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“WHY EVEN BOTHER? THEY ARE NOT GOING TO DO IT”: RACISM AND
MEDICALIZATION IN THE LACTATION PROFESSION

by

ERIN THOMAS ECHOLS

Under the Direction of Wendy Simonds, PhD

ABSTRACT

Research confirms that breastfeeding disparities persist and that lactation consultants play a key role in reducing them. However, there continues to be a limited availability of International Board Certified Lactation Consultants (IBCLCs) in the US with racial minorities in particular facing persistent barriers in the certification process. Through semi-structured interviews with 36 IBCLCs across the US, this study takes a systematic look at breastfeeding disparities through the lens of the IBCLC. Specifically, this study addresses barriers to certification and employment discrimination faced by IBCLCs of color, race-based discrimination against patients, and the ways in which IBCLCs work to both medicalize and demedicalize breastfeeding. Each of these areas can impact breastfeeding equity, and each help

to reveal the ways in which race, class, gender and medicine shape views and practices related to lactation and motherhood.

Cost and the increasingly university-focused approach of the IBCLC certification process are found to be significant barrier for participants. Race-based discrimination during the certification process and in the workplace is also an ongoing and persistent reality that affects participant's relationships with patients and coworkers and their ability to secure workplace resources and to advance in their careers. IBCLCs report instances of race-based discrimination against patients such as unequal care provided to patients of color and overt racist remarks said in front of or behind patient's backs. Finally IBCLCs are found to demedicalize breastfeeding, but they often lack the authority to change breastfeeding policies. They also engage in other work that medicalizes breastfeeding and perpetuate the idea that mothers are anxiety-prone patients in need of professional intervention.

INDEX WORDS: breastfeeding, lactation consultant, employment discrimination, patient discrimination, racism, medicalization, health equity, breastfeeding disparities

“WHY EVEN BOTHER? THEY ARE NOT GOING TO DO IT”: RACISM AND
MEDICALIZATION IN THE LACTATION PROFESSION

by

ERIN THOMAS ECHOLS

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2017

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“WHY EVEN BOTHER? THEY ARE NOT GOING TO DO IT”:
RACISM AND MEDICALIZATION IN THE LACTATION PROFESSION

by

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May 2017

DEDICATION

For Coleston – without whom this work would have never happened.

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I would like to first thank the participants who trusted me with their stories. I know firsthand how meaningful the work you do each day is for new mothers in particular. I hope that I have done your stories justice and that the product of this work assists you and others in the field. Secondly, I would like to thank my parents, whose unending support has propelled and sustained me through both the best and worst moments of my life. I love you both. Finally, to the many other people who have supported me intellectually, emotionally and financially as I pursued a PhD and worked on this project. None of this would have been possible without you.

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1 INTRODUCTION

Debates about breastfeeding have played a central role in medicine, labor arrangements, ideologies of motherhood and politics. For example, views of breastfeeding have changed considerably across time with breastfeeding seen at times as a task for lower class wet-nurses to perform. Today a wet nurse arrangement is generally seen as morally reprehensible and medically problematic. Medical professionals expect mothers to breastfeed their own children, acquire donated breastmilk from a formal, medical-approved milk bank or use formula. Attitudes about formula and its relationship with breastfeeding have also changed considerably.

Medical providers called breast milk into question in the early 1900s and increasingly came to consider formula a more suitable and modern infant food source. (Apple, 1987; Wolf 2001). Breastfeeding rates plummeted during this time and the natural childbirth movement and the women's health movement both fought to address the problems caused by the medicalization of birth and breastfeeding in the mid-20th century (Blum, 1999; Rothman, 1982; Sandelowski, 1984; Wertz and Wertz, 1989). Modern medical organizations and professionals now generally recognize the potential medical benefits of breastfeeding and attempt to support breastfeeding as a primary infant feeding choice. However, debates surrounding the medicalization of breastfeeding – the process by which breastfeeding comes to be seen as a medical event in need of medical management – continue to occur.

As views on breastfeeding have changed, so have the politics and policies that surround breastfeeding. There are ongoing political debates about adequate breastfeeding accommodations for working women and what insurance companies should be required to pay for in relation to breastfeeding. The Affordable Care Act (ACA) mandated that insurance companies pay for lactation support without co-payments. There are also specific ACA

provisions for insurance-covered breast pumps. Yet the National Women's Law Center (2015) reports that insurance companies have failed to comply by denying coverage to women on the basis of state licensure issues. With the election of Donald Trump, there is increased uncertainty about the state of these policies and other breastfeeding-related laws. Trump has expressed opposition to the ACA and has also been accused of referring to Elizabeth Beck, an attorney, as "disgusting" when she requested a break from a deposition in order to pump breast milk. (Diamond, 2015).

Class, race and gender have also shaped views of breastfeeding. Breastfeeding has, at times, been relegated to the lower class, and, at other times, it has been a symbol of upper class status. In the US, enslaved women were required to breastfeed their master's offspring even at the expense of their own children. These practices continue to shape how breastfeeding is viewed by various groups today (Collins 2002).

Breastfeeding has similarly affected women's roles in the family and the workforce and has shaped the ways in which motherhood is thought about across time. As breastfeeding first began to be seen as a medical event, and formula was considered by doctors to be superior, "good mothers" were those who spent money on expensive formula and dutifully followed the physician's advice. Good mothers have also been framed as individuals who expend a tremendous amount of time, energy, and money in raising their children" (Hays 1996). This model of "good" and "bad" mothering is both racist and classist since it ignores the historical and economic realities that make intensive mothering more readily available to White and middle class women rather than Black or lower class women (Collins 2002; Blum 1999; Hays 1996).

These images of motherhood have been tied to breastfeeding movements and organizations, which have also been influenced by race and class. La Leche League International, a

breastfeeding support and education organization, was founded in 1956 by seven White, middle-class, Roman Catholic mothers. The League has a documented history of being dominated primarily by middle class Whites. (Weiner, 1994).

Today, the CDC, the Surgeon General and the American Academy of Pediatrics recommend breastfeeding for at least the first year of a child's life. However, 13 states have a gap between Black and White breastfeeding initiation rates of at least 20 percentage points (CDC, 2010). Researchers have proposed a number of sites of intervention to address these gaps. One of these interventions involves increasing the number of International Board Certified Lactation Consultants (IBCLCs). IBCLCs are professionals who "provide expert breastfeeding and lactation care" (IBLCE, 2016).

Because of mounting evidence that IBCLCs help to significantly improve breastfeeding rates in the US, the surgeon general has identified increasing access to IBCLCs as an action step to support breastfeeding (U.S. HHS, 2011). However, IBCLCs of color continue to face significant barriers to certification, report employment discrimination, and describe ongoing instances of race-based discrimination in breastfeeding services. At the same time, IBCLCs of all races report that they face significant barriers in their work to demedicalize breastfeeding, because they are inhibited by medical norms and hospital policies that place physicians at the top of the professional hierarchy. This means that all IBCLCs, but lactation consultants of color in particular, have relatively little direct power or agency to improve breastfeeding disparities.

Using semi-structured intensive interviews with IBCLCs across the US, I take a concerted look at the lactation consultant profession in order to identify 1) barriers that lactation consultants of color face in becoming certified, 2) employment discrimination faced by IBCLCs

of color, 3) race-based discrimination against patients and 4) the ways in which IBCLCs work to both medicalize and demedicalize breastfeeding in the US.

1.1 Methods

Data for this study comes from semi-structured, intensive interviews with 36 IBCLCs across the United States. An intensive interview involves a pre-constructed research guide with open-ended questions designed by the researcher. This method was chosen in order to capture stories, feelings and thoughts that are often not available through other methods (Berg 2009, Gubrium and Holstein 2003; Weiss 1994, Lofland et al. 2006).

I recruited interviewees through the distribution of ads on various professional lactation networks, breastfeeding advocacy groups and a listserv for professional lactation providers. I added additional interviewees through snowball sampling. Interviewees included IBCLCs from private practice, hospitals, physician offices, WIC, non-profits and public health agencies. Each interview lasted approximately one hour and was conducted between November 2015 and March 2016. Participants were randomly assigned pseudonyms and study materials were labeled accordingly.

Relying largely on LaRossa's (2005) description of grounded theory, I conducted the first phase of analysis using open coding, in which similarities and variations in indicators are linked with concepts in order to begin forming variables. Next, I performed axial coding by linking variables to form a framework which I used to explain the data. Lastly, I conducted selective coding in order to develop core categories. I coded the interview transcripts with QSR NVivo. I have reported raw data from the interviews to demonstrate how the data and my interpretations of them relate and to allow the participants' voices to be expressed directly.

1.2 Theory

In this study, I utilize intersectional theory in order to examine these inequities. Intersectional theory began with the work of researchers examining the experiences of women of color (Browne and Misra, 2003). Black feminist theorists have informed intersectional approaches and placed considerable focus on the ways in which race and gender interact to affect outcomes in the labor market (Brewer, 1993; Collins, 2002; James and Busia, 1993). Separate theories of race and gender, they argue, are insufficient to explain the ways that race and gender affect the lives of women of color in ways that are “simultaneously linked” (Bambara, 1970; Brewer, 1993; Glenn, 1999; hooks, 1989; Hull et al., 1982; Spelman, 1988).

Black feminist theorists assert that both race and gender are social constructions that change across time and place (Collins, 2002; Espiritu, 1992; Glenn, 1999; Lorber, 1994; Mullings, 1997; Omi and Winant, 1994). For example, previous definitions of race relied on the “one drop rule” – which deemed anyone with “one drop” of “Black blood” to be Black. Census definitions of race have also changed historically. For example, they shifted to allow once separate “races” (ex. Italians, Irish) to be grouped under one White category and various races have been added and removed across time (Wright, 1992). Similarly, gender is socially constructed to maintain existing hierarchy (Ammott and Matthaei, 1991; Lorber, 1994). This means that the meanings we attach to gender go beyond any biological or physiological differences and are reproduced through social interaction (Ammott and Matthaei, 1991; Lorber, 1994; Festermaker and West, 2002).

Despite being socially constructed, race and gender continue to serve as organizing principles for the social system, influence individual identities, and produce social hierarchy (Collins, 2002; Glenn, 1999). Intersectional theorists argue that race and gender are

interconnected categories that do not function independently and cannot be addressed through an additive approach (King, 1989; Weber, 2001; Reskin and Charles, 1999). As Browne and Misra (2003), explain “race is ‘gendered’, and gender is ‘racialized’.” Intersectional theorists contend that the intersection of race and gender not only shapes the opportunities and experiences of women of color but also shapes the experiences of everyone else (Amott and Matthawi, 1991; Collins, 2002; Essed, 1991; Glenn, 1999, Higgenbotham, 1997, Hondagneu-Sotelo, 1994; Kibria, 1990; Landrine, 1985).

Patricia Hill Collins (2002) uses the concept “matrix of domination” to describe the ways that systems of race, class and gender are interlocking. The matrix of domination makes it possible for someone to experience both oppression and privilege simultaneously. Black feminists also articulate the ways in which race and gender are linked by noting that traditional characteristics used to describe femininity, such as passivity, are actually the ways in which White women in particular are described. Black women, in contrast, have often been described in opposition to the ideals of White femininity (Collins, 2002). Collins also identifies that Black women are stereotyped by the popular tropes of the welfare queen, the Mammy and the Jezebel.

Intersectional theory is important for understanding the labor market outcomes and experiences of IBCLCs because race, class and gender work together to shape workers’ interactions with bosses, clients and coworkers. For example, the literature suggests that White, female workers will be more likely to be seen by bosses, colleagues and patients as possessing the qualities and skills expected within the medical system, because the medical environment privileges White, middle class norms of femininity, professionalism and emotional expression. Taking an intersectional approach is an imperative step to understanding inequality in lactation and potential solutions to address those disparities.

A robust understanding of the IBCLC profession provides a window into the ways in which race, class, gender and medicine shape attitudes towards both work and motherhood. This work is an important exploration into one site of intervention for reducing breastfeeding disparities. It also contributes to the literature on employment discrimination, patient discrimination and medicalization and applies a critical and currently missing intersectional lens to lactation.

2 “YOU KNOW IF YOU QUIT THAT’S FAILURE, RIGHT?”: A SYSTEMIC FOCUS ON RACE-BASED BARRIERS TO PROFESSIONAL LACTATION CERTIFICATION

Breastfeeding for at least the first year of a child’s life is recommended by the CDC, the Surgeon General and the American Academy of Pediatrics. The medical community emphasizes the benefits of breastfeeding including: lower rates of obesity, infection, and post-neonatal death for babies, and a decrease in the risk of breast and ovarian cancer for mothers (Singh et al., 2007; Gartner et al., 2005). Scientific research also suggests that each additional week of breastfeeding can reduce the likelihood that a child will be sick enough that the parents will seek the intervention of a medical provider (Pettigrew et al., 2003). Professional support during breastfeeding has been shown to increase mothers’ rates of breastfeeding initiation and duration (Castrucci, 2006, DiGirolamo, 2003, Ma and Magnus, 2012; Caulfield et al., 1998; Taveras et al., 2004; Britton, 2007; Chung et. Al, 2008; Hopkinson, 2009; Bonuck, 2005).

International Board Certified Lactation Consultants are professionals who “provide expert breastfeeding and lactation care” (IBLCE, 2016). Because of mounting evidence that IBCLCs help to significantly improve breastfeeding rates in the US, the surgeon general has identified increasing access to IBCLCs as an action step to support breastfeeding (U.S. HHS, 2011). However, 11 states have a limited availability of professional lactation support (CDC, 2014). Lactation consultants of color face unique barriers to certification and employment (Carothers C., 2014; Payne, 2014; Mojab 2015; Lactation Summit Design Team, 2014).

Reducing barriers for people of color who seek IBCLC certification is important because, over the last decade, researchers have gathered mounting evidence of racial discrimination in the provision of medical services. These studies document differences in the diagnosis and treatment

of patients on the basis of race and provide consistent evidence that medical providers exhibit both conscious and unconscious racial bias that affects the service that patients receive. Black medical providers are shown to exhibit less of this implicit bias (Green et al., 2007; Sabin et al., 2009; White et al., 2009). Through qualitative analysis of interviews with a diverse group of IBCLCs across the US, I systematically explore barriers to IBCLC certification for the first time and place particular emphasis on race-related inequalities.

Increasing IBCLC certification for people of color and reducing race-based patient discrimination in breastfeeding services is critical given current breastfeeding disparities. Some racial gaps in breastfeeding have declined across time, but 13 states have a gap between Black and White initiation rates of at least 20 percentage points (CDC, 2010). Southern states remain particularly unequal (CDC, 2010). Between 2004 and 2008, Blacks had lower rates of breastfeeding initiation and duration in all states except for Rhode Island and Minnesota (CDC, 2010). Studies show that Black/White gaps in initiation and duration persist even when maternal age, income, education, rates of marriage and other explanatory variables are held constant (CDC, 2004).

Professional lactation support can improve rates of breastfeeding initiation and duration for women of color (Bonuck, 2005). Despite this, International Board Certified Lactation Consultants (IBCLCs) are not always readily available (CDC, 2014), are not consistently covered by insurance (Chetwynd et al., 2013), and IBCLC candidates must confront structural barriers that prevent racial minorities, in particular, from getting and maintaining certification (Carothers C., 2014; Payne, 2014; Mojab 2015; Lactation Summit Design Team, 2014). This means that Black women and babies have significant barriers to breastfeeding and are more likely to experience racial discrimination at the hands of non-Black medical providers. At the

same time, Black lactation consultants – those best poised to assist mothers of color - face significant barriers to certification. This creates a cycle of inequality for Black women in particular that must be addressed.

2.1 Background

2.1.1 History and Benefits of Lactation Support

The professionalization of lactation consultants began after La Leche League, a mother-to-mother breastfeeding support program, sought to improve breastfeeding rates that were as low as 20% in the mid-1950s. La Leche League International convened a panel of 60 experts in 1985 to develop standards that continue to shape the scope of lactation practice today. The International Board of Lactation Consultant Examiners was formed as a result of the panel, and the IBCLC remains the only internationally-recognized credential for lactation professionals (Thurman et al, 2008). IBCLCs receive certification after they complete the requirements for eligibility and pass an exam given by the International Board of Lactation Consultant Examiners. In 2013, there were 3.5 IBCLCs for every 1,000 live births - an improvement from 2.1 in 2006 (CDC, 2014).

Data from 11,525 births in Philadelphia reveal that delivering in a hospital that employed IBCLCs improved breastfeeding initiation by 2.28 times even when researchers adjusted for race/ethnicity, education, insurance status, age, marital status, route of delivery, birth weight, and gestational age. For women receiving Medicaid, the increase was even higher, at a 4.13 times increase in breastfeeding initiation (Castrucci, 2006). Studies have also found that increasing the level of intervention provided by lactation professionals through follow-up calls, for example, can significantly impact breastfeeding initiation and duration for Latina and Black mothers in particular (Bonuck, 2005). For mothers of babies admitted to the NICU, breastfeeding rates have been found to be higher when the hospital employs an IBCLC (50% rate of breastfeeding) versus

when hospitals do not employ an IBCLC (36.9% rate of breastfeeding) (Castrucci et al., 2007). In the state of New York, lactation consultants are mandated at hospitals where births occur and were responsible for an increase in breastfeeding rates in the 1980s and 1990s, when breastfeeding rates elsewhere fell (Rosenberg, 1998).

Women who receive encouragement to breastfeed from a nurse or physician are found to be four times more likely to breastfeed (Lu et al, 2001). This finding remains true for mothers who are statistically less likely to breastfeed. There is a “threefold [increase] among low-income, young, and less-educated women...[and a] nearly fivefold [increase] among Black women” (Lu et al, 2001). Lactation consultants are shown to give more positive encouragement for breastfeeding than nurses or physicians (Humenick et al, 1998). Nurses cite a lack of lactation training in their education (Hellings and Howe, 2000; Register, Eren, Lowdermilk, Hammond, and Tully, 2000), and Bunik, Gao, and Moore (2006) note that physicians are not adequately instructed in lactation.

2.1.2 The IBCLC Certification Process

While the specific requirements to sit for the IBCLC exam have fluctuated over the years, candidates have generally been required to complete an education component and engage in clinical practice. The education requirements for certification have changed considerably across time. As the education requirements to sit for the exam have evolved, the IBLCE board has placed increased emphasis on more formal and institutional forms of education through universities. Under current IBLCE requirements, candidates are required to complete 14 health science courses from an accredited institution in biology, anatomy, physiology, child development, sociology, counseling, nutrition and other disciplines. IBLCE requires these courses regardless of the pathway that the candidate chooses. However, because nurses and other

health professionals often already hold a degree, these credits are generally already fulfilled through their previous university experience. Current IBLCE guidelines also require candidates to complete an additional 90 hours of lactation-specific education.

Depending on the pathway that a candidate takes, clinical hours can range considerably. Under current eligibility criteria, candidates who are recognized health professionals (ex. nurses, dietitians, physical therapists) must complete 1000 hours of lactation-specific clinical practice. Individuals in accredited academic programs for lactation need 300 hours of directly supervised clinical experience, and candidates who pursue the mentorship pathway must complete 500 hours of directly-supervised clinical experience.

A number of more detailed rules surround what does and does not count as clinical experience. For example, recognized health professionals are allowed to count the one-on-one breastfeeding support they provide to mothers as part of their daily jobs in their hours. This means that a NICU nurse can count the hours she spends in her job with mothers related to lactation as part of her clinical hours. Those who use volunteer hours to fulfill this requirement must provide lactation services through an IBLCE-recognized mother support counselor organization.

Volunteer hours are also regulated in other ways. A WIC peer counselor can only count hours if the direct supervisor is an IBCLC or a recognized health professional, works in the same location, and is willing to verify the accuracy of her clinical hours. Individuals who complete volunteer work in person are treated more favorably (500 hours per year of volunteering) than volunteers whose work is done online or via the phone (250 hours per year of volunteering), and candidates cannot report gaps in their volunteer experience – only continuous years of paid or volunteer service can be counted in the clinical hours. This means that mothers who leave their

position for a time (due to pregnancy or in order to provide care to a family member) and candidates who lose their jobs and then regain their position (due to changes in lactation funding at their agency) could experience significant delays in their certification process.

2.1.3 Racial Inequality in Certification

Some significant conversations around inequities have begun to develop within the lactation profession. To commemorate the 30th anniversary of the lactation profession in 2015, three lactation organizations (IBLCE, ICLA, and LEAARC) joined together to address issues of access in the profession. The 2014 Lactation Summit was organized to address inequities in the profession and listen to barriers to certification that were experienced by attendees. The summary report that followed, “2014 Lactation Summit: Addressing Inequities within the Lactation Profession,” provides insights into some of the barriers to certification and employment faced by different groups. However, the summit and the responses of participants were never recorded or studied systematically. It is imperative that researchers address this gap in order to provide an adequate understanding of the barriers that racial and ethnic minorities face within the IBCLC profession and how this may affect patient care and breastfeeding equity (Carothers C., 2014; Payne, 2014; Mojab 2015; Lactation Summit Design Team, 2014).

2.2 Methods

Through semi-structured, intensive interviews with 36 IBCLCs across the United States, this study details the certification process for a diverse set of IBCLCs in order to understand the barriers that candidates of color face in reaching the highest level of lactation certification. An intensive interview involves a pre-constructed research guide with open-ended questions designed by the researcher. However, it also involves “ordinary conversation and listening as it occurs naturally during the course of social interaction and semi-structured interviewing”

(Lofland et al. 2006:17; Berg 2009; Weiss 1994). Qualitative interviewing is designed to capture stories, feelings and thoughts that are often not available through other methods (Berg 2009, Gubrium and Holstein 2003; Weiss 1994, Lofland et al. 2006). Intensive interviews allow researchers to better understand how participants make meaning of their certification experiences. This approach considers how dominant frameworks regarding race and gender shape the lived realities of respondents.

I identified potential interviewees through the distribution of recruitment ads on various professional lactation networks, breastfeeding advocacy groups and a listserv for professional lactation providers. I added additional interviewees through snowball sampling. Interviewees included IBCLCs from private practice, hospitals, physician offices, WIC, non-profits and public health agencies. Each interview lasted approximately one hour and was conducted between November 2015 and March 2016. All participants were IBCLC-certified at the time of the interview. Participants were randomly assigned pseudonyms and study materials were labeled accordingly.

Relying largely on LaRossa's (2005) description of grounded theory, I conducted the first phase of analysis using open coding, in which similarities and variations in indicators are linked with concepts in order to begin forming variables. Next, I performed axial coding by linking variables to form a framework which I used to explain the data. Lastly, I conducted selective coding in order to develop core categories. I coded the interview transcripts with QSR NVivo. I have reported raw data from the interviews to demonstrate how the data and my interpretations of them relate and to allow the participants' voices to be expressed directly.

2.3 Findings

Table 1 provides descriptive statistics for the sample population. Women make up the majority (N= 35; 97.22%) of the sample. This is not surprising since the lactation consultant profession is a pink-collar profession. Respondents self-identified their race in an open ended question. People of color make up just under half of the sample (N=16; 44.44%) while Whites make up 55.56% (N=20). The majority of respondents of color identify as Black, two identify as multiracial (ex. Black and Asian) and one participant identifies as Hispanic. The age range of the participants concentrates slightly in two age-groups. Participants between the ages of 30 to 39 make up 36% of the sample (N= 13), and participants between 50 and 59 make up the next largest age group in the sample (N = 11; 30.5%). A college degree is not required for certification as an IBCLC, but participants in the sample are highly educated with 44.44% (N=16) holding a bachelor's degree and 44.44% (N = 16) holding a master's degree or higher. Participants live across 15 different states that geographically span the United States. Respondents are most likely to be employed in hospitals (N= 12; 33.33%) or private practice (N= 11; 30.56%). Others employers include WIC agencies, federal programs and pediatric offices.

When the sample is separated by race, Whites concentrate in hospitals and private practice. Respondents of color are more evenly spread across job sites. Respondents of color in the sample are more likely to be younger with 68% (N=11) reporting between the ages of 30 and 39. By contrast, White respondents in this study tend to be older with 45% between the ages of 50 and 59 (N=9). There are no significant differences in the level of education between White and Black respondents in this sample. About half of the participants for this study were providers

of varying sorts before becoming IBCLCs. Most participants were nurses prior to certifying as lactation consultants. Others were dietitians, childbirth educators or doulas.

2.3.1 Initiation into the lactation profession

When participants were asked what initially got them interested in the lactation certification process, they cite a variety of reasons: they became interested after giving birth, they want to help or had a passion for breastfeeding, they were already an IBLCE-recognized health professional and wanted to improve their skills and/or they became connected to the IBCLC profession through a breastfeeding organization. Most women report that their interest in breastfeeding and the IBCLC certification began after the birth of their child/children. In Terri's case, "I think the experience of transitioning to motherhood and trying to breastfeed was just so awful that I really had a motivation to help other people not go through the same thing. It seemed so wrong that there was so little help available at that time and how unpleasant it had been." Like Terri, many participants also express an interest in helping others, "a passion for service to [women]" and that they "really enjoy helping breastfeeding mothers and... learning about lactation."

Participants who were IBLCE-recognized health professionals prior to certification expressed interest in improving their knowledge and skills around breastfeeding; As Lynda, a 50 year old White IBCLC, said: "Seeing mothers before and during and then after labor, I realized that I would see them at home after labor. I realized I really needed to know a lot more about breastfeeding." Participants became connected to the IBCLC profession through various breastfeeding organizations — most commonly, La Leche League International (LLL) or Women, Infants and Children (WIC).

There are no significant racial differences in most of the reasons that IBCLCs initiate certification – for example, both Black and White participants in this study were similarly likely to come to the profession as medical providers. However, there are significant racial differences in the organizations that consultants come to the profession from. The overwhelming majority of consultants who said they came to the profession through their experience with La Leche League International (LLLI) are White. Only one Black participant reports coming to the profession through her participation in LLLI.

The racial differences in LLLI membership are not surprising given previous research on the origins and evolving philosophy of the League. La Leche League was founded in 1956 by seven White, middle-class, Roman Catholic mothers who were not employed in the paid labor market. While the League did not present itself as an exclusively White, middle class or Roman Catholic organization, it has a history of being dominated primarily by middle class Whites. This is in large part because of the ideology that LLLI has espoused. The league was founded as a push against scientific mothering. Scientific mothering is the idea that mothers need to be formally trained to be “good” mothers, that “good” mothers defer to expert advice on child rearing and that babies should follow strict schedules. Instead, the ideology of intensive mothering was evident in La Leche League’s philosophies and materials (Weiner, 1994).

The ideology of intensive mothering is “a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children” (Hays, 1996). Within the ideology of intensive mothering, a “good” mother is most often presented by proponents as White and middle class. In contrast, the “bad” mother selfishly works in the paid labor market in order to afford luxuries, ignores the cries and bonding needs of her child(ren), and allows other women to care for her children (Hays 1996). This model of “good” and “bad” mothering is both

racist and classist since it ignores the historical and economic realities that make intensive mothering more readily available to White and middle class women rather than Black or poor women (Collins 2000; Blum 1999; Hays 1996; Walker 1983).

Tanya, a Black, 30 year old participant, echoes the findings from this research when she recalls her first experience attending LLLI, “The first few groups that I went to – nothing bad about them – but I knew that they wouldn’t work for women of color.” She goes on to describe feeling that most the women in LLLI were “homemakers” who had “an entire system of parenting” that did not seem like a realistic option to her and other mothers like her who may need to return to paid work, be the primary earner in their household, or have other experiences that fall outside the norms of intensive mothering.

Differences in who comes to the profession through LLLI are important, because the organization can have an impact on the resources, support and social networks that are available to prospective IBCLCs. LLLI is one of the most well-known breastfeeding organizations internationally, and it was the organization that established the IBCLC certification in the first place. White participants who connected to the profession through LLLI report gaining access to education hours, clinical hours, exam preparation materials, textbooks and other lactation resources through the organization. These resources helped White participants navigate the certification process and prepare for the exam. In addition, several of the participants who were connected to the profession through the League also report that they received job leads, mentorship, opportunities for professional networking and professional socialization through LLLI.

In contrast, IBCLCs of color in this study were more likely to report gaining access to the profession through WIC (N=10; 62.5%) than Whites (N=6; 30%). These women started as

breastfeeding peer counselors. In general, the breastfeeding peer-counselor position is designed to be held by a mother who is a WIC-recipient or former WIC-recipient and has breastfed her child(ren) for at least 6 months. As Renee, a 40 year old White IBCLC, reports, there are some exceptions to this rule: “I actually got a job at WIC as a WIC peer counselor even though I was not a peer – I was never a WIC mom, but at that time they had a real hard time hiring WIC moms because, quite honestly, the pay was so low.”

As Renee’s account suggests, the low pay of WIC peer-counselor positions can be a barrier to certification. WIC peer counselors still incur a number of costs in their certification process that may be particularly daunting given their income. Individuals in WIC positions also lack job security due to the changing nature of state and federal funding for programs that promote breastfeeding. These fluctuations in funding affect participants' economic stability. Renee recalls her own experience with the uncertainty of WIC funding: “You know, federal government budget time, WIC always gets cut back each year at the beginning of the fiscal year in October. But you never really feel secure at WIC that your job is going to last a long time or that your hours are going to be steady. Your hours go up and they go down based on funding.” When WIC connects individuals to jobs and positions, it is most often to other jobs in the WIC clinic where pay is similarly low, advancement is limited, and job security is uncertain.

The WIC peer-counselor program provides a variety of supports during the certification process. Respondents report that WIC offered them paid clinical hours and/or free or low-cost education hours. However, as Henrietta – a 30 year old, Black IBCLC - recalls, gaining access to WIC training funds can be a long and bureaucratic process, “WIC covered [the class], but it took a long time for it to get approved. So I wanted to sit for it probably two years ago, but I really couldn’t do it because I was waiting for approval for the class. And so once they approved

it, I took the class.” The resources that WIC provides are important for low-income IBCLC candidates, but navigating the red tape and dealing with bureaucratic delays remains a significant barrier. These barriers particularly affect low-income women of color who were more likely to be connected to the profession through WIC and rely on WIC education funding to complete their certification process.

2.3.2 Education hours

Because participants for this study range from individuals who certified with the first exam in 1985 to individuals who certified more recently, there is significant variation in how participants obtain their education hours. This variation often reflects the changes that have been made to the education requirements for eligibility. Individuals who certified early most often cite using conferences and workshops to fulfill this requirement. For early certifiers, these education hours are rarely connected to an institution of higher education. They are more often provided through breastfeeding advocacy groups or hospitals. Because online courses were not yet available and the profession was largely new, this often required significant travel and cost – particularly for those who lived in rural areas. While online courses and a wider variety of available education options seems to have lessened geographic disparities in lactation education options to some degree, participants report that geographic isolation and travel costs continue to be a significant obstacle in the certification process.

Because nurses and other health professionals often already hold a degree, they have generally already fulfilled the university credits that are currently required. Current IBLCE guidelines also require candidates to complete an additional 90 hours of lactation-specific education. Participants report filling these hours through short-term courses and conferences that are not connected to institutions of higher education.

Participants who have a degree and/or are existing medical providers report that the educational hours are easy to fulfill. For example, when discussing the education requirement, Heather notes that she “already had all the prerequisites taken care of through my nursing degree.” When participants did not hold a bachelor’s degree at the time of certification, they often report using a patchwork of online courses and conferences to fulfill the education requirements. This process requires a considerable amount of time, effort and money. For many participants, these costs were one of the most significant hurdles in their certification process.

Participants who already held a college degree do not discuss the costs of their degree as a part of their certification process. To them, their degree – which confers employment advantages on its own – was not a significant part of the certification process. However, when participants paid per class for online or in-person university courses that did not necessarily result in a degree, they are much more likely to discuss the burden of the educational requirement. White participants are more likely to report paying for the educational component of certification with personal funds – often relying on the financial assistance of a spouse to fund their certification. In contrast, Black participants are more likely to report relying on scholarships, student loans, or their employer to pay for these hours.

IBCLC candidates who are already employed as IBLCE-recognized medical service providers or who work in lactation through WIC or other agencies/organizations are sometimes able to leverage work training and education programs to pay for the required health science courses and lactation-specific hours. Even when employers or agencies pay for these hours, many participants report that they are required to pay the money up front and are reimbursed at a later time – a strategy that is not realistic for IBCLC candidates who are low income or lack financial reserves.

Approval for education-specific hours can also be stalled or reduced as hospital and agency funding fluctuates from year to year. For example, participants who work in hospitals and at WIC note that education funds are often the first to be cut during budget discussions. Participants also report that supervisors deny or stall the approval process for education reimbursement.

When supervisors, who are often White, have control over whose education hours are funded and whose are not, discriminatory practices can result. IBCLCs of color report workplace discrimination that impacts funding opportunities. For example, one participant recalls a supervisor who denied payment for her education hours despite those hours being consistent with the hospital's policy. The participant felt that her supervisor's resistance was related to her discomfort with having a Black coworker working "side by side" at the same level of certification as her. This sentiment is echoed in the analysis of 45 year old, Black IBCLC, Kecia:

I believe that some White folks are most comfortable with African Americans being in a subservient role. So for example, they are okay with the majority of the housekeeping staff being African American. They are comfortable with even the medical assistants being African American. They are comfortable with African Americans working under them but not working beside them.

Isabel, a 30 year old, self-identified Hispanic IBCLC for WIC also reports supervisors who did not support the advancement of minorities and actively blocked agency funding for their certification:

I encouraged my fellow peer counselors—all minorities—to do the same, not only because there's a need [for IBCLCs of color] but also because it fosters career development. The answer from management and the lead lactation consultant was that they would not support anyone else after me and would not sign off on anyone's hours to [take] the exam... The experience, money, and need are there, so what is stopping our employer from supporting this?

Isabel and Kecia's experiences show the ways that low income workers and workers of color can be disadvantaged even when workplace support is ostensibly available. Workplace resources

must be gained through soliciting and relying on managerial support that can present unique barriers to IBCLC candidates of color.

2.3.3 Clinical hours and mentorship

Recognized providers who work in areas that give them access to breastfeeding mothers and babies report the easiest time with gaining clinical hours. The required hours are generally completed as a part of their paid profession. This means that they do not have to do extensive work to find a clinical placement and do not have to pay for a placement. Instead, they are paid to complete the necessary hours as part of their professions. Medical service providers who do not work in maternal or child health (N=3), such as surgical nurses, have a more difficult time balancing their paid work and their internship or volunteer work. However, they do not express difficulty gaining access to clinical hours. They are often connected to clinical placements through their hospital or coworkers.

IBCLC candidates in lactation-specific programs report a variety of experiences. For some, their program arranges the clinical placement hours that are required for the exam. For others, their university provides little to no guidance, and they have to acquire a clinical placement on their own. When candidates lack social and professional networks with other lactation specialists, finding clinical placements may be particularly difficult. Securing a clinical placement not only requires exploiting personal networks or cold calling hospitals, programs or organizations, it also requires the hospital or organization and its employees to be willing to risk arranging and managing an internship with a stranger.

Similarly, the mentorship pathway is easier for IBCLC candidates who can leverage existing social and/or professional networks in the lactation community. For individuals who lack those social networks, gaining access to a mentorship opportunity is difficult. Participants of

color in this study note particular difficulty relative to Whites in gaining access to clinical hours and mentorship opportunities. Because social networks that could lead to mentorship opportunities differ across race and gender—to the disadvantage of people of color and women— access to mentorships and clinical hours are likely to be unequal across race (Miller, 1981; Feagin and Sikes, 1994).

Joe Feagin and Melvin Sikes (1994) discuss barriers to mentorship for middle-class Black professionals. They note that moving up in a profession often requires mentoring, yet “[a]ll too often...there are few (or no) senior White managers willing to be effective mentors for Black employees” (154). Since Blacks are underrepresented in managerial positions, this means that there are similarly few Blacks who can mentor other Black professionals. Maria, a 50 year old, Black IBCLC who was new to the profession, commented on the lack of Black mentors:

I say this understanding that mentors should be experienced people with substantial experience under their belts...but I'm mentoring people after I've only [been an IBCLC] for three years now. And I'm doing that because of the urgency of the situation -- not because I think that's the way it should be done, but because of the urgency of the situation...I do feel strongly that I should be the one leading that, as the only IBCLC of color.

Because there are a lack of Black IBCLC mentors, Maria feels that she must mentor incoming Black IBCLCs to fill this gap. She does this in spite of having relatively little experience in the profession, because she believes she has something to offer Black IBCLCs that a White IBCLC likely will not.

When Whites do mentor IBCLCs of color, participants report that they witnessed their mentor discriminate against patients in the course of their clinical hours. Prejudice that participants report ranges from implicit bias (unconscious racial bias) that led mentors to provide unequal services to patients of color to more overt racist comments. For example, Isabel, a 30 year old Hispanic-American IBCLC, who worked alongside a White mentor during her

certification process recalls her mentor leaving a room with a Hispanic WIC client and saying “I don’t understand *them*. Why are *these people* always lying?..Why are *they* liars?” These situations force IBCLC candidates of color to be prepared to unpack potentially racist remarks quickly and decide how to respond. As Kecia reports:

Sometimes I find that I have to suppress my anger to keep my job. When every bone in my body wants to tell this particular person, “What you just said to me was a very microaggressive statement. What you just said to me was obviously because you have problems with me being Black.” ... And I have to walk away and do my job. And I have done that over and over and over again. And it is difficult.

Isabel similarly reports that “asserting oneself is considered defiance to authority.” This is a burden that IBCLCs of color disproportionately shoulder in the course of their certification process.

Even when IBCLCs of color speak glowingly of their White mentors, they also express concerns over racial issues like Celeste, a 50 year old, Black respondent, does when she says, “[My mentor] walked on water. There was nothing she could tell me about lactation that I wouldn’t believe...[But] I think, because she was not an African American, it was difficult to explain sometimes the difference in culture.” Maria recalls similar feelings about how her mentor dealt with inequality:

I had a [White] mentor and her approach to make everything equitable for her was to say the same thing to everybody...And I did give her points for that because it showed that she was aware there was a problem, and this was her way of addressing the problem. However, my take on that is that it was imperfect because it didn't individualize enough. Maria’s discussion shows that White IBCLCs do serve as important mentors for IBCLCs

of color, but it also reveals the disconnect between predominate White narratives surrounding race and inequality and the lived experience of Black IBCLCs and patients. Maria recognizes that all women are not heterogeneous and that this often requires a flexible approach to providing lactation services to patients who each come to the appointment with varying lenses and resources.

IBCLC candidates of color also report that their clinical workplaces do not accommodate people of color and exclude them from the breastfeeding literature that was passed out to patients. When participants chose to address some of these issues or suggest programs and policies that were intended to benefit mothers and babies of color, they were most often shut down. For example, when Tina saw that her supervisor put only White women in the breastfeeding literature, she addressed it with her directly. Tina's supervisor responded by saying: "Well we have already sent this out to the printer. We will see about it for next time." Tina went on to elaborate by saying, "That was all she did. Yeah. Yes it was! So now maybe you can kind of see why I didn't stay [in that job]."

Similarly, when Isabel pointed out that the clinic where she was doing her clinical hours had failed to provide contact information for a single lactation consultant of color on an official list of consultants that employees could refer to, Isabel reports that management replied "that this was an oversight. And it might have been, but the point is that we are so invisible that we are not even considered as part of the group. We are an oversight." As Feagin and Sikes (1994) note, "[w]hite workplaces rarely accommodate basic Black interests and values. Instead, Black employees are expected to assimilate" (163).

Participants of color also report personally experiencing discrimination and unequal treatment that ranged from subtle microaggressions to overt discrimination by supervisors, coworkers and/or patients. Respondents most often reported racial microaggressions in their clinical experience. Microaggressions are subtle and often brief indignities that communicate a negative message to people of color (Constantine, 2007). White coworkers asked IBCLCs of color if they could touch their hair, asked multiracial IBCLCs probing questions about their racial identity, "[went] out of their way to bring up the topic of affirmative action,[and]...[went]

out of their way to let [them] know that they don't like diversity initiatives." Similarly, Tina, a 35 year old, Black participant reports ongoing experiences with a White colleague that was responsible for training her,

I was working the clinic, and I didn't have any clinic visits scheduled for the day. And I said to the entire group, "I am going to see the mothers on the Labor and Delivery floor, but let me know if you need me to take some of your patients, and I will see a few on each floor to kind of help you out." And she made the remark "Well, you have to do something to show that your time was useful today." And I was like "Ok? Why is that necessary?" I was trying to help, and it was not my fault that there were no clinic visits that day. There was nothing I could do about that. I don't schedule them. I don't seek people out for them. So why was that remark even necessary?

Tina described other instances with this colleague that she categorized as "bullying" and "culturally insensitive". She goes on, "Or if I was making a personal call, that was something we had to discuss. But if she bought airline tickets on the computer, no one was going to say anything about that. You know? So just little things that are nitpicky."

Microaggressions can be hard to recognize and address because of their subtle and commonplace nature. Research suggests that Whites often attribute microaggressions to mere misunderstandings and fail to recognize the harm that people of color experience from routinely being subjected to such indignities (Sue et al., 2008). Yet racialized microaggressions are shown to have a negative impact on work relationships, on the psychological and emotional well-being of people of color, and affect their self-esteem and health (Brondolo et al., 2008; Sellers, et al, 2003; Sue, et al, 2008; Franklin et al, 2006; Brondolo et al 2003; Constantine & Sue, 2007). Microaggressions require workers of color to deal intimately with racism in an environment where they often have little power to challenge the negative treatment.

Respondents also report being the token Black IBCLC in clinical placements that are dominated by White culture and stereotypical assumptions about people of color. Respondents express that their colleagues and supervisors make racialized assumptions about them being

“angry Black women,” being lazy, and being unqualified. IBCLCs of color are given racial tasks such as being made responsible for seeing all patients of color and being asked to defuse confrontations between Black clients and the organizations that they were employed by (cf. Wingfield and Alston, 2013). Celeste reports that "Whenever there is a confrontation, they come and get me. It is like 'Why do you always come and get me when a confrontation happens?'... I think they think, 'Here is another African American woman. She will probably know how to handle this.' "

Participants report that Whites often fill supervisory positions. As Isabel notes about the organization she worked for during her certification process: “[i]nstitutional racism is almost tangible... There has never been a minority in the role of a manager, supervisor, or dietitian – and this is [a diverse area of the country] so diversity is not lacking.” When IBCLCs of color experience discrimination during their clinical placements, they often lack the power to address it. For example, Irene, a 37 year old Black IBCLC, who was called “stupid” and “other derogatory names” by the supervisor who oversaw her clinical hours reports:

The work environment was really hostile. It was not friendly at all. It didn't start off that way, but as time went on, as it got closer to the end of the program, it started getting more and more hostile and unfriendly and stressful ... so much so that I had threatened to quit at least two or three times because it was just so overwhelming. It was stressful.

When Irene reported these issues to her superiors, there was no follow-up to address the underlying issues. Instead, Irene, a 37 year old Black IBCLC, reports being cast as the “angry Black woman” with a “bad attitude.” She goes on, "I would try to coach myself to get through the remaining time of the program... I did make it to the end, and I was glad I kind of did it. But, then again, if I had to choose to do it again, I don't think I would do it again. As a matter of fact, I know I wouldn't do it again.”

Irene's experience shows the complex ways that racism works in the certification process. Irene dealt intimately with workplace hostility from coworkers and supervisors during her clinical placement hours and had no meaningful resolution to the concerns she expressed. Instead, she was blamed for the hostility. These experiences led Irene to consider quitting the program – which would have meant quitting the IBCLC certification process altogether or experiencing serious setbacks as well as confirming the negative stereotypes about Black workers that her supervisor already held. Because Whites disproportionately hold positions of power, IBCLCs of color are more likely to deal intimately with both subtle and overt racism that impacts their ability to complete the certification process and negatively impacts their job satisfaction, self-esteem and health.

2.3.4 Certification exam

Once IBCLC candidates have completed their educational and clinical hours, they must apply for and sit for the exam. The exam is currently administered electronically – though many of the test takers in this study originally certified under a written exam format. The exam is distributed in 17 languages across 102 countries, and candidates can choose the language they wish to test in. All participants in this study report taking the English language exam. The IBLCE creates a content outline or test blueprint for the test which has two dimensions: scientific disciplines (ex. Development and Nutrition, Pharmacology and Toxicology, Clinical Skills) and chronological periods (Prenatal, 0 to 2 days, 1 to 3 months, etc.). The IBLCE site reports that approximately half of testing items include pictures. In early tests, these pictures were displayed on slides in the testing room. Images are now displayed in photographs that are embedded in the test document.

Depending on the year that they certified, participants in this study report that they paid anywhere from \$300 to \$600 for the exam fee. Participants also often paid out of pocket for exam prep materials such as practice tests and textbooks and for exam preparation courses that sometimes included travel time and expenses. Once certified, IBCLCs must maintain continuing education credits and submit them every five years. Ten years after their initial certification, IBCLCs are also required to sit for the exam again in order to maintain their certification.

One of the biggest barriers to certification is the cost associated with the exam. Pam, a 40 year old, White IBCLC, who reports spending money on courses and preparation materials, estimates that she spent over \$1,200 to prepare for the exam. While some women, particularly White women in this study, report the expense as relatively minimal, these women often rely on a spouse, partner or their employer to pay for exam expenses.

For other women, the expense was daunting and required extensive saving. Bridget, a White IBCLC, recalls her experience planning for the costs when she first certified: “We were low income. I remember that at the time we were making \$10 a month too much to qualify for WIC. I think it was over \$400...I was like ‘How am I ever going to get this?’” Tanya, a 30 year old, Black IBCLC, reports a similar experience: “Another issue was the cost of the test itself. I was like ‘I am not going to have the \$600.’ I am a single mom with kids. I was not going to have it.”

Tanya was able to qualify and sit for the exam when she became connected to a local Black breastfeeding group that provided free education and a local breastfeeding coalition that had a scholarship for women of color interested in taking the exam. She reflects on the importance of those resources when she says, “So really and truly the only reason that I am certified is because of [those two organizations]. Without those two things I would still be saying

‘I wish I had the money to take the test. I wish I had this. I wish I had that.’ I really feel that way.” Like Tanya, IBCLCs of color in this study are more likely to report relying on scholarships to pay for the exam fee and/or preparation materials. At least four of the women in this study received exam scholarships directed specifically toward women of color.

Due to the effects of systemic racism, people of color hold significantly less wealth than Whites and earn less even when they have the same level of education (Oliver and Shapiro, 2006; Shapiro 2004; Conley 1999, 2001; Herring and Henderson, 2016; Carnevale et al, 2011). Given existing economic disparities in the US between Whites and people of color, specific scholarships for people of color are likely to have meaningful impact in assisting lower-income IBCLCs of color with the certification process and can help to reduce racial disparities in the IBCLC profession.

The IBCLCs in this study note that IBCLC candidates who were already health providers had an advantage when taking the exam. Participants argue that newer versions of the exam were increasingly medical. Individuals who had taken both early versions of the test in the 80s and 90s and had then later recertified note changes in the questions and rigor of the test. Participants describe more recent versions of the exam as being “harder” and having a stronger emphasis on medical and pathological aspects of breastfeeding rather than aspects of counseling mothers.

One of the biggest disparities that IBCLCs identify is that candidates who are already medical providers had an advantage when dealing with questions that focused on medical and pathological aspects of breastfeeding. Kecia discusses one example of a question she found to be problematic:

The question was "Is this a typical newborn rash, or is this sepsis?" I believe that as a non-medical provider that is an unfair question...If I had seen spots on a baby's back and was unsure, I would also do a process of elimination. I would look at the whole child. Is this a baby who is eating well? Is this a baby whose stool is going well? A septic baby

would not be able to do that. If I was unsure I would immediately tell the mother to call her provider. I would not make a diagnosis. That is outside of my scope. So I disagree with that question even being on the test.

Others note that the test required them to know what medications could and could not be taken while breastfeeding. Participants report that questions like these are unfair and unhelpful since it is standard practice to look up any medication a mother is prescribed (since prescription information related to breastfeeding can change frequently). IBCLC participants who are medical providers before entering the exam do not discuss medical questions as problematic, as Kecia does above. However, they do consistently note that they feel their medical background made taking the test easier for them compared to their peers.

In general, participants identify the exam content as fair. The biggest complaint related to exam content arises out of the portion of the tests in which testers are presented with images. For earlier test takers, participants note that the image slides were extremely blurry and that where they sat in the testing room could severely impact a tester's ability to see and interpret the images. Participants who had taken more recent tests where images were not presented on slides also complain about the quality of the images. In addition to quality, participants worry that an isolated picture of a mother's nipple or a baby's rash provides insufficient information for them to give a thorough and accurate analysis of breastfeeding concerns.

This complaint is linked to another key complaint of the test. Testers identify that much of the test is disconnected from their lived experiences as IBCLCs in professional work environments. As IBCLCs, they note rarely dealing with some of the pathological issues discussed in the test and are concerned that the test did not adequately address the more common skills they use and view as fundamental to the IBCLC profession, such as counseling.

A few participants point out that the images in the exam lack racial diversity or present patients of color in a negative light. For example, Kecia notes that "the majority of the pictures of African American babies were emaciated babies. And I believe that what that does is that it sets up those taking the exam to make assumptions about African Americans and African American babies. And I have a problem with that." Yvonne similarly notes that "there wasn't a lot of ethnic variety, and so that was a little bit of a challenge."

People of color also report dealing with other concerns surrounding the exam. The literature on racial disparities in testing suggests that people of color must deal with "stereotype threat" when taking tests. Stereotype threat refers to the risk of confirming a negative perception of one's race or social group (Stelle and Aronson, 1995). Researchers on stereotype threat have conducted over 300 studies that find that Black students, for example, perform poorly on standardized tests when race was emphasized but performed better or equivalent to their White peers when race was not emphasized (Nguyen & Ryan, 2008; Walton & Cohen, 2003). In other words, when testers fear that a test may confirm a stereotype about people in their social group, they perform less favorably.

Irene, who reports a hostile and racially discriminatory clinical experience, explains how racial stereotypes from her supervisors affected how she thought about and prepared for the exam:

I did nothing but study day and night, like 14 to 16-hour days' worth of studying, before the exam. Because I wanted to pass – not only because I wanted to become an IBCLC so badly, but I also wanted to prove to the people that I was 'mentored' by that I could do this and I was deserving of it.

Celeste reports similar pressure related to the exam. She recalls feeling that her coworkers did not expect her to pass: "There were comments like 'Well if you don't pass, then you can always take it again.' And I was like 'Who said we were not going to pass?' When Celeste and her

other Black colleagues did pass the exam, she also felt resentment from the White IBCLCs in her workplace: “They kept saying ‘the *new* IBCLCs’ And I was like “Can you take this ‘new’ off? Is it really important to call us the *new* IBCLCs?” ... The *new* IBCLCs were all African American.”

2.3.5 Discussion

It is important to note that his study has a number of limitations including a small and non-generalizable sample size. Participants in this study are all certified IBCLCs and highly educated with the overwhelming majority holding a Bachelor’s degree or higher. This means that they likely represent the best-case scenario for certification. They succeeded in the certification process and often had education-related privileges in navigating certification. Future studies need to look at a more diverse set of participants including IBCLC candidates who did not complete their certification process and IBCLC candidates who lack education-related social capital to better understand barriers experienced by these groups.

Despite the limitations, this study provides critical insight into barriers that IBCLCs face in the certification process. IBCLC certification is a multi-step and sometimes complex process. Candidates must understand the requirements, which are subject to change over time. They must manage the education and certification hours and finance the costs of certification. In this study, a number of barriers arise surrounding the IBCLC certification process. Candidates who are already medical providers are better positioned for certification, have existing networks that link them to clinical hours, are more likely to receive financial support from their workplace and express advantages related to medical questions on the exam. The International Board of Lactation Consultant Examiners (IBLCE), IBCLC educational programs and clinical placement sites should work diligently to reach out to, encourage, support and provide financial assistance

to IBCLC candidates without medical backgrounds. This is not only a matter of equity but also an important part of maintaining a diversity of experience and perspectives among IBCLCs.

Cost is another significant barrier for IBCLC candidates. Candidates must pay for educational requirements through universities, conferences and online courses. Participants also incur costs through their clinical experiences, the exam preparation and the exam fee. IBCLC organizations, programs and clinical placement sites need to provide robust financial assistance to IBCLC candidates – particularly for low income candidates for whom cost is a significant burden and for candidates of color who are underrepresented and experience discrimination in their certification process. As IBCLC requirements continue to move toward more university-focused programs for certification, it is important that IBCLC and others also examine the impact of these changes on low income students and students of color who have a long and continued history of barriers to higher education access, cost and retention (Museus et al, 2015).

In fact, I am skeptical that university education is a necessary or useful path for IBCLC to emphasize as they continue to shape IBCLC certification requirements. As Collins (1979) and Bowles and Gintis (1976) have argued elsewhere, school expansion and differentiation have routinely benefited the capitalist class while relatively disadvantaging the lower class and people of color. In other words, as educational requirements have increased throughout time, the upper and middle class have continually received the advantages of educational expansion and have also worked deliberately to differentiate themselves (through private schools, elite universities, etc.) from the increasingly educated lower class as a way to maintain their relative advantage. There is no reason to suspect that similar results should not be expected as IBCLC certification requirements place increased emphasis on higher education.

Given existing economic disparities in the US between Whites and Blacks, costs are a particularly strong barrier for IBCLC candidates of color. While White participants also experience cost-related barriers, White participants in this study are more likely to rely on their own money or the support of a spouse to pay for certification costs. Black respondents are more likely to report relying on scholarships and other free or low-cost resources. Scholarships and other resources that target IBCLC candidates of color can be an important tool for reducing racial disparities in the IBCLC certification process. However, resource allocation is not likely to be sufficient for recruiting and maintaining IBCLCs of color, because racism remains a systemic problem in the certification process.

Participants of color in this study report dealing with both overt and subtle racism in their clinical experience affecting work relationships, psychological and emotional well-being, and self-esteem. IBCLC candidates of color candidates face barriers when securing clinical hours and mentorship opportunities due to being shut out from professional networks and social capital and because White-dominated management may be less willing to provide clinical placements and mentorship for IBCLC candidates of color candidates.

Given the structure of inequality in the US and the ways in which structural inequality (ex. residential segregation) affects racial attitudes, organizations should not be surprised that employees exhibit racial bias and may consciously or unconsciously act on that bias in the course of managing a clinical placement with an IBCLC candidate. Instead, organizations should provide evidenced-based implicit bias training to employees, but they should also critically consider the ways that the organization, its culture and the institutions that it is connected to uphold and maintain inequality. This will likely require organizations and placement locations to collect data on their organization and the IBCLC candidates in their program. Without collecting

data on candidate completion rates and without asking supervisors to provide justifications for candidate success or failure, educational reimbursement approvals and more, implicit bias is likely to remain unexamined and unchecked. Robust program evaluation systems will not unilaterally eliminate discrimination in clinical placement, but they do provide an opportunity to understand how the organization is meeting and maintaining its goals for equity.

3 “I HAVE TO WALK AWAY AND DO MY JOB.”: IBCLC WORKPLACE DISCRIMINATION AND UNEQUAL PATIENT CARE

Decades of research has documented the ongoing prevalence of workplace discrimination which ranges from subtle aggressions against workers of color to exclusion from social networks and overtly racist remarks (Acker 2006; Tomaskovic-Devey 1993; Wilson 1997; Kirchenman and Neckerman 1991; Reskin and Roos 1991; Roscigno 2007; Royster 2003; Wilson and McBrier 2005; Wingfield 2013). At the same time, there has been mounting evidence of the role that implicit bias plays in unequal health outcomes across race (Smeldley et al. 2003; Sabin et al 2008; Middleton et al. 2005; Hirsh and Robinson 2010; Stepanikova 2006; Burgess et al. 2008; Weisse et al. 2001; Schulman et al. 1999; Cabral et al. 2005; Drwechi 2011). Researchers have focused on the individual aspects of implicit bias and have failed to link the implicit attitudes of individual providers to their structural roots in the organizations and societies in which providers are embedded (Matthew 2015). Through a concerted look at the profession of lactation consulting, I link providers’ implicit bias and labor market discrimination to show the ways that organizations maintain and perpetuate inequality.

3.1 Background

3.1.1 Racial discrimination in the labor market

Employers regularly exhibit racial discrimination in the hiring process. Research documents that workers of color are more likely to hold lower paying jobs and are less likely to hold positions of power and influence in an organization (Acker 2006; Tomaskovic-Devey 1993; Wilson 1997). These racial disparities in the workplace are fueled by structural discrimination, racist preferences of employers, and differential access to social networks (Kirchenman and Neckerman 1991; Reskin and Roos 1991; Roscigno 2007; Royster 2003). Employers give Black

workers less power and responsibility than Whites, assign them to supervisory positions primarily over other people of color, and tend to ask them to perform narrowly-defined tasks (Wilson 1997; Wilson and McBrier 2005). Black workers must work harder than their White counterparts to prove their abilities (Wilson 1997; Wilson and McBrier 2005; Tomaskovic-Devey 1993; Roscigno 2007) and tend to be excluded from the social networks that assist in mobility (Feagin 2006; Feagin and Sikes 1994; Pierce 2002).

When minorities land jobs in primarily White fields, they are often treated as tokens. Rosabeth Moss Kanter (1977) argues, in her study *Men and Women of the Corporation*, that women in mostly male careers experience tokenism that results in an increase in visibility, stereotyping and isolation. Because women in these professions are regarded in these ways, they often have trouble integrating into the group or professional culture and experience limited advancement. Researchers who have extended her work describe a similar process for Black workers, whom, they argue, also experience heightened visibility, stereotypes, and isolation in majority-White professional environments (Wingfield 2013; Bell and Nkomo 2001; Feagin 2006; Higginbotham and Weber 1999; Jackson et al. 1995).

This isolation is fueled in part by the organizational culture of most professional spaces. Sociological research has detailed the ways in which “feeling rules,” the emotional norms of a given context, are not neutral but are instead both gendered and raced (Hochschild 1983; Wingfield 2013). This means that there are different rules of professional behavior for men and women and for Whites and people of color. For example, while men can express anger and frustration openly in some professional settings, women are expected to be deferential, nurturing and caring. These gendered structures and expectations result in a funneling of men and women

into different types of jobs (ex. construction vs. nursing) that reinforce the idea that women and men are best suited for certain jobs and are fundamentally different (Acker 1990; Acker 2006).

Similarly, African American workers report that the emotional expressions that their White colleagues are able to engage in are often not open to them (Wingfield 2013). For example, Black workers report feeling unable to express frustration and feeling like they were not allowed to respond to racism in the workplace without fear of supervisor retaliation. Emotional labor, or the emotions that workers must produce and sell as part of a capitalist economy, are structured around White, middle class and often male norms regarding emotionality (Anderson 1999; Chase 1995; Feagin and Sikes 1994; Pierce 1995). For African American women, the raced and gendered aspects of feeling rules and emotional labor intersect to significantly structure their lives and reinforce existing inequality (Wingfield 2013).

Combining this research into a theoretical umbrella, Adia Harvey Wingfield and Renee Skeete Alston (2013) argue that Black workers are given “racial tasks” that are ideological, interactional and physical, and which serve to reify inequality. Workers engage in ideological racial tasks when they “maintain an organizational culture that is normatively White and middle class” (Wingfield and Alston 2013: 3). At the interactional level, workers engage in racial tasks as they construct their self-presentation and do emotion work. For example, practicing restraint or laughing when a racist joke is told is an interactional racial task. Similarly, working to demonstrate competencies – that are assumed among White workers – is a racial task in which workers of color must engage. Finally, racial tasks that are physical include those that privilege Whiteness in the construction of a physical space. Workers engage in physical racial tasks when people of color serve as security officers for majority-White spaces and are asked to physically protect a space that is structurally closed to them (Wingfield and Alston 2013).

Studies of discrimination and experiences of racism among medical providers provide critical insight into racial discrimination within the medical setting. Scammell and Olumide (2010) argue that Whiteness subconsciously dominates the healthcare field. White worldviews are privileged over others in nursing education and organizational culture. White nursing students in their study engaged in strategies that served to discredit, marginalize and dehumanize nurses of color and nurses who were internationally educated (Scammell and Olumide 2010; see also: Puzan 2003; Blackford 2003). Similar studies conducted among physicians of color report experiences of racial and ethnic discrimination (Coombs and King 2005; Corbie-Smith et al. 2005; Peterson et al. 2004; Price et al. 2005;), low job satisfaction (Peterson et al. 2004; Palepu et al. 2000), less frequent promotion despite similar accomplishments (Fang et al. 2000; Palepu et al. 1998) and experiences of isolation and disempowerment (IOM 2004).

Among medical providers, nurses are found to be the most likely targets of patient's verbal aggression (Chen, Hwu and Williams 2005; Gilies and O'Brien 2006; National Audit Office 2003). In a study of 213 US nurses, 96% reported at least one experience of verbal abuse. 79% reported an experience of abuse perpetrated by a patient while 75% reported abuse by other nurses (Rowe and Sherlock 2005). The most serious instances of verbal abuse (racism, abuse that is sexual in nature and threats to kill or cause bodily harm) are most likely to be experienced in general medical wards, mental health wards and surgical wards and generally occur in communal areas that are in public view during periods of personal care, assessment of pain and administration of medication (Ferns and Meerabeau 2007). Nurses reported general verbal abuse and physical threats (ex. "Gonna fucking punch your lights out") as well as threats that were sexual in nature (ex. "He called me a dirty whore. Said... 'all nurses should be fucked to show them who's boss'") (Ferns and Meerabeau 2007).

Black and Latin@ nurses, who remain underrepresented in the nursing population, are particularly vulnerable to abuse and aggression (USDHHS 2010). Beishon et al, (1995) found that 66% of Black nurses in their study reported difficulties with patients that were racist in nature. For example, Ferns and Meerabeau (2007) report racist statements directed at nurses such as “I don’t want any Black monkey to come to my bedside, fuck off” and “What is this country coming to? Where is all the White nurses?” Other studies have reported similar findings of marginalization, denial of racism (Hagey et al. 2001), racist comments and verbal abuse (Scammel and Olumide 2012; Stone et al. 2011; Deacon 2011; Rippon 2000; Celik and Bayraktar 2004).

Researchers find that younger nurses, less experienced nurses and less educated nurses are more likely to experience aggression from patients (Baxter et al 1992, Grenade and Macdonald 1995; Little 1999). Because Black nurses hold varying degrees of privilege and disadvantage based on their other social locations (gender, sexuality, age, class, etc.), they may remain particularly vulnerable to intersecting forms of oppression.

3.1.2 Racial discrimination in medical provision

In addition to workplace discrimination, numerous studies have now found evidence of racist beliefs and practices among medical providers. This racism has been linked to racial health disparities since the “Unequal Treatment” report of 2003 – an IOM study requested by Congress in 1999 to assess disparities and medical care quality for ethnic and racial minorities in the US (Smeldley et al. 2003). Medical providers’ decisions about the health of minorities are influenced by racism (Sabin et al 2008; Middleton et al. 2005; Hirsh and Robinson 2010; Stepanikova 2006; Burgess et al. 2008; Weisse et al. 2001; Schulman et al. 1999; Cabral et al. 2005; Drwechi 2011). For example, physicians are less likely to refer Black women for cardiac catheterization even

when they exhibit symptoms similar to their White or male counterparts (Schulman et al, Schulman et al. 1999).

Physicians and medical providers are influenced by implicit racial bias – unconscious racial bias - that affects how they care for patients (Penner et al. 2010; Sabin et al 2008; Green et al. 2005; Sabin 2009). Still other researchers report evidence that physicians exhibit overt racism (Van Ryn and Burje 2000; Mitchell and Sedlacek 1996; Joseph 1997; Moskowitz et al 2011), have more negative views of Black patients, perceive them to be less likely to follow medical advice and perceive them as less intelligent (Moskowitz et al 2011). Physicians also exhibit differences in perceptions of disease prevalence among racial groups that affect how patients are diagnosed (Balsa et al 2005). William Hall et.al. (2015) and Dayna Matthew (2015) provide extensive reviews of the literature on implicit bias in healthcare.

Reducing disparities in the provision of lactation care is of critical concern given current breastfeeding disparities. Between 2004 and 2008 Blacks had lower rates of breastfeeding initiation and duration in all states except for Rhode Island and Minnesota. (CDC 2010). Southern states in particular show serious racial inequality in breastfeeding with 13 states having a gap between Black and White breastfeeding that was at least 20 percentage points different (CDC 2010). Studies show that Black/White gaps in initiation and duration persist, even when maternal age, income, education, rates of marriage and other explanatory variables are held constant (CDC 2004).

Breastfeeding matters because it is linked to an array of health benefits, and breastfeeding for at least the first year of a child's life is recommended by the CDC, the Surgeon General and the American Academy of Pediatrics (Singh et al. 2007; Gartner et al. 2005). Research shows that professional lactation support can improve rates of breastfeeding initiation and duration

(Castrucci 2006, DiGirolamo 2003, Ma and Magnus 2012; Caulfield et al. 1998; Taveras et al. 2004; Britton 2007; Chung et. Al 2008; Hopkinson 2009; Bonuck 2005), but these effects are likely lower when providers exhibit implicit bias and provide unequal care. Studies also suggest that Black medical providers exhibit less implicit bias (Green et al. 2007; Sabin et al. 2009; White et al. 2009). Because a provider's implicit bias is demonstrated to negatively impact the care that patients receive, understanding the structural forces that contribute to implicit bias and differential care is an imperative step in reducing breastfeeding disparities in the US.

3.2 Methods

Through semi-structured, intensive interviews with 36 IBCLCs across the United States, I examine how race and gender shape labor market discrimination and patient discrimination in the IBCLC profession. I utilize qualitative methods in order to capture stories and thoughts that are difficult to measure through other methods (Berg 2009, Gubrium and Holstein 2003; Weiss 1994, Lofland et al. 2006). An intensive interview involves a pre-constructed research guide as well as “ordinary conversation and listening as it occurs naturally during the course of social interaction and semi-structured interviewing” (Lofland et al. 2006:17; Berg 2009; Weiss 1994). From November 2015 to March 2016, I conducted intensive interviews with 36 IBCLCs across the United States to identify barriers that IBCLC candidates face in reaching the highest level of international lactation certification.

I identified potential interviewees through the distribution of recruitment ads on various professional lactation networks, breastfeeding advocacy groups and a listserv for professional lactation providers. Finally, I added additional interviewees through snowball sampling. Interviewees included IBCLCs from private practice, hospitals, physician offices, WIC, non-profits and public health agencies. All participants were IBCLC-certified at the time of the

interview. After a review of scholarly literature on breastfeeding professionals to understand existing knowledge and gaps, I developed a semi-structured interview guide from this review, and conducted interviews via telephone. Interviews generally lasted approximately one hour and were audio recorded and transcribed with the participant's permission. Study materials were labeled with unique, random identification numbers.

Relying largely on LaRossa's (2005) description of grounded theory, I conducted the first phase of analysis using open coding, in which similarities and variations in indicators are linked with concepts in order to begin forming variables. Next, I performed axial coding by linking variables to form a framework that I used to explain the data. Lastly, I conducted selective coding in order to develop core categories. I coded the interview transcripts with QSR NVivo. I have reported raw data from the interviews to demonstrate how the data and my interpretations of them relate and to allow the participant's voices to be expressed directly.

3.3 Findings

Table 1 provides descriptive statistics for the sample population. Respondents self-identified their race in an open ended question as either White (N=20), Black (N=13) multiracial-Black (N=2) and one participant identified as non-White Hispanic. Participants in the sample are highly educated with 44.44% (N=16) holding a bachelor's degree and 44.44% (N = 16) holding a master's degree or higher. Participants live in 15 different states. Respondents are most likely to be employed in hospitals (N= 12; 33.33%) or Private Practice (N= 11; 30.56%). Other are employed in Federal, State or Local Breastfeeding programs, pediatric offices, WIC or multiple setting.

When the sample is separated out by race, Whites are concentrated in hospitals and private practice, while respondents of color are more evenly spread across job sites. Respondents

of color concentrate in lower age groups with 68% (N=11) reporting between the ages of 30 and 39. By contrast, Whites concentrate in their 50s (N=9; 45%). There are no significant differences in the level of education between White and Black respondents in this sample.

3.3.1 Discrimination at work

Black participants in this study report an array of discriminatory behavior and racialized workplace concerns. Many respondents report being the only – or “token” – Black IBCLC in work environments dominated by coworkers with stereotypical assumptions about people of color. Racism in the workplace was both overt (patients refusing to be treated by Black providers) and subtle. Respondents express that their colleagues and supervisors made racialized assumptions about them being “angry Black women,” being lazy and or being less qualified. IBCLCs of color also report being given racial tasks in the workplace and dealing with exclusion from networks that could be important for their career advancement.

Respondents most often report racial microaggressions in their work environment. White coworkers ask IBCLCs of color if they can touch their hair, ask multiracial IBCLCs probing questions about their racial identity, “[went] out of their way to bring up the topic of affirmative action,[and]...[went] out of their way to let [them] know that they don’t like diversity initiatives”. Microaggressions are shown to have a negative impact on the psychological and emotional well-being of people of color, and affect their self-esteem, health and work relationships (Brondolo et al. 2008; Sellers, et al 2003; Sue, et al 2008; Franklin et al 2006; Brondolo et al 2003; Constantine & Sue 2007). They require workers of color to deal intimately with racism in an environment where they often have little power to challenge the negative treatment or normative White culture.

Tokenism and feeling invisible at work

Many participants report being the only IBCLC of color in their work environment. As Carlene notes: “you feel like the token Black IBCLC who has to answer all the questions for the entire community.” Tokenism in White-dominated spaces often leads directly to racial tasks and exclusion. Reyna, who report being the token Black professional in her workplace noted that, “I am the only person of color who has ever been hired to do this job.....So, they will give me a list of like ‘Mom in room 200 kind of looks like you, you should go help her.” Celeste, a 50 year old, Black IBCLC, reports similar instances of racialized tasks: “Whenever there is a confrontation, they come and get me. It is like ‘Why do you always come and get me when a confrontation happens?... I think they think, ‘Here is another African American woman. She will probably know how to handle this.’”

In one instance, Celeste was asked to intervene when a Black client became irate and was “standing on the counter,” calling an Asian employee derogatory names. Celeste was singled out to address the situation and was able to talk the client off the counter. This task involved a physical racial task – securing the physical space that houses White institutional norms – and an interactional and ideological racial task – serving as a buffer between the organization and clientele and engaging in intense emotional labor. She also expresses feeling responsible for setting an example for her White colleagues as she addressed the confrontation with the client of color:

If [the client] had stayed on the counter and called me names, I probably would have called the police. I don’t like to call the police, because I don’t want people to think that is the best way to deal with things. The police are not always a good thing. Especially in the communities that we serve. The odds of them coming in and over-reacting is really, really great. So I try not to call them unless I have to.

Celeste perceives that her employer and coworkers interpret her emotional labor as a method to protect the organization from accusations of racism and prevented Non-Black employees from being required to perform emotional labor and engage in conflicts with customers of varying races.

Research suggests that race and gender intersect to inform how patients, coworkers and supervisors view and treat workers of color. The “angry Black woman” stereotype is exploited by White coworkers when Black workers, like Celeste, are asked to engage in racial tasks such as intervening in and defusing confrontations with clients. However, this stereotype is also used against workers. When lactation consultants of color report workplace hostility or challenge organizational norms, they are dismissed as combative, “angry Black women”, and their concerns are ignored.

When minorities are tokens in their workplaces, they lack power in organizational systems that are often dominated by racialized assumptions about people of color. In Isabel’s workplace, “[i]nstitutional racism is almost tangible... There has never been a minority in the role of a manager, supervisor, or dietitian – and this is [a diverse area of the country] so diversity is not lacking.” She similarly experienced exclusion in her workplace. Isabel reports that the WIC clinic she worked in had created an official list of IBCLCs in the county that WIC staff could refer mothers to. As she states, “The list not only excluded me but also excluded the 3 other minority IBCLC's in the county.” When she confronted management about the exclusion, they told her that it had been an oversight. This explanation provides little consolation to Isabel. “[T]he point is that we are so invisible that we are not even considered as part of the group; we are an oversight.”

Overt discrimination on the job

Coworkers, supervisors and patients also engage in more overt discrimination against IBCLCs of color. IBCLCs of color report that patients/clients of color are treated as “others” and referred to as “your people.” Racialized remarks are made about the way that various racial and ethnic groups dress, the food they eat, or the ways that they express their religion. Patients refuse services from a Black IBCLCs by asking, IBCLCs like Reyna, “Is there anyone else here who is not Black that can help me?”

Overt bullying from supervisors also occurs. As Irene, who was called “stupid” and “other derogatory names” reports:

The work environment was really hostile. It was not friendly at all. It didn't start off that way, but as time went on, as it got closer to the end of the program, it started getting more and more hostile and unfriendly and stressful ... so much so that I had threatened to quit at least two or three times because it was just so overwhelming. It was stressful.

When Irene reported workplace issues to her superiors, there was no follow-up to address the underlying issues. Instead, Irene reports being cast as the “angry Black woman” with a “bad attitude.” After she threatened to quit the program, Irene’s supervisor responded by saying “Well, you know if you quit, that's failure, right?” Confronted with the pressure of feeling like a failure, Irene decided to continue with the program:

I would try to coach myself to get through the remaining time of the program...I did make it to the end, and I was glad I kind of did it. But, then again, if I had to choose to do it again, I don't think I would do it again. As a matter of fact, I know I wouldn't do it again.

Irene’s experience shows the complex ways that racism works in the workplace and in the certification process. Irene, who also reports being routinely assigned racial tasks, dealing intimately with workplace hostility from coworkers and supervisors in an environment she describes as “a program that was set out to help Black women become IBCLCs, but was also done in a way which created more barriers and more hurdles to overcome.” When she challenged

workplace hostility, she was denied meaningful support, instructed that quitting would make her a failure, and blamed for the hostility. When another Black intern entered the program behind her, the intern experienced similar hostility and left the program after a few months. Irene reflects that “there was no longer, you know, a door where you could say, ‘It was all her. She made that up. She was the problem.’”

Emotion Rules

Like Irene, other IBCLCs report having a limited set of options when dealing with workplace discrimination or hostility. When patients refuse lactation services from Black providers, when coworkers engage in microaggressions against consultants of color, and when supervisors act in a discriminatory fashion, IBCLCs of color are still expected to maintain the feeling rules of their professional environment. As Chase (1999) points out, this means that employees must remain affable and pleasant, be agreeable and amiable, and leave personal issues at the door. As Kecia reports:

Sometimes I find that I have to suppress my anger to keep my job. When every bone in my body wants to tell this particular person, “What you just said to me was a very microaggressive statement. What you just said to me was obviously because you have problems with me being Black.” ... And I have to walk away and do my job. And I have done that over and over and over again. And it is difficult.

These emotion rules in professional environments are built on assumptions of a White, male worker who is unaffected by external issues (Acker 1990).

Put another way, professional standards are built around assumptions of “acceptable” masculine emotional expression that are often closed to women and people of color. For example, while a certain degree of aggression is both sanctioned and rewarded for White men in the workplace, women and people of color who engage in similar emotional expressions are labeled “bossy”, “angry”, “shrill” or “hostile”. At the same time, emotional expressions that remain open to women and minorities – being deferential, for example – are not rewarded in

professional environments. Female workers of color may therefore find it particularly laborious to adhere to “professional” emotion rules when they habitually confront structural barriers and race-based and gender-based discrimination in the workplace.

As Kecia explains, when lactation consultants of color do address instances of discrimination or hostility they are “labeled as the angry Black woman if [they] do stand up for [themselves] - even if [they] are in the right.” Isabel similarly reported that “asserting oneself is considered defiance to authority.” These examples demonstrate the ways that professional feeling rules are leveraged against workers of color, are used to protect the existing organizational culture and exclude non-White workers from positions of power and influence.

White perceptions of workplace inequality

When White IBCLCs are asked if their coworkers experience discrimination, only three report that they knew about coworker discrimination. These three IBCLCs note that they witnessed a Muslim-American experience discrimination for praying during work or that they witnessed discrimination among co-workers who spoke English as a second language. White IBCLCs in this study, some of whom recognized aspects of racial prejudice against patients, are not necessarily all intentionally discriminatory. Because organizational culture – and, indeed societal structures at large - are routinely constructed to privilege Whites, it is normative – if still highly problematic - for White workers to fail to notice and address racial oppression in their workplaces. Kecia addresses the unquestioned White cultural frame of most workplaces when she discusses her own efforts to construct an organization with a clear African-American lens.

I tried to create a space that I never before had on my own, and when you walk into [my organization] it's very apparent that you're seeing the world through a Black lens when you walk through the door there... I'm trying to create this contrast to show how everything I've experienced up to that point, you know, the previous years to that, everything wasn't that. It wasn't for me. I just had to get in line with whatever it was, but it wasn't something that was handmade for me.

Because Black IBCLC colleagues are often forced to hold in anger and frustration on the job, it is unsurprising that White colleagues are routinely able to ignore workplace discrimination. When their colleagues of color do express anger or frustration, White IBCLCs are able to rely on existing racialized assumptions of people of color that cast the accuser as being angry, lazy or antagonistic.

To be clear, I am not suggesting a wholesale conspiracy whereby Whites get together collectively to explicitly construct and reinforce a racialized work culture. Instead, what I am suggesting is that Whites, who often live in racially segregated communities apart from people of color and who have been educated and socialized by schools, religious institutions and workplaces that have routinely privileged Whiteness, are able to consistently deny or ignore racialized aspects of everyday life. Many Whites remain wholly unaware of structural discrimination – including the structural discrimination from which they have personally benefited - while also being deeply averse to claims that they may be complicit in any form of racism and discrimination. Indeed, most Whites hold that society is post-racial.

The post-racial ideology argues that racism is no longer a significant contributor to racial inequality in the United States (Bonilla-Silva 2010). Individuals who hold to post-racial ideologies contend that racism has diminished overtime and often point to the civil rights movement as a consistent marker of progress. Sociologists have consistently challenged this view by pointing to continued inequalities in all major social institutions.

Because most contemporary organizations – including hospitals, clinics and pediatric offices – are dominated by White (and often male) leadership who hold to post-racial ideologies and lack basic awareness of structural racism (and sexism), the organizations are typically unable to address the unique concerns of workers of color and the workplace discrimination that they

experience. Relying on assumptions of a post-racial society, racialized aspects of work bubble under the surface of these organizations and place undue burden on workers of color who routinely experience isolation, exclusion, and hostility, and are asked to engage in racial tasks and emotional labor that is both racialized and gendered. Post-racial views and racialized assumptions about people of color, likewise spill over into interactions with patients.

3.3.2 *Patient discrimination*

Both Black and White IBCLCs report numerous instances of racial discrimination toward patients. However, consistent with previous research, IBCLCs of color report more instances of race-based patient discrimination. Reports of patient discrimination most often involve assumptions that patients of color will not breastfeed which results in less attention being given to providing lactation services to patients of color. Others report explicit racial remarks and negative views made by colleagues about patients of color, White-dominated imagery in breastfeeding resources and instances of Black mothers being more likely to receive referred for birth control measures immediately after birth.

“Unwishing prejudice” toward patients

The majority of participants report instances of implicit bias on the part of physicians, nurses and lactation consultant colleagues. Kyra, a 30 year old, Black IBCLC, describes it this way: “I see Black moms come in there outside of means and no one really helps them with breastfeeding because the statistics say that they don’t really breastfeed. So why waste the money if they are not going to do it?” Anna echoes Kyra’s and others observations when she notes that,

There is already a preconceived idea that all Hispanic mothers will want to give formula or that all African American mothers are not going to initiate breastfeeding. So I would see almost like less effort given to them. You know like: “Why even bother; they are not going to do it.” You know? ... I definitely saw that.

These observations are consistent with existing research on racial discrimination and inequality in healthcare. Implicit bias is one of the most commonly discussed forms of patient discrimination in the literature. Patricia, an older, White IBCLC sums up the essence of this kind of discrimination when she says, “I have certainly seen – I would call it ‘unwishing prejudice’ – people who don’t realize what they are doing.” Implicit bias is unconsciously used in these situations to categorize and make decisions about how to prioritize work within existing time constraints. Because IBCLCs and other lactation providers hold assumptions about patients of color, they are likely to focus their efforts on clients they perceive to be more interested in breastfeeding.

The assumptions that providers make about patients are not only race-based, but often intersect with other social identities. As Nancy shows, providers often perceive African American clients who are also on Medicaid as not wanting breastfeeding services: “The OB/GYN office used to think that their clientele didn’t lend itself to wanting to breastfeed. And by clientele, I mean African Americans who are on Medicaid.” Lactation consultants reported that this discrimination was most often directed at Black mothers but is also noted to occur with various Asian groups – particularly with Asian immigrant groups, Latinas, and individuals who speak English as a second language.

For example, Pam, a middle-aged, White IBCLC, who classifies her town as “pale, pasty White” reports instances of colleagues providing differential care to various immigrant groups:

I also have noticed that, if someone comes from, let's say, China, the nurses might not work as hard on breastfeeding because they assume that they're going to be formula feeding because that's what all Chinese women do, right? All immigrants do that. All, you know, Muslims do that. So there's a lot of that sort of like – group everyone together and take one characteristic, label it to everyone, and then you know, you're kind of excused from maybe working a little harder or actually getting to know that person. I do see a lot of that.

These reports suggest that groups for whom breastfeeding rates are already low are also those that are least likely to be offered professional lactation services. When lactation services are provided to them, participants note that those services are sometimes provided with less care and attention. Irene describes one such situation,

I worked in the outpatient breastfeeding clinic...with the White mothers, [the consultants] seemed to take their time with. Like they would let the appointments go longer than the normal expected time, and things like that. African-American mothers, they were kind of like, “Okay, let's get this solved.” It felt more rushed.

These microaggressions - subtle and often brief indignities that communicate a negative message to people of color (Constantine 2007) - can be hard to recognize and address. Research suggest that Whites often attribute microaggressions to mere misunderstandings (Sue et al. 2008). This means that IBCLCs of color, who are more likely to lack the structural power to challenge the discrimination they witness, are forced to unpack patient discrimination and decide how to respond quickly among supervisors and coworkers who may dismiss their observations as aberrant misinterpretations.

Overt racial discrimination against patients

Stereotypes about racial minorities are employed in more overt ways as well – most often behind patients’ backs. Isabel, a 38 year old, self-identified Hispanic-American IBCLC, worked alongside a White mentor during her certification process and recalls her mentor leaving a room with “a Hispanic WIC client” and saying “I don’t understand them. Why are these people always lying?...Why are they liars?” Isabel suggested to her mentor that “[The mother] is not lying to you. It is that she is telling you what she thinks you want to hear because she doesn’t trust you yet.”

Anna, a 30 year old White participant, similarly notes that she had witnessed Asian families “want certain drinks or privacy and things. And you know it really turned the nurses off

and makes them not go back and help them. They wanted them to just comply.” Even more overt examples of discrimination include remarks like those made by Tina’s supervisor when she said: “She has these big huge Asian nipples. You know what I mean? Asian nipples?!” and “Everything smells like curry in there.” These provider’s biases reflect larger societal trends in the ways that the bodies of people of color are sexualized, fetishized and racialized (Collins 2004) and are consistent with a long and ongoing history of Whites casting minorities as having unique and offending smells (Smith, 2006). These participants’ comments are also consistent with studies that find that medical providers more often interpret people of color as non-compliant and are likely to give less care and attention to them (Hall et al. 2015).

Assumptions made about patients of color are also displayed in the services and referrals that are provided to patients who use drugs, are drug dependent, or show signs of mental illness.

As Kecia reports:

What I have experienced in our hospital is drug addicted mothers who could be in treatment – so a mother who is trying to kick heroine might be taking methadone; a mother who smokes marijuana might be trying to kick the habit. Many of the methadone mothers are White. Many of the pot smokers are Black. And I have seen that more of the methadone mothers are receiving support than the marijuana users.

Mothers were not only provided varying levels of support on the basis of race but were also funneled into social work and other referral systems differentially. Irene echoes these observations when she discusses mothers on the postpartum floor with a history of drug use, depression or anxiety,

Social work was always quick to be ordered to go see [Black] mothers, [compared to] a White mother. They would say, "Oh, that mother, she's really going through a lot. Oh, my God, I feel so sorry for her." But the Black mother, they were like, "Is there a social work consult? If there's not a social work consult, then we need to order one."

The consequences of this differential treatment can of course be quite significant for patients of color who could fail to get adequate treatment for their drug dependence or mental health

concern, be referred to law enforcement, or have their children removed from their custody. These reports are substantiated by existing literature in which researchers have documented that physicians are more likely to require postpartum drug tests for African American mothers (Chibnall et al., 2003), that people of color are more likely to be reported for child maltreatment (Derezotes & Poertner, 2005), that people of color who are accused of abuse are more likely to be “screened in” for an investigation (Sedlak & Schultz, 2005; Gryzlak, Wells, & Johnson, 2005) and that disparities and bias in mental healthcare referrals continues (HHS, 2001). These findings are also consistent with a breadth of research that document the ways that minorities disproportionately experience punitive treatment across social institutions – such as in education, law, healthcare and employment. (Some examples: Morris and Perry 2016; Hamner 1974; Bowles and Gelfand 2009; Artiles & Trent 1994; O ’Connor & Fernandez 2006; Rocque, & Paternoster 2011; Skiba, Michael, Nardo, & Peterson 2002; Skiba et al. 2011; Glaze 2011; U.S. Department of Justice 2014; Jacobs and Carmichael 2002 Eberhardt et al. 2006).

Respondents reported that birth control methods like Depo-Provera are often pushed on women of color directly after birth. Depo-Provera, a contraception injection, was the most commonly mentioned form of birth control pushed on women of color by providers. This form is particularly problematic for breastfeeding disparities because one of its common side effects is a reduction in breastmilk. Because it is an injection, patients who are not properly informed about this side effect may have increased difficulty breastfeeding for several months until the injection wears off. Other forms of birth control are also pushed on women of color as Emily, a White IBCLC, discusses:

I've seen clients and patients and friends, actually, they go to the hospital, they have their baby...The doctor comes in and goes, "Hey, do you want us to tie your tubes?"...Yes! But she had been told by other friends to expect that because apparently it's kind of

common that if you're a Black woman, and you're on Medicaid, you will be asked if you want to tie your tubes. Which is – that's fucked up!

These practices are not noted to occur among White women and are undoubtedly influenced by negative images that paint Black mothers – and low-income Black mothers in particular – as welfare queens that are draining society (Collins 2002).

“Images of people who looks like them”

IBCLCs report that White imagery and culture dominates much of the breastfeeding literature and resources. For example, as Tina – a 35 year old, Black IBCLC - details, her supervisor chose only White women for the educational literature that her hospital designed. “In my opinion, for people to be successful at something, at anything, it is good for them to see images of people who look like them that are successful...I thought [choosing only White images for a pamphlet] was a great oversight.” Her supervisor responded by noting that the material was already sent to the printer, so they will have to consider that next time the materials were printed. Blaming the budget or the printer absolved this supervisor from taking personal responsibility and answering for a discriminatory and inept decision. When Whites hold positions of authority, they are able to conceal their – intentionally or unintentionally – discriminatory behavior from a wider audience. This protects their own interests and the normative White culture of the organization.

Similarly, participants confirm decades of research regarding the organizational culture of some prominent breastfeeding organizations. This is clear in Tanya’s description of her own experience at La Leche League.

When I went I saw lots of women who were homemakers. They were what we like to call granola – cloth diapering, organic eating, attachment parenting, and those types of things. But they were awesome with the breastfeeding. I felt like women who were more like me – meaning they wanted to breastfeed but not necessarily to adopt everything else - especially women who have to go back to work, maybe there is no spouse or someone at home to help you. It just didn’t seem like it was a place where they could have shared and

similar experiences with women who looked like them and had you know similar experiences...so they might toss out the breastfeeding with the rest of it.

This form of motherhood that Tanya describes is consistent with the ideology of “intensive mothering.” The ideology of intensive mothering is, “a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children” (Hays 1996).

A “good” mother is most often presented as White and middle class. In contrast, the “bad” mother selfishly works in the paid labor market in order to afford luxuries, ignores the cries and bonding needs of her child(ren), and allows other women to care for her children (Hays 1996). This model of “good” and “bad” mothering, historically connected to the LLLI movement, is both racist and classist since it ignores the historical and economic realities that make intensive mothering more readily available to White and middle class women rather than Black or lower class women (Collins 2002; Blum 1999; Hays 1996). The profession of lactation consulting was born from La Leche League International and LLLI remains one of the most prominent breastfeeding organizations. LLLI’s prominence allows the league to contribute considerably to the cultural lens through which IBCLCs view their patients.

Confronting racial prejudice against patients

When IBCLCs of color witness discrimination against patients, they may experience feelings of frustration, sadness or anger. Yet IBCLCs of color often lack the institutional authority to challenge such comments. Instead, consultants must find small ways to push back on racist assumptions, remain silent or potentially risk confronting the situation. Confronting the situation could result in being cast as the “angry Black woman” and/or job loss. Lactation consultants of color report being acutely aware of the risks associated with addressing racism in the workplace. They regularly discuss the consequences of speaking out and how they weigh when, how and/or if they should address workplace racism. They also discuss the pain and

frustration that comes from being unable to address racial issues. Isabel reflects:

I'm going to get emotional talking about it. It feels wrong to me that people can get personal if someone like me - or anyone who has felt a victim of [racism] - bring it up. They are like, "How dare you accuse me of such a thing." ...I was thinking about it the other day. I just need to voice it. It is not like I am pointing the finger at you. It is just like "Hear me out!" All I need to do is say it. Just listen...[Talking about racism] is one of those things that is like "Don't talk about it" And it is shameful and that is like shutting my voice down. And that hurts even more.

In this excerpt Isabel identifies the post-racial ideology that dominates society and structures workplaces across the US. It silences the concerns of minorities and covers up discriminatory practices.

Bonilla-Silva (2010) argues that the silence that surrounds racial matters is a result of post-Civil Rights era changes in social norms that have suggested that any discussion that could sound or be perceived as racist is immoral. As he notes, "because the dominant racial ideology purports to be color blind, there is little space for socially sanctioned speech about race-related matters" (Bonilla-Silva 2010: 55).

"Did I choose the wrong word?": White semantic moves that conceal racism

White IBCLCs in this study consistently acknowledge that patients experience some form of race-based discrimination. Most often they report discrimination that involves coworkers giving less care or attention to mothers and babies of color. However, when White IBCLCs are asked about discrimination against patients, they often seem uncertain or hedge their statements. Bonilla-Silva (2010) argues that Whites use semantic moves in their speech to express and conceal racial views that post-Civil Rights norms no longer permit. For example, when asked if patients are discriminated against in the hospital, Toni, a 40 year old White IBCLC notes: "One of my African American clients said that she felt not listened to, but since I wasn't there I can't comment on what I would have observed." These kinds of statements suggest that the lived

experiences of clients of color cannot be trusted at face value, but require a third party, “unbiased” observer to determine if discrimination did in fact occur.

Similarly, Sara, a 40 year old, White IBCLC, said “I don’t know if this would count but ...there are a lot of judgements made about patients you know...Is that what you mean?” Like Sara, other White IBCLCs appear uncertain and/or uncomfortable discussing racial discrimination. Renee, a 40 year old White IBCLC makes this explicit when she discusses her fears addressing racial inequality:

I’m almost scared to say this – I do think there are some fears of properly welcoming other races. So sometimes I am worried about getting it wrong. If I was to post “Black moms welcome” would that be seen as positive? Did I choose the wrong word? Should it be African American? I have to say that I have some of those fears. And especially with so much social media, it is very easy to get blasted for doing – even if you do something with a good heart.... The term microaggression and privilege, they both scare me and leave me somewhat frightened of reaching out at times, because if I chose the wrong word, it may be seen as a microaggression and really I was just trying to do the right thing.

In Renee’s exposition, we see how post-civil rights era norms about race-related speech make her fear being labeled a racist. This fear overwhelms her ability to see that any White person in a racialized society is likely to engage in behavior or language that is racist. The goal then, is not to stop speaking about racism, but to be open to feedback. Her reluctance to address racial issues perpetuates inequality by maintaining “post-racial” norms that silence discussions of race within her workplace and leaves her coworkers and patients of color subject to discrimination.

3.4 Discussion

Bonilla-Silva (2010) argues that in a post-civil rights world, because overt racism is no longer seen as acceptable, Whites find other more covert ways of talking about and reinforcing the racial order without appearing overtly racist. For example, Whites may use the following frames when talking about race: naturalization (suggesting racial differences are a result of

natural process), abstract liberalism (“I disagree with racism in hiring, but affirmative action shouldn’t be forced on people”), cultural explanations (ex. “Hispanics just don’t emphasize breastfeeding”) and minimization (suggesting discrimination no longer occurs or has vastly improved). White IBCLCs used many of these frames when asked to explain racial disparities in breastfeeding.

White IBCLCs are more likely to blame economic inequality for breastfeeding disparities, suggest that a lack of role models who breastfeed in communities of color leads to lower rates of breastfeeding and/or suggest that differences in culture or family structure affect breastfeeding rates. These IBCLCs, for example, do not link a potential lack of “breastfeeding role models” to historical and contemporary structural disadvantages that Blacks face in acquiring breastfeeding resources or accessing quality breastfeeding services. Many of these explanations boil down to “that is just the way it is” and fail to consider the structural roots of breastfeeding inequality. These frames help White IBCLCs to justify racial inequality in breastfeeding without appearing racist.

It is unsurprising that White IBCLCs are more likely to hold these views. But it is important to note that the origins of these beliefs and feelings are structural – not individual. Bonilla-Silva (2010) has argued that most Whites share a “White habitus,” that is, they experience spatial segregation and isolation from minorities that fosters a racialized socialization process that shapes White’s tastes attitudes, emotions, and views. This “universe of Whiteness” that Whites experience on a daily basis “fosters a high degree of homogeneity of racial views and even of the manners in which Whites express these views. Despite the civil rights revolution, Whites, young and old, live a fundamentally segregated life that has attitudinal, emotional, and political implications” (Bonilla-Silva 2010:125).

Bonilla-Silva draws attention to the structural roots of White beliefs and attitudes and the ways that Whites learn to uphold “post-racial” silence regarding racial matters through semantic moves. Drawing from this same tradition of thought, Matthew (2015) has argued that implicit bias in healthcare delivery is structural in its roots and emanates from larger inequalities in society. Providers and patients are separated by racial segregation in housing, inequalities in education, employment inequality and more that all impact the stereotypes and unconscious bias that providers have against patients.

In other words, implicit bias on the part of medical providers is not unique to the medical setting. It exists and originates from elsewhere in society. The implicit biases that providers exhibit are endemic of larger social inequities and must be addressed at their source. As Williams and Rucker (2000) suggest:

Effectively addressing healthcare disparities will require comprehensive efforts by multiple sectors of society in order to address larger inequities in major societal institutions. There is clearly a need for concerted society-wide efforts to confront and eliminate discrimination in education, employment, housing, criminal justice, and other areas of society which will improve the socioeconomic status (SES) of disadvantaged minority populations and indirectly provide them with greater access to medical care. While research suggests that implicit biases can be altered (Blair 2002; Dasgupta 2004),

this strategy fails to hold organizations and institutions accountable for their role in perpetuating implicit bias. Matthew argues that:

A broader view of racial biases that impact health outcomes must include discrimination in all social determinants of health including residential segregation, employment inequity, inequitable education funding, and enormous income disparities that reinforce the implicit bias that physicians have been shown to hold against their patients.

This strategy may seem daunting and unrealistic for hospitals, agencies and organizations that provide day to day services for women who are breastfeeding. Indeed, many of the solutions that Matthew (2015) suggests involve policy and legal work that falls outside of a given organization’s capacity. However, these organizations can – at the very least – take a concerted

look at their workplace structure and culture to uncover the ways that their particular hospital, clinic, agency, etc. is organized to reinforce racial inequality.

As I have demonstrated previously, the work environments in which the participants in this study are embedded exhibit evidence of racial discrimination in hiring – with Blacks largely serving as token employees of color who lack power and fill lower rather than managerial roles. IBCLCs in these environments report overt and covert discrimination, feelings of invisibility and exclusion from social networks and experience negative stereotypes about people of color that affect the tasks they are asked to perform and that are leveraged against them when workers complain about workplace discrimination. When workplaces structure employment in discriminatory ways and conceal or ignore racism, implicit biases - which employees bring into the workplace already- are maintained and perpetuated in interactions with patients.

Put another way, workers come to jobs with existing implicit biases that are influenced by structural inequality outside of the workplace. White workers, for example, may be racially isolated from people of color due to race-based inequality in housing, wealth, education and more that shape life outside the workplace. They are influenced by stereotypes about people of color from an array of sources. This is largely outside the organization's immediate control - though organizations should prioritize ways that they can assist in addressing structural inequalities that affect their workers and patients. However, workplaces allow implicit bias to remain unchecked when they structure employment in discriminatory ways, when they intentionally or unintentionally conceal the complaints and concerns of workers of color, and when they unequally distribute positions of power and influence across an organization.

When supervisors ignore or deny racial discrimination and cast Black workers as “angry Black women,” they reinforce negative images of Black women and confirm racist stereotypes

about people of color. When White workers lack meaningful connections with racial minorities in other spheres of their lives (neighborhoods, religious organizations, etc.) this can have a significant impact on worker's implicit bias since these organizations are providing a legitimating authority to the implicit biases that workers already hold.

In order to address patient discrimination, employers cannot merely require implicit bias training. Instead, they must also take a concerted look at their hiring and employment data, mentorship programs, education-related reimbursement programs, educational materials that are provided to patients and various policies (ex. such as referral policies related to mental illness and substance abuse) in order to uncover and systemically address discrimination. Organizations should not be surprised that employees exhibit implicit bias – indeed, it would be surprising, given the structure of inequality in the US, if they did not. Instead, employers should provide evidenced-based implicit bias training, and they should also critically consider the ways that the organization, its culture and the institutions that it is connected to (e.g. insurance agencies, law, government and contractors) actively uphold and maintain inequality.

4 “THE DOCTOR IS THE HEAD OF THE TEAM AND THERE IS NO DOUBT.”:

MEDICALIZATION AND DEMEDICALIZATION IN LACTATION

Public health organizations, government agencies and professional medical associations have emphasized the medical benefits (Singh et al., 2007; Gartner et al., 2005; Pettigrew et al., 2003; Conrad, 2007). However, some researchers have called the medical frame into question. Joan Wolf (2007) argues that the benefits of breastfeeding are overstated in part because breastfeeding studies rely on observational studies that fail to parse out the benefits of breastfeeding from the benefits of deciding to breastfeed. Mothers who choose to breastfeed, for example, may exhibit other positive health behaviors that affect the perceived health outcomes of breastfeeding.

Medical studies of breastfeeding are critiqued for placing emphasis on small and weak associations. Doctors, public health professionals and medical organizations are also criticized for emphasizing breastfeeding as an individual choice and for failing to address the social forces (support networks, employment, childcare, race, class, income and education) that affect breastfeeding rates. US certified lactation consultants have often relied on this problematic medical model, but they have also challenged the medicalization of breastfeeding in significant ways. This study examines how lactation consultants are able to work toward the demedicalization of breastfeeding as well as the barriers that they face in those efforts.

4.1 Background

4.1.1 History of medicalization and the lactation profession

International Board Certified Lactation Consultants are defined by the International Lactation Consultant Association (ILCA) as professionals “who specialize in the clinical management of breastfeeding.” IBCLCs receive certification after they complete the requirements

for eligibility and pass an exam given by the International Board of Lactation Consultant Examiners. This certification must be renewed every five years (CDC, 2014). IBCLCs are not the only certified lactation consultants, but the IBCLC recognition remains the only internationally recognized certification for lactation consultants and represents a growing profession in the US. CDC reports reveal that the number of IBCLCs increased from 2006 to 2013. In 2013 there were 3.5 IBCLCs for every 1,000 live births, an improvement from 2.1 in 2006 (CDC, 2014). The Surgeon General has also identified increasing access to IBCLCs as an action step to support breastfeeding and The Affordable Care Act similarly mandated insurance providers cover breastfeeding support (U.S. HHS, 2011).

IBCLCs and other lactation consultants have been involved in both the medicalization and the demedicalization of breastfeeding in the US. Medicalization is “a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007). When a natural process, such as birth or breastfeeding, becomes medicalized, the medical management of the process is often ushered in by work to construct it as “pathological, or prone to disaster” (Torres, 2015). This happened for breastfeeding when breast milk was called into question as an adequate food source for infants in the early 1900s. Doctors began to consider formula a more modern and suitable option for infant nutrition (Apple, 1987; Wolf 2001). Breastfeeding came to be seen as a backward practice that poor, Black and Latin@ women engaged in. Because of these changes in the medical and scientific community, breastfeeding rates dropped and access to quality information on breastfeeding disappeared (Stolzer, 2006).

In the mid-20th century the natural childbirth movement and the women’s health movement both fought to address the problems caused by the medicalization of birth and breastfeeding (Blum,

1999; Rothman, 1982; Sandelowski, 1984; Wertz and Wertz, 1989). The professionalization of lactation consultants also occurred at this time after Le Leche League, a mother-to mother breastfeeding support program, sought to improve breastfeeding rates that were as low as 20% in the mid-1950s. Le Leche League International initially did this work through breastfeeding support groups and then convened a panel of 60 experts in 1985 to develop standards that continue to shape the scope of lactation practice today. The International Board of Lactation Consultant Examiners was formed as a result of the panel and now issues the only internationally recognized credential for lactation professionals (Thurman et al, 2008). Modern medical organizations and professionals now generally recognize the potential health benefits of breastfeeding and attempt to support breastfeeding as a primary infant feeding choice. However, breastfeeding remains medicalized in significant ways. For example, breasts continue to be viewed as likely to fail (Dykes, 2005; Burns, et al, 2012). And approximately half of all women who plan to breastfeed exclusively are given free formula or coupons in the hospital (Delclercq et al., 2013).

4.1.2 Challenging and contributing to medicalization

As Jennifer Torres (2014) points out, lactation consultants contribute to medicalization by viewing breast milk as a medical product and by using medical technology to manage breastfeeding. Breast pumps and infant scales are often used to quantify milk production. This can result in framing breast milk quantity and quality as inadequate. Major health organizations also place emphasis on the nutritional properties of breast milk and regard it as a medical product (Conrad, 1987). For example, mothers of premature infants who are unable to breastfeed are increasingly instructed by their doctors to use donor breast milk from milk banks (Academy of Pediatrics, 2012). These practices are derived from a view that breast milk is a product for specific medical uses.

Jenifer Torres (2014) argues that it is important to consider medicalization and demedicalization as a process or a continuum rather than an absence or presence (Torres, 2014). In her 2014 study of IBCLCs, Torres found that lactation consultants worked both to medicalize breastfeeding and to demedicalize it. In fact, Torres argues that their status as medical professionals gives them the authority to engage in some forms of demedicalization that they may not be able to engage in without their medical and professional status.

In particular, Torres (2014) found that IBCLCs worked to demedicalize in three major areas: pathology, technology, and medical control. They challenged pathology by promoting positive ideas about the quality and quantity of breast milk. IBCLCs challenged technology through questioning incorrect recommendations from radiology department professionals who were instructing women to pump and dump after receiving dyes during a medical test, and they challenged medical control through the formation of peer-support groups that provided women with non-medical support for breastfeeding.

In a comparative analysis of lactation consultants and doulas, Torres (2013) also notes that lactation consultants use their “front-door entrance” into the medical maternity system in order to affect change. While doulas work through “back door” channels that aim to make changes “one birth at a time,” Torres argues that lactation consultants are able to create formal changes to hospital policies and practices through their status as lactation specialists. For example, lactation consultants may participate in committee meetings that set policies and recommendations related to mother’s rooming with their babies rather than babies being placed in a nursery. Rooming with babies is shown to improve breastfeeding initiation and duration. While some of this is also evident in this study, I argue that professional norms and hierarchies in the hospital affect the degree of agency that lactation consultants are able to employ. Formal

changes in breastfeeding policies and practices remain largely closed to private practice IBCLCs who are only loosely connected to the medical system and have minimal interaction with physicians.

Torres (2015) makes one final and crucial argument about the work of lactation consultants. Lactation consultants engage in gendered work. They provide both physical support — helping mothers learn new positions or practice techniques for expressing milk — as well as emotional support — working to increase the confidence of women related to breastfeeding specifically but also to motherhood more generally. This work involves efforts to normalize breasts, milk supply and baby's behaviors. Lactation consultants are also required to spend considerable amounts of time with a mother. An average IBCLC in private practice, for example, aims to spend an hour to two hours with a client. Because this work is time intensive, it is unsurprising that physicians are less likely to do it. As Torres (2015) points out, lactation work can be considered an area in which physicians or patients engage in outsourcing. This is an important insight, but Torres pushes this idea further.

Much of the support that lactation consultants provide to women, particularly the emotional support that aims to increase a mother's confidence in breastfeeding and motherhood, is needed precisely because of the ways in which breastfeeding has been systematically medicalized in the US. While families would have historically provided support for breastfeeding mothers, the increasing medicalization of breastfeeding over time has led mothers and families to question their ability to provide adequate care.

Medicalization...contributes to why many women do not believe they are competent to birth or breastfeed their baby without the help of an expert.... The process of medicalization serves to deskill the public and make them believe they are uneducated and incapable of making their own health decisions....As childbirth and infant feeding have been moved further into the realm of medical professionals, they have increasingly become private events between a woman and her physician, and many women do not

have exposure to other birthing or breastfeeding women. Sometimes they simply do not know anyone who has breastfed. (Torres, 2015).

Torres notes that lactation consultants also act as guides for an increasingly complex medical system. They provide guidance on prescription drugs and insurance coverage, help clients locate resources and navigate maternity care systems, and leverage their status as professionals to advocate on behalf of patients.

This study expands on this literature by detailing the ways in which IBCLCs both resist and contribute to the medicalization of breastfeeding. It specifically looks at the ways IBCLCs use their professional status in order to demedicalize breastfeeding and how demedicalization is limited by existing social norms and structures in medicine. Finally, it addresses the ways that medicalization creates the very anxiety that IBCLCs seek to help mothers navigate.

4.2 Methods

The data for this study comes from semi-structured, intensive telephone interviews with 36 IBCLCs across the United States that occurred between November 2015 and March 2016. Interviews generally lasted approximately one hour and were audio recorded and transcribed with the participant's permission. Study materials were labeled with unique, random aliases.

An intensive interview involves a pre-constructed research guide with open-ended questions designed by the researcher. However, it also involves "ordinary conversation and listening as it occurs naturally during the course of social interaction and semi-structured interviewing" (Lofland et al. 2006:17; Berg 2009; Weiss 1994). Participants were recruited through ads on various professional lactation networks, breastfeeding advocacy groups and a listserv for professional lactation providers. I added additional interviewees through snowball sampling. Interviewees included IBCLCs from private practice, hospitals, physician offices,

WIC, non-profits and public health agencies. All participants were IBCLC-certified at the time of the interview.

Relying largely on LaRossa's (2005) description of grounded theory, I conducted the first phase of analysis using open coding, in which similarities and variations in indicators are linked with concepts in order to begin forming variables. Next, I performed axial coding by linking variables to form a framework that I used to explain the data. Lastly, I conducted selective coding in order to develop core categories. I coded the interview transcripts with QSR NVivo. I have reported raw data from the interviews to demonstrate how the data and my interpretations of them relate and to allow the participant's voices to be expressed directly. Table 1 provides descriptive statistics for the sample population.

4.3 Findings

4.3.1 Maintaining medicalization through hierarchy and social norms

The interaction between IBCLCs and physicians differs considerably between private practice and WIC IBCLCs compared to hospital and office-based IBCLCs. When asked about their relationships with physicians, most of the private practice and WIC-based IBCLC respondents in this study discussed relatively few meaningful interaction with doctors. When IBCLCs do have regular or meaningful contact with physicians, participants discuss a set of unspoken rules that govern IBCLC and physician interactions and serve to maintain the authority of the doctor. This is problematic, because IBCLCs report that physicians and other medical providers routinely give out misinformation on breastfeeding.

IBCLCs in private practice note that their primary communication with doctors is through the faxing or mailing of patient reports. For example, Toni's experience is typical of the relationships described by private practice and WIC-based IBCLCs: "Mostly when I

communicate with doctors I hand the client a piece of paper that she takes to her doctor and the doctor gives her a piece of paper that she gives back to me.” Heather’s experience points to a similarly distant relationship between private practice IBCLCs and physicians:

Well I send the fax and I also provide my fax number, but in a physician’s office, the first person who sees the fax is, you know, the desk person. So she will bring it back to the nurse and the nurse brings it to the doctor. The doctor looks at it and puts it in the chart. So it is not likely that the physicians would get back to me unless there was a particular issue.

In contrast, hospital or pediatric office-based IBCLCs have more routine daily interaction with physicians particularly when pediatricians do rounds with IBCLCs or conduct baby exams in the hospital room rather than in the hospital nursery. Sara discusses this when she mentions policy changes at her hospital that allow IBCLCs to interface with physicians more often: “For the last maybe year and a half they go into the rooms to do the baby exam. So they are walking around to every patient room and so it is a lot easier to stop and speak to them about that patient when they are going to the room then when they have twenty babies and they are trying to do an exam.”

Despite this increased contact with doctors, there are a number of social norms that help to maintain the physician’s authority in the hospital. Terri, a 60 year old, White IBCLC, addresses several of the social norms when she says:

The lactation consultant will sometimes — right in front of the doctor — say “Oh no. I don’t think we should do that.” To me, that is a misunderstanding of the role of the lactation consultant. The doctor is the head of the team, and there is no doubt. And the new doctors coming into the department try to check out if I am going to be a team player or if I am going to be a nuisance.... And to me that is just so wrong. It is not our role to tell a doctor off in front of a patient. If we disagree with a doctor’s advice —and we often do, because doctors are not trained — it is offline. You know: “Can I talk to you about this. Here is a research article on what we just dealt with.” Or “You and I are disagreeing on this. Can we work that out together?” You know you don’t do that in front of a patient and you don’t take on the doctor as someone to be contradicted.

Terri's discussion reveals a number of themes echoed throughout the interviews. First, lactation consultants provide details on the professional roles and hierarchy that structure their workplaces. Participants report that they feel they must present their disagreements to doctors based on that hierarchy. Irene's account echoes the roles evident in Terri's explanation: "You kind of have to be conscious of what you say and how you say it, and you always need some type of evidence to back up what you're saying." Themes of deference toward doctors and an emphasis on the importance of presenting doctors with evidence are apparent throughout the interviews. As Carlene similarly discusses: "I have had a physician say 'Well, based on my training, I disagree.' To that I replied, 'I definitely understand that. I would be happy to send over the clinical evidence that we have to support our position.' And that was kind of the end of that discussion."

IBCLC's insistence on evidenced-based recommendations help them to work within the existing norms of medicine and are used to legitimate their role and authority as breastfeeding specialists. These strategies appear to have mixed results, since these approaches maintain the established rules and hierarchy of the hospital – in which IBCLCs and other non-physician providers are largely subservient to doctors. However, working within the established norms does help IBCLCs promote policies that often seek to demedicalize breastfeeding. For example, Sara, 40 year old, White IBCLC discusses how she and her colleagues successfully used these strategies in committee meetings with physicians at her hospital:

We came with our evidence. First it was for feeding – like when that first feeding has to occur...how long the baby can go without feeding well. But we brought the evidence and they were okay with it. Then it was for the amount of supplementation. We brought the evidence for that. Like if a baby needed supplementation and we had some push back on that from a pediatrician who doesn't even see newborns in that area....So he was very vocal which kind of got the rest of the group stirred up. So they didn't go with our recommendations there but they did end up lowering it.

When IBCLCs discuss policy changes or changes in physician attitudes, the changes are routinely like those described by Sara – incremental.

Audrey, a 50 year old, White participant, discusses the ways that IBCLCs present their recommendations in order to maintain legitimacy even more explicitly when she says:

I guess I just have kind of kept myself a little more mainstream. And I am not strictly a mainstream person myself, but if I was going to have any kind of veracity with these doctors then I was going to have to present myself a certain way... So like now it is pretty well accepted that cabbage will help with engorgement. But when that first came out – even though I knew that it worked – I would be damned if I would admit that I suggested that the mother put cabbage on her breast. Because all of a sudden everything else I had to say would be like “Oh these crazy breastfeeding people.” Now that *hospitals* will send them home with that information I feel okay also going there.

As Torres has argued, IBCLC’s status as medical professionals bestows them with authority to engage in some forms of demedicalization that they may not be able to engage in without their medical and professional status. However, their status as medical providers is limited by existing social norms and professional hierarchies that both formally and informally govern the behavior of providers and ensure that physicians maintain relative power.

The maintenance of physician power matters practically for mothers, babies, and breastfeeding rates. Existing research has established that physicians and nurses are not adequately instructed in lactation (Bunik, Gao, and Moore 2006; Hellings and Howe 2000; Register et al. 2000). This is echoed in participant’s comments as well. IBCLCs in the study persistently discussed physicians as members of one of two groups – breastfeeding friendly physicians or breastfeeding non-friendly. Irene, a 30 year old Black respondent, discusses this distinction in her response when she says:

For physicians that are breastfeeding friendly, who support breastfeeding, [the relationship is] usually great. Now, for physicians who aren't breastfeeding friendly, it's a little more difficult... It's a little more trying, especially if you're working with a neonatologist because they believe in nothing but numbers. If it's not showing up in the numbers, then it's not good or it doesn't exist.

Irene's discussion of numbers is also a central aspect of medicalization. Medicalization seeks to control and quantify, often through the use of technology (ex. measuring milk quantity and quality). This aspect of medicalization is discussed in participant's recollection of all physicians, but neonatologists in particular are framed as "particularly difficult."

For example, Lisa, a 30 year old White participant notes: "The neonatologist was the one that I'd get into it – well, not get into it – but have disagreements with. He feels that every kid in the NICU should have formula supplementation and doesn't want to read the research regarding the relationship between that and necrotizing enterocolitis..." This is seen again in Sara's response: "Neonatology is probably our hardest – our roughest relationship. The neonatologists and their nurse practitioners. We just don't see them a lot. And it is just hard. It is a hard place to break through." This is likely due, in part, to the relative isolation of neonatologists.

Neonatologists are less likely to have daily interaction with lactation consultants on the labor and delivery or postpartum floors. The NICU also has unique norms that arise from dealing with babies who are high risk.

Participants note other instances in which physicians are prone to give out incorrect information to patients. Audrey recalls, "You still hear doctors say the stupidest things! Oh! Like I had a doctor tell a mother once that all the nutrients are out of breast milk after the first three months. That, basically, after three months, you were just feeding the baby White water – like no nutrients, no protein. It was like 'What! Why would that happen?'" Pam, a 40 year old, White IBCLC, discusses what she perceives as doctor's overuse of the word dehydration in order to push formula onto families:

If the baby has a 10% weight loss, they're like, "Oh! The baby is dehydrated. You need formula." He might be a little hungry, but it's certainly not dehydration, not by the medical definition. They're also very quick to reach for the formula. They'll say: "Oh, supplement the baby with formula." And they don't even know if the mother has milk or

not.

Tanya expresses feelings of disappointment and frustration that are characteristic of IBCLC responses:

It is disheartening when they don't support breastfeeding as much as they should. Like my own pedestrian told me that after a year that if we were in Africa, you know, where the food wasn't good or the water wasn't good, then you know maybe she would encourage prolonged breastfeeding, but since we aren't, that it is just ridiculous, and I should wean him.

These discussions reveal the tension between lactation consultants and physicians. While lactations consultants work towards the demedicalization of breastfeeding through reducing intervention, encouraging and de-pathologizing breastfeeding, doctors push back and are often able to undermine lactation consultants' advice because physicians maintain relative authority in the medical environment.

Lactation consultants also discussed patient trust in their recommendations in comparison to those of physicians. As Kayla mentions, "You can tell if the doctor is the holy bible for [a patient], because they will be like 'Well the *doctor* said.'" Betty echoes this sentiment in her discussion: "Some clients just completely shut down after I recommend one thing and then they bring it to their pediatrician and their pediatrician says 'No.' Then I follow up and they say 'Oh my doctor says that isn't needed so thank you.' So there are definitely those situations where they see MD behind someone's name and they take that for gold."

4.3.2 Medicalization: Tongue tie

One of the most surprising things that IBCLCs, physicians and their patients consistently disagree on is tongue tie. Tongue tie or "ankyloglossia" is defined by Stanford Children's Health (2016) as a condition in which an "abnormal frenulum is impairing the infant's ability to breastfeed." In order to address this, a doctor will cut the lingual frenulum in a procedure called a frenotomy so that the tissue will not be as tight. The procedure does not require anesthesia and,

while Stanford argues that there is usually “only a drop of blood or less,” the only risk that they discuss is “excessive bleeding.” Given that lactation consultants exhibit a pattern of requesting less intervention in breastfeeding, it is surprising that tongue tie was a regular topic of discussion among participants. Every IBCLC who mentioned tongue tie, approximately one-third of the sample, advocated for the use of frenotomy even when many faced considerable resistance from doctors.

Patricia’s view exemplifies those held by IBCLCs in this study: “Tongue ties are very important. . . . If a baby is tongue tied, it is very difficult for them to latch on. So part of my self-education has been learning more about tongue ties and becoming a member of an association for tongue tie professionals.” Like Patricia, most IBCLCs reference becoming members of similar organizations, relying on clinical studies to educate themselves on tongue tie or becoming self-identified experts in tongue tie. However, IBCLC accounts of their interactions with doctors surrounding tongue tie suggest that the average physician is unconvinced that having tight tissue under the tongue significantly impacts breastfeeding. As Patricia goes on to say:

In many hospitals IBCLCs are prohibited, they are actively banned — they could get fired — for even mentioning that the baby has a tongue tie. This is because one of the doctors on staff quote: “Doesn’t believe” in tongue tie. How can you not believe in something that has a physical manifestation?

Lactation consultants generally deal with these disagreements as they do with other disagreements with physicians, by presenting the evidence to a patient and/or their physician and remaining polite in the face of the disagreement. Lynda’s approach is an example of this: “Some physicians are not comfortable with infant chiropractic work or tongue tie release so it is a matter of just being polite and having good evidence and allowing the parents to get informed and make their own decision.” In general, lactation consultant’s report that physicians are dismissive of their concerns surrounding tongue tie like when Carmen, a 40 year old, Black IBCLC recounts

that she “was actually just at one of the hospitals yesterday...and the LC was saying that it is just a fact that they just won’t hear anything of tongue tie and if you ever mention it, they are just like “Yeah, yeah yeah.” While this is a more unusual case in which IBCLCs appear to be actively advocating for medicalization, the responses of doctors (ex. ignoring IBCLC suggestions) and hospitals (ex. creating policies that effectively silence discussion of tongue tie) help to display the ways in which physician power is reified in hospitals.

Occasionally, exchanges between physicians, lactation consultants and patients turn tense and result in the mother being left in the middle of a professional debate. Lynda recounts:

I made some suggestions to a mom and she went to a physician. And you know, she is a post-partum mom, so you really have to be careful with your vocabulary. And he was really rude and he told her - he insinuated that if she considered chiropractic care or tongue tie release that she could be harming her baby and that sometimes babies have strokes. And I was like what the hell are you saying that for?!

Like Lynda, other IBCLCs express deep concern when mothers are given harsh or cold advice from physicians. The way in which IBCLCs and physicians each approach breastfeeding or medical advice is another crucial divide that IBCLC’s view as separating the two profession’s approach to breastfeeding.

4.3.3 The importance of mother’s goals: empowering women that are disempowered by medicalization

At the close of each interview, I asked IBCLC participants to tell me the most rewarding part of their job. Without fail, almost every IBCLC in this study expressed some variation of the sentiment that “helping a mother reach *her* goals” was the most rewarding aspect of their work. As this phrase and theme emerged in other areas of the interview as well, I pressed participants about why this was important. In analyzing their responses, it is apparent that IBCLCs approach work in a unique way that separates them from the traditional medical model of care.

IBCLCs are acutely aware of the psychological and social aspects of breastfeeding and new motherhood. They also perceive themselves to be less likely than doctors to be highly prescriptive about exactly what a mother should do and how they should do it. Instead, they claim to make a concerted effort to connect with the mom, acknowledge her feelings and shape a breastfeeding plan around the mother's personal goals – even if/when those goals conflict with what they would do themselves or what they believe the best clinical evidence supports. Jill highlights this theme well when she says: “When you are able to reach moms with their goals – so her goal may be 6 weeks or 6 months or it may be well past a year. But if moms can reach their goals, that is all that matters.” Lisa, a 30 year old, White IBCLC echoes this sentiment when she says that she enjoys

being able to see that the parent feels validated that breastfeeding is so important to them, and, “Someone's finally listening that breastfeeding is important to me. And they're not telling me that I have to breastfeed their way. They're telling me that my goals are okay.” So I tell parents all the time, you know, “If you want to breastfeed two weeks, I'll give you the tools to make it two weeks. If you want to breastfeed two years, I'm going to meet you where you want to go.

IBCLCs are explicitly taught counseling skills in their training process. Renee details this in her discussion of her training:

I didn't have any formal counseling training before becoming an IBCLC and a La Leche League leader.... But I guess it was first through LLLI that I got training there. And even some more powerful training in WIC. Most mothers cannot receive information that they are given – I mean there are so many things going on with a new mom, she is exhausted, she might be hormonal, she might not be supported.... And then generally people who feel like: “I never thought a baby would keep me up all night.” That kind of thing. You have to validate their feelings before they will receive the information from you. That was really powerful training that I received at WIC.... You don't go off on your tirade. The emphasis that Renee places on the importance of the mother's goals and taking into

account the social and emotional state of the mother is echoed throughout participant's discussions. Terri notes that, “[IBCLCs] are lactation consultants not lactation directors.... I have no goals for [mothers]. I need to support [their] goals.”

Participants explicitly contrast this model with the way that they view doctors, nurses and hospitals more generally providing advice. As Renee notes,

You know I totally respect a mother's right to make decisions in the best interest of herself and her baby....That's just how I am. I guess because I am a little outside the usual medical model myself in terms of how I raised my kids....I had that experience personally and sometimes being demeaned by people in the healthcare field about the choices that I made. But honestly, overall, in the IBCLC profession, I feel that is pretty universal.

Terri, a private practice consultant, echoes this when she questions whether hospitals are set up to facilitate the kind of care that IBCLCs aim to provide:

It isn't clear to me that in the hospitals that they are able to 1) have the time to find out what the mothers goals are and 2) I think mothers are so overwhelmed at that point that they don't know most of the time and 3) if you are treating them all the same – all babies on all breasts at all times, clearly you are not going to be meeting mothers' wishes at all times. So yeah, it is very important to go where a mother wants to go. And again, sometimes we have to help them understand what the options are, but then it is up to them to decide.

Participant's emphasis on mother's goals and counseling mothers shows the ways that their methods of delivering services push against the traditional boundaries of medical care – which generally advocate for objective and prescriptive care with clear, almost-moral values attached to the decisions that patients make to comply with or defy medical recommendations. IBCLC's say they give their patients considerable more flexibility. However, it is important to note that these are the impressions of the lactation consultants rather than the impression of their clients. It is possible that consultants are being considerably more directive than they realize.

In part, this mother-focused philosophy is rooted in IBCLCs recognition that mothers are faced with the intense pressures of scientific mothering. Scientific mothering is the idea that mothers need to be formally trained to be “good” mothers, that “good” mothers defer to expert advice on child rearing, and that babies should follow strict schedules (Weiner, 1994). IBCLCs describe mothers who are “deer in the headlights,” are overwhelmed, are unsure what to do and who have difficulty navigating the hospital, insurance, and other resources after they give birth.

This is exemplified in Angelina's discussion of her patients: "I have so many moms coming in just defeated and like 'I know I can't do this. I couldn't do it with my last baby. I don't know why I am even here,' and it is something so small that needs to be fixed and they are able to nurse just fine. That is the best. That is the absolute best, because that changes everything."

Renee describes her own experience as a new mother in similar terms:

Really the reason I became a LLLI leader is because I had some struggles initially and then it all worked out. But when I attended my first LLLI meeting, I went there and I had this long list of questions and I was so uncertain and scared and traumatized. And I had this baby who I loved and was fearful of all at the same time, and I was really not in a good emotional or mental health state. And I was afraid to tell anyone.

IBCLC participants discussed the new mothers in these terms consistently. New mothers are depicted as overwhelmed with their own expectations of themselves, the expectations they perceive others have for them, the fast-paced information they receive in the hospital or doctor's office, sleep deprivation, depression and more.

IBCLCs perceive that it is their job to help empower mothers to trust their own bodies and to gain confidence in parenting that they will carry with them throughout their lives. Yvonne summarizes this when she says, "A woman is most vulnerable right after she has her baby. The baby is most vulnerable, you know, being born into the world and in their first few years of life. And so to be able to give support during that time, I really think it's a foundation for the community and the future." Heather explains this philosophy also: "I think it is [about] helping a mother to find her own confidence....When I get feedback from many of the clients that I help, most of the people say that it is because I was able to help them find their own kind of zone where they felt comfortable doing what they were doing and to trust themselves."

IBCLCs emphasis on empowering mothers and helping them gain confidence is not strictly a move in support of demedicalization, however. As Jennifer Torres has pointed out, medicalization and demedicalization are a continuum and can even occur in tandem. For

example, Kyra discusses one of the ways that she helps mothers realize “their bodies aren’t broken” when she says:

I love when I put that baby on the scale to do a transfer weight test and that little baby who started only transferring .5 ounces is now transferring 3 and half. That makes me happy just to see the look on [the mom’s] face because it is confirmation that their body isn’t broken, that their baby isn’t broken. So that is my favorite part of the job, when I get something that has gone off track back on.

Kyra is countering the medical model in that she is working to de-problematize and normalize breastfeeding, but she does this through using a medical form of intervention. Kyra and other IBCLCs must work to prove to the mother – and sometimes to her doctor — that her body is not broken. They attempt to do this through medical procedures because those are the norms doctors recognize as legitimate.

4.4 Discussion

Torres (2014 and 2015) has argued that IBCLCs are able to use their status as lactation professionals to engage in “front door methods” (ex. dealing directly with doctors around breastfeeding practices, making formal policy changes in hospitals) of demedicalization and advocacy on behalf of their patients. This study both confirms and challenges this finding. Private practice and WIC-based IBCLCs describe a considerable amount of isolation from physicians that inhibits their ability to affect meaningful change in breastfeeding policies. Because of this isolation and patient’s perceptions that a doctor is a more qualified authority on infant feeding, private practice physicians are able to maintain considerable power and authority over the information that patients receive and accept.

In contrast, hospital and office-based IBCLCs are more likely to have frequent interactions with physicians – though they often remain isolated from neonatologists in particular. However, the informal and formal social norms that govern professional interaction in the hospital help to ensure that doctors maintain relative power. IBCLCs report that they must

work within medical norms and show deference to doctors, even when doctor's practices are inconsistent with established lactation knowledge. This allows physicians to continue to give misinformation about breastfeeding to patients.

While IBCLCs work generally to reduce medical interventions in breastfeeding and to normalize and de-pathologize breastfeeding, they also contribute to the medicalization of breastfeeding as they increasingly rely on technology to control and quantify breastfeeding, treat breastmilk as a product rather than a process, promote surgery to address "tongue tie," and otherwise adhere to the medical norms and policies in the hospitals and offices in which they work. Private practice IBCLCs are able to resist medicalization in their daily practice to a larger degree, but they are also less able to affect larger policy changes that promote the demedicalization of breastfeeding.

IBCLCs report that they aim to empower women and to help mothers meet their personal goals. This model of care – which centers counseling as an important aspect of care – stands in contrast to the traditional and more prescriptive model of medicine. However, IBCLCs also consistently depict new mothers as vulnerable, overwhelmed and uncertain. This view of mothers stems from medicalization and feeds into the ideology that suggests that breastfeeding is destined to fail and in need of intervention. Mothers and families who are confronted with this widespread ideology may question their ability to breastfeed successfully without professional assistance.

In other words, mothers' anxieties about birth and breastfeeding stem from the medical model of breastfeeding and the pressures that surround the ideology of scientific motherhood. Medicalization works to deskill mothers and kin networks by insisting that professionals are necessary to properly manage breastfeeding. IBCLCs work to combat these ideologies, but they

also work within - and because of - these frames, and benefit from them. The IBCLC profession exists in large part because of the anxiety that the medical model of breastfeeding and scientific mothering produces. IBCLCs serve as counselors and guides to assist mothers with that anxiety, and to negotiate the complex medical system that surrounds birth and breastfeeding.

These findings help to confirm existing research and show the ways in which demedicalization and medicalization exist on a continuum. Given these findings, it is likely that IBCLCs will continue to push to demedicalize, normalize, and de-problematize breastfeeding. However, they also face considerable constraints and are limited by the structures in which they work. IBCLCs must adhere to existing medical norms that limit their agency. They are subject to the policies and procedures of the hospitals or offices in which they work and/or suffer from isolation that limits their ability to affect changes in policy and practice. As IBCLCs continue to work to legitimate their role within medicine, they are also likely to continue to adopt additional practices that are more consistent with a medical model of breastfeeding.

5 CONCLUSION

In this study, I have used interviews with IBCLCs across the US to take a systematic look at breastfeeding disparities through the lens of the lactation consultant profession. Specifically, I have addressed 1) barriers that lactation consultants of color face in becoming certified, 2) employment discrimination faced by IBCLCs of color, 3) race-based discrimination against patients, and 4) the ways in which IBCLCs work to both medicalize and demedicalize breastfeeding in the US. Each of these areas can impact breastfeeding rates and breastfeeding equity, and each help to reveal the ways in which race, class, gender and medicine shape views and practices related to lactation, motherhood and medical services.

Research confirms that breastfeeding disparities persist and that lactation consultants play a key role in reducing breastfeeding disparities. However, there continues to be a limited number of IBCLCs in the US with certain groups facing persistent barriers in the certification process. In particular, I find significant race and class-based inequality in certification and employment, disadvantages for IBCLC candidates who are not recognized health providers and evidence that the medicalization of breastfeeding leaves IBCLCs relatively powerless to positively impact breastfeeding policies.

IBCLC candidates who are already recognized health providers (ex. nurses, dieticians) are better poised to complete the educational requirements, secure clinical hours and receive financial support to complete certification. Cost and racial discrimination are also a significant burden. Low income candidates struggle to pay for courses, conferences, university programs, preparation materials and clinical placements while candidates of color face overt and covert discrimination that impact their success. As the IBCLC continues to place increased emphasis on university-level education and/or lactation programs, candidates of color and candidates who

are low income will continue to face structural barriers in access, cost and retention (Museus et al, 2015). The IBCLC certification board may perceive that an increasingly university-focused certification will provide a degree of legitimacy to the profession, but it comes at significant costs to equity.

I find that IBCLC candidates of color continue to face barriers in their clinical experience. They are more likely to report discrimination, including instances in which employer-sponsored funding for their education was denied. Candidates of color have a harder time securing clinical placements than White candidates and/or face discrimination in the course of their placements. Research suggests that these types of experiences affect work relationships, psychological and emotional well-being, and self-esteem. IBCLCs of color who complete certification and secure jobs report similar experiences during employment. Lactation consultants of color discuss both overt and covert discrimination from coworkers, supervisors and patients that affects how they feel about their work, themselves and their mobility in the workplace. IBCLCs of color also deal with isolation, invisibility and being assigned racialized tasks or feeling that they must adhere to different emotion rules than their White colleagues.

White IBCLCs in this study remained relatively unaware of the workplace discrimination that IBCLCs of color report. With few exceptions, most White IBCLCs in this study believed that their workplaces were fairly equitable. When Whites did discuss race, they seemed uncertain of what would and would not constitute racial discrimination and were more likely to downplay experiences of discrimination that they had heard about or witnessed. They also remain fairly unsure of how to discuss race and racism without “doing it wrong” or being labeled racist.

Lactation consultants in this study also reported racial discrimination directed at patients. Most often these reports involved witnessing medical providers provide unequal care to patients, for example, spending less time with a Black patient and assuming that a patient of color would not breastfeed. Other times, these reports involved overt discrimination in which providers used racial stereotypes to discuss patients with other staff members or were more likely to recommend social services or long-acting birth control – which can negatively impact milk supply - to women of color.

Finally, I reveal that IBCLCs work to demedicalize breastfeeding in many ways. They challenge providers when mothers are told that they can't breastfeed on certain medications. They advocate for delay of Depo-Provera shots in order to maintain adequate milk supply. Lactation consultants also contest the use of formula and other interventions and actively work to change hospital policies. However, IBCLCs are limited by the social norms and existing hierarchy of medicine. Doctors continue to be seen by the medical community and by patients as a more qualified authority on lactation in spite of their relative lack of training in breastfeeding. IBCLCs in private practice also remain isolated from physicians and are, therefore, less able to promote change in breastfeeding practices. Hospital-based IBCLCs have more routine interaction with doctors but are limited by the social norms of the hospital that place physicians as the ultimate authority or “head of the team”.

It is also clear that, while IBCLCs work to depathologize and normalize breastfeeding, they also continue to view mothers and breastfeeding through the lens of medicalization. The IBCLC profession exists, in large part, to help mothers navigate the anxiety that the medicalization of breastfeeding promotes. Mothers are seen by medical providers as vulnerable and fragile, overwhelmed by the large and complex medical environment and, therefore, in need of

professional assistance. IBCLCs also continue to rely on a number of medical interventions in their daily work. For example, they weigh a baby between feedings routinely as a way to “prove” to both the doctor and the mother that a mother’s milk supply is sufficient. They also advocate for surgery – even in the face of considerable resistance from doctors - in order to loosen tissue at the tongue and mouth that is deemed too tight and may impact breastfeeding.

These findings suggest that a number of interventions can help to reduce breastfeeding disparities and that a structural look at the lactation profession and the medical and social environment in which breastfeeding continues to occur is imperative to addressing these disparities. I have provided a number of suggestions within each article of ways that IBCLCs, the IBCLC Board, hospitals, breastfeeding organizations and others can work to ameliorate these issues. These include continuing to open IBCLC requirements to candidates who do not have a health background, reducing the focus on university-centered requirements in order to maintain equity and potentially reduce the influence of medicalization, working with hospitals and clinicians to reduce race and class based disparities in clinical placements and hiring and expanding the organizational authority of IBCLCs who are shown to have the expertise to positively impact hospital breastfeeding policies.

This exploratory study provides an important stepping stone to help researchers continue to uncover race, gender and class-based inequities in lactation services and the lactation profession. It is the first attempt to systematically analyze barriers to certification and reveals the connections between institutional employment discrimination and racial inequality in patient care. This research also builds on the literature around medicalization of breastfeeding and birth and shows a more nuanced picture of practitioner’s agency and the limits of the structures they are embedded in.

However, this research also faces several limitations. First, this study is exploratory and is non-generalizable. In particular, the participants in this sample are highly educated. This is likely a function of the recruitment plan. Because IBCLC participants in this study have such high education, they represent a “best case scenario” for success in certification. Candidates who do not share their high social capital, for example, may have a much harder time navigating the certification process.

This study also limited interviews to currently certified IBCLCs. This means that individuals who began the certification process, but did not complete the process, are missing from this analysis. Future research needs to include participants who have not yet finished their certification process or who hold lower levels of lactation certification (ex. CLC) in order to expand our understanding of the barriers to certification and the ways in which race, class, gender and medicine shape lactation and breastfeeding disparities.

What remains undiscussed - yet is equally important to point out - is that this study's strength lies in its analytic approach. The intersectional approach of this study reveals the ways in which race, class, gender and medicine interact in breastfeeding. Race, class, and existing hierarchies in medicine shape who is best poised to complete the certification process. They affect how individual IBCLC candidates are treated – with people of color and low income IBCLCs facing unique barriers throughout the process and overt and covert discrimination in their clinical placements. The move of IBCLC to a more university-centered education is similarly influenced by existing systems of inequality. IBCLC has likely increased its university focus in an effort to further legitimize the profession. This logic relies on existing racist, classist and medical understandings of what constitutes a “legitimate” and trustworthy professional. This move also

comes at an unexamined cost to candidates of color, low income candidates and individuals who are not already recognized health professionals.

Similarly, the employment discrimination that IBCLCs report reveals the intersection of race, class and gender inequities. Black IBCLCs, for example, reported instances of being cast by coworkers or supervisors as “the angry Black woman” and being asked to engage in racialized tasks and racialized emotion work that their White colleagues were not asked to perform. These interacting identities shape expectations and experiences in the workplace. Patients are subject to similar assumptions and experience discrimination based on their intersecting identities – with mothers of color being more likely to be stereotyped, prescribed long-acting birth control and assumed to be uninterested in breastfeeding or less likely to be compliant with professional recommendations.

Finally, the lactation consultant profession, a pink-collar profession, maintains relatively less power around breastfeeding despite consistent research findings that their work improves breastfeeding rates as much or more than the work of physicians. This is influenced by the intersection of existing medical hierarchies and gender. For IBCLCs of color, these inequities are compounded. IBCLCs of all races have relatively little power to affect policy. IBCLCs of color have even less given the relative lack of IBCLCs of color and their continued experiences with discrimination and isolation within the profession. This means that the lactation policies and practices that IBCLCs are able to shape are more likely to be shaped by Whites and are unlikely to account for the unique experiences and needs of patients of color and may perpetuate a culture of Whiteness within lactation and the hospital at large. No other study to date has addressed these multiple intersections and addressed the influence they have on organizational power and changes in policy and/or practice.

The intersectional approach of this study reveals, for the first time, the ways in which race, class, gender and medicine work to shape and impact inequalities in lactation. Previous research has largely dealt with these inequities as separate rather than interesting. Their additive approach to breastfeeding inequalities will not lead to robust and comprehensive solutions to the problems that the IBCLC profession and its patients face.

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APPENDICES

Appendix A: Table 1.1 Select Characteristics of the Sample

Table 1. Selected Characteristics of Sample	Frequency	Percent
Gender (Female)	35	97.22
Race (Self-Identified; Open Ended Question)		
White	20	55.56
Black	13	36.11
Multiracial	2	5.55
Hispanic	1	2.78
Age Group		
20 – 29	1	2.78
30 – 39	13	36.11
40 – 49	6	16.67
50 – 59	11	30.56
60 – 69	4	11.11
70+	1	2.78
Education		
High School	1	2.78
Some College	1	2.78
Associates Degree	2	5.56
Bachelor's Degree	16	44.44
Master's Degree	13	36.11
Doctorate	3	8.33
State		
CA	4	11.11
CT	1	2.78
FL	2	5.56
GA	4	11.11
MA	1	2.78
MI	1	2.78
MO	1	2.78
NC	3	8.33
NJ	1	2.78
NY	4	11.11
OH	1	2.78
PA	6	16.67
TX	2	5.56
VI	1	2.78
WI	2	5.56
Undisclosed	2	5.56
Job Site		
Hospital	12	33.33
Private Practice	11	30.56
Federal/State/Local Program	3	8.33
Pediatric Office	3	8.33
WIC	3	8.33
Multiple Settings	2	5.66
Other	2	5.66

Appendix B: Interview Guide

INTRODUCTION:

Thank you for agreeing to talk with me today. We appreciate your insight and hope that this study will help us understand barriers to IBCLC certification and the work experiences of IBCLC certified individuals.

1. Tell me about how you came to work in the lactation consultant field. (Probes: Are you IBCLC certified now? If so, when did you become certified. If not, are you pursuing certification? If so, where in the process of certification are you?)

IBCLC CERTIFICATION PROCESS:

1. One of the earliest requirements for IBCLC certification involves 8 hours of college credits. Have you completed these credits? If so, what school did you complete these credits at (or, if you have a degree, where did you finish your degree)?
2. Tell me about your educational experience. Tell me about your classroom experience. How have these courses helped to improve your knowledge and/or improved your ability to perform lactation services? What was promising and challenging about your education? How would you describe the way that your instructors treated you? Can you give some examples?
3. How difficult was it for you to apply to the college and receive these credits? How did you pay for these credits? If loans, do you still owe money for these credits?
4. Another requirement involves 90 hours of education in human lactation. Tell me about these hours. (Probes: How did you locate the courses/hours? Were you required to pay for them? If so, how did you pay for them? What other costs were associated with these hours (ex. Time away from family, time away from a job, etc.)? How have these courses helped to improve your knowledge and/or improved your ability to perform lactation services? How would you describe the way that your instructors treated you? Can you give some examples? How would you describe the way that your peers treated you? Can you give some examples?
5. You are also required to complete supervised clinical hours. Tell me about this experience. (Probes: Where did you perform these clinical hours? How did you arrange the clinical hours? How did you pay for the hours? Were you paid during these clinical hours? What other costs were associated with clinical hours (ex. Time away from family, time away from a job, etc.)? Please tell me about how these hours helped to improve your knowledge and/or improved your ability to perform lactation services?
6. Tell me about your clinical supervisor. (Probes: What was your relationship like with them? Did you feel that your supervisor respected your opinions? Explain. How would

you characterize your supervisor's management style? Did you feel that your supervisor treated you similarly to other colleagues? Why or why not?)

7. Tell me about your coworkers during your clinical hours. (Probes: What was your relationship like with them? Did you feel that your coworkers respected your opinions? Explain. How would you describe the way that your coworkers treated you? Can you give some examples? How would you describe the way that your peers treated you? Can you give some examples?)
8. Let's talk about the exam process now. Tell me about that experience. (Probes: How did you prepare for the exam? Did you participate in any study groups, exam prep classes, etc.? If so, how did you access these resources? Did any of these resources cost money? If so, how did you pay for them? (ex. Did your employer supplement the cost of these exam resources?) What was the cost of the IBCLC exam? Did your employer (or someone else) supplement the cost of the exam? How many times did you take the exam in total? Do you feel that the exam does a good job of testing the knowledge necessary to successfully perform in an IBCLC-related career? Why or why not? Did you feel the exam was designed to be fair for all different kinds of testers?)
9. Thinking about the entire process of certification, do you feel that your journey to certification was similar to the journey of your other peers? In what ways was it similar to or different from that of your peers? Thinking about the entire process of certification, how would you rate the difficulty of certification on a scale of 1 to 5 with 1 being very easy and 5 being extremely difficult? Explain. Thinking about the entire process of certification, do you feel that the process was fair and equitable – that a diverse group of individuals could all complete the certification process with a similar level of success?
10. We have just discussed many of the steps to IBCLC certification. Is there anything in particular that I have missed? Were there any other encouragements or barriers (personal, professional, in education, etc.) that you experienced at any point the process of pursuing certification? Explain. Are there any other additional thoughts you would like to share regarding the certification process or barriers faced in the process of certification?

IBCLC POST-CERTIFICATION EXPERIENCES:

Let's now switch gears and discuss your experience since being IBCLC certified (and/or during your IBCLC clinical hours).

1. Tell me about your current position. (Probes: Does the position require or suggest IBCLC certification? What is your position title? How long have you held this job? Do you hold this position as a part of your IBCLC certification hours? Tell me about an average day in your position. What kind of interactions do you have with supervisors, patients, clients, co-workers, etc.? How many hours do you work in a day?

2. Tell me about the process of finding your current position (or clinical hour placement). (Probes: How long did it take you to find the position/placement? Where did you find the position (ad, through a social/professional connection, job site, through a previous position, etc.)? Why did you choose to take the position?)
3. The Affordable Care Act has mandated that Lactation Support services be provided for without cost sharing. Please tell me about your experiences with insurance companies and insurance claims since the Affordable Care Act mandated coverage. (ex. Are you an in-network provider for any company? Do you help patients file claims or require them to pay for services upfront? Why is this your policy? Etc.)
4. Let's discuss your interactions with supervisors at your current job. (Probes: What is your relationship like with them? Tell me one positive trait about your supervisor. Tell me about any weaknesses that you feel your supervisor has. Do you feel that your supervisor respects your opinions? Explain. How would you characterize your supervisor's management style? (ex. Do you feel that your manager gives you lots of freedom/autonomy or that they often micromanage you? Do they tend to criticize? Are they positive? Are they open to feedback?) Did you feel that your supervisor treated you similarly to other colleagues? Why or why not? Have you ever had a negative interaction with your supervisor? Tell me about one or two that stand out in your mind. Has your supervisor ever acted (physically, verbally, sexually) aggressive toward you? If so, please tell me about these interactions. How did you handle them? How did your supervisors or coworkers handle this situation? (ex. Did they provide support for you?) How often would you estimate that these kinds of interactions happen? How did these interactions affect your work performance? How did these interactions affect your job satisfaction?)
5. Please tell me about your interactions with coworkers. (Probes: What is your relationship like with them? Do you feel that your co-workers respect your opinions? Explain. How would you characterize your coworker's communication style? Do they tend to criticize? Are they positive? Are they open to feedback? Did you feel that all your co-workers treat you similarly to other colleagues? Why or why not? Have you ever had a negative interaction with a coworker? Tell me about one or two that stand out in your mind. Have your co-workers ever acted (physically, verbally, sexually) aggressive toward you? If so, please tell me about these interactions. How did you handle them? How did your supervisors or coworkers handle this situation? (ex. Did they provide support for you?) How often would you estimate that these kinds of interactions happen? How did these interactions affect your work performance? How did these interactions affect your job satisfaction?)
6. Let's discuss your interactions with patients. (Probes: What is your relationship like with them? Do you feel that your patients respect your opinions? Explain. How would you characterize your patient's communication style? Do they tend to criticize? Are they positive? Do they take your advice? Do you feel that all your patients treat you similarly to other colleagues that they interact with? Why or why not? Have you ever had a

negative interaction with a patient? Tell me about two or three that stand out in your mind. Have your patients ever acted (physically, verbally, sexually) aggressive toward you? If so, please tell me about these interactions. How did you handle them? How did your supervisors or coworkers handle this situation? (ex. Did they provide support for you?) How often would you estimate that these kinds of interactions happen? How did these interactions affect your work performance? How did these interactions affect your job satisfaction?)

EXPERIENCES OF DISCRIMINATION:

1. Do you feel that you have ever been targeted by patients, supervisors and/or co-workers on the basis of your gender, race, ethnicity, religion, sexuality, disability status, etc.? Explain. (Probes: Tell me about a few situations that stand out in your mind. If so, how did you handle these situations? How did your supervisors or coworkers handle this situation? (ex. Did they provide support for you, officially report the incidence, etc.) How often would you estimate that these kinds of interactions happen? How did these interactions affect your work performance? How did these interactions affect your job satisfaction?)
2. At any point in the process of your education, certification or in your work experience, do you feel that you have experienced discrimination on the basis of your gender, race, ethnicity, religion, sexuality, disability status, etc.? If so, please explain. (Probes: How did you handle this? Did you report it? How did your supervisors or coworkers handle this situation? (ex. Did they provide support for you?) How did these interactions affect your work performance? How did these interactions affect your job satisfaction?)
3. Do you feel that you have ever witnessed a co-worker experience discrimination on the basis of your gender, race, ethnicity, religion, sexuality, disability status, etc.? If so, please explain. (Probes: How did supervisors or coworkers respond to the situation? How did you respond to the situation?)
4. Do you feel that you have ever witnessed a patient experience discrimination on the basis of your gender, race, ethnicity, religion, sexuality, disability status, etc.? If so, please explain. (Probes: How did supervisors or coworkers respond to the situation? How did you respond to the situation? In what way do you think this experience impacted the quality of care that the patient received? How often would you estimate that these instances occur?)

BREASTFEEDING DISPARITIES:

1. As you know, the academic literature demonstrates that different populations have different rates of breastfeeding. For example, while significant progress has been made, Blacks and whites still show significant disparities in breastfeeding initiation and

duration. Given your education and experience, why do you think this gap continues to exist?

2. How has your education helped you to understand health disparities (race, SES, etc.) related to breastfeeding?
3. How did your clinical hours help you to understand health disparities (race, SES, etc.) related to breastfeeding?
4. What policies/programs (if any) does your current employer have to help clinicians address health disparities?
5. In your expert opinion, what improvements could patients make to help reduce health disparities?
6. What (if anything) do you do personally in your work that you feel helps to address health disparities?
7. In your expert opinion, what (if anything) could/should be done at any level to help clinicians understand and address disparities in breastfeeding rates?

Appendix C: Informed Consent

Title: IBCLC Experiences and Certification Barriers

Principal Investigator: Wendy Simmonds Erin Echols

Co-Investigator: Erin Echols

I. Introduction/Purpose

You are invited to participate in a research study. This study attempts to collect information about the experiences of IBCLCs in the certification process and in their daily clinical service.

You are invited to participate because you are at least 18 years of age and are IBCLC certified or pursuing IBCLC certification. A total of 30 participants will be recruited for this study.

II. Procedures

If you decide to participate, you will be interviewed through face-to-face or technology-mediated (Skype, phone, etc.) interviews with the investigator, Erin Echols. This interview is estimated to take approximately 60 to 90 minutes.

III. Confidentiality

We will keep your records private to the extent allowed by law. The principal researcher, Erin Echols, will have access to the information you provide. Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP)). We will use a unique ID number known only to the researcher rather than your name on study records. The information you provide will be stored in a locked cabinet or on a password and firewall-protected computer. Your name and other facts that might point to you will not appear when we present this study or publish its results. The findings will be summarized and reported in group form. You will not be identified personally.

IV. Risks/Discomforts

In this study, you will not have any more risks than you would in a normal day of life.

V. Benefits

There are no direct benefits for participants. However, it is hoped that through your participation, researchers will learn more about the process of IBCLC certification, any barriers that may be faced in the IBCLC certification process and IBCLC clinical experience.

VI. Confidentiality

All data obtained from participants will be kept confidential and will only be reported in an aggregate format (by reporting only combined results and never reporting individual ones). All questionnaires will be concealed, and no one other than the primary investigator listed below will have access to them. The data collected will be stored in a locked and/or password protected, secure database until it has been deleted by the primary investigator.

VII. Voluntary Participation and Withdrawal

Participation in research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time. Whatever you decide, you will not lose any benefits to which you are otherwise entitled. If you desire to withdraw, please notify the principal investigator in person or via email (erinvechols@gmail.com) or phone (404-579-0844).

VIII. Contact Persons:

Contact Erin Echols at erinvechols@gmail.com or 404 579 0844 if you have questions, concerns, or complaints about this study. You can also call if you think you have been harmed by the study. Call Susan Vogtner in the Georgia State University Office of Research Integrity at 404-413-3513 or *svogtner1@gsu.edu* if you want to talk to someone who is not part of the study

team. You can talk about questions, concerns, offer input, obtain information, or suggestions about the study. You can also call Susan Vogtner if you have questions or concerns about your rights in this study.

IX. Copy of Consent Form to Participant:

Please print a copy of this consent form to keep.

I have read and understood the above consent form and desire of my own free will to participate in this study.

Signature_____Date_____

Appendix D: Recruitment Flier

LACTATION CONSULTANTS NEEDED!

FOR RESEARCH STUDY

1-2 HOUR
INTERVIEW

Study Coordinator: Erin Echols
Research Institution: GA State University



Share

your stories

Are you a lactation consultant and at least 18 years of age? Please consider providing 1-2 hours of your time (in person or by phone) to help us understand the work experiences of lactation consultants.

Contact Erin Echols at erinvechols@gmail.com for additional information.

