# Breastfeeding Program Physician Tool Literature Review

## Best Practices for Breastfeeding promotion through the use of a Physician Tool in Primary Care Settings:

## Recommendations for QSFHT physician tool development

By

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**Introduction & Background**

Breastfeeding promotion programs aim to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding. The expected beneficial outcomes of these types of programs are increased breastfeeding rates and improved health. There is convincing evidence that breastfeeding provides substantial health benefits for children, and evidence that breastfeeding provides moderate health benefits for mothers. (U.S. Preventive Services Task Force, 2010; Heinig & Farley, 2001; Couto de Oliveira, Bastos Camacho & Tedstone, 2003). In addition, there is adequate evidence, which indicates that interventions and programs that aim to promote and support breastfeeding increase the rates of initiation, duration, and exclusivity of breastfeeding. (U.S. Preventive Services Task Force, 2010; Busch et al., 2014; Scott, 2005; Guise et al., 2003). Also, no published studies focus on the potential direct harms from interventions to promote and support breastfeeding. (U.S. Preventive Services Task Force, 2010; Heinig & Farley, 2001; Scott, 2005; Guise et al., 2003)

A mother's prenatal intention to breastfeed is influenced to a great extent by the opinion and support of the healthcare providers she encounters because they trust their professional opinions and advice (Grawey, Marinelli, Holmes, 2013). Practices that foster a supportive environment for breastfeeding and employ healthcare staff trained in lactation, have significantly higher breastfeeding initiation and maintenance rates, with mothers experiencing fewer problems related to breastfeeding, than practices without such staff or environment (Grawey et al., 2013). Thus, the health care team should foster a supportive breastfeeding environment that promotes breastfeeding as the first and natural choice of nutrition for all infants (Busch et al., 2014).

However, many new mothers do not receive advice from physicians on aspects of infant care such as sleep position, breastfeeding, immunizations, and pacifier use (Eisenberg et al., 2015; Stolzer & Hossain, 2014). According to the literature, pregnant women and mothers of infants report that physicians play a pivotal role in determining what type of feeding method to use, yet physicians have been found to underestimate the power they wield when it comes to increasing breastfeeding rates in their patients (Stolzer & Hossain, 2014). Since mothers value the opinion of their physicians; physicians have an opportunity to provide new mothers with much-needed advice on how to improve infant health and decrease likelihood of childhood illnesses (Eisenberg et al., 2015; Grawey et al., 2013). Thus, ongoing parental support through in-person visits and phone contacts with healthcare providers usually results in increased breastfeeding duration (Eisenberg et al., 2015; Grawey et al., 2013). Physicians that work primarily with women and children (i.e., family practitioners, obstetrician/gynecologists, and pediatricians) are in a unique position to promote, encourage, and support both the initiation and duration of breastfeeding (Stolzer & Hossain, 2014). In addition, practices that employ healthcare professionals trained in lactation have significantly higher breastfeeding initiation and maintenance rates, with mothers experiencing fewer problems related to breastfeeding (Eisenberg et al., 2015; Grawey et al., 2013).

There is evidence that prenatal breastfeeding education interventions (including those that involve physicians) improve the initiation or duration of breastfeeding (or both) because they increase women's knowledge, confidence and skills with regards to breastfeeding (Palda et al., 2004). Although the prevalence of breastfeeding in Canada has risen, with over three-quarters of mothers now initiating breastfeeding, the duration of this practice remains short of the recommended World Health Organization (WHO) targets of exclusive breastfeeding for 6 months and partial breastfeeding for up to 2 years and beyond (Palda et al., 2004). Canadian data indicates that 22% of new mothers aged 15–49 years breastfeed for less than 3 months, and 35% do so for at least 3 months (Palda et al., 2004). This premature discontinuation is more commonly as a result of difficulties with breastfeeding, including lack of information and support, than due to women's choice or intent (Palda et al., 2004). Breastfeeding intent is consistently found to be a strong predictor of decisions to initiate and sustain breastfeeding in women (Betzold et al., 2007; Volpe & Bear, 2000). The decision about which type of infant feeding method mothers will choose is often made before pregnancy, at the beginning of pregnancy, or before the second trimester (Volpe & Bear, 2000; Couto de Oliveira & Camacho, 2011; Lumbiganon et al., 2011; Renfrew et al., 2012).

There is not a lot of evidence on the effectiveness of physician based interventions to increase breastfeeding initiation and duration. Much of the literature that was found are retrospective cohort studies which discuss topics that women wished their physicians had discussed with them before they had their babies, breastfeeding is often included in this. However, in general, education based intervention that support and promote breastfeeding have been found to be effective. Thus, physician-based interventions in the prenatal stage that focus on increasing women's knowledge, skills and confidence around breastfeeding in hopes of influencing intent to breastfeed, so that initiation and duration rates increase, may be effective. There is also not very much information about the effectiveness of providing consistent information across several health care providers.

**Overall Goals of This Research**

Thus, this paper reviews the available evidence around physician-based interventions to promote and support breastfeeding in a primary care setting in the prenatal stage. This research will be used to create a physician tool for doctors at Queen Square Family Health Team and to ensure practice-wide consistency in the information physicians provide for patients. The tool will be used during every prenatal appointment to start a discussion and help mothers make informed decisions about breastfeeding. The review will ensure the tool is evidence-based and is uses best practices. Thus, indirectly, it is hoped that the tool will help increase breastfeeding rates (initiation, duration and exclusivity) at QSFHT, by providing continued support to mothers during the prenatal stage and by fostering a supportive environment for breastfeeding.

This research will also fill a need, since the majority of the current research does not show a lot of evidence supporting consistent physician based interventions to increase breastfeeding rates.

**Methods**

A literature review was conducted to gather pertinent evidence related to breastfeeding practices by physicians in primary care settings. Specifics about topics covered by physicians and when (at which prenatal vist) these topics were covered were noted. An internet search was conducted using the following electronic databases; Cochrane Reviews, EMBASE, ProQuest, Medline, CINAHL, Ovid, WebofScience, PubMed, and Scopus. The databases were accessed from the University of Toronto Library. The following Booleans and search terms were used in various combinations to conduct the search; b*reastfeeding, service, program, project, intervention, office, primary care, family practice, doctor, physician, information, key points, topics, questions, timing, gestation, prenatal, antenatal, prompts, cues to action, best practices, indicators, evaluation, measure, recommendation.* The search was initially conducted in Medline and then adapted for all of the other databases. In addition to searching these databases, grey literature was searched, dissertations were obtained through ProQuest, and articles were hand-selected (mostly from citations presented in papers that were being appraised).

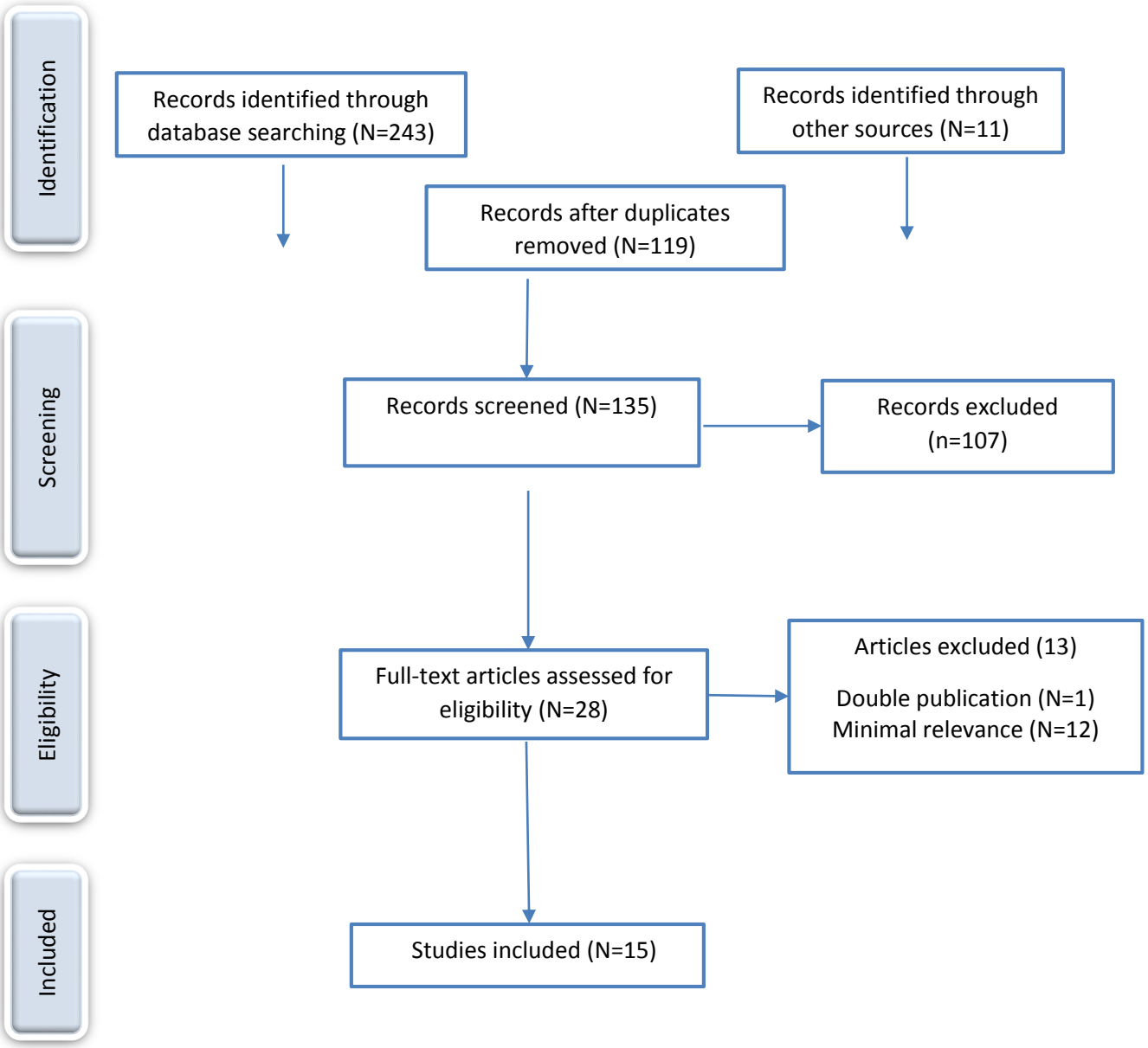
Figure 1 illustrates the process by which articles were selected, culminating in a total of fifteen articles. The articles were controlled for double publication. The following selection criteria were used: study design – initially reviews were analyzed to get a general idea of the research in this area. No restrictions were put on type of study. Participants/Practice Setting – the focus of this review, was primary care settings and physicians. Outcomes - the primary outcome was initiation or duration or exclusivity of breastfeeding or a combination of these three. Secondary outcomes (confidence, self-efficacy, knowledge, attitudes, skills etc.) were also assessed where applicable. Recommendations- specifics about topics covered and when they were covered were noted.

The review was done by appraising journal articles and charting the design, sample, setting/size, focus, methods, results, conclusions, and recommendations of the selected studies. Specific attention was given to articles that provided evidence-based recommendations for physicians with regards to breastfeeding support in primary care settings. All English language articles from the years 2005 onwards from countries that were demographically similar (Canada, USA, Australia, Sweden) were included, with the exception of a few articles from before 2005, since they were directly applicable to the research intent and there was limited data directly linked to this topic. Duplicates were eliminated.

This review is vulnerable to several types of bias. Positive and significant findings are more likely to be (a) published (publication bias), (b) published quickly (time lag bias), (c) published more than once (multiple publication bias), and (d) cited (citation bias) (Cochrane Corporation, 2014). The articles within the review, too, have associated and documented

biases. Commentaries, editorials, letters and special articles were not excluded from the search, but very rarely made it to the final review.

**Figure 1:** Breastfeeding Support by Physicians in Primary Care Settings Flow Chart



The fifteen articles that were included in this review include: one randomized control trials, five government reports (recommendation reports based on reviews of the literature and best practices), three systematic reviews, five cohort studies and one cross-sectional study. These articles were selected because they all had pertinent aspects to the research question. Each article had relevance to the research question.

The recommendations section below, is an accumulation of the recommendations and best practices from the fifteen sources that will be applicable for the creation of the Physician Tool for QSFHT.

**Results**

The literature shows that support and education during the prenatal stage does help increase initiation and duration rates of breastfeeding, but there is not a lot of evidence to conclusively say that physician led support during prenatal visits is the most effective strategy, since the literature does not clearly indicate the specifics of prenatal interventions that involve physicians. However, the literature does not state that these interventions cause any harm - there just isn't enough evidence to fully support them at the moment. Nonetheless, there is a lot of evidence supporting the provision of prenatal breastfeeding education in general, regardless of the health care provider.

A thorough literature review was conducted to examine the evidence with regards to the information/questions physicians can provide/ask and when physicians should share this information or ask these questions about breastfeeding in the prenatal stage.

Fifteen studies with a variety of study designs were included in this review. All articles had pertinent aspects to the research question. Once the data was synthesized and charted into tables major themes were chosen. The results section will outline the content and timing of questions about breastfeeding physicians should ask their patients at prenatal visits. In addition, any other major themes that emerged from the literature will also be highlighted in the results. These results will then be used to formulate recommendations so that a comprehensive and evidence based physician tool can be created for all doctors to use consistently during prenatal visits at QSFHT.

**General Important Points**

Provider's cultures and attitudes were found to affect breastfeeding promotion and support (Szucs et al., 2009). In addition, women's perceptions of their doctor's opinions about breastfeeding were found to affect breastfeeding rates (Odom et al., 2013). Breastfeeding encouragement from doctors also can influence breastfeeding initiation and duration (Thomas & Shaikh, 2007). Allowing patients to ask questions about breastfeeding and have their concerns dealt is another effective strategy because it allows them to ask questions that are specific to them, which allows for care to be tailored for each patient (Thomas & Shaikh, 2007).

Consistent and evidence based information provided by doctors was more effective than when they shared their personal breastfeeding experiences, since individual experiences are so varied (Szucs et al., 2009). Also, doctors support, specifically advice about how to breastfeed, during prenatal counselling positively affects feeding decisions and practices (U.S. Department of Health and Human Services, 2011).

Many patients retrospectively reported low breastfeeding support and guidance during the prenatal stage (Lemoine et al., 2006; Eisenberg et al., 2015). Mothers commonly reported receiving either no advice or the recommendations were inconsistent between staff or the information was deemed inadequate (Eisenberg et al., 2015; Stolzer & Hossain, 2014; Krogstrand & Parr, 2005). Provider's lack of knowledge, counselling skills, and professional education and training were gaps found in the literature about why physicians did not provide breastfeeding information to patients (Szucs et al., 2009). Many doctors indicated that they pursed knowledge in this area through workshops to increase their own personal knowledge so that they could better counsel patients (Krogstrand & Parr, 2005). It was also found that when lactation specialists (lactation consultant, nurses or doctors) provided information to patients it was found to be effective, since they had the knowledge and their patients trusted them (U.S. Preventive Services Task Force, 2003; Palda et al., 2004;). This is also why when mothers are given formula it influences their infant feeding practises because they trust their medical professional team and believe formula is equivalent to breastfeeding because their doctor provided it to them (U.S. Department of Health and Human Services, 2011)

Thus, physician involvement with breastfeeding counselling may be effective at increasing breastfeeding rates if information being provided is consistent, evidence based and focuses on increasing women's knowledge, confidence and skills; however, at the moment more evidence is needs to deem this an effective strategy (Guise et al., 2003; Palda et al., 2004). Nonetheless, women trust their doctors when it comes to breastfeeding because they believe they are being provided with an evidence based professional opinion and professional knowledge, and they believe their doctor has their and their babies' best intention at heart (U.S. Preventive Services Task Force, 2003; Palda et al., 2004; Grawey et al., 2013)

**Timing of Information**

There was no concrete evidence in the studies that indicated at what times specific information about breastfeeding should be covered with patients in the prenatal stage. The majority of mothers decide if they are going to breastfeeding as early as the first trimester, so consistent and evidence-based information should be introduced to patients at this early stage (Odom et al., 2013; Eisenberg et al., 2015; Lemoine et al., 2006; Bonuck et al., 2009; Thomas & Shaikh, 2007; Grawey et al., 2013). Thus, the subject of infant feeding should be introduced in the first trimester and there should be continued expression of breastfeeding support throughout the course of the pregnancy (Odom et al., 2013; Eisenberg et al., 2015; Lemoine et al., 2006; Bonuck et al., 2009; Thomas & Shaikh, 2007; Grawey et al., 2013). In addition, if a physician is providing postnatal care for the infant, further commitment to breastfeeding can be shown at these check-ups by asking about how breastfeeding is going, if there are any complications etc. (Grawey et al., 2013). The opinions of health care providers play an

important role in a woman's decision to breastfeed; thus during the prenatal period, health care providers have an opportunity to communicate the importance of breastfeeding (Odom et al., 2013; Eisenberg et al., 2015; Lemoine et al., 2006; Bonuck et al., 2009) Breastfeeding initiation and duration increase because of physician encouragement (Thomas & Shaikh, 2007; Grawey et al., 2013), but the timing of the information can be flexible and therefore can work around the current prenatal checkups at QSFHT.

**Information that should be covered**

The articles in this literature review discuss a variety of topics or concepts that should be covered with patients in the prenatal stage, so that breastfeeding initiation and duration can be increased. The topics were either topics women wished their doctors covered with them in the prenatal stage or main topics their doctors did cover with them. In general the goal of providing information to women is to increase women's knowledge, skills and confidence about breastfeeding. The main informational theme in the articles was to discuss the benefits of breastfeeding (risks of formula feeding) (Guise et al., 2003; Odom et al., 2013; Stolzer & Hossain, 2014; The Joint Commission, 2011).

The articles suggested that information is best provided when it is easy to understand, tangible, and allows for discussion between the patient and physician (Guise et al., 2003; Odom et al., 2013; Stolzer & Hossain, 2014; The Joint Commission, 2011). Thus, each session should contain 1–2 (so that the patient is not overloaded) brief open-ended questions that portray breastfeeding as the norm (i.e. "What are your plans for breastfeeding?"), or determine and clarify participants' understanding of current guidelines regarding breastfeeding. (Bonuck et al., 2009). Or use open-ended questions, such as ''what have you heard about breastfeeding?'' to inquire about a feeding plan (Grawey et al., 2013). This will facilitate an open discussion and will allow the physician to provide educational material that highlights the many ways in which breastfeeding is beneficial for the mother, the child etc. (Grawey et al., 2013). In addition, it is important for physicians to maintain a supportive environment (i.e. no formula advertisement or providing free formula baskets) (Guise et al., 2003; Odom et al., 2013; Stolzer & Hossain, 2014; The Joint Commission, 2011; Grawey et al., 2013; U.S. Department of Health and Human Services, 2011; Krogstrand & Parr, 2005). It is also important to ensure the information being provided is done in a non-judgemental way and all of the patient's concerns are validated/resolved or they have been given a referral where they can receive additional support (Guise et al., 2003; Odom et al., 2013; Stolzer & Hossain, 2014; The Joint Commission, 2011; Grawey et al., 2013; U.S. Department of Health and Human Services, 2011; Krogstrand & Parr, 2005). The goal of introducing the topic of breastfeeding during prenatal checkups is to reinforce important information to patients, so that they can make an informed decision. Physicians should also encourage support person(s) to attend the prenatal checkups, so that they receive the evidence-based information as well (Grawey et al., 2013; Odom et al., 2013; Stolzer & Hossain, 2014; The Joint Commission, 2011).

According to the studies included in this review one of the best strategies to get the information across was to pose questions to clients and then have a discussion with them to

provide the pertinent information. This allows the physician to develop a relationship with the patient and tailor the information. The main questions that came up in the literature that should be asked or answered during prenatal visits are:

(Guise et al., 2003; Odom et al., 2013; Stolzer & Hossain, 2014; The Joint Commission, 2011; Grawey et al., 2013; U.S. Department of Health and Human Services, 2011; Krogstrand & Parr, 2005; American Academy of Family Physicians, 2008; Bonuck et al., 2009; Eisenberg et al., 2015; Lemoine et al., 2006; Szucs et al., 2009; Thomas & Shaikh, 2007; U.S. Preventive Services Task Force, 2003)

- What are your plans for breastfeeding?
- What have you heard about breastfeeding? (benefits to mom and infant health)
- Why should you breastfeed?
- What are the benefits of breastfeeding?
- What to expect when breastfeeding?
- How do you begin breastfeeding? (positions, latch, and basic physiology and anatomy)
- How much and how often should you breastfeed?
- How long should you continue to breastfeed? Exclusive breastfeeding and when should you introduce complimentary foods?
- How can you store breastmilk?
- Where can you get additional support? Who can you get extra support from? (lactation consultant)
- What to expect at the hospital? i.e. skin to skin contact, breastfeed right away *(this might be a good place to give then the SMART goals handout created for the class)*
- What are your concerns about breastfeeding?
- If you breastfed before, do you have any concerns from that experience?
- How does your partner/family feel about you breastfeeding? Who will help out at home after the baby is born? What should their role be?
- Do you have concerns about how medications, or any smoking, alcohol, or substance abuse might affect breastfeeding?
- What can you do if you need to go back to work and still want to breastfeed?
- Can you use a breast pump instead of breastfeeding?
- How do pacifiers and bottle feeding affect breastfeeding?
- Do you need to supplement with vitamins during breastfeeding?
- Are there any reasons why you shouldn't breastfeed?
- What if you don't have enough milk for you baby?
- What if you have nipple or breast pain?
- Are you allowed to breastfeed in public?

**Recommendations**

The purpose of this literature review was to determine physician-based interventions to promote and support breastfeeding in the primary care setting, within the prenatal stage. And to use this evidence to create a physician tool for Queen Square Family Health Team physicians that would streamline information/support from physicians and complement the existing breastfeeding program. Furthermore, such a review will also help gain an understanding of best practices for prenatal breastfeeding programs guidelines/recommendations in primary care settings.

Thus, based on this literature review the following recommendations are suggested for Queen Square Family Health Team for the Physical Tool:

1.) Create a physician tool the clearly outlines the main topics that should be covered in the prenatal stage as based on the evidence above (it should be question/discussion based)
2.) Use the existing prenatal check-ins at QSFHT (based on Rourke), since clear timelines were not recommended in the literature about when information should be covered
3.) Use open-ended questions and provide evidence based and consistent information to all patients in a non-judgemental and open manner
4.) Allow for patients to ask questions and voice concerns
5.) Have a list of additional resources for women to connect with if they need extra support
6.) Link women to the prenatal breastfeeding education classes and the breastfeeding clinic to ensure continued care (existing breastfeeding program at Queen Square Family Health Team)
7.) Foster a supportive breastfeeding environment (remove formula ads, do not provide formula care packages, ensure the waiting area is breastfeeding friendly)
8.) Encourage the presence of support person(s) in prenatal checkups, so that everyone can get the breastfeeding information
9.) Since doctors don't learn a lot about breastfeeding in medical school it would be useful for them to do additional research or take an additional course/seminar to brush up on their knowledge to ensure that consistent and reliable information is being provided to all patients.

**Conclusion:**

The results of this review indicate that mothers often make the decision about breastfeeding before or during the early stages of pregnancy, so it is important to target interventions in the prenatal stage. However, the literature was vague about specifics about physician based intervention and exactly how they play or how they can play an integral role in increasing breastfeeding rates. In addition, the literature doesn't go into details about how doctor's influences women's choices about breastfeeding, other than patients tend to trust their doctors opinions. The literature also discussed how doctors don't think they learned enough about breastfeeding in school to help counsel patients. Thus, it would be helpful for

doctors to brush up on their breastfeeding knowledge or have staff that are specialized in breastfeeding, like lactation consultants present.

Most of the studies found were retrospective cohort discussing information women wish they received from their doctors, which indicates that physicians have the ability to play an important role in the mother's decision to initiate breastfeeding. Thus, physicians should provide support (that focuses on increasing knowledge, skills and confidence) and evidence-based information to mothers in the prenatal stage, so that they can make an informed decision about breastfeeding. There was some consensus in the literature about topics that should be covered during this stage, but there was no specifics about when these topics should be covered other than generally in the prenatal stage- starting as early as the first trimester.

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