

THE HISTORY OF EPISIOTOMY IN THE UNITED KINGDOM

A paper by Beverley Lawrence Beech - Hon Chair, Association for Improvements in the Maternity Services presented to a conference in Paris in May 2004.

Ladies and gentlemen, thank you for inviting me to your conference and I hope that the information I can give you about our campaign to reduce the episiotomy rates in the UK will be helpful to you in your campaign in France.

Childbirth for the majority of women is a normal physiological event. Yet, today, our society's perception of childbirth is that it is also an unbearably painful and often dangerous experience. Such perceptions have a long history. The Bible states "*I will greatly multiply thy sorrow and the conception - in sorrow thou shalt bring forth children.*" (Genesis 3:16).

Episiotomy was developed in the USA where it was vigorously promoted on the grounds of 'protecting the fetus. A great deal of emotive claims were made, for example:

'...every minute the baby's head is on the perineum two points can be deducted from its IQ'

'The fetal brain suffers prolonged pounding and congestion in a hard spontaneous delivery with possible brain damage and anoxemis (sic) or asphyxia'.

'The descent of the fetal head was also compared to the mother falling on a pitch fork which pierces the perineum, and the baby having its head crushed in a door'.

Needless to say, none of these statements was true, but they justified the expansion and widespread use of this western form of genital mutilation.

By the 1940s routine episiotomy was widely used in the USA but it was not adopted in the UK until the 1960s when it began to rise dramatically. By 1967 it had reached 25% and by 1978 it had reached 53.4%. One of the reasons for this increase was due to Active Management of Labour which was vigorously promoted by O'Driscoll in the National Maternity Hospital in Ireland. The procedures were developed as a result of the medical profession's determined closure of small, local, maternity units. The women were then required to give birth in very large, centralised, obstetric units, and as these units became increasingly overcrowded the obstetricians developed a means of processing the women through the labour wards as fast as possible.

In 1963 the optimum length of labour for a first time mother in the National Maternity Hospital was 36 hours, in 1968 it was 24 hours, and in 1972 it was formally reduced to 12 hours. In 1965 the hospital dealt with 5,063 deliveries by 1981 it was 8,964. The reduction in the length of labour was in inverse proportion to the increased numbers of deliveries (O'Regan, 1998). In order to ensure that the women gave birth within these artificial time limits the labours were

induced or accelerated and the women were vigorously encouraged to push, and an episiotomy was performed to be absolutely certain that the baby emerged as fast as possible.

A study in America in 1978 (Mehl, 1978) of women who delivered in hospital as compared with those who birthed at home had 9 times as many episiotomies amongst the women who delivered in hospital..

Another factor in the increased use of episiotomy was the decision of the Central Midwives Board (the body that governed midwifery practice in the UK) to sanction the use of episiotomies by midwives (in an emergency), but they were required to refer the woman to the doctor for suturing. Until that time midwifery philosophy promoted midwifery avoidance of episiotomy and that 'normal' cases should be left to nature. However, increasing numbers of women were required to birth in hospital, under the control of doctors and medical protocols, and episiotomy became an integral part of 'active management of labour'. A study of a 'Domino' scheme (where community midwives brought women into hospital for the birth and returned home within 6 hours) was set up by the West Middlesex Hospital, London, in 1971 showed that the community midwives performed episiotomies in 4% of deliveries whether at home or at hospital. By 1977 their use of episiotomy had increased eight-fold and had risen to 55% (see Graham I, 1997). The midwives were now required to comply with hospital rules.

An AIMS' Newsletter quoted a letter from a midwife who stated that 'episiotomy is mandatory on all primigravidae, regardless of the particular circumstances of delivery'. After she delivered a woman's first baby without an episiotomy, her every delivery is now supervised, to ensure that she does not err again. (AIMS Newsletter, 1974).

What were the consumers' views

In 1974 a midwife, who was also a National Childbirth Trust teacher, published an article in the nursing times questioning the alleged benefits of episiotomy in preventing tears and prolapse (Levett, (1974).

In 1976 an AIMS Newsletter carried an article 'Episiotomy – the unkindest cut' questioning the use of episiotomy and the skill of the attendant: 'Often episiotomies are left to medical students for practice. Young men who have never held a needle and thread before learn their first surgical skills on this most precious part of the female anatomy'.

In 1977, the AIMS Secretary, Anne Taylor, published an article in a childbirth magazine questioning the 'unkindest cut of all' and suggested that women complete a survey of women's views of this procedure (Taylor, 1977).

In 1978 both AIMS and the National Childbirth Trust wrote to the Department of Health questioning the routine use of episiotomy, they repeated the exercise in 1979 and also wrote to the Central Midwives Board. None of these letters produced any obvious changes.

Midwives were, by now, also questioning the use of episiotomy and in March 1979 Juliet Willmott wrote an article in the Nursing Times challenging the 'pernicious practice of routine episiotomy' and suggested that 'labour ward staff who perform the episiotomies rarely see the mother again, and may be unaware of the misery caused by this minor surgery'. (Willmott, 1979)

Significant change did not occur, however, until 1981 when an obstetrician, Michael House, wrote an article in a midwifery magazine analysing the evidence for and against the use of episiotomy. He concluded that 'millions of episiotomies are being carried out all over the world' and that 'it is performed in the interests of mother and child with all the good intentions in the world, but with little evidence that it benefits either' (House, 1981). The value of this article was that it was written by an obstetrician and it examined each aspect of episiotomy. AIMS members started making photocopies of it and sending it to women who did not want an episiotomy. We

also, having realised that years of drawing attention to the problems women had with episiotomy had little effect, began to challenge the medical profession to produce the evidence that episiotomy was of benefit to both the mother and the baby – knowing full well that they had no evidence at all to support their policies.

While medical research is carried out on women and babies consumers have no power at all to affect the research programme. Many of the issues that consumers would like researched (like, for instance, the adverse effects of routine ultrasound) are not undertaken because they are of no interest to the medical profession. The fact that women were having serious sexual dysfunction as a result of episiotomy was of no interest at all. By sending women an article written by an obstetrician we succeeded in giving women the confidence to stick to their views and refuse this procedure.

Women's concerns about episiotomy were also given greater prominence when the National Childbirth Trust published two booklets written by Sheila Kitzinger which were based on women's experiences of episiotomy and the physical and emotional aspects (Kitzinger, 1981 and Kitzinger, 1981). These surveys made it very much more difficult for obstetricians to dismiss women's complaints as 'anecdotal'.

By the summer of 1982, as a result of consumer pressure and questions from within the profession, a randomised controlled trial of episiotomy was mounted. In the meantime, AIMS also launched the Maternity Defence Fund, a fund established to raise money to enable patients to sue the medical profession for assault. Until that time, episiotomy was the only surgical operation that could be performed in the UK without the permission of the patient. That view changed after the Maternity Defence Fund was launched. The press release stated: 'It is common for women during childbirth to be given drugs against their wishes and without seeking their consent; it is common for procedures, such as routine episiotomy, to be carried out against mothers' wishes and without their consent'. The press release was discussed by a lawyer in a nursing magazine and it produced a flurry of concern about the rights of women to refuse treatment (Finch, 1982).

In 1984 the results of the randomised controlled trial were published. The data indicated that the routine or liberal use of episiotomy was unjustified. The trial produced no evidence to support the supposed benefits of episiotomy or that it minimized perineal trauma, reduced post partum pain, or improved perineal healing after delivery (Sleep, 1984).

The statistics for 2002 are as follows:

Reason for episiotomy	Percentage
All births	13%
All spontaneous vertex births	9%
Forceps births	76%
Ventouse births	58%
Breech births	29%
1980	52%
1990-1991	24%

The World Health Organisation has stated that 'The systematic use of episiotomy is not justified' (WHO, 1985).

The systematic reviews of obstetric research conducted by the Cochrane Library reveals that 'restrictive episiotomy policies [meaning that an episiotomy was not done routinely and only undertaken if it was considered essential] appear to have a number of benefits compared to routine episiotomy policies. There is less posterior perineal trauma, less suturing and fewer complications, no difference for most pain measures and severe vaginal or perineal trauma, but

there was an increased risk of anterior perineal trauma with restrictive episiotomy. (Carroli and Belizan, 2004).

Routine episiotomy is a classic example of a procedure introduced widely with little or no evidence of benefit. It has been responsible for widespread damage and unacknowledged postnatal complications for women throughout the developed world. There is no justification for the continued routine use of episiotomy and it is time that women were informed of the risks they run when they book with obstetricians who require it to be carried out routinely.

Beverley A Lawrence Beech
Association for Improvements in the Maternity Services
May, 2004

References:

- Anon. The sore subject, AIMS Newsletter, December 1974, p 10.
Anon. Episiotomy – the unkindest cut, AIMS Newsletter, March 1976, p7.
Carroli G and Belizan J (2004). Episiotomy for vaginal birth (Cochrane Review) In: The Cochrane Library, Issue 2, 2004, Chichester, UK: John Wiley and Sons, Ltd.
Finch, J (1982). Litigation: A simple step forward, Nursing Mirror, 8th September,
Graham, I D (1997). Episiotomy – Challenging Obstetric Interventions, Blackwell Science, Oxford.
House, M J (1981). Episiotomy – Indications, Technique and Results, Midwife, Health Visitor and Community Nurse, January 1981, Vol 17, No1, p6-9.
Levett, D (1974). Episiotomy – an over-used procedure? Open Forum, Nursing Mirror, 17 October, 89).
Mehl, L (1978). The outcome of home delivery in the United States. In: The Place of Birth (eds S. Kitzinger & J Davis), pp107, Oxford University Press, New York.
O'Regan, M (1998). Active Management of Labour – The Irish Way of Birth, AIMS Journal, Vol 10 No2, Summer 1998, p1-8.
Taylor, A (1977). Maternity Matters, Mother and Baby, June 1977, p46.
Willmott, J (1979). No need to flaw the pelvic flaw, Nursing Mirror, March 29, p31.
World Health Organisation (1985). Appropriate Technology for Birth, WHO Report.

© AIMS, May 2004