



Shawn Walker

Labour ward midwife at St Mary's, Paddington, and a PhD student at City University London



Victoria Cochrane

Matron for antenatal and community services at Imperial College Healthcare NHS Trust

Unexpected breech: what can midwives do?

Approximately 1:100-150 women at term experience diagnosis of breech presentation for the first time in labour (Walker 2013). Such an unanticipated discovery is stressful for both women and the healthcare professionals who care for them. Undiagnosed breech experiences can leave midwives and women elated, distressed or disempowered. This article suggests practical ways midwifery change leaders can improve care for undiagnosed breeches within organisations: plan or scan antenatally, and identify a multi-disciplinary breech leadership team for support, reflection and collaborative professional development.

Mode of birth for breech-presenting babies has never been a more popular topic, despite – and partially in response to – the minimal number of actual vaginal breech births (VBB) occurring in most UK maternity units in 2015. Midwives and obstetricians alike continue to challenge the repercussions of a near-universal policy of caesarean section (CS) birth for breech babies (Turner and Maguire 2015). Recently, some

trusts have seen a resurgence of VBB, founded on models of care designed around the needs of mothers with breech presenting babies, rather than attempting to fit them into standard care models, 'the wrong way around' (Dresner-Barnes and Bodle 2014). These models are appropriate where breech presentation is diagnosed antenatally, but approximately 30 per cent of breeches are diagnosed for the first time in labour, mostly among otherwise low-risk women for whom a

third-trimester ultrasound has not been indicated (Walker 2013; Hemelaar et al 2015). Recent changes in national-level guidance, encouraging women with straightforward pregnancies to give birth off labour wards have intensified the need for midwives to have the skills to care for women with an undiagnosed breech (National Institute of Health and Care Excellence (NICE) 2014). Transfer may not be an option and, when it is, midwives have a key role to play in ensuring continuity and evidence-based counselling for these women. This article suggests practical, evidenced-based ways midwifery change leaders can work within the maternity care team to improve care for unanticipated breech babies.

PLAN OR SCAN

Diagnosis of breech presentation for the first time in labour is stressful for everyone involved. Women will have been reassured in antenatal clinic that the baby is head-down and ready to be born. A diagnosis of breech presentation turns the entire birth plan upside down, and women may find the loss of choice and control distressing (Homer et al 2015). Clinicians will also feel a range of feelings, some of which interfere with the ability to provide thorough and unbiased counselling in an acute situation; these include concern over personal lack of skills or practical experience, uncertainty about skilled support from the wider maternity care team, fear of repercussions should an adverse outcome occur with a VBB, fear of criticism from colleagues if an emergency CS is not performed, even with a good outcome. The intensity of labour further complicates the process of informed consent.

However, for every 100-150 women who give birth, approximately one of them will have an undiagnosed breech baby at the start

of labour (Walker 2013). In most UK maternity units, the majority of these women will have an emergency CS, despite evidence that this intervention will not have the beneficial effect of a pre-labour CS (Su et al 2003). A CS performed in active labour significantly raises maternal risks, especially in second stage (Pergialiotis et al 2014). A routine audit of care over 20 months in one hospital, conducted by the first author, revealed that approximately 30 per cent of undiagnosed breech presentations were also missed on initial examination in labour, and 81 per cent were admitted under midwifery-led care.

A diagnosis of breech presentation turns the entire birth plan upside down, and women may find the loss of choice and control distressing

Women should be informed of the possibility antenatally, and in trusts where routine third trimester scans are not offered, encouraged to consider what they would do if their baby is breech. Antenatal education classes are an ideal venue for raising this possibility. Women could document their preference on their birth plan, as they do with many other aspects of their care, enabling further discussion with healthcare providers. This simplifies counselling in labour, enabling a swifter transfer to theatre where a CS is preferred, or initiating the pathway if a VBB is preferred, assuming a vaginal birth will occur unless complications arise. This avoids the need for a complex decision-making process which itself may interfere with the progress of labour.

Alternatively, in some areas, midwives provide presentation scans for all women >>>>



Spontaneously raising one leg, opening the pelvis further and assisting rotation of the head as it enters the pelvis

during their third trimester (Walker et al 2010). This is not a difficult service to provide within a birth centre or community setting. The scan should focus strictly on presentation, as routine third trimester ultrasound screening is not associated with improvements in neonatal outcomes (Bricker et al 2015).

DEVELOP COUNSELLING SKILLS AMONG YOUR TEAM

We frequently speak with midwives distressed at the minimal amount of counselling and support women receive when a breech is diagnosed in labour. Why is this assumed to be the responsibility of the junior doctor who

happens to be on duty? Midwives are equally responsible for ensuring that women receive complete and unbiased information. The Royal College of Obstetricians and Gynaecologists (RCOG) guideline (2006) (as well as most trust guidelines which follow them) provide very specific information which women should receive, including:

- VBB increases short-term neonatal morbidity and mortality compared with planned CS
- There is no evidence that long-term outcomes (death or neuro-motor delay at two years of age) are influenced by mode of birth
- A CS increases risks for future pregnancies
- There is no evidence that a breech baby is at increased risk from a poor outcome when diagnosed for the first time in labour; an emergency CS will not provide benefit equivalent to a pre-labour CS

Midwives are capable of providing the counselling recommended in local guidelines, from the moment the breech is diagnosed. Local guidelines on evidence-based counselling should be briefly reviewed during annual mandatory training events, as counselling in this acute situation is itself a skill requiring practice. Various study days are provided around the UK, which can help midwives to gain an even deeper understanding of the evidence base, and to practise using it to counsel women. At the very least, midwives can reassure women during transfer that they have a choice, and that a guideline is in place to offer them further information with which to make that choice. Midwives should advocate that the guideline is followed by all involved.

DEVELOP AND ENGAGE SKILLED SUPPORT

As individual practitioners, midwives often

have little influence over how breech births are managed and, advocating for an individual woman in the midst of a shocking and urgent situation, is fraught with difficulty. Midwives can emerge from these events feeling either elated at witnessing an amazing birth, traumatised from having dealt with a difficult birth, or disempowered from having felt silenced and powerless to enable a more woman-centred service. For this reason, midwives who want to improve care for unexpected breech births have to address the need to care for each other on the path to improvement.

One way of doing this is to engage a multi-disciplinary team to reflect on the management of breech births together, as soon after the birth as possible, for all breech births. Such a community of practice is able to offer a supportive, informed debrief, and contribute to the development of internal guidelines so that they are responsive to emerging evidence. A multi-disciplinary breech team is also visible as a group of professionals willing to be called upon to support a planned or unplanned breech birth, increasing the chances that these births will receive such support. Even a small group of people meeting regularly, sharing skills and information, can keep improvement of the breech care pathway on the agenda.

Who are these professionals in your organisation? Midwives can think about how these skills can be acquired and then work with like-minded colleagues to share them. While it is important to engage professionals at all levels within the organisation where possible, the midwife providing frontline care is the person a woman needs the most as her advocate. Midwives committed to being this advocate need a community of practice for support, shared learning and peer supervision. [tpm](#)

REFERENCES

- Bricker L, Medley N and Pratt J (2015). 'Routine ultrasound in late pregnancy (after 24 weeks' gestation)'. *Coch Data Syst Rev*, 6: CD001451.
- Dresner-Barnes H and Bodle J (2014). 'Vaginal breech birth – the phoenix arising from the ashes'. *The Pract Midw*, 17(8): 30–33.
- Hemelaar J, Lim LN and Impey LW (2015). 'The Impact of an ECV service is limited by antenatal breech detection: a retrospective cohort study'. *Birth*, 42(2): 165–172.
- Homer CS, Watts NP, Petrovska K et al (2015). 'Women's experiences of planning a vaginal breech birth in Australia'. *BMC Preg Childb*, 15(1): 89.
- NICE (2014). 'Intrapartum care: care of healthy women and their babies during childbirth'. *Clinical Guideline 190*, London: NICE.
- Pergialiotis V, Vlachos DG, Rodolakis A et al (2014). 'First versus second stage C/S maternal and neonatal morbidity: a systematic review and meta-analysis'. *Euro Jour Obs Gyn Rep Biol*, 175(4): 15–24.
- RCOG (2006). 'The management of breech presentation'. *Green-top Guideline 20b*, London: RCOG.
- Su M, McLeod L, Ross S et al (2003). 'Factors associated with adverse perinatal outcome in the Term Breech Trial'. *Am Jour Obs Gyn*, 189(3): 740–745.
- Turner M and Maguire P (2015). 'Vaginal breech delivery at term: the doctors' dilemma'. *Irish Med Jour*, 108(4): 69–70.
- Walker S (2013). 'Undiagnosed breech: towards a woman-centred approach'. *Brit Jour Midw*, 21(5): 316–322.
- Walker TS, Millman N and Taylor M (2010). 'Integration of a portable ultrasound device into community midwife practice: a feasibility study'. *Archives of Disease in Childhood - Fet Neonatal Edition*, 95 (S1): Fa103.