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Does episiotomy always equate violence in obstetrics? Routine and selective episiotomy in obstetric practice and legal questions

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Abstract. – OBJECTIVE: The study's main goal is to figure out whether episiotomy, a widely applied invasive procedure, may constitute a determining factor of liability for practitioners according to the standards of obstetric violence.

MATERIALS AND METHODS: The authors have aimed to analyze laws and documentation issued on the matter by sovereign states, statements and remarks from International health organizations, in addition to scientific article available on the main search engines (PubMed, Scopus, Google Scholar) and legal databases (Lexis, Justia).

RESULTS: The body of research has highlighted the existence of a wide-ranging agreement as to routine episiotomy, deemed to be a scientifically unfounded procedure, and which should, therefore, be avoided. By virtue of that, routine episiotomy might easily give rise to charges and liability for doctors and midwives alike; likewise to claims may stem from a failure to perform an episiotomy when it was actually needed.

CONCLUSIONS: Unlike routine episiotomy, selective episiotomy is far more unlikely to cause charges of obstetric violence against operators. Unfortunately, the criteria in order to establish when a selective episiotomy is indicated are far from consistent and would require an additional effort on the part of scientific societies towards a more clearly defined and shared description.

Key Words:
Episiotomy, Obstetric Violence, Malpractice.

Introduction

The current debate revolves around a "routine" *vs.* "selective" use of episiotomy[1]. A 2000 Cochrane review reports high rates of episiotomy despite the widespread recognition that a routine use of this procedure is not beneficial[2]. The international health organizations affirm the need for limited use of episiotomy[3]. Some researchers have defined episiotomy a form of genital mutilation[4,5].

The term episiotomy was first used in 1742 by Ould[6], who described it as useful for "difficult deliveries" – when parturient could not push out the baby after it was properly positioned in her vagina. The originally conceived notion of episiotomy entails a procedure aimed at preventing perineal lacerations. The procedure became popular in the early 1900s when it was believed by obstetricians that episiotomy might be instrumental in protecting pelvic floor integrity by limiting vaginal muscle damage, and could even relieve pressure on the fetal head, thus protecting the baby's brain. Such theories have nonetheless been proven to be false today[7].

Episiotomy is a surgical cut in the tissue between the vagina and the anus (called the perineum) made just before delivery to enlarge the vaginal opening. It affects the lower third of the vaginal mucosa, the skin and the posterior vaginal wall. It may entail complications that include pain, swelling, and infection of the area. In addition, an episiotomy may actually cause more severe vaginal tearing, increasing the risk that the damage will extend to the sphincter. All such adverse developments may pave the way for claims to be filed[8].

Episiotomy: Surgical Techniques

Obstetric literature reports different types of episiotomy, but the optimal surgical technique

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remains undetermined, with no universal consensus, although the RCOG and NICE advice for a mediolateral type of episiotomy in order to preserve the pelvic floor[9,10]. In fact median episiotomy, although it causes less pain and heals more easily, is linked to a higher risk of anal sphincter tears[11].

Table I shows the different types of episiotomy.

Routine Episiotomy vs. Selective Episiotomy

International health organizations affirm the need for limited use of routine episiotomy, since it has been proven to be associated with complications such as perineal trauma[14], increased blood loss, perineal infections[15] and wound dehiscence[16, 17]. For those reasons, the authors recommend ceasing routine episiotomy in favor of a selective approach to it. In fact, a recent Cochrane has observed that routine episiotomy is not effective in reducing the risk of perineal and vaginal trauma, but does not however lays out clear standards to define when selective episiotomy should be performed. The same Cochrane review recommends the use of selective episiotomy in operative vaginal deliveries, and yet points out that the procedure's actual effectiveness for such patients should be proven by further research studies[18]. Moreover, episiotomy at first vaginal delivery increases the risk of spontaneous obstetric laceration in the subsequent delivery. That finding should encourage obstetric providers to further restrict the use of episiotomy.

Pain Management for Women in Labor and During Episiotomy

A 2018 online survey reports that the majority of those surveyed were never/almost never explained reasons for performing an episiotomy

Table I. Types of episiotomy.

Types of episiotomy	
Definition	**Way of execution**
Median	Incision starts at the posterior fourchette and runs along the midline through the center of the perineal body. The incision should run for approximately half of the length of the perineum (2-3 cm) without affecting the anal muscle. Medial episiotomy usually entails less blood loss and discomfort during healing: wounds at that location heal faster and with less pain: lesser blood vessels and nerval branches are damaged[12].
Medio-lateral	An incision is performed downward and outward from the midpoint of the fourchette, either to the right or left towards the ischial tuberosity with 3-4 cm length, beginning in the midline and directed laterally and downwards away from the rectum. It affects the skin, subcutaneous tissue, bulbospongious muscle, superficial transverse perineal muscle, and the Levator Ani. This is the most frequently used type of episiotomy in Europe[13].
Lateral	The incision starts from about 1 cm (0.4 in) away from the centre of the fourchette and extends laterally. Possible complications comprise injury to the Bartholin's duct, which is why lateral incisions are deemed inadvisable by most specialists, and rarely mentioned in the obstetric literature.
'J'-shaped episiotomy	It entails a midline incision, curved laterally away from the anus. Curved scissors are used starting in the midline of the vagina until the incision is 2·5° cm from the anus, then directing the incision towards the ischial tuberosity away from the anal sphincter
Radical lateral (Schuchardt incision)	Generally considered a non-obstetrical incision, it is a fully extended episiotomy, deep into one vaginal sulcus and is curved downward and laterally part way around the rectum. It may be carried out at the beginning of radical vaginal hysterectomy or trachelectomy in order to allow easy access to the parametrium, to enable extraction of a neglected vaginal pessary or, quite rarely, to facilitate childbirth if complications arise (fetal macrosomia, difficult breech or shoulder dystocia).

(34%), never gave permission (54%) and were never given local anesthesia (5%)[19].

The pain that women experience during labor is caused by multiple physiological and psychosocial factors and its intensity can vary greatly[20]. Epidural analgesia is a central nerve block technique widely used as a form of pain relief in labor[21]. Epidural catheter can be used for urgent cesarean section as a conversion in anesthesia, or as pain relief during sutures of perineal trauma after vaginal delivery: spontaneous (tear) or intentional (episiotomy)[22]. Other types of pain relief during childbirth entail the use of parenteral opioids (remifentanil), inhaled analgesia, acupuncture or other. Analysis of trials conducted after 2005, showed that epidural analgesia had no impact on the risk of operative vaginal delivery or cesarean section, because in modern labor analgesia, low doses of local anesthetics with opioids are used[23]. When epidural catheter is not used for pain relief and repair of perineal trauma is required, topical products as lidocaine-pilocain cream (EMLA) or local infiltration anesthesia with local anesthetic Lidocaine 2%) can be used[24]. For the purpose of pain management at the post partum stage, usable medications include FANS. Use of paracetamol must be cautious because the risk of hepatoxicity[25]. Women whose infants were delivered over an intact perineum reported the best outcomes, whereas perineal trauma and use of obstetric instrumentation were related to the frequency or severity of postpartum dyspareunia and perineal pain (acute or cronic)[26]. Some perineal techniques during second stage of labor were proposed for reducing perineal trauma, such as perineal massage, warm or cold compresses and perineal management. This review confirms that warm compresses and perineal massage may reduce third and fourth-degree tears and episiotomy[27]. Pain management concerns delivery, early and late puerperium. In some countries, such as Italy, targeted pieces of legislations are in place to uphold the right to a pain free pathology treatment, including childbirth[28]. Any violation of such entitlement may bring about liability charges for doctors, midwifes and hospital managers, and may be regarded as an act of "obstetric violence".

Episiotomy and Obstetric Violence: a Literature Review

The suitability of a routine use of episiotomy has been questioned by specialists and scientific societies, and several professional medical associations and patient and women's rights advocates have been associating it with obstetric violence. Nonetheless, obstetric violence goes well beyond non-consensual routine episiotomy: it is a global issue, which is experienced by pregnant and birthing women in developed and developing countries. Furthermore, it is found to take place in public and private health care facilities. Obstetric violence typically entails disrespectful, abusive and coercive treatment of pregnant and birthing women during obstetric care and results in a violation of their autonomy, human rights and sexual and reproductive health. Performing procedures without informed consent, or with coerced consent, or enforcing procedures by an order of court are also deemed to be instances of obstetric violence[29]. It may be argued that procedures that have been identified as forms of obstetric violence are those that are imposed on women as routine without having any scientific foundation, such as episiotomy and without informed consent. These include unnecessary cesarean section deliveries, manual revision of women's uterine cavities without pain relief, inserting long-term birth control mechanisms directly after birth, collective vaginal examinations for training purposes, restraining women to the delivery table, and forced or coerced sterilizations[30]. In 2014, the World Health Organization characterized as human rights violations any form of disrespectful and abusive care during childbirth – including physical and verbal abuse, refusals of care and medication, and coercive or unconsented medical procedures. The WHO characterized as human rights violations any form of disrespectful and abusive care during childbirth – including physical and verbal abuse, refusals of care and medication, and coercive or unconsented medical procedures. The WHO lays out possible forms of obstetric violence and expounds upon five categories that could dovetail with the legal definitions of obstetric violence: (1) routine and redundant interventions and medicalization, whether they be performed on the mother or the infant; (2) verbal abuse, humiliation or physical assault; (3) insufficient availability of necessary medical supplies and ill-suited facilities; (4) medical procedures carried out by physicians and other health care operators without having gained the woman's consent, thus not based on the provision of thorough, exhaustive information; 5 - any form of cultural, economic, religious and ethnic discrimination. The WHO considers obstetric violence part of an entrenched institutional culture marked by the trivialization,

invisibility and naturalization of the phenomenon in daily care. The above-mentioned characteristics allow for the non-recognition of obstetric violence as violation of human rights and a serious global public health problem. According to WHO findings, women are being violently abused, in various forms and degrees of severity, all over the world. They experience mistreatment, disrespect, abuse, negligence, violation of human rights by health professionals, especially during delivery and birth. It is frequent to observe in obstetrical rooms half-naked women in the presence of strangers, or alone in unfriendly settings, in positions of total submission, with open and raised legs and with genital organs exposed, and routinely separated from their children soon after birth[31]. Reports of violence are quite frequent and present the following manifestations: lack of information about the procedures performed during care; unnecessary cesarean sections; deprivation of food and the possibility to move; routine and repetitive vaginal exams without justification; frequent use of oxytocin in order to expedite labor; episiotomy without the consent of the women; and Kristeller's maneuver[32,33]. Several national surveys have shown that one in four women in Brazil has suffered some type of obstetric violence during childbirth care and half of those who had abortions also had similar experiences. 10% of survey respondents reported having been subjected to painful vaginal examinations; 10% were denied pain relief aid; 9% were shouted at; 9% reported the use of profanities or having been verbally humiliated; 7% were not made aware of the medical procedures about to be performed; 23% suffered verbal violence and expressions of bias[34]. As far as national targeted pieces of legislation are concerned, in 2007 Venezuela enacted a law devised to sanction dehumanizing treatment, abuse of medication, and "the appropriation of the body and reproductive processes of women by health personnel… bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality[35,36]." Puerto Rico and Argentina have also espoused similar legislative exercises[37].

Since 2014, obstetric violence observatories in Chile, Spain, Argentina, Colombia, France and Italy have also conducted Internet surveys to gather data. A March 2016 draft bill in Italy, «*Norme per la tutela dei diritti della partoriente e del neonato e per la promozione del parto fisiologico*», based on the World Health Organization 2015 statement, was designed to institute the crime of obstetric violence, which would carry a 2 to 4 year prison sentence[38]. The legislative initiative, however, has been bitterly criticized and opposed by medical practitioners associations: the Italian Association of Hospital Obstetricians and Gynecologists (AOGOI, along with other similar associations SIGO and AGUI) has accused the bill of "offending the practitioners' professionalism"[39]. The draft bill was never enacted, and although a "humane approach to delivery" is codified in some regional regulations (e.g. the regional law of Latium, 3rd June 1985 n. 84), there is no national-scale piece of legislation contemplating "obstetric violence" in itself. As far as the refusal of medically treatment during pregnancy, the American College of Obstetricians and Gynecologists (ACOG) issued, in June 2016, a specifically targeted committee opinion, stating that: (1) Recognition of the mother's right to refuse treatment; (2) A clear statement against coercion as both ethically impermissible and medically inadvisable "because of the realities of prognostic uncertainty and the limitations of medical knowledge"; and (3) A recommendation that patient and provider conduct an open dialogue about values when there is refusal, including through a non-confrontational dispute resolution process using a team approach[40]. It is easy for medico-legal litigators to see the potential impact this ACOG Opinion can have on obstetric cases: for those involved in medico-legal practice, the evolution of this issue presents a number of conceptual questions. A 2018 cross-sectional descriptive study, which looked at qualitative and quantitative elements of women's childbirth experience in Quito, Ecuador, between July 1, 2016, and July 1, 2017, surveyed 388 Ecuadorian women about their childbirth experiences. Out of that pool, 259 patients (66.8%) delivered vaginally and 129 (33.2%) delivered by cesarean); it is worth noting that 120 women who delivered for the first time, 62 (51.7%) had an episiotomy. At the second stage of labor, Kristeller maneuver (uterine fundal pressure) was exerted in 49 (19.4%) out of 252 patients. Overall, 196 (50.5%) women reported that they were prevented from making an early attachment, and 135 (34.8%) reported getting no support for the initiation of breastfeeding[41]. Some women's organizations have been working hard toward raising awareness about "obstetric violence," but until recently, there has been widespread skepticism about its very existence[42]. However, researchers have found

that numerous patients have been pressured into consenting to medical procedures to be carried out during labor and delivery. 59% of mothers reported that they were pressured to undergo an episiotomy and another 8 to 23% reported that they were pressured to undergo labor induction, epidurals, or C-sections[43, 44]. Unwanted episiotomy or other unwanted procedures can be difficult to challenge in court. A medical malpractice lawsuit requires a woman to prove that a doctor provided substandard care. Yet, in a case of treatment refusal where the patient is given the treatment anyway, patient plaintiffs may face difficulties when attempting to prove medical malpractice if the treatment was not demonstrably delivered in a substandard fashion. For that reason, in the Kimberly Turbin case (a Californian woman who was subjected to 12 perineal cuts despite her repeated screaming "don't cut me"!) the lawsuit centered on assault and battery against her doctor[45]. In this context, routine or high rates of episiotomy can be categorized as female genital mutilation. Obstetric violence is a global issue, which is experienced by pregnant women and parturients both in developed and developing countries. Furthermore, it has been found to take place in public and private health care facilities alike. Obstetric violence concerns disrespectful, abusive and coercive treatment of pregnant and birthing women during obstetric care and results in a violation of their autonomy, human rights and sexual and reproductive health. Performing procedures without informed consent, with coerced consent, or enforcing procedures by an order of court are also deemed to be examples of obstetric violence[46]. Yet, courts and physicians alike are often willing to override a woman's choice of childbirth procedure if they believe this choice poses risks to the fetus, and both give little value to the woman's right to bodily autonomy. According to several legal scholars, particularly an opinion published in the Duke Law Journal[47], current legal systems do little to provide redress for women coerced to undergo certain medical procedures during childbirth. Courts and physicians alike are prepared to override a woman's choice of childbirth procedure if they believe this choice poses risks to the fetus, and both give little value to the woman's right to bodily autonomy. Those remarks beg the question: how does a practitioner balance patient autonomy with fetal safety? If practitioners put maternal health and choice over the health of the fetus, giving rise to poor fetal outcome, are they legally protected? Will juries embrace the primacy of maternal health when evaluating a poor fetal outcome? The issue of episiotomy is far more complex than it seems. In fact episiotomy performed in a selective fashion is believed by some to have a valuable role in obstetric care, according to most scientific societies; therefore, however rarely, doctors may find themselves on trial for failing to perform an episiotomy, if perineal lacerations or trauma arises that can be traced back to that failure. For instance, in a case occurred in 1982, H.C. B. and her husband R. E. B., brought a civil action against Dr. B. by complaint filed in the United States District Court for the Eastern District of Virginia, Alexandria Division. The case was transferred to the Western District of Virginia, Charlottesville Division. The mother's claim was based upon medical malpractice, alleging bodily injury including perineal tearing due to the defendant's failure to perform an episiotomy. In addition, Mrs. B. claimed damages for mental anguish arising from the birth of her profoundly impaired child. The father claimed damages arising from emotional distress. The child's claim was based upon her personal injuries. Veronica contended that she, as well as her mother, was Dr. B.'s patient and that her claim also arose out of medical malpractice. The three plaintiffs did not claim separate awards of damages. Rather, their complaint concluded with an *ad damnum* clause demanding $ 6,800,000 compensatory damages and $ 800,000 punitive damages for the three plaintiffs jointly. The case was tried by jury over a period of six days. On January 21, 1985, the jury returned the following separate verdicts against Dr. B[48].

(1) For V. B. Compensatory damages	$ 1,850,000
(2) For V. B. Punitive damages	$ 1,000,000
(3) For H. B. Compensatory damages	$ 1,575,000
(4) For H. B. Punitive damages	$ 1,000,000
(5) For R. B. Compensatory damages	$ 1,175,000
(6) For H. and R. B. (Medical expenses until Veronica reaches 18 years of age)	$ 1,700,000
Total verdicts	$ 8,300,000

Generally speaking, the position of doctors

and midwives is at risk because they may be held liable whether they perform the procedure or not.

Conclusions

Episiotomy, when routinely used, is considered by the WHO and some authors as a form of obstetric violence and even a perineal mutilation. Scientific literature agrees about the need to reduce the rates of episiotomy. When routine episiotomy is unnecessary and causes complications[49], it could be a possible expression of obstetric violence, but if it is necessary (selective episiotomy), it cannot be considered as violence or even worse, as a form of genital mutilation, especially if carried out following suitable techniques[50]. A major issue is represented by a shortage of clearly defined standards applicable to the procedure. Thorough criteria are of paramount importance, because they are crucial in order to draw a distinction between necessary (selective) and unnecessary (routine) episiotomy[51]. Corrêa Junior and Passini Júnior[52] in a review reported that the most cited indications of selective episiotomy are: primiparity, fetal weight greater than 4 kg, prolonged second stage, operative delivery and shoulder dystocia.

The authors report in this review about violence and liability[54] and warn the obstetric community about the need for clearly defined rules in some practices/obstetric procedures, including episiotomy, in order to avoid complications, malpractice, liability and claims. That is particularly true in cases of severe, or even deadly, complications, such as the one laid out in a 2015 case report involving a 17-year-old primigravida who perished after contracting necrotizing fasciitis as a result of a medio-lateral episiotomy[55]. It is incumbent upon the scientific community to lie out standards in order to prevent lawmakers from outlawing the practice of episiotomy altogether, labeling it violence without distinction.

Conflict of Interest

The Authors declare that they have no conflict of interests.

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