Facilitating Breech Birth:

Midwifery (and Women's) Business!

In the 2001 ACE Graphics Future Birth tour, I addressed the essentials of midwifery practice that ensure women with breech babies receive woman-centred care [1] in spite of the poorly conducted [2] Term Breech Trial [3]. This paper places the breech debate in context of the overall Caesarean epidemic. It also speaks to the need for midwives to critically explore the policies, protocols and guidelines for breech birth in their local hospitals.

The Caesarean epidemic

The Caesarean epidemic is well documented in *The National Sentinel Caesarean Section Audit Report* [4] released in the United Kingdom (UK) in October 2001. The data was collected from England and Wales for three months in 2000, as well as Northern Ireland and the Channel Islands for three months in 2001. The audit captured 99.6 % of all Caesarean section data from a total pool of 152,413 women who birthed during this time.

The audit noted a lack of consensus in reporting indications for Caesarean section, as well as inconsistent use of any particular indications list. However from the data that existed, breech presentation was placed third in importance amongst the four major determining factors as to why 70% of all Caesarean sections were performed. Breech presentation as an indicator was surpassed only by 'failure to progress' and 'foetal distress'. The fourth most frequent indicator, not surprisingly, was previous Caesarean section. The overall Caesarean sections rates ranged from 21.3 - 24.2 percent.[4]

Over half the consultant obstetricians surveyed during the UK audit expressed concern that the overall Caesarean section rate in their units was too high. All but two of the 162 saw it as "a shift in the obstetric culture toward a lower threshold for performing Caesarean section". Eighty percent agreed that "birth was a natural process that should not be interfered with unless necessary" - yet the Caesarean section rate for different units peaked at 40%.[4]

Increasingly, we hear the continuing rise in the rate being placed in women's laps as their 'choice'. This 'indicator' ignores the effect of caregivers' own personal choices of birthing and the impact this has on care delivery.

The birth preferences of caregivers

When asked what choice of birthing option midwives would make, 96% would choose to give birth vaginally to a baby. [5] However, when obstetricians were asked what choices they would make for themselves or their partners, between 7% (Ireland) and 46% (USA) [6, 7] would choose elective Caesarean sections. When there was an uncomplicated breech presenting baby 57% of UK obstetricians [8] and 50% of their Australasian colleagues [9] would choose an elective Caesarean section.

These attitudes are the fertile ground of obstetric practices that auger poorly for women with breech-presenting babies. They may well be implicated in the 88% Caesarean section rate with breech presentation that is recorded in the UK audit [4], as choosing caregivers who prefer surgical births themselves or for their partners, may predispose women and babies to the same 'choices'. However, equally, if a woman wants to have a physiological birth then an essential prerequisite may well mean she needs to go to a caregiver who would also make that same choice for herself.

It is vital to be attended by a practitioner who is not frightened by the birth process and who not only respects the physical process, but also the emotional, psychological and spiritual significance of birth as a rite of passage for women - the gateway to mothering. With the dominant birth culture so counter to healthy physiological birthing in the western world, it is not surprising that the woman and baby with the additional considerations that arise with a breech-presenting baby, will have minimal choice and support to have a physiological birth. The midwife who is well versed in physiological birthing of a headfirst baby is the one most appropriate to support the woman with the physiological birth of her breech baby. However, for this to occur, the midwife needs to have a strong presence in determining the care women receive in the maternity services. The strength of this presence can be judged using the documents which guide care.

The Midwifery Model of Care in New Zealand's obstetric hospitals

To assess the strength of the Midwifery Model of Care during breech birth in the twenty-six obstetric hospitals throughout New Zealand, I reviewed the documents guiding practice. [10]

A letter of request for the written policies, protocols and clinical guidelines was faxed to the midwife in charge of the labour ward/delivery suite area of the 20 secondary and 6 tertiary obstetric hospitals. A follow-up phone call was made if information had not been received within a fortnight. A verbal response (9) or written documentation (11) was received from twenty of the twenty-six facilities.

The review focused on two issues – firstly 'do the documents relating to breech presentation and birth in New Zealand obstetric hospitals reflect evidence-based practice?' and secondly 'do these same documents reflect the Midwifery Model of Care?'

For the purposes of this paper, I will address the second question. To answer this, four commonly accepted aspects of the Midwifery Model of Care - continuity of carer, the presence of a midwife, active birth and the use of a warm water pool/bath or shower in labour were examined. The findings were as follows:

1 Continuity of care

Continuity of carer was mentioned in only 2 documents and related only to the antenatal period. No document acknowledged the need or desirability for the Lead Maternity Carer (midwife) – the maternity professional who is responsible for providing or accessing all care in New Zealand. One document did give 'permission'(!) for an Independent Midwife to continue care during pregnancy following consultation with an obstetrician, or, in labour with an undiagnosed breech presentation.

2 The presence of a midwife

The presence of a midwife – the pivotal provider of labour care as an Independent or hospital-employed midwife – was not mentioned except for one document which referred to her organisational ability, or, her presence when an obstetrician was unavailable.

All documents reflected at least a minimum of 2 medical practitioners (obstetrician and paediatrician) as needing to be present, with the availability of a third – an anaesthetist. One facility required 7 people to be notified when birth was imminent - and therefore, 7 people could potentially attend the birth.

3 Active birth

No document gave full voice to a woman's ability to choice her birth position. While one 'Guideline' stated "there is no option but Caesarean delivery here and some women may choose to go out of town for a vaginal birth", only two facilities tentatively acknowledged the possibility of active birthing positions. In another, lithotomy was mandatory, stating 'the Professional Unit specialists [would] not be involved in breech deliveries in other positions'.

4 Use of a warm water in labour

There was no evidence in either the documents or conversations that would suggest a warm water pool/bath or shower in labour could be used.

This review of the Policies, Protocols and Clinical Guidelines governing breech presentation and birth confirms that the Midwifery Model of Care is not recognized in New Zealand's hospitals.

Conclusion

While the findings of the review will come as no surprise, it flags up the invisibility of the midwife, her practice, process and the Midwifery Model of Care in obstetrically-dominated environments. If midwives practice with non-critical acceptance of the hospitals' guiding documents, then women do not receive a woman-centred service – it will continue to be institution- or obstetrician-centred.

The New Zealand College of Midwives have been prominent in developing an 'evidence-based best practice guideline' for the care of women with breech-presenting babies (and women who have had previous Caesarean sections). This Guideline, developed over the last two years with consumer representatives, obstetricians and facility managers, is currently being circulated for endorsement from interested groups. In the near future it will be posted on the New Zealand Guidelines Group website (www.nzgg.org.nz - click on 'Guidelines' then 'Gynaecology and Obstetrics').

Significant in this Guideline is the visibility of the woman's birthplanning, the midwife and active birthing. This did not occur by accident. It reflects, once again, the commitment of women and midwives working together to protect physiological birth and to ensure safe and effective care. It is hoped that care will now shift to become evidence-based and that the facilitation of breech birth will become secured as a viable option in New Zealand's hospitals. In the meanwhile we can but just watch and wait…

© Maggie Banks, 2004, banks@ihug.co.nz . This paper supported the presentation at Birth International *Midwifery Intensives – Keeping Birth Normal*, 30 April - 11 May 2004.

1 Banks M. (2001). Reclaiming Midwifery Care as a Foundation for Promoting 'Normal' Birth. *ACE Graphics Future Birth Tour, 21-29 March 2001*, www.birthspirit.co.nz articles.

2 For further information, see M Banks. (2001). Breech Birth Beyond the Term Breech Trial. www.birthspirit.co.nz articles.

3 Hannah MA, Hannah WJ, Hewson SA, Hodnett ED, Saigal S & Willan AR. (2000, October 21). Planned Caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. *The Lancet*, 356(9239): 1375-1383.

4 Thomas J & Paranjothy S. (2001, October). *The National Sentinel Caesarean Section Audit*. RCOG Press: London. Available at www.rcog.org.uk/guidelines/nscs_audit.pdf Accessed 29 October 2001.

5 Caesarean Section Working Group of the Ontario Women's Council. (2000). *Attaining and maintaining best practices in the use of CS: An analysis of four Ontario Hospitals.* Toronto: Women's Health Council.

6 Mc Gurgan G, Coulter-Smith S & O'Donovan P. (July, 2001). A national confidential survey of obstetrician's personal preferences regarding mode of delivery. *European Journal of Obstetrical & Gynecological Reproductive Biology*, 97: 17-19.

7 Guillemette J & Fraser WD. (1992). 'Differences between obstetricians in caesarean section rate and the management of labour'. *British Journal of Obstetrics & Gynaecology*, 99: 105-108.

8 Al-Mufti R, McCarthy A & Fisk N. (1997). 'Survey of obstetricians' personal preference and discretionary practice'. *European Journal of Obstetrical & Gynecological Reproductive Biology*, 73(1): 1-4

9 Land R, Parry E, Rane A & Wilson D. (2001). 'Personal preferences of obstetricians towards childbirth'. *Australia New Zealand Journal of Obstetrics and Gynaecology*, 41(3): 249-252.

10 Banks M. (2001). 'Breech Policies, Protocols and/or Guidelines in New Zealand Hospitals (July 2001)'. Unpublished paper prepared for the *Breech Birth Seminars* held July 2001 - February 2002 in Auckland, Hamilton, Palmerston North, Lower Hutt, Christchurch and Dunedin.