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Medicalizing to demedicalize: Lactation consultants and the (de) medicalization of breastfeeding

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ABSTRACT

This paper uses the domain of breastfeeding in the U.S. and the work of International Board Certified Lactation Consultants to refine the concept of medicalization–demedicalization. Given lactation consultants' origins and current role in maternity care, they provide a unique lens on these processes because they are positioned at the crossroads of medicalization and demedicalization. Using 150 h of ethnographic observation and 39 interviews conducted between 2008 and 2012, I identify aspects of medicalization–demedicalization in the work of lactation consultants according to four dimensions: medical definition, medical control, pathology, and medical technology. Lactation consultants work to demedicalize breastfeeding by challenging the construction of breastfeeding pathology and limiting intervention. At the same time, they hold a position of medical control and medicalize breastfeeding by reinforcing a medical definition and using medical technology to treat breastfeeding problems. However, lactation consultants are not only working toward demedicalization and medicalization simultaneously, but are also medicalizing to demedicalize. Their position of medical control over breastfeeding provides them with a certain measure of authority that they can use in their efforts to depathologize breastfeeding and limit medical intervention. These findings build upon previous research that has identified cases of medicalization and demedicalization occurring simultaneously and draw attention to the need for an understanding of medicalization–demedicalization as a continuous process. Furthermore, the concept of "medicalizing to demedicalize" provides a novel contribution to the literature.

Introduction

Medicalization and demedicalization have been the subject of sociological inquiry for decades (Conrad, 1975, 2005, 2007; Freidson, 1970; Zola, 1972). Over this period of time, there has been much debate about the exact nature of these processes and how to determine if something is medicalized or demedicalized (Burke, 2011; Conrad, 1992; Davis, 2006; Fox, 1977; Halfmann, 2012; Lowenberg & Davis, 1994). This paper adds to this debate by analyzing the complex example of the medicalization of breastfeeding from the perspective of a highly under-researched occupational group that is situated within the center of this context – International Board Certified Lactation Consultants (IBCLCs).

Lactation consultants provide a unique perspective on the medicalization and demedicalization of breastfeeding because they are a relatively new occupation with roots in the women's health and natural childbirth movements and efforts to demedicalize breastfeeding. However, because of changes in the medicalization of breastfeeding, where it is increasingly supported by medical professionals and regarded as needing medical management, lactation consultants have taken the position of lactation specialists within the maternity care system (Torres, 2013). This raises two questions: 1) To what extent, and in what ways, do lactation consultants work toward demedicalization? 2) How do lactation consultants balance demedicalization with their role as the clinical managers of breastfeeding? By addressing these two questions, I am able to use the interesting and complicated situation of lactation consultants in the domain of breastfeeding to investigate the complexity of the processes of medicalization and demedicalization. Through this analysis, I provide evidence that, not only can these two processes occur simultaneously, but, ironically, medicalization can actually be used as part of a strategy to demedicalize. As I will illustrate, lactation consultants use their position of medical control over breastfeeding to challenge breastfeeding pathology and limit intervention. This stands in stark contrast to our understanding of the medicalization of natural processes, where pathologization and the creation of medical treatments and technologies are the means by which medical control is expanded.

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Background

Medicalization and demedicalization

Medicalization is most often described as "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders" (Conrad, 2007: 4). Demedicalization is the reverse: "a problem that no longer retains its medical definition" (Conrad, 1992: 224). The medicalization literature is voluminous, and scholars have defined and redefined medicalization, discussing its causes, consequences, and classifications. However, very little attention has been paid to demedicalization in comparison (some notable exceptions include Adler & Adler, 2007; Carpenter, 2010; Conrad & Angell, 2004; Fox, 1977; Wikler & Wikler, 1991).

One trend among studies looking at demedicalization is the discovery that medicalization and demedicalization can operate simultaneously. Lowenberg and Davis (1994) used the example of holistic medicine to illustrate how certain elements of this area of medicine represent demedicalization, while others represent medicalization. Burke (2011) analyzed Gender Identity Disorder (GID) activism, finding that while some activists fight for the complete demedicalization of GID by removing it from the DSM and medical texts, other activists fight to retain the diagnosis but end the pathologizing of GID. Another example of this type of scholarship is Halfmann's (2012) recent article on American abortion history, where he illustrates how abortion was medicalized and demedicalized simultaneously.

A key contribution of Halfmann's work is that he highlights the limitations of requiring a minimum threshold in order to determine if something is medicalized or demedicalized. For example, he takes issue with Conrad's (2007) statement that birth will not be demedicalized until it is no longer defined as a medical event and is no longer attended by medical professionals, because it obscures many of the changes in birth over time. I agree with his call for a more continuous value of medicalization–demedicalization, seeing each in terms of "an increase or decrease rather than a presence or absence" (p. 189), so that instead of determining whether something *is* medicalized or *is* demedicalized, we can recognize the nuance and complexity of these processes and identify situations where they are operating at the same time.

This paper builds upon this literature by examining elements of medicalization–demedicalization in the work of lactation consultants. I do so in a way that considers both the measurement of medicalization in terms of increase/decrease and the possibility of both medicalization and demedicalization occurring simultaneously. However, I extend these concepts by also considering how medicalization can be used as a strategy for demedicalizing in the work of lactation consultants.

Lactation consultants

The International Board Certified Lactation Consultant (IBCLC) certification is not the only certification in breastfeeding support, nor is it the only certification that uses the term "lactation consultant" (e.g., Advanced Lactation Consultants). However, it is one of the oldest and largest certifications, and the only one offered internationally. Currently, there are 13,292 IBCLCs in the U.S. (IBLCE, 2012b). IBCLCs work in a variety of settings, including hospitals, doctors' offices, clinics and community centers, and as independent consultants, helping breastfeeding mothers with the challenges of early breastfeeding and working to "protect, promote and support breastfeeding" (IBLCE, 2012a: 1). Although the IBCLC certification was created in 1985 (IBLCE, 2011), lactation consultants have a rich history in the medicalization and demedicalization of breastfeeding.

The medicalization of breastfeeding: past and present

During the early 20th century, the quantity and quality of breast milk were constructed as inadequate for infant feeding, and women began to feed their babies formula, which they and their doctors considered to be the more modern and scientific option (Apple, 1987; Wolf, 2001). This was impacted by the growth of "scientific motherhood" – the belief that women need scientific and medical advice to raise healthy children (Apple, 1995). As a result, breastfeeding rates dropped dramatically. With so few women breastfeeding, those who did want to breastfeed had difficulty finding information and support from medical providers, friends, and family members (Stolzer, 2006).

The natural childbirth and women's health movements emerged during the mid-20th century. There are, of course, important distinctions between these two movements. Most notably, the women's health movement was spearheaded by feminists fighting for equality, while the natural childbirth movement was more likely to include traditionalists fighting for intensive mothering (Blum, 1999). Despite their differences, however, they both fought to reverse the effects of medicalization and advocate for natural childbirth and breastfeeding (Blum, 1999; Rothman, 1982; Sandelowski, 1984; Wertz & Wertz, 1989).

Today, breastfeeding advocates have quite successfully moved us beyond the notion that breast milk is inferior to formula, and several health and medical organizations officially support breastfeeding (American Academy of Family Physicians, 2008, 2012; American Congress of Obstetricians and Gynecologists, 2003; American Dietetic Association, 2009; Centers for Disease Control and Prevention, 2011; Surgeon General, 2011; U.S. Department of Health and Human Services, 2008; World Health Organization, 2013). However, this advocacy did not completely demedicalize breastfeeding. It continues to be defined in medical terms, focusing on the nutritional properties and health benefits of breast milk. While this is partially an issue of healthicization, where behaviors and lifestyles are seen as causes of health and disease (Conrad, 1987), it goes beyond this by constructing breast milk as a medical product. For example, the American Academy of Pediatrics (2012) recommends that preterm infants should receive donor milk if the mother's own milk is not available and that, "Practices should involve protocols that prevent misadministration of milk" (p. e831). There is also a growing literature on the ability of breast milk to protect infants from pathogens through its effects on the gut flora (Liu & Newburg, 2013). These construct breast milk as a product separate from the process of breastfeeding and assign it particular properties and medical uses. Furthermore, breastfeeding continues to be constructed as likely to fail, and therefore, in need of medical management (Burns, Schmied, Fenwick, & Sheehan, 2012; Dykes, 2005).

The contemporary medicalization of breastfeeding also has serious implications for motherhood. Despite the existence of a growing body of social science literature that questions the strength of findings regarding the health benefits of breastfeeding (Blum, 1999; Wolf, 2007, 2011), breastfeeding promotion has increasingly emphasized the health outcomes of breast milk, transforming breastfeeding into a moral imperative for mothers (Crossley, 2009; Kukla, 2006; Lee, 2007; Marshall, Godfrey, & Renfrew, 2007; Murphy, 1999, 2003; Wolf, 2007, 2011). The mother who wants to do the best thing for her baby must choose to breastfeed. This reinforces what Wolf (2007, 2011) calls "total motherhood," where mothers are expected to reduce every risk to their children, no matter how small, and regardless of the impact on