Journal of Reproductive Health and Medicine 2 (2016) 101–103

Contents lists available at ScienceDirect

Journal of Reproductive Health and Medicine

journal homepage: www.elsevier.com/locate/jrhm

Short communication

Provider perspective on use of episiotomy in obstetric practice

Shalini Singh [a,*], Tushita Thakur [b], Nomita Chandhiok [c], B.S. Dhillon [d]

[a] Scientist 'E' Division of Reproductive Biology & Maternal Health, Indian Council of Medical Research, India
[b] Division of Reproductive Biology & Maternal Health, Indian Council of Medical Research, India
[c] Scientist 'G' Division of Reproductive Biology & Maternal Health, Indian Council of Medical Research, India
[d] Scientist 'F' Division of Human Resource Planning and Development, Indian Council of Medical Research, India

ARTICLE INFO

Article history:
Received 1 February 2016
Received in revised form 10 February 2016
Accepted 13 February 2016
Available online 23 February 2016

Keywords:
Episiotomy
India
Knowledge
Practice

ABSTRACT

A survey of private and public sector maternity care providers was carried out to understand their perspective on use of current guidelines advocating selective use of episiotomy. Nearly 90% of the providers were aware of guidelines on selective episiotomy use but significantly higher proportion ($p = 0.03$) of private practitioners (56.6%) advocated its use in all nullipara as compared to public sector doctors (23.3%). In actual practice, however, nearly 80% providers reported performing episiotomy in more than 75% nullipara with no difference between private and public sector doctors. Thus, awareness of current evidence was not reflected in clinical practice.

1. Introduction

Episiotomy is a common surgical procedure to widen the perineum during delivery. The practice of episiotomy has undergone a number of changes starting from the advocacy of routine episiotomy in the 1920s to selective use in the 1980s. Reported rates of episiotomy vary from as low as 9.7% in Sweden to as high as 100% in Taiwan.[1] In India, an overall episiotomy rate of around 70% has been reported.[2,3] The cochrane review does not support routine episiotomy and indicates the need for research to define indications for selective episiotomy.[4] While the benefits vs. harm of episiotomy are being researched, the healthcare providers continue to perform episiotomy routinely. A survey was carried out amongst private and public sector maternity care providers in India to understand their perspective on the use of episiotomy.

2. Methods

Doctors from private and public healthcare sector attending a national workshop organized by the Federation of Obstetrics and Gynaecological Societies of India at Jaipur were invited to participate in a questionnaire survey to assess their knowledge and views on the use of episiotomy. A partly pre-coded and partly open-ended questionnaire was administered to willing participants and adequate time was allowed for completion. The providers recorded their awareness of clinical guidelines on selective episiotomy use; the proportion of episiotomy use in their day-to-day practice; perceived benefit of episiotomy for baby and/or mother; their opinion on use of episiotomy using parity as a differential and indications for episiotomy in multipara. Additional information on the participants' demographics was abstracted from the survey data. The data were entered in MS Excel and analyzed as simple proportions and percentages. Odds ratio was calculated to compare the responses of private and public healthcare providers. A 'p' value of less than 0.05 was considered statistically significant.

3. Results

A total of 96 doctors participated in the survey; of which 55% (53) were private practitioners and 45% (43) were engaged in the public sector. Nearly 42% respondents were less than 40 years of age; 72% were women and majority (74%) had a postgraduate degree in Obstetrics and Gynecology. The providers' perspective on episiotomy use is summarized in Table 1.

Most doctors in both private and public practice described big baby (58.3%) and abnormal presentation (26.3%) as indication for giving episiotomy in multipara. Among other indications were rigid perineum (18.7%), prolonged 2nd stage (16.6%), instrumental

* Corresponding author at: Scientist 'E' Division of RBMH, Indian Council of Medical Research, V. Ramalingaswami Bhawan, Ansari Nagar, New Delhi 110029, India. Tel.: +91 9811615561.
E-mail addresses: shalinisingh.icmr@gmail.com (S. Singh), dr_tushita@yahoo.co.in (T. Thakur), n_chandhiok@hotmail.com (N. Chandhiok), balwandhillon@gmail.com (B.S. Dhillon).

http://dx.doi.org/10.1016/j.jrhm.2016.02.001
2214-420X/

Table 1
Providers' perspective on episiotomy use.

Item	Response	Private practice $n = 53$ (%)	Public practice $n = 43$(%)
Awareness of selective episiotomy guidelines	Yes	46 (86.8)	40 (93)
Advocate universal use of episiotomy in nullipara	Yes in all*	30 (56.6)	10 (23.3)
Percentage of nullipara given episiotomy in clinical practice	0–24	1 (1.9)	1 (2.3)
	25–49	4 (7.5)	3 (6.9)
	50–74	1 (1.9)	3 (6.9)
	75–100	41 (77.4)	36 (83.7)
	No response	6 (11.3)	0
Percentage of multipara given episiotomy in clinical practice	0–24	25 (47.1)	28 (65.8)
	25–49	13 (24.5)	9 (20.9)
	50–74	4 (7.5)	3 (6.9)
	75–100	4 (7.5)	2 (4.6)
	No response	7 (13.2)	1 (2.3)
Episiotomy perceived as beneficial for the baby	Always	13 (24.5)	14 (32.5)
	Sometimes	34 (64.2)	21 (48.8)
	Never	1 (1.9)	2 (4.6)
	No response	5 (9.4)	6 (13.9)
Episiotomy perceived as beneficial for the mother	Always	19 (35.8)	12 (27.9)
	Sometimes	30 (56.6)	24 (55.8)
	Never	1 (1.9)	1 (2.3)
	No response	3 (5.7)	6 (13.9)

* OR 0.041 (95%CI 0.18–0.93), $p = 0.03$.

delivery (15.6%), fetal distress (8.3%), preterm birth (7.3%), previous cesarean section (7.3%), impending perineal tear (5.2%), previous episiotomy (4.2%) and twin pregnancy (3.1%).

4. Discussion

Historically, episiotomy was performed to widen the vaginal opening during the last part of 2nd stage of labor either in the midline between perineum and anal canal, or at an angle of about 45° from the midline. Episiotomy is given to facilitate delivery of big baby, shoulder dystocia or during forceps or vacuum application; to cut short the second stage of labor in preterm and breech delivery and to prevent perineal tear in women with very tight perineum commonly seen in primigravidas. The surgical cut is about 3–4 cm in length; involves the perineal skin, perineal muscles and vaginal mucosa and is considered to heal better than a ragged perineal tear.[5] The World Health Organization advocates that liberal use of episiotomy is associated with lower rates of women with intact perineum and recommends that a goal of keeping episiotomy rates to less than 10% should be pursued.[6] However, there are no clear guidelines or strategies for perineal protection during delivery or indications for episiotomy and the episiotomy rates continue to remain high,[1] especially among primigravidas in developing countries even though there is a steep decline in developed countries.[7]

Influence of type of provider and place of delivery on episiotomy use was reported from a survey in USA. It was found that episiotomy rates were 6% among patients delivered by the resident doctors and 26% among patients delivered by private obstetricians.[8] Privately insured women were twice as likely to undergo episiotomy as compared to publicly insured women in Australia indicating a monetary advantage for the provider.[9] In this survey, significantly fewer ($p = 0.03$) public sector doctors advocated universal episiotomy in nullipara. However, they could not translate this in clinical practice and there was no difference in the reported use of episiotomy among private and public practitioners.

A cross-sectional study done amongst rural population in Chennai, India reported that the probability for episiotomy was higher (>70%) when delivery was conducted in tertiary or secondary level institutions; or in private institutions (81%) as compared to deliveries in primary health centers (51%) and public institutions (65%). Episiotomy rates were 12.6 times and 38 times higher when nurses and doctors conducted deliveries respectively as compared to those conducted by trained birth attendants.[3]

The episiotomy rate reported for nullipara in this survey supports the findings of our earlier study in which a mean episiotomy rate of 85.1% among primigravidas delivering in tertiary care teaching hospitals of India was reported.[10] Nearly a third of private and public providers in the survey considered that episiotomy was always beneficial for the mother. It has been reported that favorable personal opinion for episiotomy resulted in difficulty in restricting use of episiotomy.[11] These beliefs affect practice and need to be tackled through behavior change communication in addition to providing evidence. A study from Bangalore reported reduction in episiotomy rates from 96% to 40% among nullipara and from 48% to 14% among multipara following introduction of hospital policy of selective episiotomy.[2]

The high episiotomy use reported in this survey carried out among participants attending an academic workshop suggests that the procedure is considered routine. Even though the sample size of the survey is small, it included participants from both public and private sector with not much difference in the use of episiotomy between the groups. This reflects continuation of conventional practice patterns as providers continue to use episiotomy in spite of being aware of revised guidelines. Attitudinal barriers and practical hindrances against effective implementation of selective episiotomy need to be studied in our local context. Data from adequately powered studies are needed in India to describe the short- and long-term benefits vs. harm of episiotomy use to influence a change in practice.

Funding

This survey was supported by the Indian Council of Medical Research, New Delhi.

Conflicts of interest

None.

Acknowledgements

The authors would like to thank all the study participants.