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**Search details**

Midwives views on vaginal breech birth. Midwives and Obstetricans skills in conducting breech deliveries.

**Resources searched**

NICE Evidence; TRIP Database; Cochrane Library; BNI; CINAHL; EMBASE; MEDLINE; Google Scholar

**Database search terms:** breech; delivery; birth; presentation; exp BREECH PRESENTATION; exp BREECH DELIVERY; vagina; vaginal; childbirth; natural; midwife; midwives; midwifery; exp MIDWIVES; obstetrician*; opinion*; view*; survey*; outlook; skill*; competence*; expertise; proficiency

**Evidence / Google Scholar search string(s):** (midwives OR midwife OR obstetrician) (opinion OR views OR survey OR outlook OR skill OR competence OR expertise OR proficiency) (“breech birth” OR “breech delivery”)

**Summary**

There is some research looking at the skill level of midwives and obstetricians in relation to breech presentations, and some studies looking at views and opinions, much of it from outside the UK.
Published Research – Databases

1. **Development of a dedicated breech service in a London teaching hospital.**
   
   **Author(s)** Kidd, L, Rivers, A, George, R, Singh, N, Yentis, Sm
   
   **Citation:** Archives of Disease in Childhood -- Fetal & Neonatal Edition, 02 June 2014, vol./is. 99/(0-), 13592998
   
   **Publication Date:** 02 June 2014
   
   **Abstract:** Since the Term breech trial, elective caesarean section (CS) rather than vaginal delivery has become standard practice for breech presentation. External cephalic version (ECV), manual rotation of the fetus from a breech to a cephalic position, is an alternative to a CS(1) and is recommended by the Royal College of Obstetricians and Gynaecologists. Anxieties about procedural pain and concerns of risks to the fetus are major reasons women decline ECV.(2,3) In 2011, 3.8% (n = 190) of babies were breech in our hospital and only 16.3% (n = 31) of these women opted for ECV after seeing various health professionals. Different obstetricians had an overall success rate of 25.8% performing ECV. A dedicated breech service led by a specialist midwife and an obstetrician was developed in 2013 (Figure 1). Over the subsequent six-months, 83 women were referred to the service. Sixty women were confirmed breech at their first visit and 50 persisted as breech at their second visit. Thirty-nine women (78%) agreed to an ECV performed between 36 and 37 weeks and the ECV success rate improved to 48.6% (p < 0.05 vs pre-service using Chi-square test). Reasons for the improved uptake and success of ECV include better communication, the offer of analgesia (remifentanil) and a single operator. 83.3% of the women who had a successful ECV subsequently achieved a vaginal delivery.


   **Source:** CINAHL
   
   Available in fulltext from Fetal and Neonatal at Highwire Press

2. **Re-engaging with vaginal breech birth: A philosophical discussion.**
   
   **Author(s)** Sanders, Ruth, Steele, Dianne
   
   **Citation:** British Journal of Midwifery, 01 May 2014, vol./is. 22/5(326-331), 09694900
   
   **Publication Date:** 01 May 2014
   
   **Abstract:** The philosophical debate as to whether midwives are equipped to support women requesting vaginal breech birth continues, yet midwives are deemed able to conduct a vaginal breech birth in an 'emergency' scenario. The International Breech Birth Conference (2012) prompted the discussion of how midwives can revisit the facilitation of vaginal breech birth as a normal birth phenomenon in the post-Term Breech Trial era. The conference delegates concluded that vaginal breech birth is indeed a safe option with strict...
3. Vaginal Breech Birth: Can We Move Beyond the Term Breech Trial?

Author(s): Hunter, Linda A.

Citation: Journal of Midwifery & Women's Health, 01 May 2014, vol./is. 59/3(320-327), 15269523

Publication Date: 01 May 2014

Abstract: Since the publication of the Term Breech Trial in 2000, planned cesarean has become the preferred mode of birth for women whose fetus is in a breech presentation. Over the past 20 years, however, subsequent evidence has not shown conclusively that cesarean birth is safer than vaginal birth for a fetus in a breech presentation when certain criteria are met. Many obstetric organizations support the option of planned vaginal birth for women with a breech presentation under strict prelabor selection criteria and intrapartum management guidelines. The growing trend toward cesarean unfortunately has left midwives and other intrapartum care providers in training with dwindling opportunities to competently master skills for vaginal breech birth. Although simulation training offers opportunities to practice infrequently encountered skills such as vaginal breech birth, it is unknown if this alternative will provide sufficient experience for future generations of clinicians. As a result, women with a breech presentation at term who desire a trial of labor often have limited choices. This article reviews the controversies surrounding the ideal mode of birth created by the Term Breech Trial. Criteria for vaginal breech birth are summarized and the role of simulation explored. Implications for midwifery practice when a breech presentation is diagnosed are also included.

Source: CINAHL

4. A qualitative interview study exploring pregnant women's and health professionals' attitudes to external cephalic version

Author(s): Say, Rebecca, Thomson, Richard, Robson, Stephen, Exley, Catherine

Citation: BMC Pregnancy and Childbirth, Jan 2013, vol. 13, no. 4, p. 9 pages, 1471-2393 (January 16, 2013)

Publication Date: January 2013

Abstract: Background: Women who have a breech presentation at term have to decide whether to attempt external cephalic version (ECV) and how they want to give birth if the baby remains breech, either by planned caesarean section (CS) or vaginal breech birth. The aim of this study was to explore the attitudes of women with a breech presentation and health professionals who manage breech presentation to ECV. Methods: We carried out semi-structured interviews with pregnant women with a breech presentation (n=11) and health professionals who manage breech presentation (n=11) recruited from two hospitals in North East England. We used purposive sampling to include women who chose ECV and women who chose planned CS. We analysed data using thematic analysis, comparing between individuals and seeking out disconfirming cases. Results: Four main themes emerged from the data collected during interviews with pregnant women with a breech presentation: ECV as a means of enabling natural birth; concerns about ECV; lay and professional accounts of ECV; and breech presentation as a means of choosing planned CS. Some women's attitudes to ECV were affected by their preferences for how to give birth. Other women chose CS because ECV was not acceptable to them. Two main themes emerged from the interview data about health professionals' attitudes towards ECV: directive counselling and attitudes towards lay beliefs about ECV and breech presentation. Conclusions: Women had a range of attitudes to ECV informed by their preferences for how to give birth; the acceptability of ECV to them; and lay accounts of ECV, which were frequently negative. Most professionals described having a preference for ECV and
reported directly counselling women to choose it. Some professionals were dismissive of lay beliefs about ECV. Some key challenges for shared decision making about breech presentation were identified: health professionals counselling women directly about ECV and the differences between evidence-based information about ECV and lay beliefs. To address these challenges a number of approaches will be required. [PUBLICATION] 23 references

**Source:** BNI
Available in fulltext from BMC Pregnancy and Childbirth at BioMedCentral
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Available in fulltext at BMC Pregnancy and Childbirth: Collection notes: On first login to a ProQuest journal you will need to select 'Athens (OpenAthens Federation)' from Select Region, and then 'NHS England' from Choose your Library.
Available in fulltext from BMC Pregnancy and Childbirth at National Library of Medicine
Available in fulltext from BMC Pregnancy and Childbirth at Directory of Open Access Journals


**Author(s)** Walker S

**Citation:** Practising Midwife, March 2012, vol./is. 15/3(18, 20-1), 1461-3123;1461-3123 (2012 Mar)

**Publication Date:** March 2012

**Abstract:** Over the last decade, there has been a loss in confidence and eroded skills due to the near universal policy of advising caesarean section in the wake of the Term Breech trial (Hannah et al 2000). Breech birth has been increasingly viewed as a complication, and management of the breech presenting baby at term has shifted firmly into the realm of obstetric practice in most parts of the UK. Small pockets of exception remain, among NHS and independent midwives who have maintained their skills with breech birth and are sought out by women denied the choice of a vaginal birth elsewhere. With continued focus on consumer choice, women led care and increasing normality, we urgently need to address the issue of how the NHS can safely provide the option of normal breech birth before these skills are permanently lost. This article suggests ways midwives may play a role within the NHS in ensuring women have a choice to birth their breech babies normally, in the safest possible way.

**Source:** Medline
Available in print at Pilgrim Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library


**Author(s)** Maier, Barbara, Georgoulopoulos, Alexander, Zajc, Michael, Jaeger, Tobias, Zuchna, Christian, Hasenoehrl, Gottfried

**Citation:** Journal of Perinatal Medicine, 01 July 2011, vol./is. 39/4(385-390), 03005577

**Publication Date:** 01 July 2011

**Abstract:** Objective: To show that the fetal outcome in vaginal deliveries (VD) of breech presentation in a setting of a senior obstetrician stand-by system is as good as in planned
Patients and methods: This observational prospective intent-to-treat study (n=211 singleton breech presentation pregnancies of ≥35 weeks of gestation) compared two groups of breech deliveries: planned cesarean sections (PCS, n=126) and intended VD (IVD, n=85) resulting in vaginal deliveries (VD, n=46) as well as secondary cesarean sections (SCS, n=39). Women's informed choice as well as strict pre-selection criteria for vaginally intended breech presentation deliveries was followed. Results: Fetal outcome of vaginal breech deliveries and of primary as well as SCS (45.9% of IVD) was comparable in terms of cord blood pH, base excess, Apgar score, fetal trauma, and transfer to neonatal intensive care unit. Conclusions: Vaginal breech delivery is a safe option in a stand-by system of senior obstetricians with controlled decision-making before labor.

Source: CINAHL
Available in fulltext from Journal of Perinatal Medicine at EBSCOhost
Available in fulltext from Journal of Perinatal Medicine at EBSCOhost


Author(s) Rijnders M, Offerhaus P, van Dommelen P, Wiegers T, Buitendijk S
Citation: Birth: Issues in Perinatal Care, 01 June 2010, vol./is. 37/2(124-133), 07307659
Publication Date: 01 June 2010

Abstract: Background: Until recently, external cephalic version to prevent breech presentation at birth was not widely accepted. The objective of our study was to assess the prevalence, outcomes, and women's experiences of external cephalic version to improve the implementation of the procedure in the Netherlands. Methods: A prospective cohort study was conducted of 167 women under the care of a midwife with confirmed breech presentation at a gestational age of 33 completed weeks or more. Results: Between June 2007 and January 2008, 167 women with a confirmed breech presentation were offered an external cephalic version. Of this group, 123 women (73.7%, 95% CI: 65.5-80.5) subsequently received the version. These women had about a ninefold increased probability of a cephalic presentation at birth compared with women who did not undergo a version (relative risk [RR]: 8.8, 95% CI: 2.2-34.8). The chance of a vaginal birth after an external cephalic version was almost threefold (RR: 2.7, 95% CI: 1.5-5.0). The success rate was 39 percent, although considerable differences existed associated with region and parity. Ninety-four percent of women with a successful version rated it as a good experience compared with 71 percent of women who had a failed version (p = 0.015). Significant pain during the version was experienced by 34 percent of women, of whom 18 percent also experienced fear during the version, compared with no women who reported little or no pain (p = 0.006). Women who reported significant pain or fear during the version experienced the version more negatively (OR: 6.0, 95% CI: 3.3-12.2 and OR: 2.7, 95% CI: 1.1-6.0, respectively). Conclusions: One in every four women with a breech presentation in independent midwifery care did not receive an external cephalic version. Of the women who received a version one third experienced significant pain during the procedure. Considerable regional variation in success rate existed. (BIRTH 37:2 June 2010)

Source: CINAHL
Available in fulltext from Birth: Issues in Perinatal Care at EBSCOhost

8. Obstetric trainees' experience in vaginal breech delivery: Implications for future practice

Author(s) Chinnock M., Robson S.
Citation: Obstetrics and Gynecology, October 2007, vol./is. 110/4(900-903), 0029-7844 (October 2007)
Publication Date: October 2007

Abstract: OBJECTIVE: To determine whether trainee obstetricians intend to offer vaginal breech delivery once they become certified as specialists and to quantify their experience in vaginal breech delivery. METHODS: This was an anonymous postal survey of all Australian trainee obstetricians. The survey inquired about experience with, confidence in,
and intentions regarding planned vaginal breech delivery after trainees' certification as specialists. RESULTS: Surveys were sent to all 303 Australian registered trainee obstetricians. The response rate was 65%. Experience in vaginal breech delivery increased with year of training, from a median of one delivery for first-year trainees to a median of 12 deliveries for final-year trainees. Although 53% of final-year trainees reported feeling confident with vaginal breech delivery, only 11% reported an intention to offer planned vaginal breech delivery at term as a specialist. CONCLUSION: Few of the next generation of specialist obstetricians plan to offer vaginal breech delivery to their patients. 2007 The American College of Obstetricians and Gynecologists.

Source: EMBASE
Available in fulltext from Obstetrics & Gynecology at the ULHT Library and Knowledge Services' eJournal collection
Available in fulltext from Obstetrics and Gynecology at Free Access Content


Author(s) Rietberg CCT, Elferink-Stinkens PM, Visser GHA
Citation: BJOG: An International Journal of Obstetrics & Gynaecology, 01 February 2005, vol./is. 112/2(205-209), 14700328
Publication Date: 01 February 2005
Abstract: OBJECTIVE: To examine the effects of the Term Breech Trial on the medical behaviour of Dutch obstetricians and on neonatal outcomes. DESIGN: Retrospective observational study. SETTING: The Netherlands. POPULATION: Infants born at term in breech presentation in the Netherlands between 1998 and 2002, with birthweights < or =4000 g (n= 33,024) and >4000 g (n= 2429), respectively. Multiple pregnancies, antenatal death and major congenital malformations were excluded. METHODS: Data derived from the Dutch Perinatal Database were used to compare modes of delivery and neonatal outcome of infants born in breech position in the 33 months preceding publication of the Term Breech Trial and in the 25 months thereafter. MAIN OUTCOME MEASURES: Incidence of planned and emergency caesarean section, vaginal breech delivery, perinatal death, 5-minute Apgar score and birth trauma. RESULTS: Within two months after publication of the Term Breech Trial, the overall caesarean rate increased from 50% to 80% and has remained stable thereafter. In the group of infants < or =4000 g, this was associated with a significant decrease of perinatal mortality from 0.35% to 0.18%, a decrease of the incidence of a 5-minute Apgar score <7 from 2.4% to 1.1% and a decrease of birth trauma from 0.29% to 0.08%. In the (small) group of infants >4000 g, a similar trend was observed. CONCLUSIONS: The Term Breech Trial has resulted in an exceptionally rapid change in medical behaviour by Dutch obstetricians. This change was followed by improved neonatal outcome.

Source: CINAHL
Available in fulltext from BJOG: An International Journal of Obstetrics & Gynaecology at EBSCOhost
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Available in print at Lincoln County Hospital Professional Library
Available in fulltext from BJOG: An International Journal of Obstetrics and Gynaecology at Wiley

10. A breech too far.

Author(s) Hall, J
Citation: Modern Midwife, Apr 2004, vol. 7, no. 4, p. 4-5, 0963-276X (April 2004)
Abstract: Commentary on the reluctance of the midwifery profession to allow expectant mothers with breech presentations to choose vaginal delivery. Issues of concern included their lack of experience in breech birth and the need to devise training aimed at midwives rather than doctors in techniques such as external cephalic version. ([BNI unique abstract]) 3 references

Source: BNI

11. External cephalic version -- a new midwifery role.
Author(s) Taylor P, Robson S
Citation: British Journal of Midwifery, 01 April 2003, vol./is. 11/4(207-210), 09694900
Publication Date: 01 April 2003
Abstract: The RCOG (2001) recommend external cephalic version (ECV) for breech presentation at term. When practised at term ECV has been shown to be safe and effective avoiding the associated risks of a vaginal breech delivery for the fetus and caesarean section for the mother. However, despite evidence of benefit, the provision of ECV varies due to lack of appropriately trained medical staff available to perform this procedure safely and effectively. This article describes the introduction of a midwife-led ECV service at the Royal Victoria Infirmary Newcastle and includes the preparation and rationale for expanding the midwife’s role, the training undertaken and results of independent clinical practice. The authors report a midwife success rate of 43%, which is comparable to that of an experienced obstetrician.

Source: CINAHL
Available in print at Pilgrim Hospital Staff Library
Available in print at Grantham Hospital Staff Library
Available in fulltext from British Journal of Midwifery at EBSCOhost

12. Staff experience in vaginal breech delivery.
Author(s) Thornton, J, Hayman, R
Citation: British Journal of Midwifery, Jul 2002, vol. 10, no. 7, p. 408-410, 0969-4900 (July 2002)
Publication Date: July 2002
Abstract: Editorial on midwives' and obstetricians' lack of experience. [(BNI unique abstract)] 6 references

Source: BNI
Available in print at Pilgrim Hospital Staff Library
Available in print at Grantham Hospital Staff Library
Available in fulltext from British Journal of Midwifery at EBSCOhost

Author(s) Harder U, Reutter R, Luyben A, Gross MM
Citation: Zeitschrift fur Geburtshilfe und Neonatologie, April 2002, vol./is. 206/2(72-4), 0948-2393:0948-2393 (2002 Apr)
Publication Date: April 2002
Abstract: Increasing caesarean section rates are a world wide concern in obstetrics. One of the latest contributing factors is the elective caesarean section in uncomplicated singleton pregnancy at term. The preference for this mode of delivery was primarily brought forward by obstetric practitioners (Al Mufty, McCarthy, Fisk 1996). A questionnaire, which
mainly aimed to ask German-speaking midwives in Austria, Germany and Switzerland about their personal choice of delivery mode, was included in one of the issues of the German-language midwifery journal “Die Hebamme”. This questionnaire contained 5 half-closed/half open questions describing specific obstetric occurrences. The midwives were asked to express their preferred mode of delivery and describe their reason for choosing. 446 questionnaires (12%) were returned. The majority (100%) of the German-speaking midwives preferred a normal vaginal delivery in an uncomplicated singleton pregnancy at term with a child in cephalic presentation. The rating was about the same (97%) in the presence of general risk factors which don’t indicate a primary caesarean section. Breech presentation and macrosomia are a matter of concern to the midwives. Midwives arguing for a first child in breech presentation or with macrosomia > 4.5 kg vote highly significantly more frequently for elective caesarean section than midwives arguing for at least the second child. The first-rate reasons for the preference of vaginal delivery concern the natural and physiological way of delivery, the personal experience of delivery, the higher risks of caesarean section and the possibility of a later caesarean section in case of fetal distress during first or second stage of labour. Concerns are expressed about the maintenance of competence amongst practitioners, thus influencing the choice of mode of delivery in obstetrics.

Source: Medline

14. Midwives and breech births.

Author(s) Cronk M

Citation: Practising Midwife, 01 July 1998, vol./is. 1/7/8(44-45), 14613123

Publication Date: 01 July 1998

Abstract: Mary Cronk reflects on some breech births which she has attended, and describes the conditions in which it is likely that a vaginal birth will be safe and straightforward.

Source: CINAHL

Available in print at Grantham Hospital Staff Library

Some additional results

1. Personal birth preferences and actual mode of delivery outcomes of obstetricians and gynaecologists in South West England; with comparison to regional and national birth statistics.

Author(s) Lightly K, Shaw E, Dallami N, Bisson D

Citation: European Journal of Obstetrics, Gynecology, & Reproductive Biology, October 2014, vol./is. 181/(95-8), 0301-2115;1872-7654 (2014 Oct)

Publication Date: October 2014

Abstract: OBJECTIVE: To determine personal birth preferences of obstetricians in various clinical scenarios, in particular elective caesarean section for maternal request. To determine actual rates of modes of deliveries amongst the same group. To compare the obstetrician’s mode of delivery rates, to the general population.STUDY DESIGN: Following ethical approval, a piloted online survey link was sent via email to 242 current obstetricians and gynaecologists, (consultants and trainees) in South West England. Mode of delivery results were compared to regional and national population data, using Hospital Episode Statistics and subjected to statistical analysis.RESULTS: The response rate was 68%. 90% would hypothetically plan a vaginal delivery, 10% would consider a caesarean section in an otherwise uncomplicated primiparous pregnancy. Of the 94/165 (60%) respondents with children (201 children), mode of delivery for the first born child; normal vaginal delivery 48%, caesarean section 26.5% (elective 8.5%, emergency 18%), instrumental 24.5% and vaginal breech 1%. Only one chose an elective caesarean for maternal request. During 2006-2011 obstetricians have the same overall actual modes of birth as the population (p=0.9).CONCLUSIONS: Ten percent of obstetricians report they would consider requesting caesarean section for themselves/their partner, which is the lowest rate reported within UK studies. However only 1% actually had a caesarean solely for maternal choice.
When compared to regional/national statistics obstetricians currently have modes of delivery that are not significantly different than the population and suggests that they choose non interventional delivery if possible. Copyright 2014 Elsevier Ireland Ltd. All rights reserved.

**Source:** Medline

2. 1. Vaginal breech birth - the phoenix arising from the ashes

**Author(s)** Dresner-Barnes, Helen, Bodle, Julia

**Citation:** Practising Midwife, Sep 2014, vol. 17, no. 8, p. 30-33, 1461-3123 (September 2014)

**Publication Date:** September 2014

**Abstract:** Vaginal breech birth all but disappeared from UK maternity units after the publication of the Term Breech Trial (Hannah et al 2000). However, mounting evidence does not support caesarean section as the safest mode of birth for the baby or the mother when the baby is presenting breech. But the intervening years have depleted the attending professional's skills. We describe our personal journey to regaining them, learning better ones and introducing safe choice for women. This article is the first in a series which examines the practice and evidence base for the care of women and babies aspiring to experience a safe breech birth. [PUBLICATION] 20 references

**Source:** BNI

Available in print at *Pilgrim Hospital Staff Library*

3. Patients' and professionals' barriers and facilitators to external cephalic version for breech presentation at term, a qualitative analysis in the Netherlands.

**Author(s)** Rosman, A. N. (Ageeth), Vlemmix, F. (Floortje), Fleuren, M. A. H. (Margot), Rijnders, M. E. (Marlies), Beuckens, A. (Antje), Opmeer, B. C. (Brent), Mol, B. W. J. (Ben Willem), van Zwieten, M. C. B. (Myra), Kok, M. (Marjolein)

**Citation:** Midwifery, 01 March 2014, vol./is. 30/3(324-330), 02666138

**Publication Date:** 01 March 2014

**Abstract:** Objective: external cephalic version (ECV) is a relatively simple and safe manoeuvre and a proven effective approach in the reduction of breech presentation at term. There is professional consensus that ECV should be offered to all women with a fetus in breech presentation, but only up to 70% of women eligible for ECV undergo an ECV attempt. The aim of the study was to identify barriers and facilitators for ECV among professionals and women with a breech presentation at term. Design: qualitative study with semi-structured interviews. Setting: Dutch hospitals. Participants: pregnant women with a breech presentation who had decided on ECV, and midwives and gynaecologists treating women with a breech presentation. Measurements: on the basis of national guidelines and expert opinions, we developed topic lists to guide the interviews and discuss barriers and facilitators in order to decide on ECV (pregnant women) or advice on ECV (midwives and gynaecologists). Findings: among pregnant women the main barriers were fear, the preference to have a planned caesarean section (CS), incomplete information and having witnessed birth complications within the family or among friends. The main facilitators were the wish for a home birth, the wish for a vaginal delivery and confidence of the safety of ECV. Among professionals the main barriers were a lack of knowledge to fully inform and counsel patients on ECV, and the inability to counsel women who preferred a primary CS. The main facilitator was an unambiguous policy on (counselling for) ECV within the region. Conclusion: we identified several barriers and facilitators possibly explaining the suboptimal implementation of ECV for breech presentation in the Netherlands. This knowledge should be taken into account in designing implementation strategies for ECV to improve the uptake of ECV by professionals and patients.

**Source:** CINAHL

Available in print at *Pilgrim Hospital Staff Library*

Author(s) Davis, Jude
Citation: MIDIRS Midwifery Digest, 01 June 2013, vol./is. 23/2(241-241), 09615555
Publication Date: 01 June 2013
Source: CINAHL

5. The Disappearing Art (but Increasing Prevalence) of Breech Birth.

Author(s) Goslin, Diane
Citation: Midwifery Today, 01 June 2013, vol./is. /106(24-25), 08917701
Publication Date: 01 June 2013
Source: CINAHL

6. The Influence of Practice Management on Primary Cesarean Birth.

Author(s) Socol, Michael L.
Citation: Seminars in Perinatology, 01 October 2012, vol./is. 36/5(399-402), 01460005
Publication Date: 01 October 2012
Abstract: As the cesarean delivery rate has increased to once unimaginable levels, obstetricians should question the loss of our credibility. Older mothers, obesity, larger birth weights, too many twins, and no more breech vaginal deliveries have all been cited as contributing factors to the increase in primary cesarean birth, but one cannot neglect the influence of physician practice style. Attempts to curtail or reverse the escalating incidence of primary abdominal deliveries should focus on caution with inductions of labor, patience with the management of arrest disorders, more accurate assessment of fetal compromise, patient education and informed decision making about the benefits/risks of operative delivery, and improvement in the medicolegal environment.
Source: CINAHL


Author(s) Cole, Penny
Citation: MIDIRS Midwifery Digest, 01 September 2012, vol./is. 22/3(341-344), 09615555
Publication Date: 01 September 2012
Source: CINAHL

8. Attitudes of the New Generation of Canadian Obstetricians: How Do They Differ from Their Predecessors?

Author(s) Klein, Michael C., Liston, Robert, Fraser, William D., Baradaran, Nazli, Hearps, Stephen J. C., Tomkinson, Jocelyn, Kaczorowski, Janusz, Brant, Rollin
Citation: Birth: Issues in Perinatal Care, 01 June 2011, vol./is. 38/2(129-139), 07307659
Publication Date: 01 June 2011
Abstract: Attitudes drive practice, perhaps more than evidence The objective of this study was to determine if the new generation of Canadian obstetricians has attitudes differing from those of their predecessors. Employing a cross-sectional, Internet, and paper-based survey, we conducted an in-depth study of obstetricians responding to the Canadian National Maternity Care Attitudes Survey. Of the 800 Canadian obstetricians providing intrapartum care, 549 (68.6%) responded. Participants were stratified by age less than or equal to 40 years compared with those over 40 years; 81 percent of those 40 years or
younger were women versus 40 percent over 40 years of age. Younger obstetricians were significantly more likely to favor use of routine epidural analgesia and believed that it did not interfere with labor or lead to instrumentation; were more concerned and feared the perineal and pelvic floor consequences of vaginal birth compared with cesarean section; and were significantly less supportive of vaginal birth after prior cesarean section, home birth, birth plans, routine episiotomy, and routine electronic fetal monitoring as providing maternal or fetal benefits. They were less positive than the older generation about a range of approaches to reducing the cesarean section rate, the importance of maternal choice and role in their own birth, and peer review, and they were more likely to believe that women having a cesarean section were not missing an important experience. No significant generational differences were found for ambivalent attitudes to vaginal breech birth. Younger obstetricians were more evidence-based for some issues and less for others. In general younger obstetricians were more supportive of the role of birth technology in normal birth, including routine epidural analgesia, and they were less appreciative of the role of women in their own birth. They saw cesarean section as a solution to many perceived labor and birth problems. Results suggest a need to examine how obstetricians acquire their favorable attitudes to birth technology in normal birth. (BIRTH 38:2 June 2011)

Source: CINAHL
Available in fulltext from Birth: Issues in Perinatal Care at EBSCOhost


Author(s) Kotaska, Andrew

Citation: Birth: Issues in Perinatal Care, 01 June 2011, vol./is. 38/2(162-164), 07307659

Publication Date: 01 June 2011

Source: CINAHL
Available in fulltext from Birth: Issues in Perinatal Care at EBSCOhost

10. Mode of delivery for breech presentation

Author(s) Opalic J., Babovic I., Petronijevic M., Vukajlovic S., Ljubic V., Vrzic-Petronijevic S., Bogdanovic Z., Maricic Z.

Citation: International Journal of Gynecology and Obstetrics, October 2009, vol./is. 107/(S489), 0020-7292 (October 2009)

Publication Date: October 2009

Abstract: Objectives: To analyse different modes of delivery for fetus in breech presentation. Material and Methods: A retrospective study of 505 live born breech neonates, delivered vaginally or by caesarean section after 28 weeks of gestation and weighing >1000 g in our Institute during 2-year study period (1/1/2007-31/12/2008). We analysed maternal parity and age at delivery, education level, birth weight and gestational age according to mode of delivery. Statistical analysis: Chi-square, Mann-Whitney and Student’s t-test. Results: Delivery modes: vaginal deliveries (VD) in 205 (40.6%), planned caesarean sections (CS) in 157 (52.3%) and urgent CS in 143 (47.7%). We performed Lowset maneuver in 84.1%. Primiparae were more frequently delivered by CS than vaginally (71.6% vs. 53.7%; p < 0.01). There was statistically significant difference in the mean maternal age between planned CS and VD groups (31.0+5.5 y vs. 28.5+4.2, p = 0.010;p < 0.05). We did not find difference in maternal education among groups although planned CS was more frequently performed in patients with university degree (71.6% vs. 53.7%; p < 0.01). There was statistically significant difference in the mean maternal age between planned CS and VD groups (31.0+5.5 y vs. 28.5+4.2, p = 0.010;p < 0.05). We did not find difference in maternal education among groups although planned CS was more frequently performed in patients with university degree (71.6% vs. 53.7%; p < 0.01). There was statistically significant difference in the mean weight between planned C and VD (3359+543 g vs. 2882+652 g, p = 0.018, p = 0.018; p < 0.05) and urgent CS and VD (2995+732 g vs. 2882+652 g, p = 0.000; p < 0.05). Caesarean section was most frequently performed in the group with BW> 2500 g (61.2%) while vaginal delivery was most frequent in the group with BW< 2500 g (50.6%). Conclusion: Mode of delivery for breech presentation depends on maternal parity and age, fetal gestational age and weight as well as on skills of obstetrician in the art of breech
delivery.

Source: EMBASE

11. Hands off the breech.

Author(s)

Citation: Midwifery Matters, 01 June 2008, vol./is. /117(25-25), 09611479
Publication Date: 01 June 2008
Source: CINAHL
Available in fulltext from Midwifery Matters at EBSCOhost
Available in print at Lincoln County Hospital Professional Library

12. Training need.

Author(s)

Citation: Midwifery Matters, 01 June 2008, vol./is. /117(25-25), 09611479
Publication Date: 01 June 2008
Source: CINAHL
Available in fulltext from Midwifery Matters at EBSCOhost
Available in print at Lincoln County Hospital Professional Library

13. Sharing the skills.

Author(s) Tucker J

Citation: Midwifery Matters, 01 December 2004, vol./is. /103(34-34), 09611479
Publication Date: 01 December 2004
Source: CINAHL
Available in fulltext from Midwifery Matters at EBSCOhost
Available in print at Lincoln County Hospital Professional Library

14. Normal birth -- is it possible in the 21st century?

Author(s) Lee B

Citation: RCM Midwives, 01 September 2004, vol./is. 7/9(396-398), 14792915
Publication Date: 01 September 2004
Abstract: This is part one of a report of a meeting of the Forum on Maternity and the Newborn of the Royal Society of Medicine, held on Thursday 22 April 2004. The meeting was chaired by Professor Wendy Savage, retired senior lecturer in obstetrics and gynaecology at Middlesex University, and Susan Oakey, consultant midwife at Chelsea and Westminster Healthcare NHS Trust.
Source: CINAHL

15. A breech too far.

Author(s) Hall, J

Citation: Modern Midwife, Apr 2004, vol. 7, no. 4, p. 4-5, 0963-276X (April 2004)
Publication Date: April 2004
Abstract: Commentary on the reluctance of the midwifery profession to allow expectant
mothers with breech presentations to choose vaginal delivery. Issues of concern included their lack of experience in breech birth and the need to devise training aimed at midwives rather than doctors in techniques such as external cephalic version. 

Source: BNI


Author(s) Reed, B

Citation: Modern Midwife, Oct 2003, vol. 6, no. 9, p. 16-18, 0963-276X (October 2003)

Publication Date: October 2003

Abstract: Case study of a vaginal breech birth and discussion of the consequences of the Term Breech Trial (TBT) meaning that caesarian is considered a safer option, reducing both women's choices and midwives' professional development. 

Source: BNI

17. The management of breech pregnancies in Australia and New Zealand.

Author(s) Phipps H, Roberts CL, Nassar N, Raynes-Greenow CH, Peat B, Hutton EK

Citation: Australian & New Zealand Journal of Obstetrics & Gynaecology, August 2003, vol./is. 43/4(294-7; discussion 261), 0004-8666;0004-8666 (2003 Aug)

Publication Date: August 2003

Abstract: AIM: To assess current obstetric practice in the management of singleton breech pregnancies in Australia and New Zealand.METHODOLOGY: Survey mailed to all members and fellows of the Royal Australian and New Zealand College of Obstetrics and Gynaecology.RESULTS: Of 1284 surveyed, 956 (74%) responded of whom 696 (73%) were practicing obstetrics. Prior to the Term Breech Trial (TBT), 72% of obstetricians reported that they routinely offered vaginal breech birth for uncomplicated singleton breech pregnancies. After the TBT publication this rate declined to 20%. External cephalic version (ECV) was usually recommended by 67% of obstetricians and only 53% use tocolytics. Common practices for which safety has yet to be demonstrated included 28% of obstetricians carrying out ECV outside hospitals and 42% carrying out ECV before 37 weeks' gestation.CONCLUSIONS: While the majority of obstetricians recommend ECV and/or planned Caesarean section for breech presentation, barriers to the promotion of ECV and the use of tocolysis for ECV need to be identified if the rates of this effective manoeuvre are to be increased.

Source: Medline

Available in fulltext from Australian & New Zealand Journal of Obstetrics & Gynaecology at EBSCOhost

Available in fulltext from Australian & New Zealand Journal of Obstetrics & Gynaecology at EBSCOhost

18. National breech rescue!

Author(s) Wickham, S

Citation: Modern Midwife, Mar 2003, vol. 6, no. 3, p. 38., 0963-276X (March 2003)

Publication Date: March 2003

Abstract: The number of student midwives qualifying without having witnessed a vaginal breech birth, raises the questions as to the support mothers will receive in future for breech births. 

Source: BNI

**Author(s)** Wright JB, Wright AL, Simpson NA, Bryce FC

**Citation:** European Journal of Obstetrics, Gynecology, & Reproductive Biology, July 2001, vol./is. 97/1(23-5), 0301-2115;0301-2115 (2001 Jul)

**Publication Date:** July 2001

**Abstract:** OBJECTIVE: To determine trainee obstetricians personal preferences regarding mode and place of delivery given various scenarios.STUDY DESIGN: An anonymous nationwide postal survey of 365 specialist registrars.RESULTS: The response rate was 76%. About 2.5% preferred a home birth. And 16% of men and 15% of women opted for elective cesarean section (CS). When faced with a proposed trial of instrumental delivery in theatre, 60% accepted and a further 12% accepted only if they could choose the obstetrician performing the delivery. Regarding a breech presentation at term, 78% would accept external cephalic version (ECV).CONCLUSIONS: The percentage of obstetricians who preferred vaginal delivery and ECV were considerably higher than previously reported, and there were no significant gender differences. This study shows a more balanced attitude from obstetricians and refutes the previously held view that they necessarily advocate high levels of intervention for themselves.

**Source:** Medline

**Google Scholar**

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**Commentary: routine cesarean section for breech: the unmeasured cost**

A Kotaska - Birth, 2011 - Wiley Online Library
... of the possible causal role of this policy in the death or the failure of either obstetrician to “offer” a ... Instead, midwives have cautiously attended breech labor at home. By maintaining trust, women generally accept the midwife's recommendation to transfer to hospital if labor is not ...

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H Churchill, C Francome - British Journal of Midwifery, 2009 - search.livjm.ac.uk
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F Monari, S Di Mario, F Facchinetti, V Basevi - Birth, 2008 - Wiley Online Library
... (%) 16 (10.8), 36 (36.0). All but 2 practitioners (1 midwife and 1 obstetrician) agreed with the statement that “birth is a natural process that should not be interfered with unless necessary.” Eighty-seven midwives (58.8%) and 57 obstetricians (57%) largely agreed with the ...
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1 CINAHL (breech adj2 deliver*).ti,ab 122
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10 CINAHL 6 AND 9 142
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15 CINAHL 11 OR 12 OR 13 OR 14 23224
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| EMBASE | 40 OR 41 OR 42 OR 43 OR 44 | 5203 |
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59 MEDLINE (breech adj2 deliver*).ti,ab  1285
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61 MEDLINE (breech adj2 (birth* OR deliver* OR presentation)).ti,ab  3083
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67 MEDLINE 65 OR 66  14255
68 MEDLINE 64 AND 67  1041
69 MEDLINE midwi*.ti,ab  17520
70 MEDLINE exp MIDWIVES/  15728
71 MEDLINE (midwife OR midwives).ti,ab  12529
72 MEDLINE obstetrician*.ti,ab  11216
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83 CINAHL 6 AND 15  167
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87 CINAHL 16 OR 85  48