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Concerning conclusions that may negatively impact on safe sleeping, successful breastfeeding, parent wellbeing and open communication between health professionals and parents

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Dear Editor,

The paper published in your journal by Carpenter et al [1], claims to resolve uncertainties associated with bedsharing and SIDS. We believe however, it does little other than fuel further confusion in the minds of parents and the health professionals charged with providing them with information and support.

As outlined in other letters the authors chose to use a selection of older studies (data collected between 1987 and 2003) in their analysis that contained incomplete data on key variables such as alcohol, substance and medication use. Whereas a 2009 British study by Blair et al. [2] did collect data on smoking, alcohol, prescribed and illegal drugs in the 24 hours prior to death. These researchers did not find an increased risk for bedsharing and SIDS when these variables and other hazardous cosleeping arrangements, such as sofa and chair cosleeping were excluded. Instead they found that the number of babies bedsharing in the SIDS group (6%) was actually lower than in the control group where there were no deaths (10%).

It is also problematic that the older studies analysed by Carpenter et al. also used variable definitions for SIDS and for bedsharing and did not report breastfeeding data except in a few studies where only initiation data was collected. The lack of detail on how the breastfeeding data in Carpenter et al's analysis was obtained and what operational definitions were used for exclusive, partial and initiation of breastfeeding were not made available. Due to the known impact breastfeeding has on the prevention of SIDS [3] the lack of detail in this area places significant limitations on the study's findings.
Additionally the author's explanation of the saving of health costs associated with the reduction in bedsharing in relation to its effects on successful breastfeeding completely overlooks the very broad range of morbidities and mortalities that breastfeeding protects against across the lifespan. Likewise there is no acknowledgement when quoting unpublished data from the Netherlands, where there are active campaigns against bedsharing, that there is a strong likelihood that parents would not disclose their bedsharing activities due to fear of censure, resulting in significant potential for under reporting of bedsharing.

Furthermore there is an unhelpful emphasis on the comparably small risk for SIDS they have calculated from their analysis in relation to bedsharing. This potentially leads the novice reader, media and health consumer to conclude these results, and the author's subsequent finding that bedsharing should never be undertaken in any circumstance, are irrefutable. In reality, the significant limitations imposed by the study design make such a conclusion most inappropriate. Even the attempt to soften this conclusion by the authors saying they do not suggest babies shouldn't breastfeed in bed, only that they shouldn't fall asleep in bed, shows significant lack of insight into the realities and pressures of night time parenting.

Removing the option of bedsharing as a commonly used night-time parenting strategy is likely to have significant effects on the wellbeing of parents. It is also likely to impact negatively on successful breastfeeding, a factor associated with reduced infant mortality and morbidity, and may create a riskier sleep environment for some babies, when parents fall asleep on sofas or armchairs while trying to follow the authors' advice of 'never bedsharing'. The lack of acknowledgement of these important issues in the authors' discussion, overlooks important health promotion opportunities.

Consequently, we are most concerned by the message this paper sends to the general community. Mothers have already indicated in previous research [4] that advice against any form of bedsharing doesn't ring true for them and those who do decide to bedshare would not now disclose their intentions to health professionals. Such a response to the blanket advice against any bedsharing shuts down communication channels with parents and removes the opportunity for health professionals to have open discussions regarding safe sleeping options. Health professionals have also reported policies requiring them to advise against any bedsharing did not allow them to accept and respond to the realities of people's lives and negotiate low risk alternatives that were appropriate to their individual situations (4). As health professionals were then unable to meet parent's needs in this respect this created feelings of personal conflict and moral tension in having to comply with such policies.

Evidence based practice has been defined as the integration of best research evidence, clinical expertise and patient values [5]. The authors have proposed a risk elimination approach to the complex issue of bedsharing in this paper, which is not evidence based and will not be effective in reducing infant deaths for three key reasons: 1) current evidence is not reflected for low risk families; 2) bedsharing is a valued cultural practice in many communities including those of low and high risk; and 3) the practicalities of where mothers feed their babies at night needs serious consideration so that we do not introduce recommendations that actually increase risk for babies.

A consistent national risk minimisation approach to co-sleeping, in which the values and circumstances of families is integrated into the informed decision making process [6], is the only responsible and ethical approach to address this issue [7], and is required if we are going to succeed in further reducing sudden
infant deaths associated with shared sleeping environments.

We are extremely disappointed with the conclusions reached by the authors of this study and the potentially negative impact it may have on safe sleeping, successful breastfeeding, parent wellbeing and open communication between health professionals and parents.


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None declared

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