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Current Scope of Practice for Breastfeeding and Lactation

Medicine Physicians and Providers: Description of an Emerging Subspecialty

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Abstract:

Breastfeeding and Lactation Medicine is an emerging medical subspecialty that addresses the physiology, pathology, and sociodemographic components of breastfeeding and lactation. In the past 50 years, the field has grown into an international subspecialty supported by the Academy of Breastfeeding Medicine. Training programs are emerging in many countries, and it has become a reimbursable, board-certified medical specialty in the United States and Canada. Breastfeeding and Lactation Medicine providers manage routine and complex issues arising during lactation, across multiple care settings. Care requires a comprehensive skill set that includes a strong understanding of the distinct and interdependent physiologies of presenting patients as well as a consideration of the context in which families are immersed. Providers in this field are also advocates, researchers, policy consultants, and educators, leading global improvement in the clinical care and social support for families who are breastfeeding or lactating. Struggles for the field have included difficulties with institutionalizing programs, a research agenda not focused on diagnosis and management of common conditions, competition with commercial milk formula marketing practices, and limited training opportunities. This paper was developed by an international group of Breastfeeding and Lactation Medicine providers and the Academy of Breastfeeding Medicine to describe the scope of the field, who practices in the field, the problems addressed, challenges faced, and some cases that exemplify this work.

Keywords: breastfeeding, breastfeeding medicine, lactation, subspecialty, scope, practice, physician, doctor

About ABM Statement

The mission of the Academy of Breastfeeding Medicine (ABM) consists of medical doctors "educating and empowering health professionals to support and manage breastfeeding, lactation and human milk feeding" with the vision that there will be "healthier lives worldwide through excellence in the medical care of breastfeeding and lactation." As such, position statements help to disseminate the philosophy of the organization with regard to key topics related to breastfeeding and lactation. This position statement is based on the best available evidence and interpretation by the expertise of our members.

The Academy of Breastfeeding Medicine recognizes that not all lactating individuals identify as women. Using gender inclusive language, however, is not possible in all languages and all countries and for all readers. The position of the Academy of Breastfeeding Medicine (https://doi.org/10.1089/bfm.2021.29188 .abm) is to interpret clinical protocols and position statements within the framework of inclusivity of all breastfeeding, chestfeeding, and human milk-feeding individuals.

Introduction

Breastfeeding and lactation medicine (BFLM) is an emerging subspecialty that addresses the physiological, pathological, and psychosocial components of breastfeeding and lactation. In the past 50 years, the field has grown into an international subspecialty supported by the Academy of Breastfeeding Medicine (ABM). Training programs are emerging in many countries, and it has become a reimbursable, board-certified medical specialty in the United States and Canada, with a board-certification process underway in the Philippines. This article describes the scope of the field, who practices in the field, the problems addressed, and some cases that exemplify this work.

What is BFLM?

BFLM clinicians recognize, diagnose, and treat conditions that impact breastfeeding and lactation across the lifespan. They offer inclusive support for breastfeeding and lactation, helping families achieve their goals and optimizing outcomes, thereby contributing to improving global health and development. In addition to providing clinical breastfeeding care, BFLM providers engage in research and provide education in community and medical settings. Their expertise is sought to inform guidelines and public policy. BFLM providers are uniquely qualified to lead donor human milk banks and to address medical issues related to availability, use, or impact of donated human milk (**Fig. 1**).

Central to the practice of BFLM is the equal care of *at least two* individuals—in most cases a child and a mother, but in some cases multiple children and lactating parents who may be breastfeeding, chestfeeding, or feeding expressed human milk. A BFLM provider is knowledgeable and specifically skilled in providing clinical care, making differential diagnoses and treating any lactation or breastfeeding problem (e.g., primary low milk production) and managing medical conditions that interfere with optimal breastfeeding and lactation (e.g., anemia and hypothyroidism). They also work to prevent complications that may limit the optimization of breastfeeding outcomes, such as mastitis, peripartum mood disorders, or secondary low milk production from inappropriate supplementation with commercial milk formula (CMF). As consultants, BFLM providers support

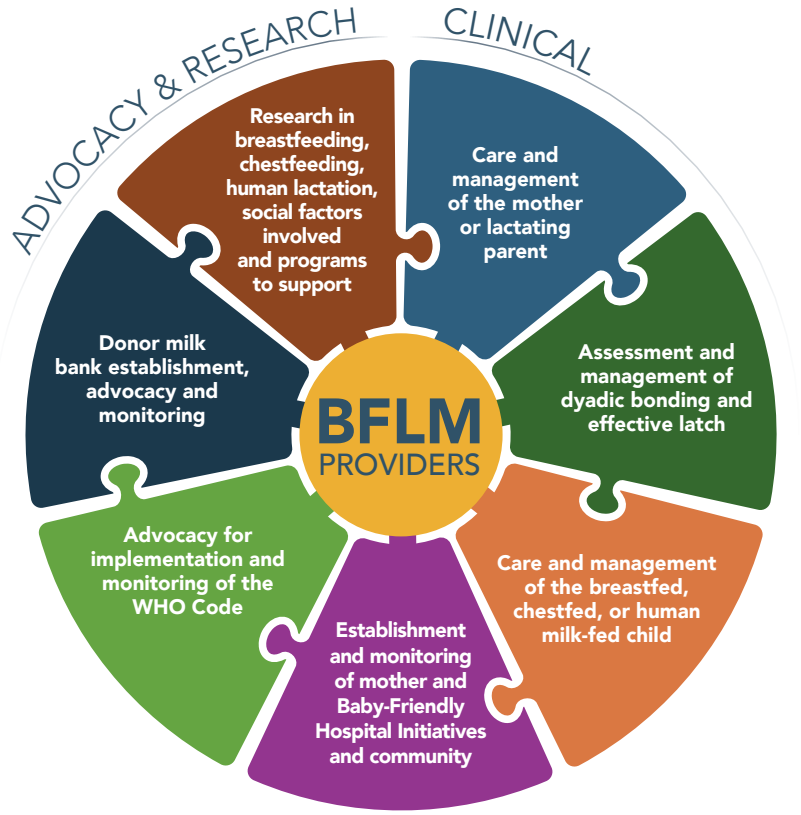

FIG. 1. Roles and expertise of breastfeeding and lactation medicine providers around the globe.

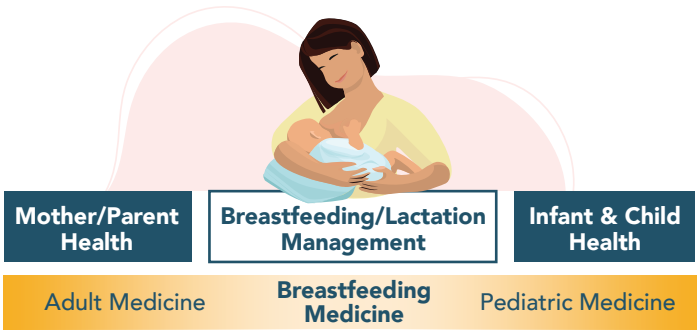

FIG. 2. Elements of integrative clinical breastfeeding care and who can provide it.

other providers caring for breastfeeding persons to manage medical and surgical concerns while supporting patients in the continuation of breastfeeding or lactation, when possible.

While different specialties have a role in the promotion, protection, and support of breastfeeding and lactation, each addresses a piece of this dyadic and complex physiological process. In contrast, to practice BFLM, it is necessary to comprehensively address the health issues of any mothers/lactating parents of the infants/children and the lactation/ feeding management issues that need professional care (**Fig. 2**).

The Landscape of Practice for Breastfeeding & Lactation Medicine Providers

Why breastfeeding?

Breastfeeding is the physiological norm for infant and young child feeding and completes the reproductive cycle. By breastfeeding, women and lactating parents protect their own health, help their newborn and young children to achieve optimal development, and avoid incurring health risks associated with CMF feeding. Breastfeeding provides species-specific nutrients and essential bioactive components, all of which ensure optimal growth and development, while protecting them from external threats (infectious and environmental).[1,2] Breastfeeding also activates parental caring behavior and facilitates bonding, loving care, security, warmth, and skin-to-skin contact for the infant. It allows the body to heal and recover physiologically after each pregnancy. The longer the cumulative period of lactation along a life span, the lower the risk of cancer (mammary, uterus, and ovary), metabolic disorders (diabetes), cardiovascular disease, mood disorders, and rheumatic and osteopenic fractures.[3] Moreover, the practice of artificial feeding damages the environment, hinders social development, and carries significant social and environmental costs.[4]

Breastfeeding is now recognized as the biological norm against which all other forms of infant and young child feeding should be compared and as a human right of children and women.[2,5–8]

Global health authorities recommend that infants initiate breastfeeding immediately after birth, exclusively breastfeed for 6 months, and continue breastfeeding afterwards while eating other safe, nutritious complementary foods for at least 2 years or as long as the breastfeeding dyad mutually desire.[2,9]

Who breastfeeds?

Worldwide, 95% of infants initiate breastfeeding, while 71% of women breastfeed at 1 year and 45% at 2 years. The Global Breastfeeding Collective Scorecard reported that 48% of infants under 6 months were exclusively breastfed in 2023.[10] A 70% objective for exclusive breastfeeding in the first 6 months has been set for 2030 by this collective led by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). Underlying inequalities resulting from disparities in access to support and care for marginalized groups lead to lower breastfeeding rates that vary geographically. Methodological challenges exist in the collection and interpretation of breastfeeding data, including lack of standardized collection methods, lack of agreed-upon definitions, and reporting methods that vary significantly by country. This limits the field's ability to compare outcomes, determine needed interventions, and track their success or failure.[11,12] To improve assessment, monitoring, and targeted interventions, the WHO has suggested the use of key indicators to evaluate breastfeeding outcomes.[13,14]

What gets in the way of breastfeeding and human milk feeding?

Challenges to breastfeeding, lactation, and human milk feeding are multidimensional and are shaped by several interconnected factors. Structural barriers, including insufficient sociocultural and political support, together with influential marketing strategies by the CMF industry, hinder breastfeeding promotion and protection. Challenges within settings such as health care facilities, workplaces, and communities undermine optimal breastfeeding practices. Furthermore, these broader determinants influence individual attitudes and behaviors, which may negatively impact breastfeeding.[15,16]

Structural factors

While there is sound scientific evidence about the importance of breastfeeding, aggressive marketing practices of the CMF industry, starting in the last decades of the 19th century and expanding widely in the 20th century, had an important role in the abandonment of breastfeeding as the normative behavior.[4,16–18] In parallel, breastfeeding as care work was, and still is, largely overlooked and undervalued. A clear example of this is its exclusion from national and international measures of gross domestic product, while production and commercialization of CMF are included.[4,19] It is also noteworthy that the excess cost

of disease and environmental damage incurred by the CMF industry are often disregarded or minimized.[4,15] Moreover, the lack of political will to address and change these structural barriers to public health is the key underlying factor in all of these challenges.[4] Consequently, CMF industries and governments perpetuate and deepen gender inequities while stifling sustainable development worldwide.[4,19]

Even in areas where breastfeeding continues to be the normative feeding practice, the implementation of breastfeeding may still be hindered by a number of factors. These include cultural misperceptions or taboos against the use of colostrum, social norms and attitudes that may act as barriers to continued breastfeeding (e.g., legally unprotected breastfeeding in public paired with the sexualization of breasts), a lack of support for breastfeeding difficulties (including during emergencies), and a lack of safe and culturally acceptable access to donor milk.[18,20–26] In addition, breastfeeding has often been stigmatized as a difficult behavior, in opposition to feminist values, and/or more of a lifestyle decision than an important health decision, with the dangerous trend toward "normalization" of, and dependence on, artificial feeding with CMFs.[4,17,25,27]

Settings factors

Although some countries have demonstrated progress in enhancing breastfeeding rates and support, the global landscape for breastfeeding is complex and shaped by historical, gendered, socioeconomic, and education factors.[20,28–33] The frequent lack of adequate and sufficient paid parental leave, the difficulties encountered upon returning to the labor force, and the challenges to accessing quality childcare present barriers to breastfeeding initiation and continuation.[4,16,26,34–36]

In health care settings, the adherence to the Ten Steps to Successful Breastfeeding, as outlined by the Baby-Friendly Hospital Initiative to address facility-level issues, is not consistently implemented.[26,37] The receipt of formula samples, in contravention of the International Code of Marketing of Breastmilk Substitutes ("The Code"), has been associated with earlier cessation of breastfeeding.[38–40] Moreover, the CMF industry sponsors health care providers training, scientific societies, journal publications and meetings, inviting conflicts of interest and diverting the focus from breastfeeding and human lactation.[4,17,41,42]

Physicians and health care providers are inconsistently and insufficiently educated in the care of the breast, breastfeeding, and human lactation.[26] The lack of knowledge and training among physicians leads to a lack of appropriate medical support and misinformed medical advice, which contributes to untimely breastfeeding cessation.[4,15,17,18,43,44]

Individual factors

Individual factors influencing breastfeeding initiation and continuation include anticipated breastfeeding difficulties, inadequate support (especially in the first weeks postpartum), previous negative experiences with lactation, misinformation of typical infant behavior, and underlying maternal conditions such as smoking, metabolic syndromes, and depression.[4,15,36] As a result, parents, families, and health care providers feel the need to resort to CMF supplementation or the use of specialized CMFs. Powerful CMF industry marketing practices support this understanding and shape individual attitudes and decisions around infant feeding and care.[15,16] This highlights a more broad societal and systemic failure to adequately support, recognize, and value human lactation.[4,15,36]

Who is working to help breastfeeding families?

Supporting, promoting, and protecting breastfeeding mothers and lactating people worldwide is an effort of many organizations and committed individuals. In 1956, a pioneer group of breastfeeding mothers in the United States founded the first formal breastfeeding support group and named themselves La Leche League.[45] They later funded the International Board of Lactation Consultant Examiners and the International Lactation Consultant Association in 1985.[46,47] The International Baby Foods Action Network, a global network of citizen groups,[48] championed social efforts to protect babies and mothers from damaging CMF marketing practices and supported the work and passage of the International Code of Marketing of Breastmilk Substitutes by the World Health Assembly in 1981.[49] In 1991, the WHO and UNICEF launched the Baby Friendly Hospital Initiative to support global adoption of the Ten Steps to Successful Breastfeeding.[50] Unfortunately, these practices are incompletely adopted, and there are inequities in their implementation. The World Alliance for Breastfeeding Action was born that same year as an umbrella for citizen organizations to defend the right of infants and mothers to breastfeed.[51]

In recent years, medical associations dedicated to the promotion, protection, and support of breastfeeding and lactation were formed around the world. In 1995, The ABM was founded by 2 medical students and 10 physician leaders in the field, representing the first academic organization of physicians working in the field.[52] The European Academy of Breastfeeding Medicine unites European and Israeli members from various medical specialties in BFLM. Medical associations devoted to BFLM exist in Australia, Israel, Ireland, New Zealand, and the Philippines, with the aim of fully integrating BFLM into mainstream medical specialties and contexts.

The WHO and UNICEF led the Global Breastfeeding Collective to call for increased political commitment to support and protect breastfeeding in 2017. In 2023, the WHO and a Lancet series reported on the scope and impact of the marketing of CMF. They

TABLE 1. LACTATION CARE SPECIALISTS BY EDUCATION,CREDENTIAL, AND SCOPE

Breastfeeding and Lactation Specialist Type	Supervised Clinical Education	Credential or Designation	Hands-on Training Requirement	Clinical Lactation Assessment and Plan of Care	Diagnosis and Treatment of Medical Issues
BFLM Provider	Undergraduate and Graduate Medical Education (6-8 years), Medical Residency (3-6 years) OR Advanced Supervised Clinical Training or Practicum (e.g., NP: 500 hours, CNM: 2-3 years)	Board certification varies by country and specialty NABBLM-C FABM	Yes	Yes	Yes
Community Supports (e.g., LLL, CHW)	Varies	None	Personal breastfeeding experience, mentorship	No	No
IBCLC®	95 didactic hours plus 300-1000 clinical hours	IBCLC®	Yes	Yes	No
Peer Counselor (e.g., WIC)	Varies	None	Personal breastfeeding experience, mentorship	No	No
Other (country-specific)	Varies	CLC®/CLE® Champion Counselor	Varies	No	No

BFLM, breastfeeding and lactation medicine; **CLC,** certified lactation counselor; **CLE,** certified lactation educator; **CNM,** certified nurse midwife; **CHW,** community health worker; **FABM,** Fellow of the Academy of Breastfeeding Medicine; **IBCLC,** International Board Certified Lactation Consultant; **LLL,** la leche league; **NABBLM-C,** North American Board of Breastfeeding and Lactation Medicine; **NP,** nurse practitioner; **WIC,** women, infant and children.

documented how these harmful marketing practices undermine breastfeeding at all levels (social, political, scientific, and health care-related) and also what can be done to curtail these practices and protect public health.[17,53]

As a result of these global efforts, the need for breastfeeding support and protection was made visible. Support groups flourished globally, as well as increasing numbers of committed individuals that offer breastfeeding care and support. Other than BFLM providers, there are many trained lactation advocates and caregivers who support breastfeeding and lactating families. These include International Board Certified Lactation Consultants (IBCLC®) and peer counselors, among others, and many vary by country. Each is trained differently and provides a different approach based on their unique skill set. Table 1 describes the training, certification and scope of some lactation specialists, and how they differ from those of a BFLM provider. BFLM providers are unique, as their training allows them to care for all aspects of a lactation journey (education, counseling, and medical). Nevertheless, they often work in teams to help patients gain access to the benefits of each type of lactation care while supplementing it with medical care when needed. In a supportive environment, lactation education and management can be provided by the existing health infrastructure. BFLM providers in these areas may manage only medically complex patient concerns that arise at any stage of the lactation journey. In contrast, in a less supportive environment, a BFLM provider may serve as the "primary care" for breastfeeding and lactation as well as manage complications if they arise. The Appendix provides examples of how a BFLM provider would assist patients with breastfeeding and lactating problems, as compared with care provided in a supportive environment without a BFLM provider or care provided in an unsupportive environment.

The ABM medicine: a start of physician involvement

Officially incorporated in 1995, the mission of the ABM is "medical doctors educating and empowering health professionals to support and manage breastfeeding, lactation, and human milk feeding."[52] Since its founding, the ABM has grown, creating a global community of health care providers across diverse specialties; expanding evidence-based education for those who work in health care; and helping to advance research and promote advocacy in support of human milk feeding. Physicians and dentist members can become a "Fellow" of the ABM (FABM) by demonstrating excellence across areas of clinical care, research, and advocacy. As of

2024, the current ABM membership includes 755 physician members, of whom 109 have FABM status from 18 countries. An affiliate membership status was added in 2016 to support and include the growing group of nonphysician clinicians, scientists, and advocates who practice in the field. This membership includes 64 nurse practitioners (NPs), 26 certified nurse midwives, 193 IBCLCs, and 159 in other categories from 11 countries.

In order to formalize the growth of the field, an ABM focus group was convened in 2016 to discuss core skills, knowledge, and training. The group included physicians with a background in Family Medicine/General Practice, Pediatrics, Obstetrics and Gynecology (OBGYN), and primary BFLM practice. After the initial draft, feedback was solicited from the ABM membership-at-large, international reviewers, and the Board of Directors and resulted in a consensus document published in 2022 as the "Recommended Core Competencies for Specialists Practicing Breastfeeding and Lactation Medicine."[54] This article outlines the clinical, social, and educational competencies expected of BFLM providers.

Highlighting the role of BFLM providers as consultants, the ABM also publishes best practice guidelines for multiple conditions in lactation and affecting lactation. These are available online as clinical protocols (https://www.bfmed.org/protocols). In addition, the ABM outlines the objectives and skills associated with the minimum standards for a breastfeeding curriculum for all physicians, including competencies for undergraduate, graduate, and postgraduate students.[55]

The Work of BFLM Providers

Who Practices BFLM?

Although the ABM was founded and is led by physicians, its membership currently extends to dentists, other health care providers, and PhDs in the field of BFLM. BFLM providers are therefore often new additions to the community frameworks of support. A collective approach to supporting human lactation, at different levels and in different settings, can improve breastfeeding practices,36 and the BFLM sub-specialty should support this goal. BFLM providers must acknowledge the importance of collaboration with other lactation care professionals and strive to work as a team. At the medical level, BFLM providers therefore range from physicians in varied fields (generally family medicine/general practice, pediatrics, and obstetrics) to midwives, dentists, and other allied health professionals (NPs and physician assistants). Because levels of independent practice vary substantially around the globe, who practices in one country within their scope of practice may be very different from one who provides these services, and how, in another country. Each member of the lactation support team should work to the extent of their scope of practice, as defined by their primary degree.

Where is BFLM practiced?

Breastfeeding and lactation care begins in the preconception stage and extends through antenatal care, labor, neonatal, and postpartum care, continuing to support the breastfeeding dyad through early childhood.[56] Reaching a breastfeeding goal requires anticipatory guidance, help with goal-setting, assistance with establishment of latch and/or milk production, as well as addressing the challenges and difficulties that may arise at any stage of this journey. A BFLM provider may be more likely to be involved in care of the challenges and difficulties, rather than the routine establishment of goals or lactation. An integrative approach in lactation management should include this preventive and routine care and be ready for urgent or emergency routine cases.

BFLM may be practiced at outpatient and inpatient care facilities, in government, community, and private clinics to large academic medical centers. BFLM specialty services can be delivered using an integrative approach that includes antenatal care, hospital care (birthing units and neonatology), primary care (family medicine/general practice and pediatric), and urgent or dental care. Alternatively, specialty services may function as an independent practice that is dedicated to one or more of these areas and can be delivered face to face or via telehealth.[57,58] Other community support locations should include in-home, prisons and detention centers, refugee camps, and shelters, where BFLM providers can positively contribute to the work currently offered by other lactation supports or work to establish increased services as needed.[59,60] Fewer BFLM providers are found in rural areas, and many geographic areas do not have access to this provider type at all. In those areas, this work is likely done by other care provider types or not done at all, and breastfeeding problems that could be managed successfully may be more likely to result in breastfeeding cessation. Telehealth for BFLM is an emerging trend to address barriers to access for this type of care and has shown promising results.[61,62] In addition, social media platforms, such as Facebook, include groups that offer support to lactating people as well as health care providers.

What is the value of BFLM providers?

With worldwide rates of breastfeeding falling well below all established goals, one of the priority areas identified to improve outcomes is increasing access to skilled breastfeeding counseling and clinical care. Because of their training in full-scope care of the breastfeeding dyad, BFLM providers are uniquely situated to provide this, at the same time as leading efforts to promote the health care and community-based

structures that support breastfeeding. BFLM providers achieve this by being:

1.) **Clinical experts** with a medical background and skills in lactation management, who assess and treat difficult and high-risk situations in lactation. They bridge the science of lactation to practical application in day-to-day settings to improve breastfeeding outcomes. In this role, BFLM providers act as direct providers of care or consultants to other medical professionals who are treating unrelated medical situations in the context of lactation,

2.) **Educators** who empower families to realize their breastfeeding goals, educate other health care professionals on current information for effective management of breastfeeding, and train other BFLM providers to improve access to this service globally,

3.) **Researchers** who contribute to the body of evidence that informs practice,

4.) **Leaders and advocates** who partner with families and health care teams to implement and monitor large-scale projects to improve maternal and child health through breastfeeding and lactation support, and

5.) **Expert policy consultants** who contribute to public health, institutional and legislative initiatives and policies that influence breastfeeding, including paid family leave and milk banking.

The BFLM Approach to Breastfeeding and Lactation Problems

General concepts

BFLM providers care for multiple people interacting in a biological system that involves reciprocity and dynamism. Central to this practice is the concept of the "dyad," usually a mother/infant pair, that is physiologically and psychologically interdependent, but may involve several lactating parents and multiple infants and children. Care therefore entails a comprehensive skill set that includes a strong under-standing of the distinct and dependent physiologies of presenting patients as well as consideration of the context in which families are immersed—being mindful of cultural practices, providing trauma-informed care, and being people- and family-centered.

Public health data inform but do not determine individualized care, and multiple variables affect lactation and breastfeeding. Therefore, BFLM providers blend guidelines, protocols, published research, and clinical experience to provide breastfeeding and lactation support effectively, compassionately, and respectfully to help families reach their personal infant feeding goals.

Parents and children presenting to BFLM providers are almost always under the care of other health professionals, who can have varying training and knowledge of breast-feeding.[63] BFLM specialists therefore must maintain open channels of communication across specialties and roles to advocate for the dyad and support a family's feeding goal. BFLM providers take into consideration the presence of barriers and facilitators (above) when working with families using holistic and tailored approaches.

Specific Approach

BFLM specialists have the competencies to provide equitable and integral lactation support in a thorough and efficient manner. While counseling, education, and care can be provided by peer groups and other lactation specialists,[64] advanced care requires not only time allotted exclusively for this purpose but also specialized training in complex and multifactorial problems.[65,66] BFLM specialists are licensed medical professionals who are able to diagnose problems and prescribe treatments and therapies. BFLM visit duration is usually long, reflecting the complexity of the physiology and the number of patients. There are many conditions in infants and breastfeeding mothers or lactating parents that can make breastfeeding challenging. Those that should be understood and evaluated by BFLM providers are addressed in the "Recommended Core Competencies for Specialists Practicing Breastfeeding and Lactation Medicine."[54] The most commonly cited problems with breastfeeding across cultures include concerns about milk production, nipple pain, and infant satiety.[67,68] The ABM has developed Clinical Protocols for managing some of these medical conditions **(Table 2)**.

Clinical management of breastfeeding and lactation requires care of two (or more) persons, usually a mother and infant, of the encounter and relationship and, finally, of the process of milk transfer, which includes positioning and latch or milk expression and infant/child feeding the expressed milk and/or supplements if needed. Problems may originate at any or all levels of this process, and inputs may have upstream and downstream effects **(Fig. 3)**.

BFLM providers may also have a unique longitudinal relationship with patients in the prenatal and postpartum periods, which provide an opportunity to screen for, prevent, and address other health concerns such as preeclampsia, postpartum mood disorders, sleep difficulty, and bonding concerns. They can also assist families and other care providers to make feeding decisions and manage lactation in the setting of medical complexity (e.g., medication management, cancers, and postpartum coma).

TABLE 2: CLINICAL PROTOCOLS FROM THE ACADEMY OF BREASTFEEDING MEDICINE (with Available Languages)[a]

#	Protocol	Year (last revised)	Languages	Notes
1	Hypoglycemia	2021	zh, hr, en, ja, ko, es, pt	
2	Going Home Discharge	2022	zh, hr, en, it, ko, es, pt	
3	Supplementation	2017	zh, hr, en, ko, es, uk	
4	Mastitis			See #36
5	Peripartum Breastfeeding Management	2013	zh, hr, en, ko, es, uk	
6	Bedsharing and Breastfeeding	2019	zh, en, de, it, ja, ko, es, tr	
7	Model Maternity Policy	2018	zh, en, de, ko, es, it	
8	Human Milk Storage for Home Use	2017	zh, en, de, ko, es, uk	
9	Galactogogues	2018	zh, en, it, ko, es, uk	
10	Breastfeeding the Late Pre-Term Infant	2016	zh, hr, en, el, it, ja, ko, es, uk	
11	Ankyloglossia			See REF[b]
12	NICU Graduate Going Home	2018	zh, en, ko, es, uk	
13	Contraception and Breastfeeding	2015	zh, hr, en, de, ko, es	
14	Breastfeeding Friendly Office	2021	zh, hr, en, de, ko, pt, es	
15	Analgesia and Anesthesia for the Breastfeeding Mother	2017	zh, hr, en, de, ko, es	
16	Breastfeeding the Hypotonic Infant	2016	zh, hr, en, de, ko, es	
17	Cleft Lip	2019	zh, hr, en, it, ko, es	
18	Antidepressants	2015	zh, hr, en, de, ko	
19	Breastfeeding Promotion in the Prenatal Setting	2015	zh, hr, en, ko, uk	
20	Engorgement	2016		See #36
21	Substance Use and Breastfeeding	2023	en	
22	Jaundice	2017	zh, en, ja, ko, pl, es	
23	Non-Pharmacologic Management of Procedure-Related Pain	2016	hr, en, ko, es	
24	Allergic Proctocolitis	2011	zh, en, de, ko, es	
25	Preprocedural Fasting for the Breastfeeding Infant	2012	zh, en, de, ja, ko, es	
26	Persistent Pain with Breastfeeding	2016	zh, hr, en, de, ja, ko, es	
27	Insulin-Dependent Diabetes	2017	zh, en, de, ko, es, uk	
28	Peripartum Analgesia & Anesthesia	2018	zh, en, ko, es	
29	Iron, Zinc, & Vitamin D	2018	ar, en, de, ko	
30	Breast Masses	2019	en, de, ko, uk	
31	Radiology	2019	en, de, ko, tr, uk	
32	Hyperlactation	2020	en, de, pt, uk	
33	LGBTQ+ Patients	2020	en, de, uk	
34	Breast Cancer	2020	en, de, pt, uk	
35	Supporting Breastfeeding During Maternal or Child Hospitalization	2021	en, de, pt, es	
36	The Mastitis Spectrum	2022	ar, en, it, ja, pt, tr, uk	
37	Physiological Infant Care	2023	en, de, it, pt, tr	

Arabic=ar, Chinese=zh, Croatian=hr, English=en, German=de, Greek=el, Italian=it, Japanese=ja, Korean=ko, Polish=pl, Portuguese=pt, Spanish=es, Turkish=tr, Ukrainian=uk

1 ABM. Protocols. 2024. https://www.bfmed.org/protocols. Accessed May 30, 2024

2 LeFort Y, Evans A, Livingstone V, et al. Academy of Breastfeeding Medicine Position Statement on Ankyloglossia in Breastfeeding Dyads. Breastfeed Med. 2021; 16(4):278-281. doi:10.1089/bfm.2021.29179.ylf

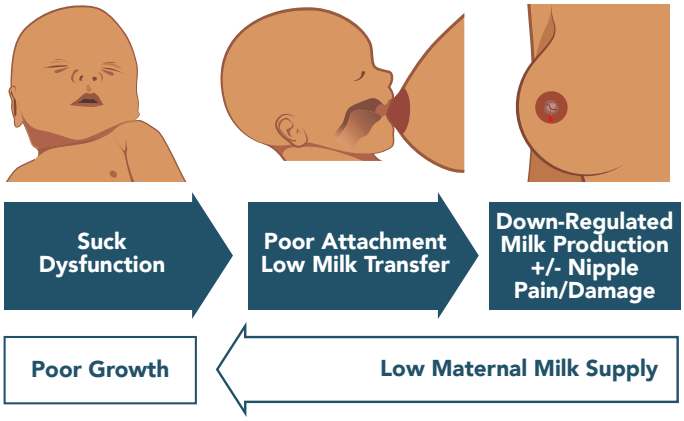

FIG. 3. Three levels of breastfeeding problems and their interdependence.

Infant-initiated problems

A common example of the type of problem faced by a BFLM provider involves an exclusively breastfeeding infant with suck dysfunction and poor attachment. The poor latch mechanics cause ineffective milk transfer and slow growth. The lack of a coordinated, strong suck fails to stimulate the let-down arc, and ineffective milk transfer downregulates milk production, which may further exacerbate poor infant growth (**Fig. 3**). BFLM providers can assess positioning and attachment, evaluate the infant for suck function or other impacting oral anatomical conditions, monitor infant growth and guide targeted supplementation when indicated, evaluate and treat the mother's low milk production, and help to re-establish exclusive breastfeeding.

Mother or lactating parent-initiated problems

Problems may also arise on the mother or lactating parent's side of the breastfeeding or lactation relationship. A common presenting scenario is low milk production, with or without poor infant growth. BFLM providers work to discover whether the problem is perceived or actual, and whether it arises from inherent (primary) low milk production, difficulty with milk transfer (latch or expression/pump), or low milk production due to inadequate expression or inhibitory factors (secondary). Through a careful history, physical exam, chart review, latch evaluation, and pump evaluation, BFLM providers can identify and treat causes of low milk production and help families get as close as they can to their feeding goals while promoting infant growth and family well-being.

A particular area in which BFLM providers receive additional training is in the care of mothers with mental health conditions. While breastfeeding can improve bonding and lower the risk of postpartum mood disorders, a difficult breastfeeding journey can also worsen maternal mental health.[69,70] Common complaints of depressed and anxious mothers are anxiety related to breastfeeding, difficulty breastfeeding, and concerns about the health of the child.[71] BFLM providers may help parents in this situation with breastfeeding or lactation difficulties while addressing any contributions of these difficulties to mood, advocating for consistent care, simplifying feeding plans, supporting parental sleep, and helping to guide medication choices compatible with lactation.[69,72,73]

Multifactorial problems

Some problems may not only have effects in all parts of the breastfeeding or lactating family but may be multifactorial in origin. An example is when a lactating parent with low milk production is diagnosed on physical exam with mammary hypoplasia, and at the same time their infant has an ineffective latch due to suck dysfunction with insufficient milk removal, thereby resulting in suboptimal infant growth and further downregulation of the parent's milk supply (**Fig. 3**). BFLM providers will address a family's goals in these situations, whether they are more focused on maximizing milk production, sustaining latching at the breast or chest, or both. Assessing internal and external resources is also crucial. Treatment may vary from simply supporting bonding through effective and comfortable latching, as an ineffective latch may shorten the duration of breastfeeding, to intensive interventions that may prolong breastfeeding but incur significant cost in time, effort, and money. These latter may require laboratory tests, prescribed galactogogues, milk expression/pumping, infant supplementation, and/or infant referral to occupational or speech therapy. BFLM providers therefore must be excellent at patient-centered communication and shared decision-making, supported by their expertise in the complexities of the peripartum period and family dynamics.

Risks, Growth, and the Future of the Field

Challenges to the field of BFLM

The field of BFLM has grown significantly in the past 50 years and continues to face challenges in the extent of its reach, research foundation, and support.

The reach of the field of BFLM is limited by the lack of basic breastfeeding and lactation training received in medical education. Inadequate training of health care providers often results in families' breastfeeding problems being dismissed, not recognized in a timely way, or resulting in an abrupt switch to CMF feeding rather than a referral to a lactation specialist. Improving the skills of health care providers to protect and support breastfeeding families will result not only in improved access to basic care but also will increase appropriate and

timely referrals to BFLMs, whose competencies expand to more complex problems and situations and to patients and families with special needs.

In many areas, BFLM services are further determined by the difficult landscape of reimbursement. BFLM providers struggle to either find homes in capitated or government-funded models of care or appropriate reimbursement in fee-for-service models. Supplies for these clinics have a cost and are often not covered by insurers or governmental centers. Furthermore, funding for advanced education in the field is lacking, limiting the accessibility to appropriately trained BFLM providers.

The research foundation for the field is growing. Since the sentinel studies proving the benefits of breastfeeding and risks of CMF 1980s and 1990s, there has been an exponential increase in published research in the field. The ABM coalesces these and best practices into the 37 clinical protocols, available online.[74] Despite these advances, foundational research in the field began with studies proving the benefits of breastfeeding and human milk, while the current research agenda focuses heavily on the biochemistry of milk components and public health programming to improve breastfeeding outcomes. This means that relatively little research addresses the differential diagnoses, pathophysiologies, and best treatments for common conditions such as nipple pain and low milk production. A more supportive research agenda would focus on issues identified by patients, and efforts are underway to use patient-centered outcomes to guide future interventions and research.[75,76]

Finally, the field of BFLM and its supporting organizations (e.g., the ABM) abide by "The Code" and therefore do not accept financial support from CMF manufacturers. This is in contrast to most other medical specialties and subspecialties, who accept this support. The field thereby struggles to maintain a competitive presence in medical and research societies, and its educational messages compete against those of the multibillion dollar infant formula industry. The WHO has called on all medical societies to divest from this support due to its well-documented harms.[77] More universal support for this International Code would not only improve patient well-being and provider knowledge but would also level the playing field for BFLM providers working to support breastfeeding families.

Future directions

BFLM providers face a difficult landscape of care, in which patients have limited support to engage in this work-intensive and time-sensitive health behavior. Other providers are undereducated in BFLM and may even not be aware of the need for this support. CMF marketing undermines breastfeeding as a means of furthering their profit and in many cases sequesters physician training on infant feeding, and systems and policies frequently undermine breastfeeding practices. Nevertheless, the BFLM workforce is growing, primarily driven by patient needs. Fellowship programs are beginning to emerge at academic medical centers in the United States, and a growing online presence has created fora for case discussion[78–80] and high-level training opportunities[81–83] worldwide.

These opportunities must expand to meet the growing need for skilled providers in BFLM patient care, leadership in key institutions (such as milk banks and Mother-Baby Friendly initiatives accreditation), and researchers who understand the complexity of dyadic physiology.

As the field grows, it will be critical to determine which outcomes BFLM providers should most influence and develop tools to track them. Because BFLM providers are most likely to see patients with complex problems, breastfeeding exclusivity and duration may not be achievable by all presenting patients and therefore may not be the best outcomes to measure. Furthermore, these outcomes are heavily socially determined in ways that BFLM providers may not be able to impact directly (e.g., the lack of universal paid parental leave). Rather, BFLM providers may be best recognized for providing individualized, evidence-based care that supports parental autonomy, bonding, and well-being while helping families to set and achieve goals determined by their own needs and physiological capabilities and manage complications when they arise.

Instead of functioning as a local "champion" of breastfeeding, BFLM providers should be integrated into all health systems as essential subspecialists, with a view toward sustainability.[84,85] Growing recognition of the field as its own discipline will increase opportunities for program development, education, and research. Creating "medical directors" and "divisions" of BFLM represents a growing effort to incorporate the field into the structure of large academic medical centers. In other delivery models, BFLM providers may be similarly institutionalized, so that their programs continue after any founding "champions" leave. This means that patients would no longer need to navigate a fractured health system that divides breastfeeding care between many providers with variable training. Instead, BFLM providers can coalesce their care under one delivery system, providing subspecialist-driven, evidence-based health care, and building social and research programs to support this work.[86]

Conclusion

BFLM physicians and providers represent a growing subspecialty that foregrounds the experience of patients who are navigating a complex dyadic physiology with a heavily-laden

socially determined behavior. Struggles for the field have included difficulties with institutionalizing programs, a research agenda not focused on diagnosis and management of common conditions, competition with CMF marketing practices, and limited training opportunities. Moving the field more solidly within the fabric of medical care will provide both patients and trainees more opportunities to access this unique approach to care of breastfeeding and lactating patients.

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Appendix

Real-Case Examples of Patients with Multifactorial Problems, with How They Would Be Managed in an Unsupportive Environment, a Supportive Environment Without a BFLM Provider, and by a BFLM Provider

Example 1

History	A 26 year old Gravida2, Para1 presented after a stillbirth vaginal delivery at 24 weeks gestation. She had breastfed her currently 2-year-old toddler until two months prior to the stillbirth. Workup found no clear cause for the early labor or death of the fetus.		
Presenting problem	Engorgement of breasts and breast pain starting day 3 after stillbirth. Worsened pain on day 5 presenting as breast redness and chills without fever. Grief and bereavement with a toddler at home.		
Type of support environment	Low Support Environment	High Support Environment without Breastfeeding and Lactation Medicine Provider	Breastfeeding and Lactation Medicine Provider
Management	**Immediately after stillbirth:** Patient not given options for milk suppression or ongoing nursing of 2-year-old. **Day 3:** Patient given some information on engorgement and minimal support for execution of plan. **Day 5:** Patient may or may not be prescribed antibiotics for early mastitis.	**Immediately after stillbirth:** Cabergoline for milk suppression offered by obstetrician, patient given conflicting information and declined. **Day 3:** Cabergoline for milk suppression prescribed by obstetrician and started by patient. **Day 5:** Advised by lactation consultant via telelactation to pump to alleviate pain, redness and chills. Symptoms returned after pumping. 1. Family medicine doctor prescribed antibiotics for mastitis. 2. Grief counseling may be accessed. Peer support groups may be offered. Psychiatric support offered as needed.	**Immediately after stillbirth:** Goal-directed conversation with BFLM provider with patient options for milk suppression, or to resume breastfeeding toddler if desired. 1. Support of normal bereavement – including assessment of available support services, counseling, and treatment if indicated for depression/anxiety. 2. Education and management of engorgement, weaning, milk donation, and pump management. Education and management of reestablishing toddler nursing and bonding, if applicable. 3. Non-pharmacological management of early inflammatory mastitis with NSAIDS, ice, gentle lymphatic massage. Monitoring and treatment should infectious mastitis develop.

Possible consequences	Patient develops worsening mastitis, potential abscess or sepsis. 1. Postpartum grieving course and parenting of a 2-year-old interrupted by a painful condition and medical complications.	Patient receives appropriate management but requires the input of many providers. 1. Decision-making is difficult due to disagreements between providers. 2. Inappropriate prescribing of antibiotics for early inflammatory mastitis as outdated care provided. 3. Grief process may be interrupted by time and effort needed to address medical complications.	Improved evidence-based management. 1. Continuity of care across the lactation problem with one care provider and fewer visits. 2. Avoidance of antibiotics if needed. 3. Improved postpartum grieving course, and time for care of a toddler.

Example 2

History	A breastfeeding infant was born by vaginal delivery at 39 weeks gestation, weighing 3100 grams. Her lactating parent was Gravida 2, Para 2 with no medical complications. The infant passed all newborn screens and was discharged breastfeeding. She regained birth weight at 4 weeks of life.		
Presenting problem	Poor weight gain, nipple pain.		
Type of support environment	Low Support Environment	High Support Environment without Breastfeeding and Lactation Medicine Provider	Breastfeeding and Lactation Medicine Provider
Management	Pediatric care provider instructs the family to supplement with formula, ad lib after each breastfeed OR advises to switch to formula entirely. 1. Infant sleeps through breastfeeding and gradually breastfeeds less, then loses interest in nursing, begins to refuse the breast. 2. Infant grows well on infant formula.	Pediatric care provider instructs the family to supplement with targeted amount of pumped breastmilk or infant formula to support growth. Infant grows well. 1. Lactation consultant assesses a shallow, painful latch and counsels family on milk expression for supplementation. 2. Family is referred to an ENT surgeon, dentist, or pediatric surgeon for ankyloglossia evaluation and frenotomy. 3. Lactation consultant helps to reestablish exclusive breastfeeding. 4. OBGYN gathers social history including significant social stressors (financial, grief, low support, sleep deprivation). Discusses management of sleep and depression, considers medication and counseling.	1. BFLM provider instructs the family to supplement with targeted amount of pumped breastmilk or infant formula to support growth. 2. BFLM provider assesses shallow painful latch, evaluates ankyloglossia and provides a frenotomy. 3. BFLM provider counsels on milk expression if effective latch cannot be immediately re-established and starts galactogogues to enhance milk production. 4. BFLM provider gathers social history including significant social stressors (financial, grief, low support, sleep deprivation). Discusses the management of sleep and mood disorders, and considers medication and counseling.

Possible consequences	Breastfeeding ends. Benefits to both the infant and parent are lost. Increased health risks due to weaning and the infant feeding only commercial milk formula. 1. The parent develops a sense of failure, grief and guilt that they could not breastfeed.	Patient receives appropriate management but requires the input of many provider types. 1. Care for ankyloglossia may be delayed. Time and effort by the patient is increased. Cost to the patient and any insurers may be increased.	Continuity of care across the lactation problem with one care provider means, fewer visits and lower cost. 1. Care for ankyloglossia provided at the time of diagnosis provides a more timely return to exclusive breastfeeding and decreased pain of parent.