To Micaela Notarangelo (Task Force Recognition), and to all IBCLC colleagues throughout Europe
Cc: Mihaela Nita (president of ELACTA)

Re.: Aspects of the revision process and its underpinnings for the Dutch NVL Professional Profile

Dear Micaela, dear colleagues throughout Europe,

Following up on the document explaining the preparation in the focus group for the revision of the Dutch Professional Profile, this present document explains the actual revision process and its underpinnings. In the latest editing round for the NVL Professional Profile (PP), many wordings have been changed in line with the biological blueprint, the new Vision & Mission and some of the aspects of the focus group analysis. This document offers the following:

- Below, on page 2 and 3, you first find the PowerPoint-slides from the presentation of the revised edition in the General Assembly of November 2019.
- The text starting on page 4 gives further considerations regarding the revision and the underpinnings for the adjustments.
- On page 8, a quick timeline provides some insight into the process leading up to this revision.
- As an attachment to this document, you receive the English version of the PP in which the changes in the Dutch version have been integrated in the English version. Changes are still visible for easy access and comparison and often have some really thorough explanation in the sidebar that matches with the information below. For the reader to be able to read all remarks, the text is spread over an increased number of pages to make sure all the remarks are readable in the pdf-format. Remarks with information of crucial importance are coloured red. (All spelling is in English, not American, so ‘behaviour’ and ‘organisation’, for example.)

Throughout the PP, the latest neurobiological insights have informed the chosen wordings. In the last decades, science has reconfirmed many insights from John Bowlby’s attachment theory. Human babies are extremely immature and dependent at birth and are therefore hardwired for connection: staying close to their caregivers is the only way they can survive. Their prosocial tendencies are innate and human babies expect to be in close proximity of caring adults. Science has additionally shown that the more buffering protection against (neuro)toxic stress babies receive from attuned, sensitive and responsive caregivers, the more likely it is that they will experience healthy development of setpoints regarding stress regulation and metabolism and the richer the neurological network in the brain will be. All of this together increases chances of good adult health and the characteristics of the process and product inherent in breastfeeding support this in a beautiful way.

Much of this is not explicitly mentioned, but it is implied in the way many sentences have been worded and especially in the fact that the biological blueprint was added. There is, of course, much more that could be said about these aspects, but we hope that the reader can sense the spirit of this information in the way certain sections have been revised. Most of all we hope that these changes will inspire our colleagues throughout Europe to find their own culturally sensitive ways of integrating this universal knowledge of compassion and kindness in their local profiles so that babies and mothers can get the most out of this age-old yet time and again very special, foundational, and also transformative stage in their lives together. We wish everyone much inspiration and success with this revised version!

Warm regards,

Marianne Vanderveen-Kolkena IBCLC, MSc
General board member of the NVL
Member of the working group for the revision of the Professional Profile

NVL Professional Profile: revised version 2020

Editorial revision in line with
the adjusted NVL Vision & Mission
from the General Assembly 2018,
presented in the General Assembly 2019

Isabel Klein IBCLC
Stephanie Sanders IBCLC, MA
Marianne Vanderveen-Kolkena IBCLC, MSc

Presentation outline

- Refreshing Vision & Mission (GA 2018)
- Basic starting points
- Adjustments and underpinning
- Decided after further discussion
- Conclusion

Refreshing Vision & Mission

- **Vision:**

Every child has the right to be breastfed and all parents have the right to healthy family building. The ~~professional~~ organisation NVL stands for ~~the expert~~ engagement of Lactation Consultants IBCLC for parents and children in this stage of life.

- **Mission:**

1. The NVL strives to create broad public support for breastfeeding as the norm throughout society.
2. The Lactation Consultant IBCLC is the expert par excellence for professional, high quality care in relation to breastfeeding.
3. The professional organisation ~~connects~~, supports and strengthens Lactation Consultants IBCLC working in different fields within Dutch society and also strives for multidisciplinary cooperation.
4. At their request, every family receives care from a ~~Lactation Consultant~~ IBCLC. Engagement of Lactation Consultants IBCLC has a preventive and cost-effective impact on national healthcare.

Basic starting points

- **The biological blueprint:** the mother-infant dyad has a number of biological needs that are recognised by the IBCLC and implementation of which is encouraged by the IBCLC.
- **Breastfeeding as the norm:** breastfeeding is the biological norm for normal development, making idealising language inappropriate (such as 'optimal', 'health advantages/profits/benefits', 'less risk').
- **Breastfeeding as process and product:** where necessary, the multi-faceted character of breastfeeding has been indicated explicitly and the reductionist focus on the product has been nuanced.
- **Breastfeeding being more than feeding:** where necessary, this has been explained in accordance with the biological blueprint.
- **Parental autonomy:** the final responsibility in caring for the child lies with the parents, which makes them the ones who solve problems if they arise; the IBCLC does not improve health, but supports and facilitates parental goals.

Adjustments and underpinning

- **Page 10:** The phrasing with the term 'work' has been adjusted (now: 'return to work environment'), because it is in essence the 'mother and child being separated' making breastfeeding complicated and necessatating pumping. What it is exactly that happens during the separation, is less relevant.
- **Page 10:** A (Dutch) document on the importance of context-based practice was added; something similar may be available in other languages and seems well-worth adding.
- **Page 11:** Powerfully positioning the IBCLC profession seems to be benefitted by providing the IBLCE-Detailed Content Outline, which was therefore mentioned repeatedly to clearly indicate the breadth of the scope of practice and to embed the profession internationally.
- **Page 17:** It was added that not every IBCLC will (be able to) develop all competencies mentioned, seeing the great variety in work settings.

Adjustments and underpinning, 2

- **Page 24:**

- It read 'maximizing breastfeeding success rate'; this was changed to 'maximizing chances for a succesful breastfeeding relationship', to emphasise the reciprocity of the relationship (giving/receiving, not just maternal action).
- It read 'whether solicited or not' regarding training other healthcare professionals; wording was made a bit more friendly, less pushy, aimed at good cooperative working relations.
- It read 'development of the child', but also the mother herself and the breastfeeding relationship develop further.
- It read 'solving problems'; this has been changed to 'contributing to solving problems' (for the sake of autonomy).

Adjustments and underpinning, 3

- **Page 28:** The following sentence was deleted (considered too pretentious and problematic in relation to client autonomy): 'The IBCLC is responsible for promoting a healthy lifestyle and responsible for influencing (future) mothers' behavior in relation to breastfeeding in general, and as critical consumers.'
- **Page 30:** In the description of activities, the Detailed Content Outline has explicitly been added to make sure that the scope of practice of the IBCLC is clear (broader than often thought).

Adjustments and underpinning, 4

- **Page 36:** This page had several sentences and wordings in Dutch that are very specific for the legal requirements in the Netherlands. These can therefore not be (and in the previous English version have not been) translated into English.
- Other issues may need unique consideration in all countries. The sentence that says: 'Discusses feeding plan with the healthcare professional who has the final legal and medical responsibility, unless the parents explicitly refuse to give their permission' seemed problematic in Dutch, as many IBCLCs can operate independently in the Netherlands and do not have to report back to a doctor. This wording thus clashes with parental autonomy in decision making. This sentence was therefore deleted from the Dutch version, but may have to remain in in a different version in different countries.

Decided after further discussion

- **All pages where task fields/roles are described:** On page 17, something of a disclaimer has been added: knowledge and competencies vary according to work setting and not all IBCLCs will (be able to) develop the same competencies.
- **Introduction:** In a careful way, a couple of studies have been included, without mentioning too many (time-sensitive) statistics, but focusing on general trends instead.
- **Page 12:** The word 'lactational differential diagnosis' has been chosen in the interest of appropriate, legitimate clarity.
- **Page 15:** Due to changes in the recertification procedure this, section has been adjusted, but kept pretty general, to prevent the whole profile from becoming outdated too easily.

Decided after further discussion, 2

- **Page 27:** Intervision and supervision have been added, even though this still has to get further form and shape in practice. Because of the wish for professionalisation, it has already been included.
- **Page 28:** As mentioned before, several lists with 'has knowledge about' seem somewhat pretentious (risking unrealistic external expectations) and therefore fall under the 'disclaimer' on page 17.
- **Page 30:** Where it said 'abide by codes and protocols', it was said 'respect and critically reflect on', to encourage people to be aware of outdated or harmful policy guidelines in which the biological blueprint is not the core yet ('primum non nocere').
- **Page 34:** The whole section on the history of the lactation profession in the Netherlands has been rewritten and updated, something which all organisations will probably have to look at to make sure it is in accordance with local/national situation.

Conclusion

- We have made a serious effort to **give centre stage to the needs of infants and mothers/parents**, paying attention to the biological blueprint and its attending (neuro)physiology.
- We have given **parental autonomy** an important place, paying attention to wordings that put parents in a dependency position, instead using wordings that empower them.
- We have strived to **allow the knowledge, expertise, and competencies of the IBCLC the powerful place they deserve** without losing sight of the importance of multi- and inter-disciplinary cooperation.
- We hope you experience the profile as a still stronger docu-ment and beautiful 'business card' to present yourself with!

We hope that the new version of the Professional Profile will contribute to a clear view of the IBCLC's work for colleagues in different disciplines.

We wish everyone a lot of success!

Introduction (Slides 2 & 3)

The NVL Vision & Mission underwent substantial change in the General Assembly of 2018. They informed the revision process and are now as follows:

Vision:
Every child has a right to be breastfed and all parents have a right to healthy family building. The professional association NVL stands for the expert engagement of Lactation Consultants IBCLC for parents and children in this stage of life.

Mission:
1. The NVL strives to create broad public support for breastfeeding as the norm throughout society.
2. The Lactation Consultant IBCLC is the expert par excellence for professional, high quality care in relation to breastfeeding.
3. The professional organisation connects, supports and strengthens the Lactation Consultants IBCLC working in different fields within Dutch society and also strives for multidisciplinary cooperation.
4. At their request, every family receives care from a Lactation Consultant IBCLC. Engagement of Lactation Consultants IBCLC has a preventive and cost-effective impact on national healthcare.

The basic starting points for the revision were as follows:

- **The biological blueprint:** the mother-infant dyad has a number of biological needs that are recognised by the IBCLC and implementation of which is encouraged by the IBCLC.
- **Breastfeeding as the norm:** breastfeeding is the biological norm for normal development, making idealising language inappropriate (such as ‘optimal’, ‘health advantages / profits / benefits’, ‘less risk’).
- **Breastfeeding as process and product:** where necessary, the multi-faceted character of breastfeeding has been indicated explicitly and the reductionist focus on the product has been nuanced.
- **Breastfeeding being more than feeding:** where necessary, this has been explained in accordance with the biological blueprint.
- **Parental autonomy:** the final responsibility in caring for the child lies with the parents, which makes them the ones who solve problems if they arise; the IBCLC does not improve health, but supports and facilitates parental goals.

Basic starting points (Slide 4)

Overall, the document is now more descriptive instead of comparative (so not ‘benefits of breastfeeding’, but ‘positive characteristics of breastfeeding’ or ‘positive results of breastfeeding’). By constantly using comparatives in the wordings of a text (‘better’, ‘worse’, ‘less risk’, ‘more so and so’), an atmosphere of competition is being created, instead of letting breastfeeding stand on its own strong feet. The document was, in other words, ‘wiessingerised’: all language has breastfeeding as the norm, meaning that breastfeeding does not create ‘health gains’, but prevents ‘health loss’. Breastfeeding does not reduce healthcare costs; lack of breastfeeding increases healthcare costs.

This is not mere wordplay, as is sometimes thought. Esteemed IBCLC-colleague and evolutionary biologist Diane Wiessinger shows in her presentations and articles on this topic that it also changes statistics, thus creating a clearer view on where the health risks actually are. A risk reduction for something of 50% with breastfeeding has non-breastfeeding as its reference point. With breastfeeding as the reference point, one would say that something has a risk increase of 100%. (If a risk is 4 without breastfeeding and it is 2 with breastfeeding, it is, turned around, 2 with breastfeeding and 4 without

breastfeeding – a 100% increase.) Diane Wiessinger calls it unethical science to not take breastfeeding as the norm, seeing that the core tenet of scientific research is to study an intervention and see what happens and what risk it brings. With breastfeeding being the defining characteristic of mammals, not breastfeeding (or formula feeding) is the intervention that should be studied and carries the burden of proof of no harm. This approach has informed the whole revision of the profile.

In the introduction, there is a shift away from problems towards description, towards providing parents who want to breastfeed with information, knowledge and expertise about needs of mothers and babies in the pre-, peri-, and postnatal period. Their basic human need is building a secure and joyful relationship. This means that the PP should avoid choosing a reductionist approach of breastfeeding in the form of 'human milk' or 'mother's milk', and should emphasise the holistic importance of breastfeeding as an intersubjective process, the start of building of a lifelong relationship between people who love each other, a relationship in which the baby is an equal, competent and communicative partner from the very beginning, who, at breast, enjoys several species-specific characteristics, such as nutrition, immunological protection, communication, and socioemotional comfort.

Adjustments and underpinning (Slides 5, 6, 7 & 8)

Slide 5

With regard to statements about 'work', a different wording was chosen, based on these aspects:

- By using the term 'work', all other activities that separate mother and infant and cause breastfeeding to be (experienced as) problematic, are excluded. One can think of sports, hobbies, hospital visits, social events.
- Mothers who do not have a paid job and are home with their child(ren), also work, but they may have more (easy) opportunities to continue the breastfeeding relationship.
- By making a distinction between 'working' and 'non-working' mothers, mothers who do whatever form of unpaid work may be framed and dismissed as 'non-doers', although they usually do work that others, such as paid childminders, cleaners, financial administrators, taxi drivers, volunteer care givers and so on, do for a salary.

Based on the above, it was decided to use an inclusive approach and focus on what the real issue is: the separation, regardless of what is being done during that time. There were several other spots where the wording was adjusted according to these considerations.

The essence of Evidence Based Medicine is often considered to be primarily about scientific evidence. The founder of the concept, however, David Sackett, insisted on combining scientific evidence with clinical experience and patient values. Therefore, the importance of context-based approaches was mentioned. The social environment often plays a crucial role in decision making by parents, depending on what is feasible for them and what fits their world view. A document on context-based approaches thus emphasises why it may be problematic to focus solely on and administer the highest value to research based on RCT; there are many forms of valuable 'evidence'.

With regard to competencies, a remark was added regarding the great diversity in work settings of IBCLCs and the different experience they consequently develop. This was done to prevent coming across as too pretentious and creating expectations that cannot be met. Clinical IBCLCs may know a lot about the ill baby, for example, and private practice IBCLCs may have more experience with breastfeeding toddlers, to mention a difference.

Seeing the mammalian heritage of humans, we consider the biological blueprint the foundation of the profession. This was therefore included in the part on the essence of the profession.

The IBCLC is not the one who solves the problem; through transfer of knowledge and expertise, the IBCLC supports the development of competencies and self-efficacy in the parents and their confidence in their own parenting. This will lead to mothers/parents being able to solve problems themselves. The IBCLC does not take over the problem-solving role and is not the 'hero' or 'rescuer' in the drama triangle where the client is the 'victim'. Without the motivation and effort of the client, the IBCLC cannot solve anything, so a certain modesty seems appropriate. Presenting the IBCLC as the rescuer could be perceived as paternalistic and could harm or undermine parental autonomy.

Slide 6

With regard to 'breastfeeding success rate', the wording was changed toward more emphasis on the relationship, seeing the scientific evidence of the last few decades around epigenetic effects of nurturing relationships. Because humans are wired for connection, their sense of security is rooted in secure, sensitive and responsive relationships. Therefore, there is more to breastfeeding than 'just' the milk and the immunological protection. These are embedded in the relationship, that, when experienced by the baby as secure, in itself fosters competent immunity, due to the neurophysiological effects of healthy homeostasis and low cortisol levels. This way, the wording is more in line with the information in the description of the biological blueprint. Additionally, the aspect of the mother also developing was integrated to emphasise the reciprocity in the process: mother and baby 'feed' each other and the baby thus supports the mother through this transformative stage in her life (see also side bar remark).

Slide 7:

This slide speaks for itself.

Slide 8:

The sentence on reporting back was deleted from the Dutch version, as IBCLCs in the Netherlands do not necessarily have to report back to another healthcare provider or doctor, as they can operate independently. Parents sometimes explicitly state they do not want the IBCLC to report to other healthcare providers, because of problematic experiences or the lack of breastfeeding support they encountered.

The need for this sentence will depend on the social relations in a country and this is clearly a point of cultural difference, related to the power distances in a specific culture. Where the lactation profession is a stand-alone profession with personal decision making possibilities and not one that is subordinated to a more powerful and hierarchically 'higher' medical profession, the obligation to report back will not be present or will at least not be as compelling.

(Also, there seems to be some contradictory wording in this bullet.

1. The IBCLC has to report back to the one with the end responsibility.
2. The IBCLC does not have to report back if the parents refuse permission for that.
3. The IBCLC can deviate from 'THIS' (what… from reporting back or from not reporting back?) when there are serious concerns.

This seems to point to the IBCLC being allowed to ignore the parental refusal for permission in case of serious issues (so the IBCLC can report back against the parents' will if the situation is dangerous), but the sentence is somewhat ambiguous.)

Decided after further discussion (Slides 9 and 10) and wrap-up (Slides 11 & 12)

Slide 9:

The results of the working group for the revision of the Professional Profile were presented to the board early 2019 and then presented by Marianne in the General Assembly of September 2019. During that GA, a couple of last issues were decided in a plenary discussion with all the members present.

Several descriptions with regard to what the IBCLC does or is able to do, are quite firm, even though many competencies may not apply to all or most IBCLCs. Local Professional Profiles seem to do wise in preventing pretentious descriptions and the possibly resulting too high expectations. National boards will have to discuss and decide how to deal with this in their own socioeconomic and cultural setting.

Also discussed was the mentioning of statistics, which may be complicated for several reasons:
- Statistics may be illustrative, but are also quickly outdated, making the PP as a whole outdated.
- Many studies may not match the organisation's vision and mission (e.g. do not have breast-feeding as the frame of reference; see the section on Diane Wiessinger's approach).
- Comparison of statistics may be problematic because the studies differ too much in design.
- Aspects that are relevant for a good insight may have been omitted in calculating the numbers.
- Recruitment of study participants may be biased towards breastfeeding enthusiasts, leading to too rosy results, which complicates emphasising the urgency of improved policies.

Based on these aspects, wordings on research and statistics have been kept as general as possible.

It is often said that IBCLCs are not allowed to make a clinical diagnosis. By using the term 'lactational differential diagnosis', an effort has been made to illustrate the process IBCLCs use to decide whether a problem is theirs to address or whether they have to refer to a different healthcare provider. Every diagnosis needs a differential diagnosis first to decide who is the designated professional. Also, the problem is that many healthcare providers are not yet knowledgeable enough on the topic of breast-feeding and lactation, to come to a diagnosis that shows that the problem is a lactation issue. Because the professional profile is meant to show the strength of the IBCLC, it seems desirable and appropriate to strategically mention this point, without infringing territories beyond our scope of practice.

Slide 10

Supervision and intervision have already been added as part of the intended professionalisation process, although they still need attention with regard to how to implement them.

Following protocols that are contradictory to evidence-based lactation knowledge, such as reducing or limiting feeding frequency or weaning in case of mastitis, clashes with the primary and ultimately ethical principle of 'primum non nocere', 'first do no harm'. It seems advisable for all organisations to take a critical look at this aspect and choose a wording that does not interfere with local legislation or institutional regulation, but at the same time respects the interests of the mother-baby dyad, for whom the IBCLC is a crucial and expert advocate. We could ask ourselves whether we take our professional knowledge seriously if, through wordings in the PP, we encourage following prescribed practices that are known to be harmful and/or contradict the latest research. We could wonder how to view taking a subservient stance towards policies based on insufficient knowledge at the expense of the mother-baby dyad? How can we address these issues in a way that our knowledge is heard and heeded? These are difficult yet important ethical questions to deal with; depending on the cultural climate and hierarchical structures in a society, they may have to be dealt with differently.

The section on the history of the lactation profession will probably have to be rewritten for each country, as all histories are unique and have their own special milestones that are worth mentioning!

Slide 11

In this conclusion, we mention again the main considerations that informed the revision process.

Slide 12

We wish everyone succes with the implementation of their Professional Profiles in their countries!

Timeline towards the revision of the Dutch Professional Profile

- **Early 2018:**
  A focus group initiated by Stephanie Sanders IBCLC, MA and Marianne Vanderveen-Kolkena IBCLC, MSC meets with three NVL-members (Ellen Kamman IBCLC, MSc, Mieke Saras IBCLC, RN, and Marga Wapenaar IBCLC, RN) to discuss aspects relevant to the future of the IBCLC profession.
- **April 2018:**
  Marianne gives a presentation about the analysis of the focus group meeting in the NVL General Assembly. The board invites her and Stephanie to start a revision process for the Professional Profile, based on the focus group analysis.
- **May/June 2018:**
  Marianne and Stephanie start the revision process, together with colleague Isabel Klein IBCLC as a working group, 'Revision Professional Profile' within the NVL.
- **Fall 2019:**
  With some holiday periods and other activities interrupting the process every now and then, the working group finishes the revision somewhere in October 2019.
- **October 2019:**
  The working group discusses with the board what the status of the process is and makes the agreement with the board that the issues still to be discussed will be presented to the General Assembly in November.
- **November 2019:**
  Marianne presents the process and the result of the revision at the NVL General Assembly. Points that need more input from the members are discussed during the GA.
- **Early 2020:**
  The document is finished after a last round of input from the board on the final decisions.
- **Spring 2020:**
  The document is ready to be implemented and is shared with the members.
- **Spring/Fall 2020:**
  ELACTA asks the NVL to share with them the revisions in the Professional Profile.
- **Fall 2020:**
  Marianne (NVL board member by now) translates the presentations of the focus group meeting/analysis and the revision process of the Professional Profile into English, adding to both the underpinnings for the choices and analysis.
- **November 2020:**
  Marianne finishes all documents and sends them to ELACTA for dissemination among the ELACTA members.

The NVL wishes all professional bodies and their members inspiring discussions within their organisations and the best of luck with integrating the aspects that do justice to the biological blueprint that encompasses baby's needs and expectation patterns, to parental goals that are often hard to achieve considering socioeconomic structures and cultural convictions, and to the valuable role that the Lactation Consultant IBCLC can play in all this. May the global situation soon allow us to exchange dreams and ideas on these topics in real life again!