When Doctors Failed Her

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Introduction

In a foreword to a book on breastfeeding, Dr D. K. Tank, former President of the Federation of Obstetric and Gynaecological Societies of India, stresses the need for promotion of breastfeeding at an individual level. He emphasises, that though breastfeeding comes naturally to most mothers, it needs to be nurtured in others. Accurate information and thoughtful suggestions over a period of time should be provided to the mother (Tank 1998).

Successful efforts were made during Dr. Tank's term as President to promote breastfeeding. However, the following letter dated May 4, 1999 from a breastfeeding mother to the author indicates that we may still be lagging behind in supporting such mothers. In this article, an effort is made to discuss how we could have helped her better.

Letter from the mother (May 4, 1999)

"I work as a Medical Officer in Delhi. I have a one and a half month old baby boy. During my third trimester we browsed through a lot of books on child care and decided to buy the 'Penguin India Guide'. I decided to exclusively breastfeed my baby.

After two three days, I experienced soreness in my nipples. I continued to feed him and resisted everyone's suggestions to apply ghee, coconut oil or massage cream. The soreness worsened. I developed cracks and by the end of the week, both nipples were badly ulcerated. The pain was unbearable. I decided to express the milk and feed him with a paladai (Fig. 1). He took to the Paladi very well but he was never satisfied. He would keep crying and refuse to sleep. I did not want to start him on top feed. Everyone who came to see him - the neighbours and maid servant would accusingly comment that the

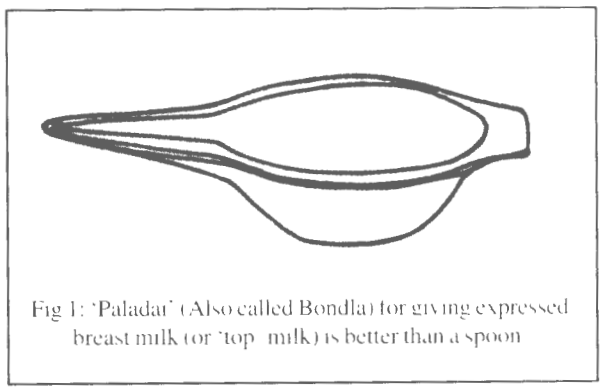

Fig 1: 'Paladai' (Also called Bondla) for giving expressed breast milk (or 'top' milk) is better than a spoon

baby was being starved and he should be given top milk.

At the end of the second week, I consulted a gynaecologist, who put me on an antibiotic ointment and pain - killers and advised me to use nipple shield. I did that. Even this was not totally painless. The baby seemed to be okay for a couple of days. Then he started the same routine of crying and not sleeping. He would take a feed, and demand one within half to one hour. He would take one hour over the feed, apparently sleeping but waking up each time he was removed.

Unable to take it after one very severe bout of crying, we consulted his paediatrician who asked me to discontinue the nipple shield and start him on top feed with a cup and spoon. For the next 10 days, we put him on toned milk and fed him with a cup and spoon. I kept expressing my breasts regularly and we used this milk too. It was an

exhausting and frustrating time for me as he would have to be fed by my mother while I stood with a cup in my hand busy expressing. If I did not, at the sound of his cry, there would be a continuous dripping and I would get drenched in milk. His hunger seemed to be satisfied. In fact he would not stop feeding till he fell asleep. He would sleep for half an hour and then get up after wetting himself or bringing out the milk. And he would be extremely irritable. Many times we had to feed him again within an hour or so to get him back to sleep.

In the meantime, my ulcers had begun to heal. I put him gradually back to the breast. But the pain reappeared after a couple of feeds and started worsening. I continued in this state for about four days. I started dreading feed times and the torture that I would have to endure. And one day I gave up. I slept through the night without expressing and woke up with extremely engorged breasts and had a spike of fever. I consulted a gynaecologist who put me on antibiotics, another application of an ointment and pain-killers. The baby was back on top feed. My expressed milk had to be discarded as the ointment was supposed to be absorbed in. She told me to try feeding him after four to five days. Otherwise she said that she would give me something to stop the milk flow and the baby would continue on top feed. I followed the advice but was unsure if it would work. I was very upset and tense about the possibility of not being able to breastfeed my baby. The only source of comfort I found was the book The Penguin India Guide to Child Care, mentioned earlier. It helped me to keep up my conviction and desire to breastfeed. It gave me the courage to try again.

I tried again very tentatively and with a great deal of hesitation. It was uncomfortable but not painful. The pain kept reducing with each successive feed. I could finally wean myself off all those pain-killers I had been taking for the last month. Even now the pain is not all gone, but I am now exclusively breastfeeding him. He is much more relaxed and happy. He seems to be getting enough as he passes frequent light coloured urine.

My own guess why all this happened is that he must have initially been wrongly positioned. I have flat though protractile nipples and it is even now sometimes difficult to position him right. Having failed to empty the breast in a nipple-feeding position, he (the baby) must have left it in a semi-engorged state. A vicious cycle thus got set up, the engorged breasts being more difficult for the baby to suckle".

Discussion

It goes to the credit of the doctors that they did encourage the mother to continue breastfeeding as far as possible. Also, breastfeeding was initiated within half an hour of

Box-1

Doctor's Missed Opportunities

Following are the possible reasons for problems with breastfeeding when a doctor and his/her team fail to help the mother :

Likely reasons in the case under discussion

1. Wrong management of sore nipples, specially failure to help the baby suckle in correct position.
2. Putting doubts in the mother's mind that she was not producing enough milk.
3. Failure to realise that crying may not be due to hunger. Colic, for instance, is an important cause of discomfort and crying.
4. Lack of antenatal preparation for breastfeeding.
5. Lack of training of health workers in counselling a breastfeeding mother.

Other possible reasons

6. Delayed first breastfeed and introduction of prelacteal feeds.
7. Indiscriminate overdoping of mother with sedatives, analgesics and anaesthetics prior to delivery.
8. Keeping a normal newborn in the nursery and not with the mother.
9. Failure to routinely teach manual hand expression of breastmilk to the mother and preventing engorgement.
10. Failure to tell the mother that loose motions in an exclusively breastfed child who is passing normal urine does not need medication, nor change of milk.

birth. The good response of the newborn shows that the obstetrician had not overdoped the mother.

Let us now discuss why breastfeeding problems might have haunted this particular mother (Also see Box - 1).

Wrong management of sore nipples

Slight tenderness of the nipples, when a woman begins to breastfeed, is quite normal in the first two or three days after delivery. However, sore nipple can be extremely painful. The mother under discussion has visibly described her agony. If she would have been guided by the medical staff to correctly position her baby on the breast, she might not have developed sore nipples in the first place. When she did have them, breastfeeding should have been continued while the mother is helped to properly position her baby on the breast. Nipple shield should not have been used. The nipple should have been exposed to air (and also to sun if possible) and instead of any ointment or cream, a drop of hind-milk expressed from the breast should have been applied to the cracked nipples. In this way, the soreness usually settles down within a few days. If the soreness persists or it suddenly appears after a week or two of delivery, it is mostly due to a fungus infection. In that case, the area around the nipple feels itchy and the pain seems to shoot down into the breast. The baby may also have thrush inside the mouth. While the fungus infection is treated, breastfeeding is continued.

Failure to help the baby suckle in correct position

Early soreness of nipple is always due to improper positioning of the baby on the breast. The baby should be helped to 'breastfeed' and not 'nipple feed'. It seems that the doctor as well as the nurses did not help this mother to position the baby properly on the breast. The medical staff, as a routine policy, must find time to see that the mother was positioning the baby on the breast properly.

For effective transfer of milk from the breast to the baby's mouth, the mother should be guided as given below.

Guiding mother for correct positioning of the baby on the breast.

"You can choose a sitting or a lying position. Lift your breast with the palm. Touch the nipple of the breast to the baby's lips. Wait for the baby to open the mouth wide. If the baby opens the mouth a little, do not offer the breast and the nipple. As soon as the mouth opens wide and the baby shows interest in feeding, quickly move him/her on to the breast".

- "To know that your baby is positioned properly at the breast, check the following points (Fig. 2).
- Your baby's entire body including the neck, shoulder and abdomen should be facing you and close to your body. His/her chin should touch the breast.
- The mouth should be wide open with enough areola into the baby's mouth. The lips of the baby should be curled outwards.
- You should not feel nipple pain while suckling".

Flat or small but protractile nippls are normal. The mother under discussion rightly observes "Having failed to empty the breast in a nipple feeding position, he (the baby) must have left it in a semi-engorged state. A vicious cycle thus got set up, the engorged breast being more difficult for the baby to suckle".

Putting doubts in the mother's mind that she was not producing enough milk.

As doubt was put in the mother's mind that she was not producing enough milk for her baby, the 'oxytocin reflex' (also called the 'let-down' or 'ejection reflex) was probably hindered. In such a case, enough milk could be there in the alveoli of the mother's breasts but her anxiety stops the milk from flowing. This particular mother fortunately knew that an exclusively breastfed baby who was mostly passing a light-coloured urine, was getting

Fig 2. Suckling in good position. Baby is unwrapped, is close to the mother, chin touches the breast, mouth is wide open, lips are everted and much of the areola is in the mouth. Baby takes slow deep sucks and causes no pain to the mother (Courtesy, F. Savage King)

enough breastmilk. An occasional passage of dark urine can be ignored. However, in the first few days at the hospital after delivery, the frequency of urine may be less, as the colostrum has less amount of water in it. Also, if the baby is kept wrapped up all the time, he/she may sweat and thus pass less urine.

Failing to realise that crying is not necessarily due to hunger.

Colic in the first three to four months of life is a common cause of crying and irritability in a baby. These babies may suckle frequently for comfort. Besides other management, dicyclomine can give dramatic relief to such babies.

Did this particular baby in question need top milk? The mother says "At the sound of his (babies) cry, there would be a continous dripping and I would get drenched in milk". This shows that the mother was having more than enough milk. Even then the baby was prescribed top feed. Mercifully, it was not given with a bottle. Otherwise the baby would have got used to bottle-feeding and going back to breastfeeding then could have been difficult, if not impossible. Incidentally, it is much more convenient to give expressed breastmilk (or top milk) directly with a small glass or a paladai (Fig. 1) than a spoon. Even prematures can learn direct feeding from a glass or a paladai quite soon without any danger of aspiration. Switching to breastfeeding in such babies is easy

Lack of antenatal preparation for breastfeeding

The mother being referred to here was able to persist with breastfeeding because of her own motivation and assistance from the book on child care. However, it seems that she did not get antenatal advice from her doctor(s). According to the International Federation of Gynaecology and Obstetrics, information on breastfeeding should be given to mothers and families as part of all pregnancy related services (1982). Are such recommendations followed in practice ? We studied and found that in 1982, one mother out of hundred in Mumbai (Bombay) was given prenatal advice on breastfeeding compared to five in 1986 (Anand, 1987) and thirty four out of hundred in 1996 (unpublished data). In another study, only 51% carried out antenatal breast examination (Anand et al, 1989). Dalal et al (1992) have documented the role of single antenatal breast examination and advice in establishment of successful lactation.

Most public hospitals run regular antenatal clinics. In some of these, the breast of the mother is examined and she is motivated in advance for breastfeeding. Unfortunately it is not done routinely in all hospitals. Some of the private hospitals do not have such antenatal clinics. The mothers who deliver in these private hospitals see their doctor for regular check-ups. In such a setting, many hospitals have found it helpful to give a question answer booklet on breastfeeding costing only Rs. 5/- to the mothers when they register for delivery in that hospital. This is available from the Association for Consumers Action on Safety and Health (ACASH, Box 2498, Mumbai-400 002). The obstetrician motivates the mother to read this booklet which answers most of the questions related to successful breastfeeding. Mothers who come directly for delivery are given this booklet in Hindi, Marathi or English in the maternity wards.

Lack of training of health workers in counselling a breastfeeding mother.

It is obvious that this mother did not get the required support from the health workers. In a study, mentioned earlier (Anand et al, 1989), there was no training programme in place in the maternity homes to train health workers in the skills of counselling a breastfeeding mother. It is suggested that the maternity homes get in touch with the Breastfeeding Promotion Network of India (BPNI, BP33, Pitampura, Delhi 110034) or the Association for Consumers Action on Safety and Health to organise such a training programme for them.

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