EXPLORING THE SOCIAL ORGANIZATION OF BREASTFEEDING KNOWLEDGE AND
DEVELOPING STRATEGIES FOR PROMOTING BREASTFEEDING

by

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Thesis submitted in conformity with the requirements for the degree of Master of Science in
Nursing
Graduate Department of Nursing
University of Toronto

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0-612-63161-3
ABSTRACT

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Master of Science 2001

Graduate Department of Nursing Science

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Employing a radical new methodology put forth by feminist sociologist Dorothy E. Smith, this thesis is an empirical examination of the social production of breastfeeding knowledge. Beginning from the site of her own standpoint in the everyday/everynight world, the author encounters a three part video text whose primary subject is infant feeding. Led by disjuncture, (a term used to describe the rupture between women’s knowing and father tongue) - the author explicates the ideological practices which accomplish the following conceptual construction of the video text: the equivalency between breastmilk and infant formula; the epidemiologic homogeneity among infants regardless of diet; and the detachment of the mother, and her milk, from her baby. Finally, the author leaves the surface of the text to, in a preliminary way, discover how these concepts are socially organizing and by whom - that is, the relations of ruling, of which the author, as a nurse, is a member.
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Peterborough, Ontario. Summer of 1996. The academic year had ended - so too my daily commute back and forth to Toronto. It was an exquisite pleasure to be at home during the early evening enjoying the company of my young daughters. That evening they were happily engaged upon the swings in the park located just beyond our back yard hedge. Smiling as their bursts of laughter reached my ears, I was experiencing the sublime maternal pleasure of witnessing her children's happy engagement with one another. I was lounging on my back deck, perusing that day's edition of the local newspaper, when my eyes fell upon an advertisement for an upcoming breastfeeding class. The ad detailed the date and location of the class, the fact that it was free and its' sponsorship - the formula company, Mead Johnson. My mind, which a few moments earlier had been free of any particular rumination, enjoying the free association of ideas that the glancing of a newspaper allows, was now alert, concentrating on this item. The subject of breastfeeding was captivating to me and I was personally, professionally and politically invested in it. A breastfeeding class sponsored by a formula company? Disquietude crept over me. My relaxation ended, I rose from my chair, went into the house, and made a telephone call.

The advertisement had prompted the same reaction in other women. Disquietude had apparently been widely felt; many telephone calls had been made. We co-ordinated our intention to attend the class. And so we were a group gathered there, in that church basement, conjoined by this uneasy feeling as well as our sisterhood in the womanly art of breastfeeding. The young mothers amongst us had their nurslings with them; mothers with older children came
alone or, like me, brought their children with them. Then there were the others - the women who were the true intended audience. These were the pregnant women - the uninitiated. The room was set up like a classroom. It had all of the accoutrements: chairs for the students to sit upon, pens and notepaper, educational materials to be disseminated at the end of the class, an easel at the front of the room, and a teacher. The purpose of the meeting was the dissemination of breastfeeding knowledge to the mothers-to-be. The group of experienced breastfeeding mothers of which I was a part were committed to this task. Thus there were two experts present that evening - Mead Johnson, and us.

Our experience as breastfeeding mothers had heightened our awareness of practices, intended or otherwise, which threatened to undermine women's decisions or ability to nurse their infants. It was true that we conceptualized the multi-national corporations who manufactured infant formula as the enemy. Indeed, much social action had been undertaken to curtail what was considered to be the unethical marketing practices of formula companies. The reader may recall the international ban against Nestle's in the 1970's. The World Health Organization document: Protecting Infant Health: A Health Worker's Guide to the International Code of Marketing of Breastmilk Substitutes was published in 1985. The concept of the formula companies directly teaching prenatal breastfeeding classes signalled a new marketing strategy. We were suspicious of the intended content of this class. We certainly expected to hear a negative conceptualization of breastfeeding and the dissemination of erroneous information. Our presence at the meeting therefore was intended to act as a corrective. Our group intended, if necessary, to counter Mead Johnson's virtual conceptualization of breastfeeding with our actual experience of it; and to establish women as the proper authorities of their own breastfeeding practice.
What happened? Well I remember the uncomfortable physical experience of sitting there in that state of nervous anticipation; I knew it was inevitable that I would speak. The passion of my convictions were manifest throughout my body, my stomach was full of butterflies; my mind ordered calm and willed eloquence. The Mead Johnson representative began her presentation. The format was obviously scripted. The inevitable was actualized. The breastfeeding knowledge put forward broke with ours. Many of us spoke that evening, exposing these ruptures and speaking what we knew about breastfeeding through them. We hoped to provide the mothers-to-be with a critical visibility. We wanted to expose the discourse of the formatted presentation as emanating from one standpoint - the perspective of the multi-national corporation; there were others. We spoke that night from our collective knowledge as nurses, lactation consultants, La Leche League Leaders, feminists and as a breastfeeding mothers. This insight, we hoped, would heighten women's awareness of such relations, and ultimately, facilitate more freedom of infant feeding choice.

Our group was clear about which side of this relational split we were on. The Mead Johnson representative was not. As we deconstructed the knowledge she was claiming, her presentation fell apart like a house of cards. She tried her best to professionally support her employer. Increasingly, however, she became unnerved. She was torn, I think, between those whose discourse she was supposed to espouse and her membership with the community of women who sat before her. Visibly shaken and upset, she stopped her presentation. No longer an authority figure, she became another woman in the room, and we collectively discussed our plight. She hadn't realized what she had become involved with. She said she was just trying to make some extra money by teaching these classes. We did our best to support her. The mothers-to-be sat there with mouths as round as their bellies - in shock and awe at what had
There was to have been a draw, the representative told us. There were many nice gifts to be won. It was decided that the draw should proceed - after all, it was part of her job. We laughed together. An acquaintance of mine won a three part video series produced by Mead Johnson, entitled “Your Baby, Your Doctor And You.” The winner knew I was commencing a post-graduate nursing program and was intending to explore infant feeding issues in the context of a Master’s thesis. She said that although she wanted this video, she would lend it to me if I thought it would be useful; moreover, she hoped that whatever I did would contribute to our shared commitment to the promotion and protection of breastfeeding. I accepted the video - and her terms.

My thinking has changed dramatically since that night. The video was the passport to my transformation. That night I believed in such concepts of freedom of consumer choice in matters of infant feeding, as well as the dichotomization of the split between the bad guys like Mead Johnson and the good guys like me. That night I could not see beyond the textual debate we were engaged in. Beyond our presence in that room that night was a knowing that superceded us - that passed beyond our actual gathering, to a place where ideas for such marketing schemes are born. I did not know that world then as I know it now - this knowing has made all the difference.

This thesis emanates from the same enterprise our group was engaged in the night we attended the breastfeeding class. The purpose of this inquiry is to explore knowledge as a socially organized and organizing practice. Specifically I will explore the conceptual construc-
tion of breastfeeding knowledge by a formula company. Mead Johnson’s video production entitled “Your Baby, Your Doctor And You”, (Fox, Fulford & Goldberg Productions Inc., 1993), will constitute the vehicle for this exploration. Furthermore, this inquiry will explore, in a preliminary way, the conceptual organization of breastfeeding practice. The final purpose of this research initiative was to attempt an innovative methodology put forward by sociologist Dorothy E. Smith. This methodology and the central theoretical tenets which undergird it will now be explicated.

Research Design

Sociologist Dorothy Smith has created an innovative method of social scientific inquiry. Although her methodology is fundamentally atheoretical in nature, it is sometimes, necessarily theoretical. Thus what will first be presented are the central tenets of Smith’s feminist sociology of knowledge and then, following these, the method of inquiry which emanates from them.

Knowledge is Ideological though not Wholly Subjective

The first central tenet is that the standpoint of women is an appropriate, indeed essential, position from which to commence any scientific investigation into the social organization of our actual world. This tenet emanates from Smith’s critique of the way sociology has traditionally been thought and practiced. (1990) This tenet has many radical implications. The first of these is that the researcher may be present in her research investigation and analysis. This is antithetical to traditional sociology’s ethic of objectivity which demands the eradication of any trace of the subjective researcher or her biases, interests, values in her work. This sociology believes therefore in its ability to generate knowledge as a product which may be separated
from the knower that produced it. Indeed knowledge must be held as separate from the knower if it is to be considered objective, true, pure; knowledge into which the subjective researcher has crept is conceptualized as contaminated, unscientific. Methodologies therefore focus upon the achievement of this separation. Smith (1990) describes the procedures which sociology uses to achieve this separation, its methods of thinking, writing, as ideological.

Smith argues against such traditional sociological conceptualizations of knowledge and its methods by which such knowledge may be generated. Smith (1990) asserts that "Knowing is always a relation between knower and known." (p. 33) The human mind is ineluctably grounded within an embodied knower whose existence is situated within a given historical and cultural context. This is a fundamental human condition. Smith's feminist sociology asserts its own unique method of inquiry as well. It insists that the only way to know anything about a socially constructed world then, is from inside of it. Smith states: "A feminist sociology must, it seems to me, begin with actual subjects situated as they actually are; it must be, therefore, an insider's sociology, a sociology of society as it is and must be known by people who are active in it." (1990, p. 32) Smith's (1990) feminist sociology of knowledge therefore asserts that the only way to glean any knowledge about our social world is as insiders within it. Her perspective insists on the validity of an inquiry that is interested and that begins from a particular site in the world - the standpoint of women.

Smith does not intend her methodology to be wholly subjective, exploring as it were, the individual consciousness of the woman from whose standpoint inquiry has begun. Some believe, like Sandra Harding, that such standpoint theories, as she terms them, repudiate the possibility of knowledge and replaces it with "multiple partial knowledges discovered from multiple sites and perspectives, with multiple interests in knowing, none prevailing, each equally valid." (Smith, 1990, p. 34) Smith
argues that "such a degree of ontological tolerance defeats the essential character of inquiry as a project." (1990, p. 34) Smith believes in an ontological common ground which may be discovered by beginning with our own actual experiences. Indeed Smith argues that whereas traditional sociology adheres to its ethic of objectivity as its emblematic seal of proper science, in fact it is precluded by its conceptualizations and procedures from really knowing anything at all about the way society really operates. Smith, extrapolating from Marx, proposes to ground social science in the activities of actual individuals and the material conditions thereof." (1990, p. 34) Inquiry which begins from the standpoint of women can produce a knowing that can be relied upon in an ordinary and unproblematic way.

Women's Everyday World of Actual Local Experience is an Appropriate Site for the Development of Systematic Knowledge

The second tenet of Smith's feminist sociology of knowledge is that the local world of women's experience is an appropriate world in which to develop systematic knowledge. Alternatively expressed, Smith asserts the everyday world to be a viable problematic. This tenet implies the presence of another world. Indeed established sociology has as its predominant site for investigation the abstract world of theoretical frameworks and conceptualizations. This abstract world is sociologically constructed through the utilization of specific methods of reasoning and procedures which are characterized by Smith as ideological. Ideological procedures have already been mentioned as the means by which established sociology separates the knower from the known. Here this ethic of objectivity is extended to the knower's world as well. Ideological practices separate the knower's actual world from the extra-local world of knowledge. In Smith's terms an Archimedean point is thereby constructed outside of the actual world for the knower to
stand in. (1990) Smith (1990) borrows Marx's conceptualization of ideology: "In Marx's critical procedure ideology is not equivalent to the totality of another's theory, beliefs, or ideas. His method identifies as ideological definite procedures or methods of thinking and reasoning about social relations and processes. Ideology names a kind of practice in thinking about society. To think ideologically is to think in a distinctive and describable way. Ideas and concepts as such are not ideological. They are ideological by virtue of being distinctive methods of reasoning and interpreting society." (p. 35-6) Ideological practices are those which conceal and suppress the grounding of social science in people's actual activities, specifically the social relations that arise from and organize these activities. Thus ideological practices eliminate the presence of subjects as agents and give ontological primacy to concepts. Thinking ideologically then would go something like this: Prima facie there is the local world of actual embodied existence. Traditional sociology reflects upon this actuality and theorizes about it. This theory or concept is then used to dip down into the actual world and select those pieces of it that fit. How the world is interpreted then is in relation to the theory and not the fact of actual existence. Alternatively expressed, ideological processes sever concepts from the subjective reality from which they originated.

Ideological practices confine us to the conceptual level suppressing the presence and workings of the underlying relations they express. In this way ideological modes of thinking "deprive us of access to, hence of critique of, the social relational substructure of our experience." (Smith, 1990, p. 42) Concepts divorced from the social relations they originally expressed are now able to be speculatively manipulated. Now part of the extra-local world of theory, concepts become abstractions no longer confined to a pattern of actual existence. As Smith explains: "When concepts are detached from the relation in which they make the world of living people observable, they become a means of operating selectively upon it and in sorting it out in ways that preserve the
ideal representation. Ideology can be viewed as a procedure for sorting out and arranging conceptually the living actual world of people so that it can be seen to be as we already know it ideologically." (1990, p. 42-4) Concepts thus manipulated are constitutive of a virtual reality bearing no essential resemblance to the actual one. Similarly knowledge acquired through investigative inquiry based in this abstract world bears little resemblance to real knowing. "Ideological practices ensure that the determinations of our everyday, experienced world remains mysterious by preventing us from making them problems for inquiry." (Smith, 1990, p. 43) Sociology therefore, because of its ideological practices is confined to the legislation of knowledge rather than its discovery.

Smith, extrapolating from Marx's new materialism, posits an alternative approach. Making the everyday problematic is sharply contrasted with making the everyday ideological. Rather than grounding social science in concepts, Marx proposed the "activities of actual living individuals as the ontological ground of social science." (Smith, 1990, p. 38) Rather than divorcing concepts from their constitutive social relations Marx sought to preserve this relationship: "Marx's example instructs us not to treat a concept as a theoretical primitive, in the logical sense, nor as interpretable solely in terms of other concepts. Rather we are called on to explore the ground of a concept in the actual ordering of what living people do." (Smith, 1990, p. 41) Essentially, Marx provided a method of undoing ideology; rather than working a concept up from subjective reality he posits working back through the concept to the social relations in which it is embedded. Smith extends Marx's materialist method to an exploration of social consciousness: "For knowledge itself is made problematic when we insist that there are knowers "doing knowing" and that we can explore, make explicit, know, the socially organized practices in and through which we accomplish knowledge." (Smith, 1990, p. 51) Thus Smith intends to extend Marx's materialism of actual
individuals and their ongoing activities to thought and knowledge itself.

We live in a very different world from Marx. The crucial difference in this regard is that unlike his, ours is a textually mediated society. Much of what we know about contemporary capitalist society is not known in any direct or experiential way but is mediated to us through texts. Marx presupposed a direct relationship between concepts and the relations expressed. In our modern day of textually mediated social relations this relationship is hardly as simple. Smith explains: "But in this kind of society, this relationship is complicated in that much of what we recognize as that which we know, much that is classifiable as what here has been called an observable, is already worked up and produced in a process mediating its relation to what people have done in the place where the process begins. Concepts and categories reflect social relations mediated and organized by concepts and categories." (1990, p. 56) Texts contain virtual realities which have already been worked up conceptually from actual social practices. Indeed this working up is a social practice. "The procedures by which this is done are definite social practices that must be understood and explained if sociologists are to be returned to the actualities of the world they claim to know." (Smith, 1990, p. 55)

The character of ideology has changed since Marx's time. More than a reflection of reality, it has become a form of reality. (Smith, 1990) Ideology is a form of concrete action undertaken by actual individuals. "Marx's insistence on returning to what people do, on seeing how social forms are produced by actual individuals, directs us not to a theoretical but to an empirical examination of the social production of ideology." (Smith, 1990, p. 57) Marx's simple reversal of the ideological procedure is no longer possible. We are instructed to consider the relation between the ideological uses of the forms of thought and the actualities of living individuals as it is mediated in people's
practical activities. Inquiry here addresses our own practices as knowers; by making these objects of investigation they are brought into view not only as knowledge of the world but of our own practices within it. (Smith, 1990) Such an investigation is possible only in the local world of actual embodied existence.

Objectified Knowledge is a Social Practice

The standpoint of women stands in stark contrast to forms of objectified knowledge. As we have already discussed, the standpoint of women asserts the preservation of the experienced as fundamental to social science investigation and inquiry; the standpoint of women validates the local world of experience. Objectified forms of knowledge, as their name implies are constitutive of an objective world of discourse. Disjuncture refers to the line of fault that women recognize as existing between their knowledge of the world as they experience it and the way in which it is discursively known. Because the standpoint of women problematizes the everyday world we are able to investigate these knowledges as actual practices within it.

Objectified forms of knowledge mediate the relations of ruling. "The ruling apparatuses are those institutions of administration, management, and professional authority, and of intellectual and cultural discourses, which organize, regulate, lead and direct, contemporary capitalist societies." (Smith, 1993, p. 2) Contemporary capitalist societies are governed by conceptual currency. Language in Smith's view is not artificially separated from its local historical uses. Fathertongue refers to the mode of participation in the relations of ruling: its language and its conceptual practices. The fact that fathertongue is the language and the conceptual currency that governs us has important implications for women.
First of all the relations of ruling, as the term fathertongue implies, emanate from the standpoint of men. Theories, concepts and research methodologies that organize these relations have been worked up from a male social universe. Women may not find the conceptual correlates of their experience in these theories. Second, the principal worlds of women - home, children, neighbourhood have been subordinated to the worlds of men. Smith explains how these relate to each other in a special way. Women are compelled to "think their world in the concepts and terms in which men think theirs. Hence the established forms of social consciousness alienate women from their own experience." (1990, p. 13) When women speak fathertongue they are entered into the relations of ruling either as superordinates or subordinates of it, as agents or objects. Smith (1993) refers to the alienation of utterance: "the modes of speaking, writing, and thinking that take our powers of expression away even as we use them." (p. 199-200)

The standpoint of women enables the critical visibility of objectified knowledge. This visibility facilitates the bringing to our consciousness our participation in the relations of ruling and what we are engaged in when we take these up. Furthermore it offers women an opportunity to assert their own voices, experience and authority over it on the same terrain as the relations of ruling. (Smith 1990)

Texts obtain their authority, their power, in part from appearing as social accomplishments. Their documentary form stabilized, then published, has expunged all traces of its production. Thus texts appear, and are accepted as knowledge. The standpoint of women however does not accept knowledge without knowers. Knowledge is thus problematized: How is it that knowledge can exist independently of knowers? The focus here then becomes that of the social organization of knowledge, its social and material organization "as produced by individuals in actual settings, and
as organized by and organizing definite social relations." (Smith, 1990, p. 62)

Textual work, concepts, thought and what is ordinarily thought of as meaning "is understood to be practices that people do, as existing in time, and as integral constituents of social relations and organization." (Smith, 1990, p. 202) Knowledge may therefore be investigated as the actual social practices of actual people. Conceptualizing knowledge as practice displaces the surface of the text as the focus of inquiry: "The text is analyzed for its characteristically textual form of participation in social relations. The interest is in the social organization of those relations and in penetrating them, discovering them, opening them up from within, through the text. The text enters the laboratory, so to speak carrying the threads and shreds of the relations it is organized by and organizes. The text then, is not used as a specimen or sample, but as means of access, a direct line to the relations it organizes." (Smith, 1993, p. 4) Thus texts are not constituted as meaning which is disassociated from the world which constitutes them and in which they are read. "Texts are taken up as constituents of ongoing social relations into which our own practices of reading enter us." (Smith, 1993, p. 11)

Textual investigation therefore directs us to investigate the social organization of textual production and the social organization of our reading, interpretation. With respect to the constitutive practice of textual production it would be helpful to remind ourselves of the ideological practices of thinking and writing which characterize objectified knowledges: "Thus the practices of thinking and writing that are of special concern here are those that convert what people experience directly in their everyday/everynight world into forms of knowledge in which people as subjects disappear and in which their perspectives on their own experience are transposed and subdued by the magisterial forms of objectifying discourse." (Smith, 1990, p. 4) Objectifying discourse attempts to confine the
reader to what Smith calls the surface of the text. This confinement prevents us from discovering the social relations and apparatuses of the relations of ruling that substruct the text. Smith says, "The textual surfaces of discourse obliterate the structures of power sustaining their coherence and authority." (1990, p. 203) Investigating the social organization of facticity demands the resurrection of the subjective in the text. Revealing the doers brings the social relations to light.

Textual critique is also reflexive. According to Smith the investigation of the social organization of reading begins with the subject as she exists in her local experience before engaging with the text. This differs from theories which argue that the subject is constituted as she enters the text. Smith wants us to see that we ourselves participate in the relations of ruling through the practice of reading. The disjuncture that women experience is a socially organized practice which we ourselves participate in. Reading therefore as it engages us in the relations of ruling facilitates our disassociation from our own consciousness: "The power of objectified knowledge arises in the distinctive organization it imparts to social relations. Knowing how to read, and reading, a given factual text is to enter a coordinated set of relations subordinating individual consciousness to its objectification; subjects subdue their particularized experience to the superordinate virtual reality of the text." (Smith, 1990, p. 70) Analysis focuses upon the intersection of the reader and the text, specifically how the reader operates the text to enter the objectified modes of knowing characteristic of the relations of ruling. (Smith, 1993)
Mode of Inquiry

My investigation begins with my embodied and thoughtful existence in the world. I am regarded to be an expert in the area of breastfeeding. This reputation is based upon the usual credentials: I possess a baccalaureate degree in nursing science; I am near completion of a post graduate program the focus of which is perinatal nursing. In 1987 I became one of the first 60 Canadians to be accredited as an International Board Certified Lactation Consultant. In 1988 I was elected the Canadian Delegate for the International Board of Lactation Consultants. Clinically I have been employed in such specific settings as Prenatal Education Departments, Neonatal Intensive Care Units, and Breastfeeding Clinics. I have been contracted as a Teaching Assistant by the University of Toronto. My knowledge and clinical skills are regularly sought by family physicians, neonatology residents, nurse colleagues and lay groups of breastfeeding mothers who occasionally contract my services as a conference speaker. Essentially therefore it is my status as a professional that entitles me to be considered an expert.

I know, however, that the basis of my expertise is first and foremost my experience as a mother who breastfed two children as well as my privileged intimate knowledge of other women’s breastfeeding experience. I am an accredited La Leche League Leader; personal experience of breastfeeding an infant for at least one year is a prerequisite of this accreditation. This organization of breastfeeding mothers exposed me a culturally unique manner of breastfeeding infants. When I became pregnant with my first child I somehow just knew that the proper length of time to nurse an infant was 4 to 6 months. Through La Leche League I met women who breastfed their children for one year and longer. Why had I never seen this before, I wondered.
Why had I never even heard about the possibility of extended nursing? When I became a health professional I heard other nurses discredit this organization - its' members were 'radicals' and 'breastfeeding fanatics'; its' expertise was discredited. It was ironic to me how it was possible that I could be respected as an expert on the one hand, and yet the source of this expertise could be discredited, on the other.

How was I to understand this apparent contradiction between my professional and personal knowledge? Dorothy Smith's (1990) concept of a bifurcation of consciousness helped to clarify this confusion for me. This concept refers to the establishment of "two modes of knowing and experiencing and doing, one located in the body and in the space it occupies and moves in, the other passing beyond it." (P. 171) Corollary to the severance of the knower from the known, is the severance of the actual world of the knower from the virtual world of the conceptual order. This latter world passes through the world of the actual and occupies a superior position to it. It is the proper site for the development of systematic knowledge; its' concepts are considered to be objective knowledge, untainted by subjective bias. Its' concepts are the currency with which the activities of the actual world are governed. I was therefore the corporeal embodiment of this bifurcated consciousness: I was well steeped in professional discourse - I understood the theoretical underpinnings of my profession, I understood the science of lactation, I understood nursing process with its' emphasis upon evidence based practice, assessment and diagnosis. I was well equipped to govern. Alternatively, I knew the womanly art of breastfeeding as an insider. I developed an appreciation of the site of knowledge which authorized me to govern breastfeeding practice as well as an appreciation of the site of knowledge which was vulnerable to governance. My professional knowledge therefore was valued; the personal knowing that arose from my experience as a woman and a mother was not.
This deep knowledge was critical to the development of a keen sensitivity to disjuncture. Disjuncture occurs when there is a split between "how women experience the world and the concepts and theoretical schemes by which society's self-consciousness is inscribed." (Smith, 1990, p. 13) With respect to breastfeeding, then, disjuncture is experienced whenever a concept is presented which breaks with women's actual knowing of breastfeeding. Because I am a woman who breastfed but also a woman well educated in the area of infant feeding, I would experience disjuncture when confronted by a concept or a theory which broke from my knowing as either an academic or as a breastfeeding mother.

The conceptual practices which incite disjuncture are ideological. Smith (1990) defines ideological practices as those practices of thinking and writing that "convert what people experience directly in their everyday/everynight world into forms of knowledge in which people as subjects disappear and in which their perspectives on their own experience are transposed and subdued by the magisterial forms of objectifying discourse." (p.4) Thus breastfeeding texts which expunge the presence of its' practitioners, that is women, and further silence women's knowing of breastfeeding - texts which give ontological primacy to concepts are undoubtedly ideological. Alternatively phrased, objectifying discourse is the emblem of objectified knowledge which textually mediate the relations of ruling.

The tripartite video series: "Your Baby, Your Doctor And You" (Fox, Fulford & Goldberg Productions Inc., 1993) exemplifies objectified knowledge; I elaborate upon those characteristics which are isomorphic with other objectified knowledges in order to validate this claim. While viewing this video series I experienced many ruptures between my knowing breastfeeding and the discursive knowledge that was presented throughout this text. Ruptures
aggregated thematically to form concepts. Three principal concepts constitute the conceptual framework of this video text. The analysis that follows elucidates the ideological construction of these concepts. Emphasizing the social construction of objectified knowledge I take the reader below the conceptual surface of the text to render observable how it has been put together - to show, as Smith would say, how it works. The three principal concepts are asserted to be non-problematic; my analysis elucidates the underlying social relations which reveal them to be highly problematic. The ideological procedure of selective revealing and concealing information is made observable. Essentially, the ideological circle which constructs each of the concepts is revealed. The power of this conceptual currency and the relations of ruling which come into view are revealed and commented upon. Implications for nursing practice is discussed. Future research initiatives are delineated.
Introduction to the Textual Analysis of this Video Series

An elucidation of the ideological practice of textual production will be effected by the forthcoming analysis of the tripartite video series entitled "Your Baby, Your Doctor, and You." The focus of this analysis will be the explication of the interpretative schema which is implicit in the organization of knowledge which constitutes this text. Making the interpretive schema observable will effect our discernment of the knower(s) from whose perspective this knowledge emanates: it will introduce us to his standpoint, his values and his intentionality. This is not meant to suggest that the identification of the knower in the text taints it by exposing it as ideological rather than objective. Such a viewpoint is antithetical to the approach I am attempting to use here. Rather, the explication of the interpretive schema heightens our awareness of the inevitable ideological practices which constitute texts. Thus it will orient us to both the social construction of this text as well as the social relations we enter into upon viewing it. Smith (1973) states: "Our knowledge of society and of the conceptual procedures apt for accomplishing the sense of what comes to us in the forms of knowledge appear to be grounded in a "ruling class" relation to the objects of that knowledge. In taking this social organization of knowledge for granted we confine ourselves within that relation". Explicating the interpretive schema of this text will identify it as an objectified knowledge produced and supported by the relations of ruling. Knowledge about breastfeeding therefore, (and ergo its practice), which in contemporary society is largely textually mediated, is now understandable as socially constructed, organized and governable. This critical visibility can act as a new co-ordinate among knowers. It can potentiate and authorize their own perspective, thus practice. Elucidating a conceptual framework as but one which emanates from a particular standpoint enables a multiplicity of interpretations from various standpoints. Other values may
predominate, other intentionalities may be actualized. Ultimately such critical visibility enables a different toe hold upon the same terrain; the path that has been laid before her now apparent, one can decide to follow it or forge her own.
Analysis

Producing the Video Series as Objectified Knowledge

Introduction.

Not all texts are objectified knowledges. Shakespearean sonnets, Romantic poetry, billets doux, even grocery lists are textual forms which are antithetical to objectifying discourse. Within Dorothy Smith's conceptualization of the social organization of knowledge, "Language is not addressed as a phenomenon artificially differentiated from its local historical uses. Rather the focus is on the socially organized and organizing practices of using language that constitutes objectified knowledges." (p. 4) Objectified knowledges then are the linguistic culmination of specific practices that are both socially organized and organizing. Such practices are referred to as alienating or ideological: "Thus the practices of thinking and writing that are of special concern here are those that convert what people experience directly in their everyday/everynight world into forms of knowledge in which people as subjects disappear and in which their perspectives on their own experience are transposed and subdued by the magisterial forms of objectifying discourse." (Smith, 1990, p. 4)

The conceptual practices about to be analyzed here are ideological in this sense: First I will argue that what the video series organizes conceptually as knowledge, stands in stark opposition to my own tacit knowledge and experience of breastfeeding. Indeed it is this disjuncture which first identified the video series as an objectified knowledge. As Smith explains: "The standpoint of women, which locates us in the particularities of our experience, is
profoundly contradictory to objectified forms of knowledge." (P. 61) Thus my particular breastfeeding experience was certainly subdued and transposed by this objectifying discourse. But this text is also ideological in this sense: The intended audience of this video is pregnant women who have not yet experienced breastfeeding. Thus it does not subsume subjective experience, since the latter has not yet happened, but rather acts as a co-ordinator of the anticipated experience. Smith (1990) states that "Facts mediate relations not only between knower and known but among knowers and the object known in common." (p. 69) Furthermore, facts co-ordinate "the activities of anyone who is positioned to read and has mastered the interpretive procedures it intends and relies on." (Smith, 1990, p. 69) Objectified knowledge has the potential to preclude people from an untutored knowing. It has already been stated that one of the repercussions of father tongue for women is that it compels them "to think their world in the concepts and terms in which men think theirs. Hence the established forms of consciousness alienate women from their own experience." (Smith, 1990, p.13) In this paper I shall argue that the video about to be analyzed produces objectified knowledge which socially constructs a breastfeeding consciousness; since consciousness is "integral to people’s activities and the co-ordination of their activities" (Smith, 1990, p. 36) this text has the potential to co-ordinate the activity of breastfeeding itself. As such it has the capacity to preclude women from knowing breastfeeding as an unstructured personal experience. Similarly, the social construction of a breastfeeding consciousness has the authority to govern breastfeeding practice in a way that may be different, based upon maternal experience of breastfeeding, from how mothers would wish it to be practised. Objectified knowledges are defined by their subjugation of the subjective experience - that which is, or has been, and, potentially, that which is yet to be.
Objectified forms of knowledge mediate the relations of ruling. Smith posits that the relations of ruling comprised by such various institutions as nursing, medicine, government, hospital, university, multi-national corporations, and media, among others are isomorphic with one another in their utilization of "practices that construct an alienated consciousness vis a vis the standpoint of women." (1990, p. 31) Therefore, although the text selected for analysis has been produced by a multi-national corporation and is endorsed by medical and university institutions, any breastfeeding texts produced by any of the other constituents of the relations of ruling could have been selected for examination. We can posit further, that since the ideological practices among the relations of ruling are isomorphic with one another, then the objectified knowledges which are the culmination of these must be isomorphic as well. Indeed, objectified knowledges share characteristic modes of thinking and writing. This study intends to evidence the video text as objectified knowledge by explicating the ideological modes of thinking embedded in it and illuminating the relations of ruling it mediates.

**Constructing Dual Realms: The Conceptual Order and the everyday/everynight world.**

The first ideological mode of thinking evidenced in this text is the construction of the two realms: the everyday/everynight world of actual existence and its' converse - the conceptual order. Ideological practice demands this dichotomy since by definition, such practice is the subjugation of the actual world to the authority of the conceptual order - governance and subjugation require both realms. The utilization of discreet physical sets is one device utilized within this video series to manifest these two realms. There are two principal sets: the interview set and the domicile. (The physician's office constitutes a third, lesser used set.) These sets are discreet entities; each is the appropriate domain of specific characters; that is, with the
exception of the host who exclusively has the capacity to traverse both settings, (this unique ability will be commented upon later), the other characters who appear in the video inhabit either one or the other of these sets, but never both.

The interview set is the manifestation of the conceptual realm - provides the stage for the relations of ruling. Indeed the interview set houses the doctor and other experts - constitutes the principal site for the dissemination of their expertise. The principal expert, Dr. Julie Fabbro is representative of the relations of ruling - medicine specifically. Dr. Fabbro disseminates her knowledge about breastfeeding from her seat in that artificial creation - the interview set. She is never situated within the domestic kitchen or nursery. Rather, she occupies this 'Archimedian point' outside of the everyday world of mothering. Evidently, infant feeding and care are her professional, not actual, concerns. It is her license, not her personal experience, which authorizes her knowledge. We do not know anything about her personally - whether she is a mother, how she fed her children and so on. We are to trust what she tells us because she is a doctor. Furthermore, although she is the only physician who physically materializes within this video, she is among a consortium of colleagues whose presence is invoked within the heading "Medical Advisory Board of Pediatricians" or whose identities appear in print at its conclusion. Institutions of medical education, the University of Toronto, and exemplary clinical practice, the Hospital for Sick Children are credited with lending their expertise to this video production. Dr. Fabbro's credentials: BSc, MD, and F.R.C.P. connect her to such institutions as the university, the government, and the medical community which, respectively, educated her, licensed her and now claims her as a fellow within the elite consortium of physicians referred to as the Royal College. Dr. Fabbro therefore represents the medical establishment - its discourse, its membership; she is generically, "Your Doctor".
The other physical set, the home, is predominantly inhabited by mothers and babies. (Fathers are present, but to a far lesser extent). Women/mothers are the proper tenants within this manifestation of the everyday/evernight world. Constituents of the actual world rather than the conceptual order, their mode of experience is embodied: thus, they are depicted as being physically engaged in a myriad of tasks such as feeding, cleaning and caring for.

**Constructing a Bifurcation of Consciousness which is Predicated Upon Gender.**

The physical sets are the manifestation of the conceptual order and the everyday/evernight world; moreover, they are symbolic of the modes of knowing emblematic of each realm. Smith (1990) states: “Entering the governing mode of our kind of society lifts actors out of the immediate, local, and particular place in which we are in the body. What becomes present to us in the governing mode is a means of passing beyond the local into the conceptual order. This mode of governing creates, at least potentially, a bifurcation of consciousness. It establishes two modes of knowing and experiencing and doing, one located in the body and in the space it occupies and moves in, the other passing beyond it.” (p. 17) Embodied knowing is emblematic of the material world and virtual knowledge emblematic of the conceptual order.

This bifurcation of consciousness or dichotomization of subjectivity is predicated upon gender: that, is these distinct modes of experience are predicated upon the essential differences between men and women. Women bear children and men do not. Thus the distinct mode of women’s experience is an “experience of work around particular individuals, especially children “and through complex institutional mediations organized as caring and serving work directed towards particular others or groups of others.” (Smith, 1997, p. 45) Thus, the women in the
video are in the home; they are predominantly engaged in the provision of child care including breastfeeding. Men, on the other hand, are not obligated to the same degree of care provision as are breastfeeding mothers - less grounded by such actual activities of the everyday/everynight world. Men are more liberated to pass beyond embodied knowing into the conceptual realm where they may predominantly engage in thought. Thus the fathers in the video are evidenced to be in the home, but to a lesser extent than the mothers; they dwell in the material world, but leave it to enter into the conceptual order. When the mothers are evidenced to be engaged in caregiving tasks, it is assumably daytime and daddies are working outside of the home.

Furthermore, according to Smith, women may be both objects and agents of this bifurcation of consciousness; that is, like the host who exclusively can traverse both physical sets, women uniquely may be grounded by the tasks of the material world but these can include those which perpetuate the conceptual order. Dr. Fabbro, for example, exemplifies the role of agent. Although she is obviously a woman, her professional identity is wrought out of the relations of ruling. Her mode of experience is clearly conceptual. Her role is expert - on the interview set she is asked questions and she responds to them. The movement of her mouth is her only embodied activity. Essentially she is a talking head. Even her costuming, mostly blue in colour, and always pants, symbolizes her maleness. Indeed the relations of ruling - its methods, conceptual schemes, and theories - has been based on and built up within the male social universe, even when women have participated in its doing." (Smith, 1990, p. 13) Objectified knowledge therefore has characteristically been wrought out of the male standpoint.
Producinq Obiectivity and Neutrality.

Congruent with the severance of the conceptual from the actual and the concomitant bifurcation of consciousness, is the severance of the knower from the known - the objective from the subjective. Although objectified knowledges are wrought up out of the actualities of the material world, they abjure the subjective, intending instead an unbiased conceptual understanding of the everyday world. The video text produces objectivity.

The first mechanism utilized to construct objectivity is the paucity of subjects. Although replete with human characters, this text is devoid of thinking, feeling, experiencing subjects. Certainly none of the video parents have an identity nor do they ever engage in that characteristic act of self-expression - speech. They are not known as unique human beings existing within a living texture of actual, material concerns. The women are virtually homogenous: they have babies, a heterosexual orientation, a husband, a single family dwelling, a socioeconomic (middle class) status, nice furniture, gold jewellery, diamond rings and access to medical care. Even the babies are startlingly uniform. The little boys in their blue sleepers, the little girls adorned by pierced ears, are all happy recipients of parental and medical care. No eyes wet with tears, no mouths round with cries, no wee arms outstretched to be held, no hands clumsily attempting self-feeding, no bodies protesting being diapered, no fear of the physician as a stranger. The children of the first video are striking in their passivity - their paucity of self-agency. Only the not-yet parent could tolerate the degree of Wordsworthian 'willing suspension of disbelief' required here. That neither the parents nor the children are anyone specifically means that they are everyone generally. They are generically, "Your Baby" and "You". Homogenization is objectification.
Similarly, the panel of experts are known by name but their identities are secondary to their credentials, their qualification to edify. Indeed, Dr. Fabbro, Daniel Bogue and Anne Secord-Houston are the quintessential talking heads. There are more close up shots of their faces than camera angles that reveal their entire human bodies. There is but one example of self-reference when Daniel Bogue says, “I think...” (893) Mostly they are spokes-persons of professional discourse. Daniel Bogue states “In our work at the George Hull Centre, a concept which we find useful...” (899) Dr. Fabbro and her fellow representatives of the relations of ruling are scripted, discoursed, monotonal mouth pieces. Even the physicians whose names appear at the conclusion of the video are released from their subjectivity to the extent that the concluding disclaimer obviates them from litigation. Only their licensed personas were of interest to this work, it seems, their flesh and blood selves are released from the project. We have no idea what any member of this consortium of experts really feels, believes, opines about the topics inherent in the video - breastfeeding particularly. The knowledge disseminated by these experts therefore is more that merely what they as individuals know; as articulators of discourse they disseminate what is known. Moreover, it is ostensibly pure knowledge, untainted by subjective bias.

The inherent objectification which characterizes this video series situates this text in the "extralocal relations and apparatuses of ruling." (Smith, 1990, p. 65) Objectified knowledges characteristically “create an appearance of neutrality and impersonality that conceals class, gender, and racial subtexts.” (Smith, 1990, p. 65) The video series being analyzed here exemplifies these properties. The video characterizes itself as non-racist, (by including non-Caucasian families within its cast), non-sexist, (by making statements like “I said he but this technique works equally well with both genders...”), (117) and non-biased, (invites the viewer
to access other information about breastfeeding and includes a reference to La Leche League, an organization whose grassroots information is generally regarded to be contradictory to more institutional forms of knowledge). Thus the video establishes itself as neutral, disinterested, unbiased - components of objectivity all. Indeed, "The objectification of knowledge is a general feature of contemporary relations of ruling." (Smith, 1990, p. 67)

**Producing Objectified Knowledge as Authoritative.**

Another mode of ideological thinking evidenced in this video which is characteristic of objectified knowledge, is the greater authority vested in virtual knowledge than embodied knowing. Dr. Fabbro is constructed to be the expert; as a representative of the relations of ruling, her mode of experience is conceptual, her expertise an exponent of discourse rather than personal experience. We are expected to trust her knowledge even though we do not know if she has had any personal breastfeeding experience. Actual experience, however, is not produced as knowledge. Neither the breastfeeding mothers nor grandmothers are consulted; indeed, they are mute. Ideologically, therefore, it is the known not the knower that is imbued with authority. Fathertongue, the objectified knowledges that mediate the relations of ruling, is more authoritative than mothertongue, the subjective knowing of women.
Silencing Women's Knowing.

Ideologically, the concept of objectified knowledge as authoritative is produced via its juxtaposition with and subsequent transposition of subjective, specifically women's knowing. Although women's knowing is acknowledged, ("In most communities you'll find a network of people who can help you get started with breastfeeding and offer help with any problem you might have. . .friends who've successfully nursed their babies, La Leche League. . ") (565-568) (an organization of breastfeeding mothers committed to helping other breastfeeding mothers), it is not taken up as authoritative knowledge. Corollary to the practice of thinking already evidenced wherein the dichotomization of actual and virtual realities is first established and then the former is transposed by the discourse of the latter - corollary to this, is the acknowledgment of women's knowing but its ultimate discreditation or silencing by father tongue. Experiential knowing is subjugated by such forms of objectified knowledge as text or medical expertise.

The discrediting of women's knowing is produced via the juxtaposition of this subjective knowing is produced via the juxtaposition of this subjective knowing with medical expertise - this juxtaposition constructs the concept of maternal dependency upon the discourse which mediates the relations of ruling - or, alternatively, constructs the medical governance of mothering of which breastfeeding is one component. Here's how it works: At the beginning and the conclusion of this video series, women are urged to exercise "common sense" (3) at all times. Common sense connotes that sense which the common woman has - women's knowledge as it were. Denotatively, of course, common may be defined as base, conceptually evoking its converse, sophisticated, formally educated, or institutional knowledge. Within the same imperative sentence women are also directed to consult their doctor. Consultation is the
seeking of expert or respected or authoritative advice. The juxtaposition of such phrases as “common sense” but “consult your doctor” (493) creates a dichotomy whereby the former is evaluated as worthy but less authoritative than the latter. In this way women’s knowing is acknowledged but devalued vis a vis medical knowledge.

Establishing the Authority of Medical Discourse.

Furthermore objectified knowledge is constructed as magisterial to the extent to which medical expertise governs mothering. Medical governance of mothering is textually produced by first creating a medical/maternal-infant dyad - (the very title of the video series “Your Baby, Your Doctor, and You”, establishes the pivotal intermediary role the physician will have in the woman’s mothering of her infant) - and then depicting the former as authoritative and the latter as dependent. This authoritative-dependent relationship is established via the repeated textual imperatives which direct women to consult their doctors. The text informs us that “Life with a baby involves very frequent visits to a doctor.” (503) Implying the need for a pediatrician, (“The choice of a doctor for your baby is an important one”) (508), the text will suggest “some criteria you might want to keep in mind” (509) in selecting one. Thus the procurement of a physician is constructed to be essential, moreover, the fundamental tenet of this doctor-patient relationship is frequent interaction: “Even if your baby is healthy, regular check ups are necessary to make sure that the baby is growing and developing normally.” (503-505) On the other hand, “it is inevitable that he or she is going to be sick now and again during the first year.” (Indeed, in the second video appropriately entitled, “Your Doctor”, we are taught about those “inevitable” common childhood illnesses. Symptoms appear in bold print upon the screen, we learn the diagnosis and are instructed how to intervene, which ultimately means getting medical help.
Thus, whether in sickness or in health, the parents must vow to take the baby to the doctor. Indeed, the text is replete with such directives: "Over the counter medications should only be used when prescribed by your doctor" (741-743); "If the child is not improved in 10 minutes seek medical attention" (752); "...there may be an infection related to the cold which needs treatment by a doctor" (755-756); "...that they may be treated by a doctor immediately"; "...without seeking your doctor’s advice..."; "...after discussion with your doctor..."; "...unless your doctors advise otherwise..." (199); "a doctor should be consulted", and "contact your doctor, do not try to treat the illness yourself." (701) "Consult the doctor" (667) becomes the maternal mantra.

Establishing the Locus of Authoritative Knowledge Outside of the Mother.

In addition to the conceptualization of women’s knowing as “common” and mothering as dependent upon medical expertise, the utilization of the metaphor of the eye further produces the authority of objectified knowledge by establishing its locus outside of the woman/mother herself. I have already evidenced the degree to which mothers are, within this video series, instructed to consult their doctors; this creates a feeling of being monitored, watched. Indeed the metaphor of the eye is evident in the medical perspective which "watches for any signs" (656) and "looks for unusual behaviour". (669) Analogous to the ‘male gaze’, the eye of the physician may be referred to as the ‘medical gaze’. In the final section of the first video entitled "Baby Care" (332) we are taught to assume the same standpoint vis a vis our infant as the doctor assumes with us. From our superior position, (literally and figuratively), we are taught how to gaze down upon our infant as we conduct what is tantamount to a physical examination. Our focus begins with the baby’s head (eyes, ears, nose and mouth), continues through skin,
the body (breasts, umbilicus) and ends with the baby's genitals (vagina, penis, scrotum).

Similarly, the breastfeeding mother is taught to assess her baby's latch upon the breast by such visual cues as "tongue down" (107, 593) and "lip out". (107, 593) Further, "When the baby is properly latched on you see a strong rhythmic motion. . ." (108) This, as opposed to teaching the mother to assess from her internal, subjective experience: Do you feel your uterus contract as the baby suckles? You may feel the milk move from the back of your breast to the front. You may feel your breast emptying as the baby is nursing. You may feel a feeling of total relaxation wash over you as the nursing continues. But it is the objective, external eye of medical authority that oversees the internal, maternal perspective. Indeed the medical gaze is focussed upon the mother - from outside of, and above her.

Effects of the Authority of Objectified Knowledge upon Mothering: Women Conceptualize their Mothering through the Medical Perspective.

Ostensibly this section on baby's health teaches the new mother the normal physical characteristics of the newborn. In fact, it accomplishes much more. Smith states that one of the consequences of the governance of male derived objectified knowledges is that they "compel women to think their world in the concepts and terms in which men think theirs. Hence the established social forms of consciousness alienate women from their own experience." Ergo the assimilation of the physician's perspective orients the mother to the medical world and her requisite dependency upon it. Internalizing the mantra - "consult the doctor", is better accomplished if she understands its rationale. Thus imitating the medical gaze enables her to better see how medicine is essential to her role as a mother. Her baby's body is metaphorically new territory to her, requiring medicine to provide the signposts. Thus what was probably invisible to her previously, for example, "the yellow hue of jaundice" (345), is now critically
apparent. She sees how limited her own perspective is, how dependent she is upon medical discourse to show her what she would otherwise be unable to see.

Women Interpret their Experience through the Language of Medical Discourse.

In addition to gaining insight into the medical world, the new mother comes to understand its discourse. Recall that Smith (1990, p.13) instructs that objectified knowledges compel women to think their world in both the concepts as well as the terms of the ruling relations they mediate. It's language, replete with new words, and medical jargon, is foreign to her. The text is replete with anatomical and physiological terms such as: "jaundice" (345), "umbilicus" (357), "vaginal" (407) and "scrotal sac" (408) - words which reflect a language not typical of everyday vernacular. Some sentences evidence a profusion of medical terms which constitutes a kind of alliteration, for example: "Some babies may have an umbilical hernia which is a bulging of the naval due to a space between the muscles of the abdomen in midline." (412-13) Ostensibly the intention of this explanation is to reassure the parent that this condition "usually takes care of itself over time." (415) but the greater effect, I think, is intimidation. Similarly, simple behaviour like a hiccup becomes hyperbolically translated into "a sudden spasm of the diaphragm." (173) Medical definitions such as: "Fontanelles, the area of the skull where the bones have not quite fused together are covered by a tough membrane. . ." (391-392) imply their relevancy to parental practice, " . . . which will not be damaged with gentle washing." (392) But what if this membrane was susceptible to damage by gentle washing, the mother wonders, and she hadn't known about this susceptibility? Exposure to this language alerts the new mother to the limitations of her own. Furthermore, it alerts her to the relevancy of medical discourse to her practice as a parent. Such lessons are so well learned that by the end of this section, in
reference to cutting the infant's nails, the mother is metaphorized into a surgeon who is able to "perform this delicate operation when the baby is asleep." (419) This operating room metaphor orients the viewer to the medical paradigm and teaches the new mother to see from its' perspective and to think in its' terms. Focussing less upon her own internal insight, the new mother internalizes the directive to seek external expertise to guide her practice. Just as the internalization of medical discourse licences the physician to practice medicine, the new mother's proximity to medical expertise accredits her practice as a good parent. Medical discourse is constructed to be that upon which good mothering depends.

Text as Authoritative.

Medical discourse, the expertise which mothers avail themselves of when they consult their doctors, is but one form of objectified knowledge. Text is another form of objectified knowledge constructed to be authoritative.

The knowledge which constitutes the content of texts "often stands in for an actuality which is not directly accessible." (Smith, 1973, p. 273) For example, although breastfeeding is a feature of our society, few members have direct knowledge of it in their everyday world. Texts mediate this gap. Although the knower may not yet know breastfeeding, breastfeeding is already known; "The object constituted as known is already socially constructed prior to the knower's entry into the relation." (Smith, 1973) Thus knowledge about breastfeeding is accessible in a virtual sense, through text. This video constructs itself to be an authoritative source of such knowledge: "A must for new mothers." (Fox, Fulford & Goldberg Productions, 1993, cover) But how can a video, generally procured for entertainment purposes, be taken
seriously as an authoritative text? This is accomplished by the construction of its own facticity.

Facticity is “constructed in a context of telling.” (Smith, 1973) The construction of facticity is effected by the video text’s endorsement of textual authority generally. Indeed one of the first values discernible within this video is respect for textual authority. Although mention is made of consultation with family and friends, texts are constructed as the predominant source of authoritative knowledge. Reference is made to “books” (5), “published standards” (6), and “published information” (58); the official document - Canada’s Food Guide (51) is materially held up by the narrator - therefore by association shall this video text too be upheld. Furthermore facticity is constructed by the video text’s alignment with other sites of fathertongue: respected institutions, “this video was made in association with The Hospital for Sick Children”, (461) and experts, “This video series was written and produced with the assistance and direction of a national Medical Advisory Board of Pediatricians, Doctors and Technical Advisors.” (462-463) Certainly this text aligns itself with various sites of institutionalized knowledge: “The public health department and doctor’s offices are also reliable sources of information.” (827-828) The textual authority of this video is thereby well assembled.

Text as Magisterial Discourse.

Just as medical discourse has been produced as authoritative knowledge which governs mothering, so too is text exemplary of magisterial discourse. Indeed this video text produced itself as instructive, educational. The narrator states: “In this series of videos we try to anticipate some of the concerns and questions we think you as a new parent might have about the first year of your baby’s life.” (10-12) Similarly, at the conclusion of each video in the series
the host states: "And remember, if you want to learn more, you can always refer to the other videos in this series." (457-459)

The video cover proclaims itself to be "A helpful guide...during that all important first year." Text is therefore established as a source of authoritative knowledge upon which parents may depend.

The first scene in this video opens with the host situated in a nursery congratulating the parents: "Suddenly you feel the contractions. Baby is on its way." (7) The congratulations therefore were not extended for the birth of the baby, but for the accomplishment of the important decisions and purchases that have been made prenatally. The host states: "You referred to the latest published safety standards before you bought anything." (6-7) Thus the knowledge about infant care that predicated these decisions, these purchases, was virtual and textually mediated. Later, mothers are reassured that Canada's Food Guide "will steer you in the right direction" (51) and that the preparation of infant formula "exactly as instructed on the product label" (195-197) will ensure the correct constitution. Indeed the content of the video itself is a visual demonstration of parents enacting the script. We never hear the host narrate some method of infant care and then have the scene cut away to a close up of the mother's head shaking in disagreement. Rather there is strict adherence to textual instruction. This video is the object of knowledge which co-ordinates knowers: the virtual parents within it and "You."
Indeed infant feeding is the predominant subject of this video text, the practice of which is produced to be governed by both medical discourse and text. This video series constructs infant feeding, breastfeeding particularly, as properly belonging within the medical domain. It is under the section boldly entitled “BREAST FEEDING” (56) that we are first introduced to Dr. Julie Fabbro. Dr. Fabbro is a paediatrician, therefore a specialist in children’s health. The text tells us that “most doctors recommend breastfeeding” (546); thus it makes sense that it is Dr. Fabbro to whom we, following the host, turn to learn about this topic. (“We’ve asked Dr. Fabbro to cover some of the more commonly requested information about breastfeeding.”) (61-62) Thus it is Dr. Fabbro who informs us what nursing positions to assume, how often to nurse, how to deal with problems such as sore nipples, how to know if the baby is getting enough milk, when supplementation is necessary, how to introduce solids and weaning. Furthermore, it is Dr. Fabbro who reassures us that “Commercial formulas are constituted to resemble breastmilk and provided they are prepared exactly as directed they are a nutritionally sound alternative to breastfeeding.” (647-649) The physician is constructed to be the predominant expert in the area of human lactation; thus it is upon his expertise that the new mother’s breastfeeding practice will depend.

If breastfeeding is constructed to properly belong in the medical domain, then bottlefeeding is constructed to properly belong in the domestic kitchen. For it is the host, situated there, who teaches us about formula and bottlefeeding. Although the physician is still implicitly the authority who governs infant feeding overall, (“. . .you should consult your doctor prior to making any formula choice”; 185-186), generally speaking, the host is constructed to be the
expert with respect to artificial feeding. It is she who teaches us formula's composition, the
different types of formula and how long formula should be given to a baby before it is replaced
by cow's milk. It is she who teaches us how to constitute formula, ("If you're not using ready to
use formula directly from the can, prepare the formula using sterilized water"; (215-216), the
cautions to prepare it "exactly as instructed on the label" (195-197), the necessity of sterilizing
"any equipment which comes in contact with the formula" (209-210) and how to do that, "simply
boil bottles, nipples, caps, measuring cups and funnel in water for 5 minutes. . ." (212-213) She
ensures we are aware that "Sterilization is important until the baby is 3 or 4 months old". (179-
180) She also teaches us how to select artificial nipples: "Whether you select traditional,
orthodontic or square tipped nipples is a question of personal preference." (225-227)
Furthermore, she advises that formula "should be warmed to body temperature before you feed
it to the baby" (229) and that "It is advisable to use warm water or a bottle warmer rather than a
microwave" (232) to accomplish this. Finally, she teaches us how to hold the baby during the
feeding, "When you feed your baby from a bottle, cradle her in your arms so she's in a
semi-sitting position. Be sure to hold the bottle so that the neck of the bottle's always full."
(238-240) Thus it is the woman in the kitchen who is constructed to be the expert where
artificial feeding is concerned. Artificial feeding is conceptualized to properly belong within the
new mother's domain - unlike breastfeeding which requires ongoing medical intervention to
interpret it for her, bottlefeeding is more directly within her own grasp.

Although it seems that artificial feeding requires less governance than breastfeeding, this is
only ostensibly so. The host, constructed to be merely the woman in the kitchen, is actually the
video text personified. The host's textual personification as well as the label on the formula can
comprise the two principal modes of text which mediate artificial feeding. Because the host can
traverse between the kitchen and the interview set wherein she interfaces with the physician (the personification of medical discourse), textual mediation is present in both the conceptual and actual realms. Greater or lesser emphasis upon either medical discourse or text notwithstanding, both modes of infant feeding are tightly governed. The video series constitutes the objectified knowledge which will textually mediate the relations of ruling in their governance of infant feeding - breastfeeding particularly.

Textual authority, facticity and prescriptability have been organized around its intentionality. As Smith (1973) asserts: "Generally the social organization of the production aims at a particular context of reading and at particular practical purposes." This video ostensibly intends to teach new mothers what they need to know about infant feeding and care. As a stable document which has been mass produced, the knowledge inherent in this video is accessible to everyone, everywhere. Thus it becomes what everybody knows about infant feeding and care. This speaks to its administrative capacity rather than its magnanimity. As Smith (1990) states: "Issues are formulated because they are administratively relevant, not because they are significant first in the experience of those who live them." Objectified knowledge about breastfeeding is constructed so that breastfeeding practice can be administratively organized, governed. What everybody knows about breastfeeding becomes what everybody does about it.

Conclusion

In the preceding section I sought to establish the video series "Your Baby, Your Doctor, and You" as an objectified knowledge. I have elucidated those properties of this text which are characteristically isomorphic with other forms of objectified knowledges, namely: it is
conceptual, it mediates the relations of ruling, is wrought out of a predominantly male standpoint and asserts itself to be objective, neutral and authoritative and intends governance.

Objectified knowledges effect magisterial discourse. According to Smith our society is governed by concepts and symbols. Objectified texts are conceptually constructed as knowledge. An elucidation of these concepts will reveal their ideological construction, their power as conceptual currency and the relations of ruling they textually mediate. I proceed now, as Smith instructs, to make the social organization of this video text observable and understandable.

The Conceptual Organization of Objectified Knowledge

Introduction

This tri-partite video series: "Your Baby, Your Doctor, and You" evidences a tripartite conceptual construction, the sum of which constitutes a breastfeeding consciousness. These three principal concepts are: (1) the assertion of virtual equivalency between human breastmilk and commercial formula, ("Your Baby"); (2) the assertion of epidemiologic homogeneity of infants regardless of diet, ("Your Doctor"); and (3) the exclusive depiction of a unitary style of mothering referred to as detached parenting ("You"). Ultimately (and consistent with the inherent character of objectified knowledges), a unitary, exclusive, what Smith terms a "privileged perspective" (1990) of breastfeeding is posited.

I shall argue that each of these three concepts is ideologically constructed; that is, that each is
wrought out of first, the severance of the actual from its congruent conceptual counterpart, then, second, a reflective manipulation of this detached concept (what Smith (1990) refers to as a "mystical configuration") such that the concept is reconstituted. This ideological process comprises half of what Smith calls the ideological circle. The circle is complete when the newly configured concept - a theoretical ideal bearing little or no resemblance to the actuality it once represented - now functions as a lens through which to view, understand and co-ordinate the everyday/everynight world. In the following sections I shall elucidate the ideological construction of each of these concepts - the currency with which contemporary breastfeeding is governed.

In order to do this I endeavour, as Smith (1990) instructs, to "begin from my own original but tacit knowledge and from within the acts by which I bring this text (sic) into my grasp in making it observable and in understanding how it works. I aim not at a re-iteration of what I already (tacitly) know but at an exploration of what passes beyond that knowledge and is deeply implicated in how it is." (p. 23-24) Thus I - an experienced breastfeeding mother, a clinical nurse specialist in perinatology and neonatology, an International Board Certified Lactation Consultant, (and Canadian Delegate for this Board), a La Leche League Leader and scholar - encountered through viewing the video text.

I discovered that I knew breastfeeding very differently from the text’s inherent discourse. My subjective knowing of breastfeeding was alienated in its textual conceptualization. Furthermore disjuncture of another kind emerged when my medical knowledge deviated from the medical discourse of the text.
Breastfeeding is certainly appropriately situated within the context of social science. Smith (1990) states: "An analysis of ideology extrapolated from Marx's practice and applied to the social sciences explores the relation between a social scientific concept and the actual activities it expresses, between the 'forms of thought' through which social scientists make what people do observable to social science, on the one hand, and what people actually do and the way their lives are organized, on the other. (p. 37-38) Therefore the video text is conceptually constructed such that the actual social practice (or practices) of breastfeeding is silenced, transposed by its unitary conceptualization of it.

But breastfeeding is also properly situated within the domain of medical science: nutrition, immunology, and epidemiology particularly. Thus the social organization of objectified knowledge regarding breastfeeding is wrought out of the everyday/everynight world of which science is a part. "Ideological practices were identified in part with methods of creating accounts of the world that treat it selectively in terms of a predetermined conceptual framework." (Smith, 1990, p. 93) Ideological practice therefore is operationalized through a selection of revealing and concealing. "The problem" Smith (1990, p. 37) states, of what we are calling ideological practices is that they confine us to the conceptual level suppressing the presence and workings of the underlying relations they express. Furthermore, what I am calling ideological practices or procedures are the methods of reasoning that effect that concealment."

The ideological practices which construct the three principal concepts which constitute this objectified knowledge of breastfeeding are wrought out of the revealing/concealing of breastfeeding practice as well as the selective sorting of medical fact. My disjuncture therefore is emblematic of both my confronting a discourse that conceptualizes breastfeeding in a way
that is alien from my breastfeeding knowing - as well as socially constructing a medical discourse which selectively conceals information which deviates from my knowledge of the import of that which is concealed.

Ideological practice of conceptual construction then selectively operates upon these actualities of breastfeeding practice and medical knowledge and through a process of revealing and concealing offers as knowledge a conceptual reconfiguration of both the art and science of breastfeeding.

The social organization of this knowledge regarding breastfeeding, then, involves the ideological construction of concepts from socially scientific and medically scientific actualities. Part of the ideological practices which I am about to render observable is the textual assertion of these concepts as unproblematic. These concepts are made problematic: the social relations that underpin them are made observable and that which was selectively concealed, is revealed.

The Conceptual Construction of the Virtual Equivalency between Human Breastmilk and Commercial Formula

The Severance of Breastmilk from Breastfeeding

The first disjuncture I experience when I view the first video of this series, 'Your Baby', is my knowing breastfeeding as a multi-dimensional symbiotic relationship between my baby and me, other mothers and their infants, rather than its exclusive conceptualization as milk. Indeed this
video exclusively situates breastmilk in the domain of nutrition, effectively severing breastmilk from its immunologic and anti-infective properties, not to mention the complex relationship that underpins the ‘mode of delivery’ as it were, of this milk. In the everyday/everynight world breastfeeding cannot be reduced to its various components - that this video accomplishes this severance and upholds only the nutritional aspect of breastmilk is an ideological achievement. This detached concept - breastmilk as food - can now be mystically reconfigured as it proceeds through the ideological circle, as shall be seen.

Objectified knowledge intends to keep the reader at the surface of the text, confined to the conceptual level as it were, "suppressing the presence and workings of the underlying relations they express." (Smith, 1990, p. 37) The video immediately presents the mystically reconfigured concept - that of the virtual nutritional equivalency between breastmilk and commercial formula. This concept is evident in the narrative which structures equivalency thus: “Should you breastfeed or bottlefeed?” (15) This query contains subtle nuances of meaning. First the work “or” evokes an equation, thus breastfeeding and bottlefeeding are conceptualized as different but equal. Indeed the phrase is constructed so that the mode of feeding is different, that is, by breast or bottle, but the “feed” is construed to be the same. A similar construction of sameness is implicit here: “Whether to feed your baby breastmilk or commercially produced formula is a matter of personal choice.” (19-20) The dialectic of homemade, as it were, versus store bought, is well entrenched among contemporary capitalist consumers. Yes, home made is usually evaluated as best, but purchasable commodities can be of high quality too; indeed, the difference between high and superlative blurs and when one is perceived to be so close to the other they become virtually indistinguishable. Thus the text endeavours to construct a virtual sameness between breastmilk and formula: “In most
circumstances your own milk is the best food for your baby. Commercially produced formulas are made to simulate breastmilk . . . " (19-20) The construction of these sentences is isomorphic with the construction of choice itself: first, breastmilk which is best or formula which is virtually indistinguishable from it.

The nutritional equivalency between breastmilk and formula is asserted as irrefutable fact, as non-problematic. There is no textual support for this assertion, no comparison of ingredients for example. It is asserted to be simply so. The following section will make this statement problematic. I will make observable those relations which underly this concept - reveal that which is concealed.

I have begun, as does the text, with the presentation of the conceptual assertion that breastmilk and formula are virtually equivalent. I now endeavour to reveal the machinations of the ideological circle which accomplished the construction of this ostensibly unproblematic conceptual claim.

**Breastmilk is Actually a Dynamic Bodily Fluid that Can Transform Itself to Ideally Meet the Unique Needs of the Human Infant**

Far from one uniform entity, human milk is transformative: colostrum, transitional and mature are the terms ascribed to the various but predictable transformations which human milk undergoes. Colostrum, which is the first milk produced by the breast, contains three times the available protein of mature milk. (Riordan, 1983) Transitional milk evidences a decrease in the concentration of immunoglobulins and total protein and an increase in lactose, fat and total caloric content. Furthermore, water-soluble vitamins increase, and the fat-soluble vitamins
decrease to the levels of mature milk. (Lawrence, 1985, p. 70) Breastmilk produced by women who deliver a few weeks prematurely contains 20 per cent more available nitrogen than the milk of mothers who deliver at term. (Riordan, 1983) Thus the premature infant receives a higher concentration of protein to facilitate compensatory growth.

But stage of lactation impacts more than the nutritional constituents of the milk - the type and concentration of immunoglobulins varies as well. Immunoglobulins, of course, are live cells which help to confer immunity upon the newborn infant. Secretory IgA "is especially high in colostrum in the first few days after delivery, reaching levels up to 50 mg/ml." (Riordan, 1983) This immunoglobulin functions predominantly in the infant's gastrointestinal tract, protecting the intestinal mucosa from the adherence and infiltration of pathogenic bacteria and enteroviruses. The infant's gut, which is sterile at birth, is immediately vulnerable to the pathogens which proliferate in the extra-uterine environment. It makes sense therefore that the concentration of this immunoglobulin is greatest in the early post-partum period. Lactoferrin, another immunoglobulin, increases in volume as the baby ages, reaching a peak concentration by the fourth week post partum. The concentrations of other immunoglobulins such as IgG, IgM, and lysozyme are similarly dependent upon stage of lactation. As illustrated by the aforementioned examples, breastmilk's nutritional and immunological variability is based upon sound biochemical and physiological need.

Stage of lactation is but one of a myriad of factors upon which breastmilk composition depends: geographic residency of the mother, (women in hot climates produce milk with a greater water content, women living in cold climates produce milk that is higher in fat); and diurnal variability, (breastmilk produced in the morning is higher in water content, fat content peaks
mid-afternoon) (Riordan, 1983) are but two examples. Breastmilk even changes within the course of an individual feeding with lactose rich foremilk constituting the milk being suckled at the beginning and fat replete hindmilk characterizing the milk that is suckled at the end of the feed. (Riordan, 1983) Maternal and infant health status further influences breastmilk composition. Maternal or infant illness catalyzes the production of antibodies designed to target and eliminate specific pathogens. These antibodies are transferred via the enteromammary system to the maternal breast to be conferred upon the infant via her breastmilk.

Factors unique to the individual baby such as age and weight also impact breastmilk volume and composition. During the first few days of life breastmilk is quantifiable in terms of tablespoons. During the first month of life normal yield approximates 600 mls per day and increases to 750 to 800 mls per day by the sixth month. "Since each 100 mls of human milk yields 75 kcal of energy, the variable volumes produced at different stages of the infant's life correlate appropriately with the needs imposed by age and weight." (Riordan, p. 29) Far from haphazard or serendipitous, the variable nature of human milk is illustrative of an exquisite and dynamic system wherein the ever changing needs of the human infant are uniquely met.

Breastmilk's Superiority is Reflected upon as Circumstantial; its Dynamicism is Reflected upon as Haphazard

Breastmilk is best for babies. This statement is endorsed by a myriad of health care agencies worldwide. Although the video acknowledges breastmilk to be the "best food" (20) for your baby there is no elaboration upon what makes this so. Furthermore, doubt of the veracity of this statement is articulated by the host who incredulously exclaims: "It's hard to believe a baby can live only on this and nothing else." (127-128) In response Dr. Fabbro simply states:
"Breastmilk is the food nature intended for human babies." (130) Hardly an enthusiastic endorsement. In the absence of any elaboration upon the extensive documentation regarding breastmilk's superiority the unique properties underlying breastmilk's universal endorsement is concealed from the viewer. Furthermore, the superiority of breastmilk is qualified: "In most circumstances your own milk is the best food for your baby." (19) Thus sometimes breastmilk may be best, but in other circumstances it may not be. The superiority of breastmilk is reflected upon in such a way as to question the veracity of the claim.

Furthermore, formula becomes reflected upon as potentially preferable to breastmilk. The narrator states, "Breastmilk looks so thin and watery compared to commercially prepared formulas or even cow's milk." (124) Indeed, breastmilk which has been expressed and allowed to sit forms layers, some appearing clear and watery, others, opaque and white. By comparison then, formula and cow's milk are consistently and uniformly thick and white. The physician responds with the following explanation: "Even in the course of a single feeding the milk varies. (134) The first milk the baby gets, the foremilk is high in sugar and is thirst quenching..." (138) (Read: Thin, watery) "...Later in the feeding the baby gets a richer milk, the hindmilk, higher in fat, more caloric and more satisfying." (139-141) (Read: Finally white like the other milks) In the absence of a contextual explanation which would reassure that this thin and watery appearance does not correlate with nutritional inadequacy the viewer is left with the impression that sometimes breastmilk is rich and satisfying (at the end of the feed) and sometimes it isn't, whereas formula's richness is provided consistently throughout the feeding.

Severed from the lived context of the actual determinations and beneficial outcomes of breastmilk's transformability, this dynamic is reflected upon as unreliable, uncertain, even
haphazard. The video has qualified breastmilk's superiority in its statement, "In most circumstances, your own milk is the best food for your baby. . ." (19) The circumstances in which it may not be best are now delineated.

First, breastmilk is portrayed as being variable according to the nutrient intake of the mother. "When you breastfeed your baby the quality of the milk the baby receives is dependent upon you because your baby can only get the nutrients you put into your milk." (47-48) This statement connotes a direct as well as immediate correlation between nutrient intake and breast milk composition. As such it is a gross oversimplification which ignores such important physiological realities as maternal stores, for example. Mothers are advised, therefore, to eat "a well balanced diet which includes foods from each of the four food groups outlined in "Canada's Food Guide" (50-51) and cautioned to "avoid certain foods because they might irritate your baby's digestive system." (53-54) Not only does such information misrepresent breastmilk as a substance of uncertain and variable quality with the potential to harm, it misrepresents the literature. The National Academy of Sciences' publication Nutrition and Lactation states: "Women living under a wide variety of circumstances in the United States and elsewhere are capable of fully nourishing their infants by breastfeeding them. . .mothers are able to produce milk of sufficient quantity and quality to support growth and promote the health of infants—even when the mother's supply of nutrients and energy is limited." (La Leche League, 1997, p. 38) Additionally, Jelliffe and Jelliffe report that even when maternal eating habits are poor, there is surprisingly little immediate clinical evidence of deterioration of the nutritional status of her milk, at least in the early months." Thus the nutritional quality of breastmilk is remarkably constant despite the nutritional status of the mother; indeed, in dire circumstances it would make more sense to supplement the mother rather than weaning and formula feeding
the baby. This information is not provided to the viewer however. With its exclusion from the text the viewer is left with the impression that she must be scrupulous about her diet lest the quality of her milk be less than satisfactory.

Similarly, the notion that women must restrict their diets is likewise less fact than fiction. “Despite all the available information, some women are unaware that they rarely need to avoid particular foods during lactation because of their spicy or gas-producing qualities.” (Riordan, p. 63) La Leche League echoes this opinion: “There are no foods (such as milk) that must be consumed while a mother is breastfeeding, and there are no foods that must be avoided during nursing.” (1997, p. 37)

The small proportion of infants who are sensitive to some substance in their mother’s milk are overwhelmingly responding to the same allergen. Approximately 7% of infants are allergic to cow’s milk. Cow proteins that are present in formula and can cause allergic reactions are lactoglobulin, casein, bovine serum albumin and lactalbumin. Although formula production includes heat treating to reduce the size of these proteins in an attempt to increase human tolerance to them, they are not always successful. Given that a human infant will consume its body weight in formula by the age of 2 to 4 months, a baby of that age who is sensitive to cow protein is receiving a macrodose of allergen. It is the well documented adverse human response to bovine protein (gastro-intestinal symptoms including microhemmorhage of the gut wall resulting in anemia, and colic; skin disorders such as eczema; respiratory symptoms such as wheezing even asthma; and juvenile diabetes) that necessitated the production of non cow’s milk based formulae such as soy protein based formulae and others. The video states: “Most formulas are made of either cow’s milk protein or soy protein base.” There is no elaboration
however, upon what necessitated the development of the latter. Indeed, cow's milk protein is not among those foods cited by this text as having the potential to cause digestive upset despite the evidence to the contrary. The text informs mothers that they must restrict their diets to eliminate from their milk those ingredients which may cause an adverse reaction in their babies but neglects to mention the allergic potential of commercially manufactured products.

A selective process of revealing and concealing medical literature further constructs the conceptual equivalency between milks. Thus far in the ideological construction of the conceptual equivalency between human milk and commercially produced formula, the nutritional properties of human milk have been severed from the actual lived complexity of breastfeeding; its transformative properties have been severed from the actual determinants and benefits of this dynamicism and these have been reflected upon thus: that in most circumstances human milk is the best food for babies, (but not always) - that such dynamicism is more properly characterized as unreliable, specifically that circumstances such as the vagaries of the maternal diet breastmilk may be, in the case of maternal dietary exclusions - less than optimal, or in the case of maternal dietary inclusions - hazardous to the infant's well being. Thus far, the video has conceptually constructed breastmilk as inherently superior but that this is dependent upon certain circumstances and that in those circumstances infant formula may be preferable. Therefore breastmilk's quality is conceptualized to be variable but formula is conceptualized to be stable and safe.

**Conceptualizing Commercial Formula to be Stable and Safe**

The conceptualization of formula as a stable and safe product is another ideological
accomplishment. I will make observable the actuality that is severed and concealed within the construction of this concept.

Formula - its very name connotes scientific construction. "FORMULAS" the video displays (in a format evocative of an overhead presentation at an educational, evidently a nutrition, lecture), are composed of "PROTEIN, FAT, SUGAR, VITAMINS AND MINERALS". Unlike the variable constituency of breastmilk, commercially produced formula are represented to be of stable composition. The ingredients can be listed. Indeed they are: boldly, definitively and on the page,

In actuality formula production is not stable but ever changing. Thus there is no uniform product which is now nor has historically ever been singularly 'formula'. The illusion of stability is effected, in part, by maintaining the same product names, thus the consumer assumes 'Similac' for example, to be the exact same product today as it was decades ago when it first appeared on the market. In reality however, infant formulae have undergone myriad transformations; indeed even today formulas vary in certain aspects from one another.

One reason for the variation in composition among various formulae is that the breastmilk constituents which they intend to simulate cannot be specifically quantified but are referred to within ranges. Consider the plethora of mathematical possibilities for differences among formulae with 20 or 30 variables. Another explanation for the reformulation of the formula recipe has been the "problem of the limitations of our knowledge at any one time. What goes into formula is what is believed to be essential at the time of creating the standard." (Minchin, 1985, p. 11) The standards however are ongoingly revised. Maureen Minchin's text "


Breastfeeding Matters documents the extensive number of formula mishaps resulting from inadequate standards. The following examples are but a few selected from the extensive ones which her text itemizes: During the 1960's and 1970's some formulae contained "low levels of folic acid and lack of vitamin C resulting in megaloblastic anaemia"; "excessive iron caused gut bleeding, anaemia and immunological disorder", conversely, "insufficient iron caused anaemia and increased infections". As recently as 1983, "Naturiac was recalled because it was discovered to be lacking in thiamine, copper and B6." Until 1984, taurine, essential for the myelination of the central nervous system and brain after birth was almost totally absent from many formulae.(Minchin, p. 11) Both animal and human studies have identified retinal damage as a sequela to taurine deficiency.

Commerce also dictates formula transformations. Ingredient selection is predicated by nutritional requirements as well as commercial interests. Minchin quotes one researcher as having said: "It makes good economic sense to use the cheapest available fat sources, provided the fatty acid composition is satisfactory." (P. 14) Furthermore, according to Minchin's research, "when corn oil became expensive, soy oil was added to corn and coconut oil; when arrowroot became difficult to obtain tapioca starch and corn syrup replaced a mixture of maltose/sucrose, dextrins and arrowroot starch." (p. 14) It is not known whether these transformations were of benefit, risk or of no consequence to the infant consuming them. The point is that infant formula, unlike mother's milk, is a highly profitable commodity and its transformations are, in part, commercially driven.

Formula's whiteness therefore is uniform only in the most basic sense - as light which through a prism illuminates various colours, so too is the whiteness of formula, upon reflection, a
spectrum of constituents and composition.

The safety of infant formula is similarly ideologically constructed. The text states: “If you choose to use a commercial formula you’re providing a high standard of nutrition” (177) provided that you “check the expiry date” (201) and “also to check for any damage to the packaging” (202) and “you are meticulous in preparing the formula exactly as directed and in sterilizing any equipment which comes in contact with the formula.” (178-179) The product itself therefore is conceptualized to be beyond reproach, only factors external to it such as human error could taint it.

Indeed human error in formula preparation has had dire consequences. In their article entitled “Common Mistakes in Infant Feeding”, researchers documented the all too frequent errors associated with human preparation of formula: overconcentration of formula leading to hypernatraemia and brain damage, even in a hospital nursery; overdilution leading to failure to thrive, even starvation; and bacterial overgrowth due to inadequate hygiene and storage.

Although the video text emphasizes the importance of scrupulous purchase, handling and preparation, it does not articulate the potential hazards that can accompany error.

The industrial production of infant formula is not beyond error either. For example, in “March 1992, a month after cans had gone on sale, the FDA in the United States issued a public warning that Wyeth was recalling all half-million cans of its Nursoy Concentrate and Ready to Feed, as they lacked vitamin B6 and had twice the recommended amount of B1.” (Minchin, p. 222) In Australia in 1985, “Carnation Evaporated Milk was mislabelled Prosobee, a potentially fatal mistake for severely milk-intolerant babies.” (Minchin, p. 35)
The video text asserts that commercial formula is beyond reproach unless tainted by human error, but human error whether in the manufacturing plant, the hospital nursery or domestic kitchen is inevitable. It is human nature. This message however is concealed by the conceptualization that infant formula is an unequivocally safe and nutritionally sound breastmilk alternative,

**The Conceptual Currency of the Breastmilk/Formula Equivalency**

Just as I earlier argued that the video text suggested that breastfeeding was more properly situated within the domain of the relations of ruling (medicine), and that bottlefeeding was conceptualized to be more within the mother’s own grasp, there is now the conceptualization of breastmilk as inherently superior - but only ideally, that actual circumstances can undermine its superiority, moreover, that given these actual circumstances, formula, conceptualized to be stable and safe, may be preferable.

The concept of equivalency between breastmilk and formula is ideologically accomplished. The power of its conceptual currency is manifest in that it actually operationalizes the technology required to effect the replication of human milk. The production of infant formula operationalizes the final step in the ideological circle - the mystically reconfigured concept is now utilized to govern the everyday/everynight world.

The fact that breastmilk can be simulated is posited as unproblematic. It is considered to be within the capability of modern technology to do this; indeed, it is believed to have been done. Once again, I delve beneath the surface of this concept that its ideological construction would
wish to confine me, to make observable how problematic the attempt to simulate breastmilk actually is.

From whence comes the recipe for human milk? Whose milk, what sample, will constitute the prototype? Indeed the variability of breastmilk confounds this task. When, for example should the sample be taken? Consider an attempt to quantify the fat content in human milk. "Because the fat content of a feeding varies with time, spot samples give spurious results." (Lawrence, p. 72) Perhaps collecting breastmilk samples during the day will resolve this dilemma. Unfortunately, day time "consumption of milk in a given infant has been shown by Brown et al to be 46% to 58% of the total 24-hour consumption, so that reliance on less than a 24-hour sampling may be misleading ". (Lawrence, p. 66) The remedy seems to be to collect milk over a 24 hour period. But the "average fat content of pooled 24-hour samples has been reported from various sources to vary in mature milk from 2.10% to 3.33%." (Lawrence, p. 72) The following passage from Ruth Lawrence's text Breastfeeding: A Guide for the Medical Profession quintessentially expresses the problem of obtaining a representative sample that breastmilk's variability poses: "Data from samples taken every 3 hours showed a variation in milk concentration of nitrogen, lactose, and fat, as well as in the volume of milk, by time of day. Furthermore, there were statistically significant diurnal changes in the concentration of lactose and the volume within individual subjects, but the times of those changes were not consistent for each individual. Some individuals varied as much as twofold in volume production from day to day. These investigators also found a significant difference in the concentrations of fat and lactose and in the volume of milk produced by each breast. At the extreme, the less productive breast yielded only 65% of the volume of the other breast." (p. 66-67)
Furthermore, technology itself has proved problematic in this regard. “Samples obtained by pumping may vary from those obtained by the suckling infant, since there is some variation in content between the various methods of pumping.” (Lawrence, p. 66) Moreover, the technique used to derive the data have also compounded this problem. As Lawrence relates: “In 1977, Hambraeus reported that there was less protein in human milk than originally calculated. The present techniques of immunoassay measure the absolute amounts, whereas earlier figures were derived from calculations based on measurements of the nitrogen content. About 25% of the nitrogen in human milk is nonprotein nitrogen. Cow’s milk has only 5% nonprotein nitrogen.” (P. 67) Human milk’s variability makes compositional quantification and qualification elusive; historically, technology’s means of measurement has proved rudimentary and compounded the problem. Obviously, the acquisition of a representative sample of human milk is extremely difficult.

It is ideological therefore to assume that it is possible to dip down into the actual, material conditions of human milk production and extract from its multivariants a representative sample which can then be taken up, articulated as recipe and formulated as a breastmilk simulant. That such a recipe is formulated and achieves the characteristics of scientific precision, objectivity and fact is an ideological achievement par excellence. But as has been elucidated, below the surface of this near perfect conceptual construction are a myriad of actual activities engaged in sorting out the actual complex problematic of this ostensibly self-evident equivalency.
The Conceptual Construction of Epidemiologic Homogeneity Among Infants Regardless of Diet

Introduction

The second video of this series entitled "Your Doctor" demonstrates the conceptual construction of epidemiologic homogeneity among infants regardless of diet; that is, this text asserts as simply factual, the idea that all babies are equally susceptible to morbidity whether they are breastfed or bottlefed. Furthermore, that parents, mothers particularly, have little control over their babies' vulnerability to illness since it is medical care - access to and the receipt of interventions from - particularly vaccinations - that is the sole factor which can exclusively alter the course of this otherwise universal eventuality of infant illness. The first video demonstrated the conceptual accomplishment of the equivalency between breastmilk and commercial milks; this video accomplishes equivalency in health outcomes of both breastfed and artificially fed babies.

Breastfeeding is Actually Protective

The concept of epidemiologic homogeneity among infants regardless of diet is ideological: this assertion breaks from actual epidemiologic evidence which demonstrates quite distinct and different health outcomes for infants which are highly dependent upon the milk they are fed. The scientific evidence is clear: breastfeeding is highly protective against morbidity and mortality - babies fed commercial milks are sicker often and more seriously - even die - to a greater statistically significant extent. The Journal of Family Medicine (1991) reported that "There was an inverse relationship between breastfeeding and morbidity. This was most
prominent in the first year of life but was also present in the first three years." (Van den Bogaaard C. et al). Howie (1990) reported that 7% of all infants are hospitalized for respiratory infections, primarily because of the added risk of bottle feeding; formula fed infants in the United States have a 10 fold risk of being hospitalized for any bacterial infection and a four fold risk of bacteremia and meningitis. (Fallot ME et al, 1980 and Leventhal JM, 1986) Furthermore Allen Cunningham published hospitalization patterns of a homogenous, middle class, white US population and concluded that “I (sic) would expect 77 hospital admissions for illness during the first four months of life in every 1000 bottle-fed infants. The comparable figure for breastfed infants is five hospital admissions.” (1991)

Breastfeeding protects against infant mortality as well - even in industrialized countries. Cunningham, Jelliffe and Jelliffe (1991) eloquently summarize the research evidence: “It has been estimated that breastfeeding (or the use of pooled human milk) could prevent 100 deaths from necrotizing enterocolitis annually in British neonatal units. (Lucas & Cole, 1990). In Sheffield, England, breastfeeding was the single most important factor in a prevention program that reduced the postperinatal mortality rate from 5.2 to 1.9 per 1000; the emphasis on breastfeeding accounted for an estimated 24% of the reduction in the mortality rate. (Carpenter RG et al 1983) In Nottingham, England, increased use of breastfeeding was one of several factors in the decline of the postneonatal mortality rate from 8.7 to 3.6 per 1000. (Madeley RJ et al 1986) Preliminary data from the US National Centre for Health Statistics has shown a postperinatal mortality rate difference of 3.7 per 1000 when infants initially breastfed are compared with bottlefed infants (Paul Placek, personal communication, 1986) Finally, a risk-benefit analysis by the US National Institute of Environmental Health Sciences estimates that the decision to breastfeed decreases the mortality rate during the first year by 4 per 1000.
(Rogan WJ, 1989) Furthermore, Marsha Walker (1993) summarizes: "Most of the infant deaths worldwide (1.5 million/year) related to artificial feeding are due to diarrheal illness. In the United States, five hundred children aged one month to four years die each year from diarrhea. (Ho et al, 1988) At least 70% of these deaths are caused by rotavirus infection in children four to thirty-six months of age, against which breastmilk has a known protective effect. (Leventhal JM et al, 1986) In the United States and Western Europe the leading cause of postnatal death is Sudden Infant Death Syndrome. (Anderson et al. 1990) Formula feeding is considered to be a risk factor in these fatalities as a result of the SIDS study conducted by the National Institute of Child Health and Human development. In New Zealand, Mitchell et al (1992) estimated that 79% of deaths from SIDS in that country are attributable to three factors - maternal smoking, prone infant sleeping position and not being breastfed. Sudden death from infant botulism occurs only in formula-fed infants. (Arnon SS et al, 1982) "Sudden death is also more likely to occur in bottle-fed infants as a result of respiratory infections, particularly those caused by respiratory syncytial virus." (Pullan CR et al 1980; Scott DJ et al 1976; Williams AL et al, 1984 and Anderson LJ et al, 1990, in Cunningham et al, 1991, p. 662) Allen Cunningham and his colleagues (1991) concluded that "Current data permit us to estimate conservatively that there is one sudden infant death per 1000 live births as a result of failure to breastfeed in western industrialized nations." (P. 662) Although the video asserts that breastfed and bottlefed babies are virtually the same as far as susceptibility to illness is concerned, babies in the everyday world are actually epidemiologically heterogenous depending upon their diet.
Producing Epidemiologic Homogeneity Among Infants Regardless of Diet

The following section is an empirical examination of how this epidemiologic homogeneity is produced. The narrator simply states: "No matter how carefully you care for your baby, it is inevitable that he or she is going to get sick now and again during this first year." (674-676)

The simplicity of this prediction is problematized. The ideological practices, those methods of reasoning and writing that posit universal vulnerability among infants to illness and conceal the actual differences between breastfed and formula fed infants will be explicated. After demonstrating how this concept is ideologically accomplished, I will show how it, as polished objectified knowledge, is utilized as a lens through which to regard the everyday world of infant health. I will demonstrate this lens at work - alternatively revealing those facts which are congruent with its gaze, and precluding those facts which refute its' perspective from coming into view.

The first method of reasoning employed in this conceptual construction is the establishment of similarity among babies, generally. Prose is the first method of writing utilized to accomplish this verisimilitude. The narrator states unequivocally that: "it is inevitable that your baby is going to be sick now and again during the first year." (675) The phrase 'your baby' refers not to one baby in particular, but to any baby. A universality among infants is thereby posited. Although the text acknowledges that some differences among infants do exist: "Size is dependent upon many factors - race, genetics, nutritional intake (notice quantity not quality), activity level. . ." (529) these are but variations of a standard or norm. ("One of the first things parents usually want to know is whether or not their baby is of normal size.") (526-527) Standardization is further constructed via such textually demonstrated technologies as the measuring tape used by the physician to measure head circumference and the documentation of a
"growth curve". (531) Despite variations therefore babies are virtually a homogenous popula-
tion - sufficiently so that basic principals can be applied to them: "In general, you can expect
that your baby will have doubled its birth weight by five months and tripled it by twelve months."
(539-540) Morbidity becomes another such principal which can be universally applied.

The frequent utilization of the word common: "common illness" (676), "common cold" (678-679)
and its oft juxtaposition with the subject of infant illness is a further prosaic device used to
establish universal vulnerability to illness. "The common cold is unfortunately very common in
the first year of life" (731), "High fevers are common in young children" (694) and "Earaches
are a fairly common complication of colds and babies are very susceptible to them." (758-759)

Further prosaic scaffolding to support this conceptual construction is the presentation of
ostensible epidemiologic fact. Indeed not only does the text assert as known that babies
become ill, but concomitantly the knowledge of the nature and to some extent the incidence and
natural history or course of these illnesses as well. The host delineates those common
illnesses of infancy: "Colic, fever, seizures, dehydration, common cold, croup, infections,
constipation, diarrhea, jaundice, eczema and diaper rash." (678-680) Additionally, "You can
expect eight to ten colds, some mild, others more severe, each lasting between 5 to 14 days"
(732); and "colic seldom lasts more than three months and it doesn't seem to affect normal
weight gain or development." (690-692) The facticity of such data is established via its
presentation: the video devotes an entire frame to the delineation of common illnesses -
nomenclature which is presented in bold, black upper case letters. This presentation asserts
facticity - an apt visual correlative to the unequivocal statements of narrated prose. Addition-
ally, the utilization of numbers, "eight to ten colds lasting five to fourteen days" (732) and "3% of
infants and young children" (714), asserts objectivity, emblematic of the ideological construction of objectified knowledge.

This virtual presentation of the epidemiology of infant illness illustrates what Smith (1990) refers to when she states that "Concepts and categories reflect social relations mediated and organized by concepts and categories." (p. 56) Perhaps it is true that infants experience an average of eight to ten colds a year each lasting 5 to 14 days, but this concept is true only for those infants who are categorically at risk for respiratory illness. In other words this epidemiologic data may be true for those infants who are artificially fed but not for those infants who are breastfed; to assert this data to be universally true indicates that it has been worked up from a category in which infants are epidemiologically equivalent. This categorical equivalency is a social accomplishment. Therefore this section which categorically delineates infant illness is worked up from the concept of epidemiologic homogeneity among infants, which as we are seeing, is itself worked up from the actual epidemiological evidence. This working up then is a social practice which serves to produce this concept.

The conceptual construction of epidemiologic homogeneity among infants is further achieved via ideological practices which render diet irrelevant with respect to infant health. Indeed among such ideological practices is the situating of infant feeding in various domains other than that of infant health. First infant feeding is situated within the domain of maternal preference and lifestyle: "How you decide to feed your baby is a very personal choice involving consideration of lifestyle, emotional makeup and personal preference." (544-546) With respect to weaning the baby the physician states: "The timing depends on the mother - on her preferences and priorities..." (629) Furthermore, infant diet is situated within the domain of nutrition.
The host asks the doctor: "Will my baby still be given a high standard of nutrition if I wean her from breastmilk to a commercial formula?" (645-646) "Absolutely" (647), the physician responds, "commercial formulas are constituted to resemble breastmilk and provided that they are prepared exactly as directed, they are a nutritionally sound alternative to breastfeeding." (647-649) The conceptualization of infant feeding as properly belonging within the realm of maternal preference and nutrition stands in stark opposition to the standpoint of infant health and as such reveals itself to be an ideological conceit.

Furthermore, this video text virtually situates breastfeeding within the paradigm of illness; it delineates the sequelae of breastfeeding to maternal health and implies the irrelevancy of breastfeeding to infant health. This particular video is replete with examples of the ill effects of breastfeeding. The host states: "If a baby is nursing as many as 10 or 12 times a day in the beginning the nipples must get pretty sore." (606-607) The physician concurs: "Some mothers do develop cracked and even bleeding nipples at the beginning." (609) "If you can stand to nurse, start the baby on the side that is least sore." (611) Similarly "If nipples are too sore to nurse you may need to manually express milk for the baby." (613) In a preceding section the video text delineated those inevitable illnesses of infancy the infant would experience; this section delineates the inevitable pathologies to be experienced by the breastfeeding mother. Furthermore, breastfeeding is written as if fraught with failure: "What do I do if the baby just doesn't seem to be able to latch on properly to the breast?" (583-584); "What if after all my best efforts the baby is not thriving?" (621) Congruent with the reasoning "No matter how well you care for your baby, it is inevitable that she will get sick now and again in the first year" (674-676) is this statement that suggests the possibility that an infant may fail to thrive despite the best efforts of the mother. There is then an almost algebraic equivalency between 'all my best
efforts' and 'well care' and between 'failure to thrive' and 'get sick now and again'. Thus maternal care is synonymous with, or at least includes the mother's best efforts (despite sore, cracked and bleeding nipples) to breastfeed, ergo no matter how well you breastfeed your baby it is inevitable that (you and) she will get sick now and again or even fail (to breastfeed, or) to thrive.

A complementary strategy utilized to underscore the irrelevancy of breastfeeding to infant health is the exclusive utilization of breastfeeding and weaned babies as the visual correlatives to the audio text. Whenever an illness is being discussed, the baby shown is one which the viewer has previously seen breastfeeding. (702, 737) Otherwise, the babies are receiving fluids by cup. (729) No bottlefeeding infants are shown. Thus the viewer is deluged with visual demonstration of breastfed babies juxtaposed with auditory text delineating infant susceptibility to illness. A correlation is thereby established - no baby is immune from these common illnesses; alternatively, all babies, regardless of diet, are equally susceptible to them.

“Ideological modes of thinking deprive us of access to, hence critique of the social relational substructure of our experience.” (Smith, 1990) The video text does in a perfunctory way acknowledge that breastfeeding has “some very clear advantages both to the baby and to the mother.” (546-547) The method of writing these advantages however, or more accurately, underwriting them as it were, is such that the advantages are not clear but rather equivocal and lack cogency. The text states that: “Breastmilk offers the baby natural immunities to help fight off infection” (549); “It’s very digestible resulting in fewer intestinal disturbances like diarrhea and constipation (550) and there is better absorption of nutrients, especially of iron” (552); “Because exposure to foreign protein is lower when babies are breastfed there is possibly a
reduced risk of food allergies or eczema (554-555); and finally, "An added plus for the mother is that breastfeeding encourages the uterus to shrink back to its normal size more rapidly."

Equivocality is achieved through the less than definitive phrases like "helps fight" (549) and "possible reduced risk" (555). The lack of cogency is attributable to the de-contextualization of each statement. Of what significance are fewer intestinal disturbances? better absorption of iron? uterine involution? The methods of writing these advantages lack context so that their significance remains mysterious. This ideological practice further accomplishes the conceptual construction of epidemiologic homogeneity among infants regardless of diet by ensuring it remains within the virtual rather than the everyday/evetynight world.

The Conceptual Governance of Epidemiologic Homogeneity

The conceptual construction of epidemiologic homogeneity among infants is now complete. I have explicated the various ideological practices which accomplished this facticity. According to Smith (1990) "When concepts are detached from the relation in which they make the world of living people observable, they become a means of operating selectively upon it and sorting it out in ways that preserve the ideal representation. Ideology can be viewed as a procedure for sorting out and arranging conceptually the living actual world of people so that it can be seen to be as we already know it ideologically" (Smith, 1990, p. 42-4) The concept of epidemiologic homogeneity among infants has been detached from the actual epidemiologic heterogeneity that distinguishes breastfed from bottlefed infants. This severance enables this concept to be speculatively manipulated; in the section that follows I will elucidate how the concept of epidemiologic homogeneity works - specifically how it sorts out and arranges conceptually the scientific evidence which exists within the living actual world of people so that is congruent with
this ideological lens.

With respect to respiratory infections the text asserts that: "The common cold is unfortunately very common in the first year of life. You can expect eight to ten colds, some mild, others more severe, each lasting between 5 to 14 days." (731-732) Moreover, "A distressing viral infection related to the cold is croup." (745) The text suppresses the following evidence that breastfed babies actually have a lower incidence of respiratory infections than their artificially fed counterparts. "Breastfed infants evidence a decreased incidence of respiratory infection compared to bottlefed infants especially within the first six months of life (but still evident through the second year)." (Cunningham et al. 1991, p. 660). Furthermore, "Hospitalization for respiratory infections is more frequent in bottle-fed infants. Seven per cent of all infants are hospitalized for respiratory infections, primarily because of the added risk of bottlefeeding." (Pullen et al. 1980; Howie, PW et al. 1990; Chen Y et al. 1988). The Pima Infant Feeding Study whose theme was Breastfeeding and Respiratory Infections during the First Year of Life (Forman et al. 1984) studied the incidence of respiratory infection, otitis media and pneumonia particularly, in exclusively American Indian and Alaskan Native children under the age of 5 years, in whom the incidence is strikingly higher (13%) than among a general sample of US children of the same age range (4%). The investigators concluded that "the breastfeeding of infants in early life is associated with reduced risk of respiratory infection." (p. 447) Respiratory syncytial virus is the most serious respiratory pathogen among infants in Western Europe and North America and accounts for considerable morbidity and death. (Cunningham et al. p. 660) Formula-fed infants receive no such protection as do those who are breastfed. Duran et al present results found in infants who had two or more episodes of acute chronic bronchitis. They found that twice as many bottlefed infants presented with the problem as those who were
breastfed. (Facts about Breastfeeding, 1992, No. 545) Furthermore, when respiratory
infections develop in breastfed infants, the illnesses are likely to be less severe. (Cunningham,
et al. 1991, p. 660 and Lawrence, 1985, p. 332) This can translate into a lower incidence of
mortality. Cunningham (1990), summarizing the findings of Lepage et al (1981) states: "In
Rwanda, where the general infant mortality rate exceeds 100/1000, the case fatality rate for
minimally or partially breast-fed infants admitted to the hospital for respiratory illness is half the
rate for infants who are completely weaned (13% vs 27%)." Thus it is not axiomatic that the
common cold will be universally experienced among all babies in their first year of life; rather,
breastfeeding is highly protective against respiratory infections and thus, unlike their artificially
fed counterparts, breastfed babies experience such infections less often and less severely.

Similarly, the text asserts that: "Earaches are a fairly common complication of colds and babies
are very susceptible to them." (758-759) In truth some babies are more susceptible than
others. Breastfeeding confers a high degree of protection against otitis media, the middle ear
infection symptomized by ear aches, to which this text refers. Saarinen (1982) studied upper
middle class Finnish children who were not in day care. When she compared children
exclusively breastfed for 6 months or more with infants weaned before 2 months, she found a
relative risk of 3.3 for two or more episodes of otitis media in infants weaned early (6% vs 19%)
and a relative risk of 4.3 for four or more episodes for children 12 to 36 months of age (6% vs
26%) Thus otitis media is 3 to 4 times more prevalent in formula-fed infants. Duration of
breastfeeding was another factor in its protective affect: Saarinen's study evidenced that
prolonged breastfeeding conferred protection against otitis media upon infants until their third
year of life. Similarly, Alho et al (1990) concluded that "short duration of breastfeeding involved
another significant risk of recurrent respiratory infections and otitis media." Similarly,
(Timmermans & Gerson, 1980) found that even in the harsh Labrador environment chronic granulomatous otitis media is seen only in Inuit children given bottle feedings before 6 months of age; and Knishkowy (1991) concluded that "Recurrent otitis media (6 or more episodes) occurred more frequently among children whose duration of breastfeeding was less than 26 weeks." Breastfeeding also diminishes the medical course of otitis media in breastfed babies who do become afflicted: Teele et al (1989) found that the duration of secretory otitis media is reduced in breast-fed children.

Another of the common illnesses of childhood according to this text is gastro-intestinal illness symptomized particularly by diarrhea. "Abnormalities in bowel movements are another area of concern." (763) But what constitutes normal? Once again the concept of epidemiologic homogeneity reveals itself in the assumption that all babies have universal patterns of elimination. In actual fact, breast and bottlefed babies have characteristically different stools as well as frequency of bowel movements. Although the text acknowledges that normal varies depending on such factors as "what the child is eating" (764), it does not describe the characteristic appearance of breastmilk stool nor the usual stooling habits of the exclusively breastfed infant. Diarrhea is defined as "bowel movements" that are "too frequent and too loose." (771) The vagueness of such terms as "too frequent" (771) is echoed by Dr. Fabbro who states that as long as a breastfed baby is stoolsing "frequently" (576) the parents can be reassured that their baby is ingesting enough milk. She does not, however, quantify "frequency" making it a less than useful criterion; by contrast, she does quantify wet diapers with 4 to 6 in a 24 hour period indicating normal output. (575) What parents aren't told is that breastfed babies, especially those under 6 weeks, stool at least 2 to 5 times in a 24 hour period - some stool with every nursing. Moreover, the characteristic stool of the breastfed baby is very loose and unformed, of
a pea soup consistency. (La Leche League, 1991, p. 236) Conversely, the bottlefed infant characteristically produces a firmer, more formed stool, with a unpleasant odour and does not typically stool as frequently as the breastfed baby. The concept of epidemiologic homogeneity governs the interpretation of elimination patterns as healthy or indicative of illness. Although the normal stooling pattern of the breastfed baby approximates the description "too frequent and too loose", within the context of this video text the latter becomes indicative of a potentially ill state. The distinct elimination pattern of the breastfed baby gets subsumed within the context of universality. In the everyday/everynight world the implication of such ideological governance may be the misdiagnosis of a perfectly healthy breastfed infant as one afflicted with diarrhea.

According to the text diarrhea “may be caused by an infection.” Indeed most gastro-intestinal disturbances are caused by a rotavirus or reovirus. (Riordan, p. 172) Breastmilk of course contains many immunological factors including interferon which may play a role in the protection of the breastfed infant against viral infections. Thus the incidence of gastro-intestinal infection and concomitant diarrhea is much lower in the breastfed infant. “In industrialized nations, formula-fed infants have a three-to four-fold risk of diarrheal illness. The risk of moderate to severe rotavirus gastroenteritis increases five-fold in formula fed infants.” (Duffy et al, 1986) “In 1981 the US government commissioned a task force to review the scientific evidence relating infant feeding practices to infant health. The task force concluded that breast-feeding prevented infantile gastrointestinal infections in all settings and improved infant survival rates in poor countries.” (Report of the Task Force on the Assessment of the Scientific Evidence Relating to Infant-Feeding Practices and Infant Health in Pediatrics, 1984) Similarly, “It is concluded that in children up to 18 months of age, breastfeeding offers substantial protection against death in children hospitalized with diarrhoea.” (Sachdev et al. 1991) Of
course survival rates become relevant to sick premature babies in highly technological settings such as neonatal intensive care units. Lucas and Cole (1990) estimated that in babies born at 30 weeks or more gestation necrotizing enterocolitis was 20 times more common in babies fed only formula. "The authors estimated that exclusive formula feeding could account for 500 extra cases of NEC each year, and the death of 100 (20 per cent) of these babies." (Walker 1993, p. 96) In conclusion: "Important protection against gastro-intestinal infections in every setting has been confirmed and reconfirmed; most clinicians now accept such observations." (Cunningham et al. 1991) Thus gastro-intestinal infection is an important pediatric health issue causing morbidity and mortality among the world's children. The lens of epidemiologic homogeneity however conceals from view the extent to which breastfeeding confers protection.

Dehydration, "literally the drying up of the body" (724) which can lead to shock and death, is the most serious sequelae of diarrhea. Once again, the breastfed baby is protected against dehydration. "Because of breast milk's low solute load an infant can be kept well hydrated despite fever or other increased fluid losses." Solute load refers to the particular concentration of a given fluid. "Human milk has significantly lower levels of calcium, phosphorus, sodium, and potassium than cow's milk." (Riordan, p. 34) Renal solute load impacts kidney function as well as overall hydration. The solute load on the kidney of the breastfed infant is 1/3 that exerted upon the kidney of the infant fed cow's milk. Excess solutes require greater obligatory water loss so that artificially fed infants have less water to spare in conditions such as gastro-intestinal infection. Vomiting and diarrhea in these infants "can cause a more rapid osmotic shift of free (extracellular) water so that dehydration is more severe than in the breastfed infant." (Riordan, p. 35) Therefore the artificially fed infant is at greater risk of dehydration that the breastfed baby.
The text obviates this distinction in vulnerability to dehydration by offering treatment to both breastfed and bottlefed infants. "If you’re breastfeeding continue as usual and also offer other liquids. (775-776) If the infant is bottlefed, stop feeding him milk . . . and use other fluids instead." (778-779) The construction of this sentence suggests equal susceptibility to this condition. Furthermore, it emphasizes oral rehydration with supplemental fluids the predominant therapy for all infants regardless of diet: "If you have the slightest suspicion of dehydration. . . coax as many fluids as possible into the baby." (726-728) As usual, the uniqueness of breastmilk is not discussed. Breastmilk is always the fluid of choice in situations where there is a risk of dehydration, not "other fluids." Yet breastmilk is not among the fluids listed as appropriate for oral rehydration: "ORAL REHYDRATION FLUIDS, DILUTED JUICES and FLATTENED SOFT DRINKS." (780-781) Jan Riordan explains why breastfeeding should continue in diarrheal illness: "Because breastmilk is digested so rapidly, even the infant who is vomiting regularly will absorb some of the nutrients and fluid of the milk before it is regurgitated." (P. 172) Furthermore, "Only in moderate to severe diarrhea is supplementing breastmilk with an electrolyte oral solution such as Pedialyte necessary, but this is rarely a problem in the breastfeeding child." (Riordan, p. 173) Additionally, breastmilk contains anti-infective properties; these can ameliorate the course of the infection and so to supplement unnecessarily means replacing breastmilk which contains these properties with another which lacks them.

In addition to the notion that supplemental fluids are necessary in every case, the text, although technically correct that the breastfeeding mother need not interrupt her breastfeeding, does imply that milk is an inappropriate fluid in the case of oral rehydration. It does not explain why the breastfeeding mother can safely continue to nurse, whereas the formula feeding mother should discontinue feeding formula to her child. This is a very dangerous juxtaposition of
information without elaboration. The danger is that the mother, who has already been convinced of the comparability between 'milks', may interrupt her breastfeeding, as the bottlefeeding mother is instructed to do. Studies confirm that the cessation of breastfeeding during diarrheal illness has deleterious consequences for the infant: "Withdrawal of breastfeeding during diarrhoea is (sic) associated with a five times higher risk of dehydration compared with continuation of breastfeeding. (Faruque 1992) Similarly, Haffejee (1990) concluded that (a) breastfeeding should be continued during an episode of infantile diarrhea, and that (b) empirical use of soya preparations from the time of hospital admission is not justified." By failing to elaborate upon why the breastfeeding mother need not temporarily interrupt her breastfeeding this text risks the actualization of such unnecessary cessation. Of course breastfeeding cessation, regardless of the rationale upon which it is accomplished, is a potential sequelae of this text's conceptual governance.

Atopic dermatitis is another common illness of childhood. The text states equivocally that "because exposure to foreign protein is lower when babies are breastfed there is possibly a reduced risk of food allergies or eczema." (554-555) The actual immunological mechanisms by which breastfeeding confers protection against allergy are far more complex than the simplified and singular attribution to lower exposure to foreign protein offered by the video. Additionally, exclusive breastfeeding to 6 months accompanied by maternal dietary elimination of bovine protein can significantly reduce the incidence, severity and duration of eczema. "The effect of breastfeeding on allergic sensitization is both direct through the elimination of nonhuman milk protein as an exposure to antigen and indirect by affecting the absorption of antigen through the intestinal tract." (Kleinman, RE, 1983). The infant's gut is permeable to foreign species protein and other antigenic molecules until around 9 months of age. Allergic reactions are incited by
the transport of allergens across the permeable gut and into the infant’s circulation. Evidence exists that IgA antibodies play an important role in confining food antigens to the gut. Colostrum and mature breastmilk are highly concentrated with IgA. Secretory IgA is present in breastmilk in concentrations several times higher than its' presence in cow’s milk or formula. Food antigens given to a bottle fed infants before he can make his own IgA, and when he is deprived of that in human milk and the plasma cells, may be expected to be more readily absorbed. Non-specific factors may also be important. “It is, for example, conceivable that antigen uptake through the gut might be greater when the pH is higher, or when E. coli predominates over lactobacilli. (Breastfed babies have a lower pH owing to a predominance of lactobacilli and bifidobacteria. Infants fed on formula, have a higher fecal pH with a predominant flora of Streptococcus faecalis, Bacteroides sp. and E. coli.) Whatever mechanism is involved the prophylactic effect of breastfeeding appears to be substantial.” (Neville & Neiffert, p. 265)

“Grulee et al observed as early as 1934 that eczema was seven times more common in infants fed cow’s milk than in those who were breastfed.” (McCombs et al in Lawrence, p. 399) Glaser (1966) first associated the drop in breastfeeding with the rise in allergy. More recently, studies by Chandra (1979) and Gruskay (1982) validate the effectiveness of exclusive breastfeeding as one effective prophylactic strategy against infantile allergic response. A. Cantani (1991) summarizes the literature: “The allergy -preventive importance of breastfeeding has been clearly assessed since 1936 by both prospective and retrospective studies. My study shows that 81% and 43% of studies, respectively, have confirmed the indisputable advantages of breast-feeding while the conflicting studies are 21% and 28% respectively (two studies found no differences). Therefore the prospective studies have demonstrated that preventive measures are effective in the very great majority of cases, for example in our studies in 94% of cases.”
He concludes: "the prospective preventive studies have largely confirmed the high value of breastfeeding alone or associated with dietary manipulations, together with environmental controls in the prevention of allergic disease in at risk babies." (1992, p. 533)

The text states: "One of the more difficult things for the parents of newborns to cope with is colic. . . No one knows what causes colic or can offer any surefire remedy." (689) With respect to dietary practices, colic is more prevalent in artificially fed babies than breastfed babies, although breastfed babies may symptomize colic as well. (Riordan, 1983, p. 66) Although it is true that no study has identified the specific etiological agent in infant colic, it is generally hypothesized to be symptomatic of an allergic response to foreign species protein - usually bovine. Lawrence (1985) reports that "Colicky breastfed babies who are weaned to formula are usually much worse." (p. 212) The presumption is that their allergen load has gone from bad to worse.

Clinical studies have been conducted to try to ascertain whether there is an association between maternal ingestion of dairy products and colic in breastfed babies; that is, can babies become sensitized to antigens present in their mother's milk? The research evidence suggests that this can be the case. In the late seventies a Swedish study showed that "symptoms disappeared promptly in two thirds of colicky babies whose mothers were placed on a diet free of cow's milk protein. On reintroduction of cow's milk into the mother's diet, colic reappeared in all but one of the infants" (Riordan, 1983, p. 66, referring to the study by Jakobsson I and Linderg T. 1978) I. Jakobsson and T. Linderg (1983) conducted a double-blind crossover design study in mother-infant pairs in which the infant had colic. They found that 35% of the infants improved on maternal diets free of cow's milk. More recently, P. Clyne and A. Kulczycki
(1991) found a difference in the amount of bovine protein present in the milk of mothers with afflicted infants compared to the milk of those whose babies were colic-free: "Significantly higher levels of bovine IgG are present in milk from mothers of colicky infants, and bovine IgG may possible be involved in the pathogenesis of infant colic." Thus there is evidence to suggest that maternal restriction of dietary cow's milk may be an effective strategy. It is much easier to reduce the antigen load in breastmilk by reducing the ingestion of the allergen, (although this may become more difficult with the advent of genetically altered food), than to remove it from formula in which it is the principal ingredient. This may not be a "sure fire remedy" but the preponderance of evidence suggests that the elimination of cow's protein may be a viable one.

No options exist however within a text whose organizing lens precludes this knowledge from coming into view: Certainly within a conceptual framework that assumes epidemiologic homogeneity among infants regardless of diet, any evidence which implicates diet as an etiological factor or dietary manipulation as a strategy for cure, must be expunged, Hence the text asserts a homogeneity of experience among infants afflicted with colic, ("At the same time each day, usually late in the day, the baby will cry or scream") (684-685) as well as a homogeneity of parental response, ("nothing you can do will comfort her for more than a few minutes.") (685-686) Conceptual governance precludes all but one, singular parental strategy - "Endurance seems to be the only answer." (689-690) Confined to the surface of the video text, as it were, this does seem to be so.

Not only does the lens of this text preclude the distinct and different health outcomes babies have as a result of diet, but it also precludes the distinct and different responses babies have to its own recommended intervention. The text exclusively identifies immunization as providing the
infant with "insurance against serious disease." (505-506) Of course immunizations are important. Indeed, La Leche League (1991) advises that "the breastfeeding baby receive the same immunizations following the same timetable as the formula-fed baby." (p. 403) Little known however is that breastfeeding enhances vaccine response. Hahn-Zoric et al. (1990) found that "Breastfed infants showed better serum and secretory responses to peroral and parenteral vaccines than the formula-fed, whether with a conventional or low protein content." Marsha Walker (1993) explains: "High antibody levels to diptheria and polio are seen up to one to two years after vaccination in breastfed babies. This is thought to occur because breastmilk primes the infant to produce antibodies. Formula has no effect." (p. 97) Indeed breastmilk has its own affinity to confer immunity from some of these diseases: "It appears that human milk possesses an ability to inhibit B. Pertussis which is not shared by bovine milk and that this property is independent of the effect of lactoferrin, lysozyme levels, the lactoperoxidase system, and differences in the fatty acid composition." (Redhead, K et al. 1990) Thus breastmilk and vaccinations obviously work together synergistically or exponentially to confer quantitatively different responses from the bottlefed baby whose immunity to these diseases is dependent upon vaccinations alone.

Although the video text asserts that it is exclusively immunizations which provide important "insurance against serious disease" (505-506), breastfeeding may be protective against serious illnesses for which there are no vaccines: (1) Herpes Simplex. Lopez (1990) asserts that "Mother's milk could play a role in the protection of the newborn from Herpes simplex II contamination."; (2) Inflammatory Bowel Disease. Artificial feeding is a risk factor is ulcerative colitis (Whorell PJ et al. 1979) and Crohn's Disease (Koietzko, S. et al. 1989); (3) Juvenile Diabetes. Artificial feeding is a risk factor for juvenile diabetes 2:1 to 7:1 (Mayer EJ et al. 1988;
Virtanen SM et al. 1991; Glatthaar, C. et al. 1988; Scott FW 1990; Borch-Johnsen K et al. 1984); (4) Cancer. Artificially fed babies are more likely to get cancer 6:1 to 8:1 for lymphomas. (Davis MK et al, 1988); and (5) Human Immunodeficiency Disease. Newberg (1992) found that "All (human) milk samples contained a factor that inhibited the binding of HIV to CD4 receptor molecules; the findings raise questions on whether human milk is an effective agent for the vertical transmission of HIV." Ryder R. et al. (1991) state "The lack of a dose-response effect between breastfeeding and perinatal HIV-1 transmission and the presence of a protective effect of breastfeeding against common causes of early childhood morbidity and mortality support the current World Health Organization recommendation that breastfeeding should continue to be promoted in all developing countries, including those with HIV-1 prevalence rates in women of childbearing age.*

Silencing the Myriad of Benefits Breastfeeding Confers Upon the Mother

The "very clear advantage" applicable to the mother is, according to the text, the fact that "breastfeeding encourages the uterus to shrink back to its' normal size more rapidly." (562-563) While it is true that breastfeeding immediately postpartum does effect uterine involution and thereby reduces the risk of postpartum haemorrhage, there are many other maternal benefits which may be more cogent for the viewing mothers-to-be. Just as the differences between breastfed and artificially fed babies are textually silenced, so too the differences breastfeeding can make to the mothers. For example, the fact that breastfeeding encourages the mother, not just her womb, to shrink back to normal more rapidly. Indeed, several studies herald the fact that breastfeeding facilitates postpartum weight loss. Dewey et al. 1993 concluded that "lactation enhances weight loss postpartum if breast-feeding continues for at least 6 months."
Similarly, Kramer et al. (1993) found that "mothers who breast-fed exclusively or partially had significantly larger reductions in hip circumference measurements and were less above their pre pregnancy weights at 1 month postpartum than mothers who fed formula exclusively." (P. 429) The text tells the potential breastfeeding mother that the postpartum period "is decidedly not the time to restrict your diet"; what is excluded by the frame, however, is the concept that lactation precludes the necessity.

The contraceptive benefits of breastfeeding are expunged by this text. The reproductive health expert states that the 6 week check up would constitute a good time to "discuss an appropriate birth control method with your doctor. Contrary to a widely held belief, breastfeeding is only partial protection against pregnancy." (1057-1058) In fact, "At the Bellagio Consensus Conference, Italy, in August 1988, it was agreed that a mother who is fully or nearly fully breastfeeding her infant and who remains amenorrheic has a less than 2% chance of pregnancy during the first 6 months after childbirth." (Kennedy K. et al. 1989) This consensus was reached after reviewing the preponderance of the evidence that corroborated these findings. (Kennedy K. & Visness CM, 1992; Perez A. et al. 1992; Short RV et al. 1991; Lewis PR et al. 1991; Kennedy KI et al. 1991)

Other maternal benefits of breastfeeding excluded by the ideological frame of this text include: A lower risk of breast cancer, a lower risk of ovarian cancer, and reduced risk of osteoporosis. With respect to breast cancer risk Yoo et al. (1992) found that "The trend of decreasing risk with increasing average months of breastfeeding was statistically significant." Reuter K. et al. (1992) found that "Lactation had a small but statistically significant protective effect against breast cancer in all the women we studied and in the subgroup of postmenopausal women."
Other studies corroborate these findings: Byers, T. et al. (1985); McTiernan A. & Thomas DB, (1986). Gwinn, ML et al. (1990) found that the failure to lactate increased the mothers' risk of ovarian cancer (1.6 : 1). Kreiger et al.(1982), found a correlation between lactation and reduced risk of osteoporosis.

Conclusion

In the preceding section I first explicated the ideological accomplishment of objectified knowledge and then demonstrated how it works. The concept of epidemiologic homogeneity among infants regardless of diet, (which itself was worked up from the substantial evidence which demonstrates actual differences in health outcomes between breast and bottlefed babies), operates as a lens imposed upon the everyday/everynight world of infant health, revealing only that knowledge which was congruent with itself and precluding from view that knowledge which refuted it. The protective effects of breastfeeding therefore were obviated from view.

Within this tri-partite video series “Your Baby, Your Doctor, and You” this particular video, “Your Doctor”, is both aptly entitled and situated. Indeed the subject of this video, infant health, is conceptualized within the medical paradigm. The host of the video asserts the importance of medical care to the new mother: “Life with a baby involves very frequent visits to a doctor. Even if your baby is healthy, regular check ups are necessary to make sure that the baby is growing and developing normally.” (503-505) Furthermore, the physician occupies an intermediary position vis a vis the maternal infant dyad. Within this video which is conceptually constructed around the premise that all babies are equally vulnerable to illness, breastfed or not, medicine is asserted to be the sole intervention which can impact upon infant health. The
host underscores the "all important immunizations that are the infant's insurance against serious disease." (505-506) Conversely, of maternal intervention the host states: "No matter how you care for your baby it is inevitable that he or she is going to be sick now and again during the first year." (675-676) Fathertongue, the language of objectified knowledge refers to those "modes of speaking, writing and thinking that take women's (sic) powers of expression away even as we use them" (Smith, 1990, p.199-200); that "alienate women from their own experience." (Smith, 1990, p. 13) The objectified knowledge of this particular video subverts the mother's power of expression - breastfeeding - as soundly as it does the breastmilk she produces in deference to the assertion of medicine's ability to treat illness, and immunization as the quintessential technological achievement in the prevention of serious disease. "Your Doctor" is the scalpel which severs "Your Baby" from "You"; as magisterial discourse it governs the silencing of the mother's ability to confer protection upon her infant and her baby's experience of its' protection.
The Conceptual Construction of the Severance of the Breastfeeding Dyad

The detachment of the mother from her breastfeeding infant is the conceptual accomplishment of the final video of this series, "You." Methods of thinking are explicated which become what Smith refers to as "the textual coordinates" which when read, or in this case viewed, can "subordinate individual consciousness to its objectification; subjects subdue their particularized experience to the superordinate virtual reality of the text." (p. 70) This video conceptually constructs a breastfeeding consciousness of not breastfeeding - as objectified knowledge it governs the severance of the mother from her infant, the infant from its' mother's breast; the accomplishment of this severance is the ultimate ideological practice.

The Conceptual Construction of the Early Cessation of Exclusive Breastfeeding

The first method of thinking this text employs to conceptually construct this severance is the positing of a virtually preferred mode of parenting referred to as detached. Degree of contact between mother and child is the critical variable which distinguishes detached from attached parenting styles. Exclusive breastfeeding exemplifies attached parenting. As its' name implies, the breast, exclusively, is offered to the baby. Breast substitutes such as soothers and supplemental bottles are incongruent with this nursing style. Thus exclusive breastfeeding is distinguished from token or partial breastfeeding which incorporate other feeding modalities. As I shall argue, this text governs the weaning of the baby by conceptually constructing the early cessation of exclusive breastfeeding itself as well as those behaviours which accompany and facilitate it.
Exclusive breastfeeding requires frequent contact between mother and infant. Mammalian species differ in the frequency of contact with their young that feeding imposes. The digestibility of milk is one factor which determines feeding frequency. Human milk is extremely easy for the infant to digest. Human milk protein is predominantly whey which is easily acidified in the stomach into soft, flocculent easily digested curds. Digestive enzymes such as lactase, which break down carbohydrates, and lipase, which break down fats, are present within human milk itself; thus the digestive process begins before the milk even reaches the infant's gut. This facilitates an efficient metabolic process whereby the human infant need not expend a lot of energy to break food down, thus providing the brain and other organs with an ongoing, readily available source of nutrients. This quick metabolism of nutrients is evidenced by the frequent stooling so characteristic of breastfed babies; (it is not uncommon for breastfed babies to stool with every feeding.) Typically then, exclusively breastfeeding infants will nurse every 2 to 3 hours, (with a longer stretch at night), and oftener during the evening and periods of growth.

Although artificially fed infants possess the same enzymes in their guts, they are unavailable in their formula. Moreover, the foreign species protein in formula makes it less digestible than human milk. Hence, these babies must expend a greater degree of energy to digest their food. Formula fed infants also imbibe soporific ingredients which, as anyone who enjoys warm milk before bedtime knows, induces sleep. These factors culminate in longer periods of sleep between feeds. Formula fed infants therefore can tolerate 4 hour feeding schedules.

Hospital practice attests to the verity of these differences. Feed volumes are calculated based upon feeding frequency requirements. Therefore bottlefeeding infants are given volumes compatible with 4 hour feeding schedules whereas babies receiving breastmilk are fed every 2
to 3 hours. Thus hospitalized infants who are bottlefed are handled up to 50% less frequently than their breastfed counterparts. This discrepancy in handling frequency is no doubt evidenced at home as well. Unaware of the rationale for the differences in sleep/feeding patterns between breast and artificially fed infants, breastfeeding mothers are often envious of the longer sleep cycles so characteristic of formula fed infants. Extended sleeping is often misconstrued to be evidence of satiety. Parents need to have these perspectives debunked in order to understand the health context of these differences.

Since breastfeeding is a symbiotic relationship, the maternal breast also effects the high frequency of contact between the infant and her mother. Although milk is made simultaneously during suckling itself, the breast also has some storage capacity. A breast engorged with milk becomes uncomfortable and wanting emptying. Additionally, the mother has two kinds of milk letdowns (also termed the milk ejection reflex): one which occurs secondary to infant suckling and another which occurs spontaneously, say in the shower, or when thinking about her baby. These spontaneous letdowns also cue the mother to put the baby to her breast. Thus the interdependency of breastmilk digestibility, infant hunger and the discomfort of the full maternal breast culminates in frequent feeding since breastfeeding effects mutual satisfaction of these needs for food, satiety and comfort.
Unrestricted access to the breast is abjured in this text. The narrator incredulously exclaims: “Feedings every 2 to 5 hours which last for how long? Up to half an hour? Is this around the clock.” (91-92) “... I'm afraid so” (94) is the physician's less than positive response. Artificial feeding is presented as giving the mother more control over feeding frequency and greater periods of time between feeds: “A newborn should take a minimum of 20 ounces over a 24 hour period.” (251) Since newborns (depending upon weight) generally consume around 4-6 ounces per feeding, this recommendation translates into a 4 hour feeding schedule. Therefore bottlefeeding does not demand the frequency of contact that breastfeeding does.

Exclusive breastfeeding is conceptualized as arduous and exhausting: “And there is a wonderful sense of self-sufficiency in providing everything your baby needs all by yourself. But this very quality can also be exhausting.” (32-33) The final video of this series entitled “You” emphasizes the “physical and emotional exhaustion” (883) experienced by new mothers. (“You drop into bed more exhausted than you can remember ever being.” 833-834) This exhaustion is uniquely correlated with breastfeeding. In a segment within this text entitled “The First Year” (947) baby’s nighttime wakefulness is constructed less as a parenting problem than a breastfeeding problem. As the host narrates: “If your baby is often awake at night...” (952) the screen demonstrates a dramatization of a mother breastfeeding her baby. This particular video’s intention is to help articulate some strategies to "build the strength and endurance" (949) that will enable parents to cope during this “exciting first year with baby.” (950) Since
breastfeeding is constructed as the problem, the inevitable solution is its cessation. Hence this text advocates the introduction of bottles. Thus, "A breastfeeding mother could express milk, and let her partner share some of the nighttime feedings." (959-960) Similarly, "With bottlefeeding, the father, other family members and babysitters can relieve you so you can get an uninterrupted night's sleep. . ." (36-37) Bottlefeeding is constructed to be the daytime coping strategy as well: “During the day if one word could sum up an approach for this first year it would probably be 'simplify'” (979) Although the text elaborates upon this decision with sensible advice, “Simplify the meals you prepare, the housekeeping routine, your grooming routine” (979-980) the visuals which accompany this segment are exclusively of bottlefeeding mothers. Thus exhaustion is juxtaposed with breastfeeding and its coping strategy, simplification of lifestyle, is juxtaposed with bottlefeeding. Bottlefeeding is constructed to be the sensible, simpler lifestyle choice.

**Conceptualizing Exclusive Breastfeeding as Socially Restrictive and Isolating.**

Exclusive breastfeeding is also socially restrictive and isolating. Breastfeeding is constructed be an act of "self sufficiency". Thus father enters stage right, hands mother the baby, and exits, leaving she and her baby alone. Conversely, “With bottlefeeding, the father, other family members and babysitters can relieve you. . .” (36) Thus unlike the isolation of the exclusively breastfeeding mother who is the only one who can feed the baby, bottlefeeding enlists a cacophony of others to assist her in this task. Finally, mothers need to be freed from the confinement of their domain. Although the video states that “Breastfeeding is a portable, convenient way to feed your baby anytime, anywhere” (27), it undermines its' meaning by first, juxtaposing this statement with one describing the portability of bottlefeeding, “And when you
travel with the baby you can use ready-to-use formula with bottles with disposable liners so the only parts that remain to be sterilized are the nipples and bottle tops" (39-41), and then contradicting itself, "Of course if you master the art of expressing breastmilk you can enjoy the same freedom." (44-45) If the mother does master the art, she can bottlefeed her own milk to her baby when out. And if you can't master this art? (Like sculpture or painting, some people have a talent for it and others don't.) The implication is that the breastfeeding mother cannot breastfeed in public but must use a bottle filled with either formula, or, if possible her own milk, when she goes out. Either way bottles are the passport to re-integration with the social world.

Conceptualizing Breastfeeding as Incompatible with Usual Existence.

Indeed breastfeeding is conceptualized as a practice which requires a 'temporary stay against (the) confusion' of usual life: Speaking within the context of the rigours of unrestricted breast-feeding, the physician states: "That's why it's important for mothers to simplify her life as much as possible in the first few months." (94) The regimen of frequent feeding is incongruent with the more complex nature of real life. It is undeniably true that babies are problematic in this context, that life with babies demand adjustment - but they are problematic regardless of feeding method. The point is that the text constructs the breastfeeding of the baby to be uniquely and unequivocally problematic. Artificial feeding ostensibly frees the mother from interruptions in her nightly sleep, from exclusive responsibility and physical availability to feed, and from confinement at home. Bottles enable mothers to get on with their normative lives. Freedom, this video asserts, thy name is bottle.
Conceptualizing Exclusive Breastfeeding as Monotonous for Baby.

But the text cites other reasons for the cessation of exclusive breastfeeding. The exclusive consumption of breastmilk is seen to be monotonous, thus: "Juice is not necessary but it adds variety. (269) You may introduce juice when the baby is 4 to 6 months old." (271) (So we can stop exclusively nursing by as early as 4 months.)

Conceptualizing Illness as a Rationale for the Cessation of Exclusive Breastfeeding.

Illness is cited as another reason supplemental fluids may be necessary: "Extra water may be needed if the baby has diarrhea, vomiting or a fever." (263) Again the dominance of artificial feeding discourse is evident. There is no mention of the fact that first, breastfed babies are less vulnerable to these maladies than are their artificially fed counterparts. Breastmilk confers immunological protection against such pathogens that may cause such symptoms. Moreover, breastmilk is of a lower renal solute load, so risk of dehydration (which is implicit in diarrhea and vomiting) is much lower - babies can lose more water and remain well. Finally, because breastfeeding is comfort as well as food, ill babies tend to want to nurse more frequently unlike artificially fed babies who, when ill, are often too miserable to want to feed at all. Thus the treatment for illness in breastfed babies is often more frequent and exclusive breastfeeding rather than its cessation via supplemental bottles. In my clinical experience, breastfeeding babies who became seriously dehydrated were never actually breastfeeding at all, that is, the baby may have been at the breast but no effective feeding was happening. Hospital admission and intravenous rehydration while educating the mother how to breastfed properly are the solutions in these situations, not supplemental bottles. Thus breastfed and bottlefed babies
differ in their respective risks of dehydration, degree of morbidity when true dehydration is diagnosed, and concomitant treatment. This text negates these differences and instead posits equitable risk and same treatment.

**Conceptualizing Hot Weather as a Rationale for the Cessation of Exclusive Breastfeeding.**

Hot weather is presented as another reason for water supplementation: "You could also offer 2 or 3 ounces in hot weather, but make sure the water is safe and clean. (264-265) Water must be sterilized until the baby is 3 or 4 months old." (267) There is no need to supplement breastmilk with water in hot weather - the dynamism of breastmilk ensures a greater water content in such circumstances. It is interesting that the thirst quenching capacity of the "clear and watery" foremilk is not mentioned here. Of note, in this context, however, is that now we are introducing supplemental bottles to an infant as young as 3 months. The period of exclusive breastfeeding becomes shorter and shorter. Although this text articulates the caution that "Juice or water are in addition to milk, not a replacement for milk" (274), what is left unacknowledged is that the introduction of these fluids, as well as soothers, do replace a breastfeeding.

**Constructing the Complete Cessation of Breastfeeding at Around 4 to 6 Months of Life.**

Naturally the introduction of solid food concludes exclusive breastfeeding, but within this video all breastfeeding seems to have ended by this time. The Canadian Paediatric Society as well as other health organizations recommend breastfeeding for the first year of life and beyond; exclusively for the first half of that year. While this text recapitulates the recommendation for the introduction of solid food, ("When should solids be introduced?" (276) "Not before the baby
is 4 to 6 month old"; 278), it negates to mention the recommendation that breastfeeding be exclusive until that time, or that it continue through to the first birthday or later. There is an implicit but very distinct prescriptive sequence of feeding modalities within this text. Each consecutive sequence creates greater detachment of the infant from her mother's breast until weaning has been achieved.

The Conceptual Construction of Weaning

**Establishing Exclusive Breastfeeding within the Domain of the Very Young Infant**

Exclusive breastfeeding is reserved for the very young. Juxtaposed with an articulation of the feeding frequency required by unrestricted nursing, is a statement which situates such frequency within the context of early infancy: "Feedings every 2 to 5 hours which last for how long, up to half an hour? Is this around the clock?" (91-92) (Implication, How long will this last?) "While the baby is very young I'm afraid so. That's why it's important for mothers to simplify her life as much as possible in the first few months. Life with a newborn is very demanding." (94-96) Thus it is the young baby who is exclusively breastfed for "the first few months", or bottlefed. Then, if breastfeeding, bottles are introduced for the myriad of reasons discussed earlier, ("But wait until the baby is 4 to 6 weeks old"; 624-625) and then solid food is introduced.

**Establishing the Youngest Possible Age for the Introduction of Solid Food**

Although the text says that solid foods can be introduced at 4 to 6 months, it favours the earlier rather than later time frame: "Introduce solid foods one at a time (238). . . Infant cereal made of
rice is a good food to start with (286). . . Once this is well tolerated you can add other infant cereals made of grains such as oats and barley. By 6 months, baby should be able to tolerate mixed grain cereal." (289-291) If individual cereals are to be introduced one at a time, and since usual advice is to introduce one new food per week, then if the baby is able to tolerate mixed grains at 6 months, solids evidently were introduced weeks earlier.

**Establishing Formula as the Appropriate Milk for the Second Half Year of Life**

Formula is the appropriate milk to be used concurrently with solid food: "As the baby approaches the 1 year mark, more of the baby's nutritional needs will be met with solid food and his formula intake will be reduced to about 16 ounces a day." (254-255) Even the preparation of infant cereal involves the addition of formula or cow's milk rather than breastmilk; in the video the cereal is mixed with milk poured from a glass pitcher. (285) The appearance of this milk indicates that it is not breastmilk.

**Asserting the Artificially Fed Infant as the Gold Standard**

Once again we encounter the concept of epidemiological homogeneity of infants regardless of diet. The "iron fortified" formula and the cereal which are emphasized as the appropriate choices for breastmilk supplementation or replacement, and introductory food, respectively, exemplifies this concept. Both formula and infant cereal are iron fortified. The breastfed baby however does not need iron supplementation. Iron deficiency is rare in breastfed infants because of the following factors: (1) the full term newborn has ample iron stores that do not begin to be depleted until 4 to 6 months of age; (2) iron in human milk is used with a superior
degree of efficiency (49%) because of the high lactose and vitamin C levels that facilitate absorption, and (3) breastfed infants do not risk loss of iron as do bottle-fed infants, who can experience micro haemorrhages of the bowel as a result of mucosal damage by cow’s milk. (Riordan, 1983; Lawrence, 1985; La Leche League, 1991)

Indeed the results of a study done in Columbus, Ohio show that haemoglobin levels of breastfeeding infants surveyed remained well within normal limits between 4 and 12 months of age. Therefore iron supplementation is not usually needed and may in fact be detrimental to breastfeeding infants. Lactoferrin, a potent bacteriostatic and iron-binding protein is abundant in human milk. It exists in milk in an unsaturated form. In the gut it functions by binding with enteric iron that would otherwise fuel the efforts of various bacteria to cause infection. Obviously unnecessary supplementation saturates the lactoferrin, preventing its ability to bind to the enteric iron. Thus pathogenic organisms are fuelled to proliferate and infiltrate the gut wall. This first stage in the infection process can cause micro-haemorrhages which can, ironically, cause the very anemia iron supplementation intended to prevent.

It is the artificially fed infant who is uniquely at risk for iron deficiency and concomitant anemia. The iron absorption from formula is very low (4%) because of the low levels of iron initially and the paucity of iron facilitators like lactose and Vitamin C. Moreover, micro haemorrhages are more frequently seen in the guts of artificially fed babies for several reasons including a greater propensity for the proliferation of pathogenic bacteria in their gut and the absence of such immunologically protective factors such as lactoferrin.

Here we see universal nutritional recommendations being based upon the unique vulnerability
of the bottle fed baby. One could understand the need for an institutional plan to effect the most good for the most babies. But breastfed babies could be harmed simply because, as a focus, they were eclipsed. Protocols specifically targeting them, for example - recommending that a simple heel prick be done to determine haemoglobin status in order to first determine need of supplementation rather than its routine implementation could have been articulated at the same time as the 'iron supplementation for all' protocol was being devised. At any rate the iron rich foods suggested here are wrought out of a non-natural feeding frame.

Endorsing Other Commercial Food Preparations

Not surprisingly artificial milk is not the only commercially produced infant food preferred by this frame. Although natural and homemade foods are acknowledged, ("make your own purees or use commercial preparations. . .") it is the commercial product which receives the most audiovisual attention. We see mothers spooning food out of baby food jars. Moreover, it is the commercial product which is predominantly discussed: "If you are using commercial baby food, spoon a portion into the bowl rather than directly from the jar. This will avoid contamination of the rest of the jar with the baby's saliva and will allow you to use the remaining portion as long as you refrigerate it immediately and use it within 72 hours." (324-331) The text also cautions mothers to purchase commercially prepared foods which are of high nutritional quality: " . . .no added sugar, salt or preservatives." (321)

In this context it is interesting to discover that the fortified infant cereals advocated as excellent sources of iron supplementation, and suggested for use until "at least a year but preferably 18 - 24 months" are, according to a review of the literature, so poorly absorbed that they are of little
benefit to the infant. Researchers concluded that “the electrolyte iron powder used in iron-fortified baby cereals was so poorly absorbed - at a rate of less than 0.1 percent - that it should not be relied upon as a source of iron for babies.” (Fomon, 1987) Freshly cooked, whole grain cereals have more nutritional value than baby cereals because they are not highly processed. Other natural foods such as ripe banana, yam or sweet potato are suggested in other texts as ideal introductory solids. Of course these foods are not high profit making commodities and thus were not considered appropriate introductory solids according to the values implicit in this ideological framework.

Exclusion of the Older Breastfeeding Infant or Toddler

The final stage of infant feeding is the consumption, by the infant's first birthday, of all four food groups delineated in Canada's Food Guide. "Your doctor may suggest a time frame something like this: You might start the baby on egg yolks around 9 months then move to the whole egg around 12 months. Meat might be offered to a baby who is more than 6 months old at which time you could offer variety of strained meats. Fish could be introduced when the baby is 12 months." (309-317) Homogenized cow’s milk is appropriately introduced at this time as well. Therefore the baby is eating a 'normal' diet by his first birthday. The video text states that it is a guide for new parents during that all important first year. The implication is that the issues implicit in the series are moot by the end of this time period. There has been no evidence of breastfeeding since the introduction of solid food. Likewise there is no mention of breastfeeding at 1 year or beyond into toddlerhood. The movement from exclusive to partial to no breastfeeding was isomorphic with exclusive breastfeeding to early supplementation to completely independent feeding. This sequential movement through feeding modalities is previewed
visually at the very beginning of this video series. As the host narrates “Let’s start with the very basic issue of feeding baby three images appear in rapid succession: Baby breastfeeding, cut to baby bottlefeeding, cut to baby eating solids. Although exclusive breastfeeding is abjured in this text, complete weaning is sanctioned.

**Advocating Other Detached Parenting Behaviour**

While bottlefeeding is emblematic of a detached or low contact parenting style, it is often concomitant with other parenting behaviours that evidence the detachment of the parent from the child. Attached parenting is characterized by a high degree of close physical contact between the mother-infant dyad. Babies are often attached to their mothers' bodies via such infant carriers as slings, backpacks, Snugli's, Inuit amoutis among others. ‘Marsupial mothering’ is the term coined to describe the physical closeness of this parenting style. This text eschews this degree of physical closeness. Although this style of mothering is acknowledged in this text, “Babies are extremely portable. Snuggle your baby into a carrier and away you go” (1032) it is just perfunctorily mentioned. Moreover, there is dissonance between what the text states and the meaning which is implied. In this example of the text auditorially suggesting the mother snuggle her baby into a carrier, the corresponding visual demonstrates a mother putting her baby into a stroller instead, and then, for emphasis, displays a close up of the infant in the stroller, her mother cut from the scene. (1033-1034) There is no evidence of marsupial mothering in this text.

Separate sleeping arrangements for mothers and babies effect physical detachment at night. According to this text infants do not sleep with their parents. The first scene evidences the host
in a nursery well-appointed with a crib. In another video in the series, the mother is seen rising from bed to go to the crib to get her crying baby. Mothers and infants sleeping separately is a recent historical innovation. (Kitzinger, S. 1989) The family bed in which mothers, fathers and breastfeeding infants slept together was typical until this century. Expert discourse can be credited with the transition in customary sleep arrangements. In the late 1800's the germ theory was articulated. "In 1893 an advertisement for twin beds in Scrivener's magazine announced: 'Our English cousins are now sleeping in separate beds. The reason is: NEVER BREATHE THE BREATH OF ANOTHER.'" (Kitzinger, S. 1989, p. 188) Furthermore, Kitzinger explains that "New psychological theories of child-rearing emerged, too. In wealthy and middle-class houses children were banished to the nursery and 'scientific' methods of child care expounded, which entailed strict regulation of the child's life with no unnecessary cuddles or indulgence." (1989, p. 188) The text advises a nighttime routine for putting baby to bed that is congruent with such theories. First baby is put into his own bed by himself: "Now that baby is fed, bathed and dressed perhaps he'll go to sleep. Lie him flat on this back on a firm mattress, or on his side with a rolled up receiving blanket behind his back to keep him in place." (447-449) Then, with the image of the baby in his crib sucking on a soother, the host advises, "Hum a lullabye or two, cross your fingers and back quietly out of the room." (457) No breastfeeding or rocking your baby to sleep is evident in this text. Expert opinion underlies such detached parenting practices.

Constructing Breastfeeding Failure

Parenting practices which decrease the frequency as well as degree of physical contact between mother and baby effect breastfeeding failure. Breastfeeding is a neuroendocrine function which is initiated by the sensory input of the baby suckling and mediated by two
hormones: prolactin and oxytocin. In order to understand milk production and ejection one must understand two important mechanisms: the supply-demand response and the let-down or milk ejection reflex. Lactation failure is typically secondary to the misunderstanding thus mismanagement of one or both of these reflexes. The artificial feeding model of this textual frame targets these reflexes; the subjugation of maternal skill and confidence are the specific strategies employed within the detached parenting discourse to achieve breastfeeding's demise.

**Constructing Breastmilk Insufficiency**

Prolactin is referred to as the milk producing hormone. Prolactin is secreted by the pituitary gland in the brain and is received by the alveolar cells of the maternal breast; the alveoli then alter the cellular structure of its lining to facilitate the uptake of ingredients from the maternal blood supply to make milk. The most effective and specific stimulus to prolactin release is sucking. Therefore when the baby suckles the mother's breast the afferent nerve pathway to the anterior pituitary gland in the brain is stimulated. The more the breast is suckled, the more milk is made. "In the nursing mother, Tyson et al. have described three types of prolactin response to nursing at the breast. Stage one occurs during the first week postpartum. Prolactin levels are still elevated; thus suckling causes only small increases. The second stage is observed from the second week to the third month postpartum; baseline levels are two to three times normal and increase to ten to twenty times normal following suckling. During stage three (from the third month until weaning), prolactin levels are back to normal and suckling produces no rise in levels. It is interesting to note that milk production continues to be abundant despite only modest levels of prolactin." (Lawrence, p. 49) Thus the supply-demand response seems to
be most critical in the second stage of lactation. "Reduction in sucking stimulus produces a reduction in prolactin and in milk synthesis. Mammary tissue shows regression after the first week or so, if unstimulated." (Lawrence, p. 52) The early cessation of exclusive breastfeeding intended by this text specifically targets this second stage of supply-demand response.

Undermining Maternal Comprehension thus Skill

Thus milk production is dependent upon breast stimulation. Mothers need to clearly understand this prolactin reflex in order to guide their breastfeeding practice to the end they intend. Although the text acknowledges this supply-demand mechanism, Dr. Fabbro explains that "Your milk supply will change according to the baby's needs. The more the baby drinks the more milk you will produce" (133-34), it implements strategies designed to undermine the its' appropriate understanding and utilization. "How do I let my baby know it's time to eat?" (83) the host asks, implying the need for scheduling rather than nursing on demand. The danger of scheduling is that it negates infant growth spurts. During such spurts, the infant may want to suckle the breast hourly for a few days, thus bringing the maternal milk supply up to her new weight. Scheduling would preclude these periods of more frequent suckling and concomitantly, fail to increase milk production. Dr. Fabbro responds, "Chances are that your baby will let you know." (85) Thus this demand side of the equation is, by nature, potentially unreliable, thus, by implication, maybe scheduling is better after all. Parents need specific guidelines that reassure them how often their baby should rouse to nurse and what to do if she doesn't. Babies born to mothers who have had medicated childbirths often have sleepy babies; parents need to be taught how to rouse these infants to put them to the breast. With respect to specific guidelines the physician states: "A flexible schedule with feeding occurring every 2 hours with occasional
stretches of up to 5 hours works best to establish breastfeeding.” (88-89) Every 2 to 3 hours between breastfeeding works best to establish breastfeeding and oftener during growth spurts; babies who do not rouse by 4 hours should be wakened and subsequently, attempts to wake them every 2 to 3 hours should be made until the baby is rousing spontaneously with like frequency. One 5 hour stretch, during the night, during the early months is acceptable. Lack of specificity also characterizes the physician’s response to this query: “How long do I let the baby nurse before I switch sides?” (119) “There’s no specific routine and there’s no need to switch every 10 minutes or to use both sides each feeding.” (121-122) No education is given to the mother about how long a baby should nurse, what the characteristic suck-swallow-pause cycles look like during a breastfeeding, and how the feeding should end, that is, with the infant concluding it by either finally falling asleep (after several nutritive feeding cycles) and/or spontaneously coming off the breast. This lack of specificity in explicating the supply-demand mechanism subverts maternal skill and therefore her breastmilk production.

Problematizing Nighttime Feedings

Another strategy designed to undermine milk production is the problematization of night time nursings: “With bottlefeeding, the father, other family members and babysitters can relieve you so you can get an uninterrupted night’s sleep” (36-37); “A breastfeeding mother could express milk, and let her partner share some of the nighttime feedings” (959-960) and “In households where both parents work outside the home, regular turn taking of nighttime caring could be negotiated between partners.” (962-963) A significant amount of breastmilk production occurs during the night; concomitantly prolactin has a typical diurnal variation with its highest concentration occurring at night. “Daytime consumption of milk in a given infant has been shown by
Brown et al. to be 46% to 58% of the total 24-hour consumption, so that reliance on less than a 24-hour sampling may be misleading. Data from samples taken every 3 hours showed a variation in milk concentration of nitrogen, lactose, and fat, as well as in the volume of milk, by time of day." (Lawrence, p. 66) Thus, babies receive a significant amount of breastmilk during the nighttime. If nighttime nursings are altered or ceased, there will be a significant decrease in the stimulation the breast receives at a time when its milk producing hormone is at its highest concentration and concomitantly a reduction in milk production and baby's receipt of it. Indeed, La Leche League (1991) reports the findings of a study by Jelliffe and Jelliffe that babies as old as 10 months received at least 25 per cent of their intake of mother's milk at night. (p. 24) Thus to restrict or stop nighttime nursings is to have a significant and deleterious impact upon breastmilk production. The problematization of night time nursings is another strategy designed to sever the mother-infant dyad at a time exquisitely sensitive to their togetherness.

**Constructing the Inhibition of the Let-Down Reflex**

Milk production is but half the process of breastfeeding. The milk must be made available to the baby, that is, released from the alveoli to make its way down the ducts of the breast to the larger sinuses just behind the nipple and then out of the nipple and into the baby's mouth. Like the stimulation of prolactin secretion, "milk ejection involves both neural and endocrinologic stimulation and response. A neural afferent pathway and an endocrinologic pathway are required. The ejection reflex depends on the existence of receptors located in the canalicular system of the breast. When the canalicules are dilated or stretched, the reflex release of oxytocin is triggered. There are tactile receptors for both oxytocin and reflex prolactin release located in the nipple. Neither the negative and positive pressures exerted by suckling nor
thermal changes trigger the milk-ejection reflex. There is some minor effect of negative pressures, but tactile stimulation is the most important factor." (Lawrence, p.51) For years I have marvelled at how even the tiny premature infant wants to rest her hand on her mother's breast; I have enjoyed observing (and experiencing) the ingenuity of the older toddler who, while suckling one breast, reaches her hand to the other breast to fondle the nipple. The toddler has experienced in increased bursts of milk into her mouth what I am trying to capture in a physiological sense here. Touch incites the release of milk. Parental practices that inhibit physical closeness inhibit this response.

_Undermining Maternal Confidence_

Stress, too, inhibits the let down of milk. This reflex has psychogenic components clearly evident in a mother who is insecure, anxious, fatigued or in pain. "A stressed mother may experience considerable difficulty letting down her milk and provide less milk for her baby." (Riordan, p. 23) This video series is replete with statements about breastfeeding designed to compromise maternal confidence: "How can you tell if your baby is eating enough? (15) (Maybe I won't make enough. Perceived or actual breastmilk insufficiency is the number one reason women wean.); "And there is a wonderful sense of self-sufficiency in providing everything your baby needs all by yourself. But this very quality can also be exhausting." (32-33) (Maybe breastfeeding will be overwhelming to me); "When you breastfeed your baby the quality of the milk the baby receives is dependent upon you because the baby can only get the nutrients you put into your milk." (47-48) (Gabriele, A. et al. (1986) found that some women choose not to breastfeed because of concerns about such dietary stringency.) The text also states that the decision how to feed your baby is dependent, in part, upon your "emotional makeup." (545)
Everybody knows breastfeeding mothers must be relaxed, unstressed: "Find some place where you can relax without interruptions and make yourself comfortable with pillows and a footrest because baby doesn't like to be rushed." (69-72) Maybe I don't have the right temperament; the right kind of life); “What if after all my best efforts, the baby’s not thriving?” (621) Indeed the frame of this text asserts that breastfeeding is fraught with risk, and failure is inevitable in some cases. Who’re you going to call?: "Consult your doctor." (623) The treatment? "It may be necessary to supplement breastfeeding with a commercial formula." (624)

Conclusion

The conceptual framework of this text accomplishes the detachment of the mother-breastfeeding baby dyad. It accomplishes this intention through its' advocacy of a detached parenting style characterized by early cessation of exclusive breastfeeding as well as its' accomplishment of breastfeeding failure secondary to behaviours which physiologically and/or psychogenically undermine the milk producing and milk ejection reflexes.

What follows is a delineation of associated modes of thinking which ideologically support the conceptual accomplishment of the severance of the mother from her nursling.
Ensuring Patriarchy

Conceptualizing the Breast as a Bottle

Patriarchy is itself evident in the conceptual framework of this text. The breast is reductionistically conceptualized as a bottle. Within the video series one only ever sees one breast exposed at a time. Obviously this is intended to suggest a similarity between breast and artificial feeding modalities. One breast equals one bottle whereas two breasts evidence an entirely different dynamic. Furthermore, the bottlefeeding model is implicit in the way Dr. Fabbro explains how to achieve a good latch upon the breast: “Then, holding your breast just behind the areola you guide both the nipple and the areola into the baby’s mouth.” (104-105) Bottles are put into baby’s mouths, breasts are not. Similarly, the physician instructs: “In other words, make sure she opens her mouth wide enough to accommodate both the nipple and areola. . .” (587) Accommodate is a passive word indicating that the baby is the passive recipient of the breast into her mouth. By contrast, breastfeeding is an act which begins with the infant’s active latching onto the breast.

Constructing Breast Concealment

The breast is reduced to an instrument of feeding. Its form like its’ function is inhibited. Within this text the exposure of the breast must be controlled, inhibited. Breastfeeding exemplifies attached parenting because of the requisite attachment of the infant to her mother’s breast. Unlike bottlefeeding wherein an intermediate object comes between the mother and her baby, breastfeeding is characterized by direct skin to skin contact. Although a certain degree of
nakedness is essential for breastfeeding there is very little skin evidenced in this text. Babies are almost always clothed except in those scenes, such as being bathed, where it is necessarily precluded. The mother is as clothed as possible. One never sees her naked even from the waist up. Breasts are not free to exist unfettered but are only visible within the constraints of the nursing bra, momentarily liberated, one at a time, by the releasing of a flap. The suggestion is that the breast, once feeding is over, can be quickly re-concealed. The exposure of the breast in this text is limited.

Abjuring the Conceptualization of the Breast as Nurturance

Congruent with the reductionistic conceptualization of the breast as an instrument for feeding is the exclusion from the frame is its' conceptualization as an organ of nurturance. Parenting strategies in this video include talking to the baby, “You are too tired to summon the usual comforting words. . .” (845) and walking, “women who know they are going to spend a big chunk of the night walking the floor with a colicky baby. . .” (1071-1072) Indeed with respect to infant colic the host rationalizes the paucity of supportive strategies by explaining that “Endurance seems to be the only answer.” (689-690) Further, “Parents can take comfort. . .” (690) I didn’t think parental comfort was the point here. Breastfeeding is conspicuously absent from this modest array of parenting strategies. Yet anyone who has ever breastfed a baby what a source of comfort it is to the baby. Many parents I have worked with were astounded at how easy it was to quiet a crying baby or induce sleep simply by offering the breast. Perhaps because they had internalized the construction of breastfeeding as merely the provision of food, they were surprised to discover that it was also a means of providing solace. These aspects of breastfeeding had not previously been considered by them - there had been no exposure to the
Indeed nurturing behaviour itself is abjured in this text. Babies are held for the instrumental tasks of feeding, diapering, bathing, dressing, and medical examinations but are never seen to be handled within the context of sheer care or nurturing. Exceptions to this exist when infant illness such as colic and/or nighttime wakefulness is being discussed and the text requires a visual correlative for the discussion. Even then, the nurturing aspect of this care is constructed to be instrumental - that is, the provision of care for the sick or wakeful baby. Sheer nurturing is devalued, constructed to be a chore. Thus the text acknowledges that “Parents may be tempted to prop the bottle to a feeding position so that they can do something else.” (240-241) But this is not a good idea because the baby could choke.” (243) And then, secondarily, “It also deprives both the parents and the baby of a warm, cuddly time.” (243-244) The provision of infant care is within an instrumental as opposed to an emotionally expressive domain.
Devaluing Mother

If nurturing is devalued then so, too, is the nurturer. Mothering is as devalued in this text as is its' expression - breastfeeding. In the final video, expert Daniel Bogue explains that "We have a built in bias in our society that women have a natural ability to care for children." (936-937) While hearing these words, we see a mother breastfeeding. (935) While I don't disagree with Mr. Bogue that there are aspects to mothering which are learned, I do take exception to his non-acknowledgement that nature does help to equip women for the task. This text is replete with mother substitutes: soothers, mobiles, wee toys, bottles, but with one exception (the scene wherein the baby is moving to her mother's speech cadence) the mother herself, in a literal sense, is expunged as a source of infant comfort. The conceptual framework of this text therefore devalues attached mothering by devaluing the breast.

Conceptualizing Mothering as Pathological

In the final video of this series, "You" (830) mothering, the close attachment of the mother to her baby is conceptualized as potentially pathological. This evokes the discourse of behavioural psychology in the 1920's when J.B. Watson wrote about "the dangers of too much mother love." (In Kitzinger, p. 188) The conceptual framework of this text too regards strong maternal attachment, including its expression through breastfeeding, as a risk factor to the mother's mental well-being, the father's role adjustment, ergo, to the family as a unit.
Conceptualizing Close Maternal/Infant Attachment as a Risk Factor for Post-Partum Depression

Mothering or the close attachment of the mother to her child is a potential risk factor for post partum depression. The post partum emotional life of the new mother is characterized predominantly by sadness. Although the text acknowledges that “The first year of life with a newborn has tremendous ups and tremendous downs” (851) it is the latter that becomes the focus of this particular discussion. Thus, “In contrast to all these highs can be some pretty devastating lows because this first year with baby is also tremendously stressful both emotionally and physically.” (866-867) Similar sentiments are captured in a plethora of statements: “many parents comment that they give to the point of physical exhaustion” (882-83); “they feel a little bit let down because it seems their child isn’t giving them anything in return” (886); and “it’s easy for a parent to feel resentful because this demanding little thing has turned their life upside down”. (889-890) Although the phrase post partum depression is not articulated its diagnosis is implicit in comments like: “Even new mothers who have help with their babies and people around them to help keep their spirits up, may still find themselves weeping for no good reason.” (927-928) The social work expert responds, “Yes, it is quite normal for new mothers to feel weepy or even intense unhappiness for awhile after giving birth. (930-31). . . If you feel you can’t cope you may want to seek professional help. Your public health nurse or your family doctor should be able to point you in the right direction, to get the kind of help you need.” (943-946) Obviously this is a reference to the need for psychiatric care.

Disempowering the Mother

The etiological factor in the pathogenesis of post partum depression is the close attachment of
the mother to her baby. "It's easy to get caught up in a very tight relationship with your baby which excludes other people and other activities, particularly if you're staying home to take care of your baby. If you allow this situation to develop you could end up feeling isolated and out of the mainstream." (987-990) Similarly, the "exhaustion" which symptomizes this condition reminds us of the comment in the first video in which exclusive breastfeeding was characterized this way: "And there is a wonderful sense of self-sufficiency in providing everything your baby needs all by yourself. But this very quality can also be exhausting." (32-33) The solution to the exhaustion induced by mothering is to share the task. "Encourage your partner, your baby's grandparents, your extended family, your friends to get involved with your baby's life." (1000-1002) The severance of the maternal-infant dyad ostensibly optimizes the mental health outcome for the mother. But what does it really accomplish? Dr. Watson said "Ideally, (infants) should have a different nurse every week. I can't help wishing that it was possible to rotate the mothers too." (In Kitzinger, p. 188) Insofar as the text alludes to the potential empowerment of women through breastfeeding, "And there is a wonderful sense of self-sufficiency in providing everything your baby needs" then that self-sufficiency is disempowered with the sharing of the maternal role.

Mothering as a Risk Factor for Father's Role Adjustment

Of course it is father who is intended to help with the feeding of the baby. Ostensibly this is because he "is probably not only the most interested person in this network, but also the one likely to be on the scene most often." (1005-1006) It is interesting that although infant nurturing is not emphasized, the mother is implicitly tasked with the care-giving role of her partner. Again this phrase "tight world" (1009) of mother and baby becomes emblematic of pathology. In this
case the risk is father’s role uncertainty: “Fathers are sometimes uncertain about where they fit in the tight world of mother and baby. Create opportunities for your partner to experience fatherhood and help him celebrate his exciting new role.” (1008-1011) The accompanying visual is of father bottlefeeding the baby. If maternal breastfeeding was empowering to her and conflict arousing for her partner, then the status quo within the family is restored with her sharing the feedings with father. A nice visual of family harmony is displayed at the conclusion of the second video: father occupies in the centre bottlefeeding the baby, toddler at his knee and mother at his other knee wiping the baby’s mouth with a hanky. Father’s central position in the family is secure. (825-826)

Excluding the Sensuality of Breastfeeding

The breast as a means of female sensual pleasure is excluded from the conceptual framework of this text. Breastfeeding is designed to feel good. I argue that it is a form of sexual expres-
sion. Niles Newton (1971) conceptualized a “trebly sensuous woman”: “Female sexuality includes at least three reproductive acts that involve two persons: coitus, parturition and lactation.” (P. 5) To conceptualize female sexuality only in terms of intercourse is to see it from the male perspective - this is the only reproductive act most relevant to them. After all, Newton pointed out, “mature men can form reproductive relationships only with women, and only through one act: intercourse.” (1971, p. 3) Newton’s thesis is that “these three functions are closely inter-related, physiologically as well as psychologically. What occurs on the delivery table, in other words, is very pertinent to what occurs later in the marital bed; and a mother-infant relationship without enjoyable breastfeeding is in some ways similar to marriage without enjoyable sex.” (P. 5) Newton Indeed other researchers corroborate her finding parallels
between the experience of breastfeeding and sexual activity, including "(1) stimulation of the nipples and breasts, with subsequent nipple erection; (2) skin-to-skin contact; and (3) uterine contractions, as a result of oxytocin release during nursing and intercourse." (Kaufman IC, 1970 in Neiffert & Neville, p. 360) Newton referred to oxytocin as the love hormone since it mediates the muscle contractions implicit in orgasm, childbirth and the milk-ejection reflex of breastfeeding. Newton asserts that women have a "more varied heritage of sexual enjoyment than men." (1971, p. 6) According to some research studies, mothers corroborate these physiological principles in actual experience. Masters and Johnson (1966) "found that several of their subjects reported plateau level sexual responses while nursing. Three women reported that they had reached orgasm." Such sexual responsiveness to breastfeeding however was problematic for many women. The Masters and Johnson study (1966) found that six of the 24 nursing mothers they interviewed expressed guilt feelings about their sexual arousal during nursing. Bentovin (1976) interpreted such feelings as shame, modesty, embarrassment and distaste as indicative that breastfeeding was viewed as a forbidden sexual activity. Riordan suggests that "Just as some religious beliefs prescribe procreation as the raison d'être for the enjoyment of intercourse, nourishment is often regarded as the sole purpose of the breastfeeding act." (P. 338) Certainly the frame of this text excludes the sensuality of breastfeeding.

Silencing Female Sexual Pleasure

Similarly, the conceptual framework of this text negates female sexual pleasure. The operative sensation associated with nursing is pain. Comments from the host like "If a baby is nursing as many as 10 or 12 times a day in the beginning the nipples must get pretty sore" (606-607) are legitimized by the physician who concurs that "Some mothers do develop cracked and even
bleeding nipples at the beginning." (609) Soreness is the predominant sensation described in this text: "If soreness does develop. . ."(609-610); "If you can stand to nurse, start on the side that is least sore" (611); and "If nipples are too sore to nurse. . ." (613) I do not dispute that pain and soreness can accompany breastfeeding. What I am attempting to elucidate here, is the total domination of pain to the exclusion of the pleasure of breastfeeding. Conceptually this works to organize an experience as well as a language with which to describe this experience. In my experience working with breastfeeding mothers, I have often heard women's anticipation of pain more than I have heard any anticipation of breastfeeding as a pleasurable experience. Indeed, I have often borne witness to women's actual experiences of pain as a result of their breastfeeding efforts, but silence characterizes women's experience of its inverse.

This text asserts pain as the dominant sensation associated with the new mother's sexual experience. Even sexual intercourse is depicted exclusively as painful: post partum intercourse ranges from "mild discomfort" (1065) to "so painful that they are disinclined to try again for some time." (1066) This continuum of discomfort is not universally shared by postpartum women. Masters and Johnson (1966) found that "for the first three months after delivery, nursing mothers as a group reported the highest level of sexual interest. As a group, they wanted as rapid a return as possible to active intercourse with their husbands." (Newton, p. 5) This text conceptualizes female sexuality in a most reductionistic way excluding both the range of female sexual expression as well as continuum of female sexual response.

**Governing Female Sexuality**

Furthermore, this frame conceptualizes the locus of governance of female sexuality outside of
the woman herself. First of all "medical guidelines" (1054) may be used to dictate when she may resume sexual intercourse. Although the text acknowledges that a woman may have sexual feelings outside of the realm of medical guidelines, ("Medical issues aside, when is a new mother likely to feel sexual again?"; 1060), her feelings are ultimately subverted to external control. Sexual intercourse is constructed to be within the realm of her caretaking duties: "...you may feel that you need to schedule sex along with the feedings and diaper changes..." (1062-1063) Similarly, sexual desire is seen to emanate from her partner rather than from herself: "A woman in this situation might see her partner's sexual interest as just another demand on her already exhausted body." (1073-1074) Medical and patriarchal governance aside, this video series itself is an objectified knowledge intending to govern the mother's sexual expression.

Summary of the Method Used to Discover the Conceptual Framework

At the beginning of this inquiry I aspired to elucidate the conceptual framework implicit within this textual presentation of knowledge. My method was to allow the text to reveal itself to me. I viewed the videos repeatedly and transcribed them. I took notes as something about their content or presentation disturbed or puzzled me. These moments of disquietude which arose within me were possible because of my expert knowledge. Other viewers may not have experienced such moments at all. My expertise as a reader, breastfeeding mother, lactation consultant, neonatal and women's health nurse cumulatively contributed to an exquisite sensitivity to disjuncture in matters of infant feeding. Sometimes the disjuncture was immediately explicit and obvious, for example, when the text conceptualized infants as epidemiologically homogeneous regardless of diet. I knew that such a conceptualization of
universal infant susceptibility to illness broke with what I knew professionally and personally to be otherwise - that morbidity was greater in the artificially fed infant. Thus the varied and diverse experiences of illness that exist between breastfed and bottlefed babies was being silenced by the objectifying discourse of this text. Disjunction was explicit in this case. At other times, I merely sensed disjuncture, as in the third video where the concept of attachment was being discussed. It took many viewings for its' meaning to crystallize for me. What began emotionally as somewhat neutral puzzlement became outrage when I could see the conceptual construction of close maternal-infant attachment as potentially pathological.

Concepts were recorded, one by one, as they were discovered. As the textual analysis progressed concepts aggregated into themes or meta-concepts. I documented what I discovered as I discovered it. Therefore when a concept was discovered I documented and explicated it. As themes emerged I was able to insert headings into the narrative. In this way as the frame of the text revealed itself to me, so too could I frame my work - concept by concept, theme by theme until by the end of the analysis, the conceptual framework of the text became glaringly visible. Then a dynamic thing happened - all at once, social relations became visible. The text was no longer an 'inert blob of meaning' (a phrase I've borrowed from Smith), but alive and I could see both the social construction of breastfeeding knowledge and the social co-ordination of its practice. Rudimentary as my skill is at this stage in attempting this innovative methodological approach - I made real discoveries. These discoveries I think are relevant to women's real lives. Allow me to share them with you.
Summary of the Conceptual Framework

The first discovery was of the conceptual framework which organized the knowledge presented in the video series. The conceptual framework became visible as what I shall term the Artificial Feeding Framework. Within this conceptual frame emerged three meta-concepts: The Conceptual Construction of Breastmilk and Formula as Equivalents; The Conceptual Construction of the Epidemiologic Homogeneity Among Infants Regardless of Diet; and the Conceptual Severance of the Maternal-Breastfeeding Infant Dyad. The videos "Your Baby", "Your Doctor", "And You", respectively accomplished these conceptual constructions. It is interesting that these meta-concepts are the exact inverse of those which promote breastfeeding: "breastfeeding is the unequalled way to provide optimal nutritional, immunological and emotional nurturing..." (Breastfeeding Committee for Canada (1999) Breastfeeding Position Statement) This video series is not organized to be promotive of breastfeeding. It is structured to promote bottlefeeding. The Artificial Feeding Frame is now apparent even in the title. Artificial feeding requires the severance of the baby from the maternal breast; the title evidences this severance. 'Your Baby' and 'You' are separated by the intermediary presence of 'Your Doctor'. Of course 'Your Doctor' is but one representative of the relations of ruling. Multinational corporations such as the one which produced this text, created its' title, are also included amongst them.

Smith (1990) states that "The objectification of knowledge is a general feature of contemporary relations of ruling." (p. 67) This text exemplifies the characteristic objectified knowledge produced by the relations of ruling. The actual variability of breastmilk, women's experience of maternal life including breastfeeding, the divergent experiences of illness had by breastfed versus bottlefed babies, father's responses to breastfeeding - all are silenced by this
objectifying discourse. What is articulated in its stead is fathertongue - the conceptual constructions identified earlier all emanate from patriarchal institutions. Medicine, multinational corporations, academia - for example, traditional sociology which conceptualizes the nuclear family and the myriad of concepts like gender roles that that encompasses. All of these become visible within this text. Men do not know women's experience of breastfeeding or mothering and yet they attempt to govern these experiences. For indeed the purpose of objectified knowledge is that it can negotiate various relations in various sites. Smith (1990) states: “The power of objectified knowledge arises in the distinctive organization it imparts to social relations. Knowing how to read, and reading, a given factual text is to enter a co-ordinated set of relations subordinating individual consciousness to its objectification; subjects subdue their particularized experience to the super ordinate virtual reality of the text. The factual text has power at this point of conjuncture between a reader knowing how to read it as factual and the relations of which it is a constituent.” This text is a video text and so is viewed instead of read but the consequences are the same. This objectified knowledge instructs the viewer what there is to know about infant feeding; her subjective consciousness is subordinated in advance of her being able to experience it. This objectified knowledge of infant feeding is intended to be the currency with which the socially co-ordinated practice of breastfeeding is negotiated.

The Discovery of this Conceptual Framework as Practice

The extent to which the Artificial Feeding Frame was practised became visible. The myriad of relations of ruling who enacted these practices did as Smith said they would - they came into view. Suddenly I saw evidence of this framework everywhere:
The Economist (August 14, 1999) cover story was entitled "Helping the poorest of the poor". The cover photo shows an infant receiving what I assume are oral polio drops into her mouth. The article describes how third world children disproportionately suffer morbidity and mortality compared to the children in industrialized countries: “One world, two fates. Of children who die before their fifth birthday, 98% are in the developing world.” (P. 11) The problem is partly attributed to the lack of access the world’s poor have to drugs. But it emphasizes that such initiatives such as providing such medications as vaccines are “not enough to heal the poor.” “The remarkable fall in mortality rates in Europe and North America a century ago owed little to drugs and almost everything to improved nutrition and better public health arrangements: reliable water supplies, safe drains, regular rubbish disposal.” (P. 11) And yet despite this article’s ostensible awareness of the importance of nutrition, breastfeeding is not mentioned. “With some of the diseases that kill the poor, the surest answer is to change habits. No single change would save more lives than if people routinely washed their hands before touching food. They need, too, to filter what they drink, to feed babies hygienically, to use mosquito nets, to avoid drunken driving - and to practice safe sex.” This statement implies the artificial feeding of babies. To feed babies hygienically means to prepare their formula with clean water. This statement operationalizes the notion of the intrinsic safety of infant formula; artificial feeding is risky only if it is not prepared properly - for example, with non-hygienic water. This is ironic given the author’s awareness of the vulnerability of products such as drugs, similarly infant formula, to spoilage: poor countries “need to care better for those drugs they get: all too often part of the consignment ends up on the black market or spoiled by bad storage.” (P. 12) Science and technology are conceptualized as being the sole means by which to optimize infant
health: the article emphasizes the need "to make existing cheap medicines, such as oral rehydration salts and childhood vaccines, more available." I do not argue with this statement but it is incredulous to me that breastfeeding, a free source of optimal nutrition and immunological protection is not mentioned. The author does not seem to be aware of the lifesaving effects breastfeeding confers by diminishing the very gastro-intestinal disease that requires oral rehydration salts. The artificial feeding frame is implicitly at work within this text, silencing the actual nature of breastmilk itself and the optimized health experience of the babies who consume it. Was this practice non-reflexive? More insidious is the possibility that the author, or the publication, was reticent to advocate a strategy which might compromise the profit share of the multinational corporations who comprise their sponsorship.

**Government**

Canada's maternity and parental-leave benefits programs appear to influence, if not dictate, when women go back to work. Canadian women are taking shorter maternity leaves; 20% of new mothers have returned to work two months after delivery. (Statscan in The Globe and Mail September 2, 1999, p. A9) "Statscan, which surveyed 367,000 women, suggests that the rate at which new mothers go back to work appears to hinge on the potential for 'major loss of income' rather than pure passion for their jobs." Canada offers a maximum 25 week combined paid maternity and parental leave, but the replacement pay is just 55 per cent of previous earnings. "The report, Employment after Childbirth was based on a four year study of working women who gave birth during a 20 month period in 1993 and 1994. It was released in the agency's quarterly Perspectives on Labour and Income. The study found that 15 % of paid employees were back on the job in the month after childbirth." Time taken off is directly
proportional to the length of time benefits last. "The chance that a mother will return to work by the end of the first month after childbirth increases almost sixfold if she does not receive maternity leave benefits, the study notes. "Changes made in 1996 to Canada's unemployment insurance system has made it more difficult for some women to get access to maternity benefits" the article states. Therefore more women may be going back to work sooner as well. Dawn Walker, executive director of the Canadian Institute of Child Health, is concerned that early returns to work because of insufficient benefits or ineligibility may not be giving mothers' bodies time to heal, nor providing babies with a minimum of six months of breastfeeding or creating a secure parent-child bond. Such policies operationalize the severance of the maternal-breastfeeding infant dyad, catalyze the cessation of exclusive breastfeeding in the young child (considered inconsequential because formula is an apt alternative) and put infants at risk of increased morbidity. The dominant artificial feeding frame silences such concerns.

Another government program which evidences the same conceptual practices is the recent program targeted at single teenaged mothers who receive welfare. The government will provide day care for their children, will sponsor education for the mothers and even provide transportation costs. If the mothers do not attend school, however, their welfare benefits will be cut off. A radio announcer discussing this latest Harris initiative said he believed the best place for these young women were at home mothering their young infants. Silence followed and he repeated his sentiment. Were his co-anchors stunned at this valuation of mothering? This government initiative doesn't seem to value it nor breastfeeding. Mother can be replaced by daycare and formula can replace breastmilk. The artificial feeding frame dominates bureaucracy as well.
Linda Duxbury, director of the Centre for Research and Education on Women and Work at Carleton University in Ottawa states that work environments "may not allow for breastfeeding." (Globe and Mail, September 2, 1999, p. A9) Employers may also be more directly hostile to it. INFACT Canada reports the case of Michelle Poirier. "In December, 1990, Michelle Poirier returned from maternity leave to her job as a speech writer with the Ministry of Municipal Affairs, Recreation and Housing. At the time, her infant was less than four months old. She made arrangements for her child to be brought to her each day at noon hour to be breastfed. In March 1999, the Ministry sponsored a series of public 'brown bag lunch presentations during the week leading up to International Women's Day. After one of these presentations, the Ministry received a number of complaints about the fact that Michelle had breastfed in a "mixed" audience. In response, the Ministry established a policy that children were not allowed in the ministry building and Michelle was no longer allowed to breastfeed her child at her workplace during her lunch hour. In April, another public lecture was scheduled and Michelle was told she could neither bring her child to the public, noon-hour lecture nor could she receive compensatory time off work to attend to her lactation needs." (INFACT Canada Newsletter Winter 1997 p. 4)

A letter dated September 24, 1993 is sent from Calvin Bernard, Acting Director, Ontario Human Rights Commission, Policy Unit to Ms. J. A. Zablocki: "Dear Ms. Zablocki: Your letter to the Chief Commissioner regarding the woman who was fired from Coles Bookstore for nursing her baby in a back room of the store, has been referred to the Policy and Research Unit for a reply. . .Persons who believe they have been discriminated against on the basis of their sex are
entitled to pursue a complaint under the Ontario Human Rights Code. Prohibiting a woman from breastfeeding her infant in the workplace could possibly be interpreted as having an adverse impact on women in employment."

Paid employment seems to be incongruous with breastfeeding. Employers who curtail women's ability to breastfeed their infants operationalize the artificial feeding frame. This is ironic since the cessation of breastfeeding increases infant morbidity which directly impacts women's absenteeism. How is it possible that this dominant frame can even silence this impact upon the employer's bottom line?

Patriarchy

The Toronto Star (August 21, 1999) reported the “three most ghastly contemporary faux pas”, according to the new Debrett's Guide to Etiquette. These are “breastfeeding in public, droning on about one's change of sexual orientation and eating corn on the cob.” “Debrett's makes no bones about proud mothers suckling their young in restaurants. 'It is bad manners to expel any liquid from any orifice in public, and breastfeeding is no different. Thoughtful hosts should offer lactating visitors a quiet room where they can feed away from the general throng.' The editor of Debrett's is John Morgan, style editor of GQ (Gentleman's Quarterly) Magazine. Here we have patriarchy's devaluation of both the breast's form itself (an orifice) and its' function - the provision of infant sustenance and nurturance (the expulsion of a liquid). Ultimately this evidences the attempt to govern women's' breastfeeding behaviour - social banishment.

Recently published in the Canadian Journal of Law and Society was a study conducted by two
University of Alberta researchers. Having examined divorce data from Statistics Canada and the Department of Justice, "it concluded that judges award women custody of children six times more often than men, even though divorce legislation has become more gender neutral."

(National Post, September 2, 1999 p. 1) The study examined why the bias occurs and looked at a variety of factors including attitudes about breastfeeding. "Sometimes judges have this idea that a woman has breasts and so therefore she's more suited to parent the child" said Paul Millar, who co-wrote the study. "Attitudes about breastfeeding? What about the actuality of breastfeeding. Patriarchy's attitude that breastfeeding should make no difference to the father's ability to take the child for purposes of visitation or custody negates the myriad of factors unique to breastfeeding. Once again we see evidence of the conceptual practice of the equivalency of human milk to formula, the reductionism of mothering and breastfeeding and the attempt to govern breastfeeding or, in this case, its cessation.

Business intolerance for public breastfeeding may also be included within patriarchal discourse. Patriarch allows the display of breasts when the purpose is its' own consumption, for example, in strip clubs, and on the covers of men's magazines, but censures such a display in the matter of infant consumption. Countless stories have been told about women being asked to leave public places because they were breastfeeding their babies. These stories are often relayed to us through the media. Often the issue becomes academic and debate ensues. What the experience of being asked to leave was like for the mother involved becomes mute in the retelling. The following letter captures the actual experience for this young mother and hence I reproduce sections of it now:

"To Whom This May Concern: I am writing to you regarding a situation I was involved in at Eastgate Mall. On Monday, July 3, 1995; at approximately 2:00 p.m., my mother, daughter and myself were at Eastgate Mall. My mother and I were walking towards Eaton's when my
daughter, Tamara Rose, started crying due to wanting to be fed. My mother parted and went into Eaton's to shop and I went to sit down at some chairs located in front of a store called 'Cookies by George.' I started to feed my daughter; breastfeeding, for approximately one to two minutes when I was approached my a merchant from Cookies by George. The merchant, who I later learned was named Nancy, told me that I could not breastfeed in the location I was at and also that I had to purchase something from her store if I did sit there. Therefore, I went in her store and purchased a drink and a cookie. I then sat back down. . .The next thing I seen Nancy talking to a security guard. I started breastfeeding my daughter again. It was approximately two minutes from the time I started breastfeeding my daughter to the time the merchant and the security guard both, together, approached me. The security guard started telling me that I could not breastfeed where I was seated due to there was a policy in the mall regarding breastfeeding. The merchant then told me that there is a policy that they have to follow. The security guard then told me that if I wanted to breastfeed she would open up a staff bathroom for me to do so, or I could go to the women's changing room to so. . I refused to go anywhere as I felt I had the right to breastfeed my daughter anywhere. I told the merchant and security guard that they should eat their dinner in the bathroom to see how it feels. I told them both that my daughter too, as anybody else had a right to eat. The security guard and the merchant then both told me that the mall policy does not allow breastfeeding to be done in a food court as it is not the facility to breastfeed as people are eating in the area. . . At this point I became very upset and felt humiliated and embarrassed because of people watching. I felt like crying and felt as though I had stolen from a store or something as that is how they were treating me. Breastfeeding to me is just a part of what mother nature intended.”

Within the artificial feeding frame, bottles, not breasts are the passport to social integration.

The Christmas (1997) edition of Redbook displayed a cover featuring Pierce Brosnan, his wife Keeley Shane Smith and their son Dylan. Keeley was clothed but had her shirt open to facilitate breastfeeding Dylan. It seems that the breastfeeding cover was provided for the newsstands; subscribers got a non-breastfeeding version. 7-Eleven stores assigned the breastfeeding covers to the pornography section. (INFACT Canada Newsletter Fall 1997 p. 6)
The invocation of medicine within this video evidences the close collaboration that exists between this profession and the multinational corporations. The most cogent evidence of this conceptual practice is the exclusive contracts that hospitals have entered into with formula companies. Such contracts mean the hospital is provided with free formula to give its patients. This operationalizes two other concepts: it established equivalency between formula and breastmilk. If a mother of an infant in a neonatal intensive care unit, for example, does not produce enough breastmilk because of her own illness or the stress of an ill infant, formula is given as an alternative. Other hospitals in other provinces and in the United States have human milk banks from which human milk can be given to infants in such circumstances. Patients have been using banked blood when they hadn’t enough of their own, why not milk? Furthermore, it is viewed by the public as a medical endorsement of infant formula. This perpetuates the concept that this is an appropriate milk to be given to a human infant and silences the hazards of its use.

Similarly, the Canadian Pediatric Society allowed the inclusion of their document "Questions and Answers", (production of which was sponsored by an infant formula company), to be included in a two tin formula gift pack. The distribution of formula gift packs to breastfeeding mothers at discharge has been correlated with shorter courses of exclusive breastfeeding. (INFACT Canada Newsletter Summer 1997 p. 3) To quell criticism the CPS issued the following statement: "Breastfeeding provides healthy babies with the best source of nutrition in early infancy." Like the social construction of the video series, this statement conceptualizes breastmilk as best only in qualified circumstances, such as in the case of healthy babies and in
The Artificial Feeding Frame's exclusion of the hazards of infant formula is congruent with the content of most medical and nursing texts as well as prenatal classes. The information presented within the analysis of the text regarding formula hazards, recalls, etc, is not knowledge universally known by health professionals. Although the World Health Organization's published Guide to the International Code of Marketing of Breastmilk Substitutes which Canada voluntarily though not legislatively adopted states that health professionals must teach parents about "the possible risks to the baby's health" that artificial feeding poses, this is not part of standard prenatal discourse. In fact, when I was employed as a Prenatal Breastfeeding Teacher at Mount Sinai Hospital, ironically a World Health Organization collaborator, I was explicitly told that I was not to show overheads which delineated the differences in morbidity among exclusively breastfed, partially breastfed and exclusively bottlefed infants. This exclusion of such information also operationalizes the conceptualization of breastfeeding as fraught with risk and vulnerable to failure - we shouldn't make women who are going to ultimately bottlefeed, feel guilty. This exclusion of information with which to enable women to make informed choices because we don't want them to feel guilty is almost axiomatic.

Lest, as nurses, we become self-righteous and believe ourselves to be immune from such conceptual practices we need to engage in some self-reflexion. For our consideration I offer a series of thematically homogeneous research articles which appeared in such professional practice journals as Birth, Journal of Obstetric, Gynecologic and Neonatal Nursing, Nursing.
Research, Journal of Human Lactation, and the American Journal of Orthopsychiatry.Thematically these articles were linked by their focus upon breastfeeding as a risk factor for fathers. Consider these titles: “Breastfeeding and fathers: illuminating the darker side”, “Supporting the father when an infant is breastfed”, “Effects of the nursing mother-infant dyad on the family”, “Breastfeeding as a risk factor for fathers” and “Labouring for relevance: expectant and new fatherhood.” Although the purpose of these articles is ostensibly to promote breastfeeding, the elucidation of the conceptual framework implicit in these studies reveals their real focus - preserve the nuclear family at all costs. If breastfeeding interferes with male marital satisfaction better to eliminate breastfeeding then to have it catalyze the failure of the marriage. Breastfeeding was conceptualized as constitutive as a risk factor in the following ways: the mother had less time for her husband, breastfeeding changed the established relationship that the husband had with his wife, therefore fathers felt “jealous, envious, superfluous and excluded”. Furthermore, breastfeeding interfered with the sexual relations between the new parents. The solution presented in the articles was to cease exclusive breastfeeding, enable fathers to feed the baby too. Of course there are several other ways for fathers to share the parenting of an infant but feeding is the only method discussed. The introduction of supplemental bottles embarks one upon the slippery slope to infant weaning. The articles uphold father’s satisfaction as most important; the benefits of breastfeeding to mother and infant are easily sacrificed. These articles reproduce all of the meta-concepts which were evident in the video series.

Such articles in such publications are intended to inform professional practice. Thus nurses who non-reflexively adopt the recommendations of these articles, that is, assess father’s satisfaction with breastfeeding and if he is upset in any way encourage its supplementation or cessation, are perpetuating this conceptual framework. This is how ideological practice works: We have
seen how the actualities of breastfeeding were taken up into a virtual reality in which the conceptual constructions that we elucidated were created. Now we see the attempt to utilize these conceptual reformulations as governance over actual breastfeeding practice. Nurses must consider the implicit conceptual frameworks of such texts in order to first, elucidate what she is hooking herself up with if she adopts them and second, to reflect upon whether or not she wants to perpetuate such conceptualizations. Only such reflective pauses can interrupt the replication of such conceptual constructions.

Conclusion

The practice of breastfeeding is a socially co-ordinated activity. Women are oblivious to this. They believe that they truly are making a choice when deciding whether or not to breastfeed. Like embodied intelligence which is only discernible upon rupture, like your foot missing the clutch or almost tripping along the sidewalk, breastfeeding as a construct remains invisible until you overstep its’ perimeters. If you nurse too long, (say, over a year), or too openly, (say, in public), its’ independent construction becomes painfully obvious to you. Your freedom of choice is illusory.

Therefore let us stop asking who is responsible for lactation failure. This question is asked in light of an 80% rate of breastfeeding cessation by 4 months. Let us instead see this as a success. How has breastfeeding been socially co-ordinated to ensure cessation by 4 months. To a large extent women are breastfeeding just as they are enabled to - for a short period of time. Women are breastfeeding as it has been constructed for them.
Breastfeeding promotion programs have missed this point - that breastfeeding is a social construct. They either target the woman herself - ensuring she has caregivers who can help her latch the newborn, for example, or else they articulate theoretical solutions which bear little direct relations to the real world. Individual care and theoretical discourse are both important. But Smith's explication of conceptual practices enables us to deal with breastfeeding on the actual turf of its' material conditions. Making these conditions observable enables tacit interventions to do breastfeeding differently. Not to create a privileged position - not to impose upon women a new breastfeeding prescription, but to remove many of the socially co-ordinated activities that impede their ability to make free and informed choices.

What can nurses contribute to a new breastfeeding terrain? Consider reconstructing conceptual practices. For examples, current public health publications prescribe a sequence of infant feeding modalities: early chapters emphasize breastfeeding, middle chapters discuss bottlefeeding and later chapters discuss the introduction of solid food and weaning. Let's change this template of infant feeding. Why not have chapters in the middle of such texts that discuss introducing solids to the breastfeeding infant, and final chapters informing mothers of the ability to combine work with breastfeeding, and the benefits of extended nursing. Why not have breastfeeding classes for the 6 month old infant, the mother who is returning to work, and the toddler? Let's refuse to comply with the silence about the hazards of infant feeding that the artificial feeding frame imposes and enable women to make truly informed choices. Let's cogently demonstrate to our hospital employers our intolerance of institutional contracts with formula companies.

Of course broader social action is needed as well. There is some optimistic news on this front.
Earlier I detailed the experience of Michelle Poirier who was told by her employer, the Ministry of Municipal Affairs, that she could not breastfeed at work. Well Ms Poirier contested this restriction and filed a complaint with her provincial (British Columbia) Human Rights Tribunal. The decision took 6 years to arrive at, but on July 30, 1997, it was handed down. Stopping women from breastfeeding at work or in public is a form of sex discrimination and is prohibited under that province's Human Rights Code. In August, 1999, Ontario's Human Rights Commission is rewriting its policy to now explicitly include breastfeeding as a protected act. Furthermore, the complainant, Cindy Rock, who launched the complaint when told to leave a restaurant because she was breastfeeding her infant, was awarded $10,000. in damages. This represents the untying of one knot in the discursive fabric of breastfeeding prohibition.

Dorothy Smith's method of inquiry enables us to make observable those relations which organize such matters as infant feeding. Once visible, we can then reconstruct conceptual practices to weave it differently. Fibre by fibre women will reclaim governance of such maternal experiences as breastfeeding and will reconnect with their creative power to produce a perfect product with which to nourish the human infant.
Video 1; Your Baby

Your baby’s health is important. All viewers are advised to consult their doctor and to exercise caution and common sense at all times. (Host in nursery)

“You glance around the room with pride and a sense of accomplishment. Everything is ready for baby. Consulting family, friends and books you drew up lists of everything you would need. You refer to the latest published safety standards before you bought anything. Suddenly you feel the contractions. It’s time. Baby’s on the way.”

Title: Your Baby, Your Doctor and You. (Blue background)

“Well baby’s home and now it’s time to start the long process of getting to know your baby and how to care for him or her. In this series of videos we try to anticipate some of the concerns and questions we think you as a new parent might have about the first year of your baby’s life. Let’s start with the very basic issue of feeding baby.”

(Picture of mom breastfeeding baby (both in blue))

(Picture of mom bottlefeeding baby (with bottle with the Blue Jays logo on it))

“Should you breastfeed or bottlefeed? How can you tell if your baby is eating enough?

When should solid food be introduced?”

(Baby is being fed cereal with a spoon; infant girl in pink attire with pierced ears)

(Host in nursery)

“Whether to feed your baby breastmilk or commercially produced formula is a matter of personal choice. In most circumstances your own milk is the best food for your baby.

Commercially produced formulas are made to simulate breastmilk and are therefore a
nutritionally sound option. Only you can decide which feeding approach will suit you and your family."

"There are some non-nutritional aspects to this decision."

"Breastfeeding is a portable, convenient way to feed your baby anytime, anywhere."

"You don't have to get up in the middle of the night to heat a bottle or worry about how you're going to feed your baby if you travel."

"And there is a wonderful sense of self-sufficiency in providing everything your baby needs all by yourself. But this very quality can also be exhausting."

"With bottle-feeding, the father, other family members and babysitters can relieve you so you can get an uninterrupted night's sleep or go out for a few hours."

"And when you travel with the baby you can use ready to use formula with bottles with disposable liners so the only parts that remain to be sterilized are the nipples and bottletops."

"Of course if you master the art of expressing breastmilk you can enjoy the same freedom."
"When you breastfeed your baby the quality of the milk the baby receives is dependent upon you because your baby can only get the nutrients you put into your milk. For this reason it's very important to eat a balanced diet. This is decidedly not the time to restrict your diet. Eating a well balanced diet which includes foods from each of the four food groups outlined in Canada's Food Guide will steer you in the right direction.

Your doctor may suggest you avoid certain foods because they might irritate your baby's digestive system. Foods in this category might include spices, caffeine and certain vegetables in the cabbage family."

Breast Feeding

There is a great deal of published information available on breastfeeding and several sources of information in the community; for example, your public health nurse and the La Leche League. We've asked pediatrician Dr. Julie Fabbro to cover some of the more commonly requested information about breastfeeding."

Q. “Dr. Fabbro, from the perspective of a new mother how should I hold my baby for breastfeeding:"

(Father hands the baby to the mother who is seated; baby in blue attire)
68 A. "Find some place where you can relax without interruptions and make yourself
comfortable with pillows and a footrest. . .

69 (Close up of baby nursing)

70 . . . because baby doesn't like to be rushed."

71 (Mother, wearing wedding ring, and baby, in blue, on bed, attempting to latch baby)

72 "Baby and you can lie down tummy to tummy with baby's head in the bend of your elbow."

73 (Close up of baby breastfeeding)

74 " If you sit up during the feeding. . .

75 (Close up of mother breastfeeding while seated; baby is dressed in pink and occupies the
left hand side of the screen; mother does not wear a wedding ring)

76 . . . cradle your baby's head in the bend of your elbow supporting the baby's bottom in your
hand."

77 (Close up of host's face)

78 Q. "How do I let my baby know it's time to eat?"

79 (Close up of doctor's face)

80 A. "Chances are that your baby will let you know when it's time to eat."

81 (Close up of host's face, smiling)

82 (Close up of doctor)

83 "A flexible schedule with feeding occurring every 2 hours with occasional stretches of up to
5 hours works best to establish breastfeeding."

84 (Close up of host)

85 Q. "Feedings every 2 to 5 hours which last for how long, up to half an hour? Is this around
the clock?"

86 (Close up of doctor)
A. "While the baby is very young I'm afraid so. That's why it's important for mothers to simplify her life as much as possible in the first few months. Life with a newborn is very demanding."

Q. "My baby's made it very clear that she wants to be fed. How do I get her to take my breast?"

A. "Babies are born with a reflex to search for food . . .

. . . and when the baby's mouth area is stimulated the so-called rooting reflex kicks in and the baby's mouth pops open. Then, holding your breast just behind the areola you guide both the nipple and the areola into the baby's mouth . . .

. . . Make sure the baby's lips are out and the tongue is down. When the baby is properly latched on you see a strong rhythmic motion and you hear gulping noises."

Q. "What do I do if the baby hasn't latched on properly or I want to change breasts?"

A. "To relieve the baby's suction, either pull gently on your breast near the corner of the baby's mouth or slip the little finger in the corner of his mouth . . .

. . . I said his but that technique works equally well on both genders."

(Scenes of both host and doctor; both wearing pants)
Q. “How long do I let the baby nurse before I switch sides?”

A. “There’s no specific routine and there’s no need to switch every 10 minutes or to use both sides each feeding.”

Q. “Breastmilk looks so thin and watery compared to commercially prepared formulas. . .

. . . or even cow’s milk. It’s hard to believe a baby can live only on this and nothing else.”

A. “Breastmilk is the food nature intended for human babies.”

Your milk supply will change according to the baby’s needs. The more the baby drinks the more milk you will produce. Even in the course of a single feeding the milk varies . . .

The first milk the baby gets, the foremilk, is high in sugar and is thirst quenching. Later in the feeding, the baby gets a richer milk, . . .

. . . the hindmilk, higher in fat, more caloric and more satisfying.”

Q. “Mothers sometimes complain that they no sooner get milk into the baby than it comes up again. Is spitting up a problem?”

A. “Spitting up usually occurs with a burp and the baby is quite happy afterwards. . .
The volume of spit up can be quite large and it sometimes comes through the nose as well as the mouth."

Q. "Do I have to interrupt the feeding to burp the baby?"

A. "Any air which the baby swallows during the course of a feeding can produce uncomfortable pressure in the baby's stomach. Burping expels this air. You can try to burp the baby during the feeding or wait until she is finished."

Q. "Is there a special burping technique?"

A. "Put the baby over your shoulder, . . . face down across your lap. . . or prop baby into a sitting position. . . Try to coax a burp for five minutes. . ."

If he hasn't burped at the end of this period you can assume that there is no need to burp or that the baby will do it later."

Q. "What do I do if the baby starts to hiccup?"
A. "Nothing. Hiccuping is due to a sudden spasm of the diaphragm and is quite harmless."

Formula Feeding

If you choose to use a commercial formula you're providing a high standard of nutrition provided that you are meticulous in preparing the formula exactly as directed and in sterilizing any equipment which comes in contact with the formula. Sterilization is important until the baby is 3 to 4 months old.

Formulas are composed of PROTEIN, FAT, SUGAR, VITAMINS AND MINERALS.

Most formulas are made of either cows milk protein or soy protein base. Iron fortified formulas are usually recommended but you should consult your doctor prior to making any formula choice.

Homogenized milk can be given at 1 year of age. 2% or skimmed cow's milk should only be used after discussion with your doctor.

Formulas which are ready to use are the most convenient but also the most expensive...

Powder and liquid concentrates are more economical but great care must be used to prepare them exactly....
as instructed on the product labels.

(Image of woman in kitchen shaking container of constituted formula)

unless your doctors advise you to do otherwise.

(Close up of host)

"When purchasing formula it's important to check the expiry date and also to check for any damage to the packaging.

(Formula pouring out of opened can)

Liquid concentrate must be stored in the refrigerator.

(Formula being poured into bottle)

once its opened and used within 24 hours.

(Image of woman in kitchen placing container of constituted formula into refrigerator)

(Close up of host's face)

"Powders must be used within 30 days. Before you fill the bottles sterilize all equipment which will come in contact with the formula.

(Image of woman placing narrated articles into boiling water in pot on stove)

"To sterilize simply boil bottles, nipples, caps, measuring cups and funnel in water for 5 minutes.

(Image of formula being poured into sterilized bottle)

.If you're not using ready to use formula directly from the can, prepare the formula using sterilized water.

(Image of woman pouring formula into sterilized bottle)

"Store prepared bottles in the refrigerator. If you're using disposable bottles.

(Image of baby being bottlefed with a bottle containing liner; baby is on right side of screen; mother wears wedding band)
the plastic liners are already sterile but you still need to sterilize nipples, caps and measuring device."

Whether you select traditional, orthodontic or square tipped nipples is a question of personal preference. The hole in the nipple should allow a slow drip. Discard nipples when they show signs of wear such as holes, tears, cracks or stickiness."

"Formula should be warmed to body temperature before you feed it to the baby."

"Microwave warming presents the danger of uneven heating which could result in pockets of dangerously hot liquid in the bottle. Be sure to test the temperature by sprinkling some formula on the inside of your wrist before giving it to your baby."

"When you feed your baby from a bottle, cradle her in your arms so she's in a semi-sitting position. Be sure to hold the bottle so that the neck of the bottle's always full. Parents may be tempted to prop the bottle to a feeding position so that they can do something else. . .

. . . But this is not a good idea because the baby could choke. It also deprives both the parents and the baby of a warm, cuddly time."

When you feed your baby from a bottle, cradle her in your arms so she's in a semi-sitting position. Be sure to hold the bottle so that the neck of the bottle's always full. Parents may be tempted to prop the bottle to a feeding position so that they can do something else. . .

But this is not a good idea because the baby could choke. It also deprives both the parents and the baby of a warm, cuddly time."
Q. "Many mothers wonder how much formula the baby should drink and whether they should add anything to the formula. Let's turn to Dr. Fabbro again for some answers."

(A close-up of Dr. Fabbro)

A. "The amount of formula a baby takes will vary with the age and activity level of the baby. A newborn should take a minimum of 20 ounces over a 24 hour period. . ."

(Close-up of host, smiling)

(A close-up of Dr. Fabbro)

"As the baby approaches the 1 year mark more of the baby's nutritional needs will be met with solid food and his formula intake will be reduced to about 16 ounces a day . . ."

(Close-up of Dr. Fabbro)

". . . You should not add anything. No sugar, corn syrup, honey or cereal to the formula."

(Close-up of host)

Q. "Does the baby need water or juice in addition to her formula or breastmilk?"

(Close-up of Dr. Fabbro)

A. "Extra water may be needed if the baby has diarrhea, vomiting or a fever. If the baby has any of these conditions you should see your doctor. You could also offer 2 or 3 ounces in hot weather, but make sure the water is safe and clean. . ."

(Image of mother pouring water into container)

"Water must be sterilized until the baby is 3 or 4 months old . . ."

(Close-up of Dr. Fabbro)

"Juice is not necessary but it adds variety."

(Image of mother preparing juice in kitchen; pouring diluted juice into bottle)

"You may introduce juice when the baby is 4 to 6 months old. It is not necessary to buy infant juices but you must always dilute juices half and half with water. . ."

(Image of doctor)
... Juice or water are in addition to milk, not a replacement for milk."

Q. "When should solids be introduced?"

A. "Not before the baby is 4 to 6 months old. Prior to that time the baby's digestive system is too immature to handle solid food."

Q. "Once the baby is old enough, how should I go about giving her solid foods?"

A. "Introduce solid foods one at a time. Make your own purees or use commercial preparations which have no added sugar, salt or preservatives. . .

"Infant cereal made of rice is a good food to start with. At first make it quite thin and runny and gradually thicken the consistency. . .

This can be offered twice a day. Once this is well tolerated you can add other infant cereals made of grains such as oats and barley. By 6 months, baby should be able to tolerate mixed grain cereal."

Q. "How long should the baby eat these fortified cereals?"

A. "At least a year but preferably until 18 to 24 months."
A. "With the exception of berries which may cause an allergic reaction, strained fruits are well tolerated by most babies. However, . . .

(PROBLEM FRUITS AND VEGETABLES)

CORN, ONIONS, PARSNIPS, CABBAGE, CAULIFLOWER, BRUSSELS SPROUTS, BROCCOLI)

certain vegetables such as corn, onions and parsnips are not well tolerated. Cabbage, cauliflower, brussels sprouts and broccoli may also cause problems."

(Q. "That leaves eggs and milk."

(A. "Your doctor may suggest a time frame something like this: You might start the baby on egg yolks around 9 months then move to the whole egg around 12 months. Meat might be offered to a baby who is more than 6 months old at which time you could offer a variety of strained meats."

(STRAINED MEAT POULTRY RED MEAT PORK)

"Fish could be introduced when the baby is 12 months."

(FISH AT 12 MONTHS)

Q. "Any general comments about solid food?"

A. "Avoid foods with a high fat, salt or sugar content. . .

(Image of jarred food being spooned into bowl by female hand with wedding ring on finger)
... If you are using commercial baby food, spoon a portion into the bowl rather than directly from the jar...

(Image of mother feeding baby (blue rimmed bib around baby's neck) with a spoon as baby sits in blue high chair)

... This will avoid contamination of the rest of the jar with the baby's saliva...

(Image of doctor)

... and will allow you to use the remaining portion as long as you refrigerate it immediately and use it within 72 hours."

Baby Care

(Image of host in unidentifiable room)

Q. "Now that we've got the feeding part looked after, let's spend a few minutes talking about how to keep baby clean and comfortably dressed. In addition to the endless mopping up of messes on baby's face and bottom, there has to be an occasional bath. And like everything else to do with newborns, this is not completely straightforward...

(Image of mother undressing baby on kitchen counter; baby has pink sleeper and pierced ears)

... Bath time is also when you're likely to notice the little flaking and discolouration in your baby's skin, so as we talk about the cleaning techniques for various baby parts, we'll also comment on the normal appearance of these baby parts."

(Close up of host)

"The first thing you may notice is the condition of your newborn's skin. It's quite possible your baby may have a little jaundice and so have a bit of a yellow hue..."

(Black mother, baby and doctor in doctor's office)
... Dark skinned or Oriental babies may bluish patches particularly on the lower back.

The skin may appear to be dry and peeling and blocked sweat glands across the nose resemble tiny pimples. All of these conditions are normal and temporary.

"Until the baby's umbilical cord falls off, (anytime from 1 week to 4 weeks after birth is normal), . . .

most doctors recommend that you sponge bath your baby rather than immersing her in water."

"Keep the umbilicus dry and clean it with a bit of alcohol on a cotton swab."

"So, let's start with the baby's head. . .

"Use water only, no soap on the baby's face. Move around to the baby's ears which might be a little floppy until the cartilage firms up. And use the face cloth, not cotton swabs, to clean away any wax which is visible to the eye . .

Wax is a normal secretion by the ear canal and may vary in consistency and colour."

"Never probe the ear canal with anything to clean it. A bit of oil on a piece of cotton may be the most effective way to clean behind the ears. . .

(Image of mother cleaning baby's eyes)
“Clean the baby’s eyes from the inner corner outward. Pressure during the birth process may have resulted in some puffiness or redness. This is also a temporary condition. It’s also normal for eye colour to change after birth.”

“Sneezing will clear the baby’s nose, so you need only remove with a bit of moist cotton whatever mucous can be seen at the opening. Once the baby starts getting teeth, . . . clean them with a bit of gauze or cotton wrapped around your finger or a small brush, but save the toothpaste until after the baby’s birthday.”

“And once or twice a week you’ll have to tackle the hair, or whatever hair your baby happens to have. Most of the newborns’ hair will fall out and when it grows back, (it will grow back), it will have a different colour and texture. “

“Peeling on the scalp is also quite normal.”

“A cap like accumulation of scales is called cradle cap and can be removed by applying baby oil at night and washing out with a bit of shampoo or soap the next day.”

“The fontanelles, the areas of the skull where the bones have not quite fused together, are covered by a tough membrane which will not be damaged with gentle washing.”

“A small amount of soap can be used on the baby’s body, but be sure to rinse the soap off thoroughly. Drying the skin is also important. Blot, don’t rub, and get into all those tiny little skin folds and creases.”
"There may appear to be odd little swellings here and there. For example, it's not unusual for the breasts of babies of both sexes to be slightly enlarged."

"This is due to maternal hormones in the baby's body and will clear on its own in 2 or 3 months."

"A slight puffiness in the genital area is also common after birth and will also decrease on its own."

"You may notice a vaginal mucousy discharge or vaginal bleeding in the newborn girl and fluid in the scrotal sac accounts for swelling in the genitals of the newborn boy."

"Some babies may have an umbilical hernia which is a bulging of the navel due to a space between the muscles of the abdomen in midline."

"This also usually takes care of itself over time."

"Well we've pretty much covered off the routine care of the baby's body. Only the challenge of cutting the baby's nails remains. The voice of experience suggests that you perform this delicate operation when the baby is asleep, that you recruit someone to help you and that you use rounded tipped scissors. Use infinite care not to cut the baby."

"We've pretty much covered off the routine care of the baby's body. Only the challenge of cutting the baby's nails remains. The voice of experience suggests that you perform this delicate operation when the baby is asleep, that you recruit someone to help you and that you use rounded tipped scissors. Use infinite care not to cut the baby."
"Well now that the baby is fed and clean let's get her dressed. Assemble everything you're going to need. Lay baby on a flat surface and prepare to be delightfully entertaining so that her attention will be distracted and you can go about the task of dressing her."

Diaper first. If the umbilicus hasn't fallen off yet you will have to fold the diaper down out of its way. Next, the rest of the clothing, which, if you've chosen well, will have easy on and off features like wide necks or snap closings, loose sleeves and stretch fabrics.

Stretch openings before attempting to put the body part through, and ease as opposed to tug on the clothing. Reach into the sleeves and gently pull the arms through. Pull the garment away from the body to avoid pinching the skin. Beware of overdressing the baby.

A good rule of thumb is to dress the baby in a way you think you would be comfortable.

"A bit later, let's suppose you have to change a messy diaper. Remove the diaper. If you're using cloth diapers with pin fastenings, close the pins immediately and put them aside.

Use warm water and mild soap. Wipe from front to back using a clean section of the cloth for each wipe."

"Do not push back a boy's foreskin. Dry the area carefully taking care to get into the creases and folds. If the skin is irritated, use a barrier cream to protect it until the next diaper change."

"Now that baby is fed, bathed and dressed perhaps he'll go to sleep. Lie him flat on his back on a firm mattress, or on his side with a rolled up receiving blanket behind his back to keep him in place."
"If your baby tends to spit up a lot do not place him on his back."

"Remove anything from the bed that might suffocate the baby such as pillows, stuffed animals and toys."

"Hum a lullaby or two, cross your fingers and back quietly out of the room. And remember, if you want to learn more you can always refer to the other videos in this series. For your baby, your doctor, and you, I'm Lillian Klue."

This program was made possible by the generous support of Mead Johnson Canada.

Special thanks to The Hospital for Sick Children and the George Hull Centre.

This video series was written and produced with the assistance and direction of a National Medical Advisory Board of Pediatricians, Doctors and Technical Advisors.

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The material covered in this program has been approved by a national Medical Advisory Board.
Appendix B

Video 2: Your Doctor

Your baby's health is important. All viewers are advised to consult their doctor and to exercise caution and common sense at all times.

(Host in residential room)

"Our first video covered off some of the fundamentals of caring for your baby on a day to day basis. Now we're going to discuss some of the issues you might want to talk to your doctor about. Life with a baby involves very frequent visits to a doctor. Even if your baby is healthy, regular check ups are necessary to make sure that the baby is growing and developing normally. And to receive the all important immunizations that are his or her insurance against serious disease."

(Scene of parents with child and infant in physician's office)

"The choice of a doctor for your baby is an important one. In choosing a doctor here are some criteria you might want to keep in mind. You might find it easier to develop a working relationship with a doctor who seems to be approachable, concerned and knowledgeable with the ability to communicate that knowledge in a way that meets your needs."

(Camera pans from behind the doctor, over her shoulder to close up on her documenting information on the chart.)

"New parents find themselves in an unfamiliar and stressful situation and need that reassurance that baby is developing well."

Dr. Fabbro is auscultating infant's chest with a stethoscope.

"A doctor and staff who sympathize with these needs. . . ."

(Close up of Dr. Fabbro smiling)

". . . create a warm and helpful environment that which parents find very comforting."
“Perhaps we can save both you and your doctor some time in answering some commonly asked questions about a baby’s first year of life.”

(Scene: physician’s office. Dr. Fabbro, opthalmoscope in hand, is examining the eyes of a baby who is seated on mother’s lap.)

“One of the first things that parents usually want to know whether or not their baby is of normal size.”

“Size is dependent upon many factors: Race, genetics, nutritional intake, activity level. Your doctor will document the baby’s weight and height at each visit creating over time a growth curve.”

“The rate of gain indicated by this curve is more important than the actual measurements.”

“. . .because the rate of gain will reflect the effects of nutrition or chronic illness amongst other things.”

“In general, you can expect that your baby will have doubled its birth weight by five months and tripled it by twelve months.”

Feeding Your Baby

(Close up of host’s face)
"As we discussed in the previous video the decision of whether to breastfeed or bottlefeed the baby, is one that many people find difficult. How you decide to feed your baby is a very personal choice involving consideration of lifestyle, emotional makeup and personal preference. That said, most doctors will recommend breastfeeding because it has some very clear advantages both to the baby and to the mother."

"Breastmilk offers the baby natural immunities to help fight off infection. It's very digestible resulting in fewer intestinal disturbances like diarrhea and constipation. . . ."

". . .and there is better absorption of nutrients, especially of iron."

"Because exposure to foreign protein is lower when babies are breastfed there is possibly a reduced risk of food allergies or eczema. . . ."

"In addition to these medical advantages. . . ."

". . .breastfeeding also provides a safe sterile and inexpensive supply of milk which is always ready and always at the right temperature."

"An added plus for the mother is that breastfeeding encourages the uterus to shrink to its normal size more rapidly."

"In most communities you'll find a network of people who can help you get started with breastfeeding and offer help with any problem you might have. Public health nurses,
friends who've successfully nursed their babies, the La Leche League and your own doctor can be useful sources of information."

(Scene: Interview setting)

"We invited Dr. Julie Fabbro, a paediatrician, to discuss some common concerns of new parents during their babies first years. Dr. Fabbro, let's start with breastfeeding. When bottlefeeding you can see exactly how much food your baby is getting. How do I know my baby is getting enough food when I breastfeed?"

(Close up of Dr. Fabbro's face. Her title appears at the bottom of the screen)

"If you are changing a minimum of 4 to 6 wet diapers a day and the baby is having frequent bowel movements you can be quite certain she is getting enough food."

(Scene: Dr. Fabbro puts baby on weigh scale)

"Another indication is weight gain. All babies lose weight in the first few days of life..."

(Close up of baby on scale, then close up of weight 6960 grams)

"... and this weight loss can seem like a lot. Up to 10 or even 15% of their birth weight, but they are usually back to their birth weight in 10 to 14 days."

(Close up of host's face)

"What do I do if the baby just doesn't seem to be able to latch on properly to the breast?"

(Close up of Dr. Fabbro's head)

"First of all, make sure that the baby has a strong root. In other words make sure she opens her mouth wide enough to accommodate both the nipple and areola..."

(Mother breastfeeding infant girl with baby occupying left side of screen; mom has no wedding ring)

(Close up of baby attempting to latch on to breast. Breast has erect nipple that resembles a bottle. Baby does not latch well, mom is not holding her breast in the typical way)
Further, ensure that her tongue is down and her lip is out. If she hasn't latched on properly, break her suction by placing your little finger in the corner of her mouth and then reposition her.

(Mom does not reposition her)

"Engorged breasts can make it difficult for the baby to get enough of the areola. . . ."

(Close up of mom pumping her right breast, left screen)

". . .into her mouth to get her to latch properly. Before nursing the baby try to soften the areola by expressing some milk by hand or pump."

(Close up of milk squirting from breast into electric pump)

"You could try applying a warm face cloth to your breast. . . ."

(Close up of breast exposed from nursing bra, with nursing pad underneath it)

". . .or taking a warm shower."

(Close up of host's face)

"If a baby is nursing as many as 10 or 12 times a day in the beginning the nipples must get pretty sore. What can be done about that?"

(Close up of doctor's face)

"Some mothers do develop cracked and even bleeding nipples at the beginning. If soreness does develop make certain the baby is latching on properly as we discussed earlier. If you can stand to nurse, start the baby on the side that is least sore."

(Close up of baby with mouth hardly wide and poorly latched)

"If nipples are too sore to nurse you may need to manually express milk for the baby."

(Close up of milk being expressed into a container)

"After nursing, wash the nipples with plain water and allow to air dry."

(Shot of both host and physician seated opposite each other in interview setting)

"What if I take medication. Can I still nurse my baby?"
"You can still breastfeed while taking most medications, but check with your doctor."

"What if, after all my best efforts, the baby's not thriving?"

"Consult your doctor. It may be necessary to supplement breastfeeding with a commercial formula. However, you should not try to introduce a bottle until the baby is 4 to 6 weeks old because the mechanism of sucking on the breast is different from sucking on a bottle."

"How do I know when my child is ready to be weaned from the breast and how do I go about it?"

"The timing depends on the mother - on her preferences and priorities and also on the child's needs. Once you have made the decision to wean the child..."

"Once you have made the decision to wean your child, the easiest way to go about it for the mother and the baby is to go about it gradually. Every several days or weeks, replace one nursing session with a bottle feeding."

"However if you're in a hurry, you can simply stop nursing. But this creates some difficulties for both mother and child. If you decide on this approach you may find the baby accepts the bottle more readily from someone other than the mother..."

"...Even so it may take several days for the child to adjust. And of course the mother will experience some discomfort as the breasts continue to fill up with milk. "(obvious tone of disgust)
"Will my baby still be giving a high standard of nutrition if I wean her from breastmilk to a commercial formula?"

"Absolutely. Commercial formulas are constituted to resemble breastmilk and provided that they are prepared exactly as directed, they are a nutritionally sound alternative to breastfeeding."

If the baby is less than 4 months old before you wean her make sure you sterilize everything completely.

"An approach to introducing solid foods was discussed in the first video."

"As you are introducing new foods watch for any signs that the child is having an adverse reaction to a food or group of foods: Such symptoms might include:

(SYMPOMS: HIVES, SWELLING, BREATHING DIFFICULTIES, WHEEZING, DIGESTIVE PROBLEMS.)

"These symptoms may occur within minutes or hours after the baby has eaten the offending food. Examples of foods which sometimes cause difficulties are:

(PROBLEM FOODS: COW'S MILK, SOYA PRODUCTS, NUTS, EGGS, PEANUT BUTTER, SHELLFISH, FISH AND BERRIES.)

"It's important to pay attention to any unusual reaction to food, because, although very rare, allergic reactions can be severe enough to be life threatening. And reactions will worsen with each repeated exposure to the allergen. If you suspect an allergic reaction, immediately stop feeding your baby the questionable food and consult your doctor."
How can you tell if the baby is not well. Well look for unusual behaviour. Unusual for your baby, that is. Does the baby seem less energetic or interested in things than usual? Does she seem irritable? You may notice that your child is breathing differently from normal. Rapid breathing increased drooling, coughing or wheezing may signal difficulties. The appearance of the skin is another telltale sign of the child’s state of health. A rash or change in skin colour may indicate a problem. No matter how carefully you care for your baby it is inevitable that he or she is going to be sick now and again during the first year. Let’s discuss some of the common illnesses of the first year of life."

(COMMON ILLNESSES: COLIC, FEVERS, SEIZURES, DEHYDRATION, COMMON COLD, CROUP, INFECTIONS, CONSTIPATION, DIARRHEA, JAUNDICE, ECZEMA AND DIAPER RASH)

"One of the more difficult things for the parents of newborns to cope with is colic. For at least an hour and sometimes three or four hours on end, a normally healthy happy baby will appear to be in severe pain. At the same time each day, usually late in the day, the baby will cry or scream and nothing you can do will comfort her for more than a few minutes."

(Mother holding unhappy baby; then baby in bed sucking her fingers with mobile above)

"No one knows what causes colic or can offer any sure fire remedy. Endurance seems to be he only answer. Parents can take comfort in the knowledge that colic seldom lasts more than three months and it doesn’t seem to affect normal weight gain or development."

(FEVERS)
High fevers are common in young children so you may not be able to judge the severity of the illness by the thermometer reading. But a fever combined with any of these symptoms: (FEVER SYMPTOMS; LETHARGY, POOR COLOUR, IRRITABILITY, BREATHING PROBLEMS, SKIN RASHES, DECREASED FOOD INTAKE, VOMITING AND DIARRHEA) "... is cause for concern. If a fever lasts more than 48 hours or your baby is less than 2 months old, contact your doctor do not try to treat the illness yourself.”

While you’re waiting to hear from your doctor, there are some things you can do to reduce fever or relieve pain. Carefully following the dosage directions given on the packet give your baby acetaminophen. Do not use ASA. A lukewarm bath will also help cool the fever.

"A feverish baby should be dressed lightly in an undershirt and a diaper. Give the baby lots of fluids. Although a...”

"... high fever is frightening to parents it reassuring to remember that the fever itself is not harmful and that shivering is no cause for alarm. Rarely and we’re only talking about 3% of infants and young children, does a sudden rise in temperature result in a seizure or a fit. The baby suddenly starts to shudder and jerk convulsively. Seizures related to fevers do not last long and will not cause brain damage but they are frightening to watch. Your role during a convulsion is to get medical help and to protect the child from hurting himself and from choking on any vomit. Try to put the child on his side so any vomit runs out of his mouth. Protect him from rolling off a table or sofa. Do not hold the baby down or try to
restrain his arms and legs or try to keep him from biting his tongue because you could seriously hurt him. It's even possible to break a bone or even a tooth. Once the seizure is over call your doctor.

(DEHYDRATION)

"It's important to look for signs of dehydration - literally the drying up of the body. Persistent vomiting or diarrhea are danger signs because this means that vital liquid is leaving the body faster than its being replaced. If you have the slightest suspicion of dehydration call your doctor and in the meantime try to coax as many fluids as possible into the baby."

(Baby in highchair, with mother trying to give fluids by cup)

(THE COMMON COLD)

The common cold is unfortunately very common in the first year of life. You can expect eight to ten colds, some mild, others more severe each lasting between 5 to 14 days. During this time, the baby may suffer from a...

(COLD SYMPTOMS: BLOCKED NOSE, FEVER, COUGH, SORE THROAT LOSS OF APPETITE) and will probably be fussy and unwilling to eat. You can help to relieve the baby's discomfort...

(Mother and baby (who was previously shown to breastfeed well) Baby is happy, no visible signs of a cold, being entertained by mom who is holding a toy)

"...by keeping him in an upright position to allow his nose to drain and by using a cold mist vaporizer in his room. You may also use saline nasal drops to help the baby breathe easier and acetaminophen to reduce fever and discomfort. However, over the counter medications such as nasal sprays and cough syrups should only be used when prescribed by your doctor."

(Dr. Fabbro examining a child's mouth)
A distressing viral infection related to the cold is croup. The larynx or voice box becomes inflamed and because the air passage is so small in babies, breathing may become difficult or impossible. Symptoms of croup are similar to the cold but also include a hoarse voice and a barking cough. If the baby is having difficulty breathing, take him into the night air for a moment or two and then into a steamy bathroom for about 10 minutes.

(Dr. Fabbro auscultating the chest of a baby who is laying on examination table.)

If the child is not improved in 10 minutes seek medical attention.

If there is a persistent fever or a skin rash accompanying the cold, or if the baby seems excessively fussy or unusually sleepy there may be an infection related to the cold which needs treatment by a doctor.

(Doctor examining baby's ears)

Earaches are a fairly common complication of colds and babies are very susceptible to them. Untreated ear infections can result in serious complications so it is important that they be treated by a doctor immediately.

(Close up of host)

Abnormalities in bowel movements are another area of concern. What's normal? Well it varies depending on the age of the child, what the child is eating and how much. You will know your child is constipated if she has difficulty or pain in passing a bowel movement, infrequent bowel movements of if her stool are shaped like pellets or balls. Constipation is caused by an unbalanced diet, for example, too much homogenized milk and not enough fibre. Correct the diet and use natural remedies like bran.

("DO NOT USE CORN SYRUP HONEY SUPPOSITORIES ENEMAS OVER THE COUNTER LAXATIVES) . . . without seeking your doctor's advice. "Diarrhea is the
opposite problem. Bowel movements are too frequent and too loose. It may be caused by an infection and is sometimes accompanied by:

(OTHER SYMPTOMS: FEVER LOSS OF APPETITE NAUSEA VOMITING ABDOMINAL PAIN)*

"There is a danger of dehydration so it is very important to replace lost fluids. If you're breastfeeding, continue as usual and also offer..."

"...other liquids. If the infant is bottlefed, stop feeding him milk for 12 - 24 hours and use other fluids instead. Examples of fluids are..."

(OTHER FLUIDS ORAL REHYDRATION FLUIDS DILUTED JUICES and FLATTENED SOFT DRINKS)*

"Fluids should be at room temperature as cold fluids increase diarrhea. If your child is already on solids milk free diet for a day or so, and offer foods which bind: banana, rice, apple and toast."

"Some skin conditions like eczema and diaper rash are uncomfortable and need attention."

"Eczema is a red, scaly, itchy rash which is not contagious."

"Some of these patches can ooze and crust. They usually appear on the face and inside of elbows and knees. It often lasts for years and it has to be dealt with for the comfort of your child and for the health of their skin. Diaper rash is a very uncomfortable skin problem..."
which can be largely avoided, if diapers are changed frequently and skin in the diaper area is washed with soap and water at each diaper change.

"... If diaper rash does develop, use a barrier cream to protect the skin and keep it dry between diaper changes."

"Newborn skin seldom has the rosy perfection associated with older babies. It can have the yellowish cast associated with jaundice. If jaundice persists, a doctor should be consulted to check for the possibility of other health problems."

"Many of the serious life threatening diseases once associated with childhood are now prevented by following the immunization schedule directed by your doctor. Babies are routinely immunized against the following diseases:

- DIPHTHERIA
- PERTUSSIS OR WHOOPING COUGH
- TETANUS
- POLIO
- MEASLES
- MUMPS
- RUBELLA
- HAEMOPHILUS INFLUENZAE

"An immunization against Hepatitis B is also available."

"A high rate of protection against these diseases is delivered by immunizations, but if you suspect your child is showing symptoms of any of the diseases we mentioned, contact your doctor immediately. Immunizations should not be given to a baby who is fevered or very sick, but a slight cold or sniffle should not cause a problem."
If you would like more information about the medical aspects of the first year of life, there are many excellent books on the market.

The public health department and doctor's offices are also reliable sources of information. And remember if you want to learn more you can always refer to the other videos in this series. For "Your Baby, Your Doctor, and You" I'm Liliane Klue
(Alarm clock shows 2:00 AM)

(Mother is returning to bed)

"2:00 AM. Baby is finally asleep again. You drop into bed more exhausted than you can remember ever being. You sink into a deep deep sleep."

(Mother is asleep with head on pillow)

(Sound of baby crying)

"...Gradually, you become aware that the baby is crying again."

(Mother running her hand through her hair, eyes yet unopened)

"Moments later, something is forcing you awake. Gradually you become aware that the baby is crying again, You force open an eye..."

(Alarm clock shows 4:25AM)

"...4:25! Making a tremendous effort, you push the covers away, pull the bath robe around yourself, and make your way towards the baby's crib."

(Mother picking baby up out of crib)

"You are too tired to summon the usual comforting words. All that escapes is a groan of self-pity. Why didn't someone tell you it was going to be like this?"

(Mother is holding baby)

Your Baby, Your Doctor, And You

(Music; blue background)

(Close up of host in nursery )
The first year of life with a newborn has tremendous ups and tremendous downs. There is the excitement that comes with all the firsts: The first smile, the first time baby rolls over, the first step. And then there's the exhilaration of the first conversation with your baby. The first time you make verbal contact in a true give and take way. Baby’s part in this...

"(Close up of baby watching mother manipulate a toy)

"conversation is pre-language vocalizations of course, and your end..."

(Picture of mom and baby, baby is lying on change table and mom is verbalizing to her)

...probably doesn’t make much more sense to an objective observer. But...

(Mother dressing child)

(Parents and baby interacting)

(Close up of mother talking to her baby, then close up of baby enjoying the attention)

“. . . it is a conversation nonetheless with baby listening as you talk, laughing, waiting for you to finish, and then babbling away earnestly in return."

(Close up of host)

"In contrast to all these highs can be some pretty devastating lows because this first year with baby is also tremendously stressful both emotionally and physically."

(Baby coming out of bath crying)

"After all you are living with someone who is completely dependent on you for absolutely everything."

(Mother is drying baby off with towel)

(Close up of host)

"We’ve devoted two videos to discussing your baby’s needs. Let’s talk about your needs, and your life with baby. Let’s talk about you."

(Music)

(RELATIONSHIPS)
"With us today is Daniel Bogue of the George Hull Centre in Toronto."

The Centre runs programs to help new parents make a healthy adjustment to life with a baby and build strong loving relationships with their babies. Daniel many parents comment that they give and give to the point of physical and emotional exhaustion and sometimes, well, they feel a little bit let down.

"... because it seems their child isn't giving them anything in return."

"... and it's easy for a parent to begin to feel resentful because this demanding little thing has turned their life upside down."

"Ah yes, that's very true. I think that if you understand the ingredients which create the relationship between the parent and the baby, you can see a process at work in these first trying months."

"... which can result in a very gratifying love relationship between you and your baby. In our work with parents at the George Hull Centre, a concept..."
which we find useful differentiates between attachment and bonding. The infant attaches to a parent, and a parent bonds to a baby.

"Could you expand a little on the differences between attachment and bonding?"

"According to this concept, attachment is necessary for survival. It's the process through which babies try to be close to someone who will fulfill their most basic needs. Bonding in this case refers to feelings of love, caring and commitment that a parent has to. As a parent provides for the baby's needs, provides the daily consistent care, responds lovingly to the baby, the baby's developing attachment to the adult is enhanced."

"If this early attachment is healthy, the effects can last a lifetime."

"That sounds straightforward enough. But in actual fact, quite a few things can interfere with that theoretically perfect circle of loving give and take between parent and child."

"The parent and child relationship life doesn't exist in isolation. Rather each life exists in a complex context of many other lives. Often this context is positive but it can bring problems as well. The important thing to remember is that babies are resilient, that parents and babies survive situations that are less than ideal."
"Even new mothers who have help with their babies and people around them to help keep their spirits up, may still find themselves weeping for no good reason."

"Yes, it is quite normal for new mothers to feel weepy or even intense unhappiness for awhile after giving birth. Your body is still recovering from the birth process. In the meantime the physical demands of taking care of a newborn are quite taxing. Naturally, emotions are somewhat confused."

"We have a built in bias in our society that women have a natural ability to care for children. In actual fact, each woman have to learn to be a mother and this is a complex task."

"Don't be hard on yourself if you find that things aren't falling into place overnight. If you still feel you can't cope, you may want to seek professional help. Your public health nurse or your family doctor should be able to point you in the right direction, to get the kind of help you need."

The First Year
Let's consider some ways to build the strength and endurance that will see us through this exciting first year with baby."

(Mother trying to breastfeed baby)

"If your baby is often awake at night, it might help to think of yourself as a shift worker and prepare in advance to work the night shift. If you're staying home with your baby, and this is the only child you have at home during the day, try sleeping whenever your baby sleeps."

(Close up of baby breastfeeding)

"If this is impossible, see if you can't get someone to spell you off from time to time."

(Mother pumping her breast with a battery operated pump)

"A breastfeeding mother could express milk, and let her partner share some of the nighttime feedings."

(Close up of collected milk in glass bottle)

"In households where both parents work outside the home, regular turntaking of nighttime caring could be negotiated between partners."

(Close up of baby in crib, with fingers in mouth)

"If your baby tends to be wakeful for long periods at night, you'll find it easier to cope with if you make the time more interesting for yourself. Here are some ideas which you might find helpful."

(Mother picking baby up out of crib and talks to him)

"You might explore nighttime television or radio or a favourite movie. Keep your mind active and let your thoughts roam free. Your body may be confined to pacing up and down a room with a fussy baby, but your imagination can run wild. A word of caution. However much you manage to stimulate yourself to stay awake and even tempered, your baby
should find the atmosphere soothing. After all, the idea is to lull baby back to sleep, not to convince baby that nighttime is as much fun as daytime, so keep the volume and the lights low."

(Baby bottlefeeding)

"During the day if one word could sum up an approach for this first year it would probably be "simplify". Simplify the meals you prepare, the housekeeping routine, your grooming routine. If you entertain, keep it simple."

(Baby bottlefeeding)

"Pare your life down to the essentials, the essentials for you and your baby."

(Mother leaning over baby, holding a toy)

"Decide what's important, and conserve your time, conserve your strength to keep yourself on track. Keep in mind that essentials include people, interests and activities that are important to you. It's easy to get caught up in a very tight relationship with your baby which excludes other people and other activities, particularly if you're staying home to take care of your baby. If you allow this situation to develop, you could end up feeling isolated and out of the mainstream."

(Three mothers and babies at a kitchen table)

"It's important to maintain the interests, activities, and the relationships and interests that make you feel that you're involved and evolving. If you take care of yourself and keep yourself in a happy frame of mind, taking care of baby will come much easier."

(Close up of happy mothers laughing)

(Close up of host in kitchen)

"Your network of family and friends can help you find the time and strength you need to build an interesting life with your baby and to feel that you're on top of things. This is
particularly true for mothers who work outside the home, for whom, finding quality time to
spend with their babies can be very challenging. Encourage your partner, your baby's
grandparents, your extended family, your friends to get involved with your baby's life."

(Mother and grandmother spoonfeeding twins)

(Father picking baby up out of crib)

"Your partner is probably not only the most interested person in this network, but also the
one likely to be on the scene most often."

(Picture of father holding baby over his shoulder. Baby has pacifier in his mouth)

"If you don't get an offer of help from this quarter, you may have to ask. Fathers are
sometimes uncertain about where they fit in the tight world of mother and baby. Create
opportunities for your partner to experience fatherhood and help him celebrate his exciting
new role."

(Father bottlefeeding baby)

"Spending time with the baby and getting involved in the daily routine is a wonderful
opportunity to build a relationship, to bond with this little life in your keeping. Grandparents
can add another dimension of love and security to your baby's life."

(Close up of mom leaving and grandmother picking up baby)

"They'll probably welcome the opportunity to spend time alone with baby."

(Close up of grandmother happily holding grandson)

"If other people in your network of friends and family offer help, tell them in very concrete
terms what they can do to help you. Don't be shy. Say that. . . ."

(Mother in kitchen holding baby and wiping her mouth)

". . . what you would really like is a couple of hours alone to go for a walk or see a movie
and ask if they could babysit for awhile, or say that you're finding shopping difficult and ask
them to add a few things to their shopping list for you."
(Mother greets friend who comes into kitchen, mother hands baby to friend and picks up.

bags of groceries friend has brought to her)

(Mothers and babies as a group)

"Spending some time with other new parents is also a comfort. Who else is as interested in

teething, colic and where to buy the best sleepers. If you’re staying home to care for your

baby, getting out and about and doing things, by yourself and with other people, will help

to combat feelings of isolation and being out of the mainstream. Babies are extremely

portable. Snuggle your baby into a carrier and away you go."

(Scene of mother putting baby into a stroller, not a carrier)

(Close up of baby in stroller)

“If your baby typically sleeps at a certain time each day, schedule that time to meet that

friend for lunch and let baby take her nap while you chat. You may even be able to use

baby’s nap time to take in a movie."

(Close up of host in nursery)

“If you have artistic interests, a gallery or museum visit with your baby snuggled into a

carrier, can keep your mind active and provide soothing movement for a baby who likes to

be kept on the move. Of course you don’t have to do anything in particular. Long walks on

a milk day get both you and baby out into the fresh air and help keep your body fit and

your outlook bright."

Your Needs

(Interview Scene)

(Host and guest dressed in red)

“We’re now joined by Anne Secord-Houston..."
There's that whole question of how you get your sexual life going again. Anne do you have any guidelines about when it's safe to resume sexual intercourse?

There are medical guidelines. Your doctor should be able to tell you at your 6 week check up whether your body has healed sufficiently, so that intercourse will not cause physical damage. This check up would be a good time to discuss an appropriate birth control method with your doctor. Contrary to a widely held belief, breastfeeding is only partial protection against pregnancy.

Medical issues aside, when is a new mother likely to feel sexual again?

Good question. In the first chaotic months with a baby, you may feel that you need to schedule sex along with the feedings and diaper changes, it can feel like a race against the clock. Also, everyone has a different sexual personality, different needs, different expectations. Some mothers may experience no more than a mild discomfort the first few times they have sex again, while other mothers may find it so painful that they are disinclined to try again for quite some time.

Women, whose babies sleep through the night at an early age, may get enough sleep so that they return to normal quite quickly, whereas women who know they are going to spend a big chunk of the night walking the floor with a colicky baby might be less than
enthusiastic to the suggestion of having sex. A woman in this situation might see her partner’s sexual interest as just another demand on her already exhausted body."

"Building a relationship, any relationship, starts with communication and it may help to put this first year in perspective if remember that well built foundations will weather a lot of storms."

So we leave you now with the exciting world of parenting. And remember, if you want to learn more, you can always refer to the other videos in this series. For “Your Baby, Your Doctor, and You” I’m Liliane Klue."