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# Breech birth: A midwifery approach

By Beverley Lawrence Beech

AIMS Journal 2003, Vol 15, No 4

*AIMS' Chair Beverley Lawrence Beech reports from a meeting of the Royal College of Obstetricians and Gynaecologists (RCOG), 19 January 2004, which focused on the midwifery approach to breech birth.*

When I was a member of the RCOG's Maternity Forum, I pressed it to organise a conference on breech birth because of our growing concerns for women who are told that they had to have a caesarean section for a breech-presenting baby.

In 2000, the Lancet published a paper from Canadian researchers[1] who had carried out a multicentre trial comparing obstetric vaginal delivery with caesarean section for babies presenting by the breech.

The findings of this study were enthusiastically acted upon almost immediately, and the AIMS helpline began receiving regular calls from women desperately trying to find someone who would support their having a vaginal birth. Almost overnight, obstetricians were telling women that they had to have a caesarean if, having tried external cephalic version (ECV), the baby remained in a breech position. Many centres were not even offering ECV, but immediately advising a caesarean.

At one time, breech birth was considered a normal birth, just an alternative presentation, and every midwife felt confident in helping a woman have a breech- presenting baby vaginally. But, when midwives were brought into hospital, the doctors decided that breech was now abnormal and their responsibility. This resulted in the de-skilling of midwives, while obstetrically managed deliveries became the norm.

Fortunately, these midwifery skills have not been completely lost. I was able to press the Royal College into organising a day with two of the most skilled midwives in the UK - Mary Cronk and Jane Evans - so that these midwives could present their approach. Mary Cronk was invited to speak.

The day began with a presentation by Peter Young, a consultant obstetrician from North Staffordshire Hospital, of the medical evidence for vaginal breech delivery compared with caesarean section. His presentation drew largely from the Canadian study and was followed by Professor Ellen Hodnett, who spoke about the views of women who had been involved with the Canadian research.

After the coffee break, Mary Cronk presented her slides of some of the various breech births she had attended. The audience, which included obstetricians, midwives and lay people, listened and watched with rapt attention. Mary's slides and comments took the audience, stage by stage, through the births, showing a variety of different presentations such as footling, flexed breech, extended legs, and knee.

Mary was followed by Belinda Phipps, who had generously cut short her presentation so that Mary would have extra time. Phipps selected a range of quotes from women about their experiences, highlighting the psychological impact that the births had on women. She also emphasised how important it was that women be fully informed and enabled to make informed decisions about the kind of birth they wanted, and then supported in those choices.

## Different approaches

The morning session ended with a discussion of the issues. It then became clear that, while most were indeed very interested in Mary's approach, a few could not see the difference between an obstetric delivery and a breech birth.

In an obstetric delivery, the woman is invariably on her back; she may well have an epidural, and most will have electronic fetal monitoring. As the baby is delivered, the obstetrician may well use forceps or manipulate the baby's head to encourage a quick delivery. The woman may also have the labour induced or accelerated.

Indeed, one obstetrician commented to me afterwards that if Mary Cronk's slides were turned upside down, it would be precisely the position that women delivered in, so there was no difference in approach.

His was a failure to understand the effects of gravity. With the baby pressing down into the pelvis, the coccyx would be unable to move backwards-and this astounded me. During the presentation, Mary showed how, when the head was not emerging as it should, she could insert two fingers behind the baby's head and, with her other hand, gently ease the head forward and out. This manoeuvre is much more difficult if the woman is lying on her back because, then, a second practitioner has to lift the baby up by its heels - which, of course, would happen anyway by gravity if the woman is in a more natural hands-and-knees position.

The Cronk/Evans approach has a number of principles: the woman is expected to labour and give birth without oxytocic drugs (in other words, not induced or accelerated). If the labour does not progress, then the woman is advised to transfer for a caesarean section. Babies are not forced down the birth canal by drugs. The woman is allowed to adopt whichever position she wants, and most women, when left to respond to their body's messages, will get onto their hands and knees. As the baby is born, the midwife waits and may support the body, but does not otherwise interfere and use traction (see box below for further details).

One of the messages that came over strongly from the midwives was not to be prescriptive about what

women will, or should, do. Jane Evans described how she had attended a woman who wanted to lie down for the first stage of labour and, although she mused on why this should be, she decided not to interfere. The woman got off the bed for the second stage and, as the baby was arriving, Jane found that the cord was lying about the baby's neck; this was unlooped and the baby was born. Jane then found that the cord was extremely short. Had she encouraged the woman to get up off the bed during the first stage, she may well have been faced with an emergency caused by the stress placed on this short cord.

The afternoon session covered ECV, which a few hospitals are offering. Many consultants are not particularly skilled at doing this and, as a result, women are not being offered this option before resorting to caesarean section.

It was pointed out that a small proportion of breech babies will have congenital abnormalities (and some of these contribute to the higher mortality rates in breech babies, no matter how they are delivered). Brenda van der Kooy, a midwife in independent practice, pointed out the importance of listening to what the mother is saying. Her own baby was presenting by the breech and she was offered ECV. She discussed this with her obstetrician, but had the feeling that this was not for her baby and decided not to have the procedure. Her baby was born vaginally, but it was evident that the baby had an abnormality that was not compatible with life (a severe form of brittle-bone disease), and her son died shortly after birth. Had she agreed to ECV, the baby would have developed acute distress, a caesarean section would have been done, but the baby would have died anyway. She and her husband would also have missed out on a beautiful, easy birth at home and the precious 15 minutes of their son's life spent together.

During the discussion, it was suggested that a means has to be devised that will enable the skills of birthing a breech-presenting baby to be shared and developed. When it was suggested that both midwives and obstetricians learn these skills, one obstetrician felt that this should be outside the remit of junior medical staff, as the European Working Time Directive and the pressure on junior-staff training would make it difficult for doctors to take this on, and so perhaps this should be within the remit of midwifery. Furthermore, the problems were compounded by the small numbers of breech presentations - an insufficient number to maintain everyone's skills.

The difficulties of mounting a randomised controlled trial were discussed, and some obstetricians felt that what they had heard during the conference about the Cronk/Evans model of breech birth was based on anecdote, so it was the task of midwives and consumers to mount a trial and present the evidence. Easier said than done. The Medical Research Council is not noted for funding midwifery research, and even if they were, such research requires the cooperation of the obstetricians who control the access to women. However, the Independent Midwives Association (IMA) has been collecting ongoing, prospective, systematic data since the beginning of 2002, including all those babies in the breech presentation, many of whom were born with the help of midwives using the Cronk/Evans model. Even though the numbers are small, this information will be invaluable in the absence of other data of physiological breech births, and adequate funding should be directed to help with this work.

I have serious doubts as to the feasibility of undertaking a randomised controlled trial of the midwifery

model of breech birth. The Canadian researchers were asked by Gill Gyte, of the National Childbirth Trust, if they would include a midwifery model of vaginal birth in the Hannah trial, but they refused on the grounds that it would be too difficult to do. As a result, we still do not have the answers that consumers want and, as was clear from this conference, some obstetricians still do not understand the difference between a breech birth and a breech delivery.

This conference, however, was a first step towards addressing the needs of those mothers who are not willing to undergo major surgery just because their baby is lying in a breech position; and we urgently need all midwives (and ambulance crew, for that matter) to have the confidence to assist a woman to birth by the breech when a baby's bottom emerges instead of the head. Midwives, no matter how much ultrasound is done, will always be faced by an unexpected breech presentation, and it is unacceptable that so many appear to be unable to deal with the situation without panicking and desperately seeking obstetric assistance - difficult if this happens during a home birth.

**Reference**

1. Hannah M et al. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. Lancet, 2000; 356: 1375-83

Editor's note: Mary and Jane are planning a workshop course throughout Britain which will be advertised in the midwifery press. See www.sharingtheskills.co.uk for more information.