DRY UP or SPEAK OUT?

The Challenges of Breastfeeding as a Healthcare Worker

Text by Dr Joanna Chan Shi-En

Doctors and other healthcare workers generally make resilient mothers due to what we have already survived. A discussion with fellow doctor mothers revealed a roughly 50-50 split on whether taking care of a newborn is tougher than our year as house officers (HOs). For me, my HO year was a more anxious time and my basic needs of food, water, peeing opportunities and sleep were met less of the time.

When these tough mothers are asked to describe difficulties faced during pregnancy and beyond, one bugbear is the difficulty of doing calls (which includes setting lines, intubating and going up to 30 hours without sleep) up until 28 weeks of pregnancy. Currently, many pregnant doctors are not given a choice. "Has any doctor ever told a pregnant patient to work 24- to 30-hour shifts? Yet we do it to ourselves," says a colleague.

However, one of the most difficult concerns for mothers in healthcare is breastfeeding. The important message that "breast is best" is drilled into doctors in the public healthcare sector, because of the immunological benefits which breastmilk confers on the developing infant. There is, however, a gap between what we preach and what we are able to practise in our own practice of childrearing.

A straw poll which I conducted among mothers working in different public hospitals revealed some common threads.

Lack of protected time during working hours

When meal breaks are short, we must make a choice between eating and pumping, which deters many mothers from pumping during working hours. Some emergency department (ED) nurses have found a way to hack the short meal break by purchasing the Freemie (a hands-free pump) to allow simultaneous eating and pumping. The Freemie is also favoured by surgeons and anaesthetists.

Theoretically, the demands of daily work may allow mothers in senior roles more leeway to pump. Unfortunately, the availability of a meal break to a doctor, whether junior or senior, is dependent on the state of the shop floor, and the presence of sick patients in crisis, and is not guaranteed, regardless of whether one owns a Freemie. In addition, this method does not drain the breast completely and cannot keep up supply without supplemental pumping before or after an already busy work day.

Lack of appropriate facilities

For many of us who do not have the good fortune to be working in KK Women's and Children's Hospital (KKH), which was repeatedly cited by paediatric and gynaecology colleagues as the pinnacle of excellence where facilities and attitudes encouraging lactation among its employees are concerned, the experience is variable.

> "In any busy ED, our meal times can be as short as five minutes where we gobble our food down, or no time at all for meals (and to pump). [Some departments use a round robin system while others have a numbers quota]; they do not stop your queue and patient load will build up. It is not possible to pump at least once in an eight hour shift, not to mention that some shifts last longer than eight hours and most of us do not end on time."
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> **– Junior doctor, emergency medicine**

> There was no designated lactation room. I mostly pumped in what was supposed to be a breastfeeding/diaper change room at the medical centre, but it often smelt of poo. While the department and section heads verbally supported breastfeeding, requests to have at least one lactation room in the department were denied citing space constraints. There was also no protected time for pumping as patients always come first. Needless to say, my supply dropped drastically when I returned to work when my firstborn was eight months old."
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> **– Speech therapist**

> In my hospital, there's a lactation room with a card access system, divided into three sections by curtains. However, it's small, not the cleanest and shared with the whole hospital. Luckily, I had supportive colleagues who didn't mind when I hogged the call room to pump."
>
> **– Senior doctor, cardiology**

> In one particular institution, there were many female staff but no nursing room at all. I pumped in a tiny storeroom where blankets, wheelchairs and cardiac tables were kept; while pumping, I was often disrupted by requests to open the door. On one occasion, the milk almost spilled when they were moving a cardiac table. On another occasion, the nurse insisted on cleaning the room so I had to pump in the toilet; the staff there claimed it's the cleanest room in the building, but how can a toilet ever be clean?"
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> **– Pharmacist**

Note: The above three examples given are from the three different healthcare clusters, illustrating the near universal nature of the problem in the public healthcare sector.

Mental barrier concerning attitudes towards those who pump

Many mothers are made to feel that we are given special favour and inconveniencing the department if we take time out to pump. For a mother finding her feet again after a period of maternity leave and afraid of attracting more criticism, this mental barrier can in itself be a deterrent from pumping.

Institutional support for breast-feeding employees in our public hospitals remains primitive. Last year, at the groundbreaking ceremony of a new emergency medicine building at the Singapore General Hospital, a cheerily designed board sported a collection of "Dreams and Wishes" for the new beginning. Contributed by staff members, a prominent wish was the expressed desire for a lactation room. A Very Important Person, herself a mother, was heard scoffing, "Lactation room? Where do you have time for breastfeeding in the ED?"

With signals like this from the leadership, where indeed?

Challenges of shift work and long calls

Mothers who work regular office hours may sometimes be subject to reverse cycling (where the baby latches more at night to make up for maternal absence in the day). This option is not possible if the mother is doing a call or a night shift.

Also, what they don't tell you before you become a parent is how closely breastfeeding is related to your baby's sleep. While direct latching is best done for bonding and growing, and maintaining supply, a breastfed baby who is used to direct latch is prone to feed to sleep. When the mother is on call or on shift, the spouse will be saddled with a baby used to latching back to sleep. This transfers some of the sleep debt to said supportive (or suffering) spouse. While different families have developed their own coping methods, the baby may have to be weaned off the breast altogether to avoid this if this arrangement is not tenable.

In conclusion

It is no wonder, then, that many of us are mentally prepared to "dry up" soon after going back to work. It is in anticipation of the difficulties with breastfeeding that many female doctors and healthcare workers ask for a period of no-pay leave. However, no-pay leave cannot always be granted. Those who cannot resign themselves to a period of shorter breastfeeding than they would like may sometimes resign instead from the public healthcare sector, as in the case of the speech therapist quoted above. She was a valuable worker who nevertheless eventually felt compelled to make the choice to leave in order to breastfeed her second baby, which she felt was incompatible with not letting down her department. The irony is that as healthcare workers in a first-world nation, we ourselves may be unable to comply with the World Health Organization's recommendation of exclusive breastfeeding for the first six months of life. ◆

Dr Chan is an emergency medicine doctor expecting her third child. She was kindly allowed ten months off work after her first two deliveries to breastfeed as the prospect of pumping on a busy shift was too daunting, but will have to make it work for the third one when she returns to work after four months.