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Opinions Of Midwives And Obstetricians About The Episiotomy

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Abstract:
Objectives:*The study has been conducted as a descriptive document to determine the opinions of midwife and obstetricians about episiotomy*
Methods:*Research population consisted of 48 midwife and 45 obstetricians who have been working in birth clinics at Kocaeli between November and December 2007. Research data had been collected in a form containing 27 different negative and positive statements constructed about episiotomy by making use of literature and observations.Data collected has been analysed by use of SPSS software.*
Results: *It was seen that 95.8 % of midwife and 77. 8 % of obstetricians are agree with the idea that episiotomy application is a part of normal birth (p<0.05). It was concluded that 85. 4 % of midwife and 64, 4 % of obstetricians are agree with the idea that perineum should be shaved for the woman to whom episiotomy will be applied. It was established that all of midwife (100 %) an 88.9 % of the obstetricians are agree with the idea that anesthetic substances should be given before suturing the perineum. It was determined that 81.3 % of midwife and 62.2 % ofobstetricians aren't agree with the idea that the increase of episiotomy applications can result from insufficiency of midwife and obstetricians about non- pharmacological applications (p<0.05). Also it was determined that 37. 5 % of midwife and 64.4 % of obstetricians are agree with the idea that the birth by enlarging episiotomy become a frequent application used by midwife and obstetricians because it gives an opportunity*
to save more time (p<0.05).
Conclusion:*Midwives and obstetricians should be remedied ofthe misconceptions and lack of knowledge about episiotomy with in-service training programs.*
Key Words: *Episiotomy, Midwife, Obstetrician, Opinions,Misconception*

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I. Introduction

Episiotomy is a controlled surgical incision made in the perineal bulbocavernosus muscle to expand the vaginal opening [1-3]. It was first used in 1742 by Irish Sir Fielding Ould to aid difficult births [4]. It has become a routine that is widely used today and routinely performed in many centers [5].It was believed that episiotomy facilitated birth, preserved perineal tonus, prevented unwanted tears, and provided easy, rapid, and safe birth of fetus head [1-3]. However, studies have shown that restrictive use of episiotomy instead of its routine application and restrictive episiotomy application are more useful than routine episiotomy [2, 6, 7]. The World Health Organization (WHO) also recommends restrictive episiotomy to routine episiotomy [8].

It has been reported that routine episiotomy does not reduce urinary incontinence and does not affect neonatal outcomes, but leads to a reduction in vaginal muscle strength, postpartum perineal pain, disparanoya, blood loss, anal sphincter damage and anal incontinence[11-13]. For this reason, the rate of episiotomy has gradually decreased in many developed countries [7, 11, 13].

According to a limited number of studies carried outin Turkey, routine episiotomy is used in order to facilitate the birth in all primigravidas and used widely in multigravida in cases where the perineum is rigid [8]. In the study conducted by Karaçam (2001) in Aydın Province, it was found that episiotomy was applied to almost all of the first births (95%), about half of the second births (48%) and to a very small number of third and more births (12%). In Toker and Eroğlu's study (2005), it was determined that 90% of primigravidas were applied episiotomy, and this rate gradually decreased during second and third births.

The beliefs and attitudes of women and obstetricians who are primarily responsible for episiotomy can affect the routine or restrictiveuse of episiotomy. This is because the health professional's opinions about episiotomy can be reflected to woman. For this reason, it is important to determine the opinions of the midwives and obstetriciansabout the episiotomy in our country.

This study was carried out descriptively to determine the opinions of midwives and obstetriciansworking in the delivery room of the hospitals about the episiotomy.

II. Methods

The population of the study consisted of all midwives and obstetricians(48 and 45 people, respectively) who worked in the delivery room of a total of seven hospitals, including four private and three state hospitals in Kocaeli City Center between November 2007 and December 2007, and agreed to participate in the study.Two obstetriciansrefused to participate in the study. The implementation of the research started after the written permission was obtained from T. C. Kocaeli Governorship, Provincial Directorateof Health. Midwives and obstetricianssigned the written honor form, and after they agreed to participate in the research, questionnaires were given to them.

Two questionnaires were used in the research. Socio-demographic characteristics of the midwives and obstetricianswere determined with questionnaire I. In questionnaire II developed by the researcher out of literature [15-17] and observations, there were 26 positive and negative expressions to determine the thoughts of the midwives and obstetriciansabout the use of episiotomy. Midwives and obstetricianswere expected to mark agree or disagreeoptions for these expressions. Answering of the questions took about 5-10 minutes on average. The data were collected based on the self-declaration.

SPSS 10.0 (Statistical PackageforSocialScience) package program was used to evaluate the data. In the statistical analysis of the data, number, percentage tables and chi-square test were used.

III. Results

50% of midwives in the study is in the 20-30 age group, 45.8% is high school graduate, 54.2% is married and 52.0% is working at state hospitals and 81.2% is working at delivery rooms for 10 years or less. 35.6% of obstetriciansare in the 31-40age group, 75.6% are male and 80% are married. 75.6% of the obstetriciansare specialist, 42.2% are working at state hospitals, and 44.4% are working at delivery rooms 10 years or less (Table 1).

When the agreement upon the expression "episiotomy is part of normal birth" of midwives and obstetricianswere examined, the difference between the groups was found to be statistically significant ($p<0.05$). 95.8% of midwivesand 77.8% of the obstetriciansagreed to this expression ($p<0.05$). 85.4% of the midwives and 64.4% of the obstetriciansagreed upon the expression "the perineumof the woman should be shaved who will be performed episiotomy" and the difference between them was found to be statistically significant (Table 2). All of the midwives and 88.9% of the obstetriciansagreed upon the expression "anesthesia should be given before the perineum is sutured".56.3% of the midwives agreed that "the repair of laceration does not prolong the duration of stay in the delivery room but the repair of the episiotomies prolongs the duration of stay in the delivery room to a considerable extent", while 68.9% of obstetriciansdisagreed. When the agreement of midwives and obstetricianswere examined in both expressions, the difference between the groups was statistically significant ($p<0.05$) (Table 3).81.3% of midwives and 62.2% of obstetriciansdid not agree on the expression "the increase in the application of episiotomy can be caused by the fact that midwives and obstetriciansdo not have enough knowledge about non-pharmacological applications".When the agreementof midwives and obstetricianswere examined on this expression, the difference between the groups was statistically significant ($p<0.05$). 64.4% of obstetriciansagreedand 62.5% of the midwives did not agree on the expression that “birth done by performing episiotomy is more commonly used by midwives and obstetricians today because it saves more time to the health team”. The difference between the groups was statistically significant ($p<0.05$) (Table 4).

When the other expressions of midwives and obstetricians were examined, the difference between the groups was found to be statistically insignificant ($p>0.05$). However, 35.4% of the midwives and 44.4% of the obstetriciansagreed the expression that "episiotomy should be performed routinely at every birth" is quite thought-provoking. It is also striking that the majority of both groups agree that "the midwives or should decide to perform the episiotomy by themselves" (95.8, 91.1, respectively) and "no need to take consent of the woman whileperforming episiotomy" (79.2, 64.4, respectively) (Table 2).

All of the groups or nearly all of them agreed on expressions "the main benefit of episiotomy is to protect perineal tonus and to prevent unwanted tears." "Episiotomy prevents long-term pressure on the pelvic floor," "Episiotomy prevents neonatal brain damage by reducing the pressure on the fetal head in premature newborns." (Table 3).In addition, 79.2% of the and 86.7% of the midwivesagreed that "the biggest disadvantage of episiotomy is its being painful incision.", while 72.9% of the midwives and 57.8% of the obstetricians did not agree that "episiotomy reduces the sexual satisfaction of the woman" (Table 4).

IV. Discussion

Normal vaginal delivery is a process in which the fetus and its appendages that are products of conception are exteriorizedout of uterine after forty weeks of the last menstrual period without any invasive intervention [1-18]. Episiotomy is part of interventional birth. However, it is emphasized in the literature that in the presence of any indications (rigid perineum, large fetus, position-presentation disorders, etc.), episiotomy

should be performed to protect the perineal tonus and prevent unwanted tears [1, 2, 18, 19].In cases where there is indication but episiotomy is not performed, an anus sphincter or even a rectum wall may be torn down. It is contradictory that nearly all of the midwives and obstetricians in our study say that if there is any indication, episiotomy should be performed, while all of the midwives and the vast majority of see episiotomy as part of the normal birth. It is also noteworthy that 2 midwives and 1 physician agree that episiotomy should not be performed in spite of indications.Midwives and obstetricians may consider episiotomy as a part of normal birth because all of the midwives and obstetriciansbelieve that episiotomy protects the perineal tonus and prevents unwanted tears. However, Röckner et al. (1989) reported that more labia/clitoris lacerations were experienced in the group without episiotomy and 2nd and 3rd degree lacerations were more likely to be seen in the group with episiotomy. Moini et al. (2009) found that the possibility of 3rd and 4th degree lacerations in women with episiotomy increased.

It is positive that nearly all of the midwives in the study who have bachelor's degree does not see episiotomy as a routine application at birth. Particularly, it is also remarkable that the agree on the routine administration of episiotomy in every birth is directly proportionate to age. There is no evidence that routine episiotomy reduces perineal trauma, helps to heal the perineum, prevents fetal trauma, and prevents urinary or anal incontinence [22].In a systematic review by Hartmann et al. (2005), it was found that posterior traumas were more common in routine episiotomy group and more problems such as perineal pain, wound healing complications and wound openings were observed. In another study, women who did not undergo routine episiotomy had significantly fewer posterior perineal trauma, fewer sutures, and fewer complaints during recovery than women who underwent routine episiotomy [24].Hartmann et al. (2005) found that 3rd and 4thdegree lacerations and stitching were more common in the routine group. Although the midwives and the obstetriciansin this study do not support routine episiotomy in every birth in paralell with the studies conducted and the literature, nearly all of the midwives and the obstetricians agree that episiotomy is a part of normal birth.

It is thought-provoking that the vast majority of midwives and obstetricians do not see a need to take consent of the woman when performing an episiotomy. It has been determined that the vast majority of workers of state hospitals do not see a need for consent. Approximately half of those working in university hospitals believe that consent must be taken. This may indicate that university hospitals are more sensitive to patient rights. The relationship between a woman and a midwife-physician is built on trust and it is necessary to keep this confidence constant and to act in the direction of the consenttaken from the woman, by describing procedures, benefits and risks of episiotomy to the woman [25].Another application that needs to be taken consent when performing episiotomy is the perineum shaving. It has been determined that midwives, the vast majority of workers in state hospitals and more than half of agree that perineum of the woman who will be performed episiotomy should be shaved. The high agree rate to this statement especially in midwives can be caused by the fact that nearly all of the midwives are female. When we consider it according to sex, the vast majority of women agree on this statement supports this.It is known that in Turkish traditions, women believe that their perineum should be clean while giving birth, and midwives may be influenced by this belief. However, midwives and obstetriciansshould be expected to tell the woman the positive and negative aspects of the perineum shaving before the perineum is shaved, take the consent of the woman and leave this decision to woman in line with professional ethics rules instead of her their personal beliefs [26].

Non-pharmacologic methods such as hot compress application and oily massageto the perineum to increase perineal tissue blood circulation and flexibility, and ice application to reduce burning and pain in the urethra and clitoris region during pushing decrease the need for episiotomy [27, 28]. It has been determined that most of the midwives and obstetriciansin our study agreed that non-pharmacological practices should be donebefore the episiotomy. In this respect, the vast majority of midwivesand more than half of the obstetriciansdo not agree that the increase in the practice of episiotomy may be due to the fact that midwives and obstetriciansdo not have sufficient knowledge about non-pharmacological practises.However, the rate of seeing the need for non-pharmacological applications decrease as the work duration at hospitals and age increase. In the study of Karaçam (2001), it was found that all of the midwives/nurses helping the birth used the methods of perineal massage, slow delivery of the baby's head, prevent the mother's rapid pushing during the birth of the baby's head and body, and support for the spontaneous pushing efforts of the woman.In the study of Stamp (1997), when midwives were asked if they performed perineal massage, 34% of them said they never did, 16% said they did frequently, and the rest of them said they rarely or sometimes did. Episiotomy is a surgical procedure and problems such as infection, hematoma, episiotomy dehiscence (stitches opening) can be seen. Non-pharmacological methods, on the other hand, have no adverse effects on women's health and they are applications for reducing the indication for episiotomy. Positive point of view of young people, midwives and doctors who work at deliver rooms for 10 years and less to these practices is important.

Local anesthetics are usually administered before episiotomy. However, sometimes at emergency situations laceration can be made without anesthesia at the time of contraction [30, 31]. It is thought-provoking that one of every 4-5 midwives believes that anesthetic agent should not be given as it is believed that the baby's

head will leave the perineal tissue under pressure and prevent pain from being perceived. However, pain affects the person physically and psychologically and is a condition that should not be experienced [32, 33].For this reason, the correct attitude is the application of local anesthetics before episiotomy. In this study, all of the midwives and most of the obstetriciansbelieve that anesthetic agents should be given before the perineum is sutured rather than before the laceration is made. It is noteworthy that all of the midwives and the majority of obstetriciansare agree with this statement. The reason why all of the midwives agree with the administration of an anesthetic before the suture can be to ensure that the woman does not react during the procedure and so that they can suture the woman easily.

More than half of the midwives and one of every three physicians, in other words according to sex more than half of the women and one of every three men believe that repairing lacerations will not prolong the duration of stay in the delivery room but repairing the episiotomies will significantly prolong the duration of stay in the delivery room. In the study of Duran et al. (2002), the duration of stay in the delivery room was significantly longer in the episiotomy group than the one without the episiotomy. Women who gave birth with episiotomy were found to stay in the delivery room longer than other women.According to the study, it was also determined that in cases where any kind of lacerations developed, women stayed in the delivery room in a similar period of time when compared to those who did not develop lacerations. More than half of the midwives and obstetriciansin this study does not believe that the repairing process of episiotomy will delay the the initiation of mother-infant communication and the mother's resting time.In the study of Karaçam (2001), it was seen that none of the mothers with and without episiotomy/laceration could initiate communication with their infants during the first half an hour, majority of them could initiate communication in 30-59 minutes and fewer of them in 60 minutes or longer. However, for the initiation of mother-infant communication, the first half an hour after birth is the most appropriate time. Because in the first 30 minutes, the baby responds effectively to stimuli and is concerned with the environment.

If it is predicted that a small laceration will be done, the episiotomy should not be performed. More than half of the midwives and obstetriciansagreed that small lacerations recover more easily. Especially, the vast majority of university and private hospitalworkers have agreed with this statement. Lundquist et al. (2000) reported that leaving the first-degree perineal tears without stitching resulted in less pain and quick healing than stitched lacerations.

One of every three midwives and more than half of the obstetriciansagree that a birth performed with episiotomy is frequently used by midwives and obstetricianssince episiotomy saves more time to the health team. This belief of healthcare professionals may mean that they will use episiotomy more often. This shows that postpartum health of many women can be affected adverselydue to the episiotomy.

V. Conclusion

Studies suggest that the episiotomy should be restricted rather than routinely applied and should be performed in case of indication. Nearly all of the midwives and obstetriciansin this study believe that episiotomy should be performed in case of indication, episiotomy protects the perineal tonus and prevents unwanted tears and there is no need to take consent of the womanwhen performing the episiotomy. At the same time, the majority of the midwives and obstetricianssee episiotomy as part of normal birth.

Nearly all of the midwives with bachelor's degree does not see episiotomy as routine application. Majority of state hospital workers and nearly half of the university hospital workers do not think that taking consent is necessary. Majority of the midwives and more than half of the obstetriciansbelieve that perineum should be shaved before episiotomy.All of the midwives and most of the obstetriciansbelieve that anesthesia should be given before the perineum is sutured rather than before the laceration is made. Also, one of every three midwives and more than half of the obstetriciansagree that a birth performed with episiotomy is frequently used by midwives and obstetricianssince episiotomy saves more time to the health team.

According to these results, in-service training programs are recommended to midwives and obstetricians about the positive and negative aspects of episiotomy, its not being routine practice, its indications and about taking the woman's consent before the perineum is shaved.

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TABLE 1. Distribution of characteristics of midwives and obstetricians

Characteristics	**Midwife(n:48) N (%)**	**Obstetrician(n:45) N(%)**
20-30	24 (50.0)	9 (20.0)
Age31-40	18 (37.5)	16 (35.6)
41 and above	6(2.5)	20 (44.4)
High school	22 (45.8)	-
Associate's degree	19 (39.6)	-
Education Status Bachelor's degree	7 (4.6)	11 (24.4)
Postgraduate	-	34 (75.6)
State hospital	25 (52.0)	19 (42.2)
Work Place University hospital	8 (16.7)	17 (37.8)
Private hospital	15 (31.3)	9 (20.0)
Married	26 (54.2)	36 (80.0)
Marital Status		
Single	22 (45.8)	9 (20.0)

TABLE 2. Agree or disagree situations of midwives andobstetricians to the expressions for reasons of episiotomy and for applications to be made before episiotomy

Expressions for reasons of episiotomy	**Health professional**	**Agree N (%)**	**Disagree N (%)**	**x^2 *p***
Episiotomy is part of normal birth.	**Midwife** **Obstetrician**	46 (95.8) 35 (77.8)	2 (4.20) 10 (22.2)	6.737 ***0.009***
Episiotomy should be routinely performed at every birth.	**Midwife** **Obstetrician**	17 (35.4) 20 (44.4)	31 (64.6) 25 (55.6)	0.790 *0.374*
If there is any indication inpregnant woman, episiotomy should be performed.	**Midwife** **Obstetrician**	46 (95.8) 44 (97.8)	2 (4.20) 1 (2.20)	0.281 *0.596*
Episiotomy is decided according to the state of perineum.	**Midwife** **Obstetrician**	47 (97.9) 44 (97.8)	1 (2.10) 1 (2.20)	0.002 *0.963*
Expressions for applications to be made before episiotomy				
The midwife or physician must decide on their own to perform the episiotomy.	**Midwife** **Obstetrician**	46 (95.8) 41 (91.1)	2 (4.20) 4 (8.90)	0.858 *0.354*
Non-pharmacological practises should be performed before episiotomy.	**Midwife** **Obstetrician**	35 (72.9) 29 (64.4)	7 (14.6) 16 (35.6)	0.777 *0.378*
The perineum of the woman should be shaved before the episiotomy.	**Midwife** **Obstetrician**	41 (85.4) 29 (64.4)	7 (14.6) 16 (35.6)	5.488 ***0.019***
Since the fetus head is pressed, it does not need to be applied anesthesia to the perineum before the incision.	**Midwife** **Obstetrician**	18 (37.5) 9 (20.0)	30 (62.5) 36 (80.0)	3.452 *0.063*
There is no need to take consent for episiotomy.	**Midwife** **Obstetrician**	38 (79.2) 29 (64.4)	10 (20.8) 16 (35.6)	2.499 *0.114*

TABLE 3. Agree or disagree situations of midwives and obstetricians to the expressions for episiotomy repair and for the benefit of episiotomy

Expressions for episiotomy repair	**Health Professional**	**Agree N (%)**	**Disagree N (%)**	**x^2 *p***
Episiotomy repair should be done after placenta separates.	**Midwife** **Obstetrician**	45 (93.8) 39 (86.7)	3 (6.30) 6 (13.3)	1.333 *0.248*
Anesthetic must be given before the perineum is sutured.	**Midwife** **Obstetrician**	48 (100.) 40 (88.9)	- 5 (11.1)	5.636 ***0.018***
Repairing lacerations do not prolong the duration of stay in the delivery room but repairing the episiotomiessignificantly prolong the duration of stay in the delivery room.	**Midwife** **Obstetrician**	27 (56.3) 14 (31.1)	21 (43.8) 31 (68.9)	5.954 ***0.015***
Expressions for the benefit of episotomy				
The main benefit of episiotomy is to protect the perineum tonus and prevent unwanted tears.	**Midwife** **Obstetrician**	48 (100.) 44 (97.8)	- 1 (2.20)	1.078 *0.299*
Episiotomy prevents long-term pressure to the pelvic floor.	**Midwife** **Obstetrician**	43 (89.6) 37 (82.2)	5 (10.4) 8 (17.8)	1.047 *0.306*
In cases where the perineal muscles are over-stretched, the episiotomy must be performed to prevent stretching in the area.	**Midwife** **Obstetrician**	46 (95.8) 41 (91.1)	2 (4.20) 4 (8.90)	0.858 *0.354*
Episiotomy provides a larger area to facilitate the application of obstetric practices such as vacuum or forceps.	**Midwife** **Obstetrician**	48 (100.) 45 (100.)	- -	3.452 *0.063*
Episiotomy prevents neonatal brain damage by reducing the pressure on the fetal head, especially in premature newborns.	**Midwife** **Obstetrician**	45 (93.8) 37 (82.2)	3 (6.30) 8 (17.8)	2.960 *0.085*

TABLE 4. Agree or disagree situations of midwives and obstetricians to the expressions for the adverse effects of episotomyand for the increase of episotomy

Expressions for the adverse effects of episotomy	**Health Professional**	**Agree N (%)**	**Disagree N (%)**	**x^2 *p***
The biggest disadvantage of episiotomy is that it is a painful incision.	**Midwife** **Obstetrician**	38 (79.2) 39 (86.7)	10 (20.8) 6 (13.3)	0.917 *0.338*
Episiotomy increases blood loss and hematoma development risk.	**Midwife** **Obstetrician**	26 (54.2) 26 (57.8)	22 (45.8) 19 (42.2)	0.123 *0.726*
Episiotomy reduces the sexual satisfaction of women.	**Midwife** **Obstetrician**	13 (27.1) 19 (42.2)	35 (72.9) 26 (57.8)	2.359 *0.125*
It is common for sutures to open in median episiotomies.	**Midwife** **Obstetrician**	12 (25.0) 5 (11.1)	36 (75.0) 40 (88.9)	2.999 *0.083*

The repair process delays the initiation of mother-infant communication and mother's resting time.	**Midwife** **Obstetrician**	23 (47.9) 17 (37.8)	25 (52.1) 28 (62.2)	0.974 *0.324*
Episiotomy increases the cost of health care for the woman and prolongs the duration of stay in the hospital.	**Midwife** **Obstetrician**	21 (43.8) 17 (37.8)	27 (56.2) 28 (62.2)	0.343 *0.558*
If it is predicted that a small laceration will occur, the episiotomy should not be performed. Because a small laceration heals easier.	**Midwife** **Obstetrician**	29 (60.4) 31 (68.9)	19 (39.6) 14 (31.1)	0.728 *0.393*
Expressions for the increase of episotomy				
The increase in the use of episiotomy may be due to the fact that midwives and obstetriciansdo not have sufficient knowledge of non-pharmacological applications.	**Midwife** **Obstetrician**	9 (18.8) 17 (37.8)	39 (81.2) 28 (62.2)	4.175 ***0.041***
Birth done by performing the episiotomy has been used frequently by midwives and obstetricianssince it saves more time to the health team.	**Midwife** **Obstetrician**	18 (37.5) 29 (64.4)	30 (62.5) 16 (35.6)	6.746 ***0.009***

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