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Original Article

Mining for liquid gold: midwifery language and practices associated with early breastfeeding support

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Abstract

Internationally, women give mixed reports regarding professional support during the early establishment of breastfeeding. Little is known about the components of midwifery language and the support practices, which assist or interfere with the early establishment of breastfeeding. In this study, critical discourse analysis has been used to describe the language and practices used by midwives when supporting breastfeeding women during the first week after birth. Participant observation at two geographically distant Australian health care settings facilitated the collection of 85 observed audio-recorded dyadic interactions between breastfeeding women and midwives during 2008–2009. Additionally, 23 interviews with women post discharge, 11 interviews with midwives and four focus groups (40 midwives) have also been analysed. Analysis revealed three discourses shaping the beliefs and practices of participating midwives. In the dominant discourse, labelled 'Mining for Liquid Gold', midwives held great reverence for breast milk as 'liquid gold' and prioritised breastfeeding as the mechanism for transfer of this superior nutrition. In the second discourse, labelled 'Not Rocket Science', midwives constructed breastfeeding as 'natural' or 'easy' and something which all women could do if sufficiently committed. The least well-represented discourse constructed breastfeeding as a relationship between mother and infant. In this minority discourse, women were considered to be knowledgeable about their needs and those of their infant. The language and practices of midwives in this approach facilitated communication and built confidence. These study findings suggest the need for models of midwifery care, which facilitate relationship building between mother and infant and mother and midwife.

Keywords: breastfeeding, midwifery support, discourse analysis, qualitative, expert clinician, lactation science, bio-medical approach, technology.

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Introduction

In Australia, nine out of ten women initiate breastfeeding (Australian Institute of Family Studies 2008). During this time, women experience a range of emotional, hormonal and bodily changes, which, when combined with sleep disturbances and the newness of motherhood, make this a time when additional support is often needed and expected (Dixon 2006; Sheehan *et al*. 2009). While more than 90% of women in Australia commence breastfeeding, by the end of the first week, approximately 12% will have introduced other forms of nutrition or ceased breastfeeding altogether (Australian Institute of Family Studies 2008, p. 15). The rate of full breastfeeding (providing no other liquid or formula) drops at 1 month to approximately 71% and continues to rapidly decline each month thereafter, until by 4 months only 46% of infants are fully breastfed (Australian Institute of Family Studies 2008). This is despite the World Health Organization's recommendation that infants should be exclusively breastfed for the first 6 months (Kramer & Kakuma 2002).

The majority of Australian women give birth in hospital settings where support during the initiation of breastfeeding is the professional domain of

midwives. In recent years, women have described both positive and negative aspects of professional support for breastfeeding. For example, Schmied *et al.* (2011) conducted a meta-synthesis of qualitative studies exploring women's experience of breastfeeding support. The findings demonstrated that support occurs along a continuum. Women described positive professional and peer support from individuals who they perceived engaged with them in an 'authentic' way. Positive support styles included displays of empathy, listening, taking time and sharing the experience with the woman. Conversely, there were examples of negative interactions that represented 'disconnected encounters'. A lack of time, pressure to breastfeed, demoralising comments and unwanted touch reflected the style of support women found least helpful (Schmied *et al.* 2011, p. 51). This latter approach, termed 'reductionist', failed to meet individual needs for support (Schmied *et al.* 2011). Research has shown that directive, dismissive and conflicting health professional interactions impact upon a woman's confidence with breastfeeding (Sheehan *et al.* 2009).

Furthermore, women have consistently reported midwives to be 'pushing breastfeeding' with little consideration of the practical, emotional and relational support necessary to achieve the goal of sustained breastfeeding (Mozingo *et al.* 2000; Hauck *et al.* 2002; Manhire *et al.* 2007).

In the past two decades, only a handful of studies have examined the communication processes between women and midwives in relation to breastfeeding (Renfrew 1989; Dykes 2006). Renfrew identified in the 1980s that, despite increasing knowledge around optimal infant positioning and attachment at the breast (Woolridge 1986), interactions between midwives and women failed to communicate information effectively (Renfrew 1989). Dykes (2006), in her foundational work titled 'Breastfeeding in Hospital', identified some of the ways in which midwives used language to 'manage' women and communicate temporal pressure.

Although the latest Cochrane systematic review of interventions to support breastfeeding women has demonstrated improvements in breastfeeding exclusivity and duration from both lay support, and a combination of professional and lay support (Britton *et al.* 2007), there remains limited understanding of the components of health professional support that facilitates or extends breastfeeding. Given that negative hospital experiences have been seen as an impediment to optimal breastfeeding (Coreil *et al.* 1995; Dykes 2006; Sheehan *et al.* 2009), it is timely that midwifery language and practices be explored in this setting.

Aim

The aim of this study was to examine the nature and impact of the language and practices of midwives when providing breastfeeding support to women in the early post-partum period.

Method

Discourse analysis was used to examine the way in which language and discourse shaped the beliefs and practices of participating midwives and post-partum women, around breastfeeding in the first week after birth. Language and discourse are systems through which meaning and reality are created and reproduced (Weedon 1997). Communication between one individual and another, therefore, does not represent merely 'information transfer', but rather

Key messages

- Midwives held great reverence for breast milk as 'liquid gold' and many approached breastfeeding as the mechanistic transfer of superior nutrition, positioning themselves as the 'experts' available to 'manage' breastfeeding.
- Midwives who prioritised breastfeeding as a relationship between the mother and infant, adopted facilitative styles of communication and engaged with women on a personal level.
- These study findings suggest the need for models of midwifery care which enhance relationship building.

is the process of shaping two personas and subjectivities (Lupton & Barclay 1997, p. 9). Subjectivity can be described as one's sense of self in relation to the world, which is mediated by individual thoughts and feelings about oneself, and others (Weedon 1997:32).

The aim of discourse analysis is to illuminate and recognise how language or texts reflect not only a version of reality but also how they play a role in the 'very construction and maintenance of that reality itself' (Cheek 2004, p. 1144). In essence, discourse analysis allows statements under scrutiny to be slowed down to highlight the hidden interpretive processes and overall patterns. As Cheek (2004) proposed, if we can do this, we create a space through which we can open ourselves to other ways of thinking and understanding.

Settings

This study was conducted at two hospital sites in New South Wales, Australia. Both hospitals were publicly funded and offered general, and specialist, medical, surgical and paediatric health services along with maternity services. Each maternity unit was obstetric consultant led with similar caesarean section rates of approximately 26% (Centre for Epidemiology and Research 2009). One unit was part of a smaller 'general' teaching hospital, which had less than 3000 births per year. The second unit was situated within a larger tertiary referral hospital with less than 4000 births per year (Centre for Epidemiology and Research 2009). Approval to access the participating institutions and conduct the research was obtained from the relevant Human Research Ethics Committees at both Area Health Services as well as the University of Western Sydney.

Participants

Midwives

Midwives and student midwives were invited to participate if they were working with breastfeeding women during the post-natal period. Information about the study was presented at a staff meeting, and flyers advertising the study were placed in the tearooms. Interested midwives then contacted the researcher and were provided with detailed information about the study, all questions were answered and, if they agreed, a consent form signed. Participating midwives worked in a range of models of care including the standard hospital-based model, home-based post-natal care and continuity of care models. Thirty-three midwives and three student midwives participated in the observational component of this study. At site 1, 4 of the 18 participating midwives were International Board Certified Lactation Consultants (IBCLC), while at site 2, 10 of the 18 participating midwives had additional IBCLC qualifications. The average number of years of midwifery experience was 12 at site 1 and 15 at site 2. Across both sites, the range of midwifery experience spanned from a 1-year Bachelor of Midwifery student through to a lactation consultant with 43 years of midwifery experience. A full breakdown of the years of experience can be found in Table 1. Demographic data were collected from midwives, including identified sources of knowledge around breastfeeding. Some midwives volunteered that their own personal experience of breastfeeding had influenced the care they provided, both in positive and in negative ways.

Women

On the post-natal ward, women being cared for by participating midwives were invited to participate if

Table 1. Demographic summary – observed midwives

Characteristics		MUA	MUB
Qualifications	Student midwife	2	1
	Midwife	12	7
	Midwife with LC qualifications	4	10
Employment status	Full-time	8	4
	Part-time	10	14
Years of experience	<5 years	5	4
	6–10 years	2	5
	11–20 years	9	4
	21–30 years	2	3
	>30 years	0	2
Total number of midwives observed		18	18

LC, lactation consultant; MUA, maternity unit A; MUB, maternity unit B.

Table 2. Demographic summary – women

Characteristics		MUA	MUB
Parity	Multiparous	17	15
	Primiparous	18	27
Mode of birth	Vaginal	25	24
	Instrumental	0	3
	Operative	10	15
Age	<20 years of age	3	0
	20–29 years of age	18	19
	30–39 years of age	14	21
	40 years of age and over	0	2
Country of birth	Australia	22	34
	Other	13	8
Educational attainment	4 years of high school or less	6	10
	6 years of high school or less	5	9
	Further education – technical	11	6
	Further education – university	13	17
Total		35	42

MUA, maternity unit A; MUB, maternity unit B.

Table 3. Interaction summary

Characteristics of interactions		MUA	MUB
Professional group	Midwife/student	28	16
	LC	12	29
	Designated LC position	0	11
Location	Ward	30	35
	Home	10	10
Time spent	<10 min	19	5
	11–20 min	11	4
	21–30 min	4	12
	>30 min	6	24
Total number of interactions		40	45

LC, lactation consultant; MUA, maternity unit A; MUB, maternity unit B.

they were aged 16 or over, could understand written and verbal English, and were currently breastfeeding. The study was explained to them and consent was obtained prior to any observations or recording of interactions. Of the 77 women who participated, 45 were breastfeeding their first infant and 32 were breastfeeding a subsequent child. In total, 74 women had singleton births, while three had twin births. The birth history for participating women included 49 normal vaginal births, three forceps births and 25 surgical births (see Table 2).

Data collection

Observations and audio recordings of midwife–woman interactions

Observation and audio recording of interactions was conducted by the first author. In total, 85 interactions were observed and audio-recorded between women and midwives during breastfeeding support. This equated to 33 h of data, with interactions ranging in length from 30 s to 55 min. The average length of an interaction was 14 min at site 1 and 33 min at site 2. Sixty-five interactions (76%) were observed on the hospital post-natal ward and 20 (24%) in the woman's home. The average length of time spent on a home visit was similar across both sites. A breakdown of the different interactions appears in Table 3. All audio-recorded data were transcribed verbatim by a professional transcription service and then checked for accuracy. Non-verbal communication was recorded on a structured observational tool designed for the study. A full account of the process of data collection can be found in a previously published paper (Burns *et al.*, 2012).

Interviews with women

Twenty-three (30%) of the 77 women who participated in the observation of breastfeeding interactions were randomly selected to participate in a follow-up interview, approximately 4–6 weeks after discharge. Women nominated a suitable location and time. The average length of interview was approximately 30–40 min. All interviews were collected and audio-recorded by the first author and then transcribed verbatim. Interviews focused on the women's experiences of health professional support during the first week after birth. Interview discussion starters included: 'Cast your mind back to your early experience of breastfeeding, in particular during the first week after birth, can you tell me about your experience of commencing breastfeeding'. All the women were keen to share their early experiences of breastfeeding support. Generally, women tended to speak about their experiences of positive support, and

helpful midwifery support, before indicating any degree of dissatisfaction with care and/or the lack of availability of health professional support.

Focus groups with midwives

Following completion of the observational component of the study, two focus groups were held at each hospital. Midwives from each maternity unit were invited to attend to 'have their say' and 'tell it like it is' when supporting women who were establishing breastfeeding. Focus groups were conducted during the staff overlap, on an afternoon shift, and midwives working that day self-selected whether or not to attend. In total, a convenience sample of 40 midwives consented to participate. The focus groups were conducted by the first and second author and all participants were informed about the larger 'establishing breastfeeding' study prior to consent. The discussion starters included: 'How would you describe your role in postnatal care' and 'Can you tell me five main things that you think about when providing postnatal care' or 'How would you describe working in postnatal care'. Discussion was generated naturally during the focus groups, and midwives and lactation consultants, at both sites, seemed comfortable to put forward their own ideas, even if they were different to the majority opinion. The focus group interviews lasted approximately 1 h and were transcribed verbatim.

Field notes

Field notes were recorded at the conclusion of each period of observation of midwife–woman interactions. Field notes included a comprehensive record of the observation of midwife behaviour around the desk area and throughout the shift. The general 'busyness' of the ward on particular days was also captured in this way. Similar notes were made for midwifery home visits.

Data analysis

The analytical approach undertaken for this study was based on the work of Fairclough and to a lesser extent van Dijk and Wodak, all of whom advocate for the consideration of the central concept of power and the socially constitutive effect of discourse upon reality (Fairclough & Wodak 1997; van Dijk 2009; Wodak & Meyer 2009). This style of analysis has been termed 'critical discourse analysis' and includes analysis of text, context and social practices.

This three-dimensional approach to analysis incorporates the interplay between individual texts (from interactions), discourse practices (apparent in non-verbal communication) and the circumstances surrounding each interaction (Fairclough 1992; Phillips & Hardy 2002). Analysis involves a comparative and iterative process of moving between interpretation of discourse practices, descriptions of textual analysis and back again to interpretation of both the text and the discourse practices in context, thus incorporating the 'social practice' (Fairclough 1992, pp. 231, 237).

The first move operates at the macro level, revealing the intertextual and interdiscursive links between text and discourse (Fairclough 1992). Here, analysis begins with observation, field notations and observational summaries, and interaction data were categorised, for example according to whether the midwife took a technical and disconnected role in supporting breastfeeding or whether she appeared to have established a relationship with the woman. The second move, textual analysis, includes a microscopic examination of text. This captures the intricacies of the exchange such as turn-taking rules, how topics are introduced and by whom, metaphors, recurring words and interactional control. This component of analysis involves looking more closely at the data, breaking it down into themes, based on the words, ideas, attitudes and beliefs expressed. For example, the regular use of the word 'we' implied that the midwife had an equal role to the woman in managing the breastfeed. The third move specifies the contextual boundaries of discursive practices, or the social and hegemonic relations and knowledge structures within which the discourse is reinforced (Fairclough 1992). Here, we look for interdiscursive synchronicity between the language, practices and context of interactions. For example, here issues of power and control are examined together and how this impacts on midwives' practices that limit or constrain women's decisions, together with strategies that midwives may use to

Table 4. Data analysis

Three moves of discourse analysis	Sources of data
Social practices	Observation Field notes Interviews Focus groups
Text	Transcribed interactions Transcribed interviews Transcribed focus groups
Context	Field notes Interaction log Focus groups Interviews

subvert the system or, alternatively, to reinforce current discourses. Table 4 provides a diagrammatic representation of the process of data analysis adopted for this study. This table outlines the way each piece of empirical data was utilised to complete the picture and provide a more detailed understanding of the complexity of these interactions.

Findings

Critical discourse analysis revealed three distinct approaches to breastfeeding support as well as the discursive influences on the language and practices of midwives. The three discourses have been labelled 'Mining for Liquid Gold', 'Breastfeeding – it's not rocket science' and 'Breastfeeding is a relationship'. Within each of these approaches, midwives communicated and practiced differently. All direct participants quotes are identified by single quotation marks or indentation.

Mining for liquid gold

In the dominant discourse, evident in 68 out of 85 (80%) of the interactions, midwives held great reverence for breast milk as 'liquid gold' and prioritised breastfeeding as the mechanism for transfer of this superior nutrition. In taking this position, midwives focused on ensuring that the infant had sufficient access to 'liquid gold'. Midwives drew on their 'expert' knowledge to introduce a range of techniques and technology to ensure that the infant received breast milk. The midwife's 'right' to access the woman's breasts to acquire this precious resource, for the sustenance of the infant 'patient', was non-verbally communicated to women. In the hospital setting, midwives were observed to be focusing on the physical body rather than engaging with women on an emotional level. In this context, midwifery care became 'breast centred' rather than woman-centred.

Hands on – rights to the 'equipment'

The midwives desire to 'advocate' for the infant 'patient', who was constructed as the vulnerable extractor of breast milk, meant that the woman's lactating breast was seen as a piece of equipment that the midwife, as an expert, had a 'right' of access to. One of the ways midwives demonstrated this perceived 'right' was to adopt the inclusive pronoun 'we' when interacting with women. This appeared to be done in an attempt to include women in the decision making and planning that the expert clinician was engaging in; 'we' will do this and 'we' will do that, as the following, customary, scenario reveals.

Midwife: Let me get some gloves. We'll see if we can get the baby on . . . [then later]
Midwife: I'm a little bit quicker . . . (at putting the baby on)
(Interaction (Int) 72)

This was commonly followed by physically accessing and touching the breastfeeding 'equipment' often without seeking the woman's consent. Using a 'hands on' (midwife attaching the baby for the woman) approach to 'show' how to 'best' attach an infant and identify the markers of correct alignment (nose to nipple, flanged lips, massaging chin) was reportedly most expediently and efficiently achieved if conducted by the midwife in the first instance.

Midwife: You sit there and I'll do it.
(The midwife placed her gloved hands onto the woman and attached the baby to the woman's breast. The woman was non-verbally instructed to keep her hands out of the way)
Woman: Okay.

Midwife: You just deep breathe and talk to your bub [baby] (then a little time later).
Midwife: Now if you listen to me rather than focus on him trying to get on.
Woman: Oh all right. (Int 70)

During focus group interviews, some midwives acknowledged their tendency to 'do for' the woman, inferring an inability to resist placing their hands on the woman and fixing the poor positioning they observed. Some midwives indicated that the ongoing time constraints made it difficult to provide 'hands-off' breastfeeding assistance, as this was perceived to take more time, '. . . it's just easier and quicker to lean in over the top and to put those little babies on' (FG 4). There was also a sense in the data that being able to competently attach an infant, often referred to as 'having the knack', was a highly prized and sought-after skill that afforded some midwives a sense of status within their professional peer group. The following is an extract from the field note data recorded as a midwife returned from helping another midwife attach a difficult infant: '. . . just got 12 on the breast, fussy little bugger, naughty boy, got him on though . . .' (Field notes day 7).

Women commented on this 'hands-on' approach during the post-discharge interviews. Some women clearly appreciated all the extra guidance, whereas others found it intrusive and demoralising.

Woman: The only thing was like that first feed the midwife took over basically rather than me trying it first for myself. I would have liked to have tried just you know me and the baby by ourselves, with a midwife there but not taking control.
EB: Yes. So when you say she took control what sort of things did she do?
Woman: Well she basically put him on my breast for me and I wasn't really doing anything. . . . (IV 11)
Woman: I found that really confronting as a first-time mum, like having some stranger grabbing your boob and – 'cause you really don't think about any of that till after you've had them. (IV8)

This second woman went on to state that once she knew how midwives assisted with breastfeeding, she was not as distressed by the 'hands on' approach stating, 'whereas with [second child] it didn't bother me 'cause I sort of knew that's how they showed you how to do it' (Interview (IV) 8). While the focus of these interviews was on the most recent 'establishing breastfeeding' experience, women at times made reference to previous experiences.

The tools of the trade: facilitating and fixing the equipment

To ensure that the infant had access to colostrum and/or breast milk, midwives were observed introducing a range of tools and techniques. Hand expressing colostrum was a commonly used tool to entice the infant to the breast, giving the infant a 'taste' of what was on 'offer'. During the early initiation phase of breastfeeding, midwives did this 'for' the woman rather than sharing with the woman the skills and knowledge to enable her to undertake this activity herself. As a result, midwives were observed to be very much in control during these interactions and invariably the woman 'submitted' to the 'expert' clinician. The practice of 'hand expressing' colostrum for the woman often led to midwives subsequently feeding the infant for the woman.

Midwife: Probably at this stage we'll just get it out and get it into her, because there is a bit of a knack to it and if you were up it's easier you know if you were standing in front of a mirror you can sort of see where to squeeze . . . [midwife hand expressing for the woman] . . . We're doing pretty well here . . . she will probably lap it out of a cup but I might syringe it into her you don't want to waste any drops.
Woman: That's a fair bit, yeah.
Midwife: At least about four millilitres so that's great. I'll see if I can get her to suck it off my finger . . . we want it all down the hatch. (Int 46)

Additional tools such as nipple shields were also recommended by midwives. The following field notation demonstrates one midwifes' level of frustration at not being able to attach a baby to the breast on the day of birth; 'I'm going to use a nipple shield for this woman – I can't get that baby on for love nor money'. (Field notes on Int 41)

Strategies to 'protect' the breast (the breastfeeding 'equipment'), increase the supply of colostrum or milk (the product) and to sustain the newborn (the

breast milk 'extractor') were also commonly prescribed. At one site, taking the baby off the breast for a period of time was the approach of choice. The 'resting and expressing' plan traditionally recommended electric breast pump use for 10 min each breast, followed by 5 min each side at three-hourly intervals during the day and four-hourly intervals at night. Breast massage was encouraged during pump expression. Additional recommendations included the use of skin-to-skin contact with the baby (as a tool for milk production) and the application of breast milk and cream to nipples following expression. In the event of inadequate 'supply' of breast milk to meet the infant's daily needs, a quota system of topping up with formula was devised. Women were often discharged on this regime. The following excerpt captures the significant impact of early breastfeeding discourses around the use of tools.

Midwife: Yeah. Are you borrowing a soft cup feeder?
Woman: We've bought it all.
Midwife: You bought the whole lot?
Woman: Just spent a fortune but we bought the whole lot.
Midwife: That's alright.
Woman: Yeah, it's worth it.
Midwife: It sure is. Where are you getting the [expresser] from? The actual pump.
Woman: We got it.
Midwife: Oh you bought a pump? Oh wow. Okay.
Woman: We bought an electric pump. We bought the soft cup.
Midwife: Oh my goodness. Those [swing] ones are meant to be pretty good. It's just there's a mob down the road that hire the pumps like those ones . . .
Woman: So 10 mls of formula.[top-up]
Midwife: Yeah.
Woman: That's one thing we didn't buy. We have to buy formula. . . .
Woman: We bought the bottle warmer [identical to the hospital version]. I went downstairs to the chemist and spent a fortune (Int 55)

This woman's need to buy all of the equipment used by the hospital, in order to enhance the performance of her body, not only demonstrates the marketing power of 'expert' clinician recommendations but also reveals a subtle communication of the need for technological support to sustain breastfeeding.

The 'expert' midwife

Within the 'Mining for Liquid Gold' discourse, midwives adopted a position as expert clinician. This included the role as teacher and supervisor of the woman's use of her 'breastfeeding equipment'. In comparison to midwifery experience and education around breastfeeding, women were collectively assessed as lacking of relevant knowledge and skill development.

Women were encouraged to call the 'expert' midwife when necessary and the 'expert' often offered unsolicited help and advice. When women requested assistance, the focus was immediately on 'this' breastfeed, 'this' baby and the 'status' of the milk arrival rather than on a discussion of prior breastfeeding experience or knowledge. Expert supervision was deemed necessary to ensure the baby was 'getting on right', was sucking 'nutritively' and was not causing 'damage' to the breasts, communicating an impression of the woman as a novice.

Observation of breastfeeding, by a midwife or lactation consultant, invariably generated a variety of 'faults' in the woman's technique. Midwives verbally 'tweaked' at positioning by advising the woman to change her hand positioning, to hold the baby in a particular way, to take the baby off and 'try' again after waiting until the infant's mouth was open wider, and to generally give directive instructions. The common scenario of a woman 'trying' to put the baby 'on' while a midwife observed, offered suggestions and advice, or physically intervened on the infant's behalf, often played out as the teacher and novice situation. The following excerpt reveals the midwives' own presumed need to prepare for the provision of hands on 'help' with the reference to 'popping' on the gloves:

Midwife: I'll get you to try and pop him on and I'll just pop my gloves on.
Woman: Okay. Good boy.
Midwife: Keep that hold until he really continues with the big sucks. Should just take a little bit more I think. I'm going to move his arm just – I'm going to move it down. Would you

mind just moving over a little bit? Beautiful. Try again- . . . Remember that little trick we did before. I actually (remember) let him suck on my finger. Okay now I'm going to quickly get you to turn him around now. Yep, quick. That's it. Beautiful. (Int 60)

Breastfeeding – it's not rocket science

In stark contrast to 'mining for liquid gold', the second discourse 'not rocket science' saw women being left to their own devices. This was apparent in 9 out of 85 (11%) of the observed interactions and in focus group and interview data. Of note, midwives with lactation consultant qualifications did not draw upon the 'not rocket science' discourse in their language or practices. Here, breastfeeding was constructed as 'natural' or 'easy' something that all women could do if they were sufficiently committed.

Midwife: . . . If women take some time and are prepared to put in the hard yards they will get there. It's not rocket science. Anyone can do it. You don't have to have an IQ or, you know. (Senior Staff Interview (SSIV) 10)

In this approach, midwives highlighted a sense of futility in 'trying' to convince a woman to breastfeed when they perceived that the choice and commitment inevitably resided with the woman. The 'not rocket science' discourse enabled the midwife to prioritise other aspects of care such as giving medications and completing observations and documentation. This discourse was aligned with the institutional priorities of managing risk, ensuring 'patient' safety and efficiently moving women into and out of the system. This focus rendered breastfeeding unimportant and something that women should be left to get on with.

'Anyone can do it' you just need commitment

The notion that breastfeeding was an activity which all women could do, if they so chose, underpinned all aspects of this discursive approach to 'support'. Women were often positioned as proactive and autonomous individuals who sought out information about breastfeeding, if, and when, they needed it. Midwives anticipated that during pregnancy women would gather the information required, regarding feeding options, from a variety of sources and would invariably base decisions on the opinions of those who mattered the most in their lives: their family and friends.

Midwife 3: Because a lot of them don't take much notice of what we're saying.
Midwife 2: It's what mum and grandma and aunty . . .
Midwife 3: They more listen to the 'I never had enough milk'. I won't have enough milk. 'I was never able to do it, you won't be able to do it either.'
Midwife 2: Yes, there's a lot of that . . .
Midwife 4: I think family has a much more important influence than we do. (Focus Group 1)

A belief that midwifery input was superfluous for women who were 'committed' to breastfeeding was highlighted within this approach. Consequently, there was also a belief that women who were 'unsuccessful' with breastfeeding were 'not committed' enough in the first place.

Midwife: I think it comes back to the women, and whether they really want to breastfeed as well . . . I'm prepared to – and I think most of us are prepared to give as much support as we can, as far as breastfeeding goes, but the women have to have some sort of commitment as well. If they don't have that commitment, then there's no point in us busting our gut to do it, either. (SSIV3)

Field notes from conversations at the midwives desk area confirmed a midwifery focus on determining the level of 'commitment to breastfeed' before providing additional assistance. At interview, one woman described feeling a sense of pressure to 'make a decision' about whether or not to continue to breastfeed, when problems arose (IV7).

We are here if you need us . . .

Once women had made their choice to continue with the 'hard yards' (SSIV 10) while awaiting the 'milk coming in', midwives were available to help if required. The manifestation of this support, however, seemed to be influenced by the proliferation of a midwifery 'hands-off' approach to breastfeeding support.

Midwife: I still think it's a hands-off approach. See how you go. If you're having trouble, I'll help you with it . . . (SSIV4)

This senior midwife described leaving women to their own devices to initiate breastfeeding while being available for assistance if deemed necessary by the woman. While the hands-off approach to breastfeeding support observed by others in this study included 'talking' the woman through optimal positioning and attachment, while avoiding physical touch, and included long periods of verbal and non-verbal support and education, the 'not rocket science' interpretation of this approach was devoid of long verbal exchanges. Instead, what was observed were short directive communication exchanges between midwives and women, where the midwife remained detached from the interaction.

The following interaction represents this tick box approach to breastfeeding support. The interaction commenced when the midwife answered the 'call' for assistance:

Midwife: How does that feel for you? Is that ok? Not painful at all?
Woman: No.
Midwife: That's lovely, is it your first baby?
Woman: Second.
Midwife: Oh ok and you breastfed your first?
Woman: Yes.
Midwife: Good, well that looks good to me.
Woman: Yeah.
Midwife: Yes if it feels ok.
Woman: Yes, is it the right position?
Midwife: She's nice and close to you, that's right, beautiful.
(To me): Simple enough . . . then Midwife leaves. Interaction completed. (Int 5)

At times, midwives were observed resorting to the use of 'hands-on' approaches to quickly achieve infant attachment at the breast. In most cases, the midwife left the woman as soon as the baby was attached, returning to 'more important duties'. Women referred to a level of frustration when receiving care from midwives with this type of approach.

Woman: [The] Midwife put him on my breast and left.
EB: As in put him on your breast by physically . . .
Woman: Yeah, just physically put him on for me. Didn't talk to me about the process or anything. Just put him on and then she was gone and I was just feeding the baby and my husband was there and we were just like, well what do we do now. . . . That was it. For the next three hours we were alone with the baby. So it wasn't a pleasant experience and I'll never go back to [name omitted] as a result. (IV 13)

Within this discursive approach, these 'quick fix' solutions were so commonplace that they were observed to occur regardless of whether the midwife was busy or not.

There are other 'priorities'

Within the 'not rocket science' approach, midwives did not prioritise breastfeeding. Instead, they concentrated on aspects of care which could not be delegated to the woman in the way that breastfeeding could. In other words, midwives focused exclusively on the 'tasks' which were within the health professional's domain. The following excerpt from an interview with an experienced midwife captures the preferential 'priorities' midwives identified:

Midwife: . . . so basically I would check the notes, I would have their – first I'd have a diagnosis, then I'd check the notes and see if there's anything else that I need to know. Then I'd prioritise who needs medications, who needs them when, who is the most dependent, which would be surgical patients, which would be a Caesar. Who needs to get up and those sorts of things, who needs my help the most, physical help, and who needs that nursing care type thing first. There's no way you can do it any other way, because if you try to go well let's just do the breastfeeding first, we'd have patients sitting in the bed all day. And it doesn't really work that way, because then we create other problems for them . . . So I'd probably go and do the nursing things first, knowing that there's midwifery things to do and then I'd work my way through the midwifery things. . . . (SSIV3)

The prior**i**tising of what the staff termed 'nursing' aspects of care, such as the routine collection of observations, implied a separation of 'rocket science' (nursing and medical care) from 'not rocket science' (midwifery and breastfeeding care). This separation prioritised medical tasks over supportive engaged midwifery care.

'Breastfeeding is a relationship'

In the third, minority discourse, breastfeeding was viewed as one component of the developing mother–infant relationship. Data analysis revealed that in only 9% of interactions ($n = 8$) the midwife prioritised the relationship between the woman and her infant as central to the breastfeeding experience. In this minority discourse, women were considered to be knowledgeable about their own needs and those of their infant. The language and practices of midwives in this approach facilitated communication and built confidence.

Getting to know the woman

The first demonstrable difference between this 'relationship orientated' practice and the previous practices presented was the value attached to getting to know the woman. Midwives within this approach tended to begin their interactions with women by engaging in friendly 'chat' for a period of time before enquiring about the areas the woman would like to discuss. The woman was clearly at the centre of care. Midwifery communication styles, within this discourse, included open-ended questioning and opportunities for women to lead and dominate the discussions.

Midwife: What do you feel about your supply?
Woman: I was actually glad I was making her feed yesterday because my milk had come in and I was just so sore. *And* I was having obviously trouble, because I was so hard here, she couldn't get that mouthful and so it was hurting because she was only trying to grab the very tip.
Midwife: That's right, so what did you do about that?
Woman: So I stuck my finger in there to try and – and it was hard too, because I couldn't press in here too much – to get her to stop so that then I could try getting her to go back on again. . . . [*the woman continues on for another 5 minus explaining her approach and how she problem solved*]
Midwife: That's right, if it's persisting, yes, you're doing the right thing, you take her off and then you put her back on. [Int 35]

Midwives spent time assessing the situation and asking questions; commonly referred to as 'checking-in' with women. This approach included enquiries about how other aspects of her life were going and did not focus exclusively on breastfeeding. Women described this as a desire 'to know [their] story' (IV 12). Women valued midwives who wanted to know them as individuals and who went out of their way to be friendly and form connections.

Woman: She was great. I would love to have bottled her and kept her but I had her in my life for two hours. . . . She wanted to know the story. She asked the story. So how did the birth go? She was the first person who asked who really listened to that story. (Int 12)

The importance of body language was also identified by women during interviews; 'Just their body language. They smile, they don't look grumpy' (Int 6). A soft tone of voice and sense of calmness were additional factors described by women when talking about their experiences with midwives they had developed a connection with. The ability to convey a sense of having 'all the time in the world' to spend with the woman, even though the ward was 'busy', was especially noted and valued.

Getting to know the baby

Within this relationship-focused approach to breastfeeding support, infants were constructed as deeply connected to the woman, as though they were an extension of the woman. The mother and infant were seen as two components of one system. For this reason, women were encouraged to engage in 'tuning in' behaviours such as watching for signs that the infant was hungry, closely observing the infant's discovery and learning phase of breastfeeding, and recognising when the infant was tired and needed rest. The following interaction is an example of this approach. The midwife had not met the woman previously and she used a soft, gentle manner to facilitate rapport building in a very short period of time. She worked to reinforce that the infant was 'learning' to breastfeed, just as much as the mother was, challenging the woman's negative perceptions of her infant's ability to breastfeed.

Woman: No, so she cannot do this.
Midwife: Okay. But she can, she doesn't know the difference from one side to the other. So we just leave her to have a

little feel. She will just start moving her head in a minute, just like that. See how she is moving her head and she is feeling it with her cheek? [Inaudible].
Woman: [Inaudible]. She just cannot get the nipple.
Midwife: She will if we just wait. She will just be able to move her little head around. See how she is doing that again now? She's happy to stay there and she's not pulling off or crying. She's happy to be there.
Woman: Yeah. She's not sucking.
Midwife: That's okay, she's [inaudible] out here and she can hear your voice, she knows your voice, she's heard it for a long time.
Woman: Yeah.
Midwife: She can hear both our voices very clearly now. She has waited to see your face like you have waited to look at her for a long time.
Woman: Can she see us?
Midwife: Yes. When you cuddle her and hold her in your arms, she can look up into your face and see your eyes and your eyebrows . . . [Int 5]

Midwives practicing within this relational approach at times redirected maternal constructions of the breastfeeding infant as 'demanding' and reframed unfavourable representations of breastfeeding and breast milk. For example, the following excerpt indicates how the woman at times variously referred to her milk as 'stuff', implying that it was a substance that did not belong to her. The interaction also highlights the woman's inclination to construct her infant as 'disinterested' in breastfeeding or as 'stubborn' and 'sleepy'. The midwife chooses to either ignore such negative statements or offer an alternative interpretation of the infant's behaviour. In the end, the maintenance of a positive stance eventually influenced the woman's discursive representations of her newborn infant's behaviour.

Woman: . . . I've only put him on this one. I wanted to try this one but I thought, well maybe if I could just get a bit of stuff out I might be able to entice him to feed, but I don't know . . . he's a stubborn little bugger . . .
Midwife: He's having a little lick with his tongue and feeling whether it's there. He may still come back or you may need to relatch him but he had a feel and he's checking it out . . . He's thinking about it, isn't he? Slowly.
Woman: Yes. You don't make decisions real quick do you mate? A bit like your father [laughs]. Takes him for ever to make a decision . . .
Midwife: That's great. You've stimulated him and offered it to him now and he just may not be quite ready yet and it's okay if you're comfortable just to do some skin-to- skin with him. You may find that he'll just crawl across and hop on . . .
Woman: See what you're doing to me?
Midwife: Oh no. He's just saying, 'mum, I don't know what to do'.
Woman: I suppose he came out a couple of weeks early too [laughs]. You didn't get that lesson, did you?
Midwife: He's listening to your voice and smelling and feeling.
Woman: He just went to grab my finger. He's doing that himself so he must be wanting to feed.
Midwife: So would you want to keep trying?
Woman: Yes I would [Int 49]

Through the simple act of 'normalising' infant behaviour, this midwife avoided the tendency to ascribe negative personality traits onto the newborn infant. In this way, the bond between the woman and her infant was potentially enhanced.

Prioritising women's knowledge and abilities

In this approach, midwives communicated by using both verbal and non-verbal language to convey an inherent confidence in the mother and infants' abilities to breastfeed independently. The woman's own knowledge about her infant was sought, and prioritised, as was the use of open-ended questions, which facilitated the gathering of woman-led information.

The preferred style of support was gauged during a period of 'tuning in' to the woman's feelings and preferences regarding breastfeeding. Interactions commenced with a period of getting to know the woman and incorporated 'hands-off' breastfeeding support. However, if the woman indicated a desire for 'hands-on' assistance, or a demonstration from the midwife, this was also accommodated. There was a noticeable midwifery focus on facilitating the development of the woman and infant's 'own way' of breastfeeding rather than adhering to a prescriptive regime advocated by the health practitioner.

Midwives who prioritised relationship building shared many suggestions and options for women to choose from but universally avoided merely giving instructions. In this way, the woman's right to self-determination was respected and facilitated. The relational approach instantly positioned the woman as an equal, autonomous human being.

Discussion

The findings presented in this paper represent a range of midwifery support styles in contemporary post-natal care. The 'mining for liquid gold' and 'not rocket science' approaches represented two end points along a continuum of approaches to breastfeeding support. At one end of the continuum, the active and intensive 'mining for liquid gold' performances dominated. Here, women were positioned as the 'suppliers' of the precious resource and midwives as the 'experts' available to 'manage' breastfeeding. In this approach, midwifery practice was focused on the achievement of a functioning breast-baby dyad, without regard to the needs of the woman. At the other end of the continuum, breastfeeding was considered something which all women could do if they were sufficiently committed. Midwives working within the 'not rocket science' approach demonstrated a passive and/or dismissive support style.

An alternative approach was offered by midwives who viewed breastfeeding as a relationship. Within this small sample of alternative discursive styles lies the realisation of an authentic or genuine relationship-based professional support style, which facilitated ongoing breastfeeding and enhanced mother–infant synchronicity.

We argue that several discourses, in particular, have influenced the majority of these midwifery language and practices observed during the post-natal period. Firstly, the focus on breast milk as 'liquid gold' seems to reflect discourses emerging from science and medicine, particularly the relatively new science of lactation. The growth of the medical specialty 'breastfeeding medicine' has also shaped midwifery knowledge and understanding of breast milk production, concomitantly leading to a detached view of the breasts and an increased reliance on technological enhancement. These discourses appear to be informing the midwifery prioritising of 'liquid gold' and the optimising of 'breast' performance. In this context, the midwifery discourses of woman-centred and partnership care appear to be suppressed. Secondly, midwives have embraced these scientific discourses and have integrated 'authoritative' knowledge into their practice as 'expert' clinicians.

Lactation science and breastfeeding medicine

In the last 30 years, breastfeeding and breast milk have re-emerged as the superior option for optimal infant and child health and well-being. This recognition of breastfeeding as 'best' for infant health has been achieved largely as a result of the work of committed breastfeeding advocates, armed with scientific evidence demonstrating the superiority of breastfeeding for infant and maternal health (Hausman 2003; Palmer 2009, pp. 1292–1296). We contend, however, that lactation science, with its increasing focus on sophisticated analysis of the components of breast milk, and the physiology of lactation (Kent 2007; Ferro *et al*. 2009; Walker 2010), has moved well beyond highlighting the many benefits of breastfeeding towards making breast milk and breastfeeding more important than the woman herself. Heightened interest in lactation science has spurned a medical specialty referred to as 'breastfeeding medicine'. Scholarly scientific and medical research papers featuring investigations into topics such as 'Measuring milk synthesis' and 'Milk ejection in women expressing breast milk' are now common (Arnold 2006; Ramsay *et al*. 2006; Czank *et al*. 2010; Lai *et al*. 2010). Increasing medical knowledge about lactation has provided a platform for the monitoring and surveillance of the breastfeeding woman, for the benefit of society and the health care system (Academy of Breastfeeding Medicine (ABM) 2010: website). Contemporary discourses within these publications reflect a disembodiment of the breast from the woman.

Some of the practices observed during midwifery support for breastfeeding women reflected this focus on optimising 'liquid gold' production and availability for the infant 'patient'. Increasing the performance of the breast fits with the current practice of maximising

bodily performance in public health discourse more broadly (Lupton 1995; Bauman *et al*. 2002; Bauman 2004). Our study findings strongly suggest that medicalising the breast and breast milk in this way might be contributing to the disembodied, and nutrition-focused midwifery discourses and practices observed.

The midwife as the technocratic expert

The dominant style of midwifery practice observed at both hospitals reflected the incorporation of a Cartesian medical view of the body into hospital-based midwifery practice. Davis-Floyd (2001) asserts that 'Cartesian medicine' fundamentally underpins much health professional practice in hospital environments and breeds 'technocratic' health professionals. Within the technocratic model, the body is viewed as a 'machine' and is compartmentalised into its various components (Leder 1984; Davis-Floyd 2001). Health professionals become most interested in the body machine when it malfunctions (Leder 1984). This principle is evident in the review of professional literature, which reports many studies of breastfeeding 'problems' but tends to ignore analysis of trouble-free breastfeeding performed without incident (Burns *et al*. 2010).

In this study, midwives who approach breastfeeding and the breastfeeding woman from the perspective of 'mining for gold' positioned the woman as a 'passive' subject where her self-acquired knowledge and even her embodied knowledge (Bartlett 2005) were dismissed along with socio-cultural aspects of her life. In this approach, expert 'technocrats' scrutinised and assessed for malfunction, and intervention followed the detection of bodily transgressions. The technocratic midwife utilised her 'expert' skills to 'fix' problems and introduced 'sophisticated' machines when necessary. In fact, during observations at one site, the introduction of equipment such as breast pumps (technological bodily enhancement) was evident well before the natural bodily process had time to 'work'. This use of technology, as a norm, represents a central tenet of the technocratic model and reflects a desire to 'control nature' (Davis-Floyd 2001, pp. S8–10).

Similar disconnected encounters have been reported by Dykes (2006) in her study of midwives on post-natal wards in the UK. The technocratic midwife interacted with the woman in a way that communicated what Dykes (2006, pp. 130–138) has described as 'temporal pressure', using 'insensitive and invasive touch' while 'managing breastfeeding' and the 'disembodied breast'. Interactions reflected the notion that it was quicker to 'do for' rather than 'teach' which resonates with McInnes & Chambers's (2008) meta-synthesis findings. Midwives used language that effectively controlled and limited decision making by the woman and ensured a superior position in the relationship with the woman.

Time management strategies used by midwives to get through their day's work led to a devaluing of the importance of effective communication with women. These were particularly noticeable in the 'not rocket science' support style. Midwives elsewhere have reported the detrimental effect of encroachments on midwifery time, such as administrative tasks and computer work (Cattrell *et al*. 2005). Furber & Thomson (2007) have similarly reported a 'rationing' of time, undertaken by midwives, when the ratio of 'midwife to woman' was inappropriate. In their study, Furber & Thomson (2007) reported that midwives prioritised care and adopted 'popping in' strategies, or waiting for calls for assistance, while moving onto other 'tasks'. Of particular significance is the fact that midwives appeared to integrate this style of practice into their daily 'routine' regardless of whether or not the ward was busy, reinforcing the influence of the discourse on these practices.

The partnership approach

By contrast, the breastfeeding support interactions that reflected a relational and partnership approach (Guilliland & Pairman 1995, p. 7) were influenced by a different set of discourses. Here, midwives were observed interacting with women as equals, where power and responsibility were shared and relational communication resulted in mutual respect and trust. This included taking time to socially engage with the woman as well as a period of 'checking in' with her. This resonates with Dykes' (2006) description of 'touching base', which similarly involved the use of open-ended questioning to elicit how the woman

was feeling, how her children and significant others were, and general familiarising with each woman's individual situation. Elsewhere this type of engaged and responsive two-way dialogue has been described as an 'authentic presence' featuring empathic listening, genuine support, taking time, sharing the experience and providing positive confidence-building encouragement (Dykes 2006; Schmied *et al*. 2011).

During this approach, midwives also used 'chat' to establish rapport. These interactions closely reflect those identified in Fenwick's study of facilitative communication styles in the NICU (Fenwick *et al*. 2001). Social interaction during communicative exchanges facilitated engagement with women on a personal level and at times allowed midwives to share aspects of themselves in the process. The relationship between the midwife and woman protected the woman's dignity (Berg 2005) through ongoing dialogue, trust and shared responsibility. Interactions noticeably focused on the woman's needs. The key markers of positive experiences of breastfeeding support – a midwife who could 'sit through a feed', who could provide some degree of continuity of care and who had a non-judgemental and affirming communication style – were evident in this partnership approach (McInnes & Chambers 2008, p. 418; Schmied *et al*. 2011).

Interactions where midwives demonstrated a level of trust in both their own knowledge and in women's bodies (referred to as 'embodied knowledge') reflected genuine midwifery care (Leder 1984; Berg 2005). By encouraging women to 'tune in' to their body and their infant, midwives communicated a belief in the normalcy of breastfeeding, conveyed confidence in the woman and facilitated assistance in whichever form the woman desired. Like Taylor (2010), we found the conversation between a breastfeeding woman and her infant is a physically and emotionally intimate exchange. Midwives who approached breastfeeding with a 'relationship focus' facilitated, rather than interrupted, breastfeeding. In essence, the primary function of the midwife, during the early establishment of breastfeeding, was to prioritise the 'act of listening' (Taylor 2010, p. 234) and keep breastfeeding normal.

Limitations

This study was conducted in NSW, Australia, at two geographically distant maternity services. While the study produced a large amount of data, it cannot be assumed that the findings can be generalised to all Australian midwifery practice around breastfeeding.

Conclusion

The three discourses, inherent in the language and practices of midwives providing early breastfeeding support, were embedded within and constructed by powerful institutional, professional and public discourses such as the science of lactation, breastfeeding medicine, technocratic medicine and, to a lesser extent, the midwifery discourses of woman-centred care and partnership. The dominant discourse 'mining for liquid gold' inhibited effective support for women who were establishing breastfeeding and at times disrupted the mother–infant relationship. Prescriptive and authoritative communication styles denied fulfilment of midwife–woman partnerships. The midwifery focus on 'product over process' and the influence of a Cartesian dualist technocratic view of the body led to disconnected encounters and incorporated reductionist approaches to breastfeeding support. Significantly, facilitative communication styles emerged from interactions with midwives who prioritised breastfeeding as a relationship and spent time engaging with women on a personal level.

The findings from this research add to a body of knowledge calling for reform in the provision of post-natal care. Maternity care facilities need to commit significant resources to developing, implementing and evaluating models of midwifery care, which facilitate relationship formation between midwife and woman, and enable flexibility in care provision.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

All co-authors conceptualized and designed the study. EB collected and undertook preliminary analysis. All co-authors confirmed the analysis. EB and JF prepared the initial draft of the manuscript. All co-authors participated in editing and critically reviewing all sections of the paper for important intellectual content. All co-authors participated in the final preparation of the manuscript.

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