Midwifery 41 (2016) 61–67

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Midwives' views, experiences and feelings of confidence surrounding vaginal breech birth: A qualitative study

Ruth Sloman, RM, RN, MSc (Midwife)[a,*], Marta Wanat, PhD (Post-Doctoral Researcher)[b,1], Ethel Burns, RM, PhD (Senior Lecturer Midwifery)[a], Lesley Smith, PhD (Reader Maternal and Women's Public Health)[b]

[a] Department of Psychology, Social Work and Public Health, Oxford Brookes University, Jack Straws Lane, Marston Road, Oxford OX3 0FL, UK
[b] Department of Clinical Healthcare, Oxford Brookes University, Jack Straws Lane, Marston Road, Oxford OX3 0FL, UK

ARTICLE INFO

Article history:
Received 18 January 2016
Received in revised form
18 July 2016
Accepted 31 July 2016

Keywords:
Intrapartum care
Maternity practice
Focus groups

ABSTRACT

Objective: to explore midwives' views, experiences and feelings of confidence surrounding vaginal breech birth (VBB).
Design: a qualitative study was conducted with 12 participants using three focus group discussions. Data were transcribed verbatim and thematic analysis was used to analyse the data.
Setting: UK midwives were recruited from different geographical areas who worked in community areas, hospital areas and as independent practitioners.
Findings: three themes were identified. Firstly, midwives viewed VBB in dimensions of normality, perceiving it to be an unusual norm on one hand while also acknowledging potential problems. Secondly, midwives expressed varied feelings of preparedness; the majority feeling inexperienced and underprepared with VBB, yet more confident when supported by other colleagues. Lastly, midwives described restrictions on women's choice of VBB; perceiving other practitioners as limiting women's choices through coercion, yet providing a balanced choice themselves.
Conclusions: there should be an opportunity for midwives to be mentored by a more experienced practitioner in VBB. Practice areas should develop a guideline for VBB which acknowledges the role of the midwife in facilitating normal breech birth. Balanced written and verbal information on VBB may further assist decision making for women considering a VBB. Education in VBB should focus on learning what is normal for VBB and must emphasise the importance of teamwork and understanding roles within multidisciplinary teams.

Introduction

It is estimated that 3–5% of women have a breech presentation at term gestation (Hofmeyr et al., 2015a). The publication of the Term Breech Trial (TBT) (Hannah et al., 2000), sparked a global decline in vaginal breech birth as clinicians implemented its recommendation that women with a breech presentation be delivered by caesarean section (Steen and Kingdon, 2008). However, a two year follow-up of the TBT showed that the perinatal protective effect of planned caesarean did not reduce the risk of death or developmental delay at two years of age (Whyte et al., 2004). Further evidence emerged which exposed methodological flaws of the TBT (Keirse, 2002; Roosmalen and Rosendaal, 2002; Glezerman, 2006) alongside support for vaginal breech birth (VBB) for healthy women who experience an uncomplicated pregnancy (Goffinet et al., 2006; Borbolla Foster et al., 2014; Berhan and Haileamlak, 2015; Mattila et al., 2015).

Following the diagnosis of breech presentation, women are often referred for external cephalic version (ECV) as this increases the likelihood of a vaginal birth and reduce the need for a caesarean section (Hofmeyr et al., 2015b). Despite the recommendation that women have the option for an ECV, VBB inevitably occurs in practice; either when a woman presents undiagnosed in labour, too late for a caesarean, or through maternal choice (Hemelaar et al., 2015). Furthermore, UK guidelines do not recommend routine caesarean for pre-term breech or breech presentation of the second twin (Royal College of Obstetricians and Gynaecologist (RCOG), 2006). In the UK, the Nursing and Midwifery Council (NMC) recommends that midwives should be competent in

* Corresponding author. Present address: Maternity Department, Kisiizi Hospital, Rukungiri, 109, Kabale, Uganda.
E-mail addresses: ruth.sloman@googlemail.com (R. Sloman), marta.wanat@psych.ox.ac.uk (M. Wanat), eburns@brookes.ac.uk (E. Burns), lesleysmith@brookes.ac.uk (L. Smith).
[1] Present address: Department of Psychiatry, University of Oxford, Oxford, OX3 7JX.

http://dx.doi.org/10.1016/j.midw.2016.07.015
0266-6138/

assisting women having a vaginal breech birth (NMC, 2009). The presence of an experienced clinician at childbirth is shown to reduce the risk of adverse perinatal outcomes for VBB (Su et al., 2003; Goffinet et al., 2006). However, with the declining incidence, there is a high level of concern regarding the safety of VBB due to the loss of practitioner's skills (Cronk, 1998; Kotaska, 2007) despite the implementation of simulation training (Hunter, 2014).

There is little known about midwives' views, experiences and feelings of confidence surrounding VBB, other than opinions and anecdotes (Cronk, 1998; Evans, 2012; Walker, 2012). A review of the literature revealed one qualitative study conducted in Jamaica (Founds, 2007), showing that providers interpreted breech as abnormal and associated it with underlying pathology (and hence, worse outcomes). However, the study was conducted in rural Jamaica with limited resources and it did not solely focus on midwives and therefore is unlikely to reflect the experiences of midwives in the UK. Consequently, this study aimed to explore midwives views, experiences and feelings of confidence surrounding VBB in the UK, in order to improve clinical practice and education in relation to VBB.

Methods

Design and participants

A qualitative methodology was chosen to uncover the complexities and interactions of midwives views, experiences and feelings of confidence surrounding VBB. The research was advertised in community and acute areas of local hospitals within a trust via posters and newsletters and also on an online independent midwives forum. A voluntary, purposive sample was sought which selected midwives with varying ages and experience and from community, hospital and independent areas of practice (see Table 1). Midwives were eligible for the study if they were English speaking, currently practising and had at least one year of experience as a licensed midwife. A criterion of a minimum number of VBBs that midwives had experienced was not possible due to the reduced incidence of VBB and concerns about feasibility of recruiting sufficient midwives within the projected timescale for the study. Also, the researcher was interested in participants' perceptions of their skills, feelings of confidence and views of how simulated training may contribute to midwives' feelings of confidence. Midwives responded to the research advert via phone and email, whereby they were provided with detailed written information about the study and then invited to attend a focus group at a time convenient to them. Recruitment lasted six weeks in which 19 midwives volunteered, however seven were unable to participate due to midwifery shift patterns and on-calls; leaving 12 participants (ten local midwives and two midwives from South and South-West England).

Data collection and setting

Data were collected during August 2013, transcribed in September and then analysed from January- March 2014. Focus groups discussions were chosen as they provide insights into different views and how people collectively make sense of a topic; thus fitting the exploratory nature of the study (Braun and Clarke, 2013). Each focus group lasted between 1-1.5 hours. The venue was a private and comfortable room at the university and was chosen as it was known to hospital and community midwives and provided a neutral setting for independent midwives coming from other areas. RS was the moderator for all groups and a discussion guide composed of semi-structured questions was utilised, ensuring the aims of the study were met and allowing midwives to express views in their own way (Krueger and Casey, 2009; Hennink et al., 2011). The discussion guide included key questions asking midwives to recall their experiences and views of VBB; the education received and their experiences of assisting women's choices. All groups were audio recorded and transcribed verbatim by the researcher.

Data analysis

Thematic analysis was chosen to analyse the data set; whereby the data set was searched to find repeated patterns of meaning which were then grouped as themes to provide a rich description and interpretation of the data (Braun and Clarke, 2006). Firstly, transcripts were read and listened to several times to familiarise with the data. Then semantic and latent codes were applied to form explicit and interpretative meanings of the data (Braun and Clarke, 2013). The codes were then organised into themes through a recursive process of reviewing the data at a conceptual level. Computer software NVivo10 (QSR International) was used to organise the data.

Preliminary findings were emailed to the participants, whereby some participants clarified uncertainties and adjustments were made accordingly. In addition, the themes were discussed with an experienced researcher and a reflection journal was used throughout the study in order to 'bracket-off' the researcher's experience (Flick, 2009).

Ethical considerations

The study was approved by Oxford Brookes University Faculty of Health and Life Sciences Ethics Committee and the local trust Research and Development Department, thus complying with international ethical standards. Written, informed consent was

Table 1
Characteristics of participants' in each focus group.

Focus Group number	Area of work	Age	Years' experience as a midwife	Number of women cared for having a VBB (live births)
1 (P1–P4)	Community**: 1**	Range:	Range:	Range:
	Hospital (MLU* + delivery suite): **1**	**34–58 yrs**	**6 ½ –16 yrs**	**3–6**
	Independent midwifery: **2**	Mean:	Mean:	Mean:
		43 ¼ yrs	**11 ½ yrs**	**4 ¾**
2 (P5–P8)	Community**: 1**	Range:	Range:	Range:
	Hospital (MLU + delivery suite): **2**	**29–56 yrs**	**3–24 yrs**	**4–11**
	Independent midwifery: **1**	Mean:	Mean:	Mean:
		48 ¼ yrs	**13 ¾**	**5 ½**
3 (P9–P12)	Community**: 3**	Range:	Range:	Range:
	Hospital (MLU + delivery suite): **0**	**46–53 yrs**	**8–33 yrs**	**3–30**
	Independent midwifery: **1**	Mean:	Mean:	Mean:
		50 ½ yrs	**20 ¼ yrs**	**16 ⅓**

* Midwifery-led unit (within hospital).