Ask an obstetrician: “why you almost never see breech delivery in the United States these days?” and she will probably tell you about the “Term Breech Trial,” or TBT. This 2000 study, performed by a Canadian team headed by Mary and Walter Hannah, set out to determine which was safer, cesarean section or vaginal breech deliveries. It was a well-funded[[1]](#footnote-1) study and a big one, with 2,088 births in 121 medical centers in 26 countries. It was a randomized control trial, highly ranked as evidence-based medicine. And it had to be stopped midway after its interim results favored cesarean section so strongly that it was no longer deemed ethical to assign any women to vaginal breech delivery. These results were published in the Lancet(Hannah et al. 2000), widely discussed, and almost universally seen as decisive. Within months, its findings were endorsed by all prominent obstetrics societies[[2]](#footnote-2). The ACOG issued a statement to the effect that: “As a result of the findings of the study, planned vaginal delivery of a term singleton breech may no longer be appropriate.” (Committee on Obstetric Practice 2001, 1190).

*The Lancet* article became the most cited[[3]](#footnote-3) publication in obstetrics, despite Its many critiques[[4]](#footnote-4) and a partial withdrawal of TBT's recommendations by obstetrics societies[[5]](#footnote-5). After all this, it became accepted wisdom that it was the Term Breech Trial that put an end to the practice of vaginal breech delivery (For example: Dhingra and Raffi 2010; Glezerman 2012; Lawson 2012). But matters were more complicated than accepted wisdom allows. The Term Breech Trial was an important milestone, and its immediate influence in the field was significant. Nevertheless, it was also a culmination of decades of developments, without which the 2000 study itself would probably never have been undertaken and, even if it were, probably would not have had the influence that it did.

 TBT has over 1,300 publications citing it, according to data retrieved from the academic search engine *Scopus*.

 Over ten response letters were published in The Lancet in the following months after it was published, criticizing its methodology and recommendations. These followed by articles and editorial with the same attitude in the next years (For example, Dhingra and Raffi 2010; Glezerman 2012). Moderation of the TBT's conclusions was published in 2003 by the original research team (Whyte, Hannah, and Saigal 2003).

 Moderation of TBT's recommendations are evident in the ACOG Committee on Obstetric Practice no. 38 (2006); SOGC clinical practice guideline no. 226 (Kotaska et al. 2009); RCOG (2006) and more. The corpus of articles on the management of breech delivery, constitutes the medical scientific debate over breech management, retrieved from the "Scopus" academic search engine during July- August 2019 and contains the most cited studies on breech delivery by other studies from this corpus. Further discussion on the primary computational methods conducted for mapping discourses is yet to be published.

 Several reviews, particularly since the1990s, have already examined the professional literature on breech delivery management (Cheng and Hannah, 1994; Gifford et al. 1995; Grant et al. 1996), comparing study findings over the years. While these reviews illuminate well the controversy exists upon the proper management, which the TBT sought to resolve; they failed to explain this oversized influence the TBT had on breech deliveries. To answer this question, it is not enough to compare various study findings in the breech management debate.

he onset of decay in VBDs' skills and knowledge is bound with their establishment as hazardous in the 1950s and 1960s, in parallel with introducing CSs as a new standard of care in obstetrics (See Part 1). As a result, during the 1970s, several restrictions were suggested to reduce the morbidity and mortality associated with breech presentation. Protocols developed in these years sought to *narrow* conditions that allowed a vaginal birth, *tighten their supervision*, and *prevent this presentation* by promoting External Cephalic Versions (ECV). At the same time, CSs were widely liberalized and integrated as standard clinical practice in breech presentation. By the end of the 1970s, these protocols had helped establish a clinical environment in which most obstetrics wards in North America had abandoned VBD, and the related techniques were vastly forgotten over time by the following generations and became a provenance of rare “old-school” specialists (See Part 2). The “controversy” over the management of breech presentation, which the TBT was supposed to settle, did not emerge until the 1980s (See Part 3) after prominent health organizations voiced concerns over the increasing prevalence of CS and its potential repercussions. Thus, a gap arose between growing doubts in the literature over CSs’ efficacy and safety and clinical reality in which VBDs were almost nonexistent in North Americas' wards. Most obstetricians refrained from performing them as they did not have the skills, the willingness, or scared of getting sued in case of a "non-perfect" vaginal delivery. The TBT initiative was perceived as the “final chance” to resolve this growing tension in obstetrics before VBDs would disappear utterly, and Its decisive conclusions in favor of elective CS for all term breech babies came as a relief to many. They put an institutionalized "stamp" to the already established norm of treatment in breech births, in which VBDs were disattended from An examination of the number of publications on "Breech deliveries" by year shows that publications published in 1960-1973 (stood on the average of 29 publications per year) rose by more than 300% and stood in 1974-1990 on the average of 88 publications per year). This sharp incline is dramatic even compared to the gradual incline in the literature on childbirth (Source: Author's analysis of publications retrieved from Scopus' search engine on the term "Breech delivery", compared with publications with the term "Labour, Obstetrics").

Concurrently, the prevalent assumption that "once cesarean, always cesarean"”[[6]](#footnote-6), resulted in nearly a quarter of cases referred for CS in breech presentation in the 1970s were repeat surgeries (Rovinsky, Miller, and Kaplan 19 All these factors combined can be viewed as a collective dissattention of VBDs, meaning an "attentional avoidance" (Zerubavel 2015, 61) of VBDs by the obstetrics field, a process that comprises the creation of taboos around vaginal breech delivery and restriction of its maneuvers as being outdated, dangerous, and too challenging to perform. In this reality, VBDs were rarely performed, and most doctors feared or avoided them, were barred from performing them, or did not know how to. What, then, ultimately decided the fate of vaginal breech deliveries to obsolesce? Was it the TBT, for its methodological advantages, broad scope, and unequivocal resolution in favor of CS? Or has the steady increase in CSs in general in the United States and Canada since the 1970s? While both the TBT and increases in CSs doubtless contributed to the virtual abandonment of VBD, a closer examination of the medical-scientific discourse on breech management indicates that it would be more accurate to claim that the VBDs were not “doomed” in 2000. instead, the TBT served as a significant landmark, as It accelerated the progressive process in which VBD had been collectively disattended and forgotten by obstetrics, unfolded over five decades, starting the 1950s. The TBT was mere VBDs' "executioner," hardly their "judge."

1. The TBT was supported by a grant (no. MT- 13884) from the Canadian Institutes of Health Research (CIHR, previously the Medical Research Council of Canada), the Centre for Research in Women's Health, Sunnybrook, and Women's College Health Sciences Centre, and the Department of Obstetrics and Gynaecology at the University of Toronto (Hannah et al. 2000). [↑](#footnote-ref-1)
2. Such as the British Royal College of Obstetricians and Gynaecologists (RCOG April 2001), Cochrane Collaboration (Hofmeyr, Hannah, and Lawrie 2001, the Royal Australian and New Zealand College of Obstetricians Gynaecologists (RANZCOG 2001) (with a few reservations), and others. [↑](#footnote-ref-2)
3. TBT has over 1,300 publications citing it, according to data retrieved from the academic search engine *Scopus*. [↑](#footnote-ref-3)
4. Over ten response letters were published in The Lancet in the following months after it was published, criticizing its methodology and recommendations. These followed by articles and editorial with the same attitude in the next years (For example, Dhingra and Raffi 2010; Glezerman 2012). Moderation of the TBT's conclusions was published in 2003 by the original research team (Whyte, Hannah, and Saigal 2003). [↑](#footnote-ref-4)
5. Moderation of TBT's recommendations are evident in the ACOG Committee on Obstetric Practice no. 38 (2006); SOGC clinical practice guideline no. 226 (Kotaska et al. 2009); RCOG (2006) and more. [↑](#footnote-ref-5)
6. This statement originated in Edward Cragin’s book *Conservatism in Obstetrics* (1916) (Foster 2017) and in the 1970s became one of the most ubiquitous attitudes in obstetrics (Lavin et al. 1982). [↑](#footnote-ref-6)