



SECTION ONE

Historical and Work Perspectives

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Historically, breastfeeding practices have been deeply tied to family and community culture. Likewise, the success of breastfeeding is dependent on the many spheres of support that surround the breastfeeding dyad. Support should be personal and tangible including support from family members, friends, religious or spiritual communities, employers, and health care providers. Intangible support is also necessary and provides the scaffolding for tangible support to occur. Examples of intangible support include institutional policies and laws that protect the right to breastfeed in public, provide paid leave for families to establish and maintain breastfeeding, and ensure access to health care and lactation support. When tangible and intangible breastfeeding support is not optimal families have an uphill battle in meeting their breastfeeding goals.

Research has consistently demonstrated that lactation consultant services can lengthen the duration of breastfeeding and result in healthier mothers and babies. The visibility and acceptance of lactation consulting as an interdisciplinary allied health profession offers opportunities for practice in hospitals, the community, private practice, and public health.

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CHAPTER 1

The International Board Certified Lactation Consultant^{®1} (IBCLC[®]) and the Healthcare Team

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Breastfeeding and lactation support have always been a part of the human experience. For centuries, breastfeeding (or the companion activities of cross- or shared feeding, or collection and use of human milk) were the only reliable means to feed and nurture offspring, and communities came together to make sure babies were fed and cared for if the parents were not able to do so. Humans showed other humans how to breastfeed—just as they shared wisdom about hunting, growing, or gathering food for the rest of the group. The need for support and encouragement has always been there. Breastfeeding and human milk use is the biologic, mammalian norm.

In the modern era, lactation support continues within families and communities, but it has also

assumed a more formalized role in the healthcare system. The International Board Certified Lactation Consultant (IBCLC) is an allied healthcare provider: a clinical specialist trained to focus on the needs and concerns of the breastfeeding parent–baby pair, whose role is to prevent, recognize, and solve lactation and breastfeeding difficulties (International Board of Lactation Consultant Examiners [IBLCE], 2018e). Primary healthcare providers (licensed caregivers, or registered caregivers, as some countries designate them, such as physicians, midwives, and nurses) may seek additional training to boost their lactation knowledge when caring for their patients, although lactation support will be only one part of their focus of care. Other lactation support providers receive training to provide

¹ International Board Certified Lactation Consultant[®] and its acronym IBCLC[®] are certification marks (a type of trademark) owned by the International Board of Lactation Consultant Examiners[®] (IBLCE[®]). The IBLCE has exclusive rights to award the IBCLC credential to individuals who have met all requirements for the certification (specified didactic and clinical training, and successful completion of the IBCLC certification exam conducted internationally, twice yearly). For ease in reading, the registration symbol (“[®]”) will be omitted from subsequent references in this chapter.

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generalized counseling and education on breastfeeding, often working in the community in nonclinical settings, after the parents and newborn are discharged from the birthing facility. This hybrid model of support and care (part family/community based, part healthcare based) arose when families began to be routinely separated from their children during the workday (starting in the early 20th century), making it difficult for babies to be routinely fed at the breast throughout the day for months and years as their ancestors were (Papastavrou et al., 2015).

As breastfeeding initiation and duration rates waned and routine knowledge of breastfeeding management was lost, the need for organizations of support volunteers and healthcare professionals to fill the gap in care at both the lay and the skilled clinical care levels became apparent. Today, not every family needs the specialized care an IBCLC can offer; indeed, many families will find all the help they need with simple parent-to-parent advice or care from counselors trained in breastfeeding support. But the current-day rise in chronic adult disease rates, alongside improved survival rates for infants born extremely early or at extremely low weights, highlights that breastfeeding and human milk use are now also a public health imperative (Victora et al., 2016). Modern healthcare systems should include equitable access to IBCLC care so that families can meet their infant feeding goals (and the universal public health goal of healthier populations) (Anstey et al., 2016).

This chapter specifically explores how the IBCLC works within the healthcare team. It discusses the IBCLC's role of offering skilled clinical care prenatally in hospital/birth center settings and in the community for the family who is discharged home with their new baby. There is general discussion of guidance for all persons offering breastfeeding and human lactation support, whether as peers or professionals, paid or volunteer. Although the term *lactation consultant* is often used to describe the person who holds the IBCLC credential, that term is generic, meaning that anyone may use it to describe her services. It is important for IBCLCs to describe themselves and their services using the full title or acronym in its entirety. Only a currently registered IBCLC may use that designation (IBLCE, 2015a).

► History

A family today has many options for in-person and online breastfeeding help. Requirements to complete various lactation consultant and breastfeeding support educational programs vary widely, and change

with enough frequency that one reliable source to compare qualifications is not readily available. Some providers specialize in other care that might also include breastfeeding (dietitians, childbirth educators, doulas). Trusted, licensed (or registered) primary healthcare providers (physicians, nurses, midwives, etc.) giving overall care may not have received any specific training or education in breastfeeding and lactation, either in school or in practice. All these caregivers legitimately can help with lactation, but they may come to the field with anywhere from a few hours to many years of preparation. Also, not all types of providers are accessible in all communities. The choices can be confusing and overwhelming, especially for the new parent who seeks knowledgeable support in the stressful early days—adjusting to life with a baby who requires around-the-clock feeding and nurturing—to sustain a long-term breastfeeding relationship.

The IBCLC credential was launched in 1985 with the creation of the International Board of Lactation Consultant Examiners (IBLCE), the certification organization, and the International Lactation Consultant Association (ILCA), the professional association (IBLCE, 2018c; Lauwers, 2005). In 2008, the Lactation Education Approval and Accreditation Review Committee (LEAARC) was formed from earlier committees within the IBLCE and the ILCA to be a stand-alone organization responsible for establishing standards for, and recognizing quality in, lactation education worldwide (LEAARC, 2018).

The IBLCE's role is to administer the IBCLC certification exam, award the IBCLC credential to those who pass the exam, and protect the public health, safety, and welfare through disciplinary procedures for IBCLCs. Three pathways are available for candidates who seek to become IBCLC certified. In 2018, there were 30,000 IBCLCs in 108 countries (IBLCE, 2018b).

The ILCA is a voluntary international professional membership association. It is open to anyone worldwide who supports and promotes breastfeeding, although ILCA membership is primarily composed of IBCLCs. The ILCA offers continuing education and professional development opportunities, promotes the lactation consulting profession to the public, engages in international policy making as a nongovernmental organization (NGO, with recognized status at the World Health Organization), and publishes the *Journal of Human Lactation*, a peer-reviewed scientific journal.

The LEAARC's focus is on assessing education and training opportunities, and it provides the following:

- *Recognition* of individual short-term courses and classes (40–89 hours) on breastfeeding counseling

and *recognition* of clinical mentors who provide a minimum of 100 hours of supervised clinical experience for students seeking to become IBCLCs.

- *Approval* of lactation management courses (90 hours or more) that provide didactic instruction (and sometimes clinical training) for students seeking to become an IBCLC. It also offers *approval* to clinical internship programs that provide 500 hours or more of supervised clinical experience for students seeking to become IBCLCs.
- *Recommendations* to the Commission on Accreditation of Allied Health Education Programs (CAAHEP) for their accreditation of lactation-specific academic programs at institutions of higher education, where comprehensive Pathway 2 programs are offered (LEAARC, 2018). Because the IBCLC certification is relatively new, lactation-specific academic programs with approved curricula offered by independently accredited institutions of higher education are not yet widely available. As of 2018, six programs were CAAHEP accredited—all based in the United States (CAAHEP, n.d.).

► Do IBCLCs Make a Difference?

IBCLC services augment those of other healthcare workers. IBCLCs are allied healthcare providers who collaborate with, and complement, the clinical care by the primary healthcare provider (HCP) (IBLCE, 2012c, 2015, 2017). IBCLCs work in many settings—hospitals, birthing centers, clinics, private medical practices, community/public health departments, home health agencies, settings for research or academia—and in private practice. IBCLC care positively impacts breastfeeding outcomes. A 2015 meta-analysis of 30 research papers concluded that “breastfeeding support interventions using these professionals [IBCLCs and lactation counselors] increased the number of women initiating breastfeeding, improved any breastfeeding rates, and improved exclusive breastfeeding rates” (Patel & Patel, 2015, pp. 533, 535). Breastfeeding rates that meet the recommendations for initiation, duration, and exclusivity are calculated to save hundreds of babies’ and mothers’ lives, reducing disparities in health outcomes for families of color in the United States and saving billions of dollars in healthcare costs (Bartick et al., 2013; Bartick, Jegier, et al., 2017; Bartick & Reinhold, 2010; Bartick, Schwarz, et al., 2017).

Beyond offering in-person care to breastfeeding families, IBCLCs are interdisciplinary advocates,

experts, and collaborators whose expertise improves breastfeeding outcomes, reduces healthcare costs, improves patient/client satisfaction, and improves health outcomes (Henderson, 2011). The IBCLC has nine roles:

1. Advocate (for breastfeeding families)
2. Clinical expert (in lactation management)
3. Collaborator (IBCLCs have a professional ethical mandate to provide unified and comprehensive care as a member of the healthcare team) (IBLCE, 2015a)
4. Educator (to empower families; to educate healthcare providers and systems)
5. Facilitator (to help families reach their infant feeding goals)
6. Investigator (conducting research)
7. Policy consultant (breastfeeding and human milk use are a public health imperative)
8. Professional (an HCP who straddles generalized support for breastfeeding and allied health care)
9. Promoter (of evidence-informed practice and breastfeeding support for families; for public health policies that protect breastfeeding families) (Henderson, 2011)

► Pathways to Become Certified as an IBCLC

Drawing on its history as a profession born of a collaborative effort between volunteer parent/family support organizations and the preexisting medical professions working with children and families, IBLCE certification today is obtained using one of three *pathways*. Any person on any pathway seeking certification as an IBCLC must complete certain prerequisites: about 2 years’ worth of college-level coursework in general health sciences education and 90 hours of education specific to breastfeeding and lactation. Last, the IBLCE requires a considerable number of clinical hours in direct care of the breastfeeding dyad: 1000 “appropriately supervised” clinical hours in Pathway 1 (the route customarily used by preexisting licensed healthcare providers and those from specifically recognized breastfeeding peer support organizations); 300 “directly supervised” hours under specifically recognized Pathway 2 academic programs (that offer all didactic and clinical training from one source and where supervision must come from a currently certified IBCLC); and 500 clinical hours “directly supervised” by a currently certified IBCLC under

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Pathway 3 individualized and preapproved mentorship arrangements (IBLCE, 2018c).

Pathway discernment can be a source of confusion for those first seeking information about the IBCLC certification. Let us imagine people with different backgrounds who might want to become IBCLCs and walk through the three pathway options:

1. An already licensed/registered healthcare provider (MD, RN, RD, etc.) who cares for expectant or new families wishes to become certified to expand her ability to provide medically accurate breastfeeding support. Pathway 1 is her best route. Her earlier academic training will have covered the required topics in **health sciences education**. She will need to acquire 90 hours of **lactation-specific education**, obtained within the last 5 years, often at professional educational conferences or from a LEAARC-approved course. Last, she will need to show a minimum of **1000 hours of lactation-specific clinical practice** within the 5 years immediately preceding exam application. HCPs already working in maternal-child healthcare settings will have ample opportunity to acquire the clinical hours.
2. A parent-to-parent breastfeeding counselor who is part of an IBLCE Recognised Breastfeeding Support Counsellor Organisation (IBLCE, 2018a) wishes to become certified to expand her ability to provide quality breastfeeding support. Pathway 1 is her best route. She will need to demonstrate that she has academic training for the required topics in **health sciences education**. Her earlier education may have covered these topics, or she may now need to take classes. She will need to acquire 90 hours of **lactation-specific education**, obtained within the last 5 years, often at professional educational conferences or from a LEAARC-approved course. Last, she will need to show a minimum of **1000 hours of lactation-specific clinical practice** within the 5 years immediately preceding exam application. Counselors working in support organizations (whether as volunteers or in paid positions) will have ample opportunity to acquire the clinical hours.
3. A community advocate who does not have a healthcare-related degree wishes to become an IBCLC and open a private practice that provides evidence-informed clinical care, along with classes and informal meet-ups for breastfeeding families in the community. The advocate can use Pathway 2 to apply to a CAAHEP-accredited lactation education program at the local university. “These comprehensive lactation academic programmes are university or college-based, include both didactic and clinical components and require **health sciences education**, whether as a prerequisite or as education which must be earned concurrently, prior to completion of the academic programme” (IBLCE, 2018a, p. 8). All **300 clinical practice hours** are under the direct supervision of an IBCLC and are readily obtained through the Pathway 2 program. A total of 90 hours of **lactation-specific education** will be needed (perhaps offered with the Pathway 2 curriculum or perhaps obtained elsewhere). At the end of the program, the candidate will have met all requirements to sit for the IBLCE exam.
4. A new parent struggled with her own lactation experience at the start but found great help both from the breastfeeding peer support counselor and from the IBCLC who assessed a feed-at-breast and developed a care plan for slow weight gain. The parent would like to join the profession now and help others. Pathway 3 provides an opportunity to use an individually crafted mentor-led teaching and training regimen. “Pathway 3 mentorship is a structured, defined relationship between an applicant and IBCLC(s) which must be preapproved” by the IBLCE before any clinical training hours are commenced (IBLCE, 2018a, p. 9). **Health sciences education** must be demonstrated, as well as 90 hours of **lactation-specific education**, in addition to **500 hours of clinical practice**, in order to sit for the exam. Clinical training must be directly supervised by an IBCLC, but several mentors (identified earlier in the approved Pathway 3 plan) can fulfill this role. Pathway 3 candidates who are not already working in the healthcare system may find it challenging to locate sites that will allow them to do their clinical training work if not also an employee. In 2018, the LEAARC implemented recognition of Pathway 3 clinical internship programs and clinical mentors who provide

a minimum of 100 hours of supervised clinical experience for students seeking to become IBCLCs. Any Pathway 3 mentor can be helpful in finding the candidate clinical opportunities in varied settings offering lactation care.

For specific criteria on qualifying under the IBLCE pathways, see the resources at the IBLCE website (IBCLE, 2018d) and the Candidate Information Guide (IBLCE, 2018a).

► Formal and Continuing Education Programs for IBCLCs and Lactation Support Providers

Lactation education programs are widely available all over the world. Although having LEAARC review the instruction and business standards of lactation/breastfeeding courses and clinical internships is voluntary, LEAARC endorsement is an indicator that a student will receive appropriate instruction on all topics covered in the IBLCE's Detailed Content Outline for the IBCLC exam.

Because the IBCLC certification is relatively new, formalized lactation education programs with approved curricula offered by independently accredited institutions of higher education are not yet widely available. As described earlier, the LEAARC provides an important vetting process for educational programs through *recognition* of 40- to 89-hour courses and clinical mentors who provide a minimum of 100 hours of supervised clinical experience; *approval* of 90+ hours lactation management courses (with didactic and/or clinical components) and internship programs with 500+ hours of clinical training; and *recommendations* to the CAAHEP for accreditation of lactation education programs affiliated with accredited academic institutions (to fully prepare students for the IBCLC certification exam) (LEAARC, 2018). As of 2018, six programs were CAAHEP accredited, all based in the United States (CAAHEP, n.d.). A list of all programs endorsed and accredited by the LEAARC can be found at www.leaarc.org. After initial certification by the IBLCE, the IBCLC is required to demonstrate continued professional and clinical skill every 5 years. Although one can simply retake the IBCLC exam to maintain certification, many choose instead to acquire 75 Continuing Education Recognition Points

(CERPs), which represent roughly 15 hours per year for continuing education. CERPs-eligible teaching is offered in countless settings; customarily, HCPs attend live educational conferences or sign up for live or recorded webinars. Academic peer-reviewed journals provide CERPs-earning independent study module submissions. One can earn CERPs by providing breastfeeding teaching at educational venues and professional gatherings, by helping write questions or providing photos for use in future IBCLC exams, and by completing some mandatory workplace trainings (e.g., CPR courses, patient/client privacy and confidentiality). The IBLCE is responsible for awarding CERPs approval for educational opportunities offered by long-term and short-term providers (IBLCE, 2018f). The IBLCE awards CERPs for education provided by programs reviewed and endorsed by the LEAARC, and it also awards CERPs to anyone who meets the requirements for offering continuing education.

► Practice-Guiding Documents

The IBLCE has published professional standards and advisory opinions outlining the professional behaviors that all IBCLCs must follow. All IBLCE documents may be viewed and downloaded at www.iblce.org/resources/professional-standards.

1. IBLCE *Code of Professional Conduct for IBCLCs*
2. IBLCE *Disciplinary Procedures for the Code of Professional Conduct for IBCLCs for the International Board of Lactation Consultant Examiners*
3. IBLCE *Scope of Practice for International Board Certified Lactation Consultant (IBCLC) Certificants*
4. IBLCE *Clinical Competencies for the Practice of International Board Certified Lactation Consultants (IBCLCs)*
5. IBLCE *Documentation Guidelines*
6. *International Code of Marketing of Breastmilk Substitutes* (International Code) and subsequent relevant World Health Assembly resolutions. The International Code is an international health policy framework for breastfeeding promotion adopted by the World Health Assembly, the decision-making body of the World Health Organization (WHO), in 1981. The International Code is a mandatory document if it has been enacted into law by the country where

the IBCLC practices or if the IBCLC works in a facility officially designated by the WHO/UNICEF as Baby-Friendly. Otherwise, the International Code is considered a discretionary, best practices, or model document, and any IBCLC and healthcare worker can choose to follow the International Code as though it were required by law. Three advisory opinions from IBLCE are: *Frenulotomy* (IBLCE, 2013); *Professionalism in the Social Media Age* (IBLCE, 2015b); and *Assessment, Diagnosis, and Referral* (IBLCE, 2017).

Workplace policies and procedures specific to the place of employment are important practice-guiding documents for the practitioner. Generally, a workplace-established policy or procedure is mandatory for employees within that work setting. It is a condition of employment to follow the employer's policies and procedures. When conflicts arise between the employer's policy and the profession's practice-guiding documents, the employer's policy must be respected as the greater authority until and unless it is changed to better encompass the clinical role of IBCLCs and other lactation care providers.

The ILCA has published position papers, clinical guidelines, and tools that can be used to support IBCLCs in clinical practice. These documents may be purchased and downloaded at www.ilca.org/learning/resources:

1. ILCA *Standards of Practice for International Board Certified Lactation Consultants (IBCLCs)*
2. ILCA *Position Paper on the Role and Impact of the IBCLC*

► Ethics

Ethical decisions are a routine, inherent part of lactation practice. The IBLCE Code of Professional Conduct is an ethical code built on the premise that having required minimum standards of acceptable conduct is in the best interests of the IBCLC profession and serves to protect the health, welfare, and safety of the public. IBCLC certificants agree to abide by these principles and are subject to disciplinary action for failure to do so (IBLCE, 2016).

Different personalities, ethical obligations, and value systems may come into play in the IBCLC's practice, complicating judgment or limiting neutrality. Many times there is no clear right or wrong course of action in trying to resolve ethical dilemmas. Moral dilemmas and ethical issues can be subtle and

complex and are intertwined in some situations. Often they entail simply a feeling that something is not quite right about a situation, and this uneasy feeling lasts for a long time. Sometimes the IBCLC will not be able to change the outcome of the situation at hand but can initiate a review of policy and procedure to form better options for future families (and colleagues). Most hospitals and large clinics have an ethics or risk assessment committee to help sort out these issues.

► Legal Issues

As credentialed allied healthcare providers, IBCLCs will take care to use best practices in clinical care, to abide by the ethical rules of their profession, to stay within their scope of practice and clinical competencies as lactation professionals, and to follow the legal requirements of the workplace setting. Although no caregiver is immune from litigation (even excellent clinicians can be named in a specious lawsuit), excellence in professional practice is the best way to reduce such risks (Miller, 2006).

Whether the person offering lactation care is a volunteer or paid healthcare provider, each support role will have official requirements for professionalism that are rooted in law and ethics. Parameters for professionalism are not a function of whether one is paid to provide help; they stem from the role one assumes when offering help to a lactating parent. Typically, they include the following:

- An ethical or professional code of conduct that defines ethics requirements for the lactation support provider
- A scope of practice or a clinical competencies description that defines the specific areas in which the person is trained to offer skilled help
- Laws and regulations covering workplace setting behaviors (ranging from broad-reaching laws of national, provincial, or state governments, to policies and procedures that are applicable to only one workplace)

Many IBCLCs acquire certification after obtaining licensure or registration as another kind of healthcare provider (doctor, nurse, midwife, dietitian, etc.) and thus have guidance from within those other professions. Most healthcare professions have guideposts to impart the best professional practices. IBCLCs with multiple designations may have overlapping, but different, ethical and legal responsibilities. An IBCLC who wears a few "hats" (imagine an RN, IBCLC) and is in a work setting intended only for the provision of breastfeeding and lactation care should be cautious to

avoid sliding into wearing the “other hat,” practicing within the second scope of practice or clinical competencies. Assuming the second role (by using those clinical skills in patient/client care) means that one also assumes the obligations and liabilities of that role (Brooks, 2013; IBLCE, 2017).

► Avoid Civil Liability

Healthcare providers have a greater fear of medical malpractice lawsuits than actually results in litigation (Carrier et al., 2010). And yet the manner of care is altered by the misperception. Lactation support providers can use some commonsense precautions to avoid the risk:

- Carry professional liability (or malpractice) insurance, covering all practice settings. If named in a suit, the insurance provides legal counsel and advice.
- Keep up to date on new research findings and clinical practices. Read current relevant articles, network with respected colleagues, and attend live or online conferences.
- Use parent-centered care with all patients/clients, meeting each person’s needs and supporting his or her choice after the family has been offered evidence-based information and consultation. People tend to sue healthcare providers when they feel they were not treated with respect and dignity or were not provided with enough information to make an informed decision.
- Thorough documentation, as close to the time of the intervention/assessment as possible, will verify your excellence in care. Document development of the care plan, suggested interventions, and the rationale for doing so. Methodically record updates and revisions to the plan based on follow-up contacts (often made by phone). The IBLCE offers guidelines for IBCLCs in basic charting requirements (IBLCE, 2012b).
- Refer to someone else if the situation calls for expertise, diagnosis, or prescriptions that are beyond the scope of practice for the IBCLC. The IBLCE offers guidance for staying within the IBCLC’s clinical competencies and scope of practice while collaborating with the primary healthcare providers to meet patient/client needs (IBLCE, 2017).

► Confidentiality

Maintaining confidentiality and protecting the privacy of the parent, baby, and family is a primary

healthcare provider responsibility. It is part of the IBCLC’s ethics code (on professional conduct), clinical competencies, and scope of practice (IBLCE, 2012a, 2012c, 2015) and is identified by the professional association as a standard of best practices (ILCA, 2013). Privacy obligations may also be imposed by law in the practitioner’s geopolitical region, such as the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the subsequent requirements under the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act. The regulations are very clear: Protect the privacy and security of the patient/client (Health Insurance Portability and Accountability Act, 2002; U.S. Department of Health and Human Services [USDHHS], 2013).

Other areas of legal responsibility can apply to lactation care providers (i.e., respect for intellectual property laws, such as copyright), but day-to-day care will always intersect with a need to respect privacy and confidentiality and to use best practices that avoid liability. Mastering skills and professionalism in these areas will serve any lactation support provider well (Brooks, 2013).

► Hospital Lactation Services

The need for skilled lactation support in the hospital during the perinatal period and for any other hospital admission of a breastfeeding parent or child has been recognized by many healthcare organizations, including the WHO (2003), the USDHHS (2011), the European Union (EU Project on Promotion of Breastfeeding in Europe, 2008), and the Australian Health Ministers’ Conference (2009).

Only a small number of hospitals in the United States had a lactation program in the early 1990s, but over the past 3 decades, these programs have proliferated rapidly (Centers for Disease Control and Prevention [CDC], 2015). Today, more than 70% of U.S. hospitals and birth centers have lactation services staffed by IBCLCs or other certified lactation specialists, who have thus grown in number and visibility (**FIGURE 1-1**). Although some lactation expertise has long been integrated into midwifery practice in countries where midwives predominate, IBCLCs are now available in hospitals in many countries, including Australia (Lactation Consultants of Australia and New Zealand, 2018), European Union countries (European Lactation Consultants Alliance, 2017), Korea (Chung et al., 2013), Japan (Awano & Shimada, 2010), China (Shanghai Yuren, 2016), and Mexico (ACCLAM, n.d.).

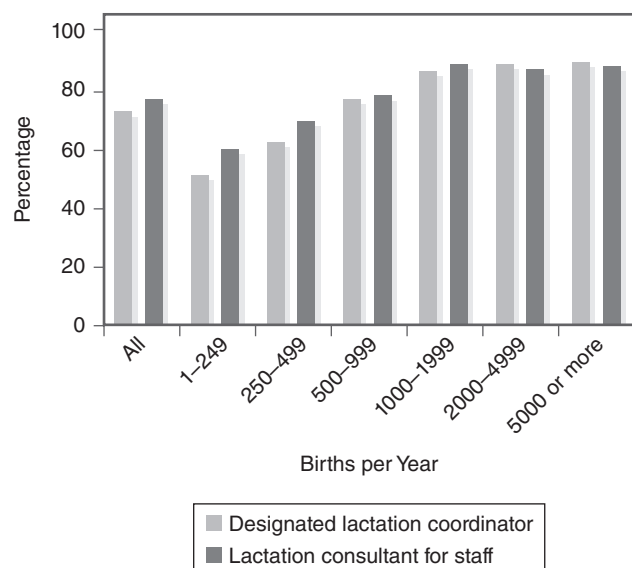


FIGURE 1-1 CDC 2015 mPINC Survey Results: Lactation Programs.

Reproduced from Centers for Disease Control and Prevention. CDC national survey of maternity practices in infant nutrition and care (mPINC), 2015. Available at: https://www.cdc.gov/breastfeeding/data/mpinc/pdf/mPINC-2015_survey.pdf. Accessed October 11, 2018.

Developing a Hospital Lactation Service

Providing quality lactation and breastfeeding care is an essential part of a hospital's maternal–newborn service. The Baby-Friendly Hospital Initiative (BFHI) provides the evidence-based guidelines for optimal hospital care (WHO, 1998, 2018), and Baby-Friendly designated hospitals demonstrate improved breastfeeding outcomes across all racial and ethnic groups (DiGirolamo et al., 2008; Pérez-Escamilla et al., 2016; Venancio et al., 2012). See the chapter “Breastfeeding Practice, Policy, and Politics” for more information on the BFHI. The European Union's Blueprint for Action on Breastfeeding (EU Project on Promotion of Breastfeeding in Europe, 2008) expects all maternity and pediatric hospitals to become Baby-Friendly designated and all mothers to have timely access to qualified lactation consultants. The United Kingdom's National Institute for Health and Care Excellence Postnatal Guidelines, updated in 2015, recommend that hospitals implement Baby-Friendly practices and ensure access to skilled lactation support from the first feeding (National Institute for Health and Care Excellence, 2015).

The U.S. Surgeon General's *Call to Action to Support Breastfeeding* compels the healthcare system to ensure that maternity care practices are supportive of breastfeeding and to provide access to IBCLC services (USDHHS, 2011). The Joint Commission, a national hospital accreditation organization in the United States, has a quality core measure on percentage of newborns exclusively breastfeeding at discharge; all hospitals that provide maternity services are required to report on this measure (Joint Commission, 2013).

The ILCA and the IBLCE now award recognition to hospitals and community-based agencies that employ IBCLCs and provide training in breastfeeding management for other healthcare professionals. For a list of organizations that have received the IBCLC Care Award and for more information on the criteria, visit www.ibclccare.org.

A key element in quality hospital lactation care is appropriate policy development and staff training. IBCLCs are ideally suited to work with a hospital's leadership team to develop evidence-based policies and education for nursing staff, including clinical competencies. Numerous resources are now available to guide hospitals in developing evidence-based policies covering all aspects of maternal/newborn care and breastfeeding (American Academy of Pediatrics, 2009; Hernández-Aguilar et al., 2018). Starting with a foundational infant feeding policy that includes the Baby-Friendly Ten Steps to Successful Breastfeeding, other policies may incorporate elements of this policy so that breastfeeding care is not isolated but instead woven into the basic elements of care. For example, a hospital may have a policy on newborn thermoregulation that includes skin-to-skin contact as a primary intervention, or a policy on radiologic procedures for lactating women that includes accurate information and guidance on the safety of radiologic dyes (American College of Radiology, 2018). Other common protocols are management of hypoglycemia or hyperbilirubinemia in newborns on a mother/baby unit that prioritizes maintenance of breastfeeding, such as using expressed breastmilk or safe donor milk for any medically indicated supplementation (Adamkin & Committee on Fetus and Newborn, 2011; Kellams et al., 2017; Maisels et al., 2009).

Hospitals are particularly concerned with patient safety and risk management issues, both of which are increased when inadequate lactation care is provided, especially in high-acuity lactation situations (**TABLE 1-1**). Identifying mothers and children who are at higher risk for poor breastfeeding outcomes enables a hospital to allocate appropriate resources in a more timely fashion (Mannel, 2011, 2013). IBCLCs are the clinical experts to refer to, whether the patient is on a mother/baby unit or in an adult or pediatric service and identified as high lactation acuity. Hospital administrators are particularly critical to securing support for a lactation program, including the director of maternity nursing (who may oversee labor and delivery, mother–baby care, and sometimes the intensive care nursery), the director of the pediatric and/or newborn intensive care unit, and the chair 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.

TABLE 1-1 Lactation Acuity Levels for Determining Lactation Resources

| | |
|---------------------------------|---|
| Acuity Level I | Level I acuity patients can be cared for by nursing staff who have basic breastfeeding knowledge and competency. |
| <i>Maternal Characteristics</i> | <ul style="list-style-type: none"> Basic breastfeeding education, routine management Latch/milk transfer appear optimal Maternal decision to routinely supplement Maternal decision to pump and feed expressed breastmilk (EBM) Maternal indecision regarding breastfeeding Mother can latch baby with minimal assistance Multiparous mother with healthy term baby and prior breastfeeding experience |
| Acuity Level II | Level II acuity patients should be cared for by IBCLC staff as soon as possible or a referral made to IBCLCs in the community. Early follow-up after discharge is critical. |
| <i>Maternal Characteristics</i> | <ul style="list-style-type: none"> Antenatal admission with increased risk of preterm delivery Cesarean section delivery Delayed breastfeeding initiation (defined as after 1 hour with routine vaginal delivery and after 2 hours with routine cesarean section) Maternal acute illnesses/conditions (e.g., preeclampsia, cardiomyopathy, postpartum depression, postpartum hemorrhage) Maternal age (mother younger than 18 years or older than 35 years) Maternal chronic conditions (e.g., rheumatoid arthritis, systemic lupus erythematosus, hypertension, cancer, history of gastric bypass, obesity) Maternal cognitive impairment (e.g., mental retardation, Down syndrome, autism) Maternal endocrine disorders (e.g., polycystic ovary syndrome, infertility, thyroid disorders, diabetes) Maternal medication concerns Maternal physical disability (e.g., paraplegic, cerebral palsy, visual impairment, psychiatric) Maternal readmission (breastfeeding well established/noncritical issues) Maternal request Multiparous mother with history of breastfeeding difficulty Primiparous mother or first-time breastfeeding mother with healthy term baby Social/cultural issues (e.g., communication barriers, domestic/sexual abuse) |
| <i>Infant Characteristics</i> | <ul style="list-style-type: none"> Consistent LATCH score less than 6 at day of discharge Breastfeeding Assessment Score less than 5 Latch difficulties (e.g., pain) Infant readmission (breastfeeding well established/noncritical issues) Newborn birth trauma (e.g., cephalohematoma, shoulder dystocia) Suboptimal/inadequate milk transfer leading to medical recommendation to supplement |
| Acuity Level III | Level III acuity patients need to be cared for by IBCLC staff while in the hospital. These patients will require in-depth assessment and ongoing management. Early follow-up after discharge is critical. |
| <i>Maternal Characteristics</i> | <ul style="list-style-type: none"> Abscess/mastitis High maternal anxiety Induced lactation Maternal breast conditions (e.g., breast/nipple anomalies, glandular insufficiency, history of breast surgery) Maternal illness/surgery Maternal readmission (breastfeeding not well established and/or critical issues) Pathologic engorgement |

(continues)

TABLE 1-1 Lactation Acuity Levels for Determining Lactation Resources*(continued)*

| | |
|-------------------------------|--|
| <i>Infant Characteristics</i> | High-risk infant on mother–baby unit (e.g., late preterm, small or large for gestational age, multiple gestation) Hyperbilirubinemia Hypoglycemia Infant admission to neonatal intensive care unit Infant congenital anomalies Infant illness/surgery Infant oral/motor dysfunction (e.g., tight frenulum, hypotonia, or hypertonia) Infant readmission (breastfeeding not well established and/or critical issues) Infant weight loss exceeds 7% of birth weight before discharge |
|-------------------------------|--|

Note: Acuity levels can change based on assessment by the IBCLC or other healthcare team members.

Modified from Mannel R. Defining lactation acuity to improve patient safety and outcomes. *J Hum Lact.* 2011;27:163–170.

The care of breastfeeding parents and children is a perfect example of the need for an interdisciplinary, team approach. IBCLCs cannot provide optimal care in isolation from the rest of the healthcare team, nor can the healthcare team provide quality breastfeeding care without the services of skilled lactation care providers. Establishing a collaborative approach is critical to ensuring that the healthcare needs of both the mother and the child are addressed while maintaining successful breastfeeding to the greatest extent possible (Mannel et al., 2019). Nurses and physicians are powerful allies when they have received adequate training and have been supported in reaching their own breastfeeding goals. One study of over 900 pediatric physician trainees in U.S. medical schools demonstrated the positive or negative influence of their personal breastfeeding experiences. One in three did not meet their own exclusive breastfeeding goals, which negatively impacted how they counseled their patients on breastfeeding (Dixit et al., 2015). Another study showed that a targeted breastfeeding curriculum for pediatric residents improved their knowledge and practice patterns and increased exclusive breastfeeding rates in their patients (Feldman-Winter et al., 2010). A 2010 study of nursing staff in several U.S. hospitals demonstrated significant improvements in their knowledge and attitudes toward breastfeeding after completing an evidence-based training program (Bernaix et al., 2010).

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 preexisting services will help ensure 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 express milk or nurse their babies during work hours. A comprehensive employee lactation program at a large children's hospital in the United States demonstrated significantly higher breastfeeding initiation and duration rates among employees than the national average (Spatz et al., 2014). Many countries are now requiring employers to provide support for working breastfeeding mothers (International Labour Office, 2010; U.S. Department of Labor, 2018), and the vast majority of countries provide some form of federally mandated paid maternity leave (World Bank, 2016).

Resources

Determining the resources needed for a quality lactation program depends on the level of service provided by the hospital in other areas (Mannel & Mannel, 2006) and the goals for the lactation service. For example, does the hospital have a neonatal intensive care unit, provide high-risk antepartum care, or have inpatient pediatric units? Does the hospital want a lactation service that provides telephone follow-up, outpatient care, or prenatal education (**FIGURE 1-2**)? All these services need to be factored into the equation when determining the necessary resources.

Mannel and Mannel (2006) collected data from the lactation program's productivity reports at a tertiary care teaching hospital (4200 births per year). They measured actual hours worked by IBCLCs over a 2-year period, allocated the hours to their respective activities, and developed ratios for optimal IBCLC staffing for each component of service. These data



FIGURE 1-2 Outpatient Breastfeeding Clinic.

Courtesy of Oklahoma Breastfeeding Resource Center.

BOX 1-1 IBCLC Staffing Guidelines from the U.S. Lactation Consultant Association

Hospital with Level I Neonatal Service

The hospital with level I neonatal service would require 1.3 full-time equivalent (FTE) staffed hours per 1000 deliveries per year for the inpatient setting. To include the breastfeeding rate in this calculation, multiply the FTEs calculated by the percentage of breastfeeding mothers in that facility.

Hospital with Level II Neonatal Service

The hospital with level II neonatal service would require 1.6 FTEs per 1000 deliveries per year for the inpatient setting. To include the breastfeeding rate in this calculation, multiply the FTEs calculated by the percentage of breastfeeding mothers in that facility.

Hospital with Level III (Tertiary Care) Neonatal Service

Based on the standard of a 20% preterm delivery rate (Mannel & Mannel, 2006), the tertiary care facility would require 1.9 FTEs per 1000 deliveries per year for the inpatient setting. To include the breastfeeding rate in this calculation, multiply the FTEs calculated by the percentage of breastfeeding mothers in that facility.

Reproduced from U.S. Lactation Consultant Association (USLCA). International Board Certified Lactation Consultant staffing recommendations for the inpatient setting, 2010. Available at: http://uslca.org/wp-content/uploads/2013/02/IBCLC_Staffing_Recommendations_July_2010.pdf. Accessed July 13, 2013.

were used in the staffing recommendations released by the U.S. Lactation Consultant Association (2010) and the Association of Women's Health, Obstetric and Neonatal Nurses (2010). See **BOX 1-1**.

► Managing a Hospital Lactation Service

A quality lactation service requires dedicated positions for lactation consultants to ensure timely access to care. Some hospitals hire only IBCLCs who are also RNs and plan to use them in nursing staffing. When it is not busy in labor and delivery, the IBCLC/RN can “do lactation.” Unfortunately, this type of service leads to inconsistent access to care and increases risk management concerns. When census is higher and no lactation consultants are available, mothers are more likely to be discharged with inadequate knowledge of breastfeeding management or even knowledge of how to identify if their babies are feeding adequately (Denison et al., 2016).

In other hospitals that have dedicated lactation positions, nursing staff may stop providing basic breastfeeding care based on their belief that all breastfeeding care is handled by the lactation consultant (Spatz, 2010). This type of environment is not effective either. As Spatz (2010) said, “Educated nurses should be the first level of intervention for all breastfeeding women and their infants. If this occurred in all institutions, the burden on the LC [lactation consultant] would decrease, and the LC could focus on complex breastfeeding cases. Educated nurses can change institutional and community breastfeeding cultures” (p. 500).

In 2010, Mannel described an effective lactation service where the IBCLCs make lactation rounds each morning to identify high-acuity patients, using a daily lactation census and scripted rounding questions (Mannel, 2010). Low-acuity breastfeeding couplets (level I) are managed by nursing staff, all of whom have had training in basic breastfeeding management according to the requirements of the Baby-Friendly Hospital Initiative (15 didactic and 5 clinical skills hours) (WHO, 2009). The IBCLCs are then able to focus more effectively on higher acuity breastfeeding couplets/patients (level II or III). This system represents a change from the hospital's previous method of relying only on referrals from physicians, nurses, and patients—a common practice in many hospitals. Results from rounding and identifying high-acuity patients have improved quality of care, lactation staff productivity, and employee satisfaction on the lactation team. As one IBCLC said, “Rounds make us more efficient . . . I know where to start.” This model has been adopted by many hospital lactation programs.

A key element in the efficacy of this model is the collaboration that occurs between IBCLCs and

nursing staff when nursing staff have had basic breastfeeding training as described earlier. Mannel recently analyzed newer data from the same facility after the hospital had been assessed for Baby-Friendly designation (Mannel, 2018). In 2013, annual births had increased 5%, nursing staff had all completed the minimum 20 hours of training, and the lactation team staffing had increased by 33% with the addition of one full-time position. Using the same acuity classification system, the lactation service completed 61% more lactation consults and increased the number of consults per patient, with 87% of their time spent on high-acuity consults, demonstrating a marked increase in efficiency. The breastfeeding rates also increased by 19% for any breastfeeding (from 74% to 88% initiation) and 121% for exclusive breastfeeding at discharge (from 24% to 53%).

Limited data have been published on lactation services in NICUs. In 2006, Mannel and Mannel reported some initial data on NICU lactation consults and estimated staffing. The 2013 data analysis presented at a 2018 regional U.S. Lactation Consultant Association conference provided more detail on some common NICU consults (Mannel, 2018). The average time spent per all NICU consults was 34 minutes, similar to what was reported in the 2006 article. When stratified by specific type/reason, there was a notable difference in the length of time required. The early follow-up consult conducted around 7 days postpartum averaged 27 minutes, whereas the later consult to help a baby transition from gavage feeding to direct breastfeeding averaged 56 minutes, and the final discharge teaching consult averaged 44 minutes. These data will help inform more accurate recommendations for lactation staffing in NICUs.

► Orientation and Documentation

As with other hospital staff, IBCLCs need verification of clinical competencies during orientation and lactation-specific education via annual mandatory trainings or updates. The IBLCE clinical competencies mentioned previously serve as an objective tool for clinical competency verification. Some hospital lactation programs have implemented annual peer review of IBCLCs during lactation consults. Peer reviews are typically done by an IBCLC in a supervisory position. Other hospital staff (RNs, clinicians, etc.) also require basic and ongoing lactation-specific education relevant to their roles, and IBCLCs are often the team

members with the most knowledge and expertise to provide this training.

Documentation of lactation care is an important part of the medical record. IBCLCs often document separately from nursing staff because they function as interdisciplinary care team members. The IBLCE has documentation guidelines that provide some guidance (IBLCE, 2012b). Some challenges in documenting breastfeeding are lack of standardized terms and approved abbreviations and recording assessment of actual breastfeedings. Labbok and Krasovec established some definitions of breastfeeding in 1990, although they are still not widely used in hospital documentation. Some hospitals may at least document exclusive breastfeeding versus any breastfeeding. Even bottle-feeding is unclear if the type of milk provided is not documented (expressed breastmilk, pasteurized donor milk, or formula). Many NICUs discharge babies as “breastfeeding” who have never actually fed at breast and are instead being bottle-fed breastmilk (Briere et al., 2015). This kind of documentation does not give an accurate picture of what is happening clinically. Documenting individual infant feedings is the responsibility of the bedside nurse, and several standardized assessment tools are available for objective evaluation of breastfeeding (CDC, 2015). IBCLCs need to document an assessment and plan of care; in addition, they must document on both parent and child if both are hospital patients—something that is unique to lactation care.

► Education, Advocacy, and Collaboration

Healthcare providers working in maternal/child health areas need basic education on breastfeeding—at a minimum, the health impact of breastfeeding, how to access skilled lactation support, and where to find information on the safety of medications used by the lactating parent. IBCLCs are well prepared to provide this education, along with basic clinical skills training. The Baby-Friendly Hospital Initiative requires 20 hours of training for maternal/newborn nursing staff and 3 hours of training for maternal/newborn clinicians providing care around the time of childbirth (WHO, 2009). In addition to training other staff, IBCLCs often lead hospital efforts to achieve Baby-Friendly designation or other breastfeeding-related quality improvement initiatives. Although IBCLCs can be strong advocates for improving breastfeeding outcomes, they cannot achieve Baby-Friendly Hospital designation or other practice changes without

support from the rest of the healthcare team. Collaboration and teamwork are key to any kind of sustainable change to evidence-based care, especially if a hospital has a long history of practices that are outdated and not evidence based.

Advocacy and collaboration are also important outside the hospital, both in the community and in the workplace. To achieve optimal breastfeeding duration rates, families need support throughout their breastfeeding journey, which may be years with each child. IBCLCs can advocate for protection of breastfeeding in public, for support of breastfeeding babies in child care, for protection for breastfeeding parents in the workplace, and for support of breastfeeding in special situations, such as those involving substance abuse and/or incarcerated mothers. These advocacy efforts require educating the public and policy makers in government about the importance of breastfeeding to the health of a particular society or population. The interdisciplinary nature of lactation and breastfeeding care requires education of a broad segment of society, which can lead to stronger partnerships and collaboration. The knowledge and clinical experience of IBCLCs can be a powerful agent in swinging the pendulum back to a cultural norm of breastfeeding.

► Professional Lactation Care and Volunteer or Paid Peer Counselors

Breastfeeding support does not always require professional lactation care. The new family will obtain the best in comprehensive care when IBCLCs, community-based counselors (whether offering their support in paid or volunteer positions), and other healthcare or program service providers all work together to provide support.

Although breastfeeding counselors and IBCLCs can offer general support to breastfeeding/lactating parents, the scope of practice and clinical competencies for the IBCLC include skill at assessing both parent- and infant-related lactation issues and an ethical duty to protect the breastfeeding relationship (IBLCE, 2012a, 2015). Volunteer and paid peer counselors are an excellent source of general support for parents, offering preventive healthcare information pertaining to breastfeeding and lactation. They may spend more time with the family, giving assistance as the child ages, whereas the IBCLC may see clients/patients only at specific time points. It is not uncommon for

a parent to continue to receive assistance and caring concern from a volunteer or paid peer counselor throughout the entire lactation course; less commonly will an IBCLC meet with a client regularly during that entire period. Instead, the IBCLC contact may be sporadic, initiated by the client/patient when a question or concern requiring specific clinical skills to assess or resolve a problem arises.

Volunteer or paid peer breastfeeding supporters and professional lactation specialists can assist one another (Thorley, 2000). The peer supporter may have seen a family in their own home and therefore is able to alert the IBCLC working in a hospital, doctor's office, or clinic to elements of the home life that may bear on the lactation care plan. The IBCLC, in turn, may serve as a referral source for persons with complex problems. When the IBCLC works in a medical center where ongoing research is part of IBCLC's role, this helps generate new knowledge. Both the peer supporter and the IBCLC can review materials written for clients/patients. The peer supporter may be sensitive to ongoing issues that crop up after the parent has left the hospital, including those that the family may be reluctant to mention to their healthcare providers. The IBCLC may be aware of aspects of the healthcare system that influence breastfeeding.

► Breastfeeding Support in the Community

Breastfeeding continues to be recognized as a public health priority. Although initiation, exclusivity, and duration rates have increased respectively, there continue to be breastfeeding disparities and lack of access to professional breastfeeding support by IBCLCs, primarily for underserved communities (Anstey et al., 2017). Initiation rates in hospitals have increased in recent years, largely due to implementation efforts of the Baby-Friendly Hospital Initiative and its Ten Steps to Successful Breastfeeding (Agency for Healthcare Research and Quality, 2018). However, families will spend only a handful of days in the hospital for the birth of a baby. They will spend most of their time in their home communities, where they live, work, recreate, and worship. Thus, community-based prenatal and postnatal education and support becomes a vital resource for families. Steps 3 ("Inform all pregnant women about the benefits and management of breastfeeding") and 10 ("Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center") (Baby-Friendly USA, 2012) encourage continuity of

community-based care for families whose infant feeding goals are to breastfeed.

Although breastfeeding initiation continues to increase, once mothers and babies return home to their communities, rates of breastfeeding exclusivity and duration often decrease. “All sectors of society (family and friends, hospitals, health care offices/clinics, childcare facilities, community-based organizations, and workplaces) can play a role in improving the health of families by supporting breastfeeding. To reach their breastfeeding goals, mothers need continuity of care, which is achieved by consistent, collaborative, and high-quality breastfeeding services and support” (CDC, 2018, para. 5). It is important—both in the hospital and after discharge—that families receive appropriate and culturally sensitive support. Therefore, the IBCLC’s awareness of and sensitivity to the needs of diverse communities will provide the best support and resources to mothers, babies, and families. The CDC’s *Guide to Strategies to Support Breastfeeding Mothers and Babies* offers information on interventions and programs that address many of the steps called for by the U.S. Surgeon General in the *Call to Action to Support Breastfeeding*. It includes new objectives to increase breastfeeding rates and improve outcome measures specific to work sites and maternity care. “These objectives are in addition to CDC’s ongoing goal of decreasing disparities in breastfeeding rates and increasing collaboration between partners at federal, state, and community levels to overcome breastfeeding challenges (CDC, 2013, p. 3).

Continuing to breastfeed after being discharged is influenced by many community factors. The IBCLC must seek to understand and consider cultural differences and practices, familial and religious influences, the need to return to work when the infant is merely weeks old, and access to reliable child care. In the 21st century, families increasingly rely on social media and other avenues of online support to find parenting and breastfeeding support and kinship. Community support may look different from community to community; however, whether the support comes from an IBCLC or a certified lactation counselor, the rates of initiation, exclusivity, and duration increase (Patel & Patel, 2015). Peer-to-peer support is commonly used in group settings, as part of in-home support, and via social media and online outlets. Social and community networks are highly influential in a women’s decision-making process, whether as barriers to, or encouragement for, breastfeeding.

The impact of structural and institutional racism on birth, access to equitable care for marginalized communities, and preventive measures that assist families early on directly affect the mother’s intent to breastfeed and the breastfeeding relationship (Jones

et al., 2015). Being aware of systemic issues will help to decrease disparities and barriers and inform care and lactation practices (Griswold et al., 2018).

Summary

The field of lactation, now into its fourth decade, is an allied healthcare specialty. Most hospitals now offer lactation services provided by IBCLCs or other licensed caregivers (e.g., nurses) who also have IBCLC certification. Some physicians are also starting breastfeeding specialty private practices or employ staff who are IBCLCs. The opportunity to work with families and babies—and to enhance early parenting and maternal/child health—has made professional lactation care a popular, satisfying field.

Key Concepts

- An International Board Certified Lactation Consultant (IBCLC) 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. IBCLCs 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 show that IBCLC services save the healthcare system enormous amounts of money through reduction in illnesses for both baby and mother.
- Certification by the IBLCE is the gold standard for working as a lactation consultant.
- Most hospitals have lactation services. These services usually include inpatient consults and may include telephone hotline and postdischarge telephone calls, prenatal classes on breastfeeding, outpatient postpartum consults, and continuing education for staff.
- A “prime mover” (e.g., a nursing director, administrator, or physician) who has institutional power is needed to develop a lactation program and to obtain the wide support of those who have influence in deciding budget allocations.
- Ethics are 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.

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