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Care during the decision-making phase for women who want a vaginal breech birth: Experiences from the field

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ABSTRACT

Background: few women are given the option of a vaginal breech birth in Australia, unless the clinicians feel confident and have the skills to facilitate this mode of birth. Few studies describe how clinicians provide care during the decision-making phase for women who choose a vaginal breech birth. The aim of this study was to explore how experienced clinicians facilitated decisions about external cephalic version and mode of birth for women who have a breech presentation.
Methods: a descriptive exploratory design was undertaken with nine experienced clinicians (obstetricians and midwives) from two tertiary hospitals in Australia. Data were collected through face to face interviews and analysed thematically.
Findings: five obstetricians and four midwives participated in this study. All were experienced in caring for women having a vaginal breech birth and were currently involved in providing such a service. The themes that arose from the data were: *Pitching the discussion*, *Discussing safety and risk*, *Being calm* and *Providing continuity of care*.
Conclusions: caring for women who seek a vaginal breech birth includes careful selection of appropriate women, full discussions outlining the risks involved, and undertaking care with a calm manner, ensuring continuity of care. Health services considering establishing a vaginal breech service should consider that these elements are included in the establishment and implementation processes.

Background

The Term Breech Trial was devised to establish the safest mode of delivery for women with a breech baby. This randomised control trial was conducted in a number of countries with the primary outcomes being neonatal death and morbidity. The trial concluded that caesarean section was the safest option for the birth of breech-presenting babies (Hannah et al., 2000).

The immediate effect of the Term Breech Trial was that many maternity facilities in high and middle income countries across the world ceased offering vaginal breech birth (VBB) as an option for women and the default management for breech birth became caesarean section (Kotaska, 2007; Lawson, 2012). Since the trial was published, there has been significant critique of its design and recommendations (Hauth and Cunningham, 2002; Kotaska, 2004; Glezerman, 2006, 2012; Lawson, 2012) and despite the initial differences in neonatal outcomes compared to those born by caesarean section, a follow-up study showed no difference in the risk of neonatal death or neurodevelopmental delay between the groups. However, this study was underpowered due to lack of follow-up, hence the results should be interpreted with caution (Whyte et al., 2004).

Since the Term Breech Trial, a number of descriptive and observational studies have demonstrated the safety of VBB in selected women with experienced clinicians (Håheim et al., 2004; Uotila et al., 2005; Goffinet et al., 2006; Maier et al., 2011; Azria et al., 2012). Other studies have also stressed the importance of careful counselling of women regarding mode of birth (Berhan and Haileamlak, 2016; Lyons et al., 2015). In recent times the woman's right to remain central to the decision making process has been referenced in guidelines on management of breech birth developed by the Royal College of Obstetrics and Gynaecology (RCOG,

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2008), the American College of Obstetrics and Gynaecology (ACOG) and the Royal Australian New Zealand College of Obstetrics and Gynaecology (RANZCOG). Similarly Cluver and Hofmeyr (2012) state that when a breech presentation is persistent, decision-making should be facilitated by skilled and individualised counselling to provide women with full information regarding mode of birth. Despite this, very few facilities in high and middle income countries support VBB, with the number of clinicians skilled in facilitating VBB decreasing to almost non-existent levels (Glezerman, 2012; Lawson, 2012).

Having a caesarean section for the first birth can have serious implications for women's subsequent pregnancies and labour. Some of these are a higher risk of abnormal placentation praevia and antepartum haemorrhage (Gurol-Urganci et al., 2011), unexplained stillbirth (Smith et al., 2003), repeat caesarean section (Raheem and Salloum, 2003), and ruptured uterus (Kennare et al., 2007). When women are not supported appropriately to have a vaginal first birth, the choice of repeat caesarean sections for future births significantly increases maternal and neonatal morbidity and mortality (Silver et al., 2006). For these reasons, facilitating normal birth, in particular for the first birth, has been the focus of government policy in New South Wales (NSW) (NSW Ministry of Health, 2010).

In Australia, few women have a VBB due to the lack of expertise of midwives and obstetricians and restrictive institutional policies. Presently in NSW, out of 99,510 women giving birth in 2012, only 3.8% had a VBB (Hilder et al., 2014). However, there are a number of clinicians who continue to give women the option of VBB who have become part of a drive to re-skill obstetricians and midwives with hands-on courses (Advanced Life Support in Obstetrics, 2013) and internal programs within hospitals. This paper examines how nine clinicians within two tertiary hospitals in one Australian state care for women who are having a VBB by providing a supportive communication process.

Methods

Research design

A qualitative descriptive methodology was undertaken. This design enables researchers to provide direct information about a topic or event instead of focussing on interpretation or abstraction. It intends to provide a full explanation of events as experienced by the study participants (Sandelowski, 2000). This design was important in this study, as it focused on clinical care of women having a VBB. Ethical approval for the study 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).

Participants

The participants in this study were purposively chosen clinicians who had cared for women in the past five years who had a breech presentation and were deciding upon mode of birth. Participants also had extensive experience of facilitating VBBs. Recruitment of participants was undertaken through distribution of an advertising flyer to the antenatal and labour areas of two tertiary hospitals that were known for their support of VBB. Information sheets and consent forms were given to all participants.

Data collection and analysis

In-depth semi-structured interviews were audio-recorded and transcribed verbatim. Trigger questions were used during the interviews that asked clinicians about how they discussed issues regarding breech presentation with women and what information was shared. Data transcripts were coded into concepts, subthemes and major themes. Two researchers (authors 2 and 3) performed the interviews, and author 1 coded the manuscript. The themes were shared with the research team and further refined after discussion. In the case of disagreement, the team continued to discuss the data and the findings until there was a consensus.

Findings

Five obstetricians and four midwives participated in this study. All were experienced in caring for women having a VBB and currently were involved in providing such a service as part of a public health service. The themes that arose from the data were: *Pitching the discussion*, *Discussing safety and risk*, *Being calm* and *Providing continuity of care*.

Pitching the discussion

All participants discussed the need to have a strategy to begin conversations with women who have a breech presentation late in pregnancy in order to gauge the woman's knowledge and feelings about VBB and caesarean section (CS). When talking to women, participants would stress that a breech position was not 'abnormal' or 'bad', but that it meant there were different things to consider compared to a cephalic presenting baby, especially around mode of birth. By doing this, the care pathway for each woman became individualised and relevant to her needs and wishes, whilst keeping within the boundaries of safe practice. Participants described this saying:

> Well, I first normalise and say, 'Well, your baby wants to come a different way and there's no need for alarm'. I try and gauge the woman's reactions so I'll just say, 'Well, what do you think about this?' OB8
>
> …some women, you know, won't be fazed by it and they will perceive it as very normal. Other women will be so agitated — I remember a young woman last year, she was so agitated that any talk, about an option, other than caesarean section… It was as though I was suggesting some form of child abuse. That was the level of apprehension. OB1
>
> So that you can then start, you know, pitching the discussion within the context of, you know, how they're already feeling. OB1

Counselling women regarding the mode of birth required working out what was best for the individual woman, and taking into account her needs and wishes. Due to the many factors that had to be considered, each woman was treated on an individual basis in this regard. This involved gauging their feelings about mode of birth at the first meeting, framing risk information in an accessible way, and changing information in relation to the woman's medical and obstetric background. They said:

> You start to get more of a feeling about the women themselves and that very much changes what my approach would be. MW3
>
> We had one lady who had had multiple vaginal deliveries previously, she was obese, would have been a high-risk caesarean section and I think the counselling around that was actually more around 'this is probably a safer delivery option for you under the circumstances'. So it does probably depend a little bit on their background. MW3