which publishes the *Journal of Human Lactation* and other documents relating to lactation consultant education and practice. In 1994, the Academy of Breastfeeding Medicine, an international physician organization, was formed. Their official journal, *Breastfeeding Medicine,* publishes peer-reviewed articles and helpful clinical protocols. La Leche League International and the Australian Breastfeeding Association also publish professional materials that teach and support the LC. This chapter traces the historical roots of lactation professionals and discusses work-related issues.

History

In a cultural setting in which nearly all mothers breastfed, help with breastfeeding was available through the shared knowledge of other family members, neighbors, and friends. As childbirth came to be managed by health professionals in hospital settings, however, knowledge of lactation, which a mother formerly shared with her daughters or a sister with her younger siblings, was set aside.

Thus, during the 1960s (at the nadir of breastfeeding) in the United States and shortly thereafter in other countries (such as Australia and Scandinavia), volunteer breastfeeding support

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

groups became a major source of assistance and information about how to breastfeed (Phillips, 1990). As the numbers of breastfeeding mothers increased, healthcare providers at first denounced these groups; later they came to appreciate them for the important role they played in helping mothers and in forcing the medical profession to consider lactation an integral part of prenatal and postpartum care.

As these volunteers relearned the art of breastfeeding, they also sought more knowledge of the science of lactation. La Leche League responded by providing research information to their group leaders, who serve as mother-to-mother helpers, and by publishing a quarterly newsletter, *Breastfeeding Abstracts,* which focuses exclusively on the scientific literature. Through La Leche League's professional liaison department, key individuals sought to cultivate and maintain communication links to health providers in local communities.

Out of this context, some experienced breastfeeding support group members began to look beyond what they could accomplish as volunteers. Many of these women sought to apply in a paid work setting what they had learned from many years of helping breastfeeding mothers. In 1982 La Leche League formed the Lactation Consultant Department. From this beginning grew the notion of the need for a new healthcare worker, and in 1985 an independent certification board, the International Board of Lactation Consultant Examiners, was formed. Shortly thereafter, the *Journal of Human Lactation (JHL)* began. Edited by Kathleen Auerbach from 1985 to 1996 when Jan Heinig became editor, *JHL* is peer-reviewed, professionally published, and cited on international indices (Bailey, 2005).

Do Lactation Consultants Make a Difference?

In this day of cost containment in health care, administrators want to know if lactation consultants are effective. Do interventions by lactation specialists and other healthcare providers make a difference in outcomes of breastfeeding? Table 1–1 presents randomized controlled trials, the highest level and most rigorous type of research study, of breastfeeding interventions worldwide. Most of the studies show that the interventions have a positive effect on breastfeeding. Note from the table that even if the results do not reach significance, any intervention (even a booklet given to the mother) results in higher rates of breastfeeding than no intervention. These results hold constant regardless of where the studies were done.

TABLE 1–1 Controlled Trials on the Effect of Lactation Specialists and Health Providers Intervention on Breastfeeding Outcomes

Author	Intervention Description	Outcome: Intervention vs. Control
Gill, Reifsnider, Lucke, 2007 United States	Convenience sample of women receiving prenatal care at health department Intervention: met with IBCLC prenatally twice; four phone calls postpartum Control: Standard education on benefits of BF	Intervention group had twice the odds of starting BF and twice the odds of continuing BF for 6 months.
Mattar et al., 2007 Singapore	Random sample of low-risk antenatal patients Intervention 1: educational	Exclusive/predominant BF 3 mo, OR 2.6, CI 1.2–5.4* 6 mo, OR 2.5, CI 1.0–6.3*

(Continues)

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–1 Controlled Trials on the Effect of Lactation Specialists and Health Providers Intervention on Breastfeeding Outcomes (Continued)

Author	Intervention Description	Outcome: Intervention vs. Control
	material and coaching Intervention 2: educational material Control: routine antenatal care Face-to-face encounter most effective	
de Oliveira et al., 2006 Brazil	One 30-minute counseling session on BF techniques No difference in exclusive BF	Exclusive BF at 7 days 70.9% vs. 82.5% Exclusive BF at 30 days 60.8% vs. 53.3%**
Labarere et al., 2005 France	Outpatient visit by 2 wks postpartum to physician who received 5-hour training program	Exclusive BF at 4 wks 83.9% vs. 71.9%* Any BF at 4 wks** 89.3% vs. 81.6%
Kools et al., 2005 The Netherlands	LC services to child care center randomly designated to program care vs. usual care No difference in duration at 3 mo.	Any BF at 3 mo 32% vs. 38%**
Aidam, Perez-Escamilla, Lartey, 2005 Ghana	Intervention 1: pre-peri, postnatal LC support Intervention 2: Peri-postnatal LC support Control: Standard care	Exclusive BF at 6 mo 90%* 74% 47%
Bonuck et al., 2005 United States	Visits: Prenatal, postnatal; hospital, home, telephone No difference in exclusive BF between groups	BF at 20 wks 53% vs. 39%**
Forster et al., 2004 Australia	Intervention 1: 1.5-hour class on practical skills Intervention 2: Two 1-hour classes on attitudes and experiences Control: Standard care	Initiation of BF 97% vs. 95% vs. 96%** Any BF at 6 mo 55% vs. 50% vs. 54%**
Albernaz et al., 2003§ Brazil	Lactation support visit in the hospital and seven visits at home	Twice as likely to be still BF at 4 mo as control group. No difference in breastmilk intake.
O'Connor et al., 2003 Ontario	Postpartum visit by public health nurses randomized to home visit or telephone call	No differences. Routine home visit not always necessary and more costly than telephone.
Pugh et al., 2002§ United States	Breastfeeding support visits by community health nurse peer counselor team. Support offered daily when in hospital, and at home during weeks 1, 2 and 4. Telephone support twice weekly through week 8.	Intervention group breastfed longer, had fewer sick visits, and took fewer meds. Intervention cost ($301) was partially offset by savings on formula and health care.

(Continues)

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–1 Controlled Trials on the Effect of Lactation Specialists and Health Providers Intervention on Breastfeeding Outcomes (Continued)

Author	Intervention Description	Outcome: Intervention vs. Control
Susin, Guigliana, Kummer et al., 1999 Brazil	Video, explanatory leaflet, discussion, and four home visits N = 400	6.5 times higher exclusive BF at end of 3rd mo than control
Jakobsen et al., 1999 Guinea Bissau	Individual session at 1st prenatal visit and until 9 mo N = 1154	Any BF at 13 wk 29% vs. 18% .003* Full breastfeeding at 4 mo 31% vs. 25%*
Froozani et al., 1999§ Iran	Hospital session, individual counseling in clinic or at home until 4 mo N = 134	Exclusive BF at 4 mo 54% vs. 6%*
Bolam et al., 1998 Nepal	Individual session (20 min), N = 540 Intervention 1: at birth and at 3 mo Intervention 2: at birth Intervention 3: at 3 mo	Exclusive breastfeeding 33% vs. 28%** 24% vs. 28%** 29% vs. 28%**
Pugh & Milligan, 1998 United States	Two home visits to help with in-home tasks at days 3–4. Phone call	Any BF at 6 mo 50% vs. 27%*
Curro et al., 1997 Italy	Booklet: instruction for breastfeeding given during 1st pediatric visit	Full breastfeeding at 6 mo 48% vs. 44%** Any BF at 6 mo 59% vs. 52%**
Duffy, 1997 Australia	Group session 3 times: 2 hr + 25 min video	Any breastfeeding at 6 wk 91% vs. 29%*
Gagnon et al., 1997 Canada	Home visits, early postpartum discharge, phone calls until day 10 postpartum, N = 201	Any BF at 1 mo 55% vs. 39%*
Brent et al., 1995§ United States	Daily round at hospital, 1 phone call, prenatal and postnatal one-on-one consult until 1 yr N = 115	Any BF at 2 mo 37% vs. 9%*
Barros et al., 1994 Brazil	Home visits at days 5, 10, 20 N = 900	Any BF at 2 mo 73% vs. 62%
Hauch & Dimmock, 1994 Australia	33-page breastfeeding booklet sent home shortly after discharge N = 150	Any BF at 6 mo 59% vs. 56%** Any breastfeeding at 12 mo 16% vs. 22%**
Rossiter, 1994 Australia	Groups session 3 times: 2 hr + 25 min video (after 12th week) N = 194	Any BF at 4 wk 50% vs. 26%*

(Continues)

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–1 Controlled Trials on the Effect of Lactation Specialists and Health Providers Intervention on Breastfeeding Outcomes (Continued)

Author	Intervention Description	Outcome: Intervention vs. Control
Serafino-Cross & Donovan, 1992 United States	Five to eight home visits during 2 mo + counselor's phone number available. N = 52	Any BF at 2 mo 62% vs. 35%**
Neyzi et al., 1991 Turkey	Hospital group session + 10-min video, 1 home visit at 5–7 days + booklet N = 941	Any BF at 4 mo 95% vs. 81%** Exclusive BF at 2 mo 4% vs. 2%**
Hill, 1987 United States	Groups session 1 time: 40-min lecture, 5–10 min of questions + pamphlets N = 64	Any breastfeeding at 6 wk 39% vs. 30%**
Frank et al., 1987§ United States	Intervention 1: bedside session in hospital; phone calls until 3 mo + research discharge pack Intervention 2: research discharge pack N = 343	Exclusive BF at 3 mo 20% vs. 6%* Any breastfeeding at 4 mo 71% vs. 54%* Exclusive breastfeeding at 2 mo 15% vs. 6%** Any breastfeeding at 4 mo 56% vs. 54%**
Lynch et al., 1986§ Canada	1 home visit within 5 days of postdischarge + phone calls until 6 mo N = 270	Any breastfeeding at 1, 3, 6, 9 mo**
Bloom et al., 1982 Canada	Phone calls at days 10, 17, 21 + referral to nurse	Any breastfeeding at 6 mo 89% vs. 77%*

* Significant

** Not significant

§ Included in Cochrane List

Source: Adapted from de Oliveira, 2001.

A Cochrane review, the "gold standard" of medical research, studied the effect of any extra support given to breastfeeding women. Lay and professional support together extended duration of breastfeeding, especially that of exclusive breastfeeding (Britton et al., 2007). Face-to-face counseling (Figure 1–1) is the most effective intervention in increasing not only exclusive breastfeeding rates but also the total duration of breastfeeding (Albernaz, 2003).

If the data from the randomized controlled trials in the table were translated to healthcare costs saved by breastfeeding, it would show that lactation services save the healthcare system enormous amounts of money through reduction in illness of both baby and mother. When rates of breastfeeding at hospital discharge were compared between facilities that employed certified lactation consultants and those that did not, those having LCs had a 2.28 times increase in the odds

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

of breastfeeding at hospital discharge (Castrucci, Hoover, Lim, et al., 2006).

Studies show that peer counselor interventions are also effective (see Chapter 25). Clearly lactation services improve the health of our nation, but we have yet to document the extent of this effect in terms of money savings.

Certification

In 1981, experienced La Leche League leaders JoAnne Scott and Linda Smith were asked to develop a certification and training program for lactation consultants. This need derived from (1) an awareness that many healthcare providers discredited the accomplishments of the volunteer because she was unpaid, and (2) a need to establish minimum standards for individuals who were already providing LC services for a fee. A certification program was viewed as a way to recognize the important role of the volunteer and to provide a credential that identified competence.

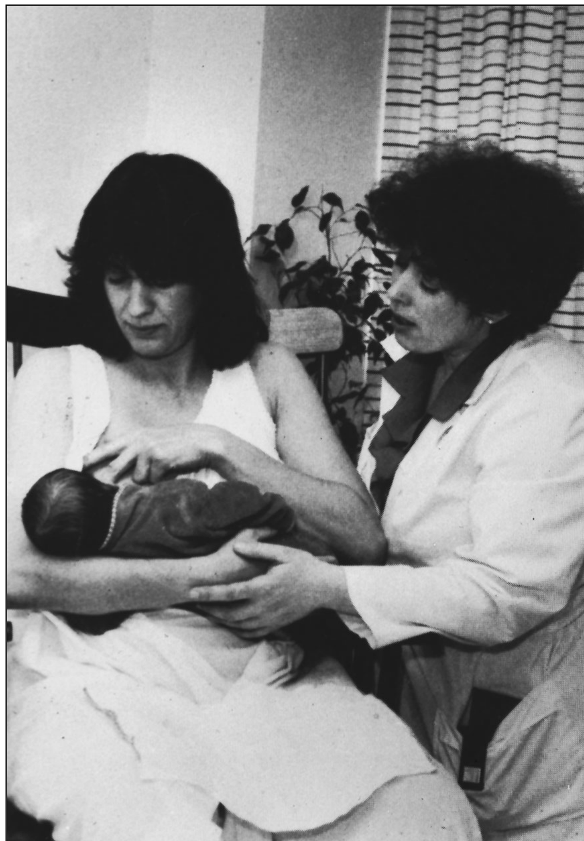

FIGURE 1–1 Early assistance promotes maternal confidence.

Scott and Smith assembled a small group of breastfeeding experts who had come to the field of lactation through voluntary service, mostly through La Leche League. In 1984, these individuals gathered and concluded that legitimacy of the field would be heightened if minimal standards of knowledge and skills were recognized through a certification examination. Subsequently, they developed the lactation consultant certification examination based on a three-dimensional content outline or test blueprint and derived from practice analysis.

The first examination was administered in July 1985 under the International Board of Lactation Consultant Examiners (IBLCE). Since 1985, a certification examination has been given annually (Table 1–2). To date, more than 15,000 candidates have been certified, the majority of whom live in Australia, the United States, and Canada. In 2008, IBLCE administered its 23rd annual examination in locations across 36 counties and territories. The test has been administered in English, Dutch, French, German, Italian, Korean, Spanish, Arabic, Japanese, Polish, Swedish, Hebrew, Italian, and Portuguese. The largest numbers of candidates have been in Australia, Canada, Europe, and the United States. Periodic recertification as an LC is required through the acquisition of continuing education credits and by reexamination. This dual-recertification option increases the likelihood that the LC will remain current. Guidelines for becoming certified by IBLCE are found in Appendix D.

IBLCE maintains a current registry of lactation specialists who are certified by the International Board of Lactation Consultant Examiners. Examiners and regulators can thus confirm that an individual is currently certified. For more information on lactation consultant certification, go to the International Board of Lactation Consultant Examiners Web site at www.iblce.org.

Certification, a process by which an individual demonstrates clinical competence in a specialty, is

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–2 IBLCE Examination Summary Data, 1985–2007

Year of Examination	Number of Candidates	Mean Score	Pass-Fail Score	Pass Rate (%)
1985	259	72.8	61.8	94.6
1990	428	72.1	64.6	89.3
1995	1,556	73.8	61.8	94.1
2000	1,862	72.7	60.9	87.8
2001	2,070	76.7	66.7	88.6
2002	2,536	75.4	65.0	90.4
2003	2,094	78.4	67.0	93.3
2004	2,163	77.5	64.0	95.4
2005	2,683	80.4	65	96.8
2006	3,207	77.9	65	95.1
2007	2,941	81.1	67	94.8
2008	3,323	77.8	65	93.5

Source: International Board of Lactation Consultant Examiners (IBLCE), www.iblce.org.

a valued and popular credential, especially in the United States. More than 40 specialty certifications exist in the field of nursing alone, despite the fact that certification is a voluntary credential. Certified nurses and healthcare workers from across a wide variety of specialties consistently place a high value on certification (Niebuhr & Biel, 2007). Nurses in the United States and Canada who earned certification in a specialty area report they felt more confident and experienced fewer errors in patient care since they were certified; thus certification may be a marker for excellence (Cary, 2000; Raudonis & Anderson, 2002).

ILCA

About the same time that IBLCE certification began, the International Lactation Consultant Association (ILCA) formed as the professional organization for LCs. ILCA has played a vital role in continuing education, development and promotion of the LC, and promoting policies to protect and support breastfeeding worldwide. Bailey (2005) points out that ILCA's action have arisen primarily through the grassroots vision and creativity of its members, such as creation of World Breastfeeding Week Action Kits and the Research Poster Session at the annual conference. ILCA's Web site is a rich and current source for information on conferences and courses. It also contains a listing of LCs and other practical resources such as low-cost professional liability insurance to help aspiring and practicing LCs in their practice (www.ilca.org). In 2006, ILCA divided into separate organizations according to country. For example, USLCA is the professional organization for LCs living in the United States.

Getting a Job as a Lactation Specialist

Most lactation consultants are health professionals who start their career in a job where they work with breastfeeding dyads. They learn about breastfeeding on the job and by personal experience rather than as part of their formal education. Others begin by affiliation with La Leche League and take the necessary courses and gain clinical experience to become certified. Applying for an LC position takes planning to be successful.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Interviewing for a Job

You discover that a position for a lactation consultant is available locally, and you want to apply. Here are some steps to follow to prepare for the interview:

- Research the position. What are the expected skills and experiences needed? Does your background match these skills and experiences? Some state laws limit clinical service to licensed medical or nursing staff, often for legal reasons. A common requirement for a hospital-based job as a lactation consultant is experience working with new mothers and babies, and certification by the IBLCE.
- Research the organization. Is it a clinic, medical office, or small or large hospital? If it is a hospital, how many deliveries does it have each year? Who is its competition? If it does not provide lactation services and a competing hospital does, highlight this lack as a major selling point for your services.
- Identify your strengths and weaknesses. Be ready to highlight skills, experience, personal qualities, and accomplishments you would bring to the healthcare agency.
- Keep in mind that first impressions count. Your appearance tells the interviewer quite a bit about your character. You want the interviewer to see you as a professional in every way including personal hygiene and wardrobe. An expensive outfit is not necessary, but your clothing should fit well and be clean and pressed. A business suit with a knee-length skirt is always appropriate.
- Know what salary to expect before you begin to interview. LCs employed by a hospital or birth center are usually paid on the same scale as staff nurses. Wages will differ according to the region you live in; however, US hospital staff nurses receive an average hourly rate of about $24. Average annual nursing income is listed in Table 1–3. Note that nurses working in a physician's medical office receive the lowest pay.
- Follow the general rule that if an employer does not bring up the subject of salary, don't ask about it until you have a job offer. Until you have that offer, salary doesn't matter. Once you have the offer, you can negotiate from a position of greater power.
- Evaluate the benefits being offered. Insurance (disability, life, and medical) and a 401(k) or 401(b) retirement plan with matches from your employer must be kept in mind. These extras can make a difference in the total compensation package. Although malpractice is rare with breastfeeding situations, it is not rare in obstetrics, and the LC might become involved in a legal case. Generally, those working in a hospital or community health agency will not need malpractice insurance.

Hafner-Eaton (2000) reported a wide range in hourly wages in her survey of 169 LCs (Table 1–4). She found that nurse practitioners or certified nurse–midwives who are also lactation consultants make the highest annual salary ($61,000).

Gaining Clinical Experience

IBLCE certification requires a considerable number of clinical hours of direct care of the breastfeeding dyad: from 300 to 1,000 clinical hours.

A healthcare professional who needs clinical hours to qualify as an applicant to take the LC certification examination should seek out a job where she will work with breastfeeding mothers to accumulate clinical hours. Working on a mother–baby unit in a hospital is an example.

TABLE 1–3 Average Annual Income of US Nurses

Setting	Average Annual Income ($)
Hospital	53,450
Community/home health	48,990
Physician's office	48,250
Mean annual earnings	52,330
Hourly wages	26.87

Source: Allied Physicians, 2006.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–4 Average Wage and Consult Time of Lactation Consultants

Practice Setting	Hourly Wage ($)	Initial Consult ($)	Length of Consult (min)
Private	55	79	95
Clinic	43	69	64
Hospital	28	62	74

Source: Hafner-Eaton, 2000.

The individual who is still in a school to become a healthcare professional can investigate the possibility of taking a supervised clinical practicum as a part of a degree. For each hour spent in a clinical practicum, a student can reduce the number of hours needed to take the exam.

Opportunities for clinical experience working with breastfeeding dyads are an issue when the individual who wishes to become an LC does not have access to clinical learning. Not everyone who desires to work as a lactation consultant wishes to become a nurse or other type of health professional. There are other ways to acquire practical experience working with breastfeeding dyads:

- Seek out a formal clinical teaching program in lactation management. The few available programs are of high quality, but you may have to travel to another part of the state (or country) in order to do the clinical practice. Sometimes a clinical arrangement can be made in your own area. For example, some students have completed their clinical requirements by working with a local pediatrician (Smillie, 2000).
- Join La Leche League and become an LLL Leader. The IBLCE will give credit for each year of active practice as a leader. Because the women attending LLL meetings are either pregnant or have breastfed for a long time, it will give you an opportunity to observe the needs and concerns of mothers just learning about breastfeeding and those who have extensive experience.
- Become a WIC peer counselor. As a peer counselor, IBLCE will grant 500 practice hours for each year that you are active in the field.
- Work in a medical office as a breastfeeding specialist teaching breastfeeding classes and counseling mothers.
- Contract with an IBLCE certified health professional to observe and assist in a clinical setting. Sometimes called *shadowing*, observing a qualified practitioner at work can take place in a clinical agency such as a hospital, in a community health clinic, or in a medical office (see Box 1–1). Permission for such an experience will need to be obtained from both the LC and the supervisor or director of the clinical agency.
- Round out your experience by visiting different work settings. For example, if your experience has been in a hospital, visit a WIC clinic to learn about the issues associated with breastfeeding older children or make arrangements to observe a breastfeeding mother in her home environment. Conversely, if your work setting has been a medical office or WIC clinic, go to a hospital setting.
- Keep track of and document the hours spent working with breastfeeding mothers either as paid staff or in a volunteer capacity. Accurate records of contact hours are necessary in order to apply to take the certification examination.

Medical Clinics

A growing number of physicians are emphasizing breastfeeding in their practices. For some this entails advocating for breastfeeding among patients in their general practice (family practice, obstetrics, or pediatrics) and providing staff to assist mothers to be successful. For other physicians, their general

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–1

Shadowing Guidelines

- Seek permission from the preceptor and the client being observed. The facility or LC may welcome you, but the mother may feel uncomfortable. Obey protocols such as wearing scrubs.
- As an observer, introduce yourself and speak only when appropriate.
- Take copious notes on what you've observed.
- Arrange with the preceptor to spend time after the observation period to discuss the cases and ask questions.
- Always thank the client being observed for her willingness to allow you into her "space."
- Do not observe on a day when you have a cold, sore throat, diarrhea, or allergies.
- Thank the preceptor in person and again with a note. Let her know how she has facilitated your education. Stress the positive things you experienced and saw.
- If there were problems during the observation, discuss these with your faculty or mentor.

Source: Smith, 2002.

practice also becomes a consulting practice for more complex breastfeeding problems referred by lactation consultants or other physicians. A small number of physicians are developing breastfeeding and lactation specialty clinics or programs either in an academic setting or as a private practice. The specialty clinics serve as tertiary referral practices for complicated medical conditions of mother and baby, for conditions that require prescription medications, or for minor procedures that may be indicated (e.g., frenotomy for tongue-tie). These tertiary centers often rely upon the close working relationships of the physicians with other nonphysician lactation consultants. Some of these offices have retail services that can provide their patients and clients with needed breast pumps, feeding devices, and other accessories. See the section on reimbursement for physicians' breastfeeding services.

Lactation Consultant Education

Most lactation consultants have another healthcare degree in an area such as nursing, medicine, dietetics, or physical therapy, and they obtain certification as an LC as a second credential. Being a health professional who is also a lactation consultant offers greater job security. In addition, this also means you will have already taken many of the courses that are required to be eligible to take the IBLCE certification examination.

As the number of lactation consultants working in health care increases, so does the availability of educational courses on lactation. Although lactation certification by IBLCE is considered the gold standard, other certifications have sprung up, including certification as a "lactation counselor" and as a "lactation educator." These programs are geared toward people, such as WIC personnel, who do not wish to become lactation consultants but want to be more knowledgeable about breastfeeding.

Wilson-Clay (2000) believes that lactation specialists have an identity crisis partly owing to inconsistent professional education. Claiming that a common education creates a sense of shared values, tradition, and practice, she calls for a comprehensive course of study on lactation followed by examination

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

and certification to guarantee consumers that someone with the LC title will be competent. In response to a call for educational standards, ILCA has moved toward a formal accreditation of educational programs that meet criteria for preparing lactation consultants.

Lactation Programs

A New York state law mandated in 1984 that any institution providing care for new mothers and babies had to have at least one person on staff that was designated to serve as a resource for other staff members and to provide breastfeeding assistance to patients. This landmark event helped launch the subsequent growth of the lactation consultant as a clinical specialty.

The 1990s could be characterized as the decade for the emergence of breastfeeding programs and clinics. Only a small number of hospitals in the United States had a lactation program in the early 1990s. But within the past two decades lactation programs have proliferated and most hospitals and birth centers now have lactation services staffed by certified lactation specialists, who have thus grown in numbers and visibility. Although lactation expertise has long been integrated into midwifery practice in countries where midwives predominate, LCs are becoming more common, especially in Australia, Canada, and Europe.

Opportunities for paid positions have increased to the point that hospitals now advertise for lactation consultants (Figure 1–2). Medical centers tend to hire registered nurses into lactation consultant positions because of state practice regulations concerning direct care of patients and because nurses can work in other units of the hospital if the maternity area census is low.

A lactation program may take many guises and offer a variety of services (Box 1–2). A breast pump rental depot, because it is so likely to generate revenue, may serve as a first kind of service for breastfeeding women (Rago, 1987). The Overlake Hospital in Bellevue, Washington, started with a

FIGURE 1–2 Advertisement for lactation consultants at West Jefferson Medical Center in Marrero, Louisiana.

Source: Courtesy of West Jefferson Medical Center.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

rental station for 10 hospital-grade pumps. It now has 150 pumps, and the majority of these, at any given time, are rented. Their women and infants boutique carries nursing pillows, nursing bras, infant clothing, CDs, books, and much more (Chagnon & Wehmeyer, 2004).

A lactation program may also develop out of a patient education program that began with childbirth preparation and other classes designed to meet the many needs of pregnant and postpartum women and their families. For clientele who have already developed rapport with the patient educator, additional classes may be provided, including prenatal breastfeeding classes and follow-up services after the baby is born.

Other programs may have begun in neonatal intensive care units and later expanded to the rest of the hospital, or they may be the outcome of patient surveys that indicate the need for lactation services. Still others may have developed from a hospital needing to "keep up with the medical Joneses"—meaning, when a competing hospital provides and then publicizes its lactation consultant services, other hospitals compete by providing similar services, such as the lactation clinic seen in Figure 1–3.

How those services are structured varies by the institution. In some programs, the LC sees all new mothers who indicate that they plan to breastfeed. In other cases, she sees all new mothers, identifying her clients when they tell her how they are feeding or planning to feed their babies. A few lactation specialists counsel both breastfeeding and bottle-feeding mothers. Other institutions restrict the LC's contact only to those breastfeeding mothers for whom the referring physician has asked for a consultation and follow-up care. Most of the time hospital-based specialists work on the birthing unit and/or postpartum area and neonatal intensive care, but they also assist breastfeeding mothers who are hospitalized in other areas. Thus their rounds take them to the surgical and medical units and to intensive care. The LC can also consult with women in the hospital for premature labor.

Workload Issues

Whatever system is used, it is wise to estimate the anticipated workload prior to the start of the lactation service. As one hard-working LC notes, "We have one breastfeeding professional each day we work and usually have 12–15 breastfeeding

BOX 1–2

Hospital-Based Lactation Programs and Services

- Daily one-on-one mother-baby rounds. Every breastfeeding mother seen by LC without referral or breastfeeding mothers seen only with referral
- Telephone hotline or "warmline"; post-discharge telephone calls
- Prenatal classes on breastfeeding
- Home postpartum visits and assistance with breastfeeding
- Pump rental and sales
- Postpartum breastfeeding consults for problems by appointment or "open clinic" hours
- Continuing education for staff, area seminars, preceptorships, and breastfeeding classes
- Research on lactation and breastfeeding issues (most often at a tertiary-care medical center)
- Evaluation of lactation products, devices, and services

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

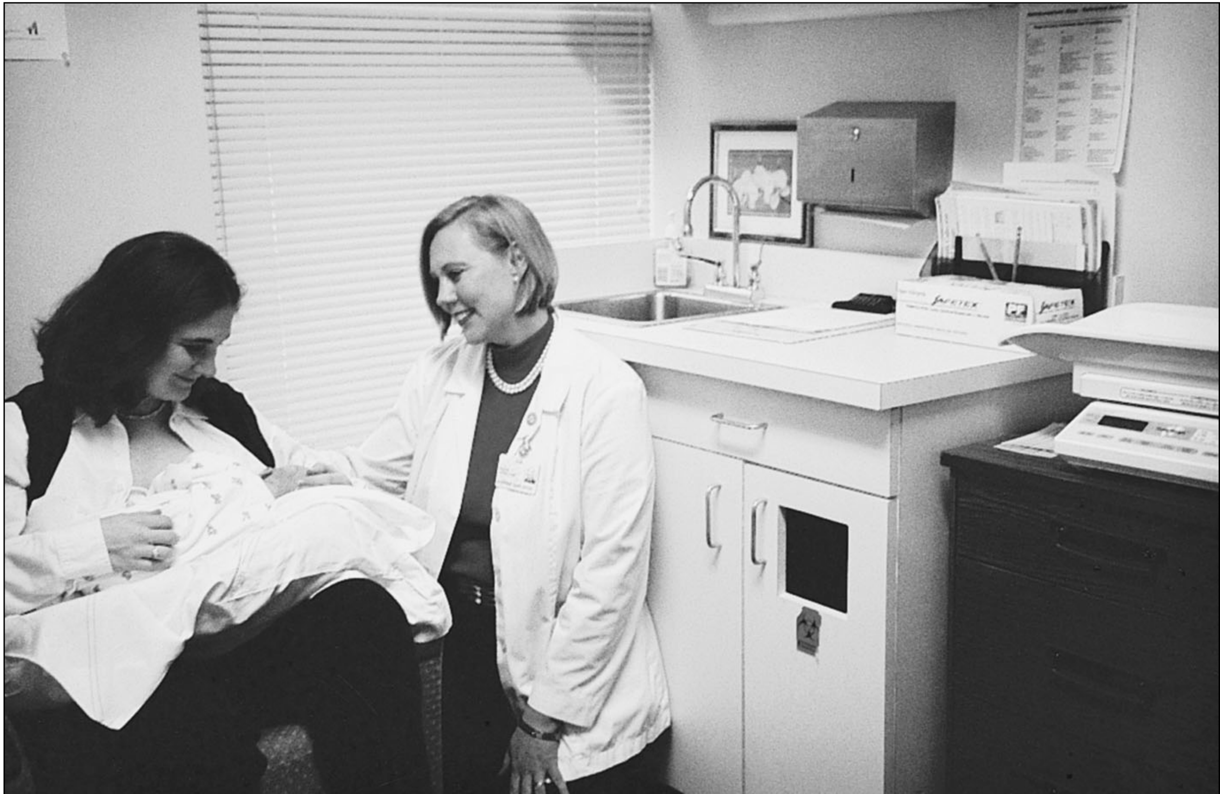

FIGURE 1–3 A hospital-based lactation clinic.

Source: With permission, Pardee Hinson.

women to see, in addition to phone calls, outpatients, pediatric, and NICU patients. We are supposed to be done in 8 hours, but guess what? It's usually 9–10." Most hospital-based programs have been in existence 6 to 10 years and employ two to eight LCs who mostly work part-time. For example, in some hospitals, three part-time LCs share 7 days per week coverage. The actual number of work hours should be based upon the number of births in the institution and the percentage of mothers who are breastfeeding.

I roughly estimate three visits (one 20-minute initial visit and two 15-minute follow-ups) from a lactation consultant for a total 50 minutes per dyad per day. Given these numbers, a lactation specialist would spend about 8 hours each day to see 10 dyads on a mother–baby unit. That does not take into account time spent charting, having lunch, meetings, planning, and so on. Daily rounds on breastfeeding women may be feasible in a hospital in which the LC sees fewer than 10 patients per day; it may not be feasible if more than 10 breastfeeding mothers are housed in the maternity unit on a given day—unless there is more than one specialist in the service or staff members providing other care are trained to provide optimal lactation-related care as well, thus reserving the LC for mothers and babies needing additional help and as a resource for the staff.

Thus, in a hospital with 200 births per month with an 80% breastfeeding rate, the lactation specialist will see about six to eight patients on weekdays (and fewer on the weekend). A hospital with 3000 deliveries each year should have a minimum of three full-time LC positions or six part-time positions. This staffing produces a bare minimum coverage that usually results in understaffing and/or part-time

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

coverage. The service—to be effective—should be available 7 days a week, on all shifts.

Lactation consultant Pardee Hinson reported 2.6 FTEs (full-time equivalents) LC positions (about 90 hours) for a hospital with 1600 deliveries (Hinson, 2000). These lactation consultants used to see each breastfeeding mother every day but now, in order to be able to keep up with the demand for their services, they see each breastfeeding mother once and see her again only if there is a referral. In an effort to meet patient needs, it is not uncommon for LCs to volunteer additional time for which they are unpaid. Heinig (1998) addressed this issue as "closet consulting," warning that when the caseload is invisible to the employer, the LC's professional time is undervalued and may result in further limits on LC time.

The two reports above are only "educated guesses." Recently Mannel and Mannel (2006) collected data from the hospital's lactation program's productivity reports at a tertiary care teaching hospital (4200 births per year). They measured actual hours worked by LCs over a 2-year period, allocated the hours to their respective activities, and developed ratios for optimal international board-certified lactation consultant (IBCLC) staffing for each component of service. Optimal IBCLC staffing was calculated as follows:

- Mother–baby inpatient care requires 1 full-time equivalent (FTE) per 783 breastfeeding couplets.
- Neonatal intensive care unit (NICU) inpatient care requires 1 FTE per 235 infant admissions.
- Mother–baby outpatient care requires 1 FTE per 1292 breastfeeding couplets discharged.
- NICU outpatient care requires 1 FTE per 818 breastfeeding infants discharged.
- Telephone follow-up requires 1 FTE per 3915 breastfeeding couplets or infants discharged.
- Education requires 0.1 FTE per 1000 deliveries.
- Program development and administration requires 0.1 FTE per 1000 deliveries.
- Research requires 0.1 to 0.2 FTE total.

Using this ratio data, IBCLC staffing needs can be calculated for hospital staffing according to number of deliveries (Box 1–3). All three hospitals have inpatient service, follow-up telephone service and education, administration, and research. Table 1–5 is a calculation of the staffing needs for a hospital with 3000 births per year using the Mannel and Mannel (2006) model. A similar table for hospitals with 1000 and 6000 births per year can be found in the *Journal of Human Lactation* (Mannel & Mannel).

Developing a Lactation Program

In proposing a lactation program, it is essential to realize that such a service will overlap with the interests of several ongoing departments or programs. As a result, it is both politic and appropriate to involve all such departments in the early stages of the proposal process. Touching base with hospital decision makers and developing a working relationship

BOX 1–3

Lactation Staffing According to Hospital Size

Hospital Size	FTEs
1. Hospital with 1000 deliveries/yr with a 85% breastfeeding rate, outpatient service. No neonatal services. (Mannel & Mannel, 2006)	2.6
2. Hospital with 3000 deliveries/yr with a 68% breastfeeding rate and neonatal services. No outpatient service. (Angeron & Riordan, 2007)	5.4
3. Hospital with 6000 deliveries/yr with a 70% breastfeeding rate and neonatal services. 50% outpatient service. (Mannel & Mannel, 2006)	13.6

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–5 Breakdown of Staffing for Hospital Lactation Program with 3,000 Births per Year

Approx. number of births/yr = 3000 (68% initiate breastfeeding)

Approx. number of NICU admissions/yr = 400 (85% initiate breastfeeding)

One FTE = 1900 work hours (excluding vacations, sick days, etc.)
1292 hours direct consult time
608 hours indirect clinical time

FTE ratio is number of available direct consult work hours divided by the amount of hours per dyad.

For example, 1292 hours/FTE divided by 1.65 hrs of direct consult with each dyad = 783 dyads per LC FTE. 2040 births (68% breastfeeding of 3000) divided by 783 = the number of LC FTEs that are needed for direct consult inpatient care.

Category	FTE Ratio	Calculation	Number	FTEs
Inpatient	1:783	3000 × .68 = 2040	2040/783 =	2.6
Outpatient	1:1292	120 couples 120 hours (1 hr each)	1292/120 =	0.1
Telephone	1:3915	3000 × .60	1800/3915 =	0.45
NICU inpatient	1:235	400 × .85 85% initiate BF	340/235 =	1.44
Education	0.1:1000	3000 × .68	2040/1000 =	0.2
Program admin	0.1:1000	3000 × .68	2040/1000 =	0.2
Research/QA	0.2:1000	3000 × .68	2040/1000 =	0.4
Total				about 5.4

Source: Adapted from Mannel & Mannel, 2006.

with them is critical. Without it, any hope of establishing and maintaining a program is seriously undermined, and the likelihood of the program becoming and remaining an integral part of the institution remains low. For example, when planning the postpartum follow-up program at Overlake Hospital, pediatricians were included in the planning to avoid the fear that the program would replace the 10-day physician visit for the newborn (Chagnon & Wehmeyer, 2004).

The hospital-based lactation specialist often creates her own position when hospital administrative personnel respond to patient demands for lactation services. She develops a plan for providing lactation services and then presents a proposal to administration for approval.

No new program will be implemented without someone in power pushing it, especially in a downsizing environment. A sponsor with "clout" is needed to lend momentum beyond the actions of the innovators and to commit resources from the institutional budget. This person can be a high-level administrator, a chief of staff, or department chair.

Department heads particularly critical to securing support for the new program include the director of maternity nursing (who may oversee labor and delivery, postpartum and nursery units, and sometimes the intensive care nursery); the director of the pediatric unit; and the chairman or medical director for obstetrics, pediatrics, and family medicine. If the institution has a midwifery service, the support of its director should also be sought. One option is a lactation service that contracts with the hospital for services. Using the contract services, the hospital saves money because

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

it does not pay for benefits for the lactation consultants who see its patients (Ferrarello, 2001).

If the institution has an employee health service or a women's health clinic, their supervisors should be informed of the proposal and asked for their support. Written proposals or documents that highlight how the new program will assist and support the services that are already being provided helps build their acceptance. For example, the head of employee health may be particularly interested in learning that the lactation program will include services to employees, such as a special place where employees returning to work after the birth of a baby can hand express or pump their breasts or nurse their babies during work hours (Dodgson & Duckett, 1997).

Hospital administrators choose new programs from dozens of possibilities for hospital investment (for example, another magnetic resonance imager versus a new diabetes center). Administration looks at two "bottom-line" factors—revenue and marketing potential—of proposed services before selecting which to offer. In deciding on any new health program, money speaks loudest.

Lactation services are usually provided in a single area that serves as the home base for telephone follow-up and inpatient services, as well as record keeping and as a site for professional resources. LCs can also see mothers who return for outpatient care in this area. In addition to outpatient services, some hospitals offer postpartum home visits as a part of the insurance coverage for the delivery. Nurses can do bilirubin checks to screen for jaundice and newborn hearing screening as well as assess breastfeeding and weight. During a postpartum visit this "perk" differs according to the insurance company with which the hospital contracts for deliveries. Income generated from inpatient care is managed through the regular accounting or finance office and submitted for insurance coverage, as occurs for other hospital-based charges.

Although lactation services generate minimal revenue compared to high-tech medical equipment, they are an effective marketing tool for the hospital. In the United States and many other developed countries, the women most likely to breastfeed are educated and in middle-to-higher income brackets; thus, a lactation service increases the hospital's visibility and credibility with young, educated families who have a high earning potential later on. The income-generating nature of patient care makes such a service attractive, particularly in settings in which several local hospitals are competing for the same patient dollars. The new trend in hospitals is product-line management, an approach that markets a product line of services: lactation services are a "product" that medical centers can offer to their "customers."

Just as the lack of physicians' support can prevent a program from being added to the array of services already offered, physician support can pave the way for the addition of a lactation program. Such support is most likely to be obtained if the key physicians—often chiefs of service or department heads—see that a lactation program will meet needs that they feel are important. In some cases, a female physician who has personal breastfeeding experience champions the need for such a service.

Physicians are still influential figures in the hospital although their power has diminished since managed care; therefore, maintaining positive relations with physicians is critical. Even with managed care, the physician as "gatekeeper" plays a major role in the fiscal health of a hospital. If the physician's patients do not want to go to a particular hospital because it lacks certain amenities—such as a lactation service—the birthing service administrator, with the backing of physicians, may create such a program rather than lose patients to a competing institution. Supportive physicians are more likely to be mothers who breastfed, fathers of breastfed children, those building a new practice, and those from countries where breastfeeding is the norm.

Marketing

Marketing—a discipline used by business to convert people's needs into profitable company opportunities—is still poorly understood and appreciated by health workers; either they need to learn marketing techniques themselves or seek assistance from marketing experts. Nurse entrepreneurs can attend marketing classes, read books on marketing, or seek help from small-business centers at universities that help small businesses at no cost.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

The following are basic marketing techniques that LCs may find useful:

- Collect data such as the number and percentage of women giving birth who breastfeed, and survey women who have used lactation services.
- Analyze strengths and weaknesses of competitors and focus on service needs not currently being met.
- Establish a niche within the healthcare market that is ignored by large healthcare providers—for example, a postdischarge visit for a back-to-work consult.
- Promote the practice by advertising and through public relations: brochures, newsletters, letterhead stationery, business cards, fact sheets, and radio and TV interviews all help to inform clients and other health workers about LC services (Gardner & Weinrauch, 1988).

The Unique Characteristics of Counseling Breastfeeding Women

There are unique aspects of working with breastfeeding women that differ from other aspects of health care. Breastfeeding is an emotion-laden subject that may be viewed as an integral part of human sexuality, not just an infant feeding method. It touches deep-seated feelings that people have about themselves and their bodies that reach back to childhood. This emotional content makes breastfeeding counseling, like sex counseling or childbirth education, unusually sensitive. Healthcare workers assisting breastfeeding families must be especially intuitive, caring listeners and advisors.

Working with new mothers and babies is a popular and thus, competitive, activity. Not only are newborns adorable, but also the mothers and fathers are (generally) healthy and happy. By working on the hospital maternity unit or in a birth center, the nurse gets to play a paid, starring role in the usually joyous family dramas of birthing and early breastfeeding. As a result, nurses compete to work there, and the mother–baby unit has a low rate of staff turnover.

Breastfeeding counseling is almost exclusively provided by women who must daily interact and work with other women: mothers and other female health workers. Women interact in the workplace differently than men do. Awareness and understanding of the typical ways that women interact and compete with each other gives the lactation specialist who comes onto the unit or into the community agency as a "new kid on the block" an advantage (Gilligan, 1982). Table 1–6 summarizes how women tend to work together and how they need to work together. Three characteristics—the emotional quality of breastfeeding, the popularity of caring for babies, and the dysfunctional, covert games that women bring to the work environment—set the stage for potential difficulties between the LC and the nurse, the nurse and the breastfeeding mother, the volunteer counselor and the LC, and the female physician and the LC.

Although workplace standards of behavior tend to follow men's rules, it does not negate feminine elements. Feminine, nurturing qualities help us in working with breastfeeding families. Our best qualities have to do with becoming attached and developing close relationships and friendships with others. These attributes are critical for all healthcare workers, including LCs, if they are to empathize with breastfeeding mothers. However, when women personalize the business or professional setting, it is counterproductive to their professional or business goals.

Survival in the workplace requires that we learn to operate within two concurrent cultures: the culture of nurturing and caring and the culture of the profession's business, which is about accomplishing tasks efficiently. Virginia Woolf noted that the values of women differ from the values of men; yet, she added, "It is the masculine values that prevail" (Woolf, 1929). Women succeed in the workplace when they use their womanly strengths of compassion and intuitiveness in their work, while playing by men's rules.

Roles and Responsibilities

The LC is responsible to the mothers she sees to provide up-to-date and accurate information and appropriate assistance. Quality practice and service are core responsibilities of a profession to the public. ILCA standards of practice are measures or levels of quality that are models for the conduct and evaluation of practice (ILCA, 2008) (See Appendix A). Table 1–7 lists the six competency areas or functions required by an LC practice. Depending upon the setting, however, these will be molded by the other services also provided there.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–6 Correcting Negative Female Workplace Behaviors

What Women Tend to Do	What Women Need to Learn to Do
Women tend to express anger covertly behind their co-workers' backs rather than openly and confrontationally. Girls learn that they should be "nice" to everyone, not fight, and especially not hit anyone. These concepts are called Mommy's Rules (Davidson-Crews, 1989), and they are deeply embedded female behaviors, especially in white, middle-class, American women.	Be overt, not covert. If there's a problem, confront, forget, and move on.
Women try to avoid being criticized; they often take it personally. Women are socialized to derive their self-worth from external, rather than internal, sources; therefore, they tend to react excessively to others' opinions, whether positive or negative. Women are more likely to hold grudges for long periods.	Communicate. Do not make scenes or public outbursts.
Women tend to become over friendly, one-to-one. Women who work together and become fast friends tell each other their deepest secrets, which are sometimes used against them when the friendship dissolves. Women give away power by giving away too much of themselves. Women are more likely to work for social rewards; men work for money.	Be friendly, but do not strive to be close friends.
Women are less likely than men to have used the give-and-take team concept of "you help me and I'll help you and we'll both get ahead." Women operate on a higher utopian level: what is right and just is more important than any other consideration. Women act as police officers of one another, making sure that what their coworkers do is right and correct and "trashing" them to keep them in their place.	Accept and love yourself. Accept (and appreciate) that some people are not your friends, now or ever.

LCs report that the majority of their time is spent in direct care of clients. The role of the LC closely parallels that of the clinical nurse specialist insofar as it requires in-depth clinical knowledge and expertise in a particular area. Gibbins et al. (2000) describe a model of the nurse practitioner (NP) or clinical nurse specialist (CNS) in the role as a lactation consultant in a breastfeeding clinic. This advanced practice role encompasses the dimensions of the advanced practice model: research, leadership, education, and clinical practice. Like the clinical specialist, the LC does the following:

- Gives direct care
- Teaches
- Consults
- Conducts or assists in conducting research

Giving breastfeeding mothers consistent breastfeeding information is vital. The patient takes for granted that the person to whom she spoke knows exactly what should be done. If confusion or controversy is found among the staff, we cannot expect the patient to become knowledgeable and comfortable with learning mother–infant tasks. Staff in-services on breastfeeding increase the likelihood that the staff will provide consistent information.

Although providing in-service education is an important, perhaps even essential, role of the lactation consultant, one can (like the proverbial horse brought to water) offer but not impel other healthcare workers to drink from the pool of knowledge. Other nursing staff may have fallen into the habit of expecting the LC to take care of all breastfeeding issues. If an LC is not available on all shifts or all days, this person cannot possibly always take care of things. Rather than

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

TABLE 1–7 Required Competencies for Lactation Practice

1. Breastfeeding education and advocacy
2. Clinical management of breastfeeding
3. Technical knowledge
4. Special knowledge and assistance
5. Professional responsibilities and activities
6. Business practices/legal considerations

expecting the LC to do it all, it is more effective for her to teach the staff, so that all healthcare workers are operating from the same frame of reference in how they assist breastfeeding mothers and when they will intervene to resolve a difficulty (Shrago, 1995).

Another function of the LC, whether she is located in a hospital or has a private practice, is to evaluate services and products related to lactation. Evaluating new products and then publishing the results is a professional responsibility. Seeking feedback from patients helps ensure that quality service is being provided (Turner, 1996).

Stages of Role Development

Roles of health professionals have been extensively studied and shown to progress through stages of development. For example, Benner (1984) used the Dreyfus and Dreyfus (1980) model of skill acquisition to describe the progression of skills and competencies of nurses in the clinical setting. This model, a structure for the metamorphosis that occurs as nurses persevere in their practice, can also apply to lactation consultants. According to Benner (1984), there are five stages of role acquisition:

- Novice: Develops technical skills, has narrow scope of practice, needs a mentor
- Advanced beginner: Enhances clinical competencies, develops diagnostic reasoning and clinical decision-making skills, begins to incorporate research findings into practice
- Competent: Expands scope of practice, becomes competent in diagnostic reasoning and clinical skills, senses nuances, develops organizational skills
- Proficient: Achieves highest level of clinical expertise, conducts or directs research projects, acts as change agent, uses holistic approach, interprets nuances
- Expert: Global scope of practice, consults widely, empowers patients and families, serves as mentor

Benner derived these insights from the stories nurses told about their practice and applied them into a logical, orderly progression of skill development. Joel (1997, p. 7) paints a vivid picture of the journey from novice to expert:

> *At first we see situations as tidbits of equal significance; later we move to the idea of a highly complex integrated whole where some pieces are just more important to solving the problem. And, finally the nurse becomes as one with the clinical situation. Rather than looking from the outside in, at the zenith of your practice, you are indivisible from the puzzle you are challenged to solve. You move right to the heart of the matter without responding to distraction.*

Using Benner's model from novice to expert as discussed earlier, LCs—such as experienced clinical nurse specialists—will spend more time as consultant and in scholarly work as they gain experience in the field (Auerbach, Riordan, & Gross, 2000). Because the role of the lactation consultant is relatively new, other health providers may be unclear about what to expect of this new healthcare worker. To clarify areas of expertise that can be expected of such an individual, the International Lactation Consultant Association has developed a set of recommendations and related competencies for LC practice (see Appendix A).

Lactation Consultants in the Community Setting

Because of the heightened awareness of the importance of breastfeeding, community health workers are becoming educated about breastfeeding, and some of them go on to certify as an LC. The 1989 WIC Reauthorization Act that mandated a breastfeeding coordinator in each state accelerated community health workers' interest in breastfeeding.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Most of these coordinators are registered dietitians or registered nurses. Home health nurses are another group of community-based health workers who frequently care for breastfeeding families.

Community-based health care is different from hospital-based care in that the healthcare provider works with the mother over the long term—throughout her pregnancy, childbirth, and postpartum course; thus community-based healthcare workers have an advantage over those working in the hospital in that they see the mother and her family in a total environment. Someone once described this as seeing a whole movie; whereas, in the hospital one sees only one frame. Being in the family home gives a much wider perspective on the mother's needs that are not otherwise apparent. For example, I visited a breastfeeding mother in her home along with a student nurse as a clinical experience. The client was a 15-year-old new mother who recently arrived from Mexico and had no family members here. She was having trouble putting the baby to breast because of extreme engorgement. After we pumped and got the baby on the breast, I suggested that we freeze the milk, since I thought she probably had not thought of this, given her youth and inexperience. She motioned me to her refrigerator and opened the freezer section, which held many bottles of breastmilk that she had expressed and saved. Clearly, this young woman had much more knowledge about lactation than I could have surmised by seeing her one time in the hospital before she was discharged.

Moreover community-based services are organized around a system of interdisciplinary community services and resources. Many times the community health nurse works with mothers who are poor and receive welfare assistance, where breastfeeding problems are but a minor star in a firmament of despairing circumstances.

Worksite Lactation Programs

Corporate lactation programs pay off. Women prefer to work at jobs where the breastfeeding woman is welcomed. Not only that, but breastfeeding mothers miss less work than mothers who are formula feeding (Cohen, Mrtek, & Mrtek, 1995). As a result corporate offices are becoming "breastfeeding friendly" with pumping rooms and hospital-grade pumps. Mothers working full-time spend less than 1 hour over the course of one workday expressing breastmilk. Click (2006) recommends basics for worksite pumping rooms:

- Privacy partitions (to accommodate 1–2 women)
- Breast pumps
- Wastebasket
- Cleaning solution
- Clock
- Sink with running water
- Reading materials

Medical Office

Physicians, especially pediatricians, realize the value of having staff who are knowledgeable about breastfeeding and can quickly and effectively work with breastfeeding women in their practice; thus lactation consultants are employed in the medical office. Their responsibilities include answering phone calls from breastfeeding women, making home visits, and working with the physician during postpartum visits to the medical office and making hospital rounds. The physician office usually pays the lactation consultant a salary; however, advanced practice nurses such as pediatric nurse practitioners may do their own billing.

Lactation Consultants and Volunteer Counselors

The client is apt to obtain more complete services when lactation consultants maintain a congenial, reciprocal relationship with volunteer counselors as well as other healthcare professionals in their community.

The volunteer counselor and the lactation consultant provide similar services. They most often differ about where such service is provided, the nature of clinical assistance, and the degree of follow-up care. For example, volunteer counselors are an excellent source of preventive healthcare information pertaining to breastfeeding and lactation. They also spend more time giving long-term assistance than the LC, particularly if the latter sees clients in a clinic or hospital setting. It is not uncommon for a mother to continue to receive assistance and caring concern from a volunteer counselor through the entire lactation course; only rarely will an LC meet with a client regularly through that entire period. Instead, she is more apt to have sporadic contact,

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

initiated by the client when a specific question or concern arises. The LC is more apt to assist a mother when specific clinical skills are needed to assess or to resolve a problem.

Volunteer breastfeeding helpers and lactation specialists can assist one another (Thorley, 2000). The volunteer may have seen a certain mother in her own home and thus may be able to alert the LC working in a hospital, doctor's office, or clinic to elements about the mother's home life that may bear on her lactation course. The LC may serve as a referral source for persons with complex problems. When the LC works in a medical center where ongoing research is part of her role, she helps generate new knowledge. Both the volunteer and the paid LC can review materials written for clients. The volunteer may be sensitive to ongoing issues that crop up after the mother has left the hospital or does not choose to mention to her healthcare providers. The LC may be aware of aspects of the healthcare system that influence breastfeeding.

Mentoring and Networking

Mentoring and networking serve several purposes. Mentoring plays a major role in any clinically based profession, especially a new specialty. Imagine nurses and physicians without mentors in their clinical training! A mentor is a trusted counselor, guide, or coach over a long period of time. Mentors nurture the novice's growth with advice, information, and support (Lauwers, 2007). As Wiessinger points out, the early pioneers are now the teachers and mentors of novice LCs (2003). Because we are a new specialty, only two decades old, educational programs with a clinical component are rare at this early stage. Moreover, clinical preceptorships are expensive to run and time consuming. Budding LCs take the opportunity to learn where they can. A vacation trip can offer the opportunity to visit the work setting of a colleague. Shadowing lactation specialists in your own home area is an excellent way to learn clinical skills. Since clinical opportunities are scarce it is not uncommon to teach the "see one, do one, teach one" method.

Networking, an established mechanism used by members of groups to exchange information and to get help in solving problems using and learn from one another—is a "good ol' girl" system (see Figure 1–4). When a difficult case arises, they feel more comfortable if they can use the phone to work through the situation with another lactation consultant. Additional assessment of the problem and how to begin moving toward a solution might offer new insights or creative alternatives to the plan of action already considered. Networking also identifies job possibilities, colleagues who will cover for one another, and referrals for clients needing equipment or specialized help. Networks may also be used to change systems and improve methods of providing care.

Opportunities to communicate with others also abound on the Internet. Foremost among these offerings is LACTNET, a worldwide breastfeeding e-mail list. Other networks have started, including one for Spanish-speaking individuals, and one exclusively for private practice. The benefits of electronic contact include ease of communication with persons for whom telephone contact would be too expensive and postal contact would be too slow. In addition, being able to vent and obtain sympathetic electronic "clucks" within minutes or hours or to seek assistance for a troubling case supports the private LC in a way that can be duplicated only by the existence of as many knowledgeable professionals

FIGURE 1–4 Making their "net" work for them, two LCs share experiences.

Source: Courtesy of Via Christi Medical Center, Wichita, Kansas.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

in the local area. It is the rare setting in which so many colleagues would be gathered in a single place. Electronic networking is here to stay.

In addition to e-mail discussion groups, numerous Web sites also provide information on items of interest to lactation specialists. Exploring the Internet can take hours of time, and new Web sites are created daily. La Leche League International, the Australian Breastfeeding Association, and the International Lactation Consultant Association all have Web sites that describe their purpose, services, and coming events.

Reporting and Charting

It is the responsibility of the lactation specialist, regardless of where she practices, to chart each contact with her clients and to provide complete reports to referring physicians and other healthcare providers (Williams, 1995). Almost all record keeping involves using a computer. Computer skills are a necessity for healthcare workers. As with other healthcare providers, computers can be used to generate records, reports, and charts that do the following:

- Provide other health workers with valuable information.
- Reflect quality of care delivered (quality assurance, continuous quality improvement).
- Highlight sometimes subtle observations or findings.
- Validate health services for insurance companies to determine reimbursement.
- Provide data that can be used for research.
- Serve as evidence in a legal dispute.

In the hospital, the mother's and infant's charts are clinical records that contain information about the hospital stay and all contacts with everyone involved in their care. Because the mother and infant usually have separate charts, it is sometimes necessary to "double chart." At the same time, care plans tend to be geared to the mother, because it is she who is taught and the baby who is the recipient of her learning.

Health professionals use personal digital assistants (PDAs) to look up medical information and to document their interventions by entering coding and diagnosis, among other things. Software for items such as coding and medications can be downloaded from the Internet for a trial period and then purchased if one desires.

The most commonly used methods of charting are narrative charting and problem-oriented charting. Flow sheets and standard care plans that are individualized are becoming more popular. They reduce paperwork and save time (and money).

Narrative Charting

Narrative documentation uses a diary or story format to document client-care events. A simple paragraph describes the client's status and the care that was given. Narrative notes, sometimes called progress notes, are used less now, with the advent of flow sheets and clinical care plans, which capture the routine aspects of care. Narrative notes (Box 1–4) can be easily combined with flow sheets or any other client record.

Problem-Oriented Charting

Charting based on a problem uses a structured problem list and logical format for each entry in the medical record. The format used in problem-oriented charting is called the SOAP or SOAPIE method. Each letter stands for a different phase of the nursing process: subjective data, objective data, assessment and nursing diagnosis, plan, interventions, and evaluation of care (see Box 1–5).

In private practice the completeness of reports also assists the referring healthcare worker to understand the "how" as well as the "why" of an LC's practice and methods. Reporting provides a database for all types of information (e.g., an increase in the number of referrals from a particular physician's practice). Early referrals may be for one or two common problems, whereas tracking over a time period may show that later referrals are for a wider variety of problems.

Electronic Health Records

A patient's lactation information is usually incorporated into existing information systems (IS) in clinics and hospitals. Lactation professionals need to work closely with IS technicians to make sure that the format for electronic healthcare records includes breastfeeding, especially if mother–infant care is

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–4

An Example of a Narrative Note

Date	Time	Progress note
05–22–03	0800	Infant alert. Rooting and suckling movements noted. Infant latched on breast and suckled effectively until asleep. Breastfeeding assessment score 9/10.
05–22–03	1500	Discussed basic breastfeeding information including normal infant elimination patterns to watch for after discharge. Mother given written materials on sore nipples, engorgement, use of breast pump, and breastmilk storage.
05–23–03	1100	Explained that a follow-up call will be made 2 to 3 days after discharge. Mother will have the option of a home visit.

involved. Transition to such a system takes significant amounts of time and resources, and often occurs with a good deal of staff frustration. Each facility, outpatient lactation clinic, private lactation practice, medical office, and hospital will have unique needs.

The Cincinnati Children's Center for Breastfeeding Medicine developed a lactation-friendly electronic health record (EHR) at their pediatric facility, which has a breastfeeding clinic. New forms specific to breastfeeding are (1) maternal history, (2) maternal exam, (3) infant feeding history, and (4) breastfeeding assessment. Their computer system includes electronic prescriptions, printed patient handouts, and telephone notes (List et al., 2008). LCs will find the computer pages and drop-down lists in this article to be helpful for developing their own computerized records.

Clinical Care Plans

A clinical care plan provides basic information about client assessment, diagnosis, and planned interventions. It also offers a guide for care, establishes a continuity of care, and represents a means of communication among all caregivers. There are two types of care plans: individual and standard. Individual care plans are developed "from scratch" for each client based on her specific needs. A standard care plan is a preprinted plan of care for a group of patients within the same diagnosis. Because each standard care plan must be tailored according to the needs of a particular client, they are designed to include space for adding information.

The Joint Commission requires a care plan for each patient in the hospital as a necessity for accreditation; however, the plan of care can be computer generated, preprinted, or appear in progress notes or standards of care (American Nurses Association, 1991). Care plans are legal requirements of practice and may also serve as protocols or standards of care.

Traditionally, individual care plans are divided into columns. Column headings change over the years to reflect new ideas in nursing, and some column labels are preferred over others. In this book, for instance, the clinical care plans include assessment, interventions, and rationale. Other commonly used labels are problem, evaluation, nursing diagnosis, patient outcomes, nursing action, or simply intervention-evaluation. An example of a nursing diagnosis and nursing care plan is seen in Box 1–6. The critical care path or

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–5

Problem-Oriented Medical Records

S = Subjective data. What the mother herself tells you. Example: "My nipples feel sore." Note: If the charting relates to only the infant, there will be no subjective data.

O = Objective data. Concrete data you can observe. Examples: Infant position at breast, temperature, and infant weight.

A = Assessment and nursing diagnosis. An assessment of physical and psychosocial factors based upon subjective and objective data; what you think is going on. Examples: Infant poorly positioned on the breast; breastfeeding at margin of nipple; ineffective breastfeeding; Latch score = 3 (1 low; 10 high).

P = Plan. Organized plan for care. Based upon the assessment, what you plan to do about the problem to help the breastfeeding mother and baby. Example: Will reposition infant on breast at next feeding.

I = Interventions. What you've done to/for the problem or what you plan to do. Includes teaching, referrals, finding the right pump. Example: Infant repositioned on mother's breast so that infant is grasping adequate breast tissue during suckling.

E = Evaluation. Review of outcomes. What happened? Was it effective? Examples: Infant appears to be suckling effectively at the breast. Infant breastfed four times during shift, three times following repositioning. Infant had bowel movement during feeding—appears well hydrated. In some cases in which a nursing care plan with diagnoses is used, evaluation may reflect only the presenting problem. Outcomes are then charted in the flow sheet.

clinical path is a commonly used type of care plan in hospitals. These paths, which are abbreviated care plans that focus on the client's length of stay in the hospital, integrate infant feeding into the overall care plan.

Legal Concerns

It is a rare event when a lactation consultant is a defendant in a malpractice suit. But that doesn't mean that it can't happen. The threat of a lawsuit because of excessive jaundice, for example, is a reality. Increased attention to professional liability in health care directly affects nurses and all healthcare workers, especially those in perinatal areas. Liability results from placing the mother and/or baby at risk even if the LC follows a physician's order.

The best way to avoid a lawsuit is by paying attention to these guidelines:

- Keep up to date on new research findings and clinical practices. Read current relevant articles and attend conferences.
- Keep positive relationships with your mother clients. People tend to sue healthcare providers because they feel they were not treated with respect and dignity.
- Document your intervention and the rationale for doing so. Write up assessments, interventions, and outcomes of care notes. Excel, Access, or dBase software programs can be formatted to create a database of your clients to keep track of your clients and record your cases.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–6

Clinical Care Plan

Nursing Interventions•Nursing Care Plan *Lactation Counseling*

COUNTY OF ORANGE • HEALTH CARE AGENCY • FIELD NURSING

NURSING INTERVENTIONS • NURSING CARE PLAN

Client's Name:________________ **Client's Number:**________

Lactation Counseling — 5244

DEFINITION: Use of an interactive helping process to assist in maintenance of successful breastfeeding.

ACTIVITIES: DATE:					
Determine knowledge base about breastfeeding					
Educate parent(s) about infant feeding for informed decision-making					
Provide information about advantages and disadvantages of breastfeeding					
Correct misconceptions, misinformation, and inaccuracies about breastfeeding					
Determine mother's desire and motivation to breastfeed					
Provide support of mother's decisions					
Give parent(s) recommended education material, as needed					
Inform parent(s) about appropriate classes or groups for breastfeeding *(e.g., La Leche League)*					
Evaluate mother's understanding of infant's feeding cues *(e.g., rooting, sucking, and alertness)*					
Determine frequency of feedings in relationship to baby's needs					
Monitor maternal skill with latching infant to the nipple					
Evaluate newborn suck/swallow pattern					
Demonstrate suck training, as appropriate					
Teach mother about:					
• Relaxation techniques, including breast massage					
• Ways of increasing rest, including delegation of household tasks and ways of requesting help					
• Record keeping of length and frequency of nursing sessions					
• Infant stool and urination patterns					
• Adequacy of breast emptying with feeding					
• Quality and use of breastfeeding aids					
• Appropriateness of breast pump use					
• Formula information for temporary low supply problems					
• Skin integrity of nipples					
• Nipple care					
• Relieving breast congestion					
• Applying warm compresses					
• Signs of problems to report to health care practitioner					
• How to relactate					
• Continuing lactation upon return to work or school					
• Signs of readiness to wean					
• Options for weaning					
• Alternative methods of feeding					
• Contraception					

Source: With permission, Parris, 1999.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

- In the hospital setting, make sure the baby has latched onto the breast before the mother and baby go home. If this has not occurred, first make sure the baby's doctor knows this. Then request that the mother and baby stay a day or two longer (refer this to the appropriate hospital case manager). If the mom and baby are not allowed to stay longer, make sure there is follow-up care: a daily phone call, an early visit to the baby's physician, a home visit—or all three.
- Refer to someone else if the situation calls for expertise you do not have in special situations.

People often sue healthcare workers not because of their clinical actions but because they are angry with them or for some other reason. Therefore, the most effective protection against such actions is establishing a mutually respectful relationship and rapport. The lactation specialist's pattern of practice should avoid causing the mother, the baby, or any other member of the client's family emotional distress as a result of words said, reports written, or other actions.

A clearly written, detailed record of the healthcare provider's actions, initial recommendations, and follow-up assistance (by phone and in person) is one of the most effective ways of avoiding legal action. Referrals increase following a well-written, complete report that is sent in a timely and professional manner. Client records are considered business records of the agency and are admissible as such under legal (court) rules of evidence. Records will often prevent cases from going to court; lawsuits often are won and lost based on what is in the record. Although testimony is another form of evidence, the written health chart is viewed as more accurate and reliable.

The LC who works in a doctor's office, clinic, or hospital is very apt to be part of the staff that are covered in an "umbrella" professional liability policy. The LC in private practice must determine for herself how much coverage she needs and what she can afford. Members of ILCA can get professional liability insurance coverage at a reasonable cost as a membership benefit. Although legal action against an LC is rare, it does occur; therefore, every individual practitioner needs to consider how she will protect herself and her family against a judgment that could ruin her financially.

Confidentiality

Maintain confidentiality about the mother, baby, and family. To fail to do so is an invasion of privacy and a tort (wrongful act) that involves confidential information that is revealed without permission to someone not entitled to know it.

Every LC should be aware of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which required the US Department of Health and Human Services (US DHHS) to develop a series of rules governing health information. In general, the rules are intended to standardize the communication of electronic health information between healthcare providers and health insurers. In addition, the rules are intended to protect the privacy and security of individually identifiable health information.

Intellectual Property Rights

The IBLCE Code of Ethics contains a tenet that deals with intellectual property rights (IBLCE, 2007). Basic rules for using other people's original materials are the following:

- Attribute the original creator of written material, slides, photographs, Internet sites, blogs, illustrations, online courses, etc. In case of a baby or minor, obtain written permission from parent.
- Seek authorization of the creator/source to reproduce, present, record, broadcast, translate, or adapt materials protected by copyright. A work is considered copyrighted as soon as it exists.
- Credit summaries of research findings, or ideas to authors or copyright owners.
- Limit photocopying of the creator's work to one copy per person/student.
- Quote directly from the original source. Generally a quotation of less than or equal to five typewritten lines should be enclosed in quotation marks, followed by a reference.
- When meaningful efforts fail to resurrect an out-of-print book, you may photocopy materials from the library book as long as the author is credited.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

For more detailed information about legal issues and sample forms of consent and other legal documents, see Chapter 31 by Priscilla Bornmann in *Core Curriculum for Lactation Consultant Practice* by Marsha Walker.

Ethics

Why study ethics? Ethical decisions are a routine, inherent part of lactation practice. If we recognize and acknowledge ethical conflicts, then we are more likely to practice ethically. A code of ethics established specifically for LCs covers professional practice and conduct to safeguard interests of clients (Scott, 2002). The code of ethics is a "must," whereas standards of care is a "should" for practice. The purpose of both documents is to provide guidance to LCs in their professional practice. The code of ethics principles, seen in Appendix B, guide the profession and outline commitments and obligations of the LC to self, client, colleagues, society, and the profession. IBLCE mandates that all individuals who take the certification examination must provide evidence of the required 45 continuing education hours, of which five must address professional ethics.

The IBLCE Code of Ethics also states that an IBLCE-certified consultant shall act in a manner that safeguards the interests of individual clients, justifies public trust in her or his competence, and enhances the reputation of the profession. These lofty words look good, but ethical issues are more than the principles put forth in the code of ethics. They range from the broader political issues to those that arise in everyday professional practice. Ethical awareness and values are just as important to an IBCLC as skills and a belief in breastfeeding. Ethical practice is essential for reputation of our profession and necessary if we are to earn public trust (Personal communication, JoAnne Scott, 2004).

Ethical Questions That Come Up in Practice

Different personalities and value systems come into play that complicate making a judgment or finding neutral ground. Many times there is no clear right or wrong but shades of gray in trying to resolve such ethical questions as the following:

- Whether to attend a continuing education boxed lunch sponsored by a formula company. Attendees receive a pen and other goodies.
- Whether to give out gift packs with formula samples and coupons to breastfeeding women being discharged from the birth setting. Do LCs employed at the birth setting have a right to refuse to distribute these items?
- Whether to turn in a colleague who removed client files from the health agency without prior consent or failed to protect a file per HIPAA regulations. Questions: What are the circumstances surrounding this incident? Was it intentional? Was the offender aware of HIPAA regulations?
- Whether to contract with a formula company to write a booklet with quality information on breastfeeding for mothers for publication.
- Whether or not to call oneself a lactation consultant without being certified by the International Board of Lactation Consultant Examiners.

There are several reasons why ethics education is relevant for lactation specialists.

- We are a relatively new profession in health care. As such the public is just now becoming aware of us, our special knowledge and skills, and the role we play in the maternal–child field. How we act will contribute to the acceptance by the public as a welcomed, respected discipline.
- The public has given us tacit approval and trust for a practice that involves touching and manipulating lactating breasts in a society where breasts are blatantly associated with sexuality.
- Birth of a child is a major family event that will be remembered (for good or for bad) by the family for years to come, if not for the rest of their lives.
- The mother (and father) of the baby are emotionally fragile during childbirth and early weeks following birth and vulnerable to suggestions—especially if this is their first child.
- Technologies of lactation practice have expanded dramatically in the last two decades. They

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

include widespread use of breast pumps, nipple shields, nursing bras, and so on, and include the opportunity for making money at the expense of young families who may not need them.

The WHO Code

LCs are expected to practice within the WHO Code. The WHO Code (International Code of Marketing Breastmilk Substitutes), an international policy, is congruent with the ILCA Code of Ethics. The code acknowledges that there is a legitimate market for formula but mandates that formula companies should not provide promotion to the public, no gifts to health workers or mothers, no free samples, and clear and accurate labeling (Arnold & Blair, 2007).

Moral Dilemmas

Moral dilemmas and ethical issues can be subtle and complex. Noel-Weiss and Walters (2006) remind us that often it is simply a feeling that something is not quite right about a situation, and this uneasy feeling lasts for a long time. Most of us remember an incident in our childhood where our mother (or father) made it very clear that we were doing the wrong thing. Although it was painful at the time, our parents inculcated a moral sense that gave us a behavior compass so that we headed in the right direction as we grew up.

Ethical Dilemmas

An ethical dilemma occurs when two or more morally acceptable courses of action are present and to choose one prevents selecting another. Tension occurs because moral obligations create differing and opposing demands. In some moral dilemmas, the lactation consultant must choose between equally unacceptable alternatives—both may have elements that are morally wrong. The dilemma can also be described as a situation where the patient's rights and professional obligations conflict (Butts & Rich, 2005).

Ethical Dilemmas in Practice

Below are ethical dilemmas most frequently encountered as reported by practicing lactation specialists enrolled in a human lactation course (Unpublished, Riordan, 2007).

- Giving gift bags/discharge packs containing formula to new mothers in the hospital
- Copying original materials (figures, videos) without permission from the author
- Disagreement with physician regarding treatment and advice given to the mother and family
- Receiving gifts (money, jewelry, entertainment tickets) and grants for educational offerings from formula companies
- Selling pumps, nipple cream/gel, breastfeeding pillows, and other gadgets to parents when they are not needed
- Recommending the use of a medication to increase milk supply that is not approved by the FDA although it is being used in other countries

What does a healthcare worker do when her job responsibilities conflict with their ethics—for example giving out gift bags containing formula? When lactation specialists feel that they are being asked to do something they cannot support ethically, it's important for them to acknowledge their personal views and analyze their feelings asking these questions:

- What is the ethical problem, and who are the people involved?
- Are there differences in the values of people involved?
- What are the alternate options for decisions in this situation?
- What is the best way to resolve this dilemma?

Many times, shades of gray complicate the issue, and different belief systems come into play. Most hospitals and large clinics have an ethics committee where the individual can go to help sort out the issues. The committee holds a forum for interdisciplinary review where discussion of the dilemma and answers to questions are addressed.

Ethics vs. Morality

Ethics is an overall set of principles that guide human conduct. Morals, on the other hand, are specific behaviors based on an individual's ideas about what he or she believes is moral and how he or she interprets their own moral experiences. Morality is

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

derived from the Latin word *moralis*, and refers to widely held social consensus about the normal conduct for human beings and society.

Principles of Ethics

Major principles of bioethics include the following (Butts & Rich, 2005):

- Autonomy
- Beneficence
- Nonmaleficence
- Justice
- Professional/client or patient relationship

Autonomy

Being autonomous is to be one's own person without constraints. The principle of autonomy is respect for self-determination and freedom to make one's own decisions.

Example. Autonomy includes the mother's right to choose whether to follow treatment suggestion or to refuse treatment. Autonomy fits well with caring for breastfeeding families because we know so much about the advantages of breastfeeding that it is difficult for us sometimes to stand back and accept the well-informed mother who decides to supplement her baby when she goes back to work even after we suggest ways that she can exclusively breastfeed in this situation. Autonomy for the patient requires the LC to recognize and appreciate the client and family's value choices.

Beneficence

Beneficence is defined as the duty to do good. Beneficence is just what it sounds like: being kind, merciful, and caring about the welfare of other people. It involves promoting the interests and well-being of other people.

Example. Maintain nurturing relationships with your colleagues. That includes those who are in training to become an LC. Seasoned LCs have an obligation to nurture individuals who are in the learning phase. Another example is when some places have out-and-out warfare going on between the nurses in the area and those who are not nurses. The remarks about each other can be vicious.

Nonmaleficence

This is the duty to do no harm. The meaning is obvious but although nonmaleficence is the opposite of beneficence, the two are linked.

Example. A mother who is HIV positive and advised to not breastfeed may deprive her baby of the benefits of her breastmilk but avoid the real potential of transferring HIV to the infant.

Justice

Justice is the right to be treated fairly and equally.

Example. Women who have been told to leave a restaurant or shopping mall because they were breastfeeding their baby. This certainly wasn't a just action.

Professional Client or Patient Relationships

Trust is the foundation of this principle. It includes keeping your word, telling the truth, maintaining privacy, and confidentiality.

Example. Before HIPAA became a law, the names of laboring women (and details) were posted openly on a blackboard in the nursing station. Childbirth and choice of infant feeding was not exactly private!

Ethics and Discipline Committee

IBLCE has an ethics and discipline committee. Members are drawn from IBLCE's board of directors and include a lawyer. The committees' deliberations are confidential and follow strict procedures. The committee reports to the full board. The way to submit a complaint is to do the following:

1. Request a copy of the procedures for making complaint and a copy of the code of ethics from the IBLCE office.
2. Complete the report form identifying which of the 24 tenets of the code were breached.
3. Provide a full explanation with supporting detail and sign it.
4. A designated reviewer will investigate the complaint and present the case to the committee. The committee will make a determination, and the complainant and respondent notified of their decision.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Actual complaints for ethics violations brought to the committee and the outcomes include the following:

- LC was accused of contradicting a physician's order. There was not clear evidence to prove the accusation to be true. Case dismissed because it was unsubstantiated.
- LC suggested a potentially dangerous practice in a published article, which carried her name and IBCLC certification. This was substantiated, but there were mitigating circumstances. Private reprimand was given.

Reimbursement

In most countries lactation services are a part of the national healthcare system, and reimbursement for these services is mainly through salaried positions paid for by government programs. In the United States, reimbursement for lactation services is extremely complex and depends upon the setting where the services are provided, educational qualifications of the provider, and the type of insurance.

Lactation specialists who work in a birthing center, hospital, or medical office are usually salaried employees reimbursed with a set hourly or weekly wage. Hospitals usually include lactation services as part of the total cost of the maternity "package." The cost package is an agreement between the insurance company and the hospital to charge a certain amount of money for healthcare coverage for each birth. This is known as capitation. Managed care companies compete with each other with price bids to win the healthcare contract, the lowest bid gaining the contract.

If postpartum home visits are part of a maternity insurance package, breastfeeding assistance is given as a part of a routine postpartum visit to the mother's home. Nurses providing these home visits are usually salaried by the home health company that employs them. Services above and beyond the packaged LC services are paid for either by a separate insurance claim or by the family themselves.

For the LC in private practice, cash payment for services rendered or for equipment is usually requested from the client at the time of the service. The client in turn seeks reimbursement from her insurance company and provides the third-party payer with the information it needs. The client may give the LC forms to complete and send to the insurer in the hope of being reimbursed. Insurance companies expect to be sent the HCFA form that can be downloaded from www.medela.com. A "superbill" with ICD-9 codes is displayed in Box 1–7. This form, along with an instruction booklet, is available from Pat Lindsey, IBCLC, at www.patlc.com.

Insurance and Third-Party Payment

Insurance and third-party payment for lactation services is a complex issue. Third-party payment—insurance or payment by another entity besides the patient—varies according to the state (and country) where the services were given. In the United States, third-party payers can be divided into two general categories: government or public health insurance (Medicare, Medicaid) and managed care organizations (MCOs).

Medicare applies to individuals over age 65 and is not applicable for breastfeeding except that insurance companies usually follow Medicare rules for payment. Medicaid is a federal program administered by the states, and state regulations apply to mothers and children who qualify on the basis of poverty. The regulations in various states may differ in billing rules and regulations. About one third of US births are paid for under Medicaid. Medicaid reimbursement for health care is further complicated by the fact that some Medicaid recipients are also enrolled in managed care plans. The plans' policies on reimbursement differ from the state and federal rules governing reimbursement when the patient is not enrolled in managed care.

Insurance policies usually spell out by title who may be reimbursed with third-party payment. Physicians and midlevel providers such as nurse practitioners, certified nurse midwives, and physician assistants, are recognized by third-party payers as providers who can receive direct payment for their services.

To receive reimbursement from Medicaid, the lactation consultant must be accepted as a Medicaid provider by her state Medicaid agency in order to be admitted to the provider panel of an MCO. Generally, providers are accepted on the basis of having a medical or medically related degree and national certification. Lactation consultants can receive direct

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–7

Superbill (Lactation Visit Receipt)

Pat Lindsey, IBCLC - Lactation Services

Board Certified Lactation Consultant - Registered Lactation Consultant
TAX ID#PROVIDER # 59-3579433
3849 Oakwater Circle, Orlando, FL 32806 - Telephone 407-859-7239 - Fax 407-850-9185 - Email PatIBCLC@aol.com

"Affordable Health Care Begins with Breastfeeding"

© 2002 Pat Lindsey, IBCLC

DRAFT

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST	INITIAL	PT'S BIRTHDATE	PATIENT: ☐ MALE ☐ FEMALE	RELATIONSHIP TO SUBSCRIBER
ADDRESS	CITY	STATE ZIP	REFERRING PHYSICIAN		
PHONE ( )	SUBSCRIBER		INSURANCE CARRIER		
ADDRESS - IF DIFFERENT	CITY	STATE	INS. ID	COVERAGE CODE	GROUP
☐ LACTATION ☐ ACCIDENT ☐ INDUSTRIAL ☐ ILLNESS ☐ PREGNANCY	DATE SYMPTOMS APPEARED:		OTHER HEATH COVERAGE?	YES ☐ NO ☐	IDENTIFY:

ASSIGNMENT. I hereby assign my insurance benefits to be paid directly,to the undersigned health care provider. I am financially responsible for non-covered services.

SIGNED: (Insured or Authorized Person) Date:

RELEASE: I authorize the undersigned health care provider to release any information acquired in the course of my examination or treatment.

SIGNED: (Insured or Authorized Person) Date:

NEW	ESTAB	OFFICE SERVICE	FEE
99203 30min	99213 15min	Hx Evaluation and Management	
99204 45min	99214 25min	Hx Evaluation and Management	
99205 60min	99215 40min	Hx Evaluation and Management	
NEW	**ESTAB**	**HOME SERVICE**	**FEE**
99342 30min	99348 25min	Hx Evaluation and Management	
99343 45min	99349 40min	Hx Evaluation and Management	
99344 60min	99350 60min	Hx Evaluation and Management	
NEW	**ESTAB**	**HOSPITAL SERVICE**	**FEE**
99221 30min	99231 15min.	Hx Evaluation and Management	
99222 50min	99232 25min	Hx Evaluation and Management	
99223 70min	99233 35min	Hx Evaluation and Management	
NEW	**ESTAB**	**TELEPHONE CONSULT**	**FEE**
99371	99371	Brief	
99372	99372	Intermediate	
99373	99373	Lengthy/complex	
TRAVEL		# Miles @	

SUPPLIES	CPT/MOD	FEE
BREAST PUMPS		
Breast Pump Collection Kit Single Double Conversion	A7002	
Pump In Style Orginial Traveler Companion	E0603	
Purely Yours with case w/out case	E0603	
Nurture III with case w/out case	E0603	
Mini-Electric	E0603	
Hand Pump Medela Ameda Avent	E0602	
Other Pump	E0603	
SUPPLEMENTAL NURSING SYSTEM Starter Regular	A7002	
BREAST SHELLS	99070	
NIPPLE SHIELDS	99070	
BOOKS/PAMPHLETS	99071	
OTHER Feeding Supplies	99070	
Baby Weigh Scale Rental - Serial # # days @ $	E1399	
ELECTRIC HOSPITAL GRADE PUMP RENTAL	E0604	
Equipment Serial Number		
Rented Date Return Date		
# days @ $ # months @ $		
Delivery / Extra Cleaning Charge on Rental Pump		
TOTAL SUPPLIES AND/OR RENTAL		
SALES TAX IF NO PRESCRIPTION		

LACTATION DX ICD 9 CM CODES

CHILD

BREASTFEEDING PROBLEM

- 783.21 Abnormal Weight Loss
- 775.5 Dehydration Newborn
- 783.41 Failure to Gain Weight
- 779.3 Newborn Feeding Problem
  - Breast Refusal
  - Latch-on Difficulties
  - Regurgitation of food
  - Slow feeding
  - Vomiting
  - Other
- 783.3 Infant Feeding Problem
  - Breast Refusal
  - Latch-on Difficulties
  - Mismanagement of feeding
  - Other
- 783.6 Polyphagia-Overeating
- 783.2 Under weight

SUCKING PROBLEMS

- 796.1 Suck Reflex Abnormal

JAUNDICE (V12.3)

- 774.39 Breastmilk Jaundice
- 774 Newborn - Physiologic
- 774.2 Newborn - Premature

ABNORMAL FUSSINESS/COLIC

- 777.8 Newborn - Colic
- 789.0 Infant - Colic
- 780.59 Sleep Disturbances Infant

DERMATITIS/INFECTION

- 691.0 Diaper Rash
- 693.1 Due to Food
- 691.8 Eczema
- 771.7 Thrush-Newborn
- 112.0 Thrush-Infant

OTHER

- 750.0 Ankyloglossia - Tongue Tie
- 530.81 GEReflux-NoInflam(V12.7
- 530.11 GEReflux-Inflam(V12.7
- 750.15 Macroglossia (V12.4
- 750.16 Microglossia (V12.4
- 520.7 Teething Syndrome

CHILD DIAGNOSIS

PRIMARY DX__________
SECONDARY DX__________
SECONDARY DX__________
SECONDARY DX__________

MOTHER

NIPPLE/AREOLA PROBLEM

- 676.14 Cracked/Fissured
- 692.9 Dermatitis Contact
- 676.04 Dimpled/Folded/Creviced
- 676.34 Flat
- 675.9 Infection (unspecific/Thrush)
- 676.04 Inverted (Retracted)
- 676.34 Sore Nipples
- 676.3 Trauma
- 676.3 Ulceration
- 676.34 Unusual Shape

BREAST PROBLEM

- 676.3 Breast Pain
- 692.9 Dermatitis Contact
- 676.9 Disorder of Lactation
- 676.8 Galactocele
- 757.6 Hypoplasia of Breast
- 611.72 Mass (es) / Lump (s)

ENGORGEMENT, BREAST

- 676.20 After the Perinatal Period
- 676.24 Perinatal, Moderate/Severe

MASTITIS

- 675.14 Breast Abscess
- 675.04 Filled Duct
- 675.20 Non-Purulent Infection
- 675.24 Plugged Duct
- 675.14 Purulent Infection

MILK SUPPLY

- 676.44 Agalactia (No Milk)
- 676.64 Galactorreah
- 676.8 Polygalactia (Over Supply)
- 676.54 Suppressed (Reduced)

LACTATION

- 676.50 Induced (Adoption) (v61.29)
- 676.54 Relactation

OTHER

MOTHER DIAGNOSIS

PRIMARY DX__________
SECONDARY DX__________
SECONDARY DX__________
SECONDARY DX__________

NOTES

INSTRUCTIONS TO PATIENT FOR FILING INSURANCE CLAIMS:

COMPLETE THE PATIENT INFORMATION SECTION AT THE TOP OF THIS FORM. SIGN AND DATE. THEN MAIL THIS FORM DIRECTLY TO YOUR INSURANCE COMPANY. PLEASE ATTACH YOUR OWN INSURANCE CARRIER'S CLAIM FORM.

PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION. REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.

REC'D BY ☐ CHARGE ☐ CASH ☐ CHECK # ______

TODAY'S FEE	
OLD BALANCE	
TOTAL DUE	
AMT. REC'D	
NEW BALANCE	

NEXT APPOINTMENT	PROVIDER'S SIGNATURE	DATE OF SERVICE

Source: With permission, Pat Lindsey, 2003.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

reimbursement if they are a physician or an advanced registered nurse practitioner (NP) (including a certified nurse–midwife) who has graduated from an accredited educational program and is certified nationally in a specialty.

Physicians or nurse practitioners can apply for a provider number through the state Medicaid agency by filing a provider application. If accepted as a provider, they can bill the state Medicaid agency on an HCFA 1500 form using the patient's name and identifying information, the ICD-9 code, the Current Procedural Terminology (CPT) code, the charge, and the provider's name, number, and location for services. Fees for CPT codes vary according to locations and providers. For example, in many states in order to receive third-party payment, LC services must be provided in collaboration with a physician. A book by Carolyn Buppert (2008), *Nurse Practitioner's Business Practice and Legal Guide* (3rd ed.), is an excellent resource for learning about reimbursement.

"Incident to" Billing

Lactation services that fall under the category "incident to" can be billed if they are an integral although incidental part of a physician's professional services; however, the physician must personally treat the client on the first visit to the practice and be on site when the service is rendered. So if the LC is a nurse practitioner working in a medical office she can bill for "incident to" services to the breastfeeding dyad if the physician sees the mother and baby first and is in the building (on-site) when the NP sees them. Medicare requires that the claim form for an "incident to" service be filled out with the physician's name and provider number.

Rejection of Billing

If the company rejects a bill, the HCFA 1500 is returned with a short explanation about why it is being rejected. Sometimes several letters back and forth are necessary before the bill will be paid. Persistence is the key, as many claims may not be paid on the first submission. Anyone in a medically related practice quickly learns from trial and error how to best file third-party insurance claims in order to maximize the number of paid claims.

Payers may require documentation to validate that the care was given, the site of the care, and the medical necessity and appropriateness of services provided. Fees for care of breastfeeding women on Medicaid are based on number and type of services provided using the CPT, published in the ninth edition of *International Classification of Diseases* (ICD-9) and the Health Care Financing Administration's Common Procedure Coding System (HCPCS) codes (see Box 1–8).

Major barriers to third-party reimbursement for nonphysician healthcare workers such as lactation consultants have been state licensure laws, opposition by the medical profession, and third-party payers who fear expansion of provider eligibility. The 1997 passage of a provision contained in the budget bill Public Law 105-33 to expand Medicare reimbursement for nurse practitioners allows for reimbursement of NP services including lactation services; however, each state has the option of covering NP services. Even though the law has passed, these nonphysician providers have difficulties in getting third-party payment.

Physicians in the United States are able to obtain reimbursement by using established ICD-9 medical codes for breastfeeding diagnoses, billing for both mother and baby as indicated, and submitting bills for insurance coverage. This often falls into the constraints of contracted fees, managed care, and/or HMO contracts. The American Academy of Pediatrics section on breastfeeding published *Breastfeeding and Lactation, The Pediatrician's Pocket Guide to Coding* in 2006. However, owing to the time-consuming nature of fully evaluating the breastfeeding dyad and observing a feeding, the physician's time will rarely be adequately compensated in full. Creative use of staff is often featured in the physician-led lactation clinic to allow effective time management for the physician.

Coding

Accurate and complete coding for services and supplies is vital to the financial success of a lactation program or service. The HCPCS is a uniform method for health providers to report professional services and supplies. Box 1–9 presents a listing of HCPCS codes for breast pumps. Keep in mind that payment coding requirements and policies vary from payer to payer, and new codes may not be recognized by all payers (International Lactation Consultant

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–8

Common Lactation ICD-9 Codes/Diagnosis Codes

Code	Mother	Code	Infant
675.2	Nonpurulent mastitis	276.5	Volume depletion, dehydration, hypovolemia
675.1	Abscess of breast	524.06	Microgenia; major anomalies of jaw size
676.1	Cracked nipple	783.2	Abnormal loss of weight
676.3	Other and unspecified disorder of breast	750.1	Abnormal tongue position
675.8	Other specified infection of breast and nipple	774.39	Breastmilk jaundice
692	Dermatitis contact	749	Cleft palate/lip
651.04	Twin pregnancy postpartum condition or complication	750	Tongue tie
676.2	Engorgement of breasts	758	Down's syndrome
676.5	Suppressed lactation	787.2	Dysphagia
676.0	Retracted nipple	784.41	Failure to thrive, failure to gain weight
676.4	Failure of lactation	783.3	Feeding difficulty—infant
676.6	Galactorrhea	779.3	Feeding problems in newborn
676.8	Other disorders of lactation	771.7	Neonatal candida infection

Association, 2002). The Reimbursement Tool Kit available from ILCA at www.ilca.org is a valuable source of information. The Healthcare Insurance Guide for Breastfeeding Families can be downloaded free at the Medela Web site (www.medela.com). The best summary of how to bill for lactation services in a pediatric office can be found at www.aap.org/breastfeeding/PDF/coding.pdf.

Private Practice

Rising rates of breastfeeding and short hospital stays have resulted in lactation services as a private practice. Some physicians are successful in building a practice that is limited to breastfeeding families. Both professional health workers and those without a healthcare background are finding they can enjoy the work they love, assisting women with breastfeeding, and still survive.

Auerbach (Riordan & Auerbach, 1999) surveyed lactation consultants in private practice in the United States and Canada to gain information about their experiences. A majority of the private practice LCs reported that they work 4 to 5 hours a day, qualifying for part-time status when seeking professional liability coverage, which all maintained. The number of clients seen in a given week or month varied widely, and was related to several factors, including how long the LC had been in practice, whether she limited herself to home visits (more time consuming and thus less frequent), and whether her practice was located in a rural or more densely populated metropolitan area. LCs in practices for only two to three years reported seeing the fewest number of clients, but their practices grew over time as satisfied customers made referrals to friends, neighbors, and colleagues.

Some LCs started by opening a breast pump rental depot. Others set up a private practice after receiving

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–9

HCPCS Codes for Breast Pumps

HCPCS Code	Description
E0602	Breast pump, manual, any type
E0603	Breast pump, electric (AC and/or DC) any type
E0604	Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplied, transformer, electric (AC and/or DC)

numerous calls from mothers who requested their help with breastfeeding. Several had been (or still were) hospital nurses who wanted to do more to help breastfeeding mothers than could be accomplished in the hospital. Still others found that a private practice in lactation consulting was an extension of their previous work as volunteer LLL leaders.

The LC's own home is the most common practice setting for nonhealth professional LCs. For health professionals, practice locations are a clinic, physician's office, or hospital where the LC receives referrals from the staff members of these organizations. Some residential neighborhoods have restrictive covenants that prevent home business or signage that a business is located in a home. Using a post office box for an address avoids neighborhood zoning restrictions. These details must be checked out in advance of opening such a facility. Inadequate road signs in suburban settings or in rural areas will make maps on the backs of flyers and other advertisements a necessity. In North American practices, busy periods clustered in March, April, and May, reflecting the higher birth rates during the warmer months, while slower periods tended to occur in November, December, and January.

The Business of Doing Business

One of the hardest lessons for an LC to learn is that a private practice is a business; if she has no business experience, she must learn about it (Auerbach, 1995). Advertising is essential in establishing and/or maintaining a client pool. Generally, the best advertising is word-of-mouth referral from clients who are satisfied with the LC's services. Other successful advertising includes distributing business cards, flyers, and magnets, and sending personal letters to hospital staff, local physicians (pediatricians, family physicians, obstetricians), community women's groups, childbirth educators, and La Leche League leaders. Teaching a prenatal breastfeeding class is a form of advertising. At the same time, the LC has to make it clear that she charges for later visits. Additional techniques include listings in the telephone book (white or yellow pages), newspaper articles, and press releases for new activities or special events relating to the business.

Lactation consultants disagree about whether to advertise in local newspapers or on the radio. Such visibility has the potential to attract the people merely posing as clients, is expensive, and rarely results in generating clients. The choice of words in advertisements or signs should be considered carefully. In one case, an LC posted a large sign with her name but not the word *breast* or *lactation*, to alert passersby to her business. Using family, parenting, or mother-related phrases works well in lieu of more obvious words. In other communities, inclusion of the words *breastfeeding* or *breast* may not be controversial.

More effective marketing techniques include meeting face to face with local physicians, their office staff, and hospital nurse managers, as well as

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

attending professional meetings, such as hospital grand rounds and continuing education programs for nurses. Presenting a case history to hospital physicians, midwives, doulas, childbirth educators, and other health providers raises the visibility of the LC practice and generates referrals.

Incorporating the private practice should be considered only after carefully reviewing the advantages and disadvantages. The advantages are that the business is a legal entity with possible tax advantages and that the business can be sold or transferred. The disadvantages are the expenses of incorporation and that the business is regulated by state and federal controls.

Payment and Fees

Most clients pay for their visits by cash, check, or credit card at the time of service. Lactation consultants, however, harbor a strong streak of idealism and on occasion refrain from charging a client when it is clear that the client cannot pay. Others establish an informal sliding scale for people for whom a total payment at the time of service is not possible or offer a payment plan for those who cannot pay in full at the time of the visit. Most people prefer to pay something rather than nothing. And when clients pay even a very small amount for the care they receive, they are more inclined to follow through with the suggestions.

Another aspect of doing business is setting fees. This issue seems to generate the greatest concern when lactation specialists first go into practice. Anxiety about how much to charge for their services may stem from having been a volunteer breastfeeding support person for many years and coming to value the helping relationships with the mothers without thinking of charging for the service. This problem is not confined to LCs. Women tend to be reluctant to charge what their services are worth. This undervaluing of skills or services is part of a woman's socialization when she is growing up. In addition, lack of familiarity with running a business results in undervaluing the service provided. Setting fees too low degrades lactation consultant services and lowers expectations for insurance company payments.

The prospective private practice LC needs to set her fees on the basis of what other comparable professionals in her community are charging for similar services (e.g., others in private practice, nurses who make home health visits, and medical office visits). Other factors to consider in setting fees are the length of visits. While well-baby visits to a physician's office may last only 15 to 20 minutes, the usual first LC visit may run 60 to 90 minutes. One lactation clinic charges $29 for 15 minutes; $46 for 30 minutes and $68 for one hour (ILCA, 2002).

If the visits take place in the mother's home, a set time for travel is included in the charge: one lactation consultant adds 1 hour to account for travel time to and from the client's home when she bills the visit. Still others charge a set fee according to the number of miles/kilometers they travel in addition to their usual visit fee. Saturday and Sunday visits are sometimes charged at double the usual rate.

Phone consultations should be considered in establishing a fee structure. Some lactation specialists do not charge for phone consultations at all, preferring instead to limit calls to no more than 10 minutes. If more time is needed, they suggest that a visit for which they will be paid is in order. LCs bill differently for phone consultations. Some bill for a specific amount of time within a set framework, such as up to 1 hour of calls within a week after the first visit. Others bill for each call separately. Still others provide free phone consultation for minor issues.

Overhead costs such as rent, taxes, phone, computers, and traveling should be added to determine fee structure. If the annual cost of overhead is added to annual salary and divided by 52 weeks, the amount should equal weekly income (Ferrarello, 2001).

LCs in private practice are most successful when they have an ongoing, mutually respectful relationship with other healthcare providers in the community who refer clients to them. A physician in private practice found the following:

> *Initially some physicians raised their eyebrows. They thought breastfeeding was not worthy of a physician's time. However, as I have seen more and more of their patients, and spoken on grand rounds, I have gained their respect and lots of referrals. Once they discover that there is a science behind the art, the breast is as complex and elegant as any other organ system, they are eager to learn more (Smillie, 2000, p. 51).*

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Relationships with physicians have established rules, one of which is that if a baby is thought to have a medical problem, before proceeding with lactation assistance, the LC refers the family to their baby's own healthcare provider. The LC who is also a nurse practitioner can assess and treat a nursing mother or baby with a medical problem in collaboration with a physician according to the nursing practice laws in her state.

Essential to developing a professional reputation and high ethical standards is sending a written report to the referring physician or calling the physician after the patient has been seen. Referrals increase following a well-written, complete report sent in a timely and professional manner (Williams, 1995).

Partnerships

Partnerships differ in how they are structured. In some cases, each partner sees all clients, and income that is generated is shared equally. In other practices, each partner maintains her own client group. Having a partner to cover for you (as long as the partner is available) is the biggest advantage. Going into a partnership requires that each LC be clear about what she wants from the arrangement at the outset. Complementary ways of working are a plus; it is not necessary for each partner to be a "clone" of the other. However, when very different philosophies exist about how to provide client services, conflicts that cannot be resolved are more likely to arise. Like a marriage, a partnership has its high and low points. Sometimes, partners can simply create a whole new set of problems such as disagreements about workload, methods of practice, and income.

Private practice is clearly not for every lactation consultant. However, those who have done so and have weathered the first 5 years report that it can provide rewards that are rarely found in another occupation. The independence, which is most frightening to persons who are used to a guaranteed salary and set working hours, also offers an opportunity to structure one's workday in a way that may allow the LC more time with her family than is possible otherwise.

Persons already in the field are the best to ask what others entering the field should know. Linda Smith's book, *The Lactation Consultant in Private Practice: The ABCs of Getting Started*, is a valuable resource for starting a private practice. Box 1–10 lists dos and don'ts suggested by LCs in practice—either when establishing a private practice or when initiating an office, clinic, or hospital-based LC service.

BOX 1–10

Dos and Don'ts of Lactation Consulting

DO . . .

- Insist on gaining credibility for the profession by passing the IBLCE examination. Ensure that people know this is the minimum credential for any person practicing as an LC in the community.
- From the very first client, behave with the utmost professionalism.
- Charge what you are worth; do not apologize for your fees.
- Set limits immediately, so that people know the boundaries of your availability.

(Continues)

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

BOX 1–10 (Continued)

- Establish your own knowledge and skills boundaries. Do not be afraid to ask for help.
- Develop a network of LCs in the community; they can serve as a sounding board for problems and as back-up when you are not available.
- Avoid repeating problems other LCs have experienced by learning from those with more experience than you have.
- Know what you are doing if you rent or sell equipment. Learn how the equipment works, and who should and should not use it. Be aware that its availability from you may influence what you tell a client to do.
- Use a computer to maintain a database of clients and practice documents and for maintaining your business.
- Learn as much as possible about running a business. It can take years to break even.
- Get a competent business advisor for accounting, marketing, and taxes. Ensure that those advisors understand exactly what you are trying to do.
- Bill the client directly for the service. The client then files a claim to her insurance company. Use standard forms for billing and a letter that the client can use to seek insurance coverage.
- Develop a specialization within the field and make your work visible to others through good care (Brimdyr, 2002).
- Document what you have done and send the original to the primary care provider, whether or not this individual made the initial referral.
- Recognize that this business is a labor of love. Do not expect to get rich.

DON'T

- Don't get heavily involved in phone consultations, paid or unpaid, without having seen the mother and baby. An overall assessment is needed.
- Don't give away your time without reimbursement.
- Don't waste your money on a lot of expensive advertising. Advertise judiciously and be patient.
- Don't use someone else's opinion as a reason for doing something. Experiment; be creative. What works in one practice may not work in another one.
- Don't get too many partners at the beginning. Knowing how each partner works as an individual will not necessarily predict how each works as part of a group. The more partners one has the greater the number of problems that can arise.
- Never forget that a happy mother and thriving baby are your best advertisements.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Summary

The field of lactation, now into its third decade, is widely accepted as a healthcare specialty. Most hospitals now offer lactation services and employ nurse lactation consultants, and physicians are starting up breastfeeding specialty private practices. And no wonder: of the 4 million women who give birth each year in the United States, approximately three fourths (3 million) start off breastfeeding. The opportunity to work with healthy families and adorable babies—and to enhance early parenting and child health—has made it a popular, satisfying field. Although growth is welcomed, rapid growth causes growing pains. Some health professionals feel threatened by the emergence of new practitioners who expect to share their turf.

The experiences of the lactation consultant in this decade are similar to those of the childbirth educator in the 1960s and 1970s. At that time, it was the childbirth educator who was the innovator and change agent who flew against the prevailing wind and traditional practices in birthing. These two disciplines share more than a common history: both empower mothers and act as change agents for women and for families during an age when technology and defensive medicine rule medical practice.

Those working with breastfeeding families cannot expect to become wealthy. However, they reap the reward of personal fulfillment as they assist other women in becoming empowered by their own breastfeeding experiences. This outcome has no price.

Key Concepts

- A lactation consultant (LC) is a specialist trained to focus on the needs and concerns of the breastfeeding mother–baby pair in hospitals, clinics, private medical practice, health departments, home health agencies, and private practices. LCs usually have educational and clinical backgrounds in the health professions.
- Randomized clinical trials consistently show that interventions by healthcare workers have a positive effect on breastfeeding. Translated to healthcare costs, these studies would show that LC services save the healthcare system enormous amounts of money through reduction in illness of both baby and mother.
- The number of candidates taking the international IBLCE certification examination for lactation consultants has grown steadily since its inception in 1985. Most candidates have been from Australia, Canada, and the United States. Passing rates usually range from 85% to 95%. Periodic recertification is required.
- Salaries for working as a lactation consultant for a clinical agency are similar to those paid to hospital nurses; working in a medical office pays the least. The fee charged for consultation with a mother ranges from about $70 to $95.
- Opportunities to gain clinical experience working with breastfeeding dyads can be obtained through La Leche League, finding a preceptor arrangement with an experienced nurse or physician, serving as a WIC peer counselor, and teaching prenatal classes.
- Certification by the IBLCE is the gold standard for working as a lactation consultant; other certifications with titles have caused confusion to the public and to employers.
- Most hospitals have lactation services. These services usually include mother–baby rounds; telephone hotline and postdischarge telephone calls; prenatal classes on breastfeeding; pump rental or sales; postpartum breastfeeding consults; and continuing education for staff.
- A hospital with 3000 births per year should have at least five full-time LC positions that can be split into part-time positions. The usual time per visit with mothers when doing daily rounds is 15 to 20 minutes. The majority of LC work time is spent in direct care of clients.
- A "prime mover" (i.e., a nursing director, administrator, or physician) who has institutional power is needed in order to develop a lactation program as well as to obtain the

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

wide support of those who have influence in deciding budget allocations.
- The role of the LC is based on an advanced practice model. Roles develop sequentially according to experience as follows: novice, advanced beginner, competent, proficient, and expert.
- A major responsibility of the LC is documentation through reports and charting. Narrative and problem-oriented charting and clinical care plans are popular methods to organize and chart clinical care. Computer skills are mandatory for getting and keeping a job.
- Ethics is a set of principles that guide human conduct. Morals are specific behaviors based on beliefs. A situation in which an individual feels compelled to make a choice between two or more actions that he or she can reasonably and morally justify, or when evidence or arguments are inconclusive is called an ethical dilemma.
- Physicians and midlevel providers such as nurse practitioners, certified nurse–midwives, and physician assistants are recognized by third-party payers as providers who can receive direct payment for their services.

Internet Resources

Breastfeeding Support Consultants Center for Lactation Education: Offers lactation courses, study modules, products, certification requirements. www.bsccenter.org

International Board for Lactation Consultant Examiners: Provides numerous documents for lactation consultants, including registry of certified lactation consultants and how to become certified. www.iblce.org

International Lactation Consultant Association (ILCA): Offers conferences, courses, professional practice documents, and the Reimbursement Tool Kit. www.ilca.org

United States ILCA: National affiliate that addresses issues important to LCs in the United States. www.uslcaonlline.org

Jones and Bartlett Publishers: Publishes books on breastfeeding. www.jbpub.com

La Leche League International: Provides publications, seminars, and answers to breastfeeding questions. www.lalecheleague.org

Medela: Offers the Insurance Reimbursement Guide. www.medela.com/NewFiles/reburstmt_pro.html

American Academy of Pediatrics: Provides reimbursement guidelines. www.aap.org/breastfeeding/PDF/coding.pdf

References

Aidam BA, Perez-Escamilla R, Lartey A. Lactation counseling increases exclusive breast-feeding rates in Ghana. *J Nutr*. 2005;135:1691–1695.

Albernaz E et al. Lactation counseling increases breast-feeding duration but not breast milk intake as measured by isotopic methods. *J Nutr*. 2003; 133:205–209.

Allied Physicians. Nurse salaries—Nursing salary surveys [Web page]. Rehoboth Beach, DE: Allied Physicians, Inc., 2006. Available at: http://www.allied-physicians.com/salary-surveys/nursing. Accessed December 3, 2008.

Aidam BA, Perez-Escamilla R, Lartey A. Lactation counseling increases exclusive breast-feeding rates in Ghana. *J Nutr*. 135:1691–1695, 2005.

Albernaz E et al. Lactation counseling increases breast-feeding duration but not breast milk intake as measured by isotopic methods. *J Nutr*. 133:205–210, 2003.

American Nurses Association (ANA). Has JCAHO eliminated care plans? *Am Nurse*. 1991; June:6.

Angeron J, Riordan J. Staffing for a lactation program. Via Christi Medical Center, Wichita, Kan. 2007, unpublished.

Arnold LDW, Blair AC. Ethical practice for lactation care providers. La Leche League, International. Unit 12: Lactation Series Two. Schaumburg, IL: La Leche League, International; 2007.

Auerbach KG. Record-keeping: making the business end of doing business work for you. *J Hum Lact*. 1995;11:220–221.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Auerbach KG, Riordan J, Gross A. The lactation consultant: an increasingly visible health care role. *Mother Baby J*. 2000;5(1):41–46.

Bailey D. ILCA: 20 years of building a profession. *J Hum Lact*. 2005;21(3):239–242.

Barros FC et al. A randomized intervention trial to increase breast-feeding prevalence in southern Brazil [in Portuguese]. *Rev Saude Publ*. 1994;28:177–183.

Benner P. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, Calif: Addison-Wesley; 1984.

Bloom I et al. Factors affecting the continuance of breastfeeding. *Acta Paediatr Scand*. 1982;300(suppl):9–14.

Bolam A et al. The effects of postnatal health education for mothers on infant care and family planning practices in Nepal: a randomized controlled trial. *Br Med J*. 1998;316:805–811.

Bonuck KA, Trombley M, Freeman K et al. Randomized controlled trial of a prenatal and postnatal lactation consultant intervention on duration and intensity of breastfeeding up to 12 months. *Pediatrics*. 2005;116:1413–1425.

Bornmann PG. A legal primer for lactation consultants. In: Walker M, ed. *Core Curriculum for Lactation Consultant Practice*. Sudbury, Mass: Jones and Bartlett; 2002:465–516.

Brent NB et al. Breast-feeding in a low-income population: program to increase incidence and duration. *Arch Pediatr Adolesc Med*. 1995;149:798–803.

Brimdyr K. Lactation management: a community of practice. In: Cadwell K, ed. *Reclaiming Breastfeeding for the United States*. Sudbury, Mass: Jones and Bartlett; 2002:51–63.

Britton C et al. Support of breastfeeding mothers (Review). *The Cochrane Collaboration*. Available at: http://www.thecochranelibrary.com. Accessed July 28, 2007.

Buppert C. *Nurse Practitioner's Business Practice and Legal Guide*. 3rd ed. Sudbury, Mass: Jones and Bartlett Publishers; 2008.

Butts J, Rich K. *Nursing ethics*. Sudbury, Mass: Jones and Bartlett Publishers; 2005.

Cary AH. *International Survey of Certified Nurses in the U.S. and Canada*. Washington, DC: Nursing Credentialing Center; 2000.

Castrucci BC, Hoover K, Lim S et al. A comparison of breastfeeding rates in an urban birth cohort among women delivering infants at hospitals that employ and do not employ lactation consultants. *J Pub Health Manage Pract*. 2006;12:577–585.

Chagnon L, Wehmeyer J. Providing comprehensive services in a hospital outpatient center. AWHONN *Lifelines*. 2004;8:336–339.

Chen C-H. Effects of home visits and telephone contacts on breastfeeding compliance in Taiwan. *Maternal Child Nurs J*. 1993;21:82–90.

Click ER. Developing a worksite lactation program. *MCN*. 2006;11:313–317.

Cohen R, Mrtek MB, Mrtek RG. Comparison of maternal absenteeism and infant illness rates among breast-feeding and formula-feeding women in two corporations. *Amer J Health Promotion*. 1995;10:148–153.

Curro V et al. Randomised controlled trial assessing the effectiveness of a booklet on the duration of breast feeding. *Arch Dis Child*. 1997;76:500–504.

de Oliveira LD, Guigliani RG, Santo LC et al. Effect of intervention to improve breastfeeding technique on the frequency of exclusive breastfeeding lactation-related problems. *J Hum Lact*. 2006;22:315–321.

de Oliveira MI. Extending breastfeeding duration through primary care: a systematic review of prenatal and postnatal intervention. *J Hum Lact*. 2001;17:326–343.

Dodgson JE, Duckett L. Breastfeeding in the workplace: building a support program for nursing mothers. *AAOHN J*. 1997;45:290–298.

Dreyfus SE, Dreyfus HO. A five-stage model of the mental activities involved in directed skill acquisition (USAF Contract No. F49620–79–C–0063) Berkeley: University of California; 1980.

Duffy EP, Percival P, Kershaw E. Positive effects of an antenatal group teaching session on postnatal nipple pain, nipple trauma and breastfeeding rates. *Midwifery*. 1997;13:189–196.

Ferrarello DP. The entrepreneurial LC: the mission and the math. Presented at: Annual Meeting and Conference of the ILCA; July 2001; Acapulco, Mexico.

Forster D et al. Two mid-pregnancy interventions to increase the initiation and duration of breastfeeding: a randomized controlled trial. *Birth*. 2004;31:176–182.

Frank DA et al. Commercial discharge packs and breast-feeding counseling effects on infant-feeding practices in a randomized trial. *Pediatrics*. 1987;80:845–854.

Froozani MD et al. Effect of breastfeeding education on the feeding pattern and health of infants in their first 4 months in the Islamic Republic of Iran. *Bull WHO*. 1999;77:381–385.

Gagnon AF et al. A randomized trial of a program of early postpartum discharge with nurse visitation. *Am J Obstet Gynecol*. 1997;176:205–211.

Gardner KL, Weinrauch D. Marketing strategies for nurse entrepreneurs. *Nurse Pract*. 1988;13:46–49.

Gibbins S et al. The role of the clinical nurse specialist/neonatal nurse practitioner in a breastfeeding clinic: a model of advanced practice. *Clin Nurse Special*. 2000;14:56–59.

Gill SL, Reifsnider E, Lucke FL. Effects of support on the initiation and duration of breastfeeding. *Western J Nurs Res*. 2007;29:708–723.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Gilligan C. In a different voice. Cambridge, Mass: Harvard University Press; 1982.

Gross LJ. Statistical report of the 2002 IBLCE examination. Available at: http://www.iblce.org. Accessed November 20, 2008.

Hafner-Eaton C. Lactation consultant reimbursement, consultation, charges/fees, and hours worked: beginning the resource-based relative value scale (RBRVS) method of reimbursement. Presented at: Annual Meeting of the International Lactation Consultant Association; July 2000; Boca Raton, Fla.

Hauch YL, Dimmock JE. Evaluation of an information booklet on breastfeeding duration: a clinical trial. *J Adv Nurs*. 1994;20:836–843.

Heinig MJ. Closet consulting and other enabling behaviors. *J Hum Lact*. 1998;14:181–182.

Hill PD. Effects of education on breastfeeding success. *Maternal Child Nurs J*. 1987;16:145–156.

Hinson P. The business of clinical practice. In: Auerbach KG, ed. *Current Issues in Clinical Lactation 2000*. Sudbury, Mass: Jones and Bartlett; 2000:43–47.

International Board of Lactation Consultant Examiners (IBLCE). Examination data. Available at: http://www.iblce.org. Accessed December, 2007.

International Board of Lactation Consultant Examiners (IBLCE). Code of Ethics. Available at: http://www.iblce.org. Accessed June 5, 2007.

International Lactation Consultant Association (ILCA). Reimbursement tool kit. Raleigh, NC: ILCA; 2002.

International Lactation Consultant Association (ILCA). Standards of practice for international board-certified lactation consultants. Raleigh, NC: ILCA; 2008.

Jakobsen MS et al. Promoting breastfeeding through health education at the time of immunizations: a randomized trial from Guinea Bissau. *Acta Paediatr*. 1999;88:741–747.

Joel LA. An epiphany in retrospect [editorial]. *Amer J Nurs*. 1997;97(11):7.

Labarere J, Gelbert-Baudino N, Ayral A et al. Efficacy of breastfeed support provided by trained clinicians during an early, routine preventive visit: a prospective, randomized open trial of 226 mother-infant pairs. *Pediatrics*. 2005;11:139–146.

Lauwers J. Mentoring and precepting lactation consultants. *J Hum Lact*. 2007;23:10–11.

List BA et al. Electronic health records in an outpatient breastfeeding medicine clinic. *J Hum Lact*. 2008;24:58–68.

Lynch SA et al. Evaluating effect of a breastfeeding consultant on the duration of breastfeeding. *Can J Public Health*. 1986;77:190–195.

Mannel R, Mannel RS. Staffing for hospital lactation programs: recommendations from a tertiary care teaching hospital. *J Hum Lact*. 2006;22:409–417.

Mattar CN et al. Simple antenatal preparation to improve breastfeeding practice: a randomized controlled trial. *Obstet Gynecol*. 2007;109:73–80.

Meier P. Letter to the editor. Concerns regarding industry-funded trials. *J Hum Lact*.

Neyzi O et al. An educational intervention on promotion of breastfeeding. *Paediatr Perinat Epidemio*. 1991;5:286–298.

Niebuhr B, Biel M. The value of specialty certification. *Nursing Outlook*. 2007;55:176–181.

Noel-Weiss J, Walters GJ. Ethics and lactation consultants: Developing knowledge, skills and tools. *J Hum Lact*. 2006;22(2):203–212.

Parris KM. Integrating nursing diagnosis, interventions, and outcomes in public health nursing practice. *Nurs Diag*. 1999;10:49–56.

Phillips V. The Nursing Mother's Association of Australia as a self-help organization. In: Katz AH, Bender EL, eds. *Helping One Another: Self-Help Groups in a Changing World*. Oakland, Calif: Third Party Publishing; 1990.

Pugh LC et al. Breastfeeding duration, costs, and benefits of a support program for low-income breastfeeding women. *Birth*. 2002;29(2):95–100.

Pugh LC, Milligan RA. Nursing intervention to increase the duration of breastfeeding. *Appl Nurs Res*. 1998;11:190–194.

Rago JL. Breast pump rental depot: a way to bridge the gap. *J Hum Lact*. 1987;3:156–157.

Raudonis BM, Anderson CM. A theoretical framework for specialty certification in nursing practice. *Nursing Outlook*. 2002;50:247–252.

Riordan J, Auerbach K. Breastfeeding and human lactation. 2nd ed. Sudbury, Mass: Jones and Bartlett; 1999.

Rossiter JC. The effect of a culture-specific education program to promote breastfeeding among Vietnamese women in Sydney. *Int J Nurs Stud*. 1994;31:369–379.

Scott J. The code of ethics from international board-certified lactation consultant: ethical practice. In: Walker M, ed. *Core Curriculum for Lactation Consultant Practice*. Sudbury, Mass: Jones and Bartlett; 2002:517–527.

Serafino-Cross P, Donovan PR. Effectiveness of professional breastfeeding home-support. *J Nutr Educ*. 1992;24:117–122.

Shrago LC. Fostering collegial relationships among lactation consultants [editorial]. *J Hum Lact*. 1995;11:1–2.

Simpson KC, Creehan, PA. *AWHONN Perinatal Nursing*. 2nd ed. Philadelphia, Pa: Lippincott; 2001.

Smillie C. A specialty practice in breastfeeding. In: Auerbach KG, ed. *Current Issues in Clinical Lactation 2000*. Sudbury, Mass: Jones and Bartlett; 2000:49–54.

Smith L. Shadowing Guidelines. Personal Communication. January 2002.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.

Susin L et al. Does parental breastfeeding knowledge increase breastfeeding rates? *Birth*. 1999;26:149–156.

Thorley V. Complementary and competing roles of volunteers and professionals in the breastfeeding field. *Int Self Help Self Care*. 2000;1(2):171–179.

Turner MR. Twenty questions for the consumer: a quality assurance tool for the lactation consultant. *J Hum Lact*. 1996;12:50–52.

Wiessinger D. Professional responsibility revisited. In: Smith L, ed. The Lactation Consultant in Private Practice. Sudbury, Mass: Jones and Bartlett; 2003:214–226.

Williams EL. Increasing your credibility with physicians: strategies for lactation consultants [editorial]. *J Hum Lact*. 1995;11:3–4.

Wilson-Clay B. Lactation consultants: are we a profession yet? In: Auerbach K, ed. *Clinical Issues in Clinical Lactation*. Sudbury, Mass: Jones and Bartlett; 2000:57–72.

Woolf V. *A room of one's own*. New York, NY: Harcourt, Brace and World; 1929.

© Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION.