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Why high episiotomy rates are considered acceptable and even desirable

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Jane Wright explains why midwives, despite the evidence, continue to carry out routine episiotomies

Reading Beverley Beech's report from a private hospital in Greece, in a previous edition of the AIMS Journal[1], the 98% episiotomy rate caught my eye. An alien from Mars observing this practice might ask; "Why would one woman, purporting to care for another woman, cause mutilation, pain and suffering routinely?" Indeed, why would the midwife, knowing professionally (and sometimes personally) the risks to the mother, the decreased chance of breast feeding and the potential damage to intimate relationships still lift the scissors and use them? I believe there are a number of answers to this question. Firstly, there must be an acceptance by the individual involved or at least societal sanction for the practice in order to avoid criminal and civil prosecution. Secondly, there must be midwives who will follow orders and policies for routine episiotomy. Thirdly, there must be an authority with the power to institute and maintain the practice. Finally, there must be a conscious or unconscious desire on the part of those with authority for the practice to take place.

Why women will accept unnecessary episiotomies

The practice of episiotomy became popular in the 1920's in the USA and during the 1950's in Britain. By 1980 the episiotomy rate varied by region from 47% to 58% and in some hospitals were as high as 90%[2]. No human being will willingly accept cutting of their body by another, unless they believe it is necessary or will confer some benefit. Many women today still accept that the cutting of women's genitals will always assist with the delivery of their baby (or avoid damaging tears) because others, whom they trust, have given them this information. Trusted others include other females, particularly female relatives and health care professionals, particularly midwives. Health care professionals do not deliberately mislead women in this matter.

Throughout most cultures there have been, at one time or another, forms of mutilation, painful physical constriction and even lethal practices, which have been inflicted mainly on the female body ostensibly by other females. Examples include; witch burning in the 15th, 16th and 17th centuries, the Indian practice of Suttee (also called Sati or bride burning) which, although now illegal, still continues[3, 4] the Chinese practice of foot binding which continued from the 12th Century until the 1920's, female genital mutilation (FGM) which is still practiced illegally in Britain, and legally abroad, on millions of girls aged 1 day to 16 years[5] and current western fetishes for caesarean section (many recipients of which will tell

you that their surgery was necessary although, clearly, there were many that were avoidable), plastic surgery, and body 'modification' (also becoming necessary to correct the defects of being a human female). Daly6 has described these fetishes as 'ritualised' and suggests that although women prepared other women for the pyres, bound the little girls feet to achieve the excruciatingly painful 3 inch 'Lotus Hooks' and continue to slash the genitals of female children, they are only the 'Token Torturers'. In other words although they physically prepare the victims for the 'procedure' and/or carry it out, it is not they who have the power to sanction the practice or maintain its use.

Why practices, which damage women, continue

Many feminists, including Daly6, argue that femicidal (women killing) and gynophobic (fear of women) practices originate with patriarchal social structures aimed at controlling women and particularly women's sexuality. Dead brides are not unfaithful to their spouses memory (do not spend son's inheritances), little girls with broken feet can barely walk, much less run away and women with painful, scarred genitals may wish to abstain from penetrative sex all together unless subjected to strong societal norms which force her to submit, for the sake of her relationship, livelihood or to produce further children. Put at its most simply, pain causes the release of stress hormones called glutocorticoids which decrease the sex hormones, including testosterone and oestrogen, which decreases sex drive. Women in pain aren't going to be sexually demanding and they certainly aren't desirous of a number of passionate sexual affairs.

This is not to say that the 'Token Torturers' do not derive benefit from their actions. Some receive payment for their actions or social status, for example the Dayas (traditional birth attendants) in the Sudan and Somalian excisors from the Midgan clan who perform FGM, but for the most part these women do what they do because they believe it is the right thing to do and will benefit their victims by increasing marriagability, improving health or hygiene, enhancing status (for the victims or their families) or conferring religious benefits. In the same way, most midwifery staff that routinely cut women receive pay but their pay does not depend on maintaining high levels of episiotomy. For the most part they cut because they believe it is the right thing to do or because they are forced to do so by policies set by others.

In 1992 I attended an AIMS conference in Co. Tyrone, Northern Ireland. Midwives from all over the province attended. Figures for episiotomy were difficult to access but in at least one hospital episiotomy rates were 80%7. One speaker, an independent midwife from the south of England, spoke on her practice and happened to mention that her episiotomy rates were less than 1%. She had carried out an episiotomy only once in the previous 4 years, none of her mums had suffered more than a minor tear (which heals better than an episiotomy) and she joked that she used her episiotomy scissors only for cutting the cord, as she found them better than cord scissors. The conference delegates were clearly incredulous. It was just too far removed from their own experience. Acceptance of this truth would have caused them to challenge beliefs and rituals they had been taught by experts they trusted. To accept that episiotomy is rarely necessary (provided delivery is well supported) would have caused them to admit that they had,

and were continuing to cause, unnecessary suffering through bad practice. If they had accepted this truth they might have been motivated to change their practice, which would have brought them into conflict with colleagues who continued to accept the practice. Recognition of episiotomy as mutilation might even caused recognition of abuse inflicted on their own bodies. For most, if not all, delegates the only option, at that time, was to reject the speaker's words as fantasy.

Denials of responsibility

In the first world we do not want to believe that parallels can be drawn between ourselves and the woman with the piece of broken glass bent over a screaming child carrying out female genital mutilation. It is not comfortable to think that the justification of "we were just following orders" used by guards in Nazi extermination camps, are echoed in the words "we are just following policies". Our need to trust medical and midwifery staff makes us disbelieve that they would routinely cause harm. It is equally uncomfortable to consider that high numbers of healthy women have been victims of surgical abuse and have, unknowingly, been complicit in their abuse. After all who wants to admit that they accepted penetration with a blade for no good reason beyond the fetish of obstetricians and a patriarchal society?

In the UK we may congratulate ourselves that our episiotomy rates have fallen considerably over the past 15 years but they are still too high in many areas. We must also remember that the fall in episiotomy rates has happened as caesarean section rates have risen and while the physical effects of the two surgeries may differ, the sociological effects may be the same. Women still recovering from infected and malodorous wounds (or any of the other effects of major surgery) are unlikely to be engaging in vigorous physical exercise.

In conclusion, I have argued that routine episiotomy is one of a number of examples of patriarchal gynophobic practices. Such practices are not restricted by culture, economic development or time. While we can recognise the abuse of the female body in other cultures it is difficult to recognise it in our own and for this reason women (both mothers and midwives) have difficulty in challenging such practices much less eradicating them.

Further reading

- Episiotomy, AIMS Journal, Vol 7, No 2, 1995

References

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6. Daly M. Gyn/Ecoogy: The metaethics of radical feminism 1991 London: The Women's Press
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What do midwives do to achieve a low (and even 1%) episiotomy rate?

We would like to hear from those midwives who rarely do episiotomies, how they achieve this, and what strategies they used to change their practice. Send your views to editor@aims.org.uk