Risk, rules and reality

Teach the Breech, Amsterdam 30 june – 1 july 2016

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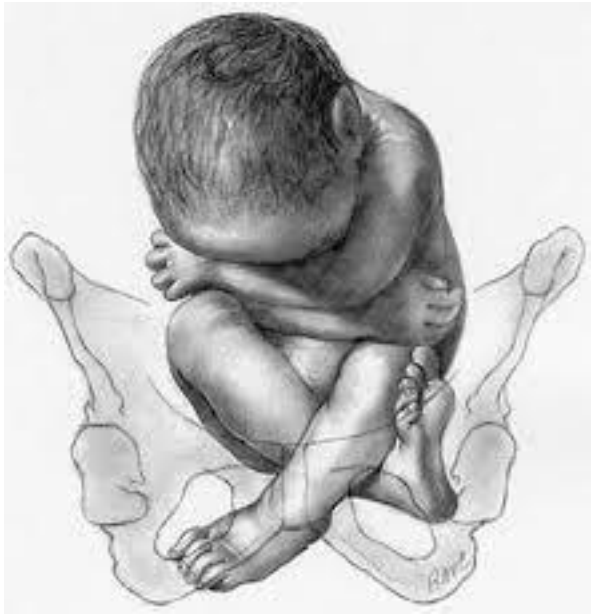
WHY me?

- POM; outpatient clinic for tailored care in Obstetrics
- Midwife, Doula and Obstetrician
- Women with a specific wish for medical interventions (outside guidelines)
- Women with a specific wish for natural birth (outside guidelines)
- 5 times “WHY”

why not?

POM in Breech

- No fetal monitoring
- Vertical position
- Supported by their (kn)own midwife
- at home



In case of a caesarean section: timing of SC *only* when labor has started, “emergency”

Risks in Breech birth

The risk of planned vaginal breech delivery versus planned caesarean section for term breech birth: a meta-analysis including observational studies.

Y. Berhan, A. Haileamlak, BJOG july 2015.

Conclusion: perinatal mortality and morbidity in the planned vaginal breech delivery were significantly higher than with planned caesarean delivery. Even taken into account the relatively low absolute risks of vaginal breech delivery, the current study substantiates the practice of individualised decision-making on the route of delivery in a term breech presentation.

27 articles, 258 953 women

Absolute risks in planned vaginal delivery group of perinatal mortality (0,3%), fetal neurologic morbidity (0,7%), birth trauma (0,7%), 5-minute Apgar Score <7 (2,4%) and neonatal asphyxia (3.3%).

Rules in Breech birth

Dutch guideline:

- Pregnancy prenatal care (from AD 36 weeks) and delivery should take place in a hospital; under responsibility of a gynaecologist
- Shared descision making for mode of delivery.
- Planned caesarean not before 39 weeks of gestation.
- Risk of asphyxia during labor due to umbilical cord compression: continuous fetal monitoring is advised.

Rules for breech birth

RCOG;

- Women should be informed of the benefits and risks, both for the current and for future pregnancies.
- Women should be informed that planned caesarean section carries a reduced perinatal mortality and early neonatal morbidity for babies with a breech presentation at term compared with planned vaginal birth.
- Women should be informed that there is no evidence that the long term health of babies with a breech presentation delivered at term is influenced by how the baby is born.
- Vaginal breech birth should take place in a hospital with facilities for emergency caesarean section.
- Continuous electronic fetal heart rate monitoring should be offered to women with a breech presentation in labor.
- In the Term Breech Trial, the most common reasons for emergency caesarean section were 'failure to progress' (50%) and 'fetal distress' (29%).
- Women should be advised that, as most experience with vaginal breech birth is in the dorsal or lithotomy position, that this position is advised.
- A practitioner skilled in the conduct of labor with breech presentation and vaginal breech birth should be present at all vaginal breech births.
- If a unit is unable to offer the choice of a planned vaginal breech birth, women who wish to choose this option should be referred to a unit where this option is available.

POM in Breech: daily practice

- No fetal monitoring: Continous electronic fetal monitoring should be offered/ is advised. Intermittend auscultation?
- Vertical position: As most experience with vaginal breech birth is in the dorsal or lithotomy position, this position is advised.
  Time to Teach the breech!
- With own midwife: A practitioner skilled in the conduct of labor with breech presentation and vaginal breech birth.
  Midwife or gynecologist?
- At home: Don’t ask the gynecologist….

Five times WHY (1)

WHY do women want delivery care other than advised?

Fear of a cascade of interventions

Fear of being treated as a number; victim of protocols

Fear to lose their autonomy

Strong believe in own strength

Intuition is more important than numbers

Five times WHY (2)

WHY do doctors don't want to make exceptions to their breech guidelines?

Fear of being responsible if the guideline is not followed

Fear of breech birth

(lost "art" of conducting breech birth)

Strong believe in numbers

Ruling out every (small) risk

More confident to do things you can control (SC)

Five times WHY (3)

WHY not fascilitate individualized and special care?

If you want, you can

Stop the argument of responsibility.

You are responsible for your deeds, not for the disicion made and not for the outcome.

Five times WHY (4)

WHY can' we solve this issue?

Centralisation,

Training of practitioners,

"Open" your clinics,

Listen to the expectations of pregnant women,

<u>Support</u> decision making

Five times WHY (5)