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ANALYSIS OF GFI VS. AAP COMPARISON CHART

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In 1998 Gary Ezzo of Growing Families International (GFI) created a chart comparing *On Becoming Babywise* with the American Academy of Pediatrics' (AAP) June 1998 edition of *Caring for Your Baby and Young Child.* This was an attempt to show that his book aligns itself with AAP guidelines and recommendations. Since then many Ezzo followers have used this comparison chart to do the same. I am a pediatrician member of the AAP and I have reviewed the above mentioned books, and have analyzed this comparison chart from GFI.

First of all, it should be pointed out who the authors are. Mr. Ezzo has a high-school diploma and a master's of arts in ministry designed for non-college graduates that gives credit for life experience. He does not have any background in medicine, lactation, psychology, or child development. He is not in the position to contradict medical research and provide information on delicate professional topics such as infant nutrition, lactation, and child development. Furthermore, he has been publicly deemed unfit for Christian ministry by three churches spanning twenty years due to character related issues. This is important since there is a lot of misinformation contained in his books. Also, the *On Becoming Babywise* book is co-authored by Robert Bucknam, M.D. However, he did not write any of the material contained in this book. This book was borne out of a previously written book, *Preparation for Parenting* (which was written by Gary Ezzo several years earlier). *On Becoming Babywise* is virtually identical to *Preparation for Parenting* with the exception of the religious content being removed.

The AAPs' *Caring for Your Baby and Young Child* was authored under the editorial direction of pediatricians Steven P. Shelov, M.D., M.S., and Robert E. Hannemann, M.D., with contributions from more than 75 pediatric specialists and a six-member AAP editorial review board (all pediatric M.D.s). In the Foreword, the book points out, "What distinguishes this child-care book from the many others in bookstores and on library shelves is that it has been developed and extensively reviewed by members of the American Academy of Pediatrics. . . .The final draft was reviewed by countless numbers of pediatricians."

The page on the GFI website leading into the comparison chart states, "The materials developed by Gary and Anne Marie Ezzo fall under the review and accountability of many medical and theological professionals." Numerous people have requested the names and addresses and/or phone numbers of these professionals, and GFI has repeatedly denied such requests, giving only a few names of supposed endorsers in the front of their books. Therefore many have wondered if such medical review and accountability actually exists.

The following analysis of the GFI comparison chart demonstrates some of the many medical problems associated with these materials, and points out misleading information, statements taken out of context, and the false impression that this infant parenting program as described in *On Becoming Babywise* is consistent with the AAP. The GFI comparison chart attempts to show similarities between the AAP and GFI, however, as is shown in the following discussion, these are inaccurate. More importantly, I have pointed out some of the many *differences* between the AAP and GFI. The reader will need the GFI comparison chart to follow along this discussion.

Abbreviations:
AAP = American Academy of Pediatrics
BW = *On Becoming Babywise*
CYB = *Caring for Your Baby and Young Child* (the AAP-published book being compared)
GFI = Growing Families International

Feeding Recommendation
1. Nursing after delivery

The main reason for nursing right after delivery is to initiate *successful* breastfeeding. CYB gives helpful information towards that goal. "If you wait until later, he may be sleepier and have more difficulty holding the nipple effectively" (CYB p. 29). And, "Breastfeeding is generally most successful when you start nursing immediately after delivery (in the first hour), keep the baby with you as much as possible ("rooming in" with her in the hospital), and respond promptly to cues of hunger (a practice called demand-feeding)" (CYB p. 87). The very first feedings are important to this success. It takes practice for both baby and mother. The mother needs to recognize her newborn's cues of hunger and the baby needs to be rewarded for demonstrating those cues by being offered the breast.

In contrast, Ezzo states, "Keeping him awake will help him take in full feedings as opposed to snacking. It's your key to success, both in terms of early lactation and establishing a healthy routine" (BW p. 78). Throughout his book, Ezzo stresses the feeding routine (schedule) as the main part of his program, even from the first few days.

2. Time Between Feeding

CYB answers the question of what's the best feeding schedule for a breastfed baby. "It's the one she designs herself. Your baby lets you know when she's hungry by waking and looking alert, putting hands toward mouth, making sucking motions, whimpering and flexing arms and hands, moving fists to mouth, becoming more active, and nuzzling against your breast (she can smell its location even through your clothing). It is best to start nursing the baby before crying starts. Crying is a late sign of hunger. Whenever possible, use these signals rather than the clock to decide when to nurse her. This way,

you'll assure that she's hungry when she eats. In the process, she'll stimulate the breast more efficiently to produce milk" (CYB p. 87).

BW states, "If your baby shows signs of hunger before her next scheduled feeding time—feed her" (BW p. 112). Also, "a mother feeds her baby when he is hungry" (BW p. 38), but in the same sentence it commands, "to guide the baby's hunger patterns by a basic routine" (BW p. 38). This routine (schedule) may be started on the third day of life (BW p. 77). In other sections, it is clear that the emphasis of Ezzo's infant feeding program is the schedule: "There will be times when you might nurse sooner than 2 ½ hours, but that should not be the norm" (BW p. 74). "Between weeks one and four, nurse your baby every 2 ½ to 3 hours" (BW p. 112). "If your baby increasingly becomes characterized by snacking, you must work on stretching the times between feedings to make the 2 ½-hour minimum" (BW p. 176). "Investigate why he is not reaching the minimum mark and start working toward it" (BW p. 176). "It's okay to deviate from the 2 ½ to 3-hour feeding norm. But do not deviate so often that you establish a new norm" (BW p. 115). For a baby three to eight weeks old whose mother is experiencing milk supply problems, she is instructed to "consider feeding on a strict 2 ½ hour routine for five to seven days" (BW p. 184).

When describing "flexibility," BW states, "The word flexibility means the ability to bend or be pliable. When you think of a flexible item, you think of something with a particular shape that can bend and then return to its original shape. Returning is perhaps the most crucial element of flexing. During the critical first weeks of stabilization, you are giving your baby's routine its shape. Too much 'flexibility' in these weeks is viewed by a baby as inconsistency. Routine must first be established. After that, when necessary deviations are made, baby will bounce back to the original routine. Doing so, however, may require your firm guidance. The flexibility you desire will come, but give yourself time to develop your child's routine. And remember, true flexibility is not a lack of routine, but a temporary alteration of what you normally do" (BW p. 109 – 110). Clearly, the word "flexibility" would not include feeding a baby 11 to 12 times per day on a regular basis as is included in the AAP Policy Statement on Breastfeeding (*Pediatrics*, Dec., 1997).

Some babies may do fine on a schedule, but unfortunately many do not, leading to poor infant weight gain, dehydration, and failure to thrive. This is why the AAP does not recommend a feeding schedule in infancy, especially one starting at 3 days of life! In fact, in 1998 the AAP evaluated BW and produced a "Media Alert," which warned about the dangers of scheduled feedings. In this document it stated, "Recent media reports have focused on the issue of whether scheduled feedings or demand feedings are best for babies. In response to these reports, the American Academy of Pediatrics (AAP) reaffirms its stance that the best feeding schedules are ones babies design themselves. Scheduled feedings designed by parents may put babies at risk for poor weight gain and dehydration" (see Media Alert, April 1998).

Furthermore, it should be pointed out that the scheduled infant feeding program designed by Mr. Ezzo continues throughout the infant 12-month period, which is completely

inconsistent with the recommendations in CYB. Many babies following this plan have moved along it too fast and have become victims of early weaning, poor infant weight gain, dehydration, and failure to thrive. For weeks five through eight, BW instructs to "feed your baby between 2 ½ to 3 ½ hours" (BW p. 113). For weeks nine to fifteen, it states, "most PDF moms transition from seven or eight feedings down to five to seven feedings in a 24-hour period" (BW p. 122). For weeks sixteen through twenty-four BW states, "Along with solid foods, continue with four to six liquid feedings" (BW p. 120). For weeks twenty-five through fifty-two BW states, "Your baby will continue to be fed on three meals a day . . . with an optional fourth liquid feeding . . . Continue with four to five nursing periods during the day" (BW p. 121).

3. Frequency of Nursing Minimum

In the comparison chart from GFI, it states, "No reference found in *Caring for Your Baby*." This is because the emphasis is not on an infant feeding schedule, but rather on the individuality of the baby's needs and observing for feeding "cues." In fact it states, "Some newborns need to nurse every two hours; others, every three. . . . .What's the best feeding schedule for a breastfed baby? It's the one she designs herself" (CYB p. 87).

BW states, "You can average between 8 to 10 feedings a day in the early weeks. These times fall well within recommendations of the American Academy of Pediatrics" (BW p. 74). Actually a 2 ½ to 3-hour schedule would come out to 8 to 9.6 feedings a day. The GFI comparison chart correctly cites the AAP Policy Statement on Breastfeeding, "Newborns should be nursed approximately 8 to 12 times every 24 hours." This is a much greater range to work with than 8 to 9.6. For some babies this could be a major difference. For example, if Baby A fed the maximum 12 feedings a day as recommended by the AAP, she would receive 84 feedings in one week. If Baby B fed the maximum 9.6 feedings a day as recommended by BW, she would receive 67.2 feedings in one week. CYB states, "By the end of the [first] week—depending on the size and appetite of the baby and the length of feedings—you [the mother] may be producing 2 to 6 ounces (60 to 180 cc) at each feeding" (CYB p. 87). If we use the average, 4 ounces, Baby A would receive 336 ounces in a week, while Baby B would receive 268 ounces in a week. This is a 20% difference. If these babies were in their second week of life, this could be an extremely significant difference if this feeding pattern were to continue over the next few months!

BW does not take into account individual differences between babies, and instead tries to fit them all in one box. In fact, individual differences can be noted within the first few days, especially when it comes to feedings. The AAP describes different eating patterns and styles, and labeled them as "barracudas," "excited ineffectives," "procrastinators," "gourmets or mouthers," and "resters" (see CYB pp. 88 – 89). Taking into account a baby's individuality is summed up in this statement: "Learning your own baby's eating patterns is one of your biggest challenges in the first few weeks after delivery. Once this is established, it will be much easier to determine when he's hungry, when he's had enough, how often he needs to eat, and how much time is required for feedings. It is

generally best to initiate a feeding at the earliest signs of hunger and before the baby cries" (CYB p. 89).

Furthermore, there are individual differences between mothers in their production of breast milk. Because of these differences in feeding patterns, as well as other physiological differences, some babies will require more frequent feedings than others will. If a particular baby requires 11 or 12 feedings a day, but only receives 9 feedings a day, over a period of a few months that baby could exhibit poor weight gain, perhaps leading to dehydration or failure to thrive. This scenario occurs gradually and subtly, usually without the parents noticing anything wrong. It is often discovered by a trained medical person and/or when the baby's weights are plotted on a growth chart.

Many Ezzo followers either deny that such medical problems have occurred or make comments such as, "The parents of these babies have taken the advice to the extreme." Unfortunately, I have read hundreds of accounts of babies who had slipped into these medical problems of poor infant weight gain, dehydration, and failure to thrive while on this scheduled feeding program as instructed by Mr. Ezzo. Are there any differences between the feeding recommendations of the AAP and BW? Yes, and these differences are **grave!**

4. Feeding Hungry Babies

This section ties in closely with the section on "Time Between Feeding." Mr. Ezzo deceptively attempts to give the appearance that the BW advice is similar to the AAP advice. Therefore, there are statements such as, "PDF parents will feed their babies on a flexible routine every two to three hours" (BW p. 64 – 65). However, Ezzo instructs a mother how to start this PDF routine on her 3 to 5 day old baby: "Maintain your basic 2 ½ to 3 hour routine" (BW p. 77). Throughout the book there is conflicting and confusing information: "During the first two months you will feed your baby approximately every 2 ½ to 3 hours from the beginning of one feeding to the beginning of the next. Sometimes it may be less and sometimes slightly more, but this time frame is a healthy average" (BW p. 74). Then on the very same page it states, "There will be times when you might nurse sooner than 2 ½ hours, but that should not be the norm" (BW p. 74). "It's okay to deviate from the 2 ½- to 3-hour feeding norm. But do not deviate so often that you establish a new norm" (BW p. 115). Shortly after that it states, "Remember the basic rule: feed every 2 ½ to 3 hours after the beginning of the last feeding" (BW p. 117). Then a work sheet is provided "based on eight feedings in a 24-hour period and is a guide for your first six to eight weeks" (BW p. 117 – 118). Note that eight feedings in a 24 hour period correlates to a 3-hour schedule. Furthermore, within this "work sheet," there is a note after the seventh scheduled feeding, "For many babies this is the last scheduled feeding of the day" (BW p. 119). "Throughout the next three to five days [of the baby's first week of life], maintain your basic 2 ½-to 3-hour feeding routine. . . .You want your baby taking full feedings as opposed to snacking. Full feedings are the key to success both in terms of early lactation and establishing a healthy routine. It is our experience that mothers who work to get a full feeding during the first week have babies

who naturally transition into predictable three-hour routines within seven to ten days" (BW p. 171). "2 ½ hour minimum" (BW p. 176) is used twice on this same page. Again, clearly the emphasis is on working towards and sticking to the 2 ½ to 3-hour schedule. Nowhere in CYB does it recommend any form of feeding schedule. In CYB the emphasis is to, "respond promptly to cues of hunger" (CYB p. 87).

Also, the comparison chart from GFI cites the BW book: "If the child routinely shows signs of hunger before the next scheduled feeding, then find out why, rather than letting the baby cry it out" (BW p. 145). However, when instructing how to eliminate a feeding in a 24-hour period BW states, "When your baby awakens, don't rush right in to him or her. Any crying will be temporary, lasting from five to forty-five minutes" (BW p. 123). Contrast that with the CYB statement, "Crying is a late sign of hunger" (CYB p. 87). Needless to say – crying for 45 minutes would be a late, late, late sign of hunger!

What if a newborn wants or needs to feed every 2 hours everyday for the first few weeks? Ezzo gives no answer, other than continuing to work towards that goal of 2 ½ hour minimum. This is when medical problems have occurred. Parents of these particular babies try to follow Ezzo's infant feeding program and never realize that their baby actually needs (physiologically) to feed more frequently.

5. Infant Feeding and Crying

Here the CYB statement and the BW statement cover two completely different topics. The CYB statement relates to not waiting for a newborn to cry before starting to feed him. The BW statement relates to sleepy newborns who do not wake up to feed even after five or six hours, very sick newborns who are not able to cry, and crying not being the only hunger cue. Although the BW statement does relate to the topic heading "Infant Feeding and Crying," it has nothing to do with the CYB statement.

The full sentence in the last part of the BW statement in the comparison chart is as follows: "Weak and sickly babies may not have the energy to cry, so the advice to sit back and let the baby direct the show could allow serious medical problems to go unnoticed that would otherwise be picked up through routine feedings." Mr. Ezzo is not a medical person. He has never treated sick babies. Sick babies usually cry a lot and do not feed well, among many other signs and symptoms. Before a baby gets to the point where he is so sick that he does not have enough energy to cry, there are many other signs and symptoms that have already occurred. A mother who feeds her baby using hunger cues would more likely recognize her baby's illness before a mother who schedule feeds her baby.

6. Defining Demand Feeding

This excerpt from BW leads the reader to believe that the PDF scheduled feeding program includes the practice called "demand feeding," and improves upon it. The CYB

excerpt in GFI's comparison chart is taken out of context and misrepresents its definition of "demand feeding." The statement, "try demand feeding her every two to three hours even if she doesn't cry for nourishment," pertains to a newborn who is not "rooming in" with the mother and has been fed on a schedule determined by the nursery staff, not the newborn's "own hunger pangs" (CYB p. 87). Therefore, the CYB statement in the comparison chart means that the mother should compensate for the feedings the newborn may have missed and needed while in the nursery by feeding him more frequently. Furthermore, the exact quote from CYB which defines "demand feeding" is, "respond promptly to *cues* of hunger," not "responding promptly to *a cue* of hunger" (which is misquoted in the GFI comparison chart). This is significant, because there are several signals a baby gives to demonstrate hunger, not just one signal.

Mr. Ezzo does give his definition of "demand feeding" elsewhere in his book: "Obviously definitions vary from household to household. For the purpose of this book, Allicin's [who is previously quoted as saying, 'I nursed my babies whenever they cried or began to fuss. On average, I was told that mothering attachment required me to nurse every two hours around the clock for the first six weeks'] definition of attachment parenting will be used when referring to demand-feeding rather than the other two moderate forms described by Julia [who previously states, 'I demand-fed my first child every three hours'] and Barbara [who previously states, 'I fed my baby on demand whenever he was hungry, but never sooner than two hours and never longer than four hours']. When attachment parenting, abbreviated AP, is noted, we are implying that the baby's cry is the primary signal for nursing. This is regardless of whether that cry is for food or the baby's presumed psychological need. The baby is offered the breast simply and immediately without any regard for the amount of time that has elapsed since the last feeding. The next feeding may be in three hours or in thirty minutes" (BW p. 33).

This is not even close to the definition of "demand feeding" in CYB. Mr. Ezzo has clearly misrepresented CYB. The statement regarding demand feeding is, "Breastfeeding is generally most successful when you start nursing immediately after delivery (in the first hour), keep the baby with you as much as possible ("rooming in" with her in the hospital), and respond promptly to cues of hunger (a practice called demand-feeding)" (CYB p. 87). Furthermore, he misrepresented himself on this topic of "Defining Demand Feeding" by not including his real definition in his comparison chart.

Also, the excerpt from the BW statement includes, "On the other hand, PDF parents will feed their babies on a flexible routine every two to three hours." As stated previously, the goal and instructions in the BW book are to work toward a 2 ½ hour minimum. "Every two to three hours" is conflicting and confusing information contained in the BW book, and is stated in the GFI comparison chart for the sole purpose of appearing to align itself with the AAP.

Infant Crying

1. Crying and Naps

Again, the CYB statement is taken out of context. In CYB it states, "The best way to handle crying is to respond promptly to your infant whenever he cries during his first few months. You cannot spoil a young baby by giving him attention; and if you answer his calls for help, he'll cry less overall. . . . If he's cold and hungry and his diaper is wet, warm him up, change his diaper, and then feed him" (CYB p. 35). Then there are ten "consoling techniques" offered, followed by this statement, "Sometimes, if all else fails, the best approach is simply to leave the baby alone. Many babies cannot fall asleep without crying, and will go to sleep more quickly if left to cry for a while. The crying should not last long if the child is truly tired" (CYB p. 36).

The BW book states in the chapter on crying, "Marisa's mom has been bombarded by clichés: 'You can't hurt a baby by picking her up whenever she cries.' 'You can't spoil her by loving her too much.' Such clichés are clouds without water. . . . Yes you can hurt a baby by picking him or her up too much" (BW p. 141). And, "constantly holding baby during every fussy time is easily overdone" (BW p. 152). Under the heading "Crying When Going Down for a Nap," examples of Mr. Ezzo's three grandchildren are given, allowing them to cry themselves to sleep up to 15 minutes (BW pp. 146 – 147). "When settling for a nap, crying for 15 to 20 minutes is not going to hurt your baby physically or emotionally" (BW p. 131).

The advice in CYB is to respond promptly to the cry, and the result is that baby cries less and the baby is not spoiled. The BW advice is to allow your baby to cry himself to sleep (up to twenty minutes), and that the result of picking the baby up when she cries spoils her and can hurt her.

2. Crying and Mothers

In addition to the statement in GFI's comparison chart, the BW book also contains the following statements: "Besides crying when hungry . . ." babies cry when they are "fed too often" (BW p. 137). "Attempts to minimize or block all crying can easily increase stress rather than decrease it. Emotional tears actually eliminate from the body chemically-activated stress hormones" (BW p. 138). "Research has clearly demonstrated that immediate-gratification training negatively impacts a child's ability to learn, affecting the skills of sitting, focusing, and concentrating" (BW p. 141). "Babies under the parent-directed feeding plan tend to cry less in the long run than babies who are demand fed" (BW p. 141). "With demand-fed babies, cries are unpredictable, leaving mom and dad guessing and anxious" (BW p. 142). These statements are posed as fact, when in reality no proof exists. In fact, for some of the statements, the opposite is true! Ezzo's goal is to get the reader to think that it is OK to allow the baby to cry until he falls asleep and/or cry until the next scheduled feeding. Again, the advice in CYB is to respond promptly to the cry.

Infant Sleep

1. Helping Your Baby Sleep

The BW statement implies that sleeping through the night is achieved by some parental intervention/guidance. BW claims that sleeping through the night "is determined predominantly by the philosophy you adopt for feeding" (BW p. 43). His philosophy is letting the baby cry for "five to forty-five minutes" (BW p. 123) while training him to drop a nighttime feeding so he can sleep through the night.

Sleeping through the night does not necessarily depend on what the parent does to the baby, but rather is based on individual factors related to the baby itself. CYB states, "By three months, most (but not all) infants consistently sleep through the night (seven or eight hours without waking)" (CYB p. 187). The reasons that babies at this age are able to sleep through the night are given: "By two months your baby will be more alert and social, and will spend more time awake during the day. This will make her a little more tired during the dark, quiet hours when no one is on hand to entertain her. Meanwhile, her stomach capacity will be growing, so that she needs less frequent feedings; as a result she may start skipping one middle-of-the-night feeding and sleep from around 10:00 P.M. through to daylight" (CYB p. 187). Also, "As she gets older and her stomach grows, your baby will be able to go longer between feedings. In fact, you'll be encouraged to know that more than 90 percent of babies sleep through the night (six to eight hours without waking) by three months. Most infants are able to last this long between feedings when they reach 12 or 13 pounds, so if yours is a very large baby, she may begin sleeping through the night even earlier than three months" (CYB p. 38). For the babies that do not sleep through the night on their own by this age, CYB does offer advice that the parent can do, but this ability of the baby sleeping through the night does not wholly depend on what the parent does. "If your child does not start sleeping through the night by three months, you may need to give her some encouragement by keeping her awake longer in the afternoon and early evening. . . .Increase the amount of her feeding right before bed" (CYB p. 187).

2. Sleep and Crying

Again the CYB statement is taken out of context and leads the reader to believe that crying is a natural part of a baby going to sleep. This excerpt is in the context of problem solving for infant sleep: (1) Not sleeping through the night, (2) Baby getting daytime and nighttime mixed up, (3) Baby waking up too early in the morning, and (4) Waking up in the middle of the night (which is where this excerpt from the GFI comparison chart is found). It is in the context of the baby waking up in the middle of the night where CYB recommends giving the baby a chance to fall back asleep, which may involve some crying.

The BW statement is taken from the chapter "When Your Baby Cries." Mr. Ezzo had just described "abnormal crying periods" and is in the middle of describing "normal crying periods" such as one entitled "Crying When Going Down for a Nap." This implies that crying is to be expected when you put your baby down for a nap when implementing the Ezzo methods for sleep training. His program of the feed/wake/sleep

cycle may be incompatible with some babies. What happens if the babies' "waketime" is different than the parents' expectations or desires? Unfortunately no answer is found in the BW book other than to continue this pattern and schedule no matter what circumstances are involved. Indeed there have been cases reported from Ezzo followers on the GFI internet forum, such as, a baby crying so much that blood came from his throat, a mother leaving a baby in the car seat in the closet so she wouldn't have to hear the crying, and turning on the vacuum cleaner to drown out the crying.

Nowhere does CYB imply that the daily duty of putting your baby to sleep involves letting him cry for five to thirty-five minutes. The BW emphasis is on sticking to the cycle and the schedule, whether the baby adapts to it or not.

3. Sleep Positioning

In the BW 1995 edition, it states, "Some researchers suggest that putting a baby on his or her back for sleep, rather than on the baby's tummy, will reduce the chance of crib death. That research is not conclusive, and the method of gathering supportive data is questionable" (BW 1995 ed., p. 166). And also it states that SIDS is not "preventable" (BW 1995 ed. p. 165). By 1992, the American Academy of Pediatrics had already started a campaign for infants to be placed to sleep on their backs to reduce the risk of sudden infant death syndrome (SIDS). By the time the 1995 edition of BW was printed, there was already a significant decrease in the SIDS rate. The latest statistic in the year 2000 shows that the SIDS rate had decreased by >40% largely due to the frequency of prone sleeping decreasing from >70% to ~20% of US infants (*Pediatrics*, March 2000, p. 650).

In the comparison chart, the 1998 edition statement still seems hesitant to give a full recommendation to place the infant on his back during sleep. In the 1998 edition it again states that SIDS is not "preventable" (BW p. 195). There are voluminous numbers of studies that have been done on SIDS since the AAPs' 1992 campaign proving that parents can do something to help prevent SIDS. This is only one of many medical issues in which Mr. Ezzo has been dangerously misleading. It is risky to trust his medical statements and opinions!

4. Bedsharing and Risk of SIDS

In the AAP statement, after "certain benefits," the words "such as encouraging breastfeeding" have been left out of the GFI comparison chart, which is an important reason for bedsharing. There are a number of studies that show a possible protective effect of human milk feeding against sudden infant death syndrome (*Pediatrics*, Dec., 1997, p.1036). Furthermore, the key phrase in the AAP statement is "under certain conditions." It had been well known that smoking, alcohol use, and drug use by a parent who is "bedsharing" with the infant increases the risk of SIDS. This same AAP policy statement states, "If mothers choose to sleep in the same bed with their infants, care

should be taken to avoid using soft sleep surfaces. Quilts, blankets, pillows, comforters, or other similar soft materials should not be placed under the infant" (*Pediatrics,* August, 1997, p. 273). Therefore, when these "certain conditions" (including prone sleeping) are avoided, the risk of SIDS while "bedsharing" is decreased. This is the point that is missing from the BW book. The "Crib Death" section of the BW book implies that it is against "bedsharing," and the AAP statement in the comparison chart leads the reader to believe that the AAP concludes that "bedsharing" increases the risk of SIDS. Actually, the AAP points out benefits to "bedsharing" and risk factors to avoid while "bedsharing," and does not condemn this practice.

Bonding

The BW book misrepresents the concept of bonding, "The theory concerns itself with ensuring that a new mother does not reject her offspring" (BW p. 192). BW refers to bonding as an "interesting psychological idea," (BW p. 192) while CYB states "researchers have labeled this the 'sensitive period'" (CYB p. 27). The context of the CYB statement is to reassure the mother who had a Caesarean birth or is sedated, or whose baby had to go to the nursery for medical attention, and NOT to say that babies do not need to bond with their mothers: "Bonding has no time limit" (CYB p. 27). The BW statement in the comparison chart says that this maternal-infant bonding relationship "is scientifically unacceptable." The CYB statement implies that this bonding process does in fact exist by such statements as, "helps lay the foundation for your relationship as parent and child," "core emotions. . . begin to develop during this brief period immediately after birth," and "this is part of the attachment process" (CYB p. 27).

AAP Breastfeeding Goals

Over several years, healthcare professionals, parents, and journalists have asked GFI to publish these studies they claim to have performed. The data cited in the comparison chart have not been published, which would allow for "peer review." One cannot accept as fact any statistics which have not been through a peer review process.

A statistician, Steve Rein, Ph.D., who has also investigated extensively this controversial parenting program, gave a critique of this so-called study by GFI:

"The study mentions 240 moms who use PDF and notes that 70 percent of them breastfeed (not necessarily exclusively) into the sixth month and compares that to data from *Pediatrics* which shows that across the US only about 20 percent of mothers breastfeed into the sixth month.

- "The sample of PDF babies was one of convenience. Such a sampling scheme brings with it the potential for bias. As an example, it points out that in the convenient sample, some 70% of moms breastfeed for at least 6 months. I would suggest that a typical LLL [La Leche League, a breastfeeding advocacy

organization] conference would contain at least 95% of mothers who have nursed their infants past the 6 month mark. The conclusion: either La Leche League is better than GFI or convenience samples give data of little value or both. Perhaps if it had been more clear about **how** the convenient sample had been obtained we could have a better idea of how representative the sample was of the population of PDF moms.

- "The sample wasn't just one of convenience from the population of those who had read Babywise or been through a Prep class. It was a sample of those who had successfully introduced the PDF schedule. We have no information about outcomes in infants whose mothers had attempted to use the PDF schedule but didn't meet the definition of "following the PDF method". This may be an unfortunate oversight, but I think that physicians and parents care about all those who attempt to use the method, not just those who use it and succeed. After all, if we only look at success stories and refuse to consider failures, we might think that bloodletting is the best cure for headaches. Hyperbole, sure, but it certainly does make the point.
- "Comparing a group of committed PDF followers to the general population in terms of breastfeeding rates is the apples versus oranges problem. Maybe if we could find a group of individuals who felt that feeding on demand was "God's Way" we could fairly assess the impact of PDF versus this other program. (Perhaps religious LLL members who feel that breastfeeding on demand is what God intended?)
- "The study nowhere defines "successful" breastfeeding but implies that at least some breastfeeding into the sixth month of life is a success. Might I remind him of the recent AAP statement which recommends that infants should be exclusively breastfeed into the 6th month. Again, without a comparable control group, such figures as the 70% it cites are essentially meaningless.
- "Even if a fact, 70% of PDF mothers breastfeeding at 6 months of age doesn't speak to the issue Dr. Aney [*AAP News*, April, 1998] raised. Namely, FTT. Many physicians and parents would also like to know of the risks before simply adopting such a method. I suspect in a case such as this one, if parents knew the true success and failure rates of the PDF method and of alternative methods (such as demand feeding), they would choose thoughtfully. I would again encourage Dr. Bucknam and Mr. Ezzo to allow lactation professionals to do a prospective study comparing the health outcomes of the infants who are subjected to their method and those who are subjected to demand feeding" (from www.mailing-list.net/redrhino/Ezzo/).

The same AAP Policy Statement that the comparison chart cites says, "Newborns should be nursed whenever they show signs of hunger, such as increased alertness or activity, mouthing, or rooting. Crying is a ***late*** indicator of hunger. Newborns should be nursed approximately 8 to 12 times every 24 hours until satiety, usually 10 to 15 minutes on each breast" (*Pediatrics*, Dec., 1997, p. 1036). The AAP has never recommended scheduled feeds, as does Mr. Ezzo. It is the scheduled feeding that leads to breast milk supply failure and therefore early weaning. In fact, for several years numerous healthcare professionals had noted an increase of mothers on the Ezzo program experiencing breast

milk supply failure by 3 to 4 months, as noted in a letter to the AAP signed by over 100 healthcare professionals (Letter of Concern, Feb. 1997). Since then I have encountered hundreds of healthcare professionals who continue to observe this same phenomenon.

Healthy Growth Indicators

The responses given in this topic mislead the reader to believe that the BW book gives more information on this topic than CYB. The reference is taken from a section in CYB titled "How Do You Know If Your Baby Is Getting Enough?" It discusses frequency of bowel movements, swallowing while feeding, sleeping a few hours right after feeding, and then a full discussion on weight gain: "Another way to judge your baby's intake over time is by weighing him once every week or two. During the first week of life, he may lose up to 7 to 10 percent of his birthweight (that's 6 to 12 ounces in an approximately 7 ½-pound full-term baby), but after that he should gain fairly steadily. By the end of his second week he ought to be back to his birthweight. . . . Once your milk supply is established, your baby should gain about 2/3 ounce a day during his first three months. Between three and six months, his weight gain will taper off to about ½ ounce a day, and after six months, it will drop even further. If your baby is gaining less than this, you should discuss the situation with your pediatrician. Depend upon the scale at your pediatrician's office for the most accurate measurements" (CYB p. 90 – 91).

The much more exhaustive and complete AAP book contains large sections of growth and development for each of the following ages: first month, one through three months, four through seven months, eight through twelve months, the second year, two to three years, and three to five years. These sections include healthy signs to look for, as well as signs to watch out for. A section found in CYB, "Too Little Feeding," lists six signs to watch out for (CYB p. 156). Furthermore, there is a "weight gain" section, which lists questions pertaining to proper weight gain in the first month (CYB p. 168). Also, growth charts for height and weight for all ages are provided on pages 122-125 and 294-297.

Weight Gain Concerns

The information from the above topic also relates to this topic. The CYB statement here gives the appearance that CYB does not contain very much information about weight gain. There is a "weight gain" section, which lists questions pertaining to proper weight gain in the first month (CYB p. 168). Also, there are sections titled "Physical Appearance and Growth" which include specific information on how much weight gain to expect for each of the following ages: one through three months, four through seven months, eight through twelve months, the second year, two to three years, and three to five years. Furthermore, growth charts for weight are found on pages 122, 124, 294, and 296.

As stated previously, for several years, healthcare professionals, parents, and journalists have asked GFI to publish these studies they claim to have performed. The data cited in

the comparison chart have not been published, which would allow for "peer review," and therefore cannot be accepted as fact. The same statistician, Dr. Steve Rein, has also critiqued this so-called study:

"This study also cites an internal study which compares the weight gain of 200 PDF and 200 demand fed babies noting no significant differences between the two groups.

- "Presumably, according to the study, it is significant that there is no significant difference between PDF and demand fed infants. Why, then, write a book critical of demand feeding? If PDF and demand fed kids are essentially the same, why bother with a schedule at all? (Of course, with a larger sample, we may, indeed, see statistically significant differences between the two groups. But no statistically significant difference in this moderately large sample means that even if there was a statistically significant difference between the two groups in a larger sampling, the difference we would not observe would not be clinically important.)
- "Again, how were the 400 infants selected? The point may be a bit belabored by now, but unless a clear protocol is presented and passed through peer-review, we have absolutely no idea that the two groups are comparable at all.
- "Even if PDF infants had gained weight better than demand fed (note: I'm still not quite sure which definition of demand feeding their study is using, the one in the first edition of his book which reads something like 'feed the baby at every cry but only then' or the one from the AAP that he recently said he agrees with) infants in a well designed study (which we don't know we have), we still wouldn't know that PDF is what helps the infants gain weight. One would need an experiment to determine this. Simply put, PDF followers may be of high socioeconomic status, highly motivated to 'follow the rules' and to 'do it right' and they may have a solid support network while the typical parent who claims to follow demand feeding in these four practices may have been poor and undereducated, not be as motivated to follow through on all aspects of their chosen method and entirely lacking in a support network. Like in the last two studies, a comparable control group, one with similar motivation as the PDF parents would provide us better information than the one we have here.
- "One of the reasons that the two groups may have had similar weight gain patterns, even if PDF were inferior to demand feeding is that the PDF infants, as a group, may very well have formula supplementation in far higher rates than the demand group. This would not be evidence of successful breastfeeding, but it would increase the typical calorie intake of infants who are not getting enough breastmilk on the PDF schedule" (from www.mailing-list.net/redrhino/Ezzo/).

Numerous healthcare providers have noted an increase of poor infant weight gain of babies on the Ezzo PDF program (see AAP District IV Resolution, and Letter of Concern, Feb. 1997).

At Home Parent Monitoring Tools
Healthy Baby Growth Charts

In the CYB column of the comparison chart it says, "None found." This is entirely misleading. According to the GFI comparison chart, the reader may assume that BW is more comprehensive and better than CYB. BW contains 217 pages and CYB contains 681 pages. In the first 255 pages of the more exhaustive and complete CYB book, information is given for the first year of life with lengthy descriptions of what to expect with regard to growth and development, basic care (including feeding), health watch (common illnesses for that age period), immunizations, and safety checks. The BW "Healthy Baby Growth Charts" are only for the first 10 weeks. These charts are helpful for "checking" the baby's urination, bowel movements, nursing minimum, and nursing length of time. The vital information for these topics is not found in a chart form in CYB, but is given in the text on the following pages: pages 44-46 (urination), pages 47-48 (bowel movements), pages 89-91 (urination and bowel movements), and pages 87-89 (nursing minimum and nursing length of time). Furthermore, the baby's weight is one of the most important factors of monitoring growth. "Breastfed babies behave a little differently in that they do not always cry when they are hungry, and the only way to be sure yours is getting enough milk is to watch his weight gain" (CYB p. 155). Therefore the AAP book has included the weight growth chart for infants on p. 122. BW does not contain this growth chart.

These "Healthy Baby Growth Charts" in BW may be helpful for some parents. Unfortunately, because of the confusing, conflicting, and medically erroneous statements in the book, some parents following the BW advice still have difficulty determining what is normal and what is abnormal, as proven by the numerous cases of early weaning, poor infant weight gain, dehydration, and failure to thrive babies observed when on the Ezzo program (see Letter of Concern, Feb. 1997, and AAP District IV Resolution).

Warning Signs of Failure to Thrive

In the CYB column of the comparison chart it says, "Discussion of FTT was not found." This is false! There is a discussion on failure to thrive on pages 674-675. It advises the parent to "plot your child's weight and measurements." Also, "Regular charting of your child's growth and comparison of her general development with others her age is the best way to make sure she is thriving." This can be done on the growth charts provided in CYB. Unfortunately, these growth charts are not found in the BW book. Among other helpful information, this discussion also gives possible etiologies to consider if your baby is not gaining weight properly.

Also, in the CYB column of the comparison chart it says, "a few guidelines designed to help parents determine if the baby is starting to lose weight are located on page 149." This is actually located on pages 155-156.

The "Monitoring Your Baby's Growth" chapter in BW gives possible causes for failure to thrive. One cause given is feeding too frequently, which is absurd and contrary to current medical knowledge and advice. Another cause given is feeding too infrequently. It says that one problem of feeding too infrequently "is that some demand-fed babies

demand too little food. As a result, the mother's breast is not sufficiently stimulated for adequate milk production. Routine feedings with a time limitation between feedings eliminates this problem. That's why neonatal and intensive care units stay close to a three-hour feeding schedule. It's healthy" (BW p. 97). This is another troubling, medically erroneous statement. This probably stems from another erroneous medical statement, "A mother who takes her baby to her breast twelve, fifteen, or twenty times a day will not necessarily produce any more milk than the mom who takes her baby to breast eight or nine times a day" (BW p. 67). The treatment for breastfed failure to thrive babies is to work on increasing the mother's milk supply. The "supply and demand" physiological property of breast milk production has been well researched for decades. Breastfeeding more frequently, pumping the breasts, avoiding supplements, avoiding bottles and pacifiers, among other proven methods is standard medical/lactation practice for failure to thrive babies. Breastfeeding less frequently could put this type of baby in danger. Furthermore, neonatal and intensive care units would never put a failure to thrive baby on a three hour feeding schedule. Babies with other problems are sometimes fed every two to three hours in a hospital neonatal unit for the nurses convenience, NOT because that is what is "healthy." That is, the nurses in these units are not performing "unhealthy" practices, but rather the baby's particular diagnosis or nutritional need may not require her to nurse more frequently. Furthermore, in a hospital nursery, many physical signs and nutritional factors are carefully monitored around the clock.

I have been involved in investigation and research into the controversy surrounding the infant feeding program implemented by Gary Ezzo. I have encountered hundreds of lactation consultants and other healthcare providers across the country, as well as in other countries, who have noted an unprecedented increase of mothers on the Ezzo program experiencing failure to thrive. In fact a letter to the AAP, signed by over 100 healthcare professionals, cited observation of this same phenomenon (see Letter of Concern, Feb. 1997), and "numerous physicians, lactation professionals, midwives, pastors, and parents have reported cases of FTT in infants associated with this program" (AAP District IV Resolution).

Failure to thrive can be a serious problem which often occurs gradually and subtly without the parents' recognition that there is a problem. Information on this topic is best obtained from a pediatrician, not an uneducated author.

None of the failure to thrive cases I investigated had been investigated by GFI, even though many had been brought to their attention. GFI could be compared to a pharmaceutical company in that their product (an infant parenting program) could be compared to a medication or vaccine. Occasionally pharmaceutical companies have to remove a product from the market because of a mere handful of people having bad side effects, even though hundreds of thousands of people did not have any side effects. One such recent example in pediatrics was the Rotavirus vaccine. Approximately 1.5 million doses of this vaccine were administered, and after ten months only 15 cases of intussusception had been reported. Nevertheless, this manufacturer voluntarily withdrew the vaccine from the market (*Pediatrics,* July 2000). Conversely, GFI has made the decision to completely ignore the unfortunate negative outcomes from their product.

Summary

This analysis points out many discrepancies between the AAP's *Caring for Your Baby and Young Child* and *On Becoming Babywise.* Some of the information on the GFI comparison chart is misleading, taken out of context, and false. There are many other topics where the information in BW is inconsistent with the AAP, but only the topics in the comparison chart are included here. This analysis was necessary since many Ezzo followers refer to this comparison chart from GFI when questioned about standard medical practice on these topics. The reader is encouraged to investigate the validity of this analysis on their own.