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Breech birth: an unusual normal

Shawn Walker explains why normal breech birth is within the midwife's sphere of practice



SUMMARY Over the last decade, there has been a loss in confidence and eroded skills due to the near universal policy of advising caesarean section in the wake of the Term Breech trial (Hannah et al 2000). Breech birth has been increasingly viewed as a complication, and management of the breech presenting baby at term has shifted firmly into the realm of obstetric practice in most parts of the UK. Small pockets of exception remain, among NHS and independent midwives who have maintained their skills with breech birth and are sought out by women denied the choice of a vaginal birth elsewhere. With continued focus on consumer choice, women led care and increasing normality, we urgently need to address the issue of how the NHS can safely provide the option of normal breech birth before these skills are permanently lost. This article suggests ways midwives may play a role within the NHS in ensuring women have a choice to birth their breech babies normally, in the safest possible way.

Keywords Breech birth, independent midwifery, normality, midwifery skills

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Women who seek out support for a breech birth often describe similar scenarios:

They told me I had to have a caesarean ... The doctor said that I could try to have a vaginal birth, but I would have to be on my back with an epidural and a drip, and have an episiotomy and forceps... They told me I was putting my baby's life at risk by wanting to give birth.

But a policy of advising caesarean section for 3-4 per cent of the birthing population has a significant impact, including increasing risk in future pregnancies (Royal College of Midwives and Gynaecologists (RCOG) 2006a,

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Verhoeven et al 2005).

Midwives can feel lost as to how to fulfil their professional responsibilities as women's advocates in this situation.

Trust policies may stipulate that care for women with breech babies be handed over to obstetricians, leaving midwives lacking experience and confidence. A midwife might feel she is putting her registration at risk by facilitating a woman's choice to birth her breech baby normally, having been told it is outside a midwife's sphere of practice.

Breech births can be normal births

If we are to truly honour women's choices and reduce an unnecessarily high operative birth rate, then we must address the issue of how we provide the choice of a normal breech birth as safely as possible. Midwives, as the experts in normal birth and co-ordinators of care for all women,



should, with appropriate training and support, have a central role to play for healthy pregnant women with healthy breech presenting babies.

The Information Centre for the NHS in England defines a normal birth as “without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery” (Department of Health (DH) 2006). The *Midwives’ rules* indicate that our professional activities should include “at least...conducting spontaneous deliveries including...in urgent cases breech deliveries” (Nursing and Midwifery Council (NMC) 2007). This defines the minimum rather than the limit of a midwife’s practice and suggests that the management of planned breech birth is an advanced skill, but not necessarily outside a midwife’s sphere of practice (Marshall 2010). As Mary Cronk famously says, breech should be viewed as an unusual variation of normal (Cronk 1998).

A number of midwife authors, including Jane Evans (2005) and Mary Cronk (1998), and more recently Kathleen Fahy (2011a), have outlined the difference between medically managed breech delivery and normal breech birth. However, our lack of research about normal and midwifery led breech birth complicates our duty to give women an informed choice.

Term breech trial

The *Term breech trial*, which has had such an influence on local guidelines despite strong criticisms of its validity (Fahy 2011b, Glezerman 2006, Kotaska 2004), did not look at normal breech birth at all, as many of the births which had problems were either induced or augmented, and lithotomy and forceps were routine management for many. A recent Cochrane Review (Hofmeyr et al 2011) made clear that we cannot generalise findings where methods differ from those in the studies reviewed. In practice, then, we cannot

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apply the findings of studies concerning assisted breech birth to midwifery led breech birth, nor should we apply the findings of studies which compare planned vaginal versus planned elective caesarean sections to women in labour with an undiagnosed breech at term.

Many of the outspoken obstetric and midwifery advocates of breech birth across the world today practise normal, often upright (all fours, for example) breech birth (Bisits 2002, Cronk 1998, Evans 2005, 2012, Fahy 2011a). They are confident enough in their results to speak out despite the general hostility that the suggestion of returning to vaginal breech birth often provokes. Perhaps we need to start listening to them and to women who are requesting support to birth normally if possible, especially where there is no evidence to undermine this choice.

What do we know?

We know that experienced care during labour is at least as important as the skills sometimes required at the moment of birth. The manual dexterity and mechanical knowledge required to control the birth of an aftercoming head is not dissimilar to that required to skilfully manage a shoulder dystocia

or maintain an intact perineum, while a majority of poor outcomes with breech birth have been associated with suboptimal care in labour rather than mechanical difficulty at the point of birth (Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) 2000, RCOG 2006a).

Midwives’ expertise lies in recognising and promoting normality and referring when progress veers from normal. Therefore, an experienced midwife is the ideal person to manage a normal breech birth, in co-operation with her obstetric colleagues, whose opinions and support are essential, as an operative birth could become the best course of action at any point.

We know that the presence of a breech-experienced and confident birth attendant contributes significantly to the safety of breech birth (Hannah et al 2000, Su et al 2003, RCOG 2006a). The lack of certainty about whether someone with such skills will be available is, for both women and providers, perhaps the biggest barrier to viewing the option of normal breech birth positively. Women who would like to give birth worry (sometimes rightly) that if no one with appropriate experience happens to be available, they will be putting their baby at risk. Doctors and midwives who themselves may be quite happy to support a breech birth are reluctant to recommend it in case they are not on duty and their fellow staff members are not confident. This presents a significant barrier to these women’s ability to access care for a normal birth, and we have a duty to address it (DH 2007).

In my opinion, the way forward in today’s NHS is to follow the trend to identify specialist teams including midwives, and to enable these midwives to organise themselves to provide on-call cover in order to provide a highly skilled service. Like other successful condition-based (Narayan and Garrard 2011) and specialist clinics, this model would enable women to

receive detailed, experienced counselling in the antenatal period (National Institute for Health and Clinical Excellence (NICE) 2011). Indeed some midwives are already providing midwifery led external cephalic version (in line with RCOG 2006b) or moxibustion for breech (Tiran 2010).

Additionally, women planning a breech birth deserve to be attended by someone they already know and trust, acknowledged to improve outcomes and increase normality (Maternity Care Working Party (MCWP) 2007). The infrequency with which a breech labour or birth is managed requires practitioners to be on call in order to acquire and consolidate a significant amount of experience, and this has been the key to the preservation of such skills within independent midwifery.

Identifying specialist midwives would also enable them to establish trusting and productive relationships with their obstetric colleagues, improving communication and thus safety, and to support skill development among all staff, thus increasing safety for unexpected breech births. Even without identified specialists, midwives' training and interest can be enabled to provide on call support to the small number of women who request a vaginal breech birth, in order to gain experience and provide continuity.

Conclusion

A midwife's sphere of practice could and should confidently include normal breech birth where

- the midwife has taken training and received mentoring in normal breech birth (in addition to annual obstetric emergency updates)
- both mother and baby are presumed healthy, and there are no other contraindications to vaginal birth
- labour has started and proceeds spontaneously at term (37-42 weeks).

Women will continue to be denied the choice of a normal breech birth until midwives become involved, as

midwives are the experts in normal birth and best placed to provide the continuity which is needed to maximise the safety of normal breech births. We need to stop discouraging breech birth because it does not fit easily into our current hierarchical paradigms and shift working patterns, and enable front line midwives to care for women in the most appropriate manner. When we allow women's and babies' needs to lead on this, the solutions are there... but will the NHS pursue them? **TPM**

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