

I have talked to three women this month whose birth plans have, in one way or another, been altered by their baby turning breech. Two had planned home births, only to find that the local support available for women having breech babies at home varied significantly from the support available for mothers-to-be of cephalic babies. Another had always intended to give birth in the hospital, but has now discovered she will not be 'allowed' to do this. Because her baby is breech, she has been told she must have an elective caesarean. Just in case.

But just in case what? Just in case someone has to remember what to do when the baby's feet come first? Just in case all the 'just in case' equipment has to be turned upside down to cope? Or just in case the worldwide obstetric fear caused by the results of the Canadian term breech trial (Hannah et al 2000) causes some poor old soul to have a heart attack on the labour ward when they hear that a fetal bum has been spotted near a woman's perineum? Despite the fear created by this research, as Michel Odent pointed out in last month's edition of *The Practising Midwife*, the summary of what we learned from the Canadian term breech trial is that, "a breech birth in a conventional hospital and in the presence of an obstetrician is dangerous" (Odent 2003: 11).

For anyone who missed it, this trial compared the difference between actively managed vaginal breech delivery (with lots of manoeuvres performed on women lying on their backs) and caesarean section. Perhaps unsurprisingly, caesarean section 'won' this comparison, an outcome which is less of a bombshell if one looks at the study methods.

Firstly, the results of this study were analysed by "intention to treat". This meant that the data on the 43.3% of women who were randomised into the vaginal birth group but who actually had a caesarean (a statistic which, in itself, might tell you something about the "keen-to-intervene" philosophy held by those involved in the trial) was analysed as if those women had given birth vaginally. Without going into too much depth about research philosophy, there is a justification for analysing the results this way, but it would have been very useful if the

researchers had also included an analysis of the results by actual mode of birth.

A large proportion of women in the vaginal birth group had their labours induced or augmented, something that midwives experienced in breech birth would rarely, if ever, recommend. Time limits were applied to the vaginal birth group – a classic example of the confounding variable of the clock as technology. More babies in the vaginal birth group acquired infections - but then prophylactic antibiotics were given to the caesarean group, so the infection rates of babies not given this advantage were bound to be higher by comparison. The researchers managed to completely ignore the possible impact of issues like mobilisation and maternal position during labour and birth and the environment of birth in general. In short, the study tells us absolutely nothing about the relative outcomes of vaginal breech birth where women are *giving* birth (as opposed to being delivered), and leaves us with a gap in our knowledge.

This gap seems to have become more pronounced in the short years since this trial was published. It is evident in the numbers of student midwives who are qualifying without having witnessed a vaginal breech birth, and in the furore which ensues anytime a baby is unexpectedly spotted emerging breech first on a labour ward. There has been a massive increase in the number of phone calls received by Independent Midwives from women whose birth plans have been shattered by the announcement that they need to have a caesarean section simply because their baby is breech. In some areas, Independent Midwives are supporting their NHS-based colleagues where women are occasionally declining caesareans and the hospital midwives feel they don't have the skills to support women giving birth to breech babies vaginally.

I am rapidly reaching the conclusion that the only way around this is for someone to volunteer to specialise in helping breech babies be born vaginally and for us all to club together and buy them a bus. Whoever this valiant soul is, she can drive around in the bus with her family, like the hippy American midwives of the

'70s, and park outside the house of anyone who had planned a home birth (or hospital vaginal birth) but whose baby has subsequently turned breech. She could join forces with a local midwife or two wherever she goes, in the interests of continuing professional development, so we can increase the number of midwives who can help women give birth this way, and perhaps Holby City would list her phone number after the show. (If you are affected by any of the issues in this episode, or think your baby might be breech, then call "National Breech Rescue" ...)

Of course, there are a million reasons why this little plan is less than ideal. But, unfortunately, it seems a better idea to me than the current situation, where women's needs are not being met, midwives are losing skills and the future breech babies who happen not to be 'diagnosed' (as if they were an illness!) before labour will be born into the hands of midwives who will have forgotten how to catch them.

## References

Odent M (2003) Home breech birth: commentary. *Practising Midwife* **6**(1): 11.

Hannah, M.A.; Hannah, W.J.; Hewson, S.A.; et al (2000) Planned caesarian section versus planned vaginal birth for breech presentation at term: a randomized multicentre trial. *The Lancet*, 2000: **356** (9239): 1375-1383.

A further midwifery critique on the Canadian Term Breech Trial can be found at:  
<http://www.birthspirit.co.nz/TermTrial.htm>