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Title: Midwives' views, experiences and feelings of confidence surrounding vaginal breech birth: a qualitative study

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Setting: UK midwives were recruited from different geographical areas and worked in community areas, hospital areas and as independent practitioners.

Findings: three themes were identified. Firstly, midwives viewed VBB in dimensions of normality, perceiving it to be an unusual norm on one hand while also acknowledging potential problems. Secondly, midwives expressed varied feelings of preparedness; the majority feeling inexperienced and underprepared with VBB, yet more confident when supported by other colleagues. Lastly, midwives described restrictions on women's choice of VBB; perceiving other practitioners as limiting women's choices through coercion, yet perceiving midwives themselves providing a balanced choice.

Conclusions: There should be an opportunity for midwives to be mentored by more experienced practitioner in VBB. Practice areas should develop a guideline for VBB which acknowledges the role of the midwife in facilitating normal breech birth. Balanced, written and verbal information on VBB may further assist decision making for women considering a VBB. Education in VBB should focus on learning what is normal for VBB and must emphasise the importance of teamwork and understanding roles within multidisciplinary teams.

***Highlights (for review)**

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- The first study to explore midwives views, feelings of confidence and experiences surrounding VBB.
- Midwives predominantly viewed that VBB can be normal whilst acknowledging potential problems.
- Midwives felt inexperienced, underprepared and wanted support from colleagues regarding VBB.
- Midwives viewed poor information provision from practitioners and inexperience to limit women's choices of VBB.

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Introduction

It is estimated that 3-5% of women have a breech presentation at term gestation (Hofmeyr et al., 2015). The publication of the Term Breech Trial (TBT) (Hannah et al., 2000), sparked a global decline in vaginal breech birth as clinicians implemented its recommendation that women with a breech presentation be delivered by Caesarean section (Steen and Kingdon, 2008). However, a two year follow-up of the TBT showed that the perinatal protective effect of planned Caesarean did not reduce the risk of death or developmental delay at two years of age (Whyte et al., 2004). Further evidence emerged, which exposed methodological flaws of the TBT (Keirse, 2002; Roosmalen and Rosendaal, 2002; Glezerman, 2006) alongside support for vaginal breech birth (VBB) for healthy women who experience an uncomplicated pregnancy (Goffinet et al., 2006; Borbolla Foster et al., 2014; Berhan and Haileamlak, 2015; Mattila et al., 2015).

Following the diagnosis of breech presentation, women are often referred for external cephalic version (ECV) as this increases the likelihood of a vaginal birth and reduces the need for a Caesarean section (Hofmeyer et al., 2015). Despite the recommendation that women have the option for an ECV, VBB inevitably occurs in practice; either when a woman presents undiagnosed in labour, too late for a Caesarean, or through maternal choice (Hemelaar et al., 2015). Furthermore, UK guidelines do not recommend routine Caesarean for pre-term breech or breech presentation of the second twin (Royal College of Obstetricians and Gynaecologist (RCOG), 2006). In the UK, the Nursing and Midwifery Council (NMC) recommends that midwives should be competent in assisting women having a vaginal breech birth (NMC, 2009). The presence of an experienced clinician at delivery is shown to reduce the risk of adverse perinatal outcomes for VBB (Su et al., 2003; Goffinet et al., 2006). However, with the declining incidence, there is a high concern regarding the safety of VBB due to the loss of practitioner's skills (Cronk, 1998; Kotaska, 2007) even with the use of simulation training (Hunter, 2014).

There is little known about midwives' views, feelings of confidence and experiences surrounding VBB, other than opinions and anecdotes (Cronk, 1998; Evans, 2012; Walker, 2012). A review of the literature revealed one qualitative study conducted in Jamaica (Founds, 2007), showing that providers interpreted breech as abnormal and associated it with underlying pathology (and hence, worse outcomes). However, the study was conducted in rural Jamaica with limited resources and it did not solely focus on midwives and therefore is unlikely to reflect the experiences of midwives in the UK. Consequently, this study aimed to explore midwives views, experiences and feelings of confidence surrounding VBB in the UK, in order to improve clinical practice and education in relation to VBB.

Methods

Design and participants

A qualitative methodology was chosen to uncover the complexities and interactions of midwives views, experiences and feelings of confidence surrounding VBB. The research was advertised in community and acute areas of a local hospital trusts via posters and

newsletters and also on an online independent midwives forum. A voluntary, purposive sample was sought which selected midwives with varying ages and experience and from community, hospital and independent areas of practice (see table 1). Midwives were eligible for the study if they were English speaking, currently practising and had at least one year of experience as a licensed midwife. Although it was preferable to recruit midwives with more experience of caring for women having a VBB, this was not a strict criterion due to the reduced incidence of VBB and concerns about feasibility of recruiting sufficient midwives within the projected timescale for the study. Also, the researcher was interested in participants' perceptions of their skills, feelings of confidence and views of how simulated training may contribute to midwives' feelings of confidence. Midwives responded to the research advert via phone and email, whereby they were provided with detailed written information about the study and then invited to attend a focus group at a time convenient to them. Recruitment lasted six weeks in which 19 midwives volunteered, however seven were unable to participate due to midwifery shift patterns and on-calls; leaving 12 participants (ten local midwives and two midwives from South and South-West England).

Data collection and setting

Data were collected during August 2013, transcribed in September and then analysed from January- March 2014. Focus groups discussions were chosen as they provide insights into different views and how people collectively make sense of a topic; thus fitting the exploratory nature of the study (Braun and Clarke, 2013). Each focus group lasted between 1-1.5 hours. The venue was a private and comfortable room at the university and was chosen as it was known to hospital and community midwives and provided a neutral setting for independent midwives coming from other areas. RS was the moderator for all groups and a discussion guide composed of semi-structured questions was utilised, ensuring the aims of the study were met and allowing midwives to express views in their own way (Krueger and Casey, 2009; Hennink et al., 2011). The discussion guide included key questions asking midwives to recall their experiences and views of VBB; the education received and their experiences of assisting women's choices. All groups were audio recorded and transcribed verbatim by the researcher.

Data analysis

Thematic analysis was chosen to analyse the data set; whereby the data set was searched to find repeated patterns of meaning which were then grouped as themes to provide a rich description and interpretation of the data (Braun and Clarke, 2006). Firstly, transcripts were read and listened to several times to familiarise with the data. Then semantic and latent codes were applied to form explicit and interpretative meanings of the data (Braun and Clarke, 2013). The codes were then organised into themes through a recursive process of reviewing the data at a conceptual level. Computer software NVivo10 (QSR International) was used to organise the data.

Preliminary findings were emailed to the participants, whereby some participants clarified uncertainties and adjustments were made accordingly. In addition, the themes were

discussed with an experienced researcher and a reflection journal was used throughout the study in order to "bracket-off" the researcher's experience (Flick, 2009).

Ethical Considerations

The study was approved by Oxford Brookes University Faculty of Health and Life Sciences Ethics Committee and the local trust Research and Development Department, thus complying with international ethical standards. Written, informed consent was sought from all participants prior to commencement of the focus group discussions. Midwives were aware that their participation was voluntary and that they were able to withdraw at any point during the study. Additionally, ground rules were stipulated at the beginning of each session to encourage confidentiality, respect of other's opinions and fairness in allowing each person to express their views and experiences. Pseudonyms have been used to replace identifying details and protect midwives' autonomy.

Findings

Demographic information of participants are shown in table 1 and the main themes and subthemes are shown in table 2.

Table 1: Participants' characteristics in each focus group.

Focus Group number	Area of work	Age	Years' experience as a midwife	Number of women cared for having a VBB (live births)
1 (P1-P4)	Community**: 1** Hospital (MLU* + delivery suite): **1** Independent midwifery: **2**	Range: **34-58 yrs** Mean: **43 ¼ yrs**	Range: **6 ½ – 16 yrs** Mean: **11 ½ yrs**	Range: **3-6** Mean: **4 ¾**
2 (P5-P8)	Community**: 1** Hospital (MLU + delivery suite): **2** Independent midwifery: **1**	Range: **29-56 yrs** Mean: **48 ¼ yrs**	Range: **3- 24 yrs** Mean: **13 ¾**	Range: **4-11** Mean: **5 ½**
3 (P9-P12)	Community**: 3** Hospital (MLU + delivery suite): **0** Independent midwifery: **1**	Range: **46-53 yrs** Mean: **50 ½ yrs**	Range: **8-33 yrs** Mean: **20 ¼ yrs**	Range: **3-30** Mean: **16 ⅓**

*****Midwifery-led unit (within hospital)

Table 2: Themes and subthemes

Theme 1: Viewing dimensions of normality of vaginal breech birth: o Viewing breech as an unusual norm o Viewing upright positions as best facilitating normal VBB o Viewing vaginal breech delivery as unsafe o Viewing breech as a non-emergency o Acknowledging potential problems and the need for a secure environment
Theme 2: Feelings of preparedness: o Feeling inexperienced with VBB o Feeling under-prepared for VBB o Negotiating support within a multi-professional context
Theme 3: Viewing restrictions on choice of vaginal breech birth: o Viewing practitioners as limiting choices for women o Perceiving other practitioners as coercing women o Viewing midwives as providing unbiased information

Theme 1: Viewing dimensions of normality of VBB

Viewing breech as an unusual norm

Midwives viewed VBB on a continuum of normality. At one end they fundamentally viewed the majority of VBB cases as being normal; this view seemed to underlie subsequent themes. It was more experienced midwives who shared this opinion (although less experienced midwives also agreed with this notion), as shown by this midwife with 24 years' experience:

P7: ...I trained long enough ago for breech to be considered one more rare than a cephalic birth but one type of normal birth! It wasn't described to me as an abnormal birth when I started...But...it is a normal birth…

Midwives used their knowledge of the mechanisms of a breech birth as a basis for seeing it as being normal and recalled experiences of uncomplicated VBBs (undiagnosed and diagnosed) which occurred in a variety of settings (home, MLUs and obstetric units). These experiences, resulting in good outcomes for mother and baby, reinforced their view that VBB can be normal.

Viewing upright positions as best facilitating normal VBB

From midwives' knowledge of the mechanisms of VBB, they viewed upright positions, including all-fours, squatting or kneeling, to be working with physiology and therefore enhancing the normal birth process.

P7: *...my favourite would be to have them on all fours...it facilitates what the baby's doing because your birth canal is now curved downwards and so the baby is following the birth canal. If you lie on your back; you do lift up because there's no gravity helping you so the gravity allows the baby to actually hang...let the body weight…bring the rest of the baby down...If you're actually on all fours…it allows the baby to…literally lift their knees and bend and bring the face through…*

Viewing vaginal breech delivery as unsafe

Midwives made a distinction between VBB and vaginal breech delivery; they saw the former as being hands-off, with the woman in her chosen position which facilitated spontaneous birth. Contrastingly, they saw vaginal breech delivery as being associated with lithotomy, medicalisation, hands-on approach and the possible use of forceps. Vaginal breech delivery was perceived by midwives to de-normalise the birthing process and to cause complications. As a result, midwives favoured Caesarean over vaginal breech delivery:

P6: ...the more you interfere, with inductions…and augmentations…I feel it's better, if this baby's not gonna start off normally…then maybe an elective section is slightly safer...you'd do better either not managing a breech, and if it's not happening, then going to section or- just going for section. Because it's that messing about in that third option [vaginal breech delivery] that leads to all the disasters...

Viewing Breech as a non-emergency

Midwives discussed VBB being treated as an emergency through the education provided and practitioner's actions in practice. They viewed this as an inappropriate label for VBB and spoke of experiences where treating VBB as an emergency had caused panicked reactions, viewed to disrupt normal birth:

P6: ...And I had to...press the emergency bell...soon as I did that all hell broke loose; a pair of forceps appeared; I'm trying to baste them off and that baby actually was not in very good condition...there was no calm! It went from 'Oh, it's a breech!' to all hell broke loose!

[caring for a woman with an undiagnosed breech in an admissions room]

Midwives appeared to want to normalise VBB by changing the education of it being an emergency, reinforcing the notion of VBB being normal and therefore a midwifery skill:

P6: ...perhaps they [educators] should take it out of obstetric emergencies along with PPH, shoulder dystocia and everything else…; cord prolapse…which is an emergency!…and put it in some other like advanced midwifery skill drill?

Acknowledging potential problems and the need for a secure environment

On the other end of the continuum, midwives discussed the elements of uncertainty surrounding the causes of breech presentation and the potential problems associated with VBB. Midwives' views moved away from viewing VBB as normal; recognising that there may

be underlying pathophysiology and therefore veered on the side of caution. Consequently, they discussed monitoring VBB progress carefully and the need for exercising judgement, especially if there was a lack of progress. d. One midwife's experience of a perinatal death polarised VBB from being normal. This unexpected outcome accentuated the view that VBB can be problematic:

[Whilst getting out of the pool to push]
P9: ...And as she stood up the cord fell out. A loop of flaccid cord; not a living-pulsating cord...And the fetal heart had been perfect until that point...Baby wasn't on the cord; there was a problem which caused the cord to come out. So, miraculously enough, we got her from home onto the theatre table and baby out within twenty minutes...he had a fetal heart when they scanned immediately before...when they got him out, he didn't. And they worked on him a long time...but the amount of brain damage that was present didn't tie in with the time scale.
P12: Oh, so it was already there from before...
P9: …yeah, for some reason it wasn't evident until she was fully…

Midwives also described experiences of resuscitating breech infants at birth. They preferred to be in a hospital environment (obstetric unit) where they had the assurance of access to theatres (and obstetric expertise) and paediatricians to provide assistance when needed:

P2: ...I feel quite...strongly that women who have a breech should have their baby in a hospital. Because they…are more likely to need help...either…the labour stalls them- they need assistance to have Caesarean section. Or...the baby may need assistance for resuscitation.

However, midwives wanted to normalise VBB within a hospital environment yet found it difficult to reconcile a hospital VBB with the normality. Midwives viewed a hospital VBB to be associated with less control of the environment; especially the intrusion of practitioners and therefore a lack of privacy:
P3: …delivery suite with lights on, everyone shouting and bulldozing their way into the room was absolutely the worst environment...in which to try and get a breech baby to be born safely and easily...

Therefore, midwives discussed balancing the potential need for help and protecting privacy:

P8: …you need a paediatrician lurching.
P7: Yes; you do!
P8: …Not a room full of people!
P6: ... you need the full Monty!
P7: ...Fine! They [those summoning assistance] can have their full Monty; on the other side of the door; quietly!

Theme 2: Feelings of preparedness

Feeling inexperienced with VBB

Midwives spoke about their experiences of VBB, in undiagnosed and diagnosed cases, where they did not feel experienced enough to provide the care they wanted to women as they felt their lack of experience affected their confidence. Although midwives felt competent to do a VBB, they talked about their inexperience due to lack of exposure to VBB. Midwives expressed that they would like more experience and exposure but were unsure about how this would happen:

P2: …I feel that it's a subject that I know quite a lot about; I would like to do more but you have to have the opportunity to do it...and [pause] I haven't had...a breech for a while.

In addition to themselves being inexperienced, midwives viewed the multi-disciplinary team as also lacking experience in vaginal breech birth; also due to lack of exposure caused by hospitals adopting a Caesarean protocol for breech presentation. Midwives linked the rarity of VBB to causing fear amongst practitioners:

P12: …But some of them [obstetricians]…have no experience at all - of vaginal breech! So they're terrified of it! They haven't seen it; they don't know how to do it; they don't want to do it; they just think it's terrifying!

Feeling under-prepared for VBB

Midwives felt that their statutory training was inadequate in teaching them the skills needed to assist a woman having a VBB, stating that it was mostly unrealistic (use of simulation manikins), obstetric focused and that some of it was irrelevant to the setting where they practiced:

P12: ...it's just with a dummy!…you need to be doing videos; they [educators] need to do a film [group agreement]; they need to have real births!
P11: Yeah…show you some breeches!

Therefore, midwives felt that they needed additional training in VBB. They were motivated and wanted to gain more in-depth understanding on the mechanisms of a VBB. This is demonstrated by midwives further discussing how they had, prior to this study, self-organised and self-funded to go on extra study days on VBB. This extra training seemed to benefit their feelings of confidence more than statutory training. Midwives discussed the benefits of visual aids coupled with explanations as greatly enhancing their understanding of the mechanisms of a VBB as it felt real:

P8: …They [educators] went into the physiology;… into great detail…to get us to completely understand the natural mechanisms of the breech...it showed videos of women…having vaginal breech births…it was such a powerful learning tool cause I feel like I've seen loads of

vaginal breech births. I haven't! But I've seen all those videos with the commentary. That's really helpful!

Negotiating support and learning within a multi-professional context

All midwives' experiences of VBB illustrated the impact of colleagues as either facilitating or hindering practice. As most midwives felt inexperienced with VBB, they expressed the importance of having the support of someone more experienced than them in VBB and able to teach them. Midwives recalled summoning support from doctors, paediatricians, paramedics and supervisors of midwives in cases of diagnosed and undiagnosed VBBs. Midwives appeared to define support as someone 'being there' rather than intruding. One midwife recalls the empowering experience of assisting a woman with a second twin breech birth with support from an obstetrician:

P11: *…I was very pleased that they let me at it. And I think, once again, down to a very confident consultant…who was there and was happy to...let me have a go...but obviously ready to step in at any second!*
P10: That's what you want really isn't it?
P11: ...Exactly! That's what you need.

Contrastingly, midwives recalled experiences where unsupportive practitioners had a negative effect on their feelings of confidence surrounding VBB. One midwife describes her experience of being 'pushed out of the way' by a doctor 'taking over' on an alongside MLU. This experience was therefore a hindrance for this midwife's learning of VBB:

[When speaking to the doctor after the VBB]
P1: ...I didn't want you to take over...I said to her [doctor] 'in the future...I haven't done it before...I'm not going to have that extra confidence of being able to of…done it...'

Theme 3: Viewing restrictions on choice of VBB

Viewing practitioners as limiting choices for women

Throughout discussion, midwives expressed their view that women are rarely offered the choice of a VBB, stating that it took an 'unusual', 'strong and confident' woman to choose a VBB. Midwives viewed other practitioners and institutional policies, as limiting the choices for women regarding VBB.

Midwives recounted experiences of caring for women who had to take extreme measures to ensure their choices were fulfilled. One midwife described a woman who had previously had a Caesarean for breech presentation, having a VBB with her second baby; demonstrating the risks that this woman took to ensure her choice was respected:

P2*: …[woman] said 'I wanted to get there so late that they couldn't do anything'. So she felt rushed into having a section first time and felt quite cross...that she'd ended up…in theatre having a section…she said 'I just waited a bit longer and then they had to catch my baby because they had no choice!'*

Midwives further viewed practitioner's lack of expertise in VBB to accentuate the complexities in decision making for women considering a VBB and therefore limiting choice:

P10: "There are a few good consultants who will give the choice. But actually I've heard [consultant] saying to people '...it's to do with…my team and my team of doctors aren't experienced' And I think…that's brutally honest, but valid!"

Perceiving other practitioners as coercing women

Midwives further discussed their experiences of caring for women (diagnosed and undiagnosed breech) who felt coerced into having a Caesarean through practitioners informing them of the risks of VBB. From the feedback midwives received from women who had been counselled about her choices of birth, midwives felt that women were 'scared into having a Caesarean.' They perceived other practitioners as providing one-sided information, promoting the choice of a Caesarean and failing to provide women with evidence which supported VBB. Therefore, midwives felt that women were not given an opportunity to make an informed choice:

P3: …it's…manipulating people to make them do what you [practitioner] think they had ought to do regardless of the evidence, regardless of the fact that there are options…you're just bulldozing people…

Viewing midwives as providing unbiased information

Unlike other practitioners, midwives viewed themselves as providing women with balanced information and therefore removing the restriction of choice to women. Some midwives tried to clarify what information women had been given by other practitioners. They saw themselves as balancing the information women had been given of promoting a Caesarean with providing information about VBB. Midwives facilitated information sharing through arranging additional appointments with women and lending women publications on breech birth:

P11: ...you'd go over the pros of...vaginal delivery, the risks, and then the...the important thing that they don't get which is...the cons of the surgery…

One midwife tells how she uses visual aids and verbal explanations to provide balanced information to women whilst also appreciating the difficulty of this:

P9: I've…counselled women beforehand. I do show them pictures; I take in slides...even ones that didn't go to plan cause the parents have given me permission to show them...I've got a picture of one whose head was stuck for ten minutes...so that you can see what...a good breech looks like and what a...
P11: …Not so good looks like...
P9: …I think…if we give women as much information as possible and try not to be biased; that's really hard...

Discussion:

This is the first study to explore midwives views, feelings of confidence and experiences surrounding VBB. The three themes demonstrated the complex relationship between midwives' feelings of confidence and experience. While midwives maintained their view that VBB can, predominantly, be normal, they also felt inexperienced in dealing with it. This subsequently impeded their confidence (and other practitioners's) in being able to assist women with VBB. They also seemed to perceive women's choices surrounding VBB as limited and therefore have seen themselves as facilitating women's decision making.

Since the advent of midwifery in the UK, its philosophies of care have revolved around promoting normal birthing, whereby midwives are considered the experts of normality (Donnison, 2004). Therefore, it is unsurprising that midwives in the present study viewed VBB as an unusual norm and clearly felt that breech babies can be born normally. Their view resonates with other experienced practitioners in VBB who promote the possibility of VBB in healthy women and babies through a holistic approach (Cronk, 1998; Evans, 2012; Walker, 2013). Throughout literature, environmental and psychological factors have been widely acknowledged to influence normal birthing (Dick-Read, 1959; Hofmeyr et al., 1991; Crabtree, 2008; Hodnett et al., 2013). Therefore, calm, peaceful environments should be protected in relation to VBB and practitioners should not treat it as an emergency without true justification, as expressed by midwives in this study.

Although midwives in this study lacked experience, they used their knowledge of physiology to support the notion of upright positions facilitating VBB. Again, this view subscribes to the midwifery role of promoting normal birthing (Royal College of Midwives' Campaign for Normal Birth, 2015). Experts in VBB also highlight that, in addition to gravity, upright positions enable the sacral prominence to move out and therefore reduces the risk of head entrapment (Cronk, 1998; Sutton, 2000; Bisits, 2002; Evans, 2012; Reitter et al., 2014). The benefits of adopting an upright birth position have been proven since the seminal work of Caldeyro-Barcia (1979). Regardless of presentation, evidence from systematic reviews demonstrates that upright positions shorten the length of labour (Lawrence et al., 2013) and reduces the need for assisted delivery (Gupta et al., 2012). These advantages correlate with the views of midwives in this study who thought that an upright position further facilitates a breech birth as opposed to the viewed suboptimal, medicalised vaginal breech delivery. Yet, lithotomy and dorsal positions still persists due to clinical traditions (Reitter et al., 2014). The RCOG (2006) recommend that women having a VBB, adopt dorsal and lithotomy positions as the available evidence supports these positions. However, recent study, although small, additionally supports upright VBB. A cohort study of 50 women found that the pelvic diameters (transverse, bituberous, bispinous) increased when women were in the kneeling squat position compared to the supine dorsal position (Reitter et al., 2014). Moreover, a prospective observational study of 41 breech births in the all fours position was associated with 70.7% of successful deliveries requiring no obstetric intervention (Bognor et al., 2014). The collective views, physiology and evidence supports the recommendation of supporting women having a VBB to adopt upright positions; an already integral aspect of midwifery practice. This will require a cultural shift for practitioners who feel more

confident supporting women in dorsal/lithotomy positions. It is also important to include education which simulates VBB in upright positions and supplementary objective research investigating the efficacy of upright VBB.

The suggestion that midwives are the ideal practitioners to assist women having VBB's may be slightly unrealistic; midwives in this study felt inexperienced, under-prepared and wanted support. This may be why midwives preferred hospital environments, as the multiprofessional team is nearby. It is well known that women having a VBB are more likely to have a Caesarean and their infants are more likely to need assistance at birth (Hannah et al., 2000; Berhan and Haileamlak, 2015; Mattila et al., 2015; Keirse, 2002). Consequently, it is not surprising that midwives in this study acknowledged potential problems and acted with caution. For these reasons, many guidelines recommend that women opting for VBB, give birth in the hospital setting (American Congress of Obstetricians and Gynaecologist (ACOG), 2006; RCOG, 2006; Society of Obstetricians and Gynaecologist Canada (SOGC), 2009; The Royal Australian and New Zealand College of Obstetricians and Gynaecologist (RANZCOG), 2013).

In addition to themselves lacking experience, midwives' viewed other practitioners in similar way. Unfortunately, research shows that obstetric experience in VBB is dwindling (Robson et al., 1999; Carcopino et al., 2007; Chinnock and Robson, 2007; Dhingra and Raffi, 2010). This may explain why midwives perceived other practitioners to be fearful of VBB. The presence of a skilled practitioner at VBBs is shown to be significantly associated with improved neonatal outcomes (Su et al., 2003); although this discussion provides a pessimistic outlook for its achievement. The obvious progressive step would be to adopt a team approach to supporting midwives wanting to gain VBB skills, whereby more experienced practitioners supervise midwives and pass on knowledge and skills and are present during VBBs. This would secure more safety for all involved and will improve midwives' experiences of VBB, opening more choice for women as practitioners become proficient in VBB. Another recommendation for clinical practice includes formulating a clinical guideline for VBB, identifying appropriate midwifery and obstetric care (and works in close collaboration between the two);. This in turn may provide clarity for practitioners. Moreover, education in VBB must be multi-professional, incorporating team working and human factors.

In relation to the education, although simulation training has been shown to improve performance and outcomes (Cooper et al., 2012), midwives felt that it was inadequate in preparing them to assist women having a VBB. Simulation methods are predominantly used for teaching emergency scenarios (Crofts et al., 2011) and this may explain why it did not meet midwives' learning needs of managing VBB from a midwifery perspective of promoting normality and utilising physiology. Nevertheless, simulation training is advocated for low-frequency, high-risk situations (such as VBB) and has its place in practicing manoeuvres and improving competence (Cooper et al., 2012; Crofts et al., 2011; Hunter, 2014). Therefore, further recommendations for education include using pictures and videos (alongside simulation) with explanations that demonstrate physiological VBB and VBBs where assistance is needed (teaching how to recognise deviations from the norm).

The present study also showed that midwives viewed women to have limited choices regarding VBB. Indeed, practitioners have been warned of neglecting women's autonomy if they only inform on the magnified risks of having a VBB (Kotaska, 2007). There has been much concern amongst practitioners (Caughey, 2007; Kotaska, 2007; Walker, 2013) regarding the poor exercise of judgement on individual cases of VBB and a lack of considering the risks that also takes into account organisational factors (i.e. staffing). Guidelines state that women should be informed of the risks and benefits of *both* a Caesarean and a VBB (ACOG, 2006; RCOG, 2006; SOGC, 2009; RANZCOG, 2013). A qualitative study on women's experiences of VBB in Australia (Homer et al., 2015), demonstrated that women highly valued balanced information when making decisions and the importance of control in their overall childbearing experience (women who eventually had a Caesarean still appreciated the opportunity to try for a VBB). This study, alongside other qualitative studies (Founds, 2007; Guittier et al., 2011; Homer et al., 2015), further highlights the organisational and societal norms that create conflict for women choosing a VBB. Another Australian qualitative study showed how practitioners relayed information of the safety and risks of a VBB, in a way which was sensitive and woman centred (Catling et al., 2015). This study was conducted in centres which had been offering VBB services for 5 years ("breech clinics") and may explain why midwives' views in the present study were dissimilar; there were no hospitals offering this service in the areas where they worked. Therefore, to overcome this, it is suggested that practice areas provide balanced written and verbal information for women considering a VBB; midwives are ideally placed to do this as they are often the diagnosing practitioners. However, it is also necessary for midwives to make referrals to obstetric colleagues for shared care and for these women to receive continuity or care if choosing a VBB (Catling et al., 2015). Moreover, given the complexity of decision making surrounding VBB, practitioners may need additional training in this, whereby the RCOG (2008) provide useful guidance.

Strengths and limitations

This study shows new insights into midwives views, experiences and feelings of confidence surrounding VBB. The exploratory nature of this study allowed many aspects of VBB to be discussed, although this conversely implies that individual aspects may not have been fully uncovered. The study benefited from participants from different areas of practice, who provided an array of views and highlighted the complex factors influencing these views, as expected of qualitative research (Hennink et al., 2011). However, one of the limitations of this study were that midwives' accounts of their experiences were to some extent retrospective as, many of the participant's experiences were from more than five years ago. In addition, the self-selecting nature of recruitment meant that only midwives interested in VBB took part and the results may not reflect views of other midwives.

Conclusion

This study showed that midwives in the UK primarily viewed VBB to be on a continuum of normality, where they saw themselves as being both the facilitators of physiological VBB and information providers in relation to choices surrounding VBB. However, all of this was

moderated by their feelings of inexperience and unpreparedness. The key findings of this study have implications for clinical practice, education and further research. Midwives should be provided with more opportunities to learn about and experience caring for women with VBB through teamwork, mentorship and the use of guidelines. Additionally balanced written and verbal information should be available to women considering a VBB. Education in VBB should focus on learning what is normal for VBB and how to detect deviations through the use of realistic teaching aids (pictures, videos) and upright simulation. VBB education must also emphasise the importance of teamwork and understanding roles. Future research needs to done investigating the efficacy of upright VBB. Moreover, it would be valuable to conduct qualitative studies focusing on the views of obstetric colleagues, to further improve the care of women having a VBB.

Conflict of interest statement

The authors declare that there is no conflict of interest. This study received no grant or funding from non-profit, public or commercial organisations.

References

American Congress of Obstetricians and Gynaecologist, 2006. ACOG Commitee Opinion No 340, Mode of term singleton breech delivery. Obstetrics and Gynaecology 108: 1, 235-237.

Berhan, Y., Haileamlak, A., 2015. The risks of planned vaginal breech delivery versus planned Caesarean section for term breech birth: a meta-analysis including observational studies. BJOG: An International Journal of Obstetrics and Gynaecology 123:1, 49-57.

Bisits, A., 2002. Upright positions in breech birth: an obstetrician's impression. New South Wales, BirthRite.

Bogner, G., Strobl, M., Schausberger, C., Fischer, T., Reisenberger, K., Jacobs, V., R., 2014. Breech delivery in the all fours position: A prospective, observational, comparative study with classical assistance. Journal of Perinatal Medicine, 1:43, 6, 707-713.

Borbolla Foster, A., Bagust, A., Bisits, A., Holland, M., Welsh, A., 2014. Lessons to be learnt in managing the breech presentation at term: An 11-year single-centre retrospective study. Australian and New Zealand Journal of Obstetrics and Gynaecology, 54:4, 333-339.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qualitative Research in Psychology 3, 77-101.

Braun, V., Clarke, V., 2013. Successful Qualitative Research: a practical guide for beginners. Sage, London.

Caldeyro-Barcia, R., 1979. The Influence of Maternal Position on Spontaneous Rupture of the Membranes, Progress of Labor and Fetal Head Compression. Birth and the Family Journal 6:1, 7-15.

Carcopino, X., Shojai, R., D'Ercole, C., Boubli, L., 2007. French trainees in obstetrics and gynaecology theoretical training and practice of vaginal breech delivery: A national survey. European Journal of Obstetrics & Gynaecology and Reproductive Biology 135: 17-20.

Catling, C., Petrovoska, K., Watts, N. P., Bisits, A., Homer, C. S. E., 2015. Care during the decision-making phase for women who want a vaginal breech birth: Experiences from the field. Midwifery (article in press) DOI: 10.1016/j.midw.2015.12.008

Caughey, A., B., 2007. Counselling patients about the obstetric risk: the breech experience. Journal of Perinatology 27, 139-140.

Chinnock, M., Robson, S., 2007. Obstetric Trainees' Experience in Vaginal Breech Delivery. American College of Obstetrics and Gynaecologist 110 ,4, 900-903.

Cooper, S., Cant, B., Porter, J., Bogossian, F., Mckenna, L., Brady, S., Fox-Young, S., 2012. Simulation based learning in midwifery education: A systematic review. Woman and Birth 25, 64-78.

Crabtree, S., 2008. Midwives constructing 'normal birth'. In: Downe, S. (Ed.), Normal Childbirth: Evidence and Debate (2nd editon). Churchill Livingstone Elsevier, London. pp. 97113.

Crofts, J.F., Winter, C., Sowter, M.C., 2011. Practical Simulation training for maternity- where we are and where next. BJOG: an International Journal of Obstetrics and Gynaecology, 118, 11-16.

Cronk, M., 1998. Midwifery Skills needed for Breech Birth. Midwifery Matters 78, 11-12.

Dick-Read, G., 1959. Childbirth without fear (4th ed.). Heinemann Medical Books, London.

Dhingra, S., Raffi, F., 2010. Obstetric trainee's experience in VBD and ECV in the UK. Journal of Obstetrics and Gynaecology 30 ,1: 10-12.

Donnison, J., 2004. A History of the Profession in the UK. In: Henderson, C., Macdonald, S., (Eds.) (13th edition) Mayes' Midwifery; a Textbook for Midwives. Bailliere and Tindall, London. pp. 1071-1099.

Evans, J., 2012. Understanding Physiological Breech Birth. Essentially MIDIRS 3:2, 17-21.

Flick, U., 2009. An Introduction to Qualitative Research (4th edition). Sage Publications Ltd, London.

Founds, S., A., 2007. Women's and providers' experiences of breech presentation in Jamaica: A qualitative study. International Journal of Nursing Studies 44, 1391-1399.

Glezerman, M., 2006. Five years to the term trial: The rise and fall of a randomised control trial. American Journal of Obstetrics and Gynaecology, 194, 20-25.

Goffinet, F., Carayol, M., Foidart, J.M., Alexander, S., Uzan, S., Subtil, D., Breart, G., 2006. Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium, 194, 1002-1011.

Guittier, M. J., Bonnet, J., Jarabo, G., Boulvain, M., Irion, O., Hudelson, P., 2011. Breech presentation and choice of mode of childbirth: A qualitative study of women's experiences. Midwifery 27: e208-213.

Gupta, J., K., Hofmeyr, G., J., Shehmar, M., 2012. Position in second stage of labour for women without epidural anaesthesia. The Cochrane Database for Systematic Reviews, issue 5.

Hannah, M. E., Hannah, W. J., Hewson, S. A., Hodnett, E. D., Saigal, S., Willan, A. R., 2000. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. The Lancet 356, 1375- 1383.

Hemelaar, J., Lim, L. N., Impey, L. W., 2015. The Impact of an ECV Service is Limited by Antenatal Breech Detection: A Retrospective Cohort Study. Birth 42, 2, 165-172.

Hennink, M., Hutter, I., Bailey, A., 2011. Qualitative Research Methods. Sage, London.

Hickok, D.E., Gordon, D.C., Milberg, J.A., Williams, M.A., Daling, J.R., 1992. The frequency of breech presentation by gestational age at birth: a large population-based study. American Journal of Obstetrics and Gynaecology 166: 3, 851-852.

Hodnett, E. D., Gates, S., Hofmeyer, G., J., Sakala, C., 2013. Continuous Support for women during childbirth. The Cochrane Database for Systematic Reviews, Issue 7.

Hofmeyr, G. J., Kulier, R., West, H.M., 2015. External cephalic version for breech presentation at term. The Cochrane Database for Systematic Reviews, Issue 10.

Hofmeyr, G. J., Nikodem, V. C., Wolman, W., L., Chalmers, B. E., Kramer, T., 1991. Companionship to modify the clinical birth environment: effects on progress and perceptions of labour and breastfeeding. British Journal of Obstetrics and Gynaecology 98, 756-764.

Homer, C. S. E., Watts, N. P., Petrovska K., Sjostedt C. M., Bisits, A., 2015. Women's experiences of planning a vaginal breech birth in Australia. BMC Pregnancy and Childbirth 15, 89.

Hunter, L. A., 2014. Vaginal Breech Birth: Can We Move Beyond the Term Breech Trial? Journal of Midwifery and Women's Health 59:3, 320-327.

Keirse, M. J. N. C., 2002. In the Literature: Evidence-Based Childbirth Only for Breech Babies? Birth 29 :1, 55-59.

Kotaska, A., 2007. Combating Coercion: Breech Birth, Paturient Choice, and the Evolution of Evidence-Based Maternity Care. Birth 34:2, 176-180.

Krueger, R. A., Casey, M. A., 2009. Focus Groups: A Practical Guide for Applied Research (4th edition). Sage Publications, London.

Lawrence, A., Lewis, L., Hofmeyr, G. J., Styles, C., 2013. Maternal positions and mobility during first stage labour. The Cochrane Database of Systematic Reviews, issue 10.

Mattila, M., Rautkorpi, J., Heikkinen, K., 2015. Pregnancy outcomes in breech presentation analysed according to intended mode of delivery. Acta Obstetricia et Gynecologica Scandinavica, 94, 1102-1104.

Nursing and Midwifery Council (NMC), 2009. Standards for pre-registration midwifery education. Nursing and Midwifery Council, London.

Reitter, A., Daviss, B., A., Bisits, A., Schollenberger, A., Vogl, T., Herrmann, E., Louwen, F., Zangos, S., 2014. Does pregnancy and/or shifting positions create more room in a woman's pelvis? American Journal of Obstetrics and Gynaecology 211:6, 662. e1-662.e9.

Robson, S., Ramsay, B., Chandler, K., 1999. Registrar Experience in Vaginal Breech Delivery. How Much is Occurring? The Australian and New Zealand Journal of Obstetrics and Gynaecology 39, 2, 215-217.

Roosmalen, J. and Rosendaal, F., 2002 There is still room for disagreement about vaginal delivery of breech infants at term. BJOG: an International Journal of Obstetrics and Gynaecology, 109, 967-969.

Royal College of Midwives, 2015. Ten top tips for practice. Available at: http://www.rcmnormalbirth.org.uk/ten-top-tips/ (accessed 04/01/2016).

Royal College of Obstetricians and Gynaecologist (RCOG) 2006. RCOG Green Top Guidelines: The management of Breech Presentation. Guideline no. 20b, London.

Royal College of Obstetricians and Gynaecologist (RCOG) 2008. Presenting information on risk. Clinical Governance Advice No. 7, London.

Society of Obstetricians and Gynaecologist of Canada guidelines, 2009. Vaginal delivery of breech presentation. International Journal of Gynecology and Obstetrics, 107, 169-176.

Su, M., McLeod, L., Ross, S., Willan, A., Hannah, W., J., Hutton, E., Hewson, S., A., Hannah, M., E., 2003. Factors associated with adverse perinatal outcomes in the TBT. American Journal of Obstetrics and Gynaecology 189:3, 740-745.

Sutton, J., 2000. Birth without active pushing: A physiological second stage of labour. Practising Midwife 3: 4, 32-34.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologist, 2013. Management of Breech Presentation at Term. College Statement: C-Obs 11.

Walker, S., 2012. Breech Birth: an unusual normal. The Practising Midwife 15: 3, 18, 20-21.

Walker, S., 2013. Undiagnosed breech: towards a woman-centred approach. British Journal of Midwifery 21: 5, 244-249.

Whyte, H., Hannah, M., E., Saigal, S., Hannah, W. J., Hewson, S., Amankwah, K., Cheng, M., Gafni, A., Guselle, P., Helewa, M., Hodnett, E. D., Hutton, E., Kung, R., McKay, D., Ross, S., Willan, A., 2004. Outcomes of children at 2 years after planned caesarean birth versus

planned vaginal birth for breech presentation at term: The International Randomized Term Breech Trial. American Journal of Obstetrics and Gynaecology, 191, 864-71.