



Standards for maternity care professionals attending planned upright breech births: A Delphi study [☆]



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ABSTRACT

Objective: to establish a consensus of opinion on standards of competence for professionals attending upright breech births.

Design: a three-round Delphi e-survey.

Setting: multinational.

Participants: a panel of 13 obstetricians, 13 midwives and two user representatives. Clinicians had attended > 20 upright breech births, or > 10 upright among > 40 total breech births. Mean level of experience = 135 breech births, median = 100 breech births.

Methods: an initial survey contained open-ended questions. Answers were coded and amalgamated to form 164 statements in the second round and 9 further statements in the third round. Panellists were asked to evaluate their agreement with each statement using a 5-point Likert scale. The pre-determined level of consensus was 70% of respondents indicating agreement or strong agreement with the statement.

Findings: the panel returned a consensus-level agreement on 63 statements under the theme, 'Standards of Competence.' Panellists supported teaching breech as a 'normal' skill rather than an emergency, including optimal mechanisms and breech-specific progress measures, upright variations of classical manoeuvres, the initiation of resuscitation with the umbilical cord intact, birth videos as learning tools, and the development of breech teams to support the wider team in all maternity care settings.

Conclusions: although every health professional should maintain basic competence to assist unanticipated breech births, establishing enhanced training and standards for those who support planned breech births may help protect users and providers of maternity services, while introducing greater choice and flexibility for women seeking the option of vaginal breech birth.

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Introduction

Mode of birth for breech presentation (approximately 3–4% at term) remains the subject of much controversy. Vaginal breech birth (VBB) carries a two- to five-fold greater relative risk of short-term morbidity and mortality than caesarean section (CS) (Berhan and Haileamlak, 2016), but long-term outcomes (serious neuro-motor delay or death at two years) appear similar when either VBB or CS is

planned (Hofmeyr et al., 2015). Despite the unfavourable short-term comparison to CS outcomes, a recent meta-analysis demonstrated that the absolute risk of VBB is lower and more similar overall to cephalic vaginal birth than previously believed, with 0.3% perinatal deaths from 75,193 deliveries (Berhan and Haileamlak, 2016). The further issue of increased risks in future pregnancies due to a scarred uterus means that VBB remains some women's preferred option (Guittier et al., 2011; Homer et al., 2015). It may also be the only option where breech presentation is diagnosed late in labour. As noted by the most recent Cochrane Review on the topic, strategies to reduce the risk of VBB by means other than CS remain important (Hofmeyr et al., 2015).

Another area of controversy concerns the most advantageous position for the mother to use when a VBB does occur. On the basis of the majority of providers' experience, the United Kingdom Royal College of Obstetricians and Gynaecologists (RCOG) guidelines currently explicitly recommend lithotomy (RCOG, 2006). However, the

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RCOG note some very experienced providers suggest upright maternal positioning (eg. mother kneeling, hands/knees, on a birthing stool, standing) affords physiological advantages (Banks, 2007; Evans, 2012; Louwen et al., 2012). In addition, service user representatives and mothers telling their own stories have advocated for more choice with regard to VBB and maternal positioning (Berkley, 2006; Thurlow, 2009). These calls for more flexibility resonate with research indicating that women feel a lack of involvement in decision-making around the time of birth when in lithotomy position (Molkenboer et al., 2008), that choice of position is restricted for breech births more than for cephalic births (Toivonen et al., 2014) and that upright positioning may lead to greater maternal satisfaction in childbirth (Thies-Lagergren et al., 2013).

However, although enabling women to make an informed choice about both mode of birth and position of birth is an important ethical principle, professionals are also required to practice within the limits of their own training and competencies (NMC, 2012; General Medical Council, 2013). The achievement of clinical competence in even mainstream lithotomy methods of breech delivery is a real concern given the decline in VBBs over the last few decades (Thornton, 2002; Paterson-Brown and Howell, 2014). The research reported in this manuscript addresses a need to consider the contextualised meaning of competence adequate for the safe support of planned VBBs in contemporary maternity care.

Further objections to the use of upright and active maternal positioning for VBBs revolve around the lack of evidence for the efficacy of this practice (Beech, 2003). Although MRI pelvimetry studies support the theory that upright and active positioning create greater space in the pelvis (Reitter et al., 2014), only limited comparative safety data is available from practice. One small study has indicated that hands and knees maternal positioning significantly reduces severe perineal trauma with no clinical difference in neonatal outcomes compared to classical lithotomy methods (Bogner et al., 2015), but larger studies are needed to confirm these observations. On the other hand, lack of significant comparative data also provides little justification for the continued intervention of lithotomy position in place of maternal choice of birth position, recommended for other normal births (NICE, 2014). Impetus for a cultural shift to include training in active maternal positioning for VBBs will require more definitive safety research. Potential trials exploring the effects of maternal positioning and professional training on outcomes for VBB require the intervention to be well defined, including a full description of standards of professional practice and competence; this research seeks to provide that description.

Methods

A Delphi e-survey was used to establish a consensus of opinion among breech-experienced midwives and obstetricians on standards of competence for professionals attending upright VBBs. The purpose of the Delphi method is to develop consensus through a series of sequential questionnaires known as 'rounds', interspersed with controlled feedback. Initial data from open-ended questions is coded and amalgamated to formulate statements, which are then put to the panel for evaluation in subsequent rounds. The process continues until a pre-determined level of consensus is achieved, usually over three rounds. This methodology is particularly useful when, due to a lack of available empirical evidence, a structured group opinion is sought, but convening the desired group is practically difficult. The Delphi method has been applied in many areas of medical and midwifery practice, including analysis of professional characteristics and competencies, developing education programmes, exploring clinical skills, and enabling expansion of the midwifery sphere of practice to include a specialist skill set (Thompson et al., 2011; Michels et al., 2012; Eskes et al., 2014; Walker et al., 2015).

Participants

The perceived expertise of the panel underpins the credibility of the Delphi method, and therefore sampling is a fundamental methodological concern that is described in detail (Cornick, 2006; Hasson and Keeney, 2011). This study prioritised experience in the niche area of practice under consideration. The selection criteria for inclusion on the panel of experienced practitioners was: 1) attendance at a minimum of 20 upright VBBs or at least 10 upright VBBs and a minimum of 40 VBBs overall; and 2) involvement in teaching about VBB. *Upright breech birth* was defined as a vaginal breech birth in which the woman is encouraged to be upright and active throughout her labour, and is able to assume the position of her choice for the birth. The number 20 was chosen based on the career total of 25 VBBs attended by Mary Cronk, MBE, referred to as one of 'the most skilled midwives in the UK' in a published report of a breech birth conference that took place at the RCOG in 2004 (Beech, 2003). The criteria was modified to 10 upright and 40 total to enable the inclusion of more experienced obstetricians on the panel.

Seventy-eight potential panellists were identified initially from a review of recent literature concerning VBB and conference activities (*purposive sampling*). Invites were sent to professionals who had published recent peer-review articles concerning VBB management or observational series, or spoken at conferences concerning VBB. It was often not possible to determine if upright positions were part of these professionals' practices, or to what extent, so this criteria was not applied during these recruitment activities. Each respondent from this initial group was also asked to nominate others in their professional network important to include in the research, and each of the additional 45 professionals who were not already contacted were invited to participate (*network sampling*). The response rate to these invitations was 46% (56/123). Finally, information about the research was posted on social media sites: Coalition for Breech Birth (Facebook), Breech Birth Network (Facebook), Breech Birth Professionals (LinkedIn), and the breechbirth.org.uk website (*social media sampling*). This resulted in another 23 expressions of interest. Of the initial 79 respondents, 40 did not join the panel due to the eligibility criteria. The recruitment process resulted in:

- purposive sampling: 29 expressions of interest and 22 participants
- network sampling: 4 expressions of interest and 2 participants
- social media sampling: 6 expressions of interest and 4 participants.

Delphi surveys in niche areas of professional practice typically involve small panels; approximately 20 participants are considered acceptable, and the inclusion of service users is recommended (Baker et al., 2006; Walker et al., 2015). Multiprofessional panels are preferable, to ensure that no professional interest alone

Table 1
Self-reported experience levels of panel members.

	Years of experience	Total breech births	Breech births in upright positions
All	693	3511	2030
Range	5–60	20–400	8–400
Mean	27	135	78
Median	25	100	30
Midwives	335	1116	904
Range	5–50	20–400	10–400
Mean	27	86	70
Median	25	50	25
Obstetricians	338	2395	1126
Range	12–60	40–400	8–225
Mean	25	184	87
Median	22	150	60

Two service user representatives were also included on the panel.

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