

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

Catling C, Watts N, Petrovska K, Bisits A. **Homer CSE**. Care during the decision-making phase for women who want a vaginal breech birth: experiences from the field. *Midwifery* (accepted 21 December 2015). DOI [10.1016/j.midw.2015.12.008](https://doi.org/10.1016/j.midw.2015.12.008)

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.

Results: 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.

Keywords: vaginal breech birth, risk, decision-making, qualitative research, mode of birth

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 (Glezerman, 2006, 2012; Hauth & Cunningham, 2002; Kotaska, 2004; 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 (Azria et al., 2012; Goffinet et al., 2006; Håheim et al., 2004; Maier et al., 2011; Uotila, Tuimala, & Kirkinen, 2005). Other studies have also stressed the importance of careful counselling of women regarding mode of birth (Berhan & Haileamlak, 2015; 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), 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, Pell, & Bobbie, 2003), repeat caesarean section (Raheem & Salloum, 2003), and ruptured uterus (Kennare, Tucker, Heard, & Chan, 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, Zhichao, Parker, Jahan, & Chambers, 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 5 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, sub-themes 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

...we do explain that we like to take each case as an individual case and that we look at all aspects of the pregnancy, what the risk factors are, fetal size all that sort of thing. MW7

DISCUSSING SAFETY AND RISK

The clinicians accepted that there were always risks involved in relation to pregnancy and childbirth, but as long as they had provided good care to women and women accepted the

risks after being given full information about a VBB, there was a satisfaction with their work. Some illustrated this by saying:

I'm fairly comfortable with risk, provided I believe the woman is of sound mind and knows what she's doing. OB4

I think you have to accept, that sometimes, things are not going to go perfectly. But ... as long as you looked after somebody well and you discussed their choices and you did the right thing when something went wrong, you have to be satisfied with that. OB8

Clinicians felt that it was important to discuss the Term Breech Trial at the first visit as it was acknowledged that women would have usually found this research on the internet, and be concerned about its findings. The information about the trial was countered by findings from other research studies. Participants described how they discussed this:

So, I then go on to quote the evidence from the Term Breech Trial saying that one in twenty babies was reported to be harmed in the vaginal breech arm of the trial. And that that was more like one in a hundred or one in two hundred, in the caesarean arm. And that striking difference was what put most people off the possibility of breech birth. However since that time, there's been heavy criticism of those results and that when you look at the experience of institutions that do a lot of breech births and have reported the results, the frequency of adverse outcomes is much less. OB1

I tend to put the figures fairly simply because I think it gets too complex if you give all the risk ratios and everything. So I'd say, "According to the Term Breech Trial there is a slightly greater risk of death or neurological injury, if you have a baby born, vaginally that's breech". But I also talk about the French data.. OB4

In relation to the Term Breech Trial, when clinicians discussed neonatal morbidity, they had particular words they used. For instance:

The Term Breech Trial was powered for morbidity. So I actually talk about morbidity. I don't talk about dead babies. OB8

And then when you talk about a broken bone you have to explain to them that a broken bone in a newborn baby is actually not quite the same thing as a broken bone [in an adult] ... it's obviously upsetting, but in actual fact they heal really well. OB8

I try to explain, that it was a composite outcome but I don't use the word "composite" because that might be too complicated. So I might say something like, "They looked at not just death, but different aspects of injury to the baby like for instance, injuries which recovered and in the long run, there was actually no difference between the two groups". OB4

Discussing possible neonatal trauma during a VBB was important to participants. This information was balanced by the safeguards that were put in place, the experience of the

clinician, one to one midwifery care and international research studies on VBB safety that contravene the Term Breech Trial. This was explained:

I simply say that, "If, we were to take ...one hundred or a thousand women with a breech birth and compare them to a hundred or a thousand women who are having a head first birth, then probably there are a few more problems in women having a breech birth. Most of those problems will centre around possible trauma to the baby, most of which fixes itself. The major concern is about a shortage of oxygen. Most of the time, that is short-lived and we can deal with it. There will be occasions where it's a bit more severe. However, the chance of that happening can be minimised with appropriate care. And also clearly", you know, "the skill of the people attending the birth and caring for the women during the labour which includes midwifery care".

OB1

The main way my discussion has been refined is clearly based on my own experience. And I can say to people now... "Well, for the past ten years, this has been our experience". Then it's also been modified by international opinion and not just opinion but also the other studies that have come out. OB1

Participants described what and how they discussed VBB with women. This was in relation to answering questions about the risks of having a VBB versus a CS in order to provide all the relevant information so that women and their partners could make an informed choice. The research studies they used to back up the information are explained here:

We finish off [the discussion] with me giving them a particular information sheet, which also has a link to the Canadian College of Obstetricians and Gynaecologists, about breech birth. It's, it's very good. Sort of, fairly consistent with what I say. And it quotes bigger numbers and has the authority of a professional body. MW7

We certainly talk about what the evidence is with respect to the kind of breech presentation that the woman might have and the safety surrounding the various types of presentation, whether it's a footling or whether it's a complete or frank breech. MW2

I'd talk to them about the difference between the PREMODA study and the Term Breech Trial and that for the right group of women it can be a better outcome for a certain group of women to have a vaginal breech birth than a caesarean section. OB6

The discussion of the pros and cons of VBB versus CS with women was described by all participants. Whilst a CS was seen as quite a safe mode of birth, the benefits of a VBB were discussed and the disadvantages of a CS were illuminated. Participants said:

I would go on to say that while we can't say it is as safe as a caesarean section from the data that we have, it's an option that women choose and under those circumstances a planned vaginal breech can be a safe option knowing that there are some risks. Then I go through the risks of emergency caesarean section... MW3

I talk to them about all the pros of vaginal births and the uncertainties that can be around it but I would certainly talk to them about the pros and cons of a caesarean section. OB6

Many participants spoke about the specifics of their management of VBB. For example:

We do explain that their chances of having a vaginal [breech] birth are a bit higher risk than if the baby's head's down because we're more likely to step in sooner rather than later with a vaginal breech birth than if their baby was head down. If you've got no progress in second stage with the bum coming first really you've got no choice but go into theatre. MW7

Even if women appeared to have their mind made up about a particular mode of birth, it was still important to give them full information so that they could make a fully informed choice. This was expressed as:

Often they'll say "we don't really want to do anything. We want a caesarean" and we ask them why and then you would say "well can I just tell you what we do know about this and what the evidence tells us about this process" and we talk about the risks of caesarean as well the risks of vaginal birth and it's awful that you have to sort of talk about risks but you have to enable women to make an informed choice. MW7

In the discussion, risk was related to everyday occurrences so that women could grasp their particular risk status. One participant illustrated this saying:

I put it in the context of things you do in daily life by getting in the car, that's probably your biggest chance of death as a pregnant woman. But we all do that without particularly thinking about it. OB8

Using language that was understandable to women and their partners was discussed by participants. Discussing very rare potential complications was not thought to be helpful. Participants said:

But I'm careful not to give them too much in-depth of all the potential negatives like placental abruption and things like that because they're at very, very, very low risk and I haven't personally ever seen them myself and consultants I've worked for have never seen them. OB6

Participants' respected women's choices after the full information regarding mode of birth had been provided. They said:

Because I still very much believe that a woman's right to choose their way of birth is equally valid if they choose a vaginal breech ... and equally if they're fully informed about an elective caesarean section. MW3

So for me, it's not about the mode of birth, it's about being fully informed and making sure that woman's made an empowered choice. MW3

BEING CALM

Maintaining a calm demeanour was paramount. It was important to participants that women were not be alarmed by the news that their baby was in the breech position, and that their carers should not dramatise the situation. The calm provision of information and management strategies was essential. For example:

And probably because of the way I say it. However, it makes them listen without getting, too uptight so they just listen to all the qualifiers. OB1

Fortunately, we have a number of clinicians that are very positive about vaginal breech birth and we generally organise an appointment with the breech clinic and we organise to go with them to that appointment even though there's midwives and doctors there that talk fairly positively about vaginal breech birth. MW2

A number of participants spoke about giving time for families to make decisions, and ensuring they had contact details of somebody to talk to regarding their decision-making. This was an important part of the care process and one that women and families had to take part in, to allow for a fully informed decision. This was expressed:

I allow space between visits for families to go home and talk about what they're feeling as far as what the ideal outcome is for them and then being available to have a conversation as those questions arise because they almost always never arise at the time [the first visit]. MW2

This is not just do 'whatever', you guys need to own this and make a decision that you guys as a family are happy to explore, and that's really crucial in my own practice, that I have families consider [mode of birth] rather than go just with what the clinicians say. MW2

It's clearly stated in that information sheet that it's their decision and, they simply have to ring me once they've considered this with their partner. OB1

Enabling calm, unhurried appointments with women, and maintaining this demeanour during labour and birth was a priority for clinicians.

PROVIDING CONTINUITY OF CARE

All participants spoke about the importance of continuity of care. This was seen as fundamental in order to provide known, trusted clinicians for women throughout the course of their care, in order to give them the best chance of a VBB. For example:

I think continuity of care is absolutely crucial to giving a woman the best opportunity to birth her baby vaginally. MW2

They've had discussions before they even come to the point of being in labour so she knows him well and trusts him [the clinician]. MW5

Sometimes I think it is very much that connection that you can make with people that if you have that supportive environment women will feel comfortable to labour. OB9

Providing continuity of care by having the same clinicians caring for women was a very strong theme in this study. This encompassed the decision making around deciding to have an External Cephalic Version (ECV), undergoing ECV, then embarking upon a VBB, if the ECV was unsuccessful. Both the midwife and obstetrician participants worked together as a team to provide continuity of care for women, with the facilitation of the births being undertaken by both disciplines equally.

DISCUSSION

This study explored nine clinician's experiences of caring for women with a breech presentation. The findings showed that clinicians carefully considered their discussion about the breech and the woman's decisions, the way they conveyed risk and the importance of continuity of carer. This has implications for other settings considering implementing a breech service. Current management of women with breech presentations varies between institutions. However evidence concludes that after offering an ECV, if the breech is persistent, then women should receive skilled and individualised counselling that provides all of the evidence to facilitate a fully informed choice for mode of birth (Cluver & Hofmeyr, 2012).

Our study has found that clinicians believed that the way in which information is relayed to the woman regarding her available birth options, in a continuity of care context, is of key importance to supporting the woman and ensuring that she remain at the centre of the pregnancy and birthing process. Understanding the woman's context, social relationships and other factors, such as any fears she may have regarding outcomes, should remain central to any woman/health care provider discussions regarding VBB. A balanced approach by clinicians, such as that taken by participants in this study, should include discussing all options available to the woman, including ECV, VBB and CS. Included in this is the intricacy of the ever-evolving international research data, the experience of the clinician, and the particular women's obstetric and medical history and personal choices.

Our findings are echoed in previous research that recommends women require additional support for decision making for VBB given the decisional conflict they may experience due to the unexpected nature of breech presentation late in pregnancy (Guittier et al., 2011). Tailoring information to the woman's own personal risk and customised to their level of knowledge, without value judgments informed by the current 'status quo' for management of breech presentations, is key to supporting the woman in making informed decisions (Founds, 2007; Raynes-Greenow, Roberts, Barratt, Brodrick, & Peat, 2004).

Successfully communicating risks and benefits is an opportunity to foster women's satisfaction by integrating their preference and the risk assessment of the provider (Kaimal & Kuppermann, 2010). When discussing VBB, as in many other health contexts, women need to be provided with evidence based information of the risks and benefits associated with each of the available options (Edwards & Elwyn, 2009). Recent research from Lyons et al. (2015) and Berhan and Haileamlak (2015) has demonstrated higher perinatal morbidity

rates for babies born by vaginal breech birth or after CS performed during labour. These studies highlight the risks associated with vaginal breech and demonstrate the importance of providing women with information about benefits and risks. In our study, participants spoke at length about risk and safety and explained how they presented complex information and made this understandable to women and their families. The participants described the personalised discussions of risk with women, and often they would use figures, frequencies and numbers needed to treat.

Making information customised to the woman and using graphics and diagrams have been recognised as a way of making information more accessible to women and tailored to her needs. For example, RCOG and the National Institute of Clinical Excellence (NICE) Guidelines have produced documents that discuss optimal ways to communicate risk, with the RCOG document providing obstetric-specific examples of how to present risk to women in maternity care. These documents support the concept of tailoring risk with a careful approach to framing concepts and also discuss the notion of understanding the woman's perception of risk. RCOG recommends that simply describing women's risk during pregnancy as 'low' or 'high' may not be sufficient and suggest providing figures, frequencies, absolute risks, and numbers needed to treat individualised this to a woman's context, as more accessible approaches to quantify risk descriptions. They also suggest the use of contextual information regarding other life risks (e.g. driving cars). While it is important to present this data in an accessible format for those women that seek statistics, clinicians should also be mindful as to how risks are framed and presented to prevent excluding women who may not be accustomed to the use of statistics to describe risk. Options for presenting risk that minimise the use of statistical data include the use of graphs or interactive methods of communicating risk that can be found online (Kaimal & Kuppermann, 2010). Despite clear risks presented to women, there are some who will still choose a vaginal breech birth (Homer et al., 2015) and therefore careful screening and discussion need to occur to ensure women are fully informed and aware.

Decision aids were not discussed in this study, although information sheets were used. Such decision aids can be very useful for women and families, and have been used for decision-making regarding vaginal birth after caesarean section (Dugas et al., 2012), and other healthcare fields (O'Connor et al., 2009). These have been found to increase women's participation in decision-making and improve knowledge of available options (Dugas et al., 2012; O'Connor et al., 2009).

As well as describing the strategies and context of risk in relation to VBB and CS, one of the other themes in the data described the manner in which clinicians approached these discussions. Using a calm manner and framing risk in a particular way when discussing options for birth with women was described by participants in this study. This is concurrent with RCOG (2008) who state that information needs to be presented in a variety of ways, specifically in a positive way. If framed as a gain, it is more likely that women will feel more confident in their decisions, as opposed to information framed as a loss (Farrell et al., 2001). For example, explaining that around 50% babies remain cephalic after an ECV (Hofmeyr et al., 2015) is a positive frame on this likelihood.

Participants in this study valued the continuity of care they offered to women, and saw this as vital to the effectiveness of their care. There are a multitude of benefits to continuity of care and relationship-based care which involve greater satisfaction with care from women and midwives, less errors (Levinson et al., 1997), and significant health benefits for women and their babies (Sandall et al., 2013). There is also evidence that this promotes effective shared decision-making (Elwyn et al., 2012). Continuity of carer relationships may have to be established quickly if the women have transferred to a facility that support VBB from one that did not. Recognising the loss that women feel when leaving their planned place of birth and planned care givers is important and needs to be acknowledged.

This study explored nine clinicians' experiences of caring for women with a breech presentation in two tertiary hospitals in NSW. These clinicians were purposively chosen as they had recent (at least 5 years) experience through working in 'breech' clinics where women were referred to with breech presentations. Purposive sampling was used in order to elicit views from individuals who had provided the studied service. Limitations include the inability of the findings to be translated to other health contexts and the small sample size. It is also acknowledged that data from this study may highlight use of personal interpretations of the risks and benefits of vaginal breech in the counselling of women.

NSW is the most populous Australia state and the maternity services are probably fairly typical of services in other parts of the country. However, NSW does have a number of health institutions that support VBB and this is not necessarily the case in all states and territories, so the findings may not reflect other areas. Nonetheless, they do explain the views and experiences of a small group of experienced doctors and midwives.

CONCLUSION

Clinicians experienced in facilitating VBB provide skilled counselling to women which involves individualising risk and safety information and providing continuity of care with a calm manner. It is acknowledged that communicating management options for breech presentation may be directly related to skills and attitudes regarding VBB. Health services considering establishing a vaginal breech service should consider that these elements are included in the establishment and implementation processes.

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