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REVIEW

From social to surgical: Historical perspectives on perineal care during labour and birth

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Abstract A review of key historical texts that mentioned perineal care was undertaken from the time of Soranus (98–138 A.D.) to modern times as part of a PhD into perineal care. Historically, perineal protection and comfort were key priorities for midwives, most of whom traditionally practised under a social model of care. With the advent of the Man-Midwife in the seventeenth and eighteenth century, the perineum became pathologised and eventually a site for routine surgical intervention – most notably seen in the widespread use of episiotomy. There were several key factors that led to the development of a surgical rather than a social model in perineal care. These factors included a move from upright to supine birth positions, the preparation of the perineum as a surgical site through perineal shaving and elaborate aseptic procedures; and the distancing of the woman from her support people, and most notably from her own perineum. In the last 30 years, in much of the developed world, there has been a re-emergence of care aimed at preserving and protecting the perineum. A dichotomy now exists with a dominant surgical model competing with the re-emerging social model of perineal care. Historical perspectives on perineal care can help us gain useful insights into past practices that could be beneficial for childbearing women today. These perspectives also inform future practice and research into perineal care, whilst making us cautious about political influences that could lead to harmful trends in clinical practice.

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Introduction

Historians have noted that midwifery has been characterised as a social role throughout history, regardless of culture or time.[1] Midwifery was taught via an apprenticeship model, with skills passed from one generation to another. Women's voices historically have remained largely silent, giving us little first-hand insight into childbirth practices from their perspective. Evidence from the available historical literature demonstrates that in the past protection and care of the perineum was an important focus of midwifery care. The aim of this study therefore was to examine historical perspectives on perineal care to help gain insights into past practices that could be beneficial for childbearing women today. A review of key texts that mentioned perineal care was undertaken from the time of Soranus (98–138 A.D.) to modern times as part of a PhD into perineal care.

A social model of perineal care

From Soranus to Trotula

Early writing on perineal care appear in the treatise *Gynaecology*, which was written by the physician Soranus of Ephesus (98–138 A.D.)[2] specifically for midwives.[3] Soranus gives one of the earliest descriptions of care of the perineum during childbirth:

> ... and one must first soothe the pains by touching with warm hands, and afterwards drench warm pieces of cloth with warm, sweet olive oil and put them over the abdomen as well as the labia and keep them saturated with the warm oil for some time, and one must also place bladders filled with warm oil alongside (Ref. 3, p. 72).

Soranus instructs the midwife to support the perineum with a linen pad while the head is advancing and advised an attendant to stand behind the midwife's stool and place a 'pledget' underneath in order to restrain the anus and avoid prolapse and rupture that can accompany straining.[3]

Little is then written on the topic for some centuries. During the Dark Ages in Europe (476–1000 A.D.) the midwife remained a shadowy figure.[1] Great literary works were destroyed by the Church, losing forever much wisdom and knowledge.[4] Byzantine midwifery is a notable exception during this time. Midwifery practice was described in some detail, especially regarding perineal care[5]:

> We must apply cataplasms to the pubes, abdomen and loins, of linseed or honied water, or of oil and water; and use similar hip-baths (Ref. 5, p. 98).

During the 11th Century a series of published works known as the *Trotula* arose from the first medical school in Salerno, Italy.[6] These works draw heavily on the works of Soranus and again instruct the midwife to support the perineum with a linen pad. The Trotula documents provide a full description of the severe perineal trauma that can occur if this precaution is neglected. A complete perineal repair is described for the first time in any written record[5] including how to repair the trauma with silk sutures. Written records for the time up until the 17th Century and early modern Europe are sparse. We could find no record of perineal care in that period.

The writings of midwives in early modern Europe

The management of childbirth in early-modern Europe was almost entirely in the hands of women. Midwifery manuals, by contrast, were almost all written by men[7] due to exclusion of women from educational institutions for much of history. There was a brief period of enlightenment in the 16th Century between Luther and Calvin before the ascendancy in the Seventeenth Century of fanatical and woman repressing Puritanism.[4] This makes Jane Sharp's 1671 book, *The Midwives Book: Or the Whole Art of Midwifery Discovered* even more remarkable.[7] In this there is a dramatic change in the way the mother's body is portrayed. Sharp's writing about the mother's body contrasted dramatically with the written works emerging from her male counterparts. The Midwives Book warns against "violent drawing forth the child" and the fact that the "privy parts and Genitals of the mother be so torn that her Urine and excrements come out against her will"Ref. 7, p. 150. She advocates a bath for a "woman great with child that contains bags of herbs boiled well in water and held against her navel and private parts". After this she is to anoint "her back, her belly and secrets (genitals)"Ref. 7, p. 141.

In the same era as Sharp, books on midwifery were written by French midwife Louise Bourgeois (1563–1636 A.D.), German midwife, Justine Siegemund (1636–1706 A.D.) and Frisian midwife Catharina Schrader (1693–1740 A.D). Justine Siegemund (1636–1706 published the book, *The Court Midwife* in 1690.[8] *The Court Midwife* is unique because it does not reproduce the medical lore and humoral medicine that fills Sharp's 1671 work.[7] *The Court Midwife* is full of practical midwifery advice with regards to the perineum:

> You certainly should not stretch or dilate anything with your fingers. This is a common mistake. This sharp stretching injures the woman's belly [genitals] and causes swelling before the child gets that far and comes forth. Thus the pain of the child's passing through is all the greater because of the swelling and the injured belly (Ref. 8, p. 74).

Like Siegemund, French midwife Madame du Coudray, warns against "too much vaginal meddling. The best thing is to wait patiently, alert to all cues".[9] Known as the 'King's Midwife,' du Coudray was famous for developing the first obstetric mannequin for her tours around the French country side educating midwives with the King's blessing, between 1760 and 1783.[9] Using her leather, hand-sewn mannequin she spent many days teaching her students about 'natural delivery' and providing them with techniques for facilitating the baby's 'slippery exit':

> Although great science is not necessary in natural delivery there are still plenty of precautions to take during labour to ensure that favorable beginnings do not end badly (Ref. 9, pp. 68–69).

In the 18th Century, midwives such as Elizabeth Nihell and Sarah Stone wrote about their practice in direct response to the rise of the Man-Midwife. English midwife, Elizabeth Nihell, wrote a vitriolic treatise on the subject in 1760, titled: *A*

treatise on the Art of Midwifery; Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments.[10] Sarah Stone wrote a similar treatise in 1773, titled: *A Complete Practice of Midwifery*.[11] Both midwives spend almost no time on descriptions of care for women experiencing normal childbirth, concentrating instead on describing care for the most complex of cases. Their focus could have been due to the fact they were mainly called to complex cases but they may also have been attempting to show their capabilities against the threatening rise of the Man-Midwife.

Very few midwives could or would write about their everyday practices and this meant that many of their practices disappeared with them. Midwives, who did write, like eighteenth century midwife Martha Ballard, were more caught up with the social detail of the woman, family and home, the biological events fading into the background.[12] Along with the emergence of the Man Midwife in the 1700s, the surgical model of care started appearing in the literature.

A surgical model of perineal care

The writings of eighteenth century man-midwives

The In 1760 John Harvie, one of the famous, English Man-Midwives, published his *Practical Directions shewing a method of Preserving the Perineum in Birth and delivering the Placenta without Violence*[13]:

> . . .every pain must be attended to; and as soon as the pain has acted long enough to render the perineum tight, the further action of that pain must be totally prevented by the palm of the left hand applied over a warm clean cloth against the perineum with a proper force (Ref. 13, p. 294).

These writings along with those of Sir Fielding Ould illustrate a concern with the mechanics of birth and contrast to Sharps advice 70 years earlier. Ould is attributed with the first description of an episiotomy in 1742:

> . . . so that the Head after it has passed the Bones, thrusts the Flesh and Integuments before it, as if were contained in a Purse; in which condition if it continues long, the Labour will become dangerous, by the Orifice of the womb contracting about the Child's Neck; wherefore it must be dilated if possible by the fingers, and forced over the Child's Head; if this cannot be accomplished, there must be an Incision made towards the Aus with a Pair of crooked Probe-Scissors. The Business is done at one Pinch, by which the whole Body will easily come Forth (Ref. 14, pp. 145—146).

Whilst no doubt this practice was used only occasionally at first, eventually episiotomy became the most common form of obstetric surgery.[15] Perineal care now moved clearly away from prevention of perineal trauma into deliberate surgical intervention.

The private perineum becomes public

The move from women giving birth in upright positions, to giving birth in a supine position, meant the perineum became more visible. The private perineum now becomes public and more accessible for surgical intervention. In the ancient texts, such as Soranus' *Gynecology* the perineum is private and the midwife is explicitly instructed to 'beware of fixing her gaze steadfastly on the genitals of the labouring woman, lest being ashamed, her body become contracted' (Ref. 3, p. 75).

With the advent of the man-midwife and the growing interest in the mechanics of giving birth, there was increasing pressure on women to give birth in a supine position. Both the accoucheur and the birth process were believed to benefit from the woman lying in the supine position for birth. We see the now very public perineum becomes a focus of fear and intervention because it is being viewed. Sir Fielding Ould's description of the head bulging against the perineum as, ''if contained in a purse'' highlights this fear demonstrating a lack knowledge around female anatomy and physiology and a perception of women's bodies as deficient and weak.

Charles White, published, *A Treatise on the Management of Pregnancy and Lying-In-Women, and the Means of Curing, but, more especially of Preventing the Principle Disorders to which they are Liable* in 1772. He advocated the use of upright positions for labour but strongly discouraged their use for birth:

> Very easy deliveries, especially in such positions [upright], are often of dangerous consequence, frequently occasioning lacerations of perineum and sphincter ani, prolapsus of the vagina and anus, inversion of the uterus, retention of secundines, flooding, after pains, syncopes, faintings and death itself (Ref. 5, p. 379).

In 1900, the popular *King's Eclectic Obstetrics*, widely used in America, was still strongly discouraging of alternative birthing positions, even the commonly used left lateral position — the real reason being the doctor's comfort.

> Females, generally, will assume the position recommended by the physician, but where they obstinately prefer a certain position, and it is immaterial, so far as the delivery is concerned, it is better to allow them their own way. Lying upon the left side, with the knees flexed, and a pillow placed between them, is the position most generally recommended in this country and England; but I do not think that the delivery proceeds with so much ease and rapidity, nor is it so convenient for the practitioner in every respect, as when the female is placed upon the back (Ref. 16, p. 301).

By the end of the 19th Century metal contraptions were being invented for restraining or moving the woman into convenient positions for the obstetrician to deliver the baby. The 20th Century saw the introduction of delivery tables with lithotomy stirrups, handcuffs and shoulder restrainers to immobilise the woman on her back and sterile drapes, 'which isolated the upper part of the woman's body from the obstetrician's working end so that the baby could be born through a hole in the sheet' (Ref. 17, p. 213). These artefacts of the industrial revolution reduced further the woman's ability to move about and also reduced the need, or indeed the ability, for carers to touch the labouring woman.[17]

In *King's Eclectic Obstetrics*[16] the perineal compress is present but has an entirely different function from that previously described. Instead of being a means to care for and protect the woman, the perineal compress becomes

protection for the accoucheur's sterile hand. Here we see the clear transition from a social model of care to a surgical one.

> It is frequently the case, that an evacuation of the rectum occurs with the expulsion of the head, but the compress at the perineum serves to protect the hand of the accoucheur from being soiled by it (Ref. 16, p. 303).

The pathological perineum is now established, and social support and care are being rapidly lost.

The pathological perineum

The basic management of the second stage of labour, was established during the 1920s and remained virtually unchanged and largely unquestioned until the 1980s, when questions began to be raised by Kitzinger and others (1981) and the first randomised controlled trial was undertaken in 1984 by Sleep and colleagues.[15]

Joseph DeLee was a prominent Chicago obstetrician in the early 20th Century and laid the groundwork for modern-day obstetrics. He proposed eliminating the second stage by routinely using episiotomy and forceps under general anaesthesia[18]:

> Labour has been called, and is believed by many to be, a normal function... and yet it is a decidedly pathologic process. If a woman falls on a pitchfork, and drives it through her perineum, we call that pathologic-abnormal, but if a large baby is driven through the pelvic floor, we say that it is natural, and therefore normal. If a baby were to have its head caught in a door very lightly, but enough to cause cerebral haemorrhage, we would say that is decidedly pathologic, but when a baby's head is crushed against a tight pelvic floor, and the haemorrhage in the brain kills it, we call this normal... In both cases, the cause of the damage, the fall on the pitchfork and the crushing of the door, is pathogenic, that is disease producing, and in the same sense labor is pathogenic, disease producing, and anything pathogenic is pathologic or abnormal (Ref. 19, p. 34).

Another prominent American obstetrician R.H. Pomeroy referred to the child's head as, ''a battering ram wherewith to shatter a resisting outlet. Why not open the gates and close them after the procession has passed'' (Ref. 20, p. 4). *William's Obstetrics* resurrected the description of a child's head as a battering ram in 1950 and continued to use it for the next six editions. Shortening the second stage seems to have arisen because of fears over what impact this would have on the baby.[21] Without pathologising the female reproductive body there would be no need for medicine so the language used was a way of insuring the sustainability of the rising medical profession and driving the increased control and market share that medicine was gaining in childbirth.

The rise in episiotomy in the USA mirrored the move from birth at home to birth in hospital.[22] In the USA in 1930, approximately 25% of women gave birth in hospital, compared with 70% in 1945. The rate of episiotomy reflects this move. From 1940 to 1980 episiotomy came to be considered as routine and necessary and ''too minor an issue for serious medical attention''.[23] The reality is routine episiotomy had become implicit knowledge by this time in obstetrics and there was a general unwillingness to challenge something that was considered essential to the care of childbearing women. The concept of evidence based practice was also not accepted and belief and tradition guided practice.

An exception to this thinking was a female obstetrician, Constance Benyon, who, in 1957, published a paper called, *The Normal Second Stage of Labour: A Plea for Reform in Its Conduct*.[24] Using the principles of a quality seamstress, and the analogy of an arm being pushed hurriedly through a sleeve, thereby causing it to tear, she advised not forcing the fetal head hurriedly through the vagina. She took one hundred consecutive cases under her care and had the midwives give them no advice to push, but to follow their natural urges. She compared the outcomes with another 393 primigravid women having normal vaginal births over the same period. The rate of episiotomy in her study fell to 39% in the non-pushing group, while it was 63% in the controls. Her calls for reform were ignored for another 25 years.

Not until the 1980s were women's voices heard again in research, when Kitzinger undertook a study with the National Childbirth Trust into women's experiences of episiotomy.[25] At this time the popular textbook *William's Obstetrics* devoted no space to a consideration of the indications for episiotomy or its risks, or to methods of protecting the perineum and avoiding episiotomies or tears. The authors unquestioningly endorse the current approach to second-stage care with the statement:

> It can be said with certainty that, since the era of in-hospital deliveries with episiotomy, there has been an appreciable decrease in the number of women subsequently hospitalized for treatment for symptomatic cystocele, rectocele, uterine prolapse and stress incontinence (Ref. 26, p. 430).

Today, fears that were evident in the 1980s over the impact of the second stage on pelvic floor morbidity are consistently raised in the medical literature.[27] While midwives try to balance the argument as best they can,[28] the dominant authority of medicine continues to be powerfully persuasive. This power has come through the 'medicalisation' of birth which occurred through medicine extending its jurisdiction over normal life events such as pregnancy and birth[29] thus extending medical authority beyond legitimate social boundaries[30] whereby social phenomena come to be defined and treated as disease.[31] Thus the medical profession used power gained through their knowledge and expertise to define and control what constituted health and illness.[30] This continues today.

We have moved from the woman's perineum as potentially harmful to her baby to being potentially harmful to herself. Both belief systems have pathologised the perineum and the process of giving birth, and led to extraordinary surgical interventions, such as routine episiotomies, elective forceps and now elective caesareans, all without evidence to support their routine use. The term 'perineal bypass' (caesarean), which has been coined this century, illustrates this. Comments by the prominent UK obstetrician Nicholas Fisk, that ''if you drink-drive or you ride a bike without a helmet the risk is much lower than with a vaginal delivery'' (Ref. 32, p. 3), add to this distrust of the birth process.

The perineum as a surgical site

With the advent of asepsis in the late 19th and 20th Century, one could argue that the perineum came to be considered a surgical site, with the warm compresses and traditional massages replaced with green drapes, chlorhexadine swabs and the episiotomy scissors, such as are described in the book *A Midwife's Story*.[33] This book details midwifery training in Scotland in the 1970s.

> Her private parts are scrubbed. Her unscrubbed parts are covered with sterile draping. The midwives scrub too: hot water, a soft brush, and iodine for fifteen minutes. We hold our hands up the entire time to keep the soiled water from dripping back onto them. Assistants help with the gowns and we dive our hands upward into sterile gloves. Then we set up the sterile trolley: Forty instruments in order: And if we fail to do that just so, then, yes, everything comes apart again, never mind the woman having a baby. No one asks what one is to do if it is a choice between the sterile trolley and the life of the baby. The idea is not to deliver babies but to become a perfect mechanism in the delivery room (Ref. 33, p. 22).

The advent of asepsis into childbirth was no doubt one of the greatest discoveries in history. Its contribution to women's health and wellbeing must not be forgotten or underestimated. However, the elaborate aseptic procedures around birth that resulted, and are still adhered to in many developed countries, limit women's freedom to move about and adopt different positions for labour, as well as unnecessarily turning birth into a surgical procedure.[34] Joseph DeLee, devoted six pages of his book, *Obstetrics for Nurses,* to asepsis during labour and one paragraph on care of the labouring woman.[19] Human touch became something to be wary of and he established firm boundaries around the woman that no one should cross.

> If the patient, as is often the case, wishes to hold a human hand, have the husband prepare his hands and put on a sterile gown. He may thus help in the labor close up (Ref. 19, p. 107).

This attitude contrasts strongly with the writings of earlier texts in which women such as midwife Catharina Schrader show the important role of neighbours and friends in the birthing chamber. "Come let us fetch friends and neighbours. I must help you immediately," Schrader instructed one of her patients in 1698 (Ref. 35, p. 282).

In mediaeval times a woman called her 'god-sibs' — literally, sisters in God — to nurture her during labour and to care for both her and the baby afterward.[17] "These women held and supported her physically, cradled her in their arms, caressed, kissed and stroked her, and used massage to help her through the birth" (Ref. 17, p. 211). This set up strong connections in the community and fostered support for the new mother in the postpartum period. Birth as a social event where one actually had a "duty to one's neighbours" (Ref. 35, p. 17) was replaced with birth as a surgical event during which the obstetrician decided who came and went and how they acted in the birth room. The woman remained at an arm's length from everyone and if she held a human hand it had to be prepared as if for surgery, as described above by DeLee. Increasingly, during the nineteenth century, women in childbirth were isolated from friends and neighbours. With hospital birth, that isolation became complete.[17]

The ultimate transformation of the perineum into a surgical site came with the advent of perineal shaving. This ritual ridding of pubic hair followed by ritual swabbing and surgical draping of the perineum constructed the next scene in this surgical drama, the ritual cutting of the perineum, almost expected rather than exceptional. The stage was set and the drama unfolds in accordance. Feminist writers allege that men rewrote the obstetric drama to make them the stars instead of women.[36]

Kitzinger talks about how women will often reach down to their own perineum to feel their baby's head or touch themselves. When the sterile area is guarded fiercely, the woman's hand has been reportedly slapped, as she reaches down and contaminates the obstetrician's sterile area.[37] She writes:

> When an obstetrician isolates and exposes a woman's vulva it becomes ritually separated from that part of her body, which she herself is allowed to control. Transformed into a sterile field it is out of bounds to her own touch. The sterile field — not, in fact, sterile because of juxtaposition of vagina and anus — is an obstetric fiction by which the woman's genital area is depersonalized and desexed (Ref. 37, p. 4).

The move to asepsis at birth had the effect of changing the way women were touched, cared for and interacted with during birth. For example:

> In the process of creating a sterile field, the medical model separated the woman from her perineum. Doctors treated a sterile vaginal area on a level devoid of the human element and inherent emotions (Ref. 38, p. 70).

By the 1970s the surgical drama was complete. Women were hospitalised and devoid of any support in labour. They were put into supine positions and anaesthetised, often unable to push their babies out. Their perineum's were shaved, swabbed and draped ready for the surgery that inevitably followed. Perineal care had moved from a social model to a surgical one.

The social/surgical dichotomy

Social rituals that supported and comforted the mother during birth were replaced during the last century with surgical rituals stemming from a view that the perineum was a pathological entity in need of expert surgical intervention, firstly to protect the baby and then the mother. With the advent of the active birth movement in the late 1970s and 1980s there was an attempt to reclaim the perineum from the surgical rituals. This active birth movement was led by consumers who reacted strongly against medical control and the prevailing reductionist approach to women's bodies. The re-emergence of methods of perineal protection and comfort once more appear in the literature. A dichotomy now exists between two models of perineal care during labour and birth; one a social model mainly promoted by midwives, in which preservation, comfort and support are the aim and the other a surgical model, mainly promoted by

obstetricians, in which pathology is anticipated and surgery is seen as a necessary response in order to protect the mother. Elective caesarean section is increasingly sought and advocated to eliminate the risk of perineal and pelvic floor damage. Even more concerning is the recent trend of masking the surgical model with a social one, found most obviously in the so called 'natural caesarean' advocated by obstetrician Nicholas Fisk:

> The scent of lavender fills the air and classical music is playing quietly. On the bed, Jax Martin-Betts, 42, is calm focused and in control. With the birth of her second child just minutes away, the midwife Jenny Smith is giving her a massage. Her husband, Teady McErlean, is whispering words of encouragement: just a tiny bit longer, and our baby will be in our arms. It could be a natural birth at any maternity unit in Britain, be we are in an operating theatre at Queen Charlotte's and Chelsea hospital in west London, and the birth we are about to witness sounds like a contradiction in terms: a 'natural' caesarean section.[39]

Conclusion

This review of history reveals that once perineal protection and comfort were key priorities for midwives, most whom practised under a social model of care. However, historical writings by midwives remain scarce, with some notable exceptions, making it difficult to fully appreciate childbirth practices from the perspective of midwives. With the advent of the Man-Midwife in the seventeenth and eighteenth centuries, the perineum became pathologised and eventually a site for routine surgical intervention. The eventual widespread use of supine positions for birth, strict asepsis techniques, perineal shaving and pharmacological pain relief increasingly enabled the perineum to be pathologised, turning it into a surgical site. In the last 30 years, in much of the developed world, there has been a re-emergence of care aimed at preserving and protecting the perineum, creating a dichotomy between a dominant surgical model and re-emerging social model of perineal care. Recent trends in birth such as seen with the 'natural caesarean', demonstrate an emerging tendency to overlay surgical models of care with a veneer of a social model, in order to make them more widely accepted. We acknowledge that whilst criticising the reductionist medicalised view of the perineum that we have also taken a reductionist approach in this article by focusing on a specific part of a woman's body, the perineum. The invading of the perineum one could argue represents the interventionist, reductionist model of birth that has dominated in the past few centuries of childbirth and it is hoped by taking this journey through history midwives will be able to be more reflective about practices that can likewise replace social models with surgical models of care. Historical perspectives on perineal care are important in helping us understand not only where we have come from but future directions that we should aim for in terms of research and clinical practice. We are also reminded that we should remain vigilant for potentially harmful trends that can evolve in clinical care due to political agendas, rather than from carefully conducted and considered research that holds women and their needs as central to all decision making.

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