Women and Birth 29 (2016) 138–143

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUALITATIVE

Barriers and facilitators for vaginal breech births in Australia: Clinician's experiences

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ARTICLE INFO

Article history:
Received 11 August 2015
Received in revised form 14 September 2015
Accepted 21 September 2015

Keywords:
Vaginal breech birth
Interdisciplinary care
Qualitative research
Obstetric care
Midwifery

ABSTRACT

Background: Since the Term Breech Trial in 2000, few Australian clinicians have been able to maintain their skills to facilitate vaginal breech births. The overwhelming majority of women with a breech presentation have been given one birth option, that is, caesarean section. The aim of this study was to explore clinician's experiences of caring for women when facilitating a vaginal breech birth.
Methods: A descriptive exploratory design was undertaken. Nine clinicians (obstetricians and midwives) from two tertiary hospitals in Australia who regularly facilitate vaginal breech birth were interviewed. The interviews were analysed thematically.
Results: Participants were five obstetricians and four midwives. There were two overarching themes that arose from the data: *Facilitation of* and *Barriers to vaginal breech birth*. A number of sub-themes are described in the paper.
Conclusions: In order to facilitate vaginal breech birth and ensure it is given as an option to women, it is necessary to educate, upskill and support colleagues to increase their confidence and abilities, carefully counsel and select suitable women, and approach the option in a calm, collaborative way.

Summary of Relevance:

Problem

There is little known about clinician's experiences of caring for women who have vaginal breech births at term.

What is Already Known

Few women are given the option of a vaginal breech birth, and few clinicians are skilled in facilitating this option.

What this Paper Adds

There are a number of facilitators and barriers that occur when enabling a vaginal breech birth for women. There is a need to creatively upskill clinicians, impart how to carefully counsel and select women, and promote a collaborative, team approach.

1. Background

It is estimated that breech presentations occur in 3–5% of pregnant women at the end of their pregnancy.[1] Data from one Australian state (New South Wales) indicates 0.4% of babies in the breech position were born vaginally, with the remainder being born by caesarean section, mostly electively before the onset of labour.[2] The small number of breech babies born vaginally is reflected in other jurisdictions in Australia as well as in many high income regions around the world.[2–4]

There has been a notable decrease in the number of vaginal breech births (VBB) following the release in 2000 of results from the Term Breech Trial (TBT)[5] which concluded that caesarean section was the safest mode of birth for babies in the breech presentation. The almost immediate response in maternity units in many parts of the world was an increase in caesarean section for breech birth and, subsequently, a decline in the number of clinicians with the skills and confidence to attend vaginal breech birth.[4,6] Researchers have since cited significant flaws in the design and recommendations of this study.[4,6–8] More recently, research has concluded that VBB is a safe option for women who meet specific criteria and who are cared for by clinicians equipped to

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http://dx.doi.org/10.1016/j.wombi.2015.09.004
1871-5192/

provide appropriate care and expertise.[9–15] However, the number of clinicians who are skilled in VBB facilitation has decreased to very low levels.[4,6,7] This means that pregnant women with babies in the breech presentation have few options regarding mode of birth.

Vaginal breech births are more common in low resource countries due to lower uptake of antenatal care, lack of access to health professionals and facilities to conduct a caesarean section. Hence, clinicians in these countries have maintained their skills in this area. However, clinicians have been able to maintain their skills at facilitating VBB in some high resource countries too. For example in Norway, an expert group in 2003 published results of the country's perinatal morbidity and mortality in term breech infants showing that this was a safe option, and because of this, access to VBB has been maintained in this country.[16] This shows that national guidelines[17] can have power over clinical practice. In Australia, there is no governmental clinical guideline or report that outlines the options of care for women with a term breech pregnancy that includes VBB.

In the most populous Australian state, NSW, there are a small number of facilities that give the option of planned VBB to women with a breech presentation at term. These facilities are led by clinicians who have maintained experience in VBB and, despite trends reflected elsewhere, continue to support women who seek a VBB. This cohort of clinicians understand the challenges of continuing to provide a breech service against the dominant paradigm of caesarean section for breech. The aim of this study was to describe the experiences of clinicians providing this service at these facilities and explore the barriers and facilitators to the provision of a vaginal breech birth service.

2. Methods

This study used a qualitative descriptive methodology to describe clinician experiences with women planning vaginal breech births. A descriptive exploratory design provides direct information about an event or a service, and places less emphasis on interpretation or abstraction than other types of qualitative methods.[18] This design is also useful when investigating experiences and events that have previously not been examined, and as such focusses on the 'who', 'what', 'why' and 'where' issues. Qualitative descriptive methodology aims to present a comprehensive summary of events as experienced by the participants. Ethical approval was received from the Human Research Ethics Committee – Northern Sector, South Eastern Sydney Local Health District, NSW Health (reference: HREC 12/072, HREC/12/POWH/163).

2.1. Setting

The study was undertaken through two major teaching hospitals in NSW. These settings were chosen as the clinicians at both these sites have considerable experience in vaginal breech birth and both facilities regularly offer vaginal breech to women. A vaginal breech birth, in this context, involves women being active and mobile, having continuous foetal monitoring especially in second stage, sometimes having an epidural anaesthetic, and being in an upright position for labour and birth. Clinicians facilitate VBBs without intervention, unless progress is delayed or the foetal condition warrants hands-on management.

2.2. Participants

Participants were clinicians who have counselled women planning a VBB and had cared for women with planned or unplanned vaginal breech presentation in labour in the past 5 years. Five years was deemed to be a period of time that would allow clinicians, who worked within a 'breech clinic' where women were referred for this mode of birth, to develop experience in caring for women having a vaginal breech birth. Five years was also a pragmatic timeframe as it indicated some level of recent experience. Purposive sampling was used as the study was designed to elicit views from individuals who had provided the service being studied.

A recruitment flyer was distributed to the antenatal and birth areas of the two hospitals. The flyer invited eligible participants (doctors and midwives) to participate in a face to face interview. Interested clinicians were asked to contact the principal investigator who arranged for the information sheets and consent forms to be provided.

2.3. Data collection

Data were collected using in-depth semi-structured interviews, and these were recorded using a digital voice recorder. A number of questions were used, and further probing questions were asked as needed throughout the interviews. The trigger questions were focused around the clinician's care of women and how they felt about their work, for example, 'tell me about your working environment in relation to caring for women having a vaginal breech birth'.

2.4. Data analysis

Data were de-identified and transcribed by a professional transcription service and then analysed using an interpretative framework.[18] Notes were initially taken on the participants responses to the questions before detailed coding took place. Transcriptions were read a number of times, and comments coded initially into concepts, then sub-themes, and lastly major themes. The themes were discussed with the research team and modified after discussion and a re-visiting of the raw data. The preliminary themes were provided to a group of clinicians (midwives and obstetricians) at an international conference as part of a presentation to see if they felt plausible. Questions and discussion at the conference and subsequently with the research team refined the major themes and sub-themes.

3. Findings

The participants included nine clinicians: five obstetricians and four midwives who were involved in caring for women who had a VBB. Individual clinicians had between three and more than 20 years of experience in caring for women with a breech presentation late in pregnancy and almost all ($n = 8$) had been providing this service at their current facility for more than three years.

There were two major themes which described the 'barriers' and 'facilitators' to VBB. Themes of collaboration, appropriate risk-based counselling and issues in leadership, training and exposure to VBB were identified. Participants articulated the many barriers and facilitators to VBB that they had encountered within their workplace to provide a VBB service (see Fig. 1).

3.1. Barriers

Many barriers were in relation to the fact that not all clinicians in their workplace were as enthusiastic about VBB as they were and this had created challenges in providing the service. Hence the barriers to facilitating a VBB centred on entrenched attitudes, lack of skills, and fear and anxiety of other clinicians. Combinations of these barriers were then thought to lead to suboptimal care which