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Perception regarding restricted episiotomy: A qualitative study

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Abstract

Background/Aim: Episiotomy is a planned surgical incision in the perineum and posterior vaginal wall in the second stage of labour to enlarge vaginal opening during delivery. It is one of the most commonly preferred obstetric operation during delivery since 1920 and practised routinely in most of the developing countries till today. Restricted practice refers to episiotomy reserved for situations where there is clear indication to perform the procedure. World Health Organisation (2018) recommends restricted practice of episiotomy. Voluminous literature highlights extensive disagreement about the necessity and benefits of the procedure. Even though the pendulum has swung back the practice of liberal episiotomy is still higher than the expected rate. Role of decision ends up in the midwives/ obstetrician's hands who conduct the delivery. Limited researchers have examined the motive behind practicing liberal episiotomy. In this context a qualitative study was conducted to address the issues from midwives/obstetrician's own perception regarding restricted practice of episiotomy.

Materials and methods: This is a phenomenological approach qualitative study using the thematic analysis. The participants included 15 midwives and 8 obstetricians with minimum experience of one year selected by purposive sampling and attended semi structured interview.

Results: The themes emerged after data analysis are Negative impact on self and maternal morbidity and Inadequate readiness.

Conclusion: The subjective opinion of midwives/obstetricians could identify reasons behind the reluctance to give up the age old practice and threw light in to the gap that exists in practice and scientific evidence. Conscious effort may be taken by the midwives /obstetricians to adopt the best evidence based protocol and deliver quality care.

Keywords: restricted episiotomy, liberal, midwives, obstetricians

Introduction

Episiotomy is a planned surgical incision in to the perineum and posterior vaginal wall in the second stage of labour to enlarge vaginal opening during delivery. It is one of the most commonly preferred obstetric operations during delivery since 1920. It is an inflicted second degree perineal injury and one of the most commonly preferred obstetric operation during delivery and practiced routinely. Internationally the practice ranges from routine use in all births to use only when clinically indicated ^[1]. Restricted practice refers to episiotomy reserved for situations where there is clear indication to perform the procedure. . World Health Organisation (2018) supports restricted practice of episiotomy ^[2]. Voluminous literature highlights extensive disagreement about the necessity and benefits of the procedure. A systemic review of randomised controlled trial showed that restrictive episiotomy has several advantages over routine episiotomy like less posterior perineal trauma, less suturing and fewer healing complications ^[1] In South America there has been a downturn in episiotomy rates from 41% to 30%. ^[4] Episiotomy rates in institutional deliveries in the country is not available. In 2006 ACOG committee in practice bulletins based on good scientific evidence recommended that restricted use of episiotomy is preferable to its routine or liberal use. ^[5] Unnecessary episiotomy leads to vulval haematoma, infection, wound dehiscence and delayed mother child bondage. Even though the pendulum has swung back the practice of liberal episiotomy is still higher than the expected rate the reason behind it still remains unclear. MEDLINE search revealed many studies have paid attention to the restricted use of episiotomy and available evidence recommends restrictive use of episiotomy ^[6]. However only a few qualitative studies on this aspect have done. Therefore our study aims to explore the subjective experience of the midwives/obstetricians to provide fundamental data related to the increase in episiotomy rate and disinclination towards restricted episiotomy practice.

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Materials and methods

A qualitative study was used with thematic analysis approach. Qualitative research is the best approach in order to explore own perception at the grass root level. The participants included 15 midwives and 8 obstetricians with minimum clinical experience of one year in conducting delivery. Participants were selected by purposive sampling. The aim of study was explained to all participants. Written informed consent was obtained from all participants. Semi structured interview was used to collect data. Interviews were conducted individually and all the interviews were recorded. Immediately after each interview data was transcribed. Interviews were conducted until saturation of information was obtained. Researchers dived in to the data by reading several times to obtain general sense for encoding them grouped into subsets. Based on the similarity, proportionality and relevance subsets were narrowed and analysis process completed with classification of themes. Interviews were coded and classified independently by the authors to ensure credibility, dependability and transferability.

Results

In our study we enrolled 15 midwives and 8 obstetricians. The working experience ranged from 1 to 26 years. All midwives possessed bachelor's degree in nursing and the obstetricians were doing their MD in obstetrics and gynaecology. The themes identified through analysis are Negative impact on self-image and maternal morbidity and inadequate readiness.

Theme 1: Emotional impact on self-image maternal morbidity: Quality care is intended to minimise the maternal morbidity. Both midwives and obstetricians expressed that episiotomy is mainly performed to prevent perineal trauma. Majority of the participants responded that:

"If we do not give episiotomy there will be tear assessment had gone wrong in most of the cases and clients had perineal tear"

"If not giving episiotomy chances of having perineal tear is more and tear is difficult to stitch and clients will have more pain. Conducting delivery without episiotomy is not a great thing. I don't want perineal tear to occur as it shows my inefficiency in conducting delivery."

"If there complicated perineal tear it is difficult to approximate and takes too much time to suture more than time required to just stitch an episiotomy."

Theme 2: Inadequate readiness: Readiness to update self and practice the latest evidence is one of the salient attitude that health workers should possess. Most participants responded that they are not ready to abandon the age old practice. For example;

"I am aware about the latest recommendations regarding restricted episiotomy and the measures to prevent perineal injury but I follow type practice of liberal episiotomy".

Discussions

The study explored the midwives /obstetrician's subjective notion on practice of restricted episiotomy. The findings of the study opened up the rudimentary concepts for the reason of still following the age old inadvisable practice. Most of the midwives/ obstetricians favours routine episiotomy practice this opinion is in concurrence with a study done by Ahmed A A, Mohamed S H in Egypt revealing majority of obstetricians recommended routine episiotomy and stated

that it is not associated with increased risk of long term dyspareunia, urine and faecal incontinence compared to tear^[7]. Fear of tearing was the concern of most of the midwives /obstetricians. This is in consistent with a study conducted in Cambodia by S Clemence *et al.*^[8]. There are ample studies recommending restricted episiotomy. The factors that influence the decision making around episiotomy in an environment where use of the procedure is restricted may be related to preconceptions about high –risks sub groups in addition to clinical indicators or the risk of impending perineal trauma.^[3] Restrictive use of episiotomy only for fetal indications resulted in 36% decrease in episiotomy rate, which was accompanied by threefold increase in the rate of intact perineum and rate of minor perineal trauma. This is of significant importance, because women whose newborns were delivered with an intact perineum or with only a first degree tear reported in a recent study the best outcomes overall with regard to postpartum sexual functioning. Professional competency empowers nurses and enable them to full fill their duties effectively^[9] two more studies have pointed out the gap between skilled birth attender's current practice during conducting delivery and evidence based guidelines.^[10]

Conclusion

Midwives/Obstetricians are the decision makers for performing episiotomy while conducting delivery. Women who undergo episiotomy have more blood loss, delayed wound healing and more pain after child birth. In spite of mounting evidence against routine use of episiotomy there is reluctance among the professionals to give up the age old practice. Study emphasis the gap that exists in practice and evidence. Conscious efforts may be taken by the midwives and obstetricians to adopt and practice the best relevant evidence based protocol and deliver quality care. Competent skilled health care worker may conduct periodic sessions on measures to prevent perineal trauma while conducting delivery.

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