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Online Social Breast-Working: Representations of Breast Milk Sharing in the 21st Century

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Abstract

This thesis explores the controversial subject of online breast milk sharing through the lens of Social Positioning Theory and interpretative repertoire analysis. I examine medical statements, Facebook wall posts on the Human Milk 4 Human Babies Global group and selected Canadian provincial groups, as well as a selection of Canadian print news media coverage pertaining to milk sharing to discover how this practice is discussed. I argue that the medical literature discusses milk sharing as unsafe, informal, and a generally unacceptable means of obtaining breast milk, whereas the HM4HB group members discuss it as a safe, intimate experience between donor and recipient, and more meaningful and accessible than obtaining milk from anonymous donors at a milk bank. I also argue that in a selection of news stories and columns, Canadian print journalists privilege the maternal discourse and offer a sympathetic outlook on milk sharing to their audience.

Keywords

Social Positioning Theory, Interpretative Repertoires, Breast milk, Breast Milk Sharing, HM4HB, Facebook, Mothers, Medical Practitioners, Canadian News Media

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Chapter 1: Introduction- Keeping Abreast of Milk Sharing

The subject of breastfeeding in Canada recently gained widespread attention when Eats on Feets, an organization that facilitates sharing of human breast milk through online postings, launched a Canadian website on October 27th, 2010. In January of 2011, Eats on Feets changed its name to Human Milk 4 Human Babies (HM4HB from now on), and it is currently the most popular online milk sharing network. HM4HB encourages and provides women with the opportunity to challenge the traditional and socially accepted concept of infant feeding. The network brings the discussion about breast milk and breastfeeding to the forefront, regardless of the fact that both the fluid and the practice are traditionally understood to be 'dealt with' in private. HM4HB offers a platform for mothers to share their breast milk--and breasts--freely and openly with other mothers who typically have no relation to one another. The posts on the publicly-accessible HM4HB Facebook page provide a site for analyzing maternal representations of milk-sharing.

Montréaler Emma Kwasnica, who was formerly affiliated with Eats on Feets, founded HM4HB, with a mission to "promote the nourishment of babies and children around the world with human milk" (HM4HB). She states that the network emerged in response to a health expert who planned to market his own brand of powdered infant formula online. Due to her belief in the superiority of breast milk over infant formula, and that it is a "baby['s] birthright to be nourished exclusively with human milk," she launched an online call to action to create a global milk sharing network (HM4HB). According to Kwasnica, the purpose for starting this network was to provide a space where "families requiring breast milk could connect with women with a surplus" (HM4HB). In addition, the low breastfeeding rates in some parts of the world and the

"aggressive infant formula marketing campaigns" contributed to her desire to create this network (HM4HB). The response she received spoke to the demand--over 200 women volunteered to serve as the administrators of local milk sharing pages (HM4HB). Currently, HM4HB has a geographical span of fifty-two countries spanning 125 pages, with over 20,000 community page members (HM4HB). Rather than having a group dedicated to residents of entire provinces of Canada, HM4HB has specific groups for women in different geographical regions of each province, such as South Western Ontario, North Ontario, and Eastern Ontario. Such geographic division allows women to ensure that they are communicating with others who are not too far away, and in turn, this facilitates the exchange of breast milk.

Medical Community's Reaction

Canadian and American medical professionals were quick to condemn the practice of online peer-to-peer breast milk exchange. Within weeks of Eats on Feet's creation, Health Canada posted a warning against the sharing of unprocessed human milk, calling it "unsanitary" (Health Canada 1). The warning led to a conflict between a government institution and families who rely on breast milk donations to feed, and in some cases, save the lives of, their children. In addition to the attention given to breast milk sharing by the government, mainstream Canadian media coverage of this issue is only growing more extensive. At the present, with the increase in online outlets for breast milk sharing, it appears that the debate will continue.

While the Canadian government has, since the 1920s, promoted breastfeeding as "the one best way to feed infants," sharing breast milk and how best to access it should the need arise, is now part of a fairly public debate between the maternal and medical

communities (Nathoo and Ostry 18). On the one hand, Health Canada recommends that all infants be breastfed exclusively for the first six months and up to two years or more, and explicitly states in their 2004 recommendation that "breast milk is the best food for optimal growth" (Health Canada "Infant Feeding"). Yet, Health Canada's warning issued on November 25, 2010 advises against obtaining breast milk from women outside of a medically supervised setting. Health Canada's response illustrates that breast milk is understood as a substance that is both a natural source of nutrition, as well as a source of apprehension. Aside from listing the diseases that can be contracted from infected milk, Health Canada states, "Obtaining human milk from the Internet or directly from individuals raises health concerns because, in most cases, medical information about the milk donors is not known" (Health Canada 1). On November 30th, 2010, the U.S. Food and Drug Administration (FDA) published its own statement about online breast milk sharing, echoing many of Health Canada's concerns. It warns women that milk obtained from an anonymous online donor could be contaminated by infectious diseases or drugs, and that it has likely not been collected, handled or stored properly (U.S. Food and Drug Administration 1). In addition to Health Canada and the FDA's press releases, Dr. Sharon Unger and Dr. Joon-Han John Kim on behalf of the Canadian Paediatric Society, La Leche League, the *Canadian Medical Association Journal*, and Dr. Sheela Geraghty, Julie Heier, and Kathleen M. Rasmussen on behalf of the Center for Breastfeeding Medicine at the Cincinnati Children's Hospital released their own statements cautioning about the dangers of online breast milk sharing.

Though the medical community listed above is unable to regulate the Facebook groups that facilitate and promote breast milk sharing, its members try to dissuade women from sharing milk online, suggesting that they obtain milk from a registered milk bank

instead. Examining the medical discourse allows me to evaluate the medical community's representation of the practice of breast milk sharing. I suspect that the fears about breast milk as a potentially contaminated substance are intensified when such intimate bodily contact (breast sharing) occurs between strangers, and that this fear is heightened when the connections are made in another anonymous and unregulated domain: online.

Maternal Community's Response

The maternal community is largely in direct opposition to the perspectives put forth by the medical community. I define the maternal community as the women involved on the HM4HB Facebook groups.[1] They challenge Health Canada's recommendation to obtain milk only from medically supervised milk banks, arguing that this is not necessarily feasible. During the period over which I analyzed HM4HB posts, the only such bank in Canada was located in Vancouver.[2] Women who donate to the bank must pay for the bottles to store their breast milk and pay to ship their milk to the bank if they live outside of Vancouver. In order to obtain milk from the bank, a physician must prescribe it to the infant. If selected, the recipient has to pay a processing fee of $2 per 75 cubic centimeters of donor milk and additional payment is required to cover the costs of shipping (if applicable) (BC Women's Donor Milk Bank). This milk bank prescribes only pasteurized milk from screened donors, and supplies only enough to support a small percentage of babies in the Lower Mainland-- those born to mothers who cannot produce enough milk and/or those who have critical illnesses and cannot digest formula. In a CBC News article entitled "Women Donate Precious Gift of Breast Milk," Frances Jones,

[1] As of February 20, 2012, there were over 10,000 women following the activities of each provincial group and the Global Group.
[2] The Calgary Mothers' Milk Bank opened in April 2012.

coordinator of the B.C Women's Milk Bank, notes that "[The B.C Women's Milk Bank] cannot supply milk for every child in Canada who might need it" (CBC News). In 2008, 1,100 babies in Canada received donor milk from the bank, which is minimal in relation to the number of babies in need (BC Women's Donor Milk Bank). Due to the limited capacity of the B.C Women's Milk Bank, feeding one's infant with formula is another available option. Though infant formula is easily accessible, the maternal community rejects its use and argues that it cannot compare to the high nutritional value of breast milk. HM4HB community members argue that, aside from lacking important nutrients, infant formulas are indigestible to many of the infants in the most critical condition. As a result, the members do not see formula as a suitable alternative to breast milk.

Role of the News Media

Within the context of the competing perspectives of the medical and maternal communities, Bill Kovach and Tom Rosenstiel in *The Elements of Journalism* note that fair and balanced reporting are two important devices "to help guide journalists in the development and verification of their accounts" (77). By analyzing a selection of articles from mainstream Canadian newspapers, I can determine how news articles and columns take up or challenge the discourses used by the medical and maternal communities, how they represent breast milk sharing and how they position donor and recipient mothers and doctors as appropriate and knowledgeable participants in the process.

Why Breast Milk Sharing is an Issue that Deserves Attention

Online social networking is a relatively new phenomenon. Using social networking sites as a means to facilitate such an intimate exchange represents one of the myriad ways that Facebook is changing how families interact with one another, and most importantly, how women come to understand and experience their bodies. I believe that this topic deserves attention, not simply because of its relevance, but also because of the significant amount of media coverage it has recently received. While breast milk sharing is not a new practice, the use of the internet as a network for exchange is.

Wet nursing and forms of human milk sharing have existed throughout history. Valerie Fildes (1988) defines wet-nursing as "the breastfeeding of another woman's child either in charity or for payment [that has] occur[ed] in all civilizations in which the death of mothers in childbed or during lactation was relatively common…" (1). In some civilizations, "lactating relatives or neighbours fed another child along with, or after weaning, their own infant," while in others, "it was highly organized among certain classes of the population" (Fildes 1). While the HM4HB network represents a contemporary take on the sharing of expressed breast milk, the administrators encourage women to engage in the practice of directly wet-nursing one another's children if they so choose. This network was met with enthusiasm by families all over the world and brought milk sharing into mainstream discussion. At the same time, however, it attracted attention from Health Canada and Canadian and American medical authorities, who were not quite as pleased with the behaviours stemming from involvement with the group. Since breast milk is considered to be the best form of infant nourishment, the active participation on HM4HB Facebook groups indicates that there is a strong demand for it. If the survival of a mother's baby depends on the online milk sharing networks--and this is a claim that

several mothers on HM4HB have made—then the subject of breast milk sharing, both pros and cons, ought not to be overlooked. Additionally, there is currently no literature regarding breast milk sharing through an online medium. This thesis represents a contemporary take on a practice that has been occurring for centuries.

Literature Review

While there is extensive literature on the subject of breastfeeding (policies, how-to, the value of breast milk, "milk theory" [breastfeeding as a symbol of maternal-child relations and maternal embodiment/identity], there is scant literature on the subject of breast milk sharing. Since the sharing of breast milk has become a fairly taboo practice in mainstream, Western cultures, it is rarely discussed and not well documented. More specifically, the contemporary practice of breast milk sharing, especially milk sharing through the medium of the internet, has been mostly overlooked by scholars. With a primary focus on the Canadian context, my research will cover this timely and important subject. In addition, my work is informed by theoretical approaches that have been tried and tested by researchers on similar topics, but which have yet to be applied to breast milk sharing through an online medium. My research will make methodological advances, using social positioning theory, which is appropriate for the theoretical framework I have chosen.

Historical Accounts of Milk Sharing

According to Janet Lynn Golden (1996), wet-nursing "is a subject that has not been studied very much in the American context" (2). She evaluates the changing perception of wet-nursing in the United States, ranging from colonial America to the present day. While Golden's book provides information about the transformation of wet nursing and the sharing of breast milk, her work precedes the use of social networking sites to share milk. Instead, she writes about the donation of milk between mothers who help those in their communities. She notes that historians have studied infant feeding and wet-nursing in Europe, but have ignored the subject of wet-nursing in America. The assumption she makes in the introduction, "that infant feeding is a significant subject" serves as the impetus behind my thesis (Golden 2). Not only do infant feeding decisions influence mortality rates, but they also define the practice of mothering and the meanings of motherhood.

Valerie Fildes (1998) offers an extensive history of wet-nursing in Europe, covering the time periods from Medieval to Renaissance to the early 20th century. But her book is dated and focuses primarily on the wet nurse who was employed by hospitals, rather than mothers who donate their milk free from the involvement of an institution. Still, Fildes' chapter on the occupational diseases of wet nurses reveals the medical preoccupation with the cleanliness of women's bodies and of their milk, a subject that is still addressed today. Though many wet nurses were publicly employed by hospitals and monitored closely, they were under the watch of hospital staff and their bodies were highly regulated. It is evident that even today, the medical community continues its preoccupation with trying to regulate the bodies of lactating women.

Medical Concerns about Milk Sharing

Katie Woo and Diane Spatz (2007), a registered nurse and a registered clinical nurse respectively, evaluate milk sharing from a medical perspective. They state that nurses should be wary of informal milk sharing and should "strongly discourage" it among their patients, since "milk shared informally has not been tested or screened and is not certified as safe" (Woo and Spatz 152). The authors' claims to the unsanitary nature of breast milk obtained from a source other than a registered milk bank (potential for HIV, hepatitis, Human T-lymphotropic virus, and bacteria contamination) resonate with the warnings issued by Health Canada. After testifying to the competence and importance of North American milk banks, Woo and Spatz argue that nurses must sway women in this direction, as opposed to searching for donors elsewhere.

Dr. Ronald S. Cohen, Sean C. Xiong, and Pauline Sakamoto's (2012) study published in the *BMJ* peer-reviewed medical journal tested the breast milk from 1,091 potential breast milk donors to who went on to have serological testing after being cleared by their physicians and passing the questionnaire. They concluded that "there is a significant incidence of positive serology among women interested in donating milk…impl[ying] that there may be significant risk associated with peer-to-peer distribution of human milk from unscreened donors" (Cohen, Xiong, Sakamoto F118). Cohen, Xiong, and Sakamoto therefore warn that the use of unpasteurized donor milk from unscreened women "may pose a significant health risk to exposed infants" (Cohen, Xiong, Sakamoto F120).

The Human Milk Banking Association's (HMBANA) statement entitled "Donor Milk: Ensuring Safety and Ethical Allocation" also outlines many of the same concerns about unpasteurized donor breast milk. HMBANA is a non-profit association of donor

human milk banks that "set[s] standards for and facilitates establishment and operation of milk banks in North America" (HMBANA 1). In the opening paragraph of the statement, HMBANA takes a stand against informal milk sharing, arguing that casually sharing milk or "procuring milk from any source other than an established donor human milk bank operating under HMBANA Guidelines, or similar guidelines established in other countries, has potential risks for both the recipient and the donor or her child" (HMBANA 1). Instead, they endorse non-profit donor milk banking, as the extensive milk testing and donor screening process is sufficient to ensure that babies receive safe milk.

The American Academy of Family Physicians' (AAFP) Position Paper (2009) advises that if an infant should become ill or have poor suction or appetite and require supplementation, they be supplemented with artificial infant formula, pumped breast milk from the biological mother, or pasteurized donor milk, which "has been found to be safe and nutritionally sound for babies who do not have access to their mother's own milk" (AAFP 1). Despite the AAFP's commitment to breastfeeding and the benefits of breast milk over formula, infant formula is still considered to be the next best option after pasteurized donor breast milk.

The World Health Organization's (WHO) report (2002) promotes exclusive breastfeeding from birth for no less than six months, arguing that "breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants" (World Health Organization 5). When "infants cannot, or should not, be breastfed," this report outlines a hierarchy of most preferred breast milk sources: "expressed breast milk from an infant's own mother, breast milk from a *healthy wet-nurse* or a human milk bank, or a breast-milk substitute fed with a cup…" (World Health

Organization 7, emphasis my own). Because this report recognizes breast milk from a healthy wet-nurse as a viable alternative to a mother's own milk, many of the women on HM4HB see this recommendation as legitimating their use of donor breast milk. As well, they use this statement to provide support for their decision to wet nurse another woman's baby, or to have their baby fed by a wet nurse. Though the report does not explicitly address online milk donation, it is the only medical literature that includes a healthy wet nurse as a suitable or safe source for breast milk.

The Medicalization of Infant Feeding: Critiques

Tasnim Nathoo and Aleck Ostry (2009) evaluate the emergence, decline and resurgence of breastfeeding policies in Canada. They consider the roles that the provincial and federal governments have played in ultimately constructing breastfeeding as the dominant method of feeding. However, breastfeeding was not always well regarded and rates of breastfeeding began to decline after 1920 (Nathoo and Ostry 4). This can be attributed to literature with a scientific and medical focus, which linked breastfeeding to malnutrition. Nathoo and Ostry note that early perceptions of the quality of a woman's breast milk were directly related to their personal characteristics, such as her diet and emotional state (5). They make a very brief comparison of historical wet-nursing practices with the current practice of online milk exchange, in which an infant can receive milk from multiple women. This thesis will further their preliminary analysis, specifically in terms of considering the scientific and medical approaches to understanding breast milk.

Linda Blum (1999) also writes about how infant feeding has been influenced by its medicalization. She argues that medical professionals "took over the supervision of

infant-care and feeding for both humanitarian and self-interested motives" (Blum 29). She explores the history of the medical involvement with motherhood in the United States, as well as the origins of shared nursing. In her first chapter, she lists questions related to breastfeeding, including, "which women's bodies 'deserve' to be seen as pure or trustworthy? Which women's bodies need to be controlled? And which women's bodies are cast as polluted and dangerous?" (Blum 1). These questions are significant to my research since the medical perspective on breast milk sharing involves a discussion about women's milk as a potentially contaminated substance. To examine the dominant knowledge of mothers and breastfeeding, Blum evaluates medical discourse, particularly infant feeding guides produced by the American Academy of Pediatrics, and articles comparing breast and bottle-feeding. She supplements this information with an interview with a pediatrician and a specialist in maternal and child health. While an understanding of the medical discourse certainly informs her research, it does not represent a major aspect of her book. My analysis of medical discourse will bridge this gap.

Penny Van Esterik (1989) looks at the development of medicalized infant feeding in North America and developing countries. Van Esterik explores the history of the association between infant feeding and medical professionals, arguing that doctors became concerned with this subject in the nineteenth century when infant foods were first commercially produced (116). By the early 20th century with the growth of pediatrics, physicians became responsible for overseeing parents' infant feeding decisions (Van Esterik 117). I found her chapter on hegemony and medical monopoly, specifically the medicalization of infant feeding in North America, especially useful. Van Esterik argues that the medical influence and involvement in infant feeding has "resulted in the domination of biomedical language, knowledge and theories for interpreting infant

feeding over other models of discourse" (Van Esterik 128). The physician's use of "biomedical jargon" with his patients establishes him as the authority to educate about infant feeding and to promote whichever method he sees as appropriate (Van Esterik 128). My study explores the ways that such biomedical language is used by physicians and challenged by mothers and the media.

Bernice Hausman (2003) explores the medicalization of infant feeding in great depth. She argues that infant feeding has become increasingly scientific because it is currently monitored by the medical profession (Hausman 20). She writes that its medicalization has "profound effects on women's maternal practices," in that "medicine both promotes breastfeeding in its official pronouncements and often mishandles it in practice" (Hausman 22). Her main argument is that the medicalized outlook on infant feeding encourages women's uneasiness regarding their ability to nourish their babies. As a result, mothers will turn to medically sponsored literature regarding how to 'properly' feed their infants, and they may feel inadequate in their ability to nourish them (Hausman 23). Hausman notes that women are constantly bombarded with information about health, yet are also burdened with notices about health risks, namely those associated with breast milk. Her argument that the medical profession closely monitors, and essentially regulates, breastfeeding corresponds directly to my research about the medical community's warnings against sharing breast milk (an example of a medical authority exercising its power over infant feeding practices). As well, she questions how mothers interpret medical information related to infant feeding, which was a topic of discussion among the mothers on HM4HB.

Maia Boswell-Penc (2006) also elaborates on the medicalized approach to infant feeding. Her book explores breastfeeding and the substance of breast milk from an

environmental and feminist standpoint. She argues that there has been little feminist attention paid to infant feeding. Boswell-Penc criticizes science as a field that devalues and subordinates women and she states that few question its power (34). I see her criticism as a basis for my research, since I consider whether the discussions among women sharing breast milk on HM4HB reject, or even neglect to acknowledge, scientific recommendations and warnings.

James E. Akre, Karleen D. Gribble, and Maureen Minchin (2011) challenge the Canadian, French and American medical community's condemnation of breast milk sharing through online networks, while questioning why this is so. The authors side with the women involved with these networks, arguing that they are extending appropriate control over their milk, and by extension, their bodies. Akre, Gribble, and Minchin claim that the medical community's rejection of these networks has three bases: "ignorance and prejudice surrounding shared breast milk, a perceived challenge to the medical establishment of a system where mothers exercise independent control, and concern that mother-to-mother milk sharing threatens donor milk banks" (2). This article, with its critical stance against health authorities, represents the only piece that looks at contemporary breast milk sharing from the perspective of milk sharing proponents. Their conclusions have served as a guide for my research on the clash between the maternal and medical perspectives.

Virginia Thorley (2009), through various interviews with Australian mothers who share breastfeeding and breast milk, discovers that women have a high regard for these practices, regardless of the warnings. She argues that existing Australian policies about breast milk sharing and cross-nursing have been written without taking into account the experiences of those involved. The mothers interviewed by Thorley told her that they

took precautionary measures and adequately screened donors before accepting their breast milk, or before allowing other mothers to breastfeed their children (Thorley 26). While Thorley makes no recommendations to change or revise policies, she hopes that her findings will encourage public health authorities to reconsider their disapproval of milk sharing.

Jane Ussher (2006) uses both her own experiences as a woman, as well as interviews that she and other researchers have conducted on women from the UK, Australia and North America, to understand the ways that women accept and resist the medicalized discourses associated with the reproductive body. She argues that breastfeeding has been medicalized and framed as a process that must be closely monitored to ensure that there are no problems that may arise during either the production of milk or the feeding process. Ussher sees medical professionals as able to exercise their power and control over women throughout maternity. My analysis in Chapter 3 shows how HM4HB members challenge the medical discourse about breast milk, and discuss themselves as the experts of their own breast milk and lactating bodies.

Similar to Ussher, Gabriella Zizzo (2011) argues that bodily substances and fluids, while clearly having positive aspects, are simultaneously often regarded as "contaminable or threatening" when they are used outside society's accepted standards (33).[3] As a result, medical authorities have constructed breast milk sharing as a threat because breast milk emphasizes the uncontrollable nature of women's bodies; the expulsion or seepage of a leaky breast is understood to be a problem that must be contained (Zizzo 3).

[3] Society's accepted standards can be defined as the exclusive mother-child dyad, rather than shared breastfeeding or breast milk.

Rhonda Shaw (2004) explores cross-nursing, wet-nursing and breast milk donation, through the theories of Merleau-Ponty and Diprose. She contends that cross-nursing and wet-nursing have reinvented the concept of motherhood, in which bodily fluids and body parts were not traditionally lent or borrowed (Shaw 288). Shaw postulates that cross-nursing practices have been regarded as inappropriate, since they disrupt the traditional biological mother-to-infant feeding (288). She cites Rosalyn Diprose's idea that an embodied connection with others contributes to women's happiness and identity, which is revealed by the sense of personal fulfillment that the HM4HB members gain from donating their breast milk to others in need.

Rhonda Shaw and Alison Bartlett's eds. (2010) "Giving Breastmilk: Body Ethics and Contemporary Breastfeeding Practice" is a compilation of chapters written by various authors on the "questions of ethics and epistemology, philosophy and politics of breastmilk" (Shaw and Bartlett 1). This book is important to the study of breast milk sharing because it is one of the first works to consider this practice in the present day. The chapter entitled "Going With the Flow" by Carol Bartle is of particular relevance to my study, as she sees breastfeeding as a valuable social practice, and recognizes the complexity of discourses surrounding donor breast milk. In Bartlett and Shaw's introduction, they note that breast milk exchange is almost absent in literature related to the body and I hope to bridge this gap with my research.

Martha McCaughey (2010) explores the practice of breastfeeding from her own experiences as a breastfeeding mother and a science, technology and society (STS) feminist scholar. She argues that there is a disconnect between pro-breastfeeding materials that "represent breastfeeding as an organic practice free from the intervention of medical experts" and her lived experience of breastfeeding as managed by medical

experts (McCaughey 79). Throughout her breastfeeding experience, which involved the intervention of many medical professionals, she was unable to feel "like an authority about [her] body" (McCaughey 89). She proposes that women should recognize the realities of breastfeeding as a practice that is influenced by social and political factors, and advocates for greater social support and resources for breastfeeding women.

Research Questions

Rather than making an argument in favour or against breast milk sharing, I will examine a selection of perspectives of the milk sharing debate, including the medical, maternal (HM4HB wall posts), and news media perspectives. I will focus on the discussions occurring online (HM4HB Facebook groups), throughout the literature published by the medical community, and finally, the Canadian mainstream news media's take on the debate. The research questions that will serve as the basis for each chapter are:

1) How is milk sharing discussed by the medical community in its formal statements, guidelines and press releases?
2) How is milk sharing discussed by the mothers on the HM4HB Facebook pages?
3) How do journalists writing news stories and columns for mainstream Canadian newspapers (*The Vancouver Sun, The Montreal Gazette, The Toronto Star, The Toronto Sun, Sherbrooke Record, The Calgary Herald, Prince George Citizen, The Vancouver Province, The Saskatoon Star Phoenix, Ottawa Citizen, The Hamilton Spectator, and The Victoria Times Colonist*) take up and challenge the medical and maternal discourses? How do they position mothers and doctors as participants in the milk sharing process? To what extent do the news stories meet the journalistic ideals of fairness and balance? Do columnists side with the medical community, the mothers sharing their milk, or explore both sides of the debate fairly?

Once these questions are answered, I will determine how the discussion of milk sharing differs between these three interest groups.

Methodology

Interpretative Repertoires

I situate my study using the theoretical and analytical approach of discourse analysis and the analytic tool of interpretative repertoires to analyze the textual interactions between women on various HM4HB Facebook groups. Social psychologists Margaret Wetherell and Jonathan Potter (1988) explain that discourse analysis "can be best understood by introducing the interconnected concepts of function, construction, variation and the analytic unit [of] the interpretative repertoire (169). Wetherell and Potter developed the concept of interpretative repertoires, which they define as "recurrently used systems of terms for characterizing and evaluating actions, events and other phenomena" (203). In other words, interpretative repertoires "…could be seen as building blocks speakers use for constructing versions of actions [and] cognitive processes (Wetherell and Potter 171). Wetherell and Potter argue that since discourse is used constructively, or perhaps argumentatively within interpretative repertoires, individuals will seek to achieve different outcomes through the language they use. Any specific repertoire comprises a "restricted range of terms used in a specific stylistic and grammatical fashion" and is organized around common metaphors or figures of speech (Wetherell and Potter 172). Speakers or respondents can draw on groups of statements, beliefs and attitudes that present themselves within interpretative repertoires.

By identifying and analyzing the construction and use of interpretative repertoires, researchers are able to understand the values and meanings that are shared among different groups or cultures, which can serve as a reflection of that society. Examining the verbal or written accounts of different people reveals the repertoires used through the patterns and repetitions among respondents. In addition to repetition, I looked at the

variations, metaphors and figures of speech in the texts that are indicative of different repertoires. Variability and repetition can be expected within different interviews or analyses of text, as respondents will either draw on different repertoires, or use the same ones in constructing several events or people. Individuals who are part of a certain community will use a language that is shared and accepted, rather than creating their own language or discourse. Therefore, interpretative repertoires legitimate the language of the group, while silencing any possible alternate discourses.

An advantage of interpretative repertoire analysis, as discussed by Wetherell and Potter, is that researchers need not group together people who are part of different social groups.[4] Instead, this type of analysis recognizes that repertoires "are available to people with many different group memberships" (Wetherell and Potter 156). For example, interpretative repertoire analysis recognizes that individuals who may have the same occupation or be part of the same social group can draw on different repertoires. In a similar vein, this type of analysis does not attempt to find consensus in people's use of repertoires by assuming that the repertoires drawn on by certain people will always remain consistent. According to Wetherell and Potter, "because people go through life faced with an ever-changing kaleidoscope of situations, they will need to draw upon very different repertoires to suit the needs at hand" (156). Interpretative repertoire analysis need not constrain or eliminate the complexity of individual responses in order to derive data, as the responses, with their variations and intricacies, are embraced in their natural contexts (Wetherell and Potter 183).

[4] Wetherell and Potter use the example of grouping biochemists, social scientists and lawyers together as members of the same social group, which is not consistent with interpretative repertoire analysis (156).

Social Positioning Theory

In addition to interpretative repertoire analysis, I will analyze HM4HB posts, medical statements, and newspaper articles using Social Positioning Theory. Once interpretative repertoires of the data are generated, I can use Positioning Theory to identify the ways that the speakers within each repertoire position themselves and others. This is particularly useful for examining how the mothers on HM4HB position themselves and the members of the medical community, how the medical community positions itself and the women who share breast milk, and how the news media positions these two interest groups.

Like Wetherell and Potter's form of discourse analysis, Positioning Theory is situated within social constructionism, which considers social phenomena as being produced in and throughout conversations, or activities that are similar to conversation. For example, one of the principles of social constructionism states that the actions of people, both private and public, are intentional and naturally regulated through cultural codes that determine acceptability (Harré and van Langenhove 2). In addition, the way that one is regarded by others, as well as one's perception of oneself, is a result of interpersonal relations (Harré and van Langenhove 2).

Rom Harré and Luk van Langenhove, the developers of this approach, explain Social Positioning Theory as "the study of local moral orders as ever-shifting patterns of mutual and contestable rights and obligations of speaking and acting" (Harré and van Langenhove 1). According to Harré and van Langenhove, a position is "a complex cluster of generic personal attributes, structured in various ways, impinges on the possibilities of interpersonal, intergroup and even intrapersonal action through some assignment of such rights, duties and obligations to an individual as are sustained by the cluster" (1)

Through the storylines or interpretative repertoires present within a conversation that "make a person's actions intelligible and relatively determinate as social acts," one can be positioned, position oneself, or position another (Harré and van Langenhove 17). To provide an example, someone who is positioned as knowledgeable about a certain skill or field will have the authority to contribute to the discussions regarding their field of expertise (Harré and van Langenhove 1). On the other hand, the person who is positioned as incompetent in that certain skill or field will not be given the right to contribute to the discussion (Harré van and Langenhove 1). And, since positioning is often relational, for someone to be positioned as knowledgeable or powerful, others must be positioned as ill informed or powerless (Harré and van Langenhove 1).

Types of Positioning

First and Second Order Positioning

First order positioning occurs when people position themselves and others "within an essentially moral space by using several categories and storylines" (Harré and van Langenhove 20). To provide an example, if person A says to person B: "Please book my appointment," both persons A and B are positioned through that account. Person A is positioned as someone who either has the power and right, or believes herself to have the power and right, to commission person B to engage in the specific task. On the other hand, person B is positioned as someone who must report to person A. If person B refuses to complete the task for person A, a second order positioning occurs, which is when the first order positioning is reconsidered or renegotiated (e.g, "Book your own appointment!")

Moral and Personal Positioning

Positions can consist of a moral order, in which one's role in society is evident through conversations-- mother/daughter, doctor/patient or a personal order, in which one's individual characteristics, attitudes or history are brought into the conversation (Harré and van Langenhove 20). Personal and moral elements are always present when people are positioned or position themselves (Harré and van Langenhove 22).

Self and Other Positioning

By positioning oneself, one also positions those who are addressed in the conversation. Similarly, when one positions someone else, he/she is engaging in a form of implied self-positioning (Harré and van Langenhove 22).

Tacit and Intentional Positioning

Tacit positioning of the first-order occurs when people do not position themselves or others in a conscious manner, while intentional positioning occurs when one wishes to "demonstrate or test [one's] dominance" of another (Harré and van Langenhove 22).

Overview

In the next three chapters, I describe my analysis of three sets of accounts. I use Wetherell and Potter's methods of discourse analysis to identify the interpretative repertoires. As well, I employ Social Positioning Theory to show how writers use these repertoires to position doctors and mothers as legitimate participants and experts (or not) in the milk sharing process.

In Chapter 2, I analyze the medical voice: press releases and literature produced by Health Canada and medical experts across Canada and the United States on the subject of breast milk sharing, The purpose of this chapter is to determine how informal milk sharing is discussed by those who oppose it.

In Chapter 3, I analyze the discussions occurring on the Canadian HM4HB Facebook pages, as well as the HM4HB Global Group, to determine how milk sharing is discussed among mothers.

In Chapter 4, I analyze 17 Canadian newspaper articles, ranging from 2008-2011, that discuss the issue of breast milk sharing. This analysis allows me to discover how journalists mediate and represent the medical and maternal discourses.

Chapter 2: Milk Sharing Gone Sour- An Interpretative Repertoire and Social Positioning Theory Analysis of Medical Literature

In this chapter, I analyze the interpretative repertoires and subject positions constructed by doctors within articles and press releases that have been published by Health Canada, the FDA, the *Canadian Medical Association Journal*, the Canadian Paediatric Society, La Leche League, and Dr. Sheela R. Geraghty, Julie E. Heier, and Kathleen M. Rasmussen in the *Public Health Reports* (the official journal of the US Public Health Service[5]) on the subject of milk sharing.

Table 1

DOCTOR/MEDICAL ORGANIZATION	DOCUMENT TITLE	DATE OF PUBLICATION
Health Canada	Health Canada Raises Concerns About the Use of Unprocessed Human Milk	November 25/2010
FDA- US Food and Drug Administration	Use of Donor Human Milk	November 30/2010
Canadian Medical Association Journal	Milk Sharing: Boon or Biohazard? [6]	February 22nd, 2011
Dr. Sharon Unger and Dr. JH Kim on behalf of the Canadian Paediatric Society	Position Statement: Human Milk Banking	November 1/2010
La Leche League International	Important Policy Update (recommendations from Health Advisory Council)	March 2011
Dr. Sheela R. Geraghty, Julie E. Heier and Kathleen M. Rasmussen on behalf of Association of Schools of Public Health	Got Milk? Sharing Human Milk Via the Internet	March-April 2011, found within Public Health Reports Volume 126

[5] The US Public Health Service is overseen by the Surgeon General of the United States and represents a team of more than 6,500 qualified public health professionals.
[6] It is important to note that while a medical doctor did not write this document, it appears in a seminal medical journal, and thus represents the views of Canadian medical practitioners.

Understanding Scientific Texts

According to Harré and van Langenhove, scientific texts can be understood in a variety of ways, which is especially important when analyzing documents authored by medical professionals. A scientific publication can be considered as:

> …a complex of speech-acts that has such illocutionary force as can be created in the act of reading between author(s) and readers. This force is maintained through into subsequent citations of the original writing, as its authority, and the subsequent positioning of authors and readers as to their authority, that is, their right to have the last word. (Harre and van Langenhove 105)

In other words, the scientific documents I analyze contain illocutionary force in the form of suggestions, assertions and demands regarding breast milk sharing to which the public is expected to adhere. The data presented within the six documents is presumed as factual and reliable because the authors position themselves as the ultimate authorities of the subject; as medical professionals (or a representative of the Canadian Medical Association) they are clearly to be trusted. On the other hand, the public is positioned by the doctors as scientifically uninformed and ignorant about the subject. The doctors, by failing to acknowledge breast milk sharing as a legitimate practice and strategically omitting any guidelines for the safe sharing of human milk, position the public as compelled to act in accordance with their recommendations or orders. Implicit in the documents is the notion that defying the scientific opinion, at one's own risk, will ultimately lead to negative consequences for babies fed with unprocessed donor milk.

Purpose of Analysis

The purpose of this analysis is to identify the repertoires drawn upon by doctors and members of the medical community within their documents and press releases on the subject of breast milk sharing. By doing so, I can make a comparison between the doctors' discussions and the HM4HB members' discussions. As well, the ways that doctors discuss and frame breast milk and its exchange among women is central to understanding both their caution towards its properties, and their lack of support for milk sharing. I use 'milk banks' to refer to the medically supervised distribution of pasteurized milk from screened human donors and 'milk sharing' as non-medically supervised mother-led and organized sharing of unpasteurized milk, which is facilitated by the internet. From the documents presented above, I identify interpretative repertoires by locating common metaphors, figures of speech and groups of statements, and then identify representations that are common to each of the four texts. The repertoires are as follows:

1. Milk sharing as risky for babies/breast milk as contaminated
2. Milk sharing as informal
3. Milk banks as safer than milk sharing
4. Doctors as primary infant feeding decision makers

Analysis

Milk Sharing as Risky for Babies/ Breast Milk as Contaminated

Despite recognizing breastfeeding as the best method of feeding infants, the medical literature, save for La Leche League's policy statement, condemns milk sharing, discussing it as a risky practice by referring to breast milk as a diseased substance, or as a substance with the high likelihood of becoming contaminated. The FDA warns that

feeding a baby with milk from women other than the biological mother brings "possible health and safety risks for the baby," including exposure to certain infectious diseases and chemicals, and "to a limited number of prescription drugs that might be in the human milk, if the donor has not been adequately screened" (U.S. Food and Drug Administration 1). By stating that there is potential for babies to be exposed to such diseases and dangerous substances through donor milk, the FDA is suggesting that donor milk brings more risks than benefits. Nowhere in the document does the FDA state the benefits of donor breast milk over formula, nor does it offer guidelines to ensure safe milk sharing. The FDA is identifying breast milk as a substance that can be easily contaminated and spoiled, rather than as vital sustenance for babies.

Health Canada's statement is similar in content to the FDA's, in that the authors position breast milk as a substance that "may be contaminated with viruses such as HIV or bacteria which can cause food poisoning, such as *Staphylococcus aureus"* (Health Canada 1). While the press release identifies that breastfeeding "promotes optimal infant growth, health and development and is recognized as the best method of feeding infants," Health Canada discourages the sharing of human milk ("unprocessed human milk should not be shared") and does not provide recommendations for women who are unable to breastfeed their babies (Health Canada 1).

The *Canadian Medical Association Journal's* report contains many of the same messages about breast milk and milk sharing. Though it is presented in the form of an article rather than a press release, the piece also reads as a formal warning against milk sharing. Lauren Vogel, of the *Canadian Medical Association Journal*, hopes that those who share or donate their breast milk, or consider doing so, will change their minds after reading the article. Vogel's article relies heavily on quotations from Dr. Unger, who

claims that breast milk is a "body fluid capable of transmitting disease" and that milk sharing is "very dangerous" (E155). Dr. Unger also positions those who share breast milk as bad parents who are willing to put their children in danger to avoid paying for banked milk, since the milk they receive is most likely unsafe ("What if a woman has a cold sore or herpes lesion on her breast? She may not be aware of it, but such a virus can be fatal to newborns. Why would you take that risk?") (Vogel E155). This statement suggests that milk sharing is extremely risky for the recipient babies, whose health can be compromised by a donor's ignorance. The article also cites Health Canada and the FDA's statements, which support Dr. Unger's stance against milk sharing. By addressing the limitations of home sterilization of expressed breast milk as recommended by online milk sharing networks ("But unless pasteurized milk is tested for heat-resistant bacteria, mothers are gambling with their children's health"), breast milk is represented as a substance that is potentially too impure or contaminated to be made safe by home pasteurization procedures (Vogel E156). Because Vogel quotes Dr. Unger frequently on the risks associated with milk sharing, her article projects the dangers of this practice through the voice of a credible and authoritative source.

Dr. Sharon Unger and Dr. Jae Hong Kim's position statement for the Canadian Paediatric Society argues on behalf of the importance of milk banks in North America, claiming, "further milk banking in Canada should be encouraged and promoted" (595). Since "the safety of human milk can again be assured" only through "current screening protocols and serological testing" at the B.C Women's Milk Bank, Drs. Unger and Kim, on behalf of the CPS, condone the sharing of human milk under these tightly controlled and medically overseen circumstances (595). They discuss breast milk as a "human body substance," which must be handled accordingly (Unger and Kim 596). Should a woman

wish to donate her milk to the registered Milk Bank, she must undergo a screening process that closely mirrors blood donation screening: an interview, serological screening and physician consent (Unger and Kim 595). Drs. Unger and Kim's use of clinical language frames breast milk as a potentially dangerous substance that requires adequate screening to assess its purity or cleanliness. While Drs. Unger and Kim do not refer to informal milk sharing, they maintain that banked milk is "collected, stored, pasteurized and cultured in accordance with food preparation guidelines as set out by the Canadian Food Inspection Agency" (596). The stringent safety control measures that are involved throughout the process of donating milk to the bank reveals the doctors' characterizations of breast milk as a potentially hazardous substance capable of carrying viruses, especially since the prevention of "…disease transmission…can never be absolutely assured" (Unger and Kim 596).

While La Leche League Leaders are unable to recommend or to facilitate milk sharing arrangements, they can discuss its benefits and risks, and this approach differs from the other medical literature that immediately discourages it (La Leche League International). The Health Experts at La Leche League International (LLLI), consisting of forty "health and social science professionals," contributed to the Policy Update regarding milk sharing and milk donation by providing recommendations from a medical standpoint (La Leche League International). Because La Leche League's "first priority…is to help mothers breastfeed their babies," the information provided in the policy update is more neutral than that of the other medical literature (La Leche League International). For example, rather than only listing the risks of milk sharing, LLLI's policy update refers to both the benefits and risks of this practice, with equal emphasis and attention. The language used describes milk sharing not as an incredibly risky practice, but one that *can*

be or has potential to be risky if the proper safety measures are not considered: "risks can include, but are not limited to: transmission of certain infectious agents, like bacteria or viruses, some of which may be found in milk expressed by asymptomatic women; drugs; possibly some environmental contaminants, and potentially unhygienic storage and handling of unprocessed donated milk" (La Leche League International). Rather than assuming that all donated milk will carry diseases, LLLI's policy statement presents breast milk as vital sustenance that, when shared properly, can be "lifesaving" (La Leche League International). This policy statement communicates the importance to readers that "donated milk be safe" if it is to be shared (La Leche League International).

Dr. Sheela R. Geraghty, in collaboration with Julie E. Heier and Kathleen M. Rasmussen, discuss the dangers of sharing breast milk online, warning readers to "proceed with caution" (Geraghty, Heier, and Rasmussen 163). The fundamental difference between this piece and the others is that the authors focus on breast milk exchanged online for profit, whereas the other statements do not differentiate between this or breast milk shared online for free. The authors state, "the 'milk' that the buyer gets is an unregulated, untested commodity" (Geraghty, Heier, and Rasmussen 163). Putting the word milk in quotations marks suggests that the substance sold may not even be breast milk, but a mysterious concoction of fluids under the guise of breast milk, which creates an even greater disjunction between safety and milk sharing (or selling). As well, the use of the word 'commodity' communicates the notion that it (the milk, or milk-like substance) is a product with no quality control measures, rather than a woman's pure breast milk. Similar to the other medical literature, the authors discuss breast milk as a substance that can host "human immunodeficiency virus, group B streptococcus, Klebsiella pneumonia, cytomegalovirus, and herpes," which can "potentially sicken the

recipient (Geraghty, Heier, and Rasmussen 163). As this document refers only to breast milk that is exchanged for profit, the authors describe this bodily fluid as one that is easily contaminated by viruses and "harmful environmental chemicals," no matter how costly (Geraghty, Heier, and Rasmussen 163).

Milk Sharing as Informal

All of the medical literature that discusses online milk sharing refers to this practice as being 'informal'. While Drs. Unger and Kim's paper does not specifically address online milk sharing, they include a list of recommendations at the end, with the last point illuminating their position on this subject: "The Canadian Paediatric Society does not endorse the sharing of unprocessed human milk" (Unger and Kim 597). Health Canada, the FDA and Dr. Geraghty, Heier, and Rasmussen, discuss milk sharing as an informal practice, in which a donor's medical information is unknown. With limited interaction between donor and recipient, these documents suggest that there is a heightened risk factor for babies who receive the milk from such anonymous sources. For example, Dr. Geraghty, Heier, and Rasmussen's document attests to the anonymity factor involved in breast milk sold online, discussing the process in similar terms to online shopping:

> The buyer and seller never need to converse through a third party, nor do they communicate directly… Buyers simply read the online descriptions of the milk and choose from the many options available. On one of the classified advertising sites, there were more than 20 milk sellers from which to choose… After deciding on which milk to purchase, the buyer simply highlights the chosen entry and then clicks on the 'Buy Now' or

> 'Add to Cart' function. At the subsequent 'Checkout' Screen, all of these sites ask for credit card or PayPal payments. (162)

In addition, Health Canada, the FDA, and Dr. Geraghty, Heier, and Rasmussen position donors as careless, anonymous persons, who knowingly send milk contaminated by prescription or non prescription drugs, engage in improper hygiene while extracting the milk, and store and handle the milk incorrectly (Health Canada 1; U.S. Food and Drug Administration 1; Dr. Geraghty, Heier, and Rasmussen 163). By stating that "it is not likely" for the donor milk to have been properly extracted, collected or stored, the FDA's language suggests that such is true for *all* milk donations, which paints a grim picture of milk sharing (U.S. Food and Drug Administration 1). Health Canada, the FDA, and Dr. Geraghty, Heier, and Rasmussen position donors as diseased and unfit, since their milk could be contaminated with harmful bacteria or viruses that could cause recipient babies to become ill, such as HIV or prescription and non-prescription drugs. Since. Dr. Geraghty, Heier, and Rasmussen's paper refers to milk that is sold for a profit[7], they speak to the dangers of this added element of monetary incentive, arguing, "a buyer will never know if a seller has added a potentially harmful substance to the milk to increase the volume, and, thus, the monetary value" (163). This one powerful statement positions these anonymous breast milk sellers as completely untrustworthy and devious, with no concern for the health of those who receive their milk. As well, it paints a grim picture of online, for-profit milk exchange as a corrupt business instead of a generous, meaningful practice. Aside from the donors, Health Canada's press release positions recipients as unfit parents, as they are willing to compromise the health and safety of their children by

[7] HM4HB Facebook groups are strictly non-commercial.

failing to request appropriate medical documentation from the donor or by being unaware of the donor's medical history, despite all of the risks outlined by a trusted medical body (Health Canada 1).

The *Canadian Medical Association Journal* echoes the sentiments of Health Canada, the FDA, and Drs. Unger and Kim regarding the informal nature of milk sharing. The article cites Dr. Unger, who juxtaposes the security and safety associated with milk banks with the ambiguity and anonymity of online milk donors: "Milk banks also test other pathogens…but with a stranger's milk you just don't know (Vogel E156). Since Dr. Sharon Unger is aligned with the medical community, her opinion can be taken as valid and trustworthy. Her statements present milk sharing as strictly informal and between 'strangers,' involving no meaningful communication between donors and recipients.

La Leche League's policy update also addresses the same risks of informal milk sharing that were articulated by the other medical literature I analyze, but in a more subdued tone. Instead of positioning all milk donors as unfit, diseased or careless, LLLI's neutral language suggests that "bacteria or viruses…*may* be found in milk expressed by asymptomatic women" and that "*potentially* unhygienic storage and handling of unprocessed donated milk" [emphasis my own] could be a risk factor (La Leche League International). Using words such as "may" and "potentially" suggest that only some donors engage in unsafe practices that can harm the quality and safety of their milk. However, by stating that, "a Leader shall never initiate the suggestion of an informal milk-donation arrangement or act as an intermediary in such a situation," the LLLI represents milk sharing as a practice that may be too risky, since Leaders are prohibited from aiding prospective donors or recipients, due to the informal aspect of its execution (La Leche League International). Though the tone of their statement may differ from that

of the other medical documents, LLLI is still sending the same message: milk sharing is unsafe when it is conducted informally.

Milk Banks as Safer than Milk Sharing

There is no question that the medical literature supports breastfeeding and the benefits of breast milk, but only so long as the infant receives milk exclusively from the biological mother. When it becomes impossible for the mother to supply her own milk, the medical literature advocates for registered breast milk banks as the only acceptable source for obtaining breast milk. While Health Canada omits any discussion about milk banks in its press release, the FDA, the *Canadian Medical Association Journal*, and Drs. Unger and Kim describe milk banks as the *only* adequate alternative to mother's own milk. Though Dr. Geraghty, Heier, and Rasmussen quote the World Health Organization (2003), in that "only under exceptional circumstances should a mother's milk be considered unsuitable for her own infant and a 'healthy wet-nurse' act as an alternative," they urge women to visit milk banks instead of purchasing breast milk online (163). While La Leche League does not describe milk banks as the only suitable alternative, it certainly represents the milk bank as the most legitimate, by recommending the use of its services: "The Leader shall also suggest the mother…contact a licensed human milk bank or other regulated and medically supervised human milk collection center in her country" (La Leche League International). As well, the policy update represents milk from banks as the safest alternative to mother's milk, arguing that "milk from a qualified milk bank will require donors meet specific health requirements before accepting their donated milk, which eliminates many of those risks [associated with informal sharing]" (La Leche League International).

The FDA "recommends that if…you decide to feed a baby with human milk from a source other than the baby's mother, you should only use milk from a source that has screened its milk donors and taken other precautions to ensure the safety of its milk" (U.S. Food and Drug Administration 1). This statement communicates a strong, cautionary message to parents that they must not feed their babies with milk obtained outside of a milk bank, since it cannot be as safe as banked milk, which is "safely collect[ed], process[ed], handle[d], test[ed] and store[d]" (U.S. Food and Drug Administration 1). As a result, the FDA is tacitly positioning those who defy the FDA recommendations and seek milk from other sources as bad or careless parents who are jeopardizing their babies' health.

The documents authored by the *Canadian Medical Association Journal*, Drs. Unger and Kim, and Dr. Geraghty, Heier, and Rasmussen emphasize the safety measures taken by milk banks, arguing that there is a complete lack of concern for safety with informal milk sharing, or for profit milk sharing (in the case of Dr. Geraghty, Heier, and Rasmussen). The *Canadian Medical Association Journal* quotes Dr. Sharon Unger, who discusses milk banks as safer than milk sharing: "Association banks dispense more than one and a half billion ounces of human milk every year and they've never had a case of disease transmission" (Vogel E155). Vogel also quotes Unger on the "stringent guidelines for donor screening and pasteurization adopted from blood services and the dairy industry, along with regulatory oversight from Health Canada and the Canadian Food Inspection Agency," which represents milk banks as the safest venue for accessing breast milk (E155). Vogel compares the advanced pasteurization capabilities of milk banks with the inadequate method of flash-pasteurization involved in online milk sharing, arguing that milk banks can test "for heat-resistant bacteria…and other pathogens," which can

certainly not be conducted outside of a laboratory setting (Vogel E156). Similarly, Drs. Unger and Kim argue that "there has never been a reported case of disease transmission…" due to the strict testing and screening protocols of milk banks (596). They outline the thorough process involved in donating milk to a bank:

> All donors must undergo a rigorous screening process similar to that used for donating blood, which includes an interview, serological screening and physician consent. Serology includes testing for hepatitis B and C as well as HIV and the human T cell leukemia virus. All milk must be properly collected, stored, pasteurized and cultured in accordance with food preparation guidelines as set out by the Canadian Food Inspection Agency. (Unger and Kim 596)

In addition to describing the extensive safety measures, Drs. Unger and Kim argue that, due to the milk bank, "the safety of human milk can again be assured" (595). This statement places an incredibly high value on the milk bank. By attributing the overall safety of breast milk to the milk bank's pasteurization and testing processes, they are representing the milk bank as the most superior and reliable, or perhaps the only, source for disease-free breast milk. Drs. Unger and Kim describe the potential for "donor milk banks [to] heighten breastfeeding awareness in the community at large, thus, conferring wider benefits to the popular as a whole" (597). While they do not specify what these benefits are, their characterization of the milk bank as a meaningful social influence is reflective of their representation of the bank as superior to milk sharing.

Dr. Geraghty, Heier, and Rasmussen's document is consistent with the other medical literature that endorses milk banks over milk sharing. In this case, the authors represent the milk banks of North America as much safer than paying for milk advertised

online. Dr. Geraghty, Heier, and Rasmussen downplay the safety involved in online breast milk selling by noting that these websites offer "some guidance on the collection, storage and preparation of frozen milk" and ask women to provide a "self reported health history" (162). This statement suggests that the websites are incapable of ensuring that all milk shipped to recipients is safe, as such measures presented above pale in comparison to those of the Human Milk Banking Association. For example, the authors argue banked milk is properly pasteurized, stored and distributed, and that members of the Human Milk Banking Association "follow strict guidelines for serologic screening for infectious disease and use a thorough lifestyle questionnaire," which presents milk from registered donors as guaranteed to be safe and free from viruses (162).

Doctors as Primary Infant Feeding Decision Makers

Aside from Drs. Unger and Kim's position statement that considers parents to have some involvement in their children's feeding options, all of the remaining medical literature overlooks parents as chief infant feeding decision makers for their babies. Dr. Geraghty, Heier, and Rasmussen do not attribute any agency to parents in terms of infant feeding decisions, as they position only doctors as those with the knowledge and authority to decide how to *properly* handle breast milk. They recommend that a "collaboration between clinicians and researchers is essential to understand not only the risks involved in this practice [selling breast milk online], but also how to educate the public about the best use of expressed human milk" (Geraghty, Heier, and Rasmussen 163). And, since they have aligned themselves with the "experts within the American Academy of Pediatrics [who] recommend against the sharing of any raw, unpasteurized human milk," they

consider this expressed breast milk as a substance that can carry viruses that must be handled accordingly (Geraghty, Heier, and Rasmussen 163).

Drs. Unger and Kim argue that "when the mother's own milk is unavailable for the sick, hospitalized newborn, pasteurized human donor breast milk should be made available as an alternative feeding choice followed by commercial formula" (595). The pasteurized human donor milk that they refer to must be derived only from registered donors at the milk bank in Vancouver, rather than from online donors. As a result, they do not discuss physician intervention *prior* to parental decision-making because infants require a prescription from a medical doctor *in order* to receive donor milk from the bank. Drs. Unger and Kim recommend that donor breast milk only be prescribed upon receiving written informed consent from a parent or guardian:

> In this era of informed consent, it is of utmost importance for parents to be fully informed of all treatment options available for their children. Parents must thus be made aware of the possibility for their children to receive human donor breast milk along with all of the perceived benefits and potential risks. They must also be made aware of the health advantages of human breast milk compared with bovine milk. They may then make an informed decision as to the best feeding plan for their baby. Written informed consent from parents/guardians must always be obtained before the administration of human donor breast milk. (597)

Because the document is written by physicians for physicians, it is worded with the assumption that this group of likeminded individuals supports the efforts of the B.C Women's Milk Bank instead of online milk sharing. Drs. Unger and Kim promote the importance of "educat[ing]…parents about the benefits of human donor breast milk" so

that doctors can "prescrib[e] an optimal feeding plan for hospitalized neonates" (597). While their statement does not overlook the role of the parents in making infant feeding decisions, it puts a greater emphasis on the role of the physician as the expert facilitator. They position physicians as the *main* decision makers, who can not only influence parents into obtaining milk for their babies from a registered milk bank, but also can ultimately dissuade them from seeking online donors.

The *Canadian Medical Association Journal's* article refers to La Leche League's outlook on milk sharing, aligning itself with their stance on the importance of consulting with one's physician prior to exchanging milk. Though Vogel quotes Teresa Pitman, a breastfeeding activist for La Leche League Canada, who believes that "women should have the chance to weigh the evidence" about online milk sharing, the possibility for women to make infant feeding decisions independent from health professionals is not further explored or encouraged (E156).

After consulting La Leche League's entire, independent policy statement, I argue that the organization promotes the active involvement of physicians in making infant feeding decisions for one's baby. LLLI states that a "mother will then make her own informed decision based on her situation and culture," but *only* after she is "directed to dialogue with the medical staff caring for her regarding hospital policies on providing human milk for a baby in their care" (La Leche League International). Since LLLI has expressed its policies on prohibiting Leaders from suggesting informal milk sharing options, it is unlikely that this group would direct a woman to any source of milk outside of the banked setting. Therefore, I can argue that her so-called informed decision must always be consistent with the doctors' recommendations to use banked milk because she would be prohibited from feeding her baby within the hospital with donor milk obtained

online. On the surface, La Leche League's statement appears to offer women greater agency in terms of making their own infant feeding decisions; however, my further examination reveals that this group intentionally, though in a covert manner, aligns itself with the medical community by positioning medical professionals as the primary decision makers.

Since Health Canada's statement was published with the intent to discourage parents from obtaining breast milk through online milk sharing, the physician is positioned as the trusted and knowledgeable authority, as well as the primary decision maker regarding infant feeding. Health Canada emphasizes that the physician must be consulted "if [parents] are considering purchasing human milk or acquiring it through the Internet or directly from individuals," communicating the notion that physicians have the final say in where the child receives milk (Health Canada 1). The FDA also recommends that parents "consult a healthcare provider first," which privileges the doctor's opinion over that of the parents, should they have conflicting viewpoints (U.S. Food and Drug Administration 1). The FDA's statement emphasizes that physicians, rather than parents, must take the lead role: "the choice to feed a baby human milk from a source other than the baby's mother should be made in consultation with the baby's healthcare provider, because the nutritional needs of each baby depend on many factors including the baby's age and health" (U.S. Food and Drug Administration 1). Through positioning the doctor as the primary decision maker of infant feeding, Health Canada and the FDA's statements, which highlight the importance of physician intervention, also position parents as less knowledgeable and dependent on doctors to guide their actions.

Chapter 3: HM4HB: An Interpretative Repertoire and Social Positioning Theory Analysis of Facebook Wall Posts

HM4HB Facebook groups provide parents (though primarily used by women), with a space to negotiate the exchange of breast milk.[8] On the network's official website, it states its mission as "promot[ing] the nourishment of babies and children around the world with human milk… [and] fostering community between local families who have chosen to share breastmilk" (HM4HB). While each of the Canadian groups and the global group have different administrators and members, the dialogue is very similar. The women participating in the online discussions share the common belief that breast milk is best for babies, which is the dominant discourse of each of the groups. By voluntarily joining, the women reject the option of baby formula, or any other breast milk substitute, and situate themselves within this discourse. Volunteer administrators who also believe in the superiority of breast milk actively mediate and participate in the discussions. Through an initial observation of the textual interactions between women on the HM4HB groups, I argue that a majority join for the purposes of donating milk to other babies, or requesting milk for their own babies. However, aside from organizing the donation and collection of milk, these women use this online environment as a means of expressing their opinions related to all aspects of breast milk: breastfeeding and infant feeding practices, concerns about breastfeeding, and experiences with milk sharing. People also use this space for posting questions or concerns pertaining to infant feeding, their babies' specific needs or ailments, milk sharing, and the donation process. In turn, they seek out the responses and

[8] To access the HM4HB group pages, visit: https://www.facebook.com/hm4hb/app_137976222934192

encouragement from other women through the 'comment' feature on their posts. Respondents often provide links for resources that may assist the mothers with any questions or issues they are facing.

In this chapter I look at the interactions among the women posting on the Canadian HM4HB Facebook groups, specifically Saskatchewan, Vancouver Island, Quebec, Prince Edward Island, South Western Ontario, Alberta, British Columbia, Manitoba, New Brunswick, and Eastern Ontario ranging from February 28th, 2011 to February 28, 2012. [9] I selected this time period because February 28th, 2011 is the day that HM4HB established its first Facebook group (the global group) and the end date of February 28th, 2012 amounts to one year of coverage, and also represents a reasonable end date for the completion of this thesis. HM4HB has groups for the North West Territories, the Yukon, Newfoundland and Labrador, Nunavut, and Nova Scotia, but there was limited activity or discussion so I did not examine these groups. I have also included the network's main page, the global group, in the analysis, as this group has the greatest number of members (7,286 as of February 28, 2012) and women often join prior to joining their local group. In total, I considered over 2,500 wall posts for my analysis, which represents around 800 individual posters.

Because all posts are freely available on the public web, I treated them as falling within provision 2.2b of the Tri-Council Policy Statement on Research Ethics.[10] However, since the intent of this research is to study similarities and variations in the use of interpretative repertoires for positioning, and not to discern similarities and differences

[9] Of all the posts I looked at, only three were written by men and did not conform to various repertoires I have chosen, and were therefore omitted.

[10] Article 2.2 Research that relies exclusively on publicly available information does not require REB review when … (b) the information is publicly accessible and there is no reasonable expectation of privacy.

among individual women, I have removed poster identifications and dates. I will describe my method for identifying the interpretative repertoires below.

Selection of Interpretative Repertoires

Following Potter and Wetherell's (1987) approach in *Discourse and Social Psychology*, I carefully read the wall posts from the selected HM4HB groups "in search for patterns and recurring organizations" (177). Using the selected HM4HB Facebook pages, I explored how the patterns present in the discourse around breast milk sharing are played out on in an informal, online setting. The aim of this analysis is to 1) identify the principal repertoires that the women drew upon in their discussions on the selected HM4HB Facebook pages; 2) examine how women position themselves, and 3) examine how the women position the medical community and resist the opposing medical discourse.

Using the HM4HB Mission, Values and Vision statement, I conducted a preliminary search for repertoires. This is due to the high number of wall posts analyzed over 10 separate groups (over 2,500), which complicates a search for common repertoires. It was also reasonable to anticipate that the language used on the HM4HB website would reflect the discussions occurring online, as the Facebook groups are monitored by the HM4HB administrators and are an environment for discussion pertaining to milk sharing. It is important to note that all of the wall posts I use as examples have not been altered, and any spelling, punctuation, or grammatical errors appeared in the original posts.

The first repertoire '*milk sharing as fostering community'* is evident in both individual members' posts and in the foundational document of the group, which reads,

"We are dedicated to fostering community between local families who have chosen to share breast milk" (HM4HB). This repertoire considers the practice of breast milk sharing as a means of establishing meaningful relationships between donors and recipients. By referring to formula and breast milk substitutes as "not without risk," HM4HB's rhetoric suggests that breast milk, namely donor milk is the best and safest alternative to a mother's own milk (HM4HB). This rhetoric informs the second and third repertoires respectively, '*breast milk as best*' and '*milk sharing as safe.'* The fourth repertoire, *'milk sharing and wet-nursing as normal'* appears in the Vision statement, which reads, "We hold the space for them and protect their right to do what is normal, healthy, and ecological" (HM4HB). While this statement does not explicitly state that breast milk sharing and wet-nursing are normal practices, HM4HB's goal is to make such practices more common and socially accepted. The fifth repertoire is '*doctors as non-experts of infant feeding/ women as infant feeding experts.'* While HM4HB "imagine[s] a world where family members, friends, lactation consultants, doctors, and midwives do not hesitate to recommend [unpasteurized] donor milk when it is needed," this is not the current reality (HM4HB). Since the medical community is vocal in its condemnation of informal milk sharing networks, HM4HB exists in opposition to the medical community's recommendations, with the members diminishing the power of medical authority through questioning doctors' expertise and ethics. The half about '*women as infant feeding experts'* is reflected in HM4HB's belief in "individual intuition," as HM4HB advocates for the power of women's intuition in guiding their milk sharing decisions (HM4HB). In other words, HM4HB positions women as able to make educated and well-informed decisions that will not compromise the health of their own babies and other women's babies. Along with intuition is the notion that women are experts of their own bodies and

can make decisions independent from medical professionals. The sixth repertoire is '*milk sharing as superior to milk banks,'* which is the only repertoire generated outside of the HM4HB main website and is derived from the women's discussions about their preference for milk sharing over milk banks. The seventh repertoire is *'breast milk as a gift.'* HM4HB states that those belonging to the groups "reogni[ze] [breast milk's] value, and are willing to share it freely with the babies and children of their communities," as HM4HB maintains a non-commercial platform (HM4HB). By using the word 'freely,' HM4HB suggests that milk is a precious gift to be exchanged, rather than a commodity to be bought and sold. Instead of the expectation of monetary compensation, there is the assumption that the donors will be thanked for their gift, as is a standard ritual with most gifts.

Analysis

Milk sharing as Fostering Community

The medical community encourages a fear of "strangers" by discussing milk sharing as an informal practice, in which the donors are anonymous and have no contact with the recipients beyond a computer screen (see Chapter 2). The medical literature argues that recipients can never be sure if their milk is safe, or perhaps if it is even human breast milk they are receiving. However, I argue that the HM4HB posters discuss milk sharing not as an anonymous, computer-mediated exchange, but as a practice involving meaningful relationships between donors and recipients. As a result, the warnings about "stranger danger" projected by the medical documents are not applicable to the posters, since they express the importance of getting to know one another before the milk exchange process commences. According to one poster, 'stranger' is not an appropriate

word to describe her relationship with the recipient of her breast milk: “When she sat in my living room with her husband and new son, and we chatted while my daughter cooed in her swing nearby, 'stranger' was not the word I would have used. We were just two moms. She had a problem, and I was in a position to help her out... Donating milk was hugely rewarding to me, even renewing much of my faith in the spirit of community”). This poster describes a warm and mutually rewarding friendship between a donor and recipient family, far from the anonymous donor/recipient agreement as described by the medical community.

An administrator of the global group refers to milk sharing as a practice based on “altruistic love, and focused on community-building at the local level,” which speaks to the value placed on relationships and the significance of donors and recipients coming together in person for the purpose of helping babies in need (HM4HB). Similarly, another poster thanks the “village community of the women who supported [her] and helped [her] feed [her babies],” as she was unable to produce enough breast milk for her sons and relied on these donors to feed them. Many milk donors express gratitude for their opportunities to give milk to babies in need, emphasizing their involvement in the recipient babies’ lives. These posters are able to witness the impact of their donations, as they meet with their recipient families regularly and interact with the babies who feed on their milk. Some milk sharing relationships are so strong that they have the potential to transcend the donation process, as indicated by one poster who plans to “keep [her] donor in her heart and life forever even though [her] baby is no longer a baby!”. In terms of milk donors, one poster refers to her recipient as “my milk baby,” which positions herself as the baby’s foster mother. Similarly, another donor receives regular photo “follow ups” of the little boy who she donates to, and notes that she places photos of him “right beside

[her] son's." Through these examples, the women on HM4HB depict milk sharing as an intimate practice, rather than one that is entirely computer mediated and detached. They morally position themselves as good mothers who will not settle for anything less than breast milk for their babies--their willingness to feed their own children with another woman's milk, or share their own milk with other babies, illustrates their commitment to breast milk.

Breast Milk as Best

This is one of the most common repertoires that the women on HM4HB draw upon. As a means of supporting their online milk sharing initiatives, many of the posters who draw upon this repertoire reference the WHO's 2003 "Global Strategy for Infant and Young Child Feeding," which reads:

> Only under exceptional circumstances can a mother's milk be considered unsuitable for her infant. For those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative – expressed breast milk from an infant's own mother, *breast milk from a healthy wet-nurse* or a human-milk bank, or a breast-milk substitute fed with a cup, which is a safer method than a feeding bottle and teat –depends on individual circumstances. (7)

The women use this hierarchy of breastfeeding, with breast milk from a wet-nurse as the best alternative to milk from the infant's own mother, to support their decision to share milk on HM4HB. This is because HM4HB members also consider breast milk from donors to be the best alterative to a mother's own milk.

Many of the posters' discussions relate to the benefits and value of breast milk, referring to it as "liquid gold," "babies' birthright," the best and most natural food designed for babies, a form of medication that promotes weight gain, and even a savior of humanity. Many of the posters mention their thriving children as a testament to the advantages and healing powers of donated breast milk ("My 16 month old has been on donor milk since day 1. She's as healthy as can be. The risks are low, and if u ask me, much higher risk feeding formula!!!!"/ "My son has many health issues, and donated breast milk has been huge in keeping him gaining weight. He has gained 2 pounds in a week, just miraculous"). Formula, on the other hand, is discussed in opposition to breast milk as an incomplete, unsafe, or simply unwanted food source for babies. Posters refer to formula as "powdered, fake milk," "poison," and "toxic," comparing its limited nutrient content to that of breast milk ("Toxic formula alone has not worked to help my son gain weight so what does that tell us? Breast is best!!!!"). One poster refers to those who feed their children formula as "brainwashed," since she argues that "everyone should know that breastfeeding and breastmilk is best for babies." Another poster goes so far as to encourage the elimination of formula in order to "fix healthcare issues," although she does not specify which issues.

According to one poster, feeding her children breast milk equates to loving them more than mothers who use formula, which represents breast milk as vital to, and indicative of, good mothering. Her statement, "Cheers to us moms out there who love their children and give them human milk, just like I do for my babies," exemplifies both the moral positioning of herself as a good mother and other positioning of mothers who feed with formula. Implicit within this statement is the notion that mothers who feed their children with formula love them less. One poster employs this same moral positioning of

mothers who feed their babies with formula, as she speaks to the ignorance of mothers using this alternative to breast milk:

> It is world breastfeeding week (according to Parents magazine) and there were a lot of mamas posting how long they have breastfed thier babies... then there was the occasional mama who said things like "never breastfed, never will" and "why is there a whole week for breastfeeding mamas, where is our formula feeding week" and the one the blew my mind "by breasts are for my husband only" (REALLY... isn't the whole purpose of breasts to make milk for your babies???).... I was shocked at how many of those mamas thought that formula was equal to breastmilk... does anyone know of any links I could send out on that page for those moms to check out the research that shows how much better breastmilk is for babies? I am a breastmilk donor to two local families and I know those moms would breastfeed if they could, so I totally understand that some moms cannot breastfeed, but I didn't realize that in todays day and age there were so many people who were misinformed!

She positions the mothers who perceive infant formula to be equal to breast milk as uneducated and in need of proper instruction about the properties of breast milk (“it’s going to take a while to teach people that breast milk really is so much better than formula…”). As well, she positions the women who choose not breastfeed their babies as bad mothers, especially those who consider their breasts the sole property of their husbands (“REALLY... isn't the whole purpose of breasts to make milk for your babies???”). Because the discourse of this community is so strongly in favour of

breastfeeding and breast milk for babies, this poster is “shocked” by the mothers who opt for formula instead of breast milk, or devote their breasts to only their husbands’ pleasure.

As well, through an emotional appeal directed towards the other members, one poster uses HM4HB to challenge the position she has been given outside of the group. She recognizes that the group’s strong discourse in favour of breastfeeding (as noted above) is not conducive to her choice to use formula, despite her guilt, reluctance, and preference for breastfeeding. She recognizes that breastfeeding is the best option, yet attempts to justify her actions through a life or death case that proves she truly is unable to breastfeed. Therefore, this poster is both participating in the discourse, and explaining her deviance from the acceptable associated practices, by pleading to the other members for forgiveness and acceptance:

> Please do not compare drug addicts to mothers who gave formula to their babies. Some mothers who gave formula to their babies were just victims of circumstances and would want to breastfeed as well. I for one would love to breastfeed and God knows how much I would love to continue breastfeeding my son. Until I found out I need a higher dose of medicine for hypertension. I refused to take for a few weeks just to continue breastfeeding my baby but I really have take it or my health is at stake. I envy those mothers who exclusively breastfeeding their babies and I support organizations with the same cause. Please don't judge mothers like us, we have a lot of guilt feelings already when we started giving formula to our babies and when we were not able to continue breastfeeding our babies. It's not true that it's easy to find a wet-nurse nor somebody who can give you a regular supply of bm. I asked some friends but they have babies

also to feed and other chores to do.

In her post, she draws on the '*breast is best'* repertoire by referring to her medical condition of hypertension that has prevented her from breastfeeding, and the guilt she experiences as a result of her inability to nurse. She also attempts to challenge her position of a bad mother, which is in her view, a mother who feeds her child formula. She pleads fellow HM4HB members to refrain from drawing a comparison between drug addicts and "mothers who gave formula to their babies," since they are "just victims of circumstances" and would prefer to breastfeed. Such an example, although extreme, illustrates the extent to which mothers on HM4HB value breast milk.

Milk Sharing as Safe

As revealed by my analysis of medical documents in Chapter 2, the medical community discusses milk sharing as an unsafe practice for a variety of reasons. The FDA and Health Canada's press releases caution women that human milk obtained from donors online is unlikely to have been properly collected, processed or screened for diseases. The various other press releases and statements also warn women that donors may be taking medications or have infectious diseases that can cause the milk to become contaminated. As well, they argue that these donors, who either remain anonymous or have no personal contact with the recipients, may intentionally tamper with, or knowingly donate their milk, regardless of their exposure to drugs, alcohol, or other harmful substances. However, the members of HM4HB discuss milk sharing as a safe and meaningful practice, and counter or dismiss many of the medical community's warnings.

The donors on HM4HB work to ensure that no problems arise within the group. They do, however, recognize the potential for disease transmission ("My only concern

with this is that the mothers and milk don't have any type of background check? Or do they?"), but discuss and recommend preventative measures that can mitigate risks ("You can always ask for bloodwork/medical records if you're worried about transmittable diseases. Most moms are happy to provide it. I met with my recipient mother and we sat down and discussed my medical records! Clean and sterilize parts for your pump. Check with your baby's pediatrician about medications that transfer through milk. Also, freeze collected milk as soon as possible to maintain the most nutrition. All the things you would do if you were collecting milk for your baby"). By disclosing her interaction with her recipient mother ("I met with my recipient mother and we sat down and discussed my medical records"), this poster challenges the medical community's positioning of donors as anonymous figures.

In addition to recommending ways to avoid any safety issues, the women who wish to donate disclose their lifestyle choices and habits, attempting to alleviate any cause for concern among milk receivers. By emphasizing her "drug free, smoke free, disease free" body and willingness to supply health records ("message me for my health records- more than happy to supply!"), this poster positions herself as an ideal donor with safe, quality milk. Similarly, another poster positions herself as an experienced and reliable milk donor, who adjusts her dietary habits to guarantee the quality of her breast milk for her recipients ("As someone who has been sharing my milk for the past 5 months I will say I am even more careful about what I eat, drink, and even what I breathe because I know I am providing for two babies."). While one poster recognizes that her medication may dissuade women looking for breast milk ("I know it is a long shot. I have about 40+ozs frozen. The only "problem" is that I am on a low dose of an anti-depressant called Celexa. It is a class B which means it COULD pass in to the breast milk. But I have not

had a problem at all with it. It would cause some tiredness but I am such a low dose even my doc wasn't concerned. I am not a smoker or a drinker or do drugs of any kind. I take the celexa, prenatals and vitamin B"), she justifies the safety of her milk using her doctor's approval. Her honesty serves to reduce the potential for risk by eliminating any unknown factors and disclosing all relevant information. Because these potential donors are so concerned about maintaining their diets and healthy lifestyles for the benefit of recipient babies, their discussions oppose the medical community's warnings about careless donors who knowingly send milk contaminated by traces of prescription and non-prescription drugs.

The most popular discussion among all of the groups I looked at pertains to the safety of milk sharing, revealing the importance of safety to HM4HB members. A poster on the global group asks, "Do you guys think there are risks in sharing each other's milk?" After examining each of the 53 responses, I organized them into one of five categories based on the posters' treatment of risk versus safety. But, due to the high number of responses, I chose only the examples that I believe best illustrate their respective categories. The categories are as follows:

1. There are no risks:

> "Not really. The fears related to it are more about stigmas attached to breastfeeding than any founded risks."

This poster describes milk sharing as completely risk free, regarding any perceived risks as associated with fears about breastfeeding in general, rather than online milk sharing.

2. Mothers are responsible and therefore would not share their milk if there was any risk:

> "I take comfort in the fact that most people interested in milk donation are well-educated in the risks and wouldn't donate if their milk would put other children at risk"/ "There's a risk in everything we do in life. I know that a donating woman has put in a lot of time and effort in expressing her milk and wouldnt send out 'bad or tainted' milk... too much work was put into it! I also know recipients of the milk will have done plenty of education not only on the subject of milk sharing but on the person they are receiving milk from. Milk sharing isnt an easy process, takes too much work from both sides to let it be THAT risky."/ "There are risks, of course, but the recieving parents can request blood work to prove that the donating mother is healthy. I personally donated to a mom who felt that as long as I was still breastfeeding my baby, she felt comfortable accepting my milk for hers, because she knew I wouldn't do anything to myself that could even potentially harm my own baby."

These posters position donors as trustworthy and reliable, arguing that a donating mother would never intentionally seek to harm a recipient baby because she is only looking out for a baby's best interests, she is educated in safety measures, and she has worked far too hard extracting the milk to send out "bad or tainted" milk. Therefore, they discuss the donor moms as responsible and capable of alleviating any risk, which minimizes the role of the recipient mother. The last poster argues that her recipient mother has positioned her as a trustworthy donor who would certainly never engage in behaviour that could affect the quality of her milk for her own baby, so the recipient mother can be sure that her own

child is receiving safe milk. These discussions oppose the medical community's warnings of a heightened risk for babies who receive the milk from online, anonymous sources.

3. There are risks to milk sharing, but parents can successfully mitigate them by doing what they believe is best for their babies:

> "There are definitely risks, Not only are you trusting a mama to be disease and medication free (or fully disclosed), but also that she properly cleans her pumping parts, washes her hands, didn't leave the milk in the fridge too long before it got into the freezer, didn't have a power outage while in the freezer, etc. There's plenty of risk, and it's important to know that before you make the decision. I am totally for milk sharing, but "informed consent" is key."/ "Indeed, of course there are risks, but there are ways of mitigating those risks and I think in general they are less than the risks associated with the available alternatives, especially for younger babies"/ "Of course there are risks, but you have to weigh the risk vs benefits and do your due diligence to make sure you choose the best for your baby."

Unlike the category above, in which posters position donors as responsible for alleviating risk, these posters position parents as knowledgeable and responsible for making the proper feeding decisions for their babies. By carefully considering all aspects of the milk sharing process and acknowledging the potential for risk, parents can properly mitigate these risks to ensure that their babies receive safe donor milk.

4. **There are risks, but milk sharing is less risky than formula:**

> "formula has it's risks as well being artificially made in a factory. Breastmilk has antibiotics, probiotics, and so much more. Human milk has 300 ingredients compared to only 40 ingredients in formula. And formula is artificial cow milk that usually has too much constipating iron"/ "the risks of formula are greater than the risks of donor milk."/ "Isn't there studies that show toxic metals in formula? Breastmilk from another mom MUST be better than that risk!"/ "If it was me, id rather use donated human milk over toxic formula."/ "Quite frankly I'd rather risk human donations than the increased risk of multitudes of cancers, autoimmune disease, diabetes and so many other things associated with artificial feeding not to mention the known (and unknown) contaminants in the milk powder itself one of which can cause meningitis."

Each of these posters describes formula as a dangerous alternative to breast milk. They identify all breast milk, including donor milk, as the best and safest form of food for their babies. While they recognize that there are risks with sharing milk online, they see the risks as trivial in comparison to those associated with "toxic formula".

5. There are risks to everything in life, not just milk sharing:

> "I believe there are risks, but there are risks with any food you and your family eats. There are risks as soon as you walk out the door and risks in your own home."

By suggesting that every aspect of life carries risks, and that milk sharing is just one of these aspects, this poster dismisses any real risks associated with this practice.

Milk Sharing and Wet-Nursing as Normal

One of HM4HB's goals as an online platform is for "milksharing and wet-nursing to be commonplace" and the members project this same ambition through their wall posts and discussions. The women on the HM4HB groups reject the warning statements from the medical community (see Chapter 2), and draw on this repertoire using four different approaches:

1. Emphasizing the inherent normalness of milk sharing and wet-nursing:

   POSTER 1: I love the part of your Vision where you say that you want to see a world where asking a neighbor for breastmilk is no different than asking for an egg. I want you to know that has become a reality in my life. Yesterday my neighbor asked me for some breastmilk for her 3-year-old son. He has had strep throat for 2 months and now has a yeast infection from the antibiotics. She is hoping the milk will boost his immune system and make him well. This is the same neighbor who a year ago thought I was crazy for nursing my son past his 1st birthday! I love to see people's attitudes change as they realize how normal and wonderful it is to breastfeed and share milk

By offering a description of her neighbour as a woman who once "thought [she] was crazy for nursing [her] son past his 1st birthday" and then expressing her pleasure in this same neighbour's request for her breast milk, this poster positions herself as a milk sharing supporter. The implication is that her neighbour's change of attitude about milk sharing is linked to the efforts of HM4HB ("I love the part of your Vision where you say that you want to see a world where asking a nerighbor for breastmilk is no different than asking for an egg").

> POSTER 2: Speaking of normalization, I spoke to a group of pregnant women at a prenatal class last night (a crunchy prenatal class, but nonetheless a fairly representative group I think) and there was not ONE horrified look when I talked about milk sharing. Loved it ♥

Poster 2 speaks to the increasing normalization of milk sharing through her discussion of the lack of a negative reaction among pregnant women on the subject of milk sharing ("there was not ONE horrified look…"). She positions herself as a milk sharing supporter by expressing her pleasure in their favourable response to this topic ("loved it").

> POSTER 3: It's been done for millennia. Unless there is a medical/medicinal issue or allergy concern there's no reason not to. It's part of how we've survived and become so successful as a species. The Taboos are psychosocial in nature and fear/shame based. Unacceptable age? That's a personal decision between the moms. Feed babies. Feed babies human milk. Period. :)

Poster 3 discusses milk sharing as a natural practice that has been occurring for centuries, which suggests that it should be regarded as normal. She argues that the only reason for women not to share their milk is if there is "a medical/medicinal issue or allergy concern." She downplays the controversy of milk sharing as merely "taboos" that are "psychosocial in natural and fear/shame based," while attributing the success of the human race to this practice.

2. Expressing pleasure with, or an interest in, the opportunity to donate or wet-nurse:

   POSTER: Amen! (my best friend has asked me if I would be her wet-nurse, I'm thrilled she doesn't think it's gross, in fact she and her partner are very much relieved to know there's another option besides formula if she has any issue with supply again!)

3. Advocating for milk sharing and wet-nursing to be widely accepted as normal practices:

   POSTER: If we had more wet nurses available, we WOULDN'T need formula. People think that mothers being unable to nurse is a new phenomena. It isn't. Before formula was invented, women who couldn't nurse their own children went to wet nurses. This needs to come back. When I have kids, I sincerely hope that I can donate and become a wet nurse for babies that need it.

4. Defending wet-nursing and milk sharing as normal practices when questioned or confronted with dissenting viewpoints from others:

   POSTER 1: i donate milk to a little boy now and to the milk banks in the past and when a relative told me I was weird i asked them if they always got their milk from the same cow? when they replied no i asked them."whats the difference then?"I would rather my baby recieve donor milk or be nursed by someone else before ever having to resort to formula(which in my house is a dirty word!)

> POSTER 2: I feel like I've just walked into a time warp or into a daydream. I can't believe what I'm seeing. It was a dream of mine, long ago, before even having children, to be able to donate my breastmilk, or perhaps prepare foods for families utilizing breastmilk. It only made sense to me, but women everywhere (all without babes) thought I was disgusting, and had a "weird obesssion." I promised them they would in their lifetime see milk banks and surrogate nursing, wet nurses return and the use of human milk in place of bovine... they only laughed and said, "Ew, gross!" Just stumbling here today has really allowed me to have just a little more fait in us humans. Way to go women!!!!! Fantastic page to find today. You really have given me tremendous Hope! I am eager to learn more about how I may contribute to this incredible cause.

Here, Poster 1 has been positioned outside of her discussion on HM4HB as engaging in inappropriate behaviour (donating breast milk) by her relative ("…a relative told me i was weird"). As well, Poster 2 has been positioned in much the same way for expressing an interest in donating and cooking with her breast milk ("but women everywhere [all without babes] thought I was disgusting, and had a "weird obsession."). Both women engage in third order positioning by using the HM4HB platform to challenge the positions they have been previously given. Poster 1 does so by retaliating against the woman's comment that she was weird with a question ("I asked them if they always got their milk from the same cow?"), while poster 2 assures the naysayers that "they would in their lifetime see milk banks and surrogate nursing, wet nurses return and the use of human milk in place of bovine."

Milk Sharing as Superior to Milk Banks

I see this repertoire as the women's means of resistance to the medical community's repertoire of '*Milk Banks as Safer than Milk Sharing.'* All of the medical literature discusses unpasteurized donor milk obtained online as unsafe, while positioning banked milk as the only safe donor milk. The Canadian Paediatric Society's statement recommends that women visit a milk bank instead of obtaining milk through a donor found online because banked milk is serologically tested and donors are rigorously screened for diseases. Similarly, the FDA, the *Canadian Medical Association Journal*, and Dr. Geraghty, Heier, and Rasmussen's statements discuss milk banks as the safest and *only* acceptable source for obtaining donor breast milk, due to the fact that it is pasteurized and free of any possible contaminants. Since the breast milk is controlled and treated by medical professionals throughout every step of the donation process, the medical literature encourages women to receive donor milk from only these sources. However, the women's discussions on HM4HB reveal an overall disapproval of the policies and procedures of milk banks, as well as a preference for donating their milk directly to a woman of their choice for free. Despite the stringent screening practices that occur at milk banks to ensure safety, the women on HM4HB express a preference for receiving unpasteurized donor milk from an online donor, and receiving donor milk from someone they meet online. This is because both donors and receivers experience a greater sense of satisfaction from making connections with one another on their local groups throughout the milk sharing process. HM4HB members value the social aspect of online milk sharing over the anonymity of a milk bank, discussing it as a mutually fulfilling process. Donors discuss this practice as a social and meaningful experience, which is impossible to achieve through donating anonymously to a milk bank ("I like donating to a

mother that I can build a relationship with and get to know. My connection with her and knowing exactly where my milk is going is the most wonderful feeling.”). And, recipients feel more comfortable accepting milk from donors they locate on HM4HB because they are able to “put a face to the precious milk that [their] babies receive.”

Posters A and B (see below) discuss milk banks as institutions that take advantage of generous mothers in two ways: 1) accepting their donated milk and providing them with no compensation (“milk banks receive donations from kind hearted mamas who receive nothing in return”/ “Its one thing to charge enough to cover your costs, but they are out to make money and give nothing to the donors and that's not right”), and 2) by excessively charging recipients for the donated milk. They morally position the doctors at milk banks as greedy and more concerned about making money than for the sick or premature babies in need (“Then they turn it around and sell it to desperate mamas who often have sick babies and will pay the exorbitant prices they charge”/ “Milk banks charge a huge amount and I’ve never seen one that was even close to what I would call reasonable.”).

> POSTER A: Milk banks receive donations from kind hearted mamas who receive nothing in return. Then they treat all of the milk together to protect against bacteria but this kills a lot of the nutrients and beneficial components of the breastmilk. Then they turn it around and sell it to desperate mamas who often have sick babies and will pay the exorbitant prices they charge. I feel that this takes advantage of both the women donating and the women buying the milk. So I am happy to donate my milk to mamas and babies in need of it through HM4HB :)

> POSTER B: I wanted to make sure that no one was making a ton of money on it. Milk banks charge a huge amount and I've never seen one that was even close to what I would call reasonable. Its one thing to charge enough to cover your costs, but they are out to make money and give nothing to the donors and that's not right.

Both Posters C and D (see below) hold different views regarding the value of milk banks. While the original poster, poster C positions herself as an advocate for the B.C Women's Milk Bank ("BCWH…supplies donated breast milk to sick and premature babies throughout the lower mainland"), Poster D, the respondent, re-positions her as misinformed ("I suggest that if you want to donate to BCWH that you find out all of the rules first."). She informs the original poster that the donation rules for the B.C. Women's Milk Bank are unreasonable and prevent many women from donating their milk ("You can't donate if you take more than a multi vitamin, or any herbal supplements etc including fenugreek") and is thankful for finding the HM4HB page so that she would not have to dispose of her expressed breast milk.

> POSTER C: Milk Sharing = awesome, but don't forget about the high risk NICU babies! BCWH has the only milk bank in the country, and supplies donated breast milk to sick and premature babies throughout the lower mainland.

> POSTER D: The donation rules there are VERY strict due to government regulations. You can't donate if you take more than a multi vitamin, or any herbal supplements etc including fenugreek. I suggest that if you want to donate to BCWH that you find out all of the rules first. I tried to donate but they couldn't take it because of fenugreek. Thank goodness I found this page on facebook! I

thought I was going to have to throw it away!

On November 13th, a poster in the Global group asked, "why would one donate or receive through HM4HB vs. a milk bank? I am a BF [breastfeeding] mam myself and believe it is the best way to feed your baby." Over twenty posters responded to her question, which represents a fairly popular discussion for the group and reveals how passionate the members are about this issue. Each of the respondents expresses a preference for donating milk or receiving milk through HM4HB instead of through a milk bank. The respondents also use the language of reproductive choice, with donors arguing that they have the right to choose who they donate to, and recipients arguing that it is their baby's right to receive breast milk from the source of their choice. I can classify their responses based on two subrepertoires: control and cost. The responses in the control subrepertoire communicate the message that doctors do not have the right to control where their donated milk goes, nor should they be able to prevent or discourage women from receiving milk from HM4HB. For example, the posters express discontent with the "doctors [who] decide which babies are the sickest and deserve the milk the most," arguing that this selection process is unfair. As well, posters assert their autonomy and preference for milk sharing by resisting their doctors' orders ("He told me not to look for milk online because it was dangerous but I have a right to feed my baby with whatever milk I choose and I found a wonderful donor on my local group."). The cost subrepertoire has the greatest number of responses, with women classifying milk banks as cost prohibitive and inaccessible, as they argue that breast milk should be free ("I don't believe a baby in need should be charged for something I make and give for free"/ "it is immoral to deny a baby the best nutrition just because their mother can't produce her own

milk and/or afford to buy it from a place that gets it free. I will never donate there [to a milk bank].”). In their posts, they discuss breast milk as being something natural and essential for babies, which has been transformed into a commodity by milk banks.

Breast milk as a Gift

Many of the donors and receivers on HM4HB discuss breast milk as a precious gift, for which only a ‘thank you’ on behalf of the recipients is expected. One poster communicates the value of a ‘thank you’ on behalf of recipients in her post, privileging acknowledgment and gratitude over material goods: “i really don’t want or expect gifts or anything, but a thank you and simple updates on how the baby I am helping to feed are most appreciated”. Women on the receiving end express their gratitude (via their group’s main discussion page) to the women who generously donate to their babies without the expectation of reimbursement of any sort. Their statements are illustrative of the ritual of gift-giving, in which something is willingly given to someone else without repayment. For example, a poster thanks the women who donate to her daughter “out of the kindness of thier hearts [without] mak[ing] it a business,” and she is “so thankful there are still women in the world who love to help people and not have to take in order to give.” Another poster echoes this sentiment, in that she is grateful to the mothers who donate to her daughter. In her post, she expresses both gratitude (“Thank you for all of your sacrifice!”), as well as an appreciation for the donors who do not make her feel indebted to them (“I love that other mommies go out of their way to do what is best for my baby without making me feel bad!”). Many of the donors express this same feeling of gratification, as a result of having the opportunity to give their gift of milk to babies in need. A donor even describes the process of donation as a gift for *her* (“it is a gift as

much for me as much as for a Mama and her baby. Maybe even more so for me!").

While the members of HM4HB discuss breast milk as a gift that requires absolutely no compensation, the administrators of the global group describe it as a gift that deserves some gesture of thanks or reciprocity: "Here at HM4HB, you cannot pay a mother for the milk which she lovingly donates to your baby/child. But you CAN and should replace breastmilk storage bags and/or provide containers to your donor(s). Also, please be sure to THANK THEM, in any way you see fit, for the gift they are offering your baby." Rather than encouraging recipients to provide monetary compensation, the administrator notes that recipients should recognize the costs of storing milk, e.g., the purchase of milk storage bags, incurred by donors. However, aside from encouraging a simple gesture of thanks, another administrator for the global group suggests that the donors should expect meaningful compensation for their breast milk, as opposed to material. She asks, "What have your recipient families done to show their appreciation for you, your contribution in nourishing their child? Has there been something really awesome that they gave you for your efforts? Or something you would LIKE them to think of? Please share (because you know the recipient families are all reading along for ideas)." This promotes an expectation of recipients to thank their donors with something that recognizes their efforts. The HM4HB members' responses communicate a sense of satisfaction with receiving a heartfelt 'thank you' in return ("A genuine thank you is enough!"/ I only ask for a thank you!"/ They once gave me a nice gift card which I wasn't expecting at all because I'm just happy to help."). As well, some responses indicate that the donor women are not necessarily looking for material compensation, but appreciate something that acknowledges and recognizes the depth and importance of their relationship with their recipient families. For example, one poster hopes to receive

"Wiese [milk storage] bags, a thank you and a pic and/or email about how the baby is doing" from her recipient families, which, for her, represents a meaningful and significant form of compensation for her milk.

Because recognition for their gift of breast milk in the form of a 'thank you' is so important to donors, some posters express dissatisfaction based on the lack of thanks they received from their recipients. Some donors' responses reveal their conception of breast milk donation as a form of physical labour that requires, or is contingent on, compensation in the form of thanks. And, when thanks are not given, they become discouraged and may even stop donating. For example, one donor's decision to stop donating stemmed from her lack of recognition, which speaks to the importance of this gesture in the HM4HB community ("I actually quit donating because three people in a row barely said thank you."). Another donor describes a "rough experience [she] had when [she] never received any follow up from the mom, and barely got a thank you when [she] gave [her] donation." This negative experience "almost stopped [her] from donating in the future because [she] felt like the hours [she] spent pumping were not appreciated whatsoever."

Doctors as Non-Experts of Infant Feeding/Women as Infant Feeding Experts

The women discuss medical professionals as the oppositional force who infringe on their rights as mothers by refusing to support donor milk for their babies. In the example below, intergroup positioning, "the process by which individual persons or groups of persons position themselves and other individuals on the basis of group membership" is evident through the discussions (Harré and van Langenhove 183). On the HM4HB Facebook groups, the women have come together to establish a 'them' and 'us'

binary, with 'them' being the doctors who are infringing on mothers' rights, and 'us' being the group members. The women use these groups not only to discuss their frustrations and disagreements with the doctors, but also to seek out and offer support to one another on issues involving negative interactions with doctors.

Of all the wall posts analyzed on HM4HB, there are only six instances where doctors were discussed positively-- as trustworthy and knowledgeable professionals who the mothers consult for any breastfeeding issues or questions they may have ("Luckily my doctor is supportive of my decision to share milk online but she just can't recommend it because of liability issues"). The remainder of wall posts pertaining to doctors fall within this repertoire, as the women often dispute or mock their status as 'experts' and express resentment towards their lack of support for milk sharing. The women on HM4HB position the doctors as non-experts by challenging their credibility, resisting their orders/recommendations and labeling them as ignorant. As a result, they position themselves and the other women on the group as experts of their bodies and infant feeding practices, seeking and valuing assistance and advice from fellow members instead of medical professionals. The fact that the HM4HB page is a site for extensive peer-to-peer advice seeking and giving is in itself evidence that the posters see one another as knowledgeable and trustworthy.

In the following example, the mother outlines the problem she is having with her son who has been losing weight ever since the doctors prevented her from feeding her son with donated breast milk in the hospital:

> some of you might have read my sons story: http://[url].blogspot.com/ anyways, since coming home from [the hospital] [Baby] hasn't been eating as well as he did on his donor

> milk, but now they wont let me use donated breast milk any more. They said he has to be fed formula with a feeding tube if he doesn't continue growing. I dont want this for my son, i want him to have the breast milk. My question is does anyone know if the doctors have to put a feeding tube in, if he does have to switch to formula? What are my rights as a parent and my choice in this? Breast milk saved his life once and it means that much to us.

In response to her question, the women who provide feedback position themselves as the dominant decision makers when it comes to infant feeding, despite the interests of the medical professionals. They do so by revealing their defiance to doctors' attempts at controlling her feeding decisions by encouraging her to lie about the origin of the milk she receives: "Don't tell them it's donated…just bring it in and put your childs info on the label, they won't know unless you tell them"/ "I agree. Don't tell them it's donated. Say it is YOUR milk…"/"they don't need to know whose body it came from"/ "I wouldn't even tell the drs its donated because they are against because of diseases n liability.") Their responses suggest that she would not be engaging in inappropriate behaviour by being deceptive about the source of the milk, since the doctors should not have the authority to make feeding decisions on behalf of any mother.

It is a common assumption that doctors are figures of authority and that their opinions must not be contested when it comes to medical issues. However, since the women position themselves as the experts about their own babies, they remain committed to using donor milk and the doctors have no power to influence this decision ("when you make a different choice than what your doctor recommends, own it and carry on"/ "Who

cares what the doctor thinks, if you're comfortable with your decision?"). The women are aware of what behaviour is expected of them by the doctors, but they remain adamant against complying, arguing that doctors "really don't have the right to tell you that you can't use breastmilk for your baby." Some mothers go so far as to encourage one another to switch pediatricians if they do not support milk sharing, which demonstrates their way of remaining in control ("Time for a new pediatrician! Breast milk is best even if it is donated milk"/ "Her mom had to tell every single pediatrician and hospital nutritionist to shove it when they tried to tell her it wasn't safe and switch her to formula"/ "New doctor for sure!")

The women regard their intuition and experience as mothers as incredibly valuable when it comes to making decisions about milk sharing ("Most doctors forget that women, as people, and as mothers, have an innate sense of who they can trust and whom they cannot, which has served them well throughout history"). The women position themselves as the genuine experts of their babies' health and well-being, crediting their intuition and instinct as the most important factors when considering milk sharing. In other words, if the women do what they think is best for their babies and other women's babies, which in this case equates to milk sharing, the medical opinion becomes irrelevant to them. Contradictory to the medicalized model, they advocate on behalf of their abilities to make informed and educated decisions regarding milk sharing based on trust, the naturalness of breast milk, and instinct: ("just do what you feel is natural and follow your instincts"/ "it is up to moms to do what they think is best for their little ones"/ "This is BREASTMILK the most natural form of nutrition…feed your baby the donated milk and don't discuss it further with your doc"/ "Basically, being a mom is about trusting your instincts and occassionally bluffing. I also sleep with my daughter in my bed, and bathe

her in more than half an inch of water! These are things I wouldn't tell the people who tell me not to! But I have confidence in myself that women have been doing this for forever, and that I am careful, but still letting my little girl's comfort lead me. Be brave, bluff when you need to, know that you're a great mom, doing a great job"/ "Id say most of us are trustworthy people who believe in the benefits of breast milk so much that we are honored to share it"/ "you made a very valuable point most donors are feeding their own babies so I highly doubt they would be harming their own children").

By positioning one another as the experts of their bodies and milk sharing, the women on HM4HB are also engaging in the positioning of doctors as non-experts, who have ulterior motives when it comes to formula use. Through undermining the entitlement of the entire category of doctors by positioning them as unethical, the women justify their decisions to act against the doctors' recommendations to use formula instead of donor milk. After a poster asked her fellow HM4HB members why "doctors don't support milk sharing and can't seem to tolerate women taking charge of their own bodies," the respondents discussed their belief that doctors are unduly influenced by formula companies ("I think it's because they can't make money off person to person milk sharing"/ "Doctors and hospitals get monetary benefits from drug companies and formula companies. Nestle paid for one neonatal ward in Canada….so why do you think they don't encourage human milk sharing? If everyone breastfed, and didn't buy into all the pharmaceutical hoopla…a lot of doctors would be outta work"). Such responses reveal an overall distrust in the medical community, as the women argue that the doctors are so easily swayed by, and primarily concerned with, monetary incentives.

In addition to positioning the doctors as potentially unethical, the women morally position the doctors as bad doctors by attributing their babies' sicknesses to the doctors' actions (preventing the use of donor milk and pushing formula). By positioning the doctors in this way, the women position themselves and their babies as innocent victims. This is evident in two mothers' responses, in which they discuss the serious health problems their babies experienced once the doctors refused their request to feed with donor milk ("I fought with doctors for the first year of my son's life because they kept saying he should be gaining weight faster. They put him on formula and would not allow me to use my donor milk. Needless to say he got so sick"/ "I was harassed and threatened and ultimately forced to feed my newborns formula while in the hospital even though I had ample donor milk on hand. I was actually told by a doctor that my babies would get AIDS if I get them donated milk. In the end my daughter ended up in the NICU because of the formula."). Similarly, many other women also morally position the doctors who recommend formula over milk sharing as bad doctors ("these doctors want our children to grow up with deformities because of formula."/ "donor milk is better than formula. I wish your doctor would educate him or herself on this instead of subjecting your little one to that toxic formula."/ "Formula is mass produced in cheap countries in non-sterile factories and doubles the chance of SIDS, increases cancer risks and autoimmune disease risks among many others, shows 'professionals' aren't 'experts'"/ "doctors are people too and most of them make mistakes. This is a mistake with real consequences to your baby so listen to your gut"/ "get a new doctor this one isn't looking out for your child's best interest"/ "be careful what these 'professionals' say. They're not as educated as we like to think they are and they often don't understand the benefits of breastmilk").

Emma Kwasnica, founder of HM4HB, challenged Health Canada's condemnation of online breast milk exchange on the global HM4HB Facebook group. On Friday, November 26, 2010, she posted a statement outlining the shortcomings of Health Canada's press release, which advises women to use only processed breast milk from a milk bank, rather than obtaining it from an online donor. Since the press release cites the World Health Organization's definition of "exclusive breastfeeding," Kwasnica's statement argues against this definition, as she claims that is contradictory to both Health Canada and the World Health Organization's policies on infant feeding (World Health Organization 2). As well, she refutes the claims made within the press release regarding potential milk poisoning and storage safety concerns. Kwasnica's statement represents both the repertoires of '*women as experts*' and '*doctors as non-experts*,' since Kwasnica advocates on behalf of mothers' efforts to ensure the safety of their milk, while providing evidence as to why she believes Health Canada's press release is erroneous and non-useful. She suggests that instead of drafting press releases concerning issues that the women are aware of and take measures to prevent (milk poisoning related to pathogens in breast milk, unsafe milk expression and storage), the government should "off[er] women guidelines and information that support milk sharing" by providing "evidence-based procedures for them to follow…" She draws a comparison between Health Canada's involvement in ensuring safe turkey preparation and its failure to take a proactive approach in ensuring safe milk sharing: "[Health Canada] provides Canadians with safe turkey preparation guidelines in order to help ensure the safety of the people consuming their turkey dinners" instead of "recommending that Canadians not share their turkey." Kwasnica believes that since women will continue sharing breast milk, due to the inaccessibility of banked breast milk, Health Canada should encourage safe breast milk

exchange through the creation of guidelines instead of simply discouraging it.

Chapter 4: Mainstream News Media: A Mediator of Discourse?

My analysis in Chapters 2 and 3 not only revealed the various ways that the medical and maternal communities discuss breast milk sharing, but also how these communities position one another. The medical community discusses milk sharing as unsafe and positions donors as negligent, particularly in their lack of concern for safety measures throughout the collection and storage of their milk. However, what I found most compelling was the way that donors were also positioned as untrustworthy and willing to donate their milk, regardless of any known health or lifestyle concerns that would render it unsafe for consumption.

In contrast, the women on HM4HB discuss online breast milk sharing as a safe and meaningful practice. They appear to have a genuine trust in the intentions of donors and the safety of their milk. They discuss milk sharing positively especially because of the close relationships they develop between donor and recipient families. HM4HB members dismiss the medical community's positioning of them as bad or unfit donors by discussing their methods to mitigate risk and ensure that their babies receive safe milk. They also challenge the medical community's positioning of itself as the authorities of infant feeding decisions, and position themselves—parents--as the experts about their own children.

The selection of news stories and columns I analyze in this chapter offers another perspective about breast milk sharing. Here, I will examine how a sample of contemporary Canadian print stories are representing milk sharing and how milk sharers and medical practitioners are consequently positioned.

News Stories

As Bill Kovach and Tom Rosenstiel point out in their text *The Elements of Journalism* (2009), the aim of journalists is to give the public "the information it needs to be free and self governing" (17). Moreover, Kovach and Rosenstiel make the argument that it is the responsibility of mainstream media to offer a place for members of the public to have a discussion about matters that affect citizens' common concerns—in this case, whether milk sharing is a good, a bad or a middling option (12). Working from this premise, reporters of news stories ought to be outlining for their Canadian audience, in a neutral fashion, what the risks of milk sharing are and what the benefits may be. By having journalists employ this style of coverage, as Kovach and Rosenstiel suggest, citizens can decide what they themselves think about the matter and perhaps the public might form opinions that could lead to legislative or institutional change. Kovach and Rosenstiel consider fairness and balance to be important journalistic devices, explaining that journalists writing news stories ought to "be fair to the facts and to a citizen's understanding of them" (77). It is the responsibility of reporters of news stories to "fairly and accurately portray a situation to the best of their ability by not purposely excluding facts, willfully excluding voices, or knowingly excluding evidence" (Benedetti). According to Kovach and Rosenstiel, journalists should consider fairness as "being fair to the facts," rather than considering whether their sources will be satisfied with their treatment in a story (77). On the subject of balance, they note that "sometimes balancing [all sides of a story] equally is not a true reflection of reality," as simply incorporating an equal number of quotes from both sides of the story, or allotting equal space to both sides, "can lead to distortion" (Kovach and Rosenstiel 77). This is because it would be misleading to suggest that both sides of a story deserve equal attention if only one side

has been proven to be factual or valid; such would be the case with something like the Holocaust. If a reporter were doing a news story about ethnic cleansing in Germany during the Second World War, he or she would not have to include the perspective of a Holocaust denier. The Holocaust is a proven fact and to include another perspective would be dishonest to readers. However, in the case of breast milk sharing, though the medical perspective argues against the maternal perspective and the medical community clearly hopes to prevent people from sharing their milk online, this practice has yet to be formally ruled as invalid or banned altogether by Canadian policymakers. Therefore, under Kovach and Rosenstiel's guidelines, both sides of the debate deserve relatively fair and equal coverage within a news story. In a similar vein, Alex Jones, Pulitzer Prize-winning journalist, in his book *Losing the News: The Uncertain Future of the News That Feeds Democracy* (2009), argues that "genuine objectivity" should remain a standard of journalism, defining it as "a genuine effort to be an honest broker when it comes to the news, [which] means playing it straight without favoring one side when the facts are in dispute, regardless of your own views and preferences" (Jones 82). The Canadian Association of Journalists 2012 Ethics Committee Report entitled "What is Journalism?" shares Jones' argument, defining journalistic work as "provid[ing] clear evidence of a self-conscious discipline calculated to provide an accurate and fair description of facts, opinion and debate at play within a situation" (Canadian Association of Journalists).

Columns

Part of the job of a newspaper is also to provide educated and often provocative opinion pieces about issues that appear in current public discourse; it is the job of columnists, as opposed to reporters, to write such pieces. Because these articles are not news stories their authors do not have the same obligation to being fair and balanced. Columnists, with the ability to express their own opinions, have a lot more latitude when writing news; however, their opinions have to speak fairly to the facts. For columnists, fair comment "is a reasonably held point of view based on the facts" (Benedetti). While the columnists use facts as a basis for writing their opinions, the resulting pieces are usually not written in a neutral manner equally representing all voices, but instead make clear the author's perspective on the issue. But I would still argue that overall, taking a larger view of the coverage from several different outlets over a reasonable period of time as I have done here, together hard news stories and columns ought to be leaving their audience with a fair and balanced view of the debate that is occurring about breast milk sharing. Given this context and goal—a fair and balanced picture of the issues the public needs to be free and self-governing and make informed decisions about matters of common concern--I analyzed how the sample of Canadian newspapers handle this controversial practice of breast milk sharing.

Selecting the Articles

I located the news stories and columns through a Lexis Nexis advanced Boolean search for the terms 'breast milk' and 'sharing' for the time period between November 1st, 2010 and February 28th, 2012—the time period encompassing the medical literature I considered in Chapter 2 throughout the period for which I considered the HM4HB wall

posts discussed in Chapter 3. The first statement produced by members of the medical community was published on November 1st, 2010 (Health Canada's press release), and the last wall posts I analyzed were posted on February 28th, 2012. Out of the 63 newspaper sources this search generated, I eliminated any repetitious or irrelevant stories leaving 17 for further consideration. Based on the criteria for news stories and columns outlined above, I classified 6 articles[11] as news stories and 11 as columns or opinion pieces. The news stories and columns are identified in the tables below:

Table 2: News Stories

SOURCE	TITLE	AUTHOR	DATE
The Vancouver Sun	Canada Urged to Open Human Milk Banks for Preemies; It Promotes Healthy Growth and Immunity	Carmen Chai/ Postmedia News	November 1/2010
The Toronto Sun	Warning About Sharing Breast Milk Unnecessary: Advocate	Kate Schwass-Bueckert QMIAgency	November 25/2010
Sherbrooke Record	Health Canada Warns of Unpasteurized Human Breast Milk Dangers	Corinna Pole (The Record)	November 29/2010
The Calgary Herald	Doctors Frown on Sharing of Breast Milk	Carmen Chai (Postmedia News)	November 30/2010
Prince George Citizen	Sharing Doesn't Extend to Breast Milk	The Canadian Press	December 2/2010
The Saskatoon Star Phoenix	FDA Warns Moms About Sharing Their Breast Milk	Reuters	December 4/2010

[11] I will use the word 'article' to refer to all newspaper pieces when speaking inclusively or generically about columns and/or news stories.

Table 3: Columns

SOURCE	TITLE	AUTHOR	DATE
The Montreal Gazette	Two Groups Help Mothers Share Breast Milk; 'A Free-Flowing Resource'	Cheryl Cornachia	November 10/2010
The Toronto Star	'I am forever grateful'' Babies at Sunnybrook Thrive Thanks to Banked Donor Breast Milk From U.S	Andrea Gordon	November 25/2010
The Toronto Star	Breast Milk Banks Latch On To Social Media; Despite Controversy, Lack of Options Prompts Mothers to Seek Donors on Facebook Groups	Andrea Gordon	November 29/2010
Vancouver Sun	Vancouver Woman Could Be City's First Breast Milk Mom-Preneur	Denise Ryan	November 30/2010
The Vancouver Province	Surrogate Mom Trying to Sell Her Breast Milk Pulled from Craigslist	Katie Webb	December 3/2010
Ottawa Citizen	Do More Than Scolding Mothers	Kate Heartfield	December 16/2010
The Hamilton Spectator	Swapping Breast Milk Online	Nicole MacIntyre	January 1/2011
The Vancouver Province	Nursing Moms Share 'Gift of Life'; Facebook Network Roused Women Across the Country to Help Sustain Terminally Ill Girl in Nelson	Sarah Douziech	April 17/2011
The Vancouver Province	Dallas Woman Meets 'Breast Milk' Mother	Sarah Douziech	April 29/2011
The Toronto Star	Canadian Mom Ends Milk Blog Controversy	Andrea Gordon	September 26/2011
Victoria Times Colonist	Got Milk? Share It	Cindy MacDougall	October 11/2011

Guiding Questions

For all the articles listed above, I will consider 1) whether the authors of news stories represent both sides of the debate fairly or depict one group or perspective more sympathetically than the other; 2) which discourses columnists took up and how they used these perspectives; 3) how both news stories and columns discuss milk sharing and breast milk. In addition, I offer a close reading of a variety of aspects of each news story and column and then I give a summary of my findings at the end of this chapter. By performing a close reading of the news stories and columns, I will be able to discover whether the news media coverage of milk sharing throughout this time period considers both sides fairly, or if one discourse—and one perspective--is dominant.

Defining Discourses

My analysis in Chapter 2 revealed that the literature published by medical professionals uses interpretative repertoires that describe breast milk as contaminated and milk donors as careless and anonymous, and that this discourse discusses milk sharing as unsafe. These representations form what I will refer to as the medical discourse in this chapter. On the other hand, my analysis of the HM4HB Facebook posts in Chapter 3 demonstrated that these members use interpretative repertoires that present milk sharing as a safe means of helping babies and developing close bonds between donors and recipients, and that this is a more meaningful process than obtaining milk from a registered milk bank. As well, these repertoires present breast milk as the best nourishment for infants, while they minimize risks involved in the process of sharing, and position women as intuitive and empowered to make their own decisions about their

children and their milk. In addition, they position doctors as non-experts regarding infant feeding. Together these representations form what I am calling a maternal discourse.

Analysis: News Stories

The six articles that I classified as news stories primarily use the medical discourse and these stories closely resemble the statements published by the FDA, Health Canada and the Canadian Paediatric Society. Many use exact phrases or identical sources to those public relations documents. Four of the articles, "Canada Urged to Open Human Milk Banks for Preemies; It Promotes Healthy Growth and Immunity," "FDA Warns Moms About Sharing Their Breast Milk," "Sharing Doesn't Extend to Breast Milk," and "Health Canada Warns of Unpasteurized Breast Milk Dangers" were published either on the same day, or within a week of their corresponding press releases. Based on the extreme similarity, lack of original content and overlapping time frame, I would argue that these articles are not news stories reporters themselves generated, but are largely summaries of press releases.[12] The articles entitled "Doctors Frown on Sharing of Breast Milk" and "Warning About Sharing Breast Milk Unnecessary: Advocate" differ from the other four because they primarily employ the maternal discourse and are framed from the assumption that breast milk, regardless of whether it is pasteurized or from a bank, is the best form of infant nourishment.

[12] This is not surprising given that newsrooms and newsroom budgets are shrinking so press releases are used more often—and are sometimes run verbatim—when this used not to be the case. See http://j-source.ca/article/future-investigative-journalism or j-source.ca/category/news-views/big-issue?page=11 for example.

Discussion of News Stories Employing Primarily the Medical Discourse

On November 1st, 2010, the Canadian Paediatric Society released its statement regarding the benefits of human milk banking and argued on behalf of the importance of another bank in Canada. Carman Chai, for Postmedia, wrote an article that appeared on the same date titled "Canada Urged to Open Human Milk Banks for Preemies; It Promotes Healthy Growth and Immunity." This piece also communicates key ideas from the Canadian Paediatric Society's press release. Chai's article opens with a statement that attests to the importance of pasteurized breast milk, alluding to Drs. Sharon Unger and Kim's words in their position statement. While Chai discusses breast milk as the best form of infant nourishment ("Studies have found breast milk is the best option when feeding newborn babies because it offers numerous benefits—from improved development to healthy growth patterns and lower rates of both infection and sudden infant death syndrome"), she only accounts for milk that has been pasteurized, which is also how the medical literature discusses breast milk (Chai, "Canada Urged" B3). Similar to Drs. Unger and Kim's position statement, Chai does not discuss the benefits of raw breast milk, or breast milk sharing in general. Instead, she lifts many facts and quotations directly from the Canadian Paediatric Society's media release on banked milk, which is a shorter summary of their lengthy position statement. By simply restating verbatim many of Drs. Unger and Kim's opinions and the statements within the position statement, Chai's article does not offer any original insights from other or opposing sources, nor others' reflections on this subject, and consequently her piece reads more as a paraphrased duplication of the position statement.

Three other articles follow this same pattern; they too were published shortly after their related press releases. “Health Canada Warns of Unpasteurized Breast Milk Dangers” and “Sharing Doesn’t Extend to Breast Milk” summarize the key points of Health Canada’s press release in order to communicate the dangers of breast milk sharing. Written just four days after Health Canada’s press releases, “Health Canada Warns of Unpasteurized Breast Milk Dangers” is devoted to paraphrasing the press release, from the dangers of “consuming unprocessed human breast milk,” to the risk involved with unknown donors, who may have milk contaminated from drugs and bacteria (Pole A5). While “Sharing Doesn’t Extend to Breast Milk” also summarizes Health Canada’s press release, the article includes many of the key points presented in the Canadian Paediatric Society’s position statement as well. Though all of these articles presented above are neutral in tone and do not state or even imply that they came from press releases, they fail to present the other side of the milk sharing debate or even to acknowledge that women are sharing their breast milk.

Unlike the articles that do not acknowledge, quote or cite sources from the opposing side of this debate, “FDA Warns Moms About Sharing Their Breast Milk” closes with a quotation from Emma Kwasnica, founder of HM4HB, who states, “It [The FDA] won’t stop us mothers…They can’t possibly regulate what women do with their bodies and their milk” (Reuters C9). However, using a quotation from a milk sharing advocate does not offer balance to the piece, since the author (an unnamed Reuters journalist) provides no context for Kwasnica’s quotation. Strategically placing this quotation at the end of the article, after all of the risks of milk sharing have been outlined, implicitly positions the women who share their milk as irresponsible and engaging in reckless or radical behaviours; they are defying the FDA’s strict warnings and dismissing

their advice as "misguided" (Reuters C9). This concluding comment also ties back to the title of the article, "FDA Warns Moms About Sharing Their Breast Milk" making it clear at both beginning and end that the women are engaging in risky behaviour and that they are defiant. In the middle of the piece, the reporter quotes a section of the FDA press release that communicates the dangers of "casually us[ing] breast milk from other unscreened mothers because of the risk of disease or contamination from bacteria, drugs or chemicals" (Reuters C9). Parents are advised to "talk to their doctors and use breast milk from special human milk banks," as recommended by the FDA (Reuters C9). As a result, the article discusses breast milk sharing as unsafe, while presenting milk banks as the proper way of obtaining pasteurized, safe breast milk, which is again consistent with the FDA's positioning.

Discussion of News Stories Employing Primarily the Maternal Discourse

"Doctors Frown on Sharing of Breast Milk" opens with a repertoire from the maternal discourse, specifically '*breast milk as best.*' Chai introduces the Eats on Feets (now HM4HB) online platform, quoting founder Emma Kwasnica on the need for such a network: "women don't want to be feeding their babies powder infant formula, and they want help so we're working together as mothers" (Chai, "Doctors Frown" A7). Chai then acknowledges the medical discourse, specifically Health Canada and the Canadian Paediatric Society's warnings against milk sharing. She provides a single quote from Health Canada's statement on the risk of viral contamination, without devoting any further space to the remaining information put forth by the press release. Chai transitions to the Canadian Paediatric Society's disapproval of milk sharing, quoting Dr. Sharon

Unger, who argues that milk banks are the only means for accessing safe donor breast milk.

While Health Canada and Dr. Unger discuss breast milk sharing as unsafe, Chai does not conclude her article with their perspectives; instead, she wraps up her piece by discussing milk sharing as safe through focusing on the online site's ability to bring together women from the same community: "Eats on Feets' local aspect increases safety because the parents would meet regularly and most mothers offer blood test results to show they are healthy candidates" (Chai, "Doctors Frown A7). In addition, Chai challenges Dr. Unger's support for the milk bank as the only source for obtaining safe donor milk by speaking to its limited capabilities: "There is only one milk bank in Canada, located at the B.C Women's Hospital and Health Centre in Vancouver. Toronto's Sunnybrook Hospital also provides breast milk, but only to premature and sick babies in desperate need" (Chai, "Doctors Frown" A7). I argue that Chai offers a sympathetic treatment of milk sharing through her strategy of refuting the medical discourse by her appeal to Eats on Feets.

Similar to Chai, Kate Schwass- Bueckert bases her article "Warnings About Sharing Breast Milk Unnecessary: Advocate" on the belief shared by many women on HM4HB that breast milk, including unpasteurized milk obtained online, is the best form of infant nourishment. She notes that mothers who cannot produce enough milk have to supplement with infant formula, which "isn't what some mothers want for their babies" (Schwass-Bueckert). Through this statement, she implies that milk sharing is safer than infant formula, despite all the controversy. She quotes Emma Kwasnica, who says that the medical organizations are "fearful" of mothers taking control of their milk, especially since the online milk sharing communities are growing rapidly (Schwass-Bueckert).

Kwasnica downplays the risks by discussing milk sharing as normal and natural, stating, "women have been wet nursing each other's babies for eons," which suggests that such an ancient practice would have been abolished long ago, if it were truly dangerous (Schwass-Bueckert). To further emphasize the value of breast milk and milk sharing, Schwass-Bueckert includes the personal story of actress Jenna Elfman. I argue that this story serves as a celebrity endorsement for milk sharing; she attempts to popularize this practice by showing her readers that celebrities also participate. She discusses Elfman's experience with milk sharing as lifesaving, in which "[Elfman] offered her breast milk to a friend who had a family member whose newborn was addicted to meth… [and] wasn't able to keep formula down while detoxing" (Schwass-Bueckert). Schwass-Bueckert describes Elfman's breast milk donation as an incredible act of kindness and quotes Elfman, who speaks to the value and healing powers of breast milk that rid the baby of all of his symptoms, provided him with the necessary nutrients to survive, and most importantly, "kept him alive for several months…" (Schwass-Bueckert). While her article makes reference to both Health Canada's and the Canadian Paediatric Society's press releases, she organizes her piece so that this material is followed by a statement from Kwasnica that emphasizes the importance of a maternal instinct over the strict, medically sanctioned protocols: "mothers who are informed should be allowed to make the decision they think is best for their babies" (Schwass-Bueckert). Kwasnica's statement positions mothers as infant feeding experts, regardless of the recommendations on behalf of the medical bodies.

Analysis: Columns

For discussion purposes, I organized the 6 columns around the three main characteristics they display. All 1) use women's positive experiences with milk sharing to emphasize the value and importance of this practice, 2) challenge the claims made by the press releases to defend the safety of milk sharing, and 3) assert the importance and necessity of online milk sharing because of the lack of milk banks in Canada. All the columns I analyze below employ primarily the maternal discourse, with the journalists expressing their support for milk sharing.

To begin, I would note that unlike the articles in the previous category that relied heavily on material from press releases, all the articles that fall within the columns category contain original content generated by the journalists. In part, though, this is probably a result of the fact that the women's groups were not issuing press releases or holding press conferences; most are private individuals, not members of government agencies. So, in order to write these kinds of stories, the columnists would have to generate their own ideas, come up with their own frameworks, choose which sources to quote, and so on.

1) Positive Experiences with Milk Sharing

Three of the columns use the personal stories of women who share their milk to emphasize the value of online milk sharing. Cindy MacDougall's column "Got Milk? Share It" is written entirely from her own perspective. MacDougall speaks to what she describes as her meaningful, fulfilling experience with donating milk to Amanda, her "milk-share partner" (MacDougall A5). As a milk sharing advocate, MacDougall "agree[s] with Kwasnica's goal of sharing milk as a 'free-flowing resource'" and

discusses it as an intimate experience between donor and recipient: "On the day Amanda came to pick up 40 ounces of my breast milk, it was like meeting long-lost family. We hugged; she shared pictures of her healthy, thriving son and met by baby boy Edward" (MacDougall A5). MacDougall emphasizes the intimacy involved in a relationship between donors and recipients through her own experience with donating milk: "As she pulled away to her next milk pickup of the trip, I thought about how children, when we let them, bring people closer together" (MacDougall A5). Her depiction of her interaction with Amanda positions them as close friends, rather than simply donor and recipient, highlighting the importance that women place on nurturing relationships with either those to whom they donate milk, or from whom they obtain it. As a result, milk sharing becomes synonymous with community and connection.

Sarah Douziech's column "Nursing Moms Share 'Gift of Life'" uses the personal story of Camara Cassin to present milk sharing in an intimate manner and to evoke emotion in her readers. Cassin gave birth to Anaya, who was diagnosed with infantile Krabbe leukodystrophy, an incurable degenerative disease that prevents her from tolerating formula (Douziech, "Nursing Moms" A3). Douziech quotes Cassin, who "feel[s] a lot of love for [her milk donors] in [her] heart" for providing her with hundreds of ounces of breast milk to keep Anaya nourished ("Nursing Moms" A3). Drawing on the repertoire of '*breast milk as best*,' Douziech highlights the "easily digestible…and built-in antimicrobial properties" of breast milk, discussing it as valuable regardless of whether it is pasteurized or from a milk bank ("Nursing Moms" A3). Douziech focuses on the generosity of over 400 HM4HB donors, including a "nursing mom in Calgary… who pass[ed] the message along to 'mommy bloggers' and traditional news media" to encourage and facilitate the donation process for baby Anaya ("Nursing Moms" A3).

Ultimately, Douziech tries to convince readers that milk sharing was responsible for keeping Anaya alive and thriving for as long as she did, an idea that constructs milk sharing as a valuable, community-centred practice.

Douziech's other article, "Dallas Woman Meets 'Breast Milk Mother" communicates many of the same messages through the emotional story of Katie Stutt, who initiated a social media campaign to keep Anaya alive. The angle that Douziech takes in this column is to highlight the personal connections among donors and recipients of milk sharing; specifically, she focuses on Stutt, who traveled to British Columbia from Texas to "meet the family [the Cassins] that has since inspired her to start a global helping federation" ("Dallas Woman" A3). Referring to the milk donations for Anaya from "more than 40 women across Canada," and the support from over 1,500 people worldwide, as "an international effort to keep the girl alive," Douziech's column discusses milk sharing as a lifesaving endeavor ("Dallas Woman A3).

2) Challenging the Claims Made by Press Releases/Defending Milk's Safety

After addressing the press releases that warn parents about the risks of milk sharing, Kate Heartfield's column "Do More Than Scolding Mothers" points out the flaws she perceives within Health Canada's press release and speaks to the safety of this practice. At the beginning of her piece, she refers to Health Canada as "good at putting pressure on breastfeeding mothers [but] less good at providing them with support" (Heartfield A16). She supports this claim by using Health Canada's press release against them, since "[it] scolds parents when they don't feed their babies breast milk, and scold[s] them when they do" (Heartfield A16).

Heartfield downplays the risks associated with milk sharing: "But there are risks to everything. There's a long list of risks that comes with using formula rather than breast milk. And formula, like breast milk, can be contaminated. There are occasional recalls of infant formula" (Heartfield A16). She argues that the risks outlined by Health Canada's press release, namely dirty equipment, improper storage or handling, and transmission of drugs or alcohol, do not take into consideration that such risks could "exist when moms express and store their own milk," especially since the milk is unpasteurized (Heartfield A16). She further downplays the risks outlined by the press release by defending the motives and credibility of donors, whom she says are unlikely to "go to the considerable trouble of pumping milk…after downing a mickey or while mucking out the barn" (Heartfield A16). Throughout her article, she not only attacks the validity of Health Canada's statements, but also describes milk sharing as safe, while simultaneously representing parents as experts, capable of "maki[ing] informed choices based on their level of confidence in the donor's health and storage practices" (Heartfield A16).

3*) Asserting Importance/Necessity of Online Milk Sharing because of the Lack of Milk Banks:*

Drawing on the repertoires of '*breast milk as best,' 'milk sharing as safe,'* and *'milk sharing as normal,'* the columns I discuss next assert the importance of milk sharing because of the lack of milk banks in Canada and the overall inaccessibility of banked milk. Cheryl Cornachia, in "Two Groups Help Mothers Share Breast Milk; 'A free-flowing resource," quotes Kwasnica, saying that "all babies have the right to receive the food that was intended for them" (Cornachia A11). Working from this premise, Cornachia's article explores how the absence of Canadian milk banks has driven mothers

to search for milk online, since Canada's only milk bank "prioritize[s] premature babies over full-term ones, and sick over healthy infants, making it less likely that mothers of healthy, fullterm babies would be able to get milk this way" (Cornachia A11). I argue that Cornachia embraces online milk sharing because she does not make reference to any of the press releases that warn parents about the safety risks associated with this practice. Instead, she adopts a sympathetic outlook, frequently citing the benefits of breast milk over formula, and quoting milk sharing recipients, who wish to "formalize and normalize" it (Cornachia A11). She closes her article with a quote from Anjana Srinivasan, co-director of the Goldfarb Breast-feeding Clinic, who views milk sharing as a viable substitute for banked milk, especially since it is incredibly difficult to receive in Canada (Cornachia A11).

Denise Ryan's article, entitled "Vancouver Woman Could be City's First Breast Milk Mom-Preneur," explores the story of Becca Shears, a surrogate mother, whose offer for breast milk on Craigslist was removed. Because of her strong conviction of the benefits and value of breast milk, Shears hoped to donate her milk to a mother in need instead of letting it go to waste. Ryan addresses the inaccessibility of the B.C Women's Milk Bank from the perspective of Shears, who, despite living in British Columbia, found it nearly impossible to donate her milk there because it would cost her too much to pump, store, and then drive to Vancouver to drop off her milk (Ryan A4). Ryan describes milk sharing as a more feasible and cost-effective option for mothers than milk banking, which prioritizes milk donations, and involves getting a prescription from a doctor and "paying at least $60 a litre" (Ryan A4). She includes a statement from Frances Jones, Program Coordinator for the B.C Women's Milk Bank to support her positioning: "Although [we] were able to provide breast milk to 1,700 babies last year, [we] cannot come anywhere

near to meeting the need…It's distressing when we have to tell women we don't have enough milk to meet their babies' needs" (Ryan A4). Because of this inaccessibility, Ryan discusses milk sharing, or "relying on the kindness of strangers" as she puts it, as a viable and in many instances only means of obtaining breast milk (Ryan A4).

Discussion of Columns that Employ Coverage of Both Medical and Maternal Discourses:

The five articles in this section employ both the maternal and the medical discourses. Though columnists are not required to transmit facts in a neutral fashion like news reporters, the columnists' inclusion of both perspectives may suggest that the coverage is fair and that they are offering points from both camps so that readers can decide for themselves with whom they most agree. To determine if these columns are, in fact, fair, I will analyze each of the five articles in this category in turn focusing on 1) how often each discourse is used; 2) how each discourse is treated, and 3) how the discourses are constructed to interact with one another. This method will allow me to determine whether one discourse dominates and which position columnists take overall in respect to milk sharing.

Column 1: "I am Forever Grateful"

This column follows a slightly different formula than the others. Regardless of Gordon's inclusion of a mother's voice, her column still supports the statements of the Canadian Paediatric Soceity. Gordon uses the personal story of Melissa Amer, who expresses her gratitude to Toronto's Sunnybrook Hospital's donor milk program for keeping her premature daughters healthy. By referring to breast milk as a "precious gift," reporter Andrea Gordon is discussing it as just that—a gift ("Forever Grateful" A1). But, in the larger context of her article, Gordon's discussion of breast milk as a gift is only true

if it is from a bank, since the milk is pasteurized "to safeguard against the transmission of diseases and bacteria" ("Forever Grateful" A1). To further support the Canadian Paediatric Society's call for milk banks in Canada, Gordon quotes Toronto breastfeeding advocate Edith Kenerman, who stresses the demand and need for milk banks. However, Gordon acknowledges that the B.C Women's Milk Bank is unable to provide milk to every baby in need, which prompts women to seek milk online. Rather than paraphrasing the facts from press releases, as exhibited by the articles analyzed above, Gordon uses a human interest story largely considered by newsrooms as a 'feel-good tale'[13] of a mother who was able to "hold [both daughters] at once for the first time," when they reached a healthy target weight from being fed banked donor breast milk ("Forever Grateful" A1). While Gordon does not necessarily offer a negative representation of milk sharing, her article supports the Canadian Paediatric Society's recommendations, which discuss breast milk banks as the only means for obtaining safe breast milk.

Column 2:"Breast Milk Banks Latch On To Social Media; Despite Controversy, Lack of Options Prompts Mothers to Seek Donors on Facebook Groups"

Gordon's article opens with an introduction to Jacqueline Brady, a mother who faced a declining milk supply right after her daughter Chayse was born. After discovering Eats on Feets (now HM4HB), Brady posted a request for milk, and "within a day, six women had offered to donate" (Gordon, "Breast Milk Banks" E1). Gordon notes that Brenda Coulter, Brady's main donor, "came willing to disclose medical history and lifestyle details, and if requested, have her blood screened" ("Breast Milk Banks" E1). Gordon draws on a maternal repertoire by describing milk sharing as safe through her inclusion of this information about Coulter's concern for health and safety. Prior to

[13] For types of stories, see *The Canadian Reporter,* an introductory journalism text, for more.

receiving the donated milk, Brady had to "reluctantly supplemen[t] with formula," which she says caused Chayse to be fussy and constipated; however, Chayse began to sleep better and was no longer constipated after feeding on Coulter's breast milk (Gordon, "Breast Milk Banks" E1). Gordon's use of the word 'reluctantly' to describe Brady's attitude towards formula, and her description of Chayse's improved health following the breast milk donations, situates breast milk as the best form of infant nourishment, regardless of source. Gordon attempts to normalize breast milk sharing by clarifying to readers that "informal milk sharing and 'wet nurses' have been around since the dawn of time," but the practice is "largely underground" today, because of its status as controversial ("Breast Milk Banks" E1). She uses this explanation as a precursor to drawing on the medical discourse citing Health Canada's warning against breast milk sharing and concern for disease transmission through breast milk. Rather than devoting much space to Health Canada's statement about the dangers associated with milk sharing, Gordon responds by justifying this practice through Brady's story: "But for mothers like Brady, who want their babies to receive the valuable nutrients and antibodies that human milk provides, there are few choices" ("Breast Milk Banks" E1). Gordon then addresses the B.C Women's Milk Bank's inaccessibility, which she suggests is why Canadian women opt to exchange breast milk online; Vancouver's milk bank "cannot even meet demands of Sunnybrook Health Sciences Centre, the only other Canadian hospital that offers donor milk to premature infants" (Gordon, "Breast Milk Banks E1). Gordon, through her rationalization for milk sharing despite the medical warnings, reveals her sympathetic outlook towards this practice.

In the second half of her article, Gordon briefly returns to the medical discourse. She quotes Dr. Sharon Unger, who co-authored the Canadian Paediatric Society's

position statement on the benefits of banked milk, which called for an initiative to set up more Canadian milk banks. Unger states, "I think it's dangerous. I completely understand why women do it, but you really don't know what you're getting…it's very unsafe" (Gordon, "Breast Milk Banks" E1). She also quotes Dr. Jack Newman, who believes that "it's so important to have a system of breast milk banks," as he too discusses milk sharing as unsafe (Gordon, "Breast Milk Banks" E1). After referencing the viewpoints of these two doctors, Gordon transitions to the maternal discourse by acknowledging the limitations of milk banks: "Even if parents could access breast milk from banks in Vancouver or the US, costs can be prohibitive…and that can translate to a cost of up to $100 a day or mothers needing milk" ("Breast Milk Banks" E1). Gordon offers a lengthy description of Eats on Feets, emphasizing the group's value for safety, comments that contradict and offset the statements made by Drs. Unger and Newman.

Gordon concludes her column in this maternal discourse just as she began-- with a mother's success story as testament to the power of milk sharing. Gordon discusses milk sharing as a means for building close relationships among women through her portrayal of Lee Anne King Matchett, a mother who was desperate for milk donations because her glandular condition limits her own production ("Breast Milk Banks" E1). After posting a request for breast milk on one of the online group pages, Matchett was easily able to locate milk for her daughter, who "was nourished on breast milk donated by at least 10 'milk mothers'" (Gordon, "Breast Milk Banks" E1). Gordon's use of the term 'milk mothers' positions the donors not as anonymous online strangers, but as significant maternal figures for her daughter, whose milk allowed Grace to thrive. Gordon also states that Matchett "became friends with all of them [her milk donors]," further demonstrating milk sharing as a community-centred act, in which recipients gain not only breast milk,

but also a friendship or two ("Breast Milk Banks" E1). As well, Gordon speaks to the safety of milk sharing by describing the efforts on behalf of Matchett's donors, who "were nursing their own babies [and] went to their physicians and had their blood screened" ("Breast Milk Banks" E1). However, Gordon notes that Matchett did not wait for the test results before using their milk, nor did she choose to pasteurize it for fear of losing important nutrients. Gordon, by choosing to include this information, represents milk sharing as a safe practice in which women can trust their donors enough to accept their breast milk without hesitation. She closes her column with a quotation from Brady and Coulter, which represents milk sharing in a most sympathetic manner: "I think it's a fantastic idea. Sometimes we just have to stick together, despite the critics or the controversy it makes" (Gordon, "Breast Milk Banks" E1).

Through my close reading of this article, I conclude that Gordon is writing within the maternal discourse: she takes a sympathetic stance towards milk sharing and incorporates success stories to enhance her support of this practice. She also draws on a variety of repertoires that the HM4HB group members drew on in their discussions about milk sharing. Though she makes use of the medical discourse in her article, she offers it limited space, responding to doctors' claims with evidence, both statistical and anecdotal, that contradicts their position.

Column 3: "Surrogate Mom Trying to Sell Her Breast Milk Pulled from Craigslist"

Webb's column, like the two analyzed above, also begins by drawing on a repertoire within the maternal discourse, namely *'milk sharing as fostering community*.' Through her depiction of Becca Shears, a woman eager to find "someone with whom she can develop a relationship and donate her milk to directly," Webb acknowledges the

importance for women to become well acquainted prior to engaging in milk sharing (Webb A18). Webb explains that Shears' ads for breast milk on Craigslist and Kijiji were pulled without reason from either of the websites. By emphasizing that Shears was not looking to make a profit off her milk, she is identifying breast milk as a gift for other mothers in need. In response to concerns over Shears' decision to donate milk online instead of dropping it off at the B.C Women's Milk Bank, Webb addresses the inaccessibility of the bank, arguing, "[Shears] was told she would have to drop it [her breast milk] off in Vancouver- a prohibitively long and expensive journey from Langley" (Webb A18). She also addresses the limitations of the bank, which has "little milk left to dispense to others who need it by the time all the babies in neonatal care are fed" (Webb A18). As a result, she challenges the medical discourse that situates banked milk as safer than unpasteurized breast milk by highlighting the shortcomings of the B.C Women's Milk Bank.

Webb quotes Frances Jones, Program Coordinator for the B.C. Women's Milk Bank as her way of incorporating the medical discourse into her article. Jones, who agrees with the warnings issued by Health Canada, cautions women against meeting donors on the Internet because "buying milk from a complete stranger could be more risky" (Webb A18). Rather than acknowledging in greater detail the health issues associated with milk sharing from the medical perspective, Webb challenges Jones' argument by positioning Shears as a safe and trustworthy donor: "Shears, whose husband Kyle is an organic gardener, said she eats a nearly all-organic diet, sticks to a strict vitamin regimen, and does not smoke, drink or do drugs" (Webb A18). This description mirrors those of the women on HM4HB, who offer brief accounts about their health and lifestyles to attest to the safety of their breast milk. Webb then provides Shears' email at the end of her article

so that "anyone with an infant in need can contact her" (Webb A18). Giving this kind of information further positions Shears as an eligible donor and encourages milk sharing. I argue that Webb supports milk sharing and privileges the maternal discourse in her article. This is evident through her endorsement of Shears as a safe donor, and her incorporation of the medical discourse for the purpose of refuting its claims, rather than as a means of adding depth to her article.

Column 4: "Swapping Breast Milk Online"

Nicole MacIntyre opens her column by drawing on the repertoire of milk sharing and wet-nursing as normal through her description of Anna Kruyssen, who enjoyed nursing "one of her five children…a niece, nephew or even friends' babies" (MacIntyre A1). When Kruyssen was no longer able to breastfeed because her supply dried up, MacIntyre describes breast milk as the best form of infant nutrition by describing Kruyssen's "relunctan[ce]" to supplement with formula" (MacIntyre A1). More specifically, MacIntyre discusses all breast milk, even unpasteurized donor milk, as best, by thanking the Eats on Feets network for "connect[ing] Kruyssen with lactating mothers across Hamilton and the country" (MacIntyre A1). MacIntyre's entire introduction is written in a maternal discourse, praising Eats on Feets for allowing Kruyssen's son to thrive on breast milk. More importantly, MacIntyre devotes the majority of her column to sharing women's positive stories about milk sharing, revealing her sympathetic outlook on this practice.

While MacIntyre notes that milk sharing is an ancient practice and that it "has occurred underground for years," she speculates Eats on Feets' rapid growth is the cause for warnings "from doctors and Health Canada, who advise parents not to participate in

informal milk sharing because of the risk of passing on viruses or bacteria" (MacIntyre A1). Similar to the strategies used within the other journalists' columns analyzed so far, MacIntyre chooses not to focus on the warnings against milk sharing, but to challenge the warnings through women's success stories with donor breast milk. MacIntyre's decision not to explore the controversy from the medical standpoint reveals a sympathetic outlook on the practice of milk sharing. She states, "the warnings, however have done little to slow the growth of the network,…[which] has already come to the aid of several Hamilton mothers who are unable to provide enough breast milk for their babies" (MacIntyre A1). The word 'aid' suggests that MacIntyre views Eats on Feets as a valuable resource for mothers, despite all of the controversy. She includes many quotations from Kruyssen on the benefits on milk sharing and Eats on Feets' structure of "mommies helping mommies take care of babies" instead of offering much attention to the medical argument (MacIntyre A1).

MacIntyre also speaks to the safety of milk sharing in her article, noting that Kruyysen "doesn't plan to [pasteurize donated milk] because she doesn't want to ruin any of its nutrients or antibodies" (MacIntyre A1). This quote implicitly situates unpasteurized donor milk as superior to pasteurized banked milk. She also positions the donors as safe and trustworthy, as a mother surely wouldn't "offer up her milk if she was ill or taking dangerous medication," legitimizing the notion of a strong maternal instinct and autonomy to make her own infant feeding decisions, just as HM4HB promotes on their website (MacIntyre A1).

In the last half of her column, MacIntyre explores in a limited manner the medical argument once again by returning to Health Canada's warning on the subject of a donor's unknown medical history. But rather than providing her own take on this issue, she quotes

part of Health Canada's press release without offering any additional context. She also quotes Dr. Jack Newman, Canada's leading breastfeeding advocate, who expresses concern over the prospect of a baby becoming ill after drinking donated milk. However, MacIntyre challenges his argument by following it with, "But the risk of receiving contaminated milk is small" (MacIntyre A1), and then proceeding to explain the safety measures taken by Eats on Feets to ensure that nobody is harmed: "The social network encourages mothers to ask donors their medical history, request blood tests and to treat the milk to rid it of any contaminants" (MacIntyre A1). She quotes Dani Arnold-McKenny, a milk-sharer and administrator of the local chapter of Eats on Feets, who argues that the risks of using donated milk, or "liquid gold," pale in comparison to the risks of formula (MacIntyre A1).

MacIntyre's column concludes by briefly discussing the B.C Women's Milk Bank, and the Canadian Paediatric Society's call for more milk banks "to provide babies with a healthier alternative to formula," which Dr. Newman hopes will come to fruition much faster because of the expansion of informal milk sharing (MacIntyre A1). MacIntyre does not go into detail about the milk bank, nor does she consider the Canadian Paediatric Society's November 1, 2010 position statement that discouraged milk sharing. But she does explain the limitations of the milk bank in response, noting, "even if mothers were able to buy treated breast milk, the cost can be prohibitive because of the cost of running a milk bank. Milk could cost $100 or more a day" (MacIntyre A1). If MacIntyre's support for milk sharing were not already clear, the very last paragraph of her piece tells the story of another mother, Elizabeth Jackson, who embraces this practice, especially "in the absence of a regulated and easily accessible milk bank" (MacIntyre A1).

Column 5: "Canadian Mom Ends Milk Blog Controversy"

Gordon's column opens with the quirky story of a California father who replaced regular food with a diet consisting of only his wife's extra breast milk; he chronicled his progress on an online blog called, "Don't have a cow, man." Gordon then quotes Emma Kwasnica, founder of HM4HB (formerly Eats on Feets), who convinced this California family to donate their extra breast milk instead, and connected them with a Canadian mom named Fiona, who was seeking donor milk for her quadruplets ("Canadian Mom" A1). Gordon draws on the repertoire of 'milk sharing as fostering community' through her statement describing the importance for milk sharing mothers to build relationships: "the notion that mothers can connect through the virtual world to provide each other with real life help is what [Kwasnica's] network is all about" ("Canadian Mom" A1). Gordon devotes most of the beginning of her article to discussing Fiona's gratitude towards the California family, who allowed her to terminate her tireless search for breast milk donors by providing her with a substantial amount. She describes breast milk as best, specifically unpasteurized donor milk, which has necessary "antibodies and nutrients" for Fiona's babies to thrive (Gordon, "Canadian Mom" A1). Prior to incorporating the medical discourse, Gordon normalizes milk sharing by reminding readers that "informal milk sharing and wet nurses have been around as long as humankind…" ("Canadian Mom" A1).

In comparison to the many quotations Gordon includes from milk sharing advocates, her treatment of the medical side of the argument is limited to two sentences--one regarding Health Canada's warnings "against using unprocessed breast milk from other women" and the other outlining the Canadian Paediatric Society's stance against informal milk sharing ("Canadian Mom" A1). She does not embrace the medical

discourse, nor offer it much space within her article. Rather, in response to the medical argument, Gordon mentions Fiona's experience of relying on previous donors "who have provided blood work and physician's notes to verify their health" as a testament to the safety of online milk sharing ("Canadian Mom" A1). Contrary to Health Canada and the Canadian Paediatric Society's emphasis on the lack of safety involved in online milk, Gordon presents milk sharing as safe by referring to the HM4HB website, which "encourages 'informed choice' and has links to public heath information on breast milk and disease transmission, safety tips for donors and recipients, details about screening, and demonstrations of how parents can flash-pasteurize donor milk on a stovetop" ("Canadian Mom" A1). And, just as each of the journalists and columnists analyzed above have concluded their articles with a story or statement recognizing the value of milk sharing, so does Gordon. She ends her column with a quote from the California milk donor, who applauds the "happy ending" of her and Fiona's story (Gordon, "Canadian Mom" A1). I argue that Gordon, whose piece is dedicated to discussing milk sharing in a most sympathetic and positive manner, shares Fiona's appreciation for this practice.

Conclusions

After conducting a close reading of the news stories, I conclude that a majority of the articles (4/6) privilege the medical discourse and discuss milk sharing as unsafe. In these articles, the journalists use the legitimacy and authority of the medical community as the focus for their stories. The remaining two news stories follow a different approach. Rather than using a lot of material from the medical community's press releases to speak to the dangers of sharing milk online, these articles discuss this practice as a viable option. In Chai's case ("Doctors Frown on Sharing of Breast Milk"), she acknowledges

the limitations of the Canadian Paediatric Society's recommendation for families to opt for only pasteurized breast milk from the B.C Women's Milk Bank by speaking to the Bank's limited capacity. Schwass-Bueckert's article takes the angle that breast milk is the best form of infant nourishment, even if it is unpasteurized. This surprised me to some extent because I thought that given mainstream journalism's preference for relying on clearly authoritative sources like government spokespeople (like Health Canada or equally authoritative members of the medical community) over laypeople, and its reliance on known or proven scientific facts as opposed to anecdotal evidence (Benedetti), I would have thought all the hard news articles would have privileged the medical community discourse.

The columns offer a contrast. With respect to these opinion pieces, the majority, or 10 out of 11 columnists expressed their support for milk sharing by drawing on many of the same repertoires as the HM4HB members in their Facebook discussions. Because columnists are not only permitted but actually encouraged to inject their own opinions into their writing, their stories generally emphasized the side of the debate that most resonated with them: the maternal perspective. While the reasons for this are unclear, I can note that all the columnists are women and one had donated her milk to a woman she connected with on HM4HB. Though the medical community's voice is powerful and authoritative, I found it compelling that not one columnist was persuaded to dismiss the practice of milk sharing as unsafe or recommend for it to be illegal or strictly regulated. Instead, a vast majority was critical of the medical community's warnings, discussing milk sharing as a legitimate, or sometimes necessary, option for families. Of the few columns that employed both maternal and medical discourses, I would argue that the authors use the medical discourse as a kind of springboard, or to use a journalistic term,

the ‘turn’, as a way to bring up the opposing side of the issue—the mothers’ positions. So in these pieces, the journalists introduce the medical discourse *only* to address both sides of the milk sharing argument. But this organizational choice does not necessarily lead to fair representation of both sides because the authors devote limited space to the medical discourse, and it is only used within each column for the sole purpose of advancing the maternal discourse. In each of these five columns, the maternal discourse is strategically pitted against the medical discourse to dismiss the warnings against milk sharing. As well, the authors incorporate many anecdotal success stories about milk sharing as testaments to the safety and value of this practice. As a result, I conclude that the maternal discourse is privileged throughout the majority of columns (4/5) that offer both discourses.

In total, 12 out of 17 articles (both columns and news stories), or about 71% of the coverage, employed primarily the maternal discourse in their discussions about milk sharing and this privileging of the maternal perspective puts the practice in a favourable light. Like my reaction to the findings of the unequal use of maternal and medical discourses in the columns, this overall finding also surprised me. One could make the argument that the discourse of the medical community is so authoritative that even if it predominates in only about 30% of the coverage, that amount is more than enough to offer ‘balance’ to the larger discussion given that the maternal discourse could be viewed as unscientific and therefore less reliable. However, I would not draw that conclusion. Instead, I argue that the columnists’ decision to take the side of the milk sharers over the medical community diminishes the authority of the medical voice and offers legitimacy to the practice of milk sharing.

Chapter 5: Conclusion

From this study, I have learned that breast milk sharing is a controversial issue with two sides, which each have well-articulated and well-publicized arguments. The medical side uses traditional biomedical channels such as press releases, journal articles, and position statements to communicate their message, while the maternal side takes advantage of the newly available forms of social media, specifically Facebook, to get their message out. Though the maternal community does not have access to authoritative medical media sources, their Facebook network has an international reach and has gained a great deal of exposure.

My analysis of the discussions of medical professionals in Chapter 2 and members of HM4HB in Chapter 3 reveals a disconnect between these two groups both in their representations of milk sharing and of one another. The medical professionals drew on the repertoires of '*milk sharing as risky for babies/breast milk as contaminated'*, '*milk sharing as informal*', '*milk banks as safer than milk sharing*', and '*doctors as primary infant feeding decision makers*'. The HM4HB members, in contrast, challenge the medical discourse through their discussions. For example, the HM4HB members disregard many members of the medical community's fears about the safety of milk sharing, discussing milk sharing not as a risky practice, but rather as a safe and meaningful one *('milk sharing as safe'*). While many women recognize that there is potential risk, they discuss their methods to mitigate these factors so that their babies receive safe milk. This is a particularly notable difference: one group confidently and proudly attests to the safety of milk sharing, while the other fervently outlines the dangers involved. Another notable difference is how the two groups discuss breast milk. The doctors, through their use of

clinical language, discuss breast milk as a substance that must be extracted, stored, tested, and pasteurized in a specific manner, so as to avoid disease transmission. On the other hand, the members of HM4HB view breast milk as a gift and as 'liquid gold,' which is most valuable when raw because it loses many important nutrients when pasteurized.

Rather than referring to milk sharing as an informal practice in which the donors are anonymous figures and have no connection with recipients or accountability for the safety of their milk *('milk sharing as informal'*), the HM4HB members discuss milk sharing as an intimate practice between donor and recipient families (*'milk sharing as fostering community'*). In response to the medical community's positioning of donors as diseased and negligent, in that they willingly put babies at risk by failing to take proper safety measures, HM4HB members position donors as trustworthy and responsible women, who ensure the safety of their milk prior to donating.

As well, the medical community is vocal in its support of milk banks, arguing that they are a much safer source for obtaining breast milk than through milk sharing *('milk banks as safer than milk sharing'*). However, the HM4HB mothers discuss milk sharing as superior to milk banks, in that they experience greater satisfaction from donating their milk cost-free to a woman they know. Lastly, the doctors draw on the repertoire of *'doctors as primary infant feeding decision makers'* through their discussions that highlight the importance of consulting a medical professional prior to making any decisions regarding their babies' food source. In contrast, the HM4HB members reject the ultimate authority of doctors by positioning them as non-experts, and positioning one another as infant feeding experts who do not require medical 'help' or physician intervention.

The only similarity I discovered between the medical and maternal discourses is their emphasis on the benefits of breast milk for babies. The members of HM4HB draw on the repertoire of *'breast milk as best'* often, discussing breast milk as a nutrient-rich and necessary food for babies, no matter from whose breast it comes. HM4HB members actively discourage the use of formula, comparing its limited nutrient content to that of the nutrient-rich breast milk, and citing the many problems they have encountered with formula. Within the medical literature, while doctors do discuss breast milk as the best nourishment for babies, they do so in a different or conditional manner. Breast milk is described as the optimal source of infant nourishment so long as it comes from the breast of the baby's biological mother, or from a registered milk bank. However, if the milk comes from a donor found online, the medical literature devalues the breast milk and presents it as dangerous or contaminated, while implicitly positioning parents who opt for donor milk as negligent. Despite the hierarchy of most preferred breast milk sources provided by the World Health Organization (2002)--"expressed breast milk from an infant's own mother, breast milk from a healthy wet-nurse or a human-milk bank, or a breast-milk substitute fed with a cup"-- the medical literature disregards the healthy wet nurse, replacing her with infant formula (7). For example, Drs. Unger and Kim, in their statement on behalf of the Canadian Paediatric Society, argue, "when the mother's own milk is unavailable for the sick, hospitalized newborn, pasteurized human donor breast milk should be made available as an alternative feeding choice followed by commercial formula" (595). The members of HM4HB cite the World Health Organization's report to support their choice for donor milk because they strongly oppose feeding their babies formula, which they refer to as poison. Though infant formula is often more easily accessible than obtaining hundreds of ounces of donor breast milk, HM4HB members are

committed to providing breast milk for their babies and will only turn to formula if it is absolutely necessary.

In Chapter 4, I considered how the maternal and medical discourses were being represented in mainstream Canadian newspapers and tried to gain a sense of what conclusions about the practice of breast milk sharing a reader might draw from reading the columns and news articles. Because the journalists draw from both medical and maternal repertoires, the authoritative medical sources and HM4HB Facebook groups represent two distinct and important sites of information to provide background on the issues. Out of the 17 stories and columns I considered, a majority came down on the side of the women who are sharing breast milk. While most of the small number of news stories primarily employed the medical discourse, these articles closely resembled the press releases they were referencing. These reporters quoted large components of the government or doctor-issued press releases rather than reporting on the issue in an original or investigative manner and often without quoting any source who might oppose this medical perspective. As a result, readers were met with primarily the same information presented by the press releases and journalists added little or nothing to the discussion. Scholarly journals and articles, medical press releases and position papers are typically considered to have significant social influence and importance. Though the medical perspective is strongly articulated in press releases that speak to the dangers surrounding milk sharing, its authority is weakened by the news media's lack of original reporting and the reporters' inability to put a 'human face' on these largely abstract and scientific issues.

But among the columns, I discovered that women's stories and experiences with sharing their breast milk are driving this kind of coverage; here the human face is

everywhere. This is particularly interesting because columnists are expected to incorporate their own opinions into their writing, yet none of them took the angle of discussing milk sharing as an unsafe practice or called for it to be banned. While there were five columns that employed both discourses, my analysis revealed that the maternal discourse, as opposed to the medical discourse, received far greater attention and sympathy from the authors. Instead of relying on press releases to make up a majority of the articles, the columns offered almost all original content, and as a result, explored the maternal issues and stories on a deeper level. Such engaging and detailed reporting was absent from the news stories employing only the medical discourse. The authors, by discussing the ways that women mitigate the risks of milk sharing ('*milk sharing as safe*'); the superiority of breast milk over formula ('*breast milk as best*'); the value of breast milk as a precious gift ('*breast milk as a gift'*); and the importance of developing close friendships between donors and recipients ('*milk sharing as fostering community'*), drew on many of the same repertoires as the HM4HB members in their Facebook posts.

I was especially surprised by my findings in Chapter 4. I had initially assumed that the medical community's rhetoric, authority, and influence would permeate much of the journalistic coverage; however, I would argue now that the women's perspective, that breast milk is 'gold,' and that sharing it is not only acceptable, but valuable, emerged as dominant in the overall coverage. Therefore, instead of championing the medical community, this sample of Canadian newspaper articles favours the "little gal," which in this case is the milk sharers.

Implications and Opportunities for Further Research

For the women and families reading mainstream Canadian newspapers as a source of information about maternity issues and family planning, it is important to consider how they would react upon reading such coverage about breast milk sharing. Since the sample of news coverage I analyzed treats the practice of milk sharing in a sympathetic way, perhaps women who have no prior knowledge about this practice can be influenced to join an online milk sharing network in hopes of donating or receiving breast milk. For those who have been exposed to this practice through other information sources, perhaps the news coverage serves as a means of influencing their future behaviours. And, for those who engage in this practice, perhaps they see the news coverage as supporting or validating their actions. Regardless, Canadian families who consulted their national mainstream newspapers for information about infant feeding (during the specific time period of my analysis), were exposed to messages about the safety of milk sharing that privileged the maternal side of the debate. Using my study as a basis, further research might test the effects of such media texts (newspapers) on audiences (mothers) to understand the news media's influence on women's infant feeding decisions.

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