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CORRESPONDENCE

Correspondents are asked to be brief

Abortion Compared with Contraception

SIR,—The two medical authors of the report "Hospital Family Planning: Termination of Pregnancy and Contraceptive Use" (3 November, p. 280) probably subscribe to the 1948 Declaration of Geneva—"I will maintain the utmost respect for human life from the time of conception. . . ." Respect for human life and a good quality of life my colleagues at King's College Hospital properly associate with responsible family planning including voluntary sterilization. Indeed, their practice and teaching are the envy of every hospital in England. The report, however, describes the abortion of 3,253 potential citizens, the pregnant patients being referred by doctors but (*my italics*) *also from local family planning clinics*. The authors further confuse those of us who strongly support the Family Planning Association with "To prevent the further rise in the total numbers of terminations of pregnancy it is necessary to have a comprehensive system closely linking those carrying out the terminations and those providing the family planning services."

May I ask my friends at K.C.H. what precisely they mean by "comprehensive"? What do they say to their patients at the clinic when advising on contraception? Do they promise routine legal abortion "if the technique fails"? Manifestly the abortee with such a promise has only to say that she did use contraceptives, going on to request abortion and perhaps a second or third abortion.

Whether or not easily available contraceptive advice will do what K.C.H. hopes—namely, the limitation of the present abortion epidemic (perhaps every fifth pregnancy is being aborted in England), remains to be seen. The Japanese are not English, but with a five-dollar abortion available in 1973 many Japanese women still do not bother with contraception. They risk repeated abortions. It could turn out equally in the U.K. that the "planners" and the "sexual chancers" are miles apart and will remain so, the latter being potential abortees. This may be a gloomy view and one hopes that K.C.H., with its excellent contraceptive services, will in fact succeed in limiting South Thames abortions. Meantime their friends would beg them not to confuse contraception with legal abortions.—I am, etc.,

HUGH CAMERON MCLAREN

Department of Obstetrics and Gynaecology,
Birmingham Maternity Hospital,
Birmingham

Pain after Birth

SIR,—Your leading article "Pain after Birth" (8 December, p. 565) should provoke much comment and discussion but, unfortunately, it probably will not. Midwives and obstetricians alike show very little interest in the puerperal perineum and analgesics are given grudgingly if at all, whereas a wound concerning muscle layers in any other part of the body would certainly be considered to merit opiates for some time. I cannot understand why perineal pain after childbirth should not be given sympathy and treatment comparable at least with that given for pain after haemorrhoidectomy.

My own complaints of pain after childbirth never seemed to be treated seriously. They were countered variously with questions about the baby's wellbeing, with delighted exclamations at my lack of stretch marks, with an exhortation not to walk like a duck, and, once, with a loud peal of joyous laughter. The skill of the accoucheur seems now to consist mainly of delivering a healthy infant rather than of delivering a healthy infant to an intact mother.

I think that episiotomies are performed much too freely. They do not necessarily prevent tearing and the wound is hideously painful for weeks afterwards, and maybe for years. The fact that women seldom complain is probably directly attributable to the social attitude that such things constitute a woman's lot, and must be borne bravely, etc. This is reinforced by a cow-like complacency which overtakes the woman in early pregnancy and stays with her till some days after the delivery. (The mental state caused by this sudden lack of complacency is then often considered to be a psychiatric disturbance.) Can one hope that the new attitudes produced by the campaigning of the women's liberation front will cause louder complaints and, eventually, less of this deliberate mutilation of the maternal perineum, or that the ranks of obstetricians will be joined more and more by women who have themselves had babies and who have interest in and sympathy for this distressing problem.—I am, etc.,

ROBYN POGMORE

Princess Margaret Hospital,
Swindon, Wilts

SIR,—With regard to your leading article (8 December, p. 565) on perineal pain after delivery, it is not surprising that women whose episiotomies are sutured by consultants and registrars experience more pain than those sutured by house surgeons. Nor is it surprising that women experience less pain if suturing was delayed or local anaesthetic was not used for the episiotomy. The explanation lies in some facts described in the survey[1] discussed in the leading article. After complicated deliveries—forceps, breech, and twins—women had more perineal pain than after a normal confinement. In these patients, who are often delivered by consultants and registrars, local anaesthetic is used and suturing undertaken immediately after delivery. Normal deliveries are generally conducted by midwives, who may not always use local anaesthetic before performing episiotomy. A further delay then results before suturing because medical staff are often engaged in other duties. I would agree it would be a retrograde step if midwives stopped using local anaesthetic before incising the perineum.

As regards delay in suturing; it is a poor surgical practice to leave an open wound in a potentially infected area. It is more logical that midwives should be trained not only to perform, but also to repair, episiotomies, reserving medical assistance for complicated lacerations. Since an experienced casualty sister may suture simple cuts under supervision it would appear sensible that midwives be allowed to do the same. Perhaps the Central Midwives Board could consider this matter.—I am, etc.,

R. A. UNDERHILL

Institute of Obstetrics and Gynaecology,
Queen Charlotte's Hospital,
London W.6.

[1] Baker, S., *A Survey into Post Natal Perineal Discomfort*. London, S. Maw and Sons, with the Royal College of Midwives, 1973.