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INFANT FEEDING

'All that you need know about infant feeding can be written on the back of a postage stamp.' This epigram is attributed to the late London paediatrician, Robert Hutchison. It seems that he was prophetic, for there is but little interest these days in infant feeding and its problems. In Hutchison's day, paradoxically enough, it was a very popular subject with medical men, and dozens of texts on infant feeding were published during the 1920s and 1930s. These began to fall off during the 1940s and probably no more than 4 or 5 texts on this topic have been published during the past 20 years. In the USA there was never any great output of books on infant feeding, and those which did appear had poor sections on maternal nursing. A couple of recent texts indicate that American interest is not so much in feeding as in nutrition.

This mirrors a general phenomenon among paediatricians. Interest in feeding is flagging while that in nutrition is increasing. There are fashions in paediatrics, the current ones being neonatology and 'chromosomology'. The earlier interest in methods and problems of sucking and suckling have given way to examinations of foods, diets and nutrition. There is also a lively concern with these matters in South Africa, enough to support a regular supplement to the *Journal* which acts as a forum for much of the valuable research in this field. The multiracial and multicultural nature of our populations lends itself to challenging nutritional studies, challenges which have been eagerly accepted at our medical schools and institutions.

The multicultural practices also lend themselves to study of feeding habits, but paediatricians show little interest, so that the subject of infant feeding has become something of an orphan in a medical household devoted to children. And yet, every so often, one wonders whether this is in fact so. During the past decade no less than 3 texts on infant feeding have been published by local medical men.

The Bantu are slowly becoming accustomed to western ways, giving up prolonged nursing in exchange for bottle feeding, often with calamitous consequences. Conversely, there are movements afoot among White sections of the population towards a return to breast feeding, notwithstanding the frequent disappointments of mothers who have to abandon suckling as a failure. In Johannesburg a small branch of the La Leche (literally, The Milk, in Spanish) League, affiliated to the American organization, is devoted to propagandizing on behalf of maternal nursing. The society publishes a valuable book called *The Womanly Art Of Breast Feeding*. Its chief defect is that it refuses to take 'I can't' for an answer, and whatever difficulties may arise, be it crying or cracked nipples, the remedy is always the same: 'Nurse more frequently'. Nevertheless, it is a good book for mothers and the La Leche League needs to be better known.

If breast feeding practices are changing, so are bottles and their contents. Bottles are becoming more complex while milks become more simple and standardized. Bottles with a teat stretched over the neck are common enough, but more popular are those with discs and screw caps, not so easy for the beginner or the unsophisticated Bantu to learn to handle. Playtex and Beniflex nursers may arrive here and prove puzzling. In England the Redifeed nurser has just been launched: a long awkward container with a small cross-cut teat, filled with Ostermilk and fully disposable; but at 8d. per unit its future is dubious. Semi-disposable bottles have more to recommend them.

Doctors are not the only professionals in the field of infant feeding. Nurses, too, offer their services in baby clinics. Such have evolved differently in various countries. They are scanty and unimportant in North America where general practitioner paediatricians are largely responsible for advice on feeding, a role with which they are seemingly dissatisfied, and there are mutterings about handing over this function to trained and interested ancillary nursing services.

In England, baby welfare clinics are plentiful and influential. English paediatricians are consultants and are insulated from feeding matters, while most general practitioners are uninterested. The clinics there have an important function to perform. Whether they do this adequately is another matter. One cannot help observing that such a strong nursing service has contributed virtually nothing in the way of research and publication over the past 30 years and more. The infant welfare movement is especially strong in New Zealand and Australia, where zealous nurses effectively keep doctors from any contact with feeding practices.

South Africa occupies an intermediate position, with welfare clinics performing important functions among the culturally and economically deprived, but having a less clearly defined role among wealthy White groups, where doctors participate more in problems of feeding. Part of this ambiguous nursing role is self made. Originally, during the early 1900s, welfare centres were primarily distributors of free, or almost free, pasteurized milk, but as poor communities became able to buy milk for their babies, so baby clinics began functioning as advisers on this or that cereal or porridge. Concurrently an authoritarian spirit pronounced various foods to be unsuitable, indigestible or dangerous, and fatty foods especially have suffered in this regard. Such fears of food have an ancient tradition (*I Corinthians* 3 : 1, 2) and in truth, doctors more than nurses contributed to these fears, blaming in turn fat, protein, sugar and minerals as the cause of infantile undernutrition and illness. Consider the 1928 opinion of American paediatrician Fischer:[1] 'A new conception of the various food elements shows that the opinion of 10 years ago regarding the dangers of high fat has been modified, and the possibility of a protein or casein element being the disturbing factor suggested. Modern science has proved beyond a doubt that one reason why the fat element or casein disagrees is due to the presence of milk sugar;

hence we today regard the carbohydrate and salt as the disturbing element in many cases.'

For all-embracing obfuscation this would be hard to beat. If such were the case, why feed babies at all? It seems just too hazardous. In fact, foods cause very little disturbance, indigestion or allergy in infancy. Minor disturbances more often have a mechanical, neurological and especially infective origin. 'It is in the minor infections that result in vomiting and/or diarrhoea that there is apparent success in changing foods, due to the fact that, given a few days, minor infections are dealt with by the infant, and the vomiting and diarrhoea disappear. The milk that baby is now taking is claimed to be the hero of the episode . . . Almost every case of feeding difficulty presenting poor feeding, vomiting or diarrhoea should be ascribable to an infective, mechanical or metabolic cause.'[2]

The intelligent public is no longer frightened by dire predictions of upset from eating this or that. Modern mothers, like ancient Eve, hear the threat 'But of the fruit of the tree . . . Ye shall not eat of it . . . lest ye die' (*Genesis* 3 : 3). Eve ate of the fruit and had neither diarrhoea nor vomiting. One can no longer tell modern mothers not to give fruit to babies of a month or younger for fear of illness, because they already know that this is not true; it does not cause diarrhoea or vomiting; quite the reverse, babies love fruits and smack their little lips for more.

Perhaps the time has come for teachers of infant feeding to re-examine their curricula and for infant welfare clinics to reassess their functions. In this respect it is gratifying to observe that Johannesburg clinics have given a welcome lead. A start has been made with a bold programme to bring health education to mothers attending the clinics and to the local community.

1. Fischer, L. (1928): *Diseases of Infancy and Childhood*, 11th ed., vol. 1, p. 12. Philadelphia: F. A. Davis Co.
2. Quinton, J. F. P. (1966): Practitioner, **197**, 307.

TYDSVERKWISTING IN DIE WAGKAMER

Daar is seker maar min mense, dokters of andersins, wat nog nie in 'n geneesheer se wagkamer gesit en wonder het wanneer sy beurt eendag gaan aanbreek nie. Daarbenewens is dit ook ongelukkig waar dat dokters se wagkamers, met enkele uitsonderings, nie gesellige of aangename plekke is om tyd in deur te bring nie. Die leesstof is meestal maar karig en wat daar is, is verouderd. Dit is skynbaar hoofsaaklik die huisvrou vir wie daar voorsorg gemaak word wat tydskrifte betref. Publikasies met 'n groot verskeidenheid van breipatrone of nuwe idees vir tafelversierings is gewoonlik volop, al is die modes miskien nie meer so heeltemal op datum nie. Maar vir die gemiddelde manspersoon is daar maar selde iets aantrekliks om sy aandag van die komende konsultasie af te trek.

Ten Cate[1] gee 'n noukeurige analise van die tyd wat verlore gaan a.g.v. vertraging in die huisartswagkamers in Nederland. Sy pessimistiese syfers is moontlik ietwat oordramaties gestel, maar die feit bly staan dat 'n werklik onrusbarende aantal man-ure op die wyse verkwis word—'n totaal wat voldoende is om 'n wesentlike verskil aan die land se produksievermoë te maak. Dit ly min twyfel dat dieselfde ook vir ons land waar sal wees.

'n Baie groot gedeelte van die huisartse het nog steeds geen vaste afspraaksisteem vir hul praktyke nie. Gedurende die tye wanneer hulle in hul spreekkamers konsulteer is enigeen welkom, en dit gebeur dikwels dat die laaste pasïent eers na sononder afgehandel is—'n pasïent wat miskien reeds sedert 3 uur in die wagkamer was. Selfs in Engeland, waar die afspraaksisteem skynbaar besonder stadig posgevat het, begin al hoe meer praktisyns besef dat dit beide vir hul eie sielerus en vir die tevredenheid van hul pasïente beter is om op afsprake aan te dring.

Op die platteland vind mens sommige praktyke met 'n soort van afspraaksisteem wat daarop bereken is om die pasïent en die dokter te troos, maar wat in werklikheid geen verskil aan die waggery maak nie. Iedere pasïent wat skakel word maar net gesê om na die spreekkamer te kom en sy naam word by 'n lys bygevoeg. Hy het dan 'n 'afspraak'. Die feit dat die arme man wat die moeite gedoen het om vooraf te bel nog net so lank moet sit voor hy die dokter kan spreek, hinder skynbaar vir niemand nie.

Maar die mees irriterende waggery is dié in 'n oënskynlik goed georganiseerde praktyk met 'n presiese afspraaksisteem. Ons weet van 'n kollega wat op twee verskillende plekke in 'n stad spreekkamers het en wat nooit by die tweede plek aankom minder as omtrent 'n uur of twee later as die afgespreekte tyd nie. Dag na dag gaan sy ontvangsdame voort om afsprake te maak wat nooit minder as anderhalfuur te vroeg is nie, seker in die salige hoop dat haar werkgewer eendag almal gaan verbaas deur betyds op te daag.

Dit is die eenvoudigste ding onder die son om met behulp van 'n stophorlosie die tydsduur van 'n reeks konsultasies in 'n praktyk te bepaal en daarvolgens 'n distribusiekurwe en 'n gemiddelde uit te werk. Aangesien ons vandag reeds weet, na al die navorsing insake praktykvoering, hoe so 'n kurwe min of meer gaan lyk, kan ons vooraf uitspraak lewer dat die lang voet na links, wat die kort konsultasies verteenwoordig, enige onverwagte vertragings (die regter voet van die kurwe) sal absorbeer. Ongelukkig is dokters traag om hulle in sulke wiskundige presieshede te begewe. Hulle vind dit meer bevredigend om maar te raai hoe lank hulle aan iedere pasïent spandeer, en daarvolgens hul afspraaksisteem in te stel. Indien die skatting te kort was, sal die pasïente maar jaar in en jaar uit moet wag en geduld beoefen, want dit is onwaarskynlik dat die geneesheer sover sal kom om die skatting in hersiening te neem in die lig van ervaring.

Die skatting sal natuurlik selde blyk te lank te wees, want volgens Parkinson se Wet sal die konsultasie eenvoudig rek om die daarvoor beskikbare tyd te vul.

Kan ons nie vra dat ons lesers 'n bydrae tot die land se produksievermoë moet maak deur te probeer verseker dat broodwinners nie onnodige tyd in hul wagkamers verspil nie?

1. Ten Cate, R. S. (1963): *Praktykvoering van de Huisarts*, p. 21. Leiden: H. E. Stenfert Kroese.