Breech Birth Beyond the ‘Term Breech Trial’

The Term Breech Trial (TBT) was established to end decades of debate around the question - which is the better way for the breech baby at term to be born: planned Caesarian section or planned vaginal birth? With twenty-five participating countries this randomized controlled trial was touted as being able to provide the definitive answer to this frequently asked question. Recruitment started in January 1997 and enrollment was stopped on April 21, 2000. There had been 2088 out of the proposed 2800 women enrolled in the trial. The Data Safety Monitoring Committee reported that “the results were clearly in favour of planned Caesarian section”. As an avid watcher of the Term Breech Trial the findings come as no surprise.

The research process started well with the 1994 Canadian Consensus on Breech Management at Term giving a clear and comprehensive guide to the medical literature to set the Protocols for the trial. It augured well that these proposed less interventionist care than many of the breech births that are ‘managed’ in hospitals in the Western world. Many routine but arbitrary interventions were to be abandoned, such as:

- Mandatory epidural anaesthesia;
- Continuous foetal heart rate monitoring (unless clinically warranted);
- Breech extraction, and;
- Unrealistic time limits on a woman pushing out her baby.

However, it did not take long for concerns to rise when reading the Term Breech Trial Newsletters available on the website. These provided commentary, handy hints, progress on enrollments and tips on how to ‘sell’ the study to women and health professionals. (A list of prizes awarded monthly to the centers that reached or passed their annual recruitment goals also featured.)

Lack of expertise in physiological breech birth

The medical literature frequently acknowledges doctors lack expertise in vaginal breech birth. Obstetric training schemes are inadequate due to the proliferation of delivery by elective Caesarian section which means doctors are simply not able to develop the skills necessary for safe vaginal breech birth. Reminders were published about the need for expertise and the importance of skilled practitioners. Reminders were published about the need for expertise and the importance of skilled practitioners. The Term Breech Trial stipulated the need for “skilled and experienced clinicians” to be present at birth but the trial was also used as a teaching time for less experienced practitioners. Reminders were published about the need for expertise and the importance of skilled practitioners. The finding of the Term Breech Trial provides important information for women with breech presenting babies regarding the medical ‘management’ of vaginal breech delivery. It gives a well-rounded overview of the injury and death rates around the time of birth (perinatal morbidity and mortality) with such management. However, the way in which vaginal breech delivery is conducted within the Medical Model of Care is no more conducive to a physiological process of giving birth than any other medically ‘managed’ birth.

Medicalised childbirth

Medical management of birth results in high levels of birth injury for women and their babies, irrespective of presentation. It ensures the rate of ‘normal’ birthing in the...
Western world falls far short of the at least 85% which is often cited as appropriate.17

Turning on the Cascade of Intervention

The interventions that are used in medicalised birth can turn a potential risk into an actual complication. A recent study18 reported in the American Journal of Perinatology examined the circumstances surrounding umbilical cord prolapse for eighty-seven women. It found that in forty-one cases (41% of its study group) obstetric practices - including artificial rupture of the amniotic membranes, (commonly known as ‘breaking the waters’), application of ‘scalp’ electrodes and intratruterine pressure catheter insertion - preceded umbilical cord prolapse.

In the Term Breech Trial amniotic membranes were artificially ruptured in 22.4% of the vaginal birth group. The impact of this intervention on the 1.2% ‘in labour’ cord prolapse rate was not discussed. Artificial rupture of membranes is known to cause irregularities in the unborn baby’s heart rate, precipitating further intervention.19 The TBT notes 15.2% of the vaginal birth group had abnormalities of the unborn babies’ heart rates and this was cited as the reason for 28.6% of the unplanned Caesarian sections performed in labour. Cause and effect as to how artificial rupture of membranes impacted on heart rate abnormalities is not addressed in this study.

There were 14.9% of women in the vaginal birth group who had labour induced and 49.8% augmented with prostaglandins or oxytocin. Such high rates (64.7% combined) are indicative of highly interventionist birth practices.

The reason for Caesarian section was given as ‘failure to progress or foeto-pelvic disproportion’ in 50.1% of the unplanned Caesarian sections in labour. The all-encompassing label of ‘failure to progress’ is regularly used in medicalised childbirth (irrespective of presentation) to describe those women who do not labour within rigid time frames – time frames that are based on flawed science.20 It would be more accurate to categorize ‘failure to progress’ as ‘failure to be patient’.

The 46.3% epidural rate in the vaginal birth group is disturbing. Epidural anaesthesia immediately places the mother and babies ‘at risk’ of the Cascade of Intervention and operative birth.21

Randomised controlled trials

It is important to question the relevance of the TBT’s findings to women who are motivated to achieve physiological, natural breech birth. As with all randomized controlled trials both the study and control groups did not have a “strong management preference”.22 The act of giving birth in highly interventionist childbirth cultures will automatically see women who wish to achieve natural childbirth exclude themselves from a lucky dip as to whether or not they are able to have a vaginal birth as their goal.

Within the study 13.5% of women in the vaginal birth group requested Caesarian section which calls into question the decision-making process of being in the study.

The women who did not agree to be in the trial were not studied. It is simply unknown if the study’s findings could be generalizable to those women who have a strong preference for natural, physiological breech birth.

The midwifery model of care

The Term Breech Trial does nothing to investigate outcomes where the Midwifery Model of Care prevails. This distinct and separate style of care that potentiates the non-injurious act of giving birth includes:

- Ensuring services are woman-centered rather than institution- or practitioner-centered;
- Providing continuity of care by a known and trusted caregiver throughout pregnancy, labour, birth and afterwards;
- Ensuring that women have the ability to maintain control over decision-making;
- Recognizing that ‘birthing potential’23 embraces the potential need for additional specialist services when alerting factors are present (such as breech presentation) rather than a routinely prescribed and performed set of interventions irrespective of the individual woman’s or baby’s circumstances; and,
- Supporting the physiological process of birthing in the absence of pathology.

The midwife: ‘expert’ in physiological breech birth

So can midwives be better placed to facilitate the act of physiological breech birth when they may be subject to the same limitations of vaginal breech experience as obstetricians in interventionist birth cultures? The answer is a resounding ‘yes’!

Fundamental to good outcomes for breech babies is the act of supporting the woman and unborn baby in a labour that is free from induction augmentation by prostaglandins, amniotomy or oxytoicics and where the woman (and baby) are not sedated with narcotics or paralysed by epidural anaesthesia. These are all basic tenets of the Midwifery Model of Care that enable the woman and baby to maximize their innate abilities.

Equally important variables are the woman’s desire to achieve natural and healthy birthing and the effects of having known caregivers (as mentioned previously, neither of which were studied in the Term Breech Trial).

The knowledgeable companionship within the continuity of care/carer relationship that the midwife can offer is fundamental to providing the opportunity to enhance the physiological process of giving birth. Her setting the scene with a dimly lit room, the use of warm water, avoidance of fear-inspired language, sedation and anaesthesia and her competence at manoeuvres to facilitate difficult birth are all skills that are fundamental to the practice of midwifery.24

Breech presentation is a variation of the usual rather than pathological in itself. The Midwifery Model of Care accepts that an extended or flexed legs breech baby at term will be born vaginally unless there is a problem or obvious contraindication - in which case, the baby needs to be born by Caesarian section for the best outcomes for the new born.25 When care is provided from this philosophy, the vaginal breech birth rate is high with no compromise to the baby.26
Supporting the woman’s right to choose

Publication of the Term Breech Trial findings11 with a commentary27 urging quick dissemination of the same will be effective in shutting down women’s options to give birth to their breech babies. Within weeks of publication, midwives in New Zealand report women have been unable to find obstetricians to support their decisions to do so. It may only be a matter of time until care from an obstetrician during a vaginal breech birth becomes unprocurable.

A policy of mandatory Caesarian section is very problematic for a number of reasons:

- There will always be those babies (approximately a quarter of all breech presentations) who remain undiagnosed until labour28 and many will be born vaginally before Caesarian section can be organized. Within the TBT, 9.6% of women experienced vaginal birth despite their allocation to the planned Caesarian section group. Of these 100 women, the reason given in 59 cases was that vaginal birth was imminent. This is unlikely to change therefore vaginal breech births will continue to occur.

- The fear evident with medicalised practitioners will only increase. It is likely that birth injuries will increase as practitioners, guided by fear, perform panicked interventions when faced with breech presenting babies, first diagnosed in labour, who go on to rapidly be born.

- Experience shows that when women have had the opportunity to consider the findings of the Term Breech Trial, some will continue with their plans to give birth vaginally to their breech babies.

It is essential that the woman making a fully informed choice to give birth to her baby is supported to do so and that support will need to come from the midwife.

Conclusion

There are midwives throughout New Zealand (and the world) who have attended women in physiological birthing of their breech babies with good outcomes.

The Term Breech Trial highlights the need for midwifery practice to become more visible. A database of midwifery experience and the Midwifery Model of Care with breech birth practice to become more organized. Within the TBT, 9.6% of women experienced vaginal birth despite their allocation to the planned Caesarian section group. Of these 100 women, the reason given in 59 cases was that vaginal birth was imminent. This is unlikely to change therefore vaginal breech births will continue to occur.

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1  http://www.utoronto.ca/minu/breech/

www.birthspirit.co.nz


