



The Confusion of Numbers: How we make clinical decisions?

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Molly has spent most her career with a focus on family-centered maternity care. Her work at Evergreen Hospital Medical Center led to the first US “Baby Friendly” hospital in 1996. Molly is currently the director of Evergreen Perinatal Education, a consulting and education program for professionals. She enjoys reviewing the breastfeeding research and is fascinated how it is used and often mis-used.

Objectives

1. Discuss the difficulties of assigning average statistical research numbers to individual babies and mothers
2. Describe a process for evaluating a newborn’s feeding patterns
3. Describe a common sense approach when an infant has lost >10% of his birth weight

In the midst of historic promotion of exclusive breastfeeding by various international pediatric societies, the use of formula supplementation for newborn infants has reached record highs throughout the world. The knowledge that there is a wide range of “normal” is often forgotten when it comes to discussion, interpretation and clinical practices regarding early supplementation of newborns. The criteria appear to be based on single studies and chosen arbitrary numbers, with an inclination to base clinical practices on partial knowledge, fear of lawsuits or personal opinion, rather than critical thinking. As a result of averages, means, and medians, healthcare systems have created erroneous dictates and policies about the frequency of early breastfeedings, the length of feedings, the expected breastmilk volume consumed per feeding, or the expected number of feedings per day. What is the origin for assuming that healthy full term newborns feed 8 times each day? Where does it say that 10% weight loss in the first days of life requires immediate supplementation with breastmilk substitutes? There are many practices which deserve questions. Do we really know the absolute answers? Probably not, but we can come up with a more astute process for evaluating our care. What has happened to our ability to assess, think and individualize our care for each mother and baby, based on research, our own and others’ experiences, and some good, old-fashioned common sense? This is the genuine “Best Practice.”



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