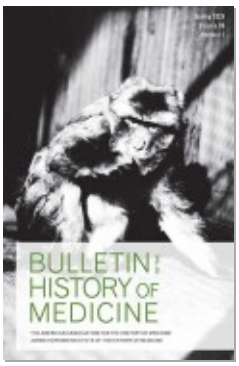
The Creation and Circulation of Evidence and Knowledge in American Medicine through the Lens of the "Husband's Stitch"



Sarah B. Rodriguez

Bulletin of the History of Medicine, Volume 98, Number 1, Spring 2024, pp. 93-121 (Article)

Published by Johns Hopkins University Press
DOI: https://doi.org/10.1353/bhm.2024.a929785

The Creation and Circulation of Evidence and Knowledge in American Medicine through the Lens of the "Husband's Stitch"

Sarah B. Rodriguez

ABSTRACT: Physicians in the twentieth century routinely used episiotomy—a cut made during childbirth—to better facilitate labor, using the evidence of their experiences that it was useful. But physicians were not alone in producing evidence regarding episiotomy and its repair. Here I consider how three groups—male physicians, husbands, and laboring women—were involved in creating evidence and circulating knowledge about episiotomies, specifically, the intention of its repair, the so-called "husband's stitch," to sexually benefit men. By doing so I seek to consider the meanings of evidence within medicine, evidence as a basis for challenging the hegemony of medicine by lay women, and how medical knowledge is produced and shared among physicians and non-physicians.

KEYWORDS: experiential evidence, feminist health activists, episiotomy, husband's stitch, knowledge circulation, medical evidence

In his 2002 book, *The Anxious Parent's Guide to Pregnancy*, under the subheading "What's the Deal with the 'Husband's Stitch'?," physician Gerard DiLeo wrote the "husband's stitch is a myth." But while noting "for the record" the husband's stitch was a myth, DiLeo also wrote he could not recall "how many times, while suturing the vaginal tissues right after a

I would like to thank my colleagues at Northwestern University for their support; Sydney Halpern and Sandy Sufian for their comments on early drafts; Judith Houck who suggested I think about the work of rumors; and Rose Holz who commented on a nearly final version and encouraged me to continue with this project. I also thank the anonymous reviewers for their strong and insightful suggestions and for challenging me to push further with what I was trying to do in this article. Finally, I am grateful for the funding I received from a Faculty Research Project grant from the Sexualities Project at Northwestern University in 2013–14 and in 2012–13.

delivery, a husband has said to me, 'Hey, Doc, how 'bout putting in that extra stitch?' And then he shoots me this mischievous grin that I'm supposed to share, because, after all I'm in the club."[1]

The suturing DiLeo referenced was the repair of an episiotomy, a cut made by physicians from the opening of the vagina downward or to the side during the second stage of labor. American obstetricians during much of the twentieth century asserted the reasons for routine episiotomies were clear: a cut was easier to repair than a tear, it shortened the second stage of labor, it reduced the possibility of a tear into the rectum, it prevented fetal brain damage, and it prevented the overstretching of the vagina.[2] Episiotomy and its repair became routine parts of birth in the United States starting in the 1930s. But despite episiotomies having been so common in the United States that nearly all first-time mothers received one for most of the twentieth century, its practice has received limited historical consideration.[3] Ian Graham's work in the 1990s provides the most thorough account.[4] Graham compared the rise of routine episiotomy in the United States and the United Kingdom during the twentieth century, in particular that the procedure became standard in the United States by the 1950s "without evidence that episiotomy was beneficial or safe." Graham then considered why episiotomy rates started dropping precipitously around 1978 in the United Kingdom but not in the United States. One reason for this divergence, Graham argued, was organized lay activists in the United Kingdom effectively challenged its routine use, whereas in the United States "an anti-episiotomy campaign never fully

1. Gerard M. DiLeo, *The Anxious Parent's Guide to Pregnancy: Pains, Pangs, Thumps, and Twinges—What's Normal, What's Not, When to Worry, and When to Stop and Enjoy Your Pregnancy* (Chicago: Contemporary Books, 2002), 240–41.

2. Nicholson J. Eastman, *Williams Obstetrics*, 10th ed. (New York: Appleton-Century-Crofts, 1950), 410.

3. Episiotomy is mentioned within childbirth and obstetrics histories, including Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: Schocken Books, 1979); Judith Walzer Leavitt, *Make Room for Daddy: The Journey from Waiting Room to Birthing Room* (Chapel Hill: University of North Carolina Press, 2009); and William Ray Arney, *Power and the Profession of Obstetrics* (Chicago: University of Chicago Press, 1982). Brief mentions are in texts critical of biomedicine, for example, Margot Edwards and Mary Waldorf, *Reclaiming Birth: History and Heroines of American Childbirth Reform* (Trumansburg, N.Y.: Crossing Press, 1984), and within the medical literature; see Christophe Clesse, Joëlle Lighezzolo-Alnot, Sylvie De Lavergne, Sandrine Hamlin, and Michèle Scheffler, "Socio-historical Evolution of the Episiotomy Practice: A Literature Review," *Women Health* 59 (August 2019): 760–74.

4. Ian D. Graham, "The Episiotomy Crusade" (Ph.D. diss., McGill University, 1994) and *Episiotomy: Challenging Obstetric Intervention* (Oxford: Blackwell, 1997).

developed," with criticisms of the procedure "embedded in criticism of the medicalization of childbirth, a much broader issue."[5]

DiLeo's story concerns three actors, the authoritative male physician, the joking male husband, and the silent laboring woman, and in what follows I consider how these three groups were involved in producing knowledge about episiotomies and, more specifically, the intention of its repair. First, by building upon Graham's work, I show how U.S. physicians did indeed use evidence, experiential evidence, to support their uptake of routine episiotomy and to situate medical challenges to routine episiotomy that arose in the 1970s and 1980s within changing ideas regarding medical evidence and what constituted "good" medical evidence. Second, while no specific anti-episiotomy campaign developed in the United States as in the United Kingdom, within their broader challenge to the medicalization of childbirth in the 1970s and 1980s, American women, especially white middle-class, feminist health activists, framed routine episiotomy and its repair as a particularly egregious example of misogynistic medicine when they asserted physicians performed the repair—with or without an extra stitch—for the male partner's sexual benefit. Their challenge was based on recognizing, and insisting clinicians recognize, laywomen's experience as evidence and, regarding episiotomy, that women's experiential evidence found neither episiotomy and its standard repair nor "that extra stitch"—the so-called husband's stitch—benefited the laboring woman. Instead, their evidence found the practice supported the "club" of male heterosexual privilege. Finally, I consider the production of knowledge regarding episiotomy repair among husbands through the sharing "many times" of a joke with the (mostly) male physicians who objectified and excluded the laboring women.

DiLeo labeled the practice of physicians performing an episiotomy repair with or without an extra stitch for the sexual benefit of men a "myth." The *Oxford English Dictionary* defines a myth as a "widespread but untrue or erroneous story or belief; a widely held misconception; a misrepresentation of the truth."[6] For DiLeo and other physicians, labeling episiotomy repair as an "extra" stitch to support the "club" of male heterosexuality was a misrepresentation of the primary purposes of the procedure. In this essay, my focus is not on proving male physicians performed episiotomy repair with the intention of supporting male sexual response nor on proving the "husband's stitch" was a myth but on the demand from laywomen for evidence to support the routine use of

5. Graham, *Episiotomy* (n. 4), 152, 155.

6. "Myth," *OED Online*, https://www-oed-com.turing.library.northwestern.edu/view/Entry/124670?rskey=uBfYU7&result=1&isAdvanced=false.

episiotomy and its repair and how this demand asserted the importance of their experience as evidence in medicine. Further, by examining experience as evidence, I consider the power of shared experiences as a form of evidence, a form of evidence used by physicians to support the routine use of episiotomy and its repair and by laywomen to challenge the routine use of this procedure and its repair. By doing so I consider the meanings of evidence within medicine, evidence as a basis for challenging the hegemony of medicine by laywomen, and how medical knowledge is produced and shared among physicians and non-physicians. I begin by outlining the medical uptake of episiotomy as routine in childbirth and the evidence to support its uptake.

The Routine Use of Episiotomy and Episiotomy Repair

To illustrate the uptake of episiotomy and its repair as routine within obstetric practice, I consider the procedure's trajectory within the principal obstetric text in the United States for well over a century, *Williams Obstetrics*. In the first edition of *Obstetrics* (1903), J. Whitridge Williams, obstetrics professor at Johns Hopkins University, noted "many authorities, when rupture of the perineum seems imminent, advise the performance of an episiotomy." It was an operation, Williams wrote, done with a "strong pair of scissors" "introduced between the head [of the infant/fetus] and the perineum," performed "in the belief that the vulval opening, if sufficiently enlarged by the incisions, will not tear further." Williams added some believed an incision, with its "clean-cut edges," was easier to repair than a tear. Williams, however, saw "no advantage in the procedure, as my experience is that ordinary perineal tears will heal almost uniformly if properly sutured and cared for."[7]

This statement appeared in the first four editions of *Obstetrics*. But in the fifth edition (1924), Williams responded to a 1918 article by physician Ralph H. Pomeroy. In "Shall We Cut and Reconstruct the Perineum for Every Primipara?," Pomeroy advocated for making a midline cut when the perineum started to bulge, "with the idea," Williams wrote, "that its accurate repair immediately after delivery would prevent the development of relaxation of the pelvic floor in the future." Though agreeing with Pomeroy "that this may be so," Williams maintained episiotomy remained "an inadvisable routine procedure."[8] In the sixth edition (1930) of his

7. J. Whitridge Williams, *Obstetrics: A Text-Book for the Use of Students and Practitioners* (New York: D. Appleton, 1903), 289.

8. Williams, *Obstetrics: A Text-Book for the Use of Students and Practitioners*, 5th ed. rev. (New York: D. Appleton, 1924), 357; See Ralph H. Pomeroy, "Shall We Cut and Reconstruct the

text, Williams added that while from his experience he saw no benefit to an episiotomy, he knew of so "many of my associates who resort to it frequently" that its use was now, he believed, "largely a matter of taste."[9]

Episiotomies were developed during the eighteenth and nineteenth centuries but recommended and performed only upon women experiencing difficult labor. By the early twentieth century, however, some prominent American physicians—such as Pomeroy in 1918 and Joseph DeLee in 1920—began advocating for episiotomy to be routine.[10] Based upon their experiences, doing so made anatomical sense; as historian Andrew Warwick observed, "A new surgical treatment is more likely to be regarded as credible if it produces visible effects that conform to an accepted model of an organ and its pathology."[11] Surgery, as historians Sally Wilde and Geoffrey Hirst concurred, is based on "conceptualizations of how the body worked and therefore how it could be fixed."[12] Regarding episiotomy, it made sense to many doctors based on their understanding of how the body worked, and based on their own experiences attending women in childbirth, to make and repair a cut rather than allowing a woman to tear during labor. Their "taste"—their experiences performing episiotomy—led an increasing number of physicians to take up its performance.

In his 1920 paper advocating for an expansive use of episiotomy, DeLee called for the end of "watchful-waiting," waiting to see signs of distress before intervening in labor, and instead advocated for routine intervention. "Freely" admitting his method of treating labor was a "revolutionary departure from time-honored custom" of waiting to intervene, DeLee stressed the "sound scientific basis" for his recommendation to make "surgical delivery" routine.[13] Importantly, Pomeroy and DeLee were not just arguing in favor of forceps and episiotomy; they were arguing for

---

Perineum for Every Primipara?," *Amer. J. Obstet. Dis. Women Child.* 78, no. 2 (August 1918): 211–20.

9. Williams, *Obstetrics: A Text-Book for the Use of Students and Practitioners*, 6th ed. rev. (New York: D. Appleton, 1930), 383.

10. Graham, "Episiotomy Crusade" (n. 4).

11. Ibid.; Andrew Warwick, "X-rays as Evidence in German Orthopedic Surgery, 1895–1900," *Isis* 96, no. 1 (March 2005): 1–24, quotation on 22.

12. Sally Wilde and Geoffrey Hirst, "Learning from Mistakes: Early Twentieth-Century Surgical Practice," *J. Hist. Med. & Allied Sci.* 64, no. 1 (January 2009): 38–77, quotation on 71.

13. Joseph B. DeLee, "The Prophylactic Forceps Operation," *Amer. J. Obstet. Gyn.* 1 (1920): 34–44, quotation on 43. Carolyn Herbst Lewis argued that DeLee intended his talk to be instructions on using forceps and performing an episiotomy when needed, but his peers saw it as a call to make them routine. Lewis, "The Gospel of Good Obstetrics: Joseph Bolivar DeLee's Vision for Childbirth in the United States," *Soc. Hist. Med.* 29 (February 2016): 112–30. See also Judith Walzer Leavitt, "Joseph B. DeLee and the Practice of Preventive Obstetrics," *Amer. J. Pub. Health* 78 (October 1988): 1353–60.

making medical intervention in childbirth the standard of care. They made this argument from a "sound scientific basis," the sound evidence of their experience.

Influenced by the experiences of authorities such as Pomeroy and DeLee, other physicians began performing episiotomy, and the routine use of episiotomy and its repair grew, increasingly so after World War II.[14] By the 1950s, the decade when the majority of births happened in a hospital, this incision was routine within obstetrics, taught from one generation to the next.[15] Some hospitals reported episiotomy rates as high as 85 percent during the 1950s, with national rates generally exceeding 70 percent in the 1960s and ranging between 50 and 90 percent in the 1970s and 1980s.[16]

When Williams stated he did not see the benefit of routine episiotomy in his 1930 *Obstetrics*, he was expressing what was becoming a decidedly minority opinion in medicine. This edition was the last Williams edited; starting with the seventh edition, other obstetricians revised what was thereafter called *Williams Obstetrics*. *Williams Obstetrics* was (and remains) a core obstetrics text in the United States, and though perhaps not aligned perfectly with actual clinical practice, what it recommended can be regarded as normative clinical practice. Comparing the shift from the last edition edited by Williams (1930) with the tenth edition (1950) illustrates the shift in ideas regarding the routine use of episiotomy. In the 1950 edition, edited by Nicholas Eastman, also an obstetrics professor at Hopkins, "Episiotomy and Repair" now had its own subheading in the chapter "Conduct of Normal Labor," thus visibly equating the incision and its repair as the standard of care within obstetrics for "normal labor." Episiotomy was no longer "a matter of taste" per Williams in 1930; now it was an "incision of the perineum meant to facilitate delivery," one that, with the exception of "cutting and tying the umbilical cord," was the "most common operation in obstetrics." The reason for its popularity, according to Eastman, was simple: episiotomy substituted a "straight, clean-cut surgical incision for the ragged, contused laceration which is otherwise likely to ensue; such an incision is easier to repair and heals better than

14. Graham, "Episiotomy Crusade" (n. 4); Stephen B. Thacker and H. David Banta, "Benefits and Risks of Episiotomy: An Interpretative Review of the English Language Literature, 1860–1980," *Obstet. Gyn. Survey* 38, no. 6 (June 1983): 322–38.

15. Leavitt, *Make Room for Daddy* (n. 3); Paul L. Cerrato and Charles J. Lockwood, "Is Clinical Research Overrated?," *Contemp. OB/GYN* 51 (March 2006): 69–75.

16. Barbara Bridgman Perkins, *The Medical Delivery Business: Health Reform, Childbirth, and the Economic Order* (New Brunswick, N.J.: Rutgers University Press, 2003); Thacker and Banta, "Benefits and Risks of Episiotomy" (n. 14).

a tear." Further, an episiotomy shortened the second stage of labor and reduced the "likelihood of third degree lacerations," tears that went into the rectum. Finally, an episiotomy spared "the baby's head the necessity of serving as a battering ram against perineal obstruction," pounding that, if prolonged, could cause fetal "brain injury."[17] These reasons for the popularity of episiotomies—as well as justifications for the routine use of the procedure—appeared in the next eight editions, published in 1956, 1961, 1966, 1971, 1976, 1980, 1985, and 1989.[18]

Experiential Evidence I

The routine use of episiotomy and its repair was based on a "sound scientific basis." DeLee's evidence for routinely using episiotomy came from observing his patients, many of whom were tearing during birth, and he concluded the risk of tearing could be reduced by making a cut, enabling the physician to control the amount needed to be repaired. For DeLee and many of his peers, a cut was easier to control compared to a tear they had no control over. Advocated by authorities whose experience performing it showed positive results, taken up by practitioners, passed along from one generation to the next, episiotomy became, by the 1950s, a normative part of hospital birth.[19] Indeed, it was such an accepted procedure, sociologist William Ray Arney argued in his 1982 examination of the power of the obstetric profession, that "no one systematically compared the effects of having an episiotomy with the effects of not having one." Instead, studies contrasted where to best make the cut, not whether a cut should be made, since physicians believed, based on their experiences, "episiotomies were better for women."[20]

17. Eastman, *Williams Obstetrics* (n. 2), 410, 411.

18. Eastman, *Williams Obstetrics*, 11th ed. (New York: Appleton-Century-Crofts, 1956), 450; Nicholson J. Eastman and Louis M. Hellman, *Williams Obstetrics*, 12th ed. (New York: Appleton-Century-Crofts, 1961), 458; Eastman and Hellman, *Williams Obstetrics*, 13th ed. (New York: Appleton-Century-Crofts, 1966), 433; Hellman and Jack A. Pritchard, *Williams Obstetrics*, 14th ed. (New York: Appleton-Century-Crofts, 1971), 424; Pritchard and Paul C. MacDonald, *Williams Obstetrics*, 15th ed. (New York: Appleton-Century-Crofts, 1976), 346; Pritchard and MacDonald, *Williams Obstetrics*, 16th ed. (New York: Appleton-Century-Crofts, 1980), 430; Norman F. Gant, MacDonald, and Pritchard, *Williams Obstetrics*, 17th ed. (Norwalk, Conn.: Appleton-Century-Crofts, 1985), 347–48; F. Gary Cunningham, MacDonald, and Norman F. Gant, *Williams Obstetrics*, 18th ed. (Norwalk, Conn.: Appleton and Lange, 1989), 323.

19. Thacker and Banta, "Benefits and Risks of Episiotomy" (n. 14), 324; Harold Speert, *Obstetrics and Gynecology in America: A History* (Chicago: American College of Obstetricians and Gynecologists, 1980), 178–88.

20. Arney, *Power and the Profession of Obstetrics* (n. 3), 73.

Physicians turned to episiotomy in an attempt to control against adverse outcomes in birth, and the routine use of episiotomy largely originated and continued based on experiential evidence: the clinical impressions of physicians. Eminent obstetricians in the early twentieth century based their assessment on the usefulness of routine episiotomies on cases they attended and then communicated the success of these cases to their peers. The expert opinion of an experienced physician communicated to his peers through a single or small number of clinical cases was considered, beginning in the mid-nineteenth century, to be the best evidence of the therapeutic effectiveness of a medical intervention. The clinical experience based on a small number of cases provided, and still provides, evidence for many routine medical therapies subsequently taken up and performed by other physicians, including surgical interventions.[21] Experiential evidence is an important means of gauging the effectiveness of medical therapies, in particular perhaps for obstetrics.[22] Physicians rely on the veracity of a therapy's effectiveness on the experience of its originators and then the experience of their peers who take up the therapy or procedure. As more physicians use a therapy or procedure, they publish favorable outcomes using the therapy, expanding upon the original case studies.[23] Evidence about episiotomy and its repair followed this path.

Experiential evidence remains an important form of medical evidence, but it began to be increasingly challenged in the 1970s.[24] One challenge

21. This reflects an emphasis on the judgment, skill, and experience of a surgeon. See Cynthia L. Tang and Thomas Schlich, "Surgical Innovation and the Multiple Meanings of Randomized Controlled Trials: The First RCT on Minimally Invasive Cholecystectomy (1980–2000)," *J. Hist. Med. & Allied Sci.* 72, no. 2 (April 2017): 117–41.

22. While obstetrics is an underresearched area of medicine, as indicated by a recent analysis finding obstetrics trials represented only 1.9 percent of all registered clinical studies, for most specialties physicians' clinical experience directs most medical decisions. Jecca R. Steinberg, Brannon T. Weeks, Griselda A. Reyes, Alison Conway Fitzgerald, Wendy Y. Zhang, Sarah E. Lindsay, Jill N. Anderson, Katelyn Chan, Michael T. Richardson, Christopher J. Magnani, Irogue Igbinosa, Anna Girsen, Yasser Y. El-Sayed, Brandon E. Turner, and Deidre J. Lyell, "The Obstetrical Research Landscape: A Cross-Sectional Analysis of Clinical Trials from 2007–2020," *Amer. J. Obstet. Gynecol. MFM* 3, no. 1 (January 2021): 100253; Richard Smith, "The Poverty of Medical Evidence," *BMJ* 303 (October 5, 1991), 798–99; Mark H. Ebell, Randi Sokol, Aaron Lee, Christopher Simons, and Jessica Early, "How Good Is the Evidence to Support Primary Care Practice?," *Evid. Based Med.* 22, no. 3 (June 2017): 88–92.

23. John B. McKinlay, "From 'Promising Report' to 'Standard Procedure': Seven Stages in the Career of a Medical Innovation," *Milbank Mem. Fund. Quart.* 59, no. 3 (1981): 374–411.

24. Martin Edwards, "Keywords in the History of Medicine: Evidence," *Lancet* 363, no. 9421 (May 15, 2004): 1657; Edwards, *Control and the Therapeutic Trial* (Amsterdam: Rodopi, 2007); Kay Dickersin and Eric Manheimer, "The Cochrane Collaboration: Evaluation of Health Care and Services Using Systematic Reviews of the Results of Randomized Control Trials," *Clin. Obstet. Gyn.* 41, no. 2 (June 1998): 315–31; Helen Lambert, "Accounting for

arose among those who advocated for the more empirical, and less susceptible to bias, evidence found through more controlled studies, especially the randomized controlled trial (RCT). In 1972, British physician and epidemiologist Archie Cochrane advocated for medical care to be implemented based on an evaluation of scientific evidence as established by the RCT rather than on the experiential evidence of clinical impressions, authority, and tradition.[25] That same year, American physician Thomas Chalmers similarly contended there were "many examples of widely advocated and commonly used therapies which have never been established to be effective by adequate clinical trials."[26] For Cochrane and Chalmers, as well as increasingly others, "adequate clinical trials" meant an RCT.[27] However, few medical therapies were evaluated by an RCT.[28] Though Chalmers used "radical mastectomy for carcinoma of the breast and freezing of the stomach for duodenal cancer" to illustrate his point of clinical therapies being widely used without empirical evidence of their safety and efficacy in his 1972 critique, he could have used episiotomy.[29]

This is essentially what physicians H. David Banta and Stephen B. Thacker did in their evaluation of the risks and benefits of episiotomy nearly a decade later: used the absence of empirical evidence to support the routine practice of episiotomy to illustrate their larger critique regarding the limitations of clinical experiential evidence being employed to support standard clinical practices. Banta and Thacker previously examined the literature to assess the evidence for routine electronic fetal monitoring and were inspired to look at episiotomy repair because of the critique from feminist health activists, especially the activist-authors of *Our Bodies, Ourselves*.[30] While Thacker and Banta knew "many physicians feel that clinical experience provides an adequate basis for good

EBM: Notions of Evidence in Medicine," *Soc. Sci. Med.* 62, no. 11 (June 2006): 2633–45. See also Harry Marks, *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900–1990* (Cambridge: Cambridge University Press, 1997).

25. Dickersin and Manheimer, "Cochrane Collaboration" (n. 24).

26. Thomas C. Chalmers, "Randomization and Coronary Artery Surgery," *Ann. Thoracic Surg.* 14, no. 3 (September 1972): 323–27, quotation on 324.

27. Edwards, "Keywords in the History of Medicine" (n. 24), 1657.

28. Dickersin and Manheimer, "Cochrane Collaboration" (n. 24).

29. Chalmers, "Randomization and Coronary Artery Surgery" (n. 26), 324. Chalmers could have followed Cochrane, who in 1978 identified obstetrics as the least evidence-based medical specialty in the United Kingdom. Archie L. Cochrane, "1931–1971: A Critical Review with Particular Reference to the Medical Profession," in *Medicines for the Year 2000* (London: Office of Health Economics, 1979), 1–11. Thank you to my undergraduate student Blair Donahue for finding this reference.

30. H. David Banta and Stephen B. Thacker, "Assessing the Costs and Benefits of Electronic Fetal Monitoring," *Obstet. Gyn. Survey* 34, no. 8 (August 1979): 627–42; Banta and

practice," influenced by Cochrane, they conducted an analytical review of the medical literature to assess what sort of evidence existed in support of routine episiotomy.[31] They examined over 350 books and articles published since 1860, specifically looking to see if there was empirical evidence to support the standard reasons for performing an episiotomy: the prevention of third-degree tears; the prevention of serious damage to the walls of the vagina, resulting in risk for conditions such as uterine prolapse as well as interferences with the sexual function of the vagina; the prevention of trauma to the head of the fetus; and the belief that a cut was easier to repair than a tear. Restricting their definition of data, and thus evidence, to what was gathered from an RCT, they found "there were *no* data to support the [routine] use of episiotomy."[32]

In the early 1980s, parallel to when Thacker and Banta started questioning clinical experiential evidence to support routine episiotomy, physicians began noting their patients were questioning the assumed need for an episiotomy and sought to avoid having one.[33] Influenced by Thacker and Banta, as well as perhaps by women who refused "to consent to the procedure," empirical evidence from studies by physicians beginning in the 1980s started showing that the reasons physicians had given for decades to support its use did not hold.[34] Ultimately, a large systematic review (a study that synthesizes evidence meeting specific criteria for answering a research question) in *JAMA* in 2005 concluded the "evidence does not support maternal benefits traditionally ascribed to routine episiotomy."[35] In response, the American College of Obstetricians and Gynecologists (ACOG) in 2006 issued a practice bulletin calling for

---

Thacker, "The Risks and Benefits of Episiotomy: A Review," *Birth* 9, no. 1 (Spring 1982): 25–30, quotation on 25.

31. Banta and Thacker, "Risks and Benefits of Episiotomy" (n. 30), 26.

32. Ibid., 26, emphasis original.

33. Robert C. Goodlin, "On Protection of the Maternal Perineum during Birth," *Obstet. Gyn.* 62, no. 3 (September 1983): 393–94.

34. Michael W. Varner, "Episiotomy: Techniques and Indications," *Clin. Obstet. Gyn.* 29, no. 2 (1986): 309–17, quotation on 314. For early studies, see Jennifer Sleep, Adrian Grant, Jo Garcia, Diana Elbourne, John Spencer, and Iain Chalmers, "West Berkshire Perineal Management Trial," *BMJ* 289 (September 8, 1984): 587–90.

35. Cochrane Library, "About Cochrane Reviews," https://www.cochranelibrary.com/about/about-cochrane-reviews#:~:text=What%20is%20a%20systematic%20review,answer%20a%20specific%20research%20question; Katherine Hartmann, Meera Viswanathan, Rachel Palmieri, Gerald Gartlehner, John Thorp Jr., and Kathleen N. Lohr, "Outcomes of Routine Episiotomy: A Systematic Review," *JAMA* 4 (2005): 2141–48, quotation on 2141.

an end to routine episiotomy, saying the "best available data do not support" its routine use.[36]

Some have suggested a decline in routine episiotomy can be seen as an example of the clinical uptake of both more empirical and so-called evidenced-based medicine (EBM) in the late twentieth and early twenty-first centuries.[37] Supporters of EBM believed evidence gathered from the experiences of physicians was not a good enough form of evidence to support clinical interventions and clinicians should no longer "blindly accept 'clinical expertise.'"[38] Changes in the routine use of episiotomy can also be seen as an example of normative clinical behavior regarding the introduction of a new therapy or procedure: an uptake begins with an enthusiastic report from authorities based on their observations, the therapy or procedure is then tried by others, who then publish their own examples regarding their use of the procedure or therapy, and use of the therapy or procedure spreads within the profession to the point where it becomes accepted as standard care. But while authority and observational reports establish the therapy or procedure as worthwhile, once the therapy or procedure has been accepted as standard, calls for evidence of effectiveness often start. Such evidence of effectiveness by the late twentieth century increasingly meant empirical evidence in the form of an RCT, and this evidence was used to confirm, reject, and discontinue or, in the case of episiotomy, modify from universal applicability to a more limited applicability.[39]

This decline in routine episiotomy as normative practice can be seen in *Williams Obstetrics*. To illustrate, the eighteenth edition (1989), after reiterating the reasons for the popularity of the procedure among obstetricians that had been standard since the 1950s, noted "more recently, the

36. American College of Obstetricians and Gynecologists, "ACOG Recommends Restricted Use of Episiotomies" (March 31, 2006), https://www.acog.org/About_ACOG/News_Room/News_Releases/2006/ACOG_Recommends_Restricted_Use_of_Episiotomies (page no longer found). This practice bulletin was withdrawn. "ACOG Practice Bulletin No. 71: Episiotomy," *Obstet. Gyn.* 107, no. 4 (April 2006): 956–62. Some clinicians noted the limitations of the evidence to support routine episiotomy in the early 1980s. See Henci Goer, *Obstetrical Myths versus Research Realities: A Guide to the Medical Literature* (Westport, Conn.: Bergin and Garvey, 1995), 275–93.

37. Justin R. Lappen and Dana R. Gossett, "Changes in Episiotomy Practice: Evidence-Based Medicine in Action," *Expert Rev. Obstet. Gyn.* 5, no. 3 (May 2010): 301–9.

38. Stefan Timmermans and Aaron Mauck, "The Promises and Pitfalls of Evidence-Based Medicine," *Health Aff.* 24, no. 1 (January/February 2005): 18–28; Jeffrey C. King and S. Robert Kovac, "Evidence-Based Practice in Obstetrics and Gynecology: Its Time Has Come," *Amer. J. Obstet. Gynecol.* 175, no. 1 (July 1996): 232–33.

39. This is taken from McKinlay's simplistic but useful outline. McKinlay, "From 'Promising Report' to 'Standard Procedure'" (n. 23).

advantages provided by episiotomy have been questioned by some individuals," referencing Thacker and Banta's 1983 article as well as several studies done later in the 1980s.[40] In the twentieth edition (1997), while the editors again noted the reasons for its continued popularity among obstetricians, they further wrote that those "advantages have been questioned by many patients and investigators."[41] Similarly, the twenty-first edition, published in 2001, noted how routine episiotomies "became controversial" in the 1970s and "with the concept of evidence-based outcomes, a number of large studies have been carried out to address these controversies," which found the historical reasons given for the procedure "appeared not to be true." As a result, the procedure "should not be performed routinely"; rather, physicians should use "**their surgical judgment and common sense**" to determine if a woman needed the procedure.[42] The 2014 edition also referenced several of what the authors called the "commonly cited but unproven benefit[s] of routine episiotomy." Like the 2001 edition, the authors of the 2014 text were "of the view that the procedure should be applied selectively for appropriate indications" and repeated the "final rule is that there is no substitute for surgical judgment and common sense" when it came to using episiotomy.[43]

Rates of episiotomy declined in the United States, from 60.9 percent of all vaginal births in 1979 to 24.5 percent in 2004.[44] One way to explain why would be to argue that physicians used EBM and began selecting women who appeared to need the procedure rather than perform it routinely.[45] But there are other narratives regarding why the decline occurred. While

40. Cunningham, MacDonald, and Gant, *Williams Obstetrics* (n. 18), 323.

41. F. Gary Cunningham, Paul C. MacDonald, Norman F. Gant, Kenneth Leveno, Larry C. Gilstrap III, Gary D. V. Hankins, and Steven L. Clark, *Williams Obstetrics*, 20th ed. (Stamford, Conn.: Appleton and Lange, 1997), 342.

42. F. Gary Cunningham, Norman F. Gant, Kenneth Leveno, Larry C. Gilstrap III, John C. Hauth, and Katharine D. Wenstrom, *Williams Obstetrics*, 21st ed. (New York: McGraw-Hill, 2001), 325–36, emphasis original.

43. F. Gary Cunningham, Kenneth Leveno, Steven L. Bloom, Catherine Y. Spong, Jodi S. Dashe, Barbara L. Hoffman, Brian M. Casey, and Jeanne S. Sheffield, *Williams Obstetrics* (New York: McGraw-Hill, 2014), web version, chap. 27, p. 22.

44. Elizabeth A. Frankman, Li Wang, Clareann H. Bunker, and Jerry L. Lowder, "Episiotomy in the United States: Has Anything Changed?," *Amer. J. Obstet. Gynecol.* 200, no. 5 (May 2009): 573.e1–7.

45. If we consider this story as starting with Banta and Thacker's articles in the early 1980s and ending with ACOG's 2006 guidelines, it does suggest another interesting story: that what is thought of as normative clinical practice does not necessarily change quickly because of research, or change at all, given the high rates of episiotomy in the United States. John Kelly and Alison Young, "Episiotomies Are Painful, Risky, and Not Routinely Recommended; Dozens of Hospitals Are Doing Too Many," *USA Today*, May 21, 2019,

perhaps not causation, the decline in routine episiotomy parallels an increase in the number of women obstetricians: in 1975, only about 16 percent of obstetric residents were female, but by 1986 this percentage was 51 and by 2015 around 85 percent of obstetric residents identified as female.[46] Perhaps women obstetricians were more attentive to concerns regarding an episiotomy since they typically shared similar genitalia. Moreover, this decline also parallels the dramatic increase in the use of cesarean sections in the United States—up by 500 percent since the 1970s.[47] Telling the story of the rise and fall (from official favor, at least, as represented by ACOG's guidelines and *Williams Obstetrics*) of routine episiotomy and its repair solely within the parameters of the rise of EBM is problematic, for it potentially hides other causes for its decline. Here I turn to another challenge to its routine use, one suggested in the 1997 *Williams Obstetrics*, and the person who was the silent subject/object of DiLeo's story: the laboring woman patient.[48]

Experiential Evidence II

Though some women expressed frustration with medicalized childbirth practices during the 1950s and 1960s, the tension between birthing women and physicians peaked in the 1970s.[49] Distrust of the medical establishment, the rise of seeing medicine as a commodity, and a push for consumer rights and health education all rose to prominence during this

---

https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2019/05/21/episiotomy-vs-tearing-moms-cut-in-childbirth-despite-guidelines/3668035002/.

46. Lyndra Vassar, "How Medical Specialties Vary by Gender" (AMA, February 18, 2015), https://www.ama-assn.org/residents-students/specialty-profiles/how-medical-specialties-vary-gender; LaTasha B. Craig, Samantha D. Buery-Joyner, Susan Bliss, Elise N. Everett, David A. Forstein, Scott C. Graziano, Brittany S. Hampton, Margaret L. McKenzie, Helen Morgan, Sarah M. Page-Ramsey, Archana Pradhan, Laura Hopkins, Undergraduate Medical Education Committee, and Association of Professors of Gynecology and Obstetrics, "To the Point: Gender Differences in the Obstetrics and Gynecology Clerkship," *Amer. J. Obstet. Gyn.* 219, no. 5(November 2018): 430–35.

47. Neel Shah, "The Rise of C-Section—and What It Means," *U.S. News*, September 25, 2019, https://www.usnews.com/news/healthiest-communities/articles/2019-09-25/the-rise-of-c-sections-and-what-it-means.

48. Graham also considered the role of activists, but not their use of experience as evidence. Graham, "Episiotomy Crusade" and *Episiotomy* (n. 4).

49. Jacqueline H. Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (Baltimore: Johns Hopkins University Press, 2012). Earlier concerns can be seen in articles such as Gladys Denny Schultz, "Journal Mothers Testify to Cruelty in Maternity Wards," *Ladies' Home J.*, December 1958, 58–59, 135, 137–39.

decade.[50] Women, in their roles as both patients and family care providers, saw their ability to participate in medical decisions denied by paternalistic physicians; as white health activist Carol Downer stated in 1972, women were "discriminated against as medical patients" since a "doctor's professional behavior and all information directed at us assumes" that women "don't know anything about their bodies."[51]

Challenging the hegemony of medical authority was central to the feminist health movements of the 1970s and 1980s, as medical knowledge was seen as based in sexist prejudice as well as within racist and classist oppressions. These activists criticized medicine as paternalistic to women, medicalizing normative functions such as birth and menopause and reinforcing and reiterating stereotypes along gender as well as racial, ethnic, and class lines.[52] As Susan Bondurant, a member of the Seattle-based Radical Women, wrote in 1975, "The women's movement has taken health as a primary focus because of the biased, incorrect and often dangerous treatment women suffer at the hand of this male chauvinist profession."[53]

American women active in health movements in the 1970s and 1980s were diverse, with white middle-class women often motivated by a lack of access to birth control or abortion, while white working-class and/or Black, Brown, and Indigenous women were often motivated both to expand access to birth control and abortion and to expand access to health care, to end abusive practices such as forced sterilizations, and to support those who desired to have and raise a child.[54] These women contested medical authority in a variety of ways in the 1970s and 1980s, from setting up clinics managed by laywomen to advancing hospital patients' bills of rights.[55] A core theme for many of these women centered upon

50. Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill: University of North Carolina Press, 2016).

51. Carol Downer, "Covert Sex Discrimination Against Women as Medical Patients" (address, American Psychological Association, September 5, 1972), L Femina Pamphlets D948w, Deering Library Special Collections, Northwestern University, Evanston, Ill. (hereafter Deering).

52. Carol S. Weisman, *Women's Health Care: Activist Traditions and Institutional Change* (Baltimore: Johns Hopkins University Press, 1998), 72.

53. Susan Bondurant, "Warning: Sexist Medicine Is Dangerous to Women's Health," *University of Washington Daily*, February 14, 1975, Radical Women, L Femina Pamphlet B711w, Deering (n. 51).

54. Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003); Johanna Fernández, *The Young Lords: A Radical History* (Chapel Hill: University of North Carolina Press, 2020).

55. Weisman, *Women's Health Care* (n. 52), 74–75; Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012).

challenging the authority of the largely white and largely male medical profession by enabling women to learn about their own bodies in order to gain control over their bodies and their health.[56]

Childbirth was one area where many women focused their efforts.[57] As part of this emphasis, women established and sought alternative birthing methods as well as locations and attendants for childbirth, including home births and midwife-attended births.[58] Some women sought alternatives such as home births or midwife births because they did not want to deal with having to say no to routine hospital procedures such as having their pubic hair shaved or having an episiotomy.[59] A 1983 article on giving birth at home in the Black newspaper *National Leader* noted how midwives were less likely to perform episiotomies and women could avoid the repair, as the stitches were "extremely painful as they heal."[60] These women wanted control over what happened during their labors; as one woman told the *New York Times* in 1971, one of the reasons she decided to give birth at home was "I didn't want the episiotomy."[61]

This woman's rejection of routine episiotomy occurred during a time when not only laywomen were starting to advocate for childbirth reform but some within medicine also began raising concerns about the over-medicalization of childbirth. These health care professionals raised questions regarding the routine use of some medical interventions, expressing concern over the lack of evidence to support routine procedures such as episiotomy. For example, during the first international childbirth conference held in June 1973 in Connecticut, those in attendance charged there was "no scientific evidence" to support routine episiotomy.[62] Nurse Carol

56. Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave* (Chicago: University of Chicago Press, 2010); Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011); Evan Hart, "Building a More Inclusive Women's Health Movement: Byllye Avery and the Development of the National Black Women's Health Project, 1981–1990" (Ph.D. diss., University of Cincinnati, 2012).

57. Wolf, *Deliver Me from Pain* (n. 49), 146.

58. Paula A. Michaels, *Lamaze: An International History* (Oxford: Oxford University Press, 2014).

59. Valmai Howe Elkins, "How to Find Your Obstetrician," *Chatelaine*, March 1977, 28, 30, 121; Fredelle Maynard, "Home Births vs. Hospital Births," *Woman's Day*, June 28, 1977, 10, 12, 161–62, 164.

60. Donna Sutter, "Birth at Home: Alternative to Technology," *National Leader*, November 10, 1983.

61. Judy Klemesrud, "Giving Birth at Home: A Great Experience or a Step Backward?," *New York Times*, November 9, 1971.

62. *Proceedings of the First International Childbirth Conference*, June 2, 1973, 10, WEF–Women's Ephemera File, Childbirth Conference 1973–Childbirth–Childbirth Conference Folder, Deering (n. 51).

Brendsel, psychologist Gayle Peterson, and physician Lewis Mehl, in a paper presented at the 1977 American Foundation of Maternal and Child Health Conference, asserted that while some "believe that episiotomy protects against later pelvic relaxation," a "search of the literature indexed in the U.S. National Library of Medicine reveals no research providing evidence for this, even though stated as fact in *Williams Obstetrics*."[63] Similarly, nurse-midwife Kathryn Schrag asked whether routine episiotomies were "truly of benefit to the mother and infant," something she declared "remains to be determined." Schrag continued, "Based on assessment of the potential risks and benefits of episiotomy in each individual situation, an episiotomy can become a *selectively* applied procedure, as is every other type of surgery."[64]

These points reflected the concerns some white feminist health activists had that routine episiotomy was unnecessary and overused. These women encouraged other women to ask their physicians about the use of procedures such as episiotomy and to request it not be used unless it was necessary.[65] In a 1975 article in the white feminist newsletter the *Monthly Extract: An Irregular Periodical*, the editor noted that "the most unnecessary surgery" performed by obstetricians was the "cutting of the perineum to facilitate a doctor's delivery from an inert uterus in a drugged woman."[66] Other women also questioned the routine need for the procedure. "Episiotomies," wrote the editors of the 1973 and 1976 editions of the seminal feminist health text *Our Bodies, Ourselves*, are "done routinely in the United States" although "there is often no need for them."[67] The 1984 edition went further, stating there was "no justification for routine episiotomy," calling it "female genital mutilation."[68] Similarly, in the 1981 *Ms. Guide to a Woman's Health*, physician Cynthia Cooke and coauthor Susan Dworkin told women that since episiotomies were often unnecessary, if "your physician thinks it is necessary, he or she should *tell* you on the

63. Carol Brendsel, Gayle Peterson, and Lewis E. Mehl, "Routine Episiotomy and Pelvic Symptomatology," *Women Health* 5, no. 4 (1981): 49–60, quotation on 49–50.

64. Kathryn Schrag, "Maintenance of Pelvic Floor Integrity during Childbirth," *J. Nurse-Midwifery* 24, no. 6 (November–December 1979): 26–31, quotations on 26, 29, emphasis original.

65. Elkins, "How To Find Your Obstetrician" (n. 59); Maynard, "Home Births vs. Hospital Births" (n. 59).

66. *Monthly Extract: An Irregular Periodical*, December 1975 / January 1976, 16, L Femina Serial AM M7893, Deering (n. 51).

67. Boston Women's Health Book Collective, *Our Bodies, Ourselves: A Book by Women for Women* (New York: Simon & Schuster, 1973), 187; Boston Women's Health Book Collective, *Our Bodies, Ourselves* (New York: Simon & Schuster, 1976), 286. Hereafter BWHBC and *OBOS*.

68. BWHBC, *OBOS* (New York: Simon & Schuster, 1984), 383.

spot." Moreover, since "episiotomies may be overused in this country," they further advised their readers to "make sure that your physician does not expect to do one on you as a matter of routine, but only if the birth requires it."[69] Questioning whether episiotomy was routinely necessary also occurred in majority-culture magazines targeted to women. The author of a 1976 article in *Woman's Day*, for example, wrote that while "sometimes necessary," an episiotomy was "not always" needed, and the doctor should wait to see if one was necessary rather than perform one out of routine.[70]

These comments illustrate the frequency with which women were left out of decisions regarding their bodies when it came to medical interventions, including episiotomies. As reflected by one woman in 1981 regarding her episiotomy, "The doctor just walked in and did it. I felt it and said 'What was that?' He just smiled. He never really told me what he was doing."[71] Increasingly in the 1970s, many women expressed frustration and anger at such treatment by male physicians, and their sentiments were expressed succinctly in one of the most important and influential texts to arise from the white feminist health movement of the 1970s, *Our Bodies, Ourselves* (*OBOS*). Authors of the book called for women to take control of their own medical care from "condescending, paternalistic, judgmental, and non-informative physicians."[72] The book was more than merely a source of information, as historian Wendy Kline argued: *OBOS* "promoted the revolutionary concept that experiential knowledge based on personal stories is a critical component of women's health." *OBOS*, written by women to help women understand their bodies and their health, was, Kline asserted, "revolutionary not only for its attack on the medical establishment, but also for its creation of an alternative knowledge base structured around personal stories. *OBOS* legitimized the notion of experiential knowledge as a central component of health. In other words, every woman's body contained the seeds of knowledge crucial to defining her own well-being." According to Kline, the book essentially enabled "a 'feminist reconceptualization of biology' that privileged individual women's experiences over clinical research."[73]

69. Cynthia W. Cooke and Susan Dworkin, *The Ms. Guide to a Woman's Health* (New York: Berkley Books, 1981), 156, emphasis original.

70. Flora Davis, "Who's Having the Baby—You or the Doctor?," *Woman's Day*, March 10, 1976, 146–48, 152.

71. Margaret K. Nelson, "Client Responses to a Discrepancy between the Care They Want and the Care They Receive," *Women Health* 6, no. 3 (Fall 1981): 135–52, quotation on 147.

72. BWHBC, *OBOS* 1976 (n. 67), 11.

73. Kline, *Bodies of Knowledge* (n. 56), 5, 11.

This privileging of women's experiences as evidence, reflected in *OBOS*, "had its most direct roots in women's liberation," a movement that grew out of civil rights activism.[74] A member of the largely white feminist group New York Radical Women in the late 1960s coined the slogan "the personal is political," a slogan, as historian Ruth Rosen noted, meant to "convey the then-shocking idea that there were political dimensions to private life, that power relations shaped life in marriage, in the kitchen, the bedroom, the nursery, and at work."[75] The personal as political within the feminist health movement centered on bodily autonomy; taking control of the clinical encounter was regarded as both a woman's right to her own individual body as well as collectively about the place of women's bodies in society.[76] A fellow member of New York Radical Women created the other powerful term for what was an outgrowth of seeing the personal as political, "consciousness raising," described as "the process by which women in small groups could explore the political aspects of personal life." The sharing of life stories in these small groups resulted in women "questioning the 'natural order of things,'" enabling women to see their experiences as part of a pattern reflected in other women's experiences.[77] Within largely white middle-class American feminist movements, ideas, personal stories, and shared experiences, rather than goals or strategies, "united a broad range of women who came to identify themselves as feminists," historian Wendy Kline argued. Further, it was the experiences, and women sharing their experiences, that led to seeing the political implications of their shared experiences, and the recognition that sexism was often the basis for their struggles.[78] In this manner, experiential evidence, collected from the lived experience of a woman and collectively shared among women, was a central component of the white feminists' call for resistance to oppression: the personal was political.[79]

Other historians who have looked at this movement have argued these women sought to elevate experience as epistemic values. As such, historian Michelle Murphy argued, they emphasized the epistemic privilege "that

74. Ibid., 13.

75. Ruth Rosen, *The World Split Open: How the Modern Women's Movement Changed America* (New York: Viking, 2000). This idea carried over into other movements, such as the Young Lords. Fernández, *Young Lords* (n. 54).

76. Kelly O'Donnell, "Our Doctors, Ourselves: Barbara Seaman and Popular Health Feminism in the 1970s," *Bull. Hist. Med.* 93, no. 4 (Winter 2019): 550–76, quotation on 565–66.

77. Rosen, *World Split Open* (n. 75), 196–97.

78. Kline, *Bodies of Knowledge* (n. 56), 13.

79. Joan W. Scott, "The Evidence of Experience," *Crit. Inquiry* 17 (Summer 1991): 773–97.

all knowledge production should begin with women's experiences."[80] Kline also situated this questioning of the claims of medical objectivity as a challenge to laboratory-based research that had been privileged since the late nineteenth century over clinical observation. Moreover, feminist health activists, Kline argued, sought to "challenge the division between subject and object in medicine and to introduce a different form of knowing based on subjective experience." According to Kline, feminist health activists sought for women to have access to information regarding their bodies, and "they should also help to *create* this knowledge."[81] These activists sought for women's experiences, anecdotes, and even intuition to count as evidence as strongly as, if not more strongly than, physicians' experiences, anecdotes, and intuition, and perhaps even more strongly than other, more objective forms of evidence, such as the evidence coming from more empirical data gathered by RCTs. And while I am not suggesting causation here, that it was during the moment when laywomen began insisting their experience count as evidence when some physicians began arguing experiential was not "good" evidence seems to suggest a moving of the evidence goal posts.

The experiential evidence collected by laywomen regarding episiotomy and its repair was that it was being done not for the reasons given within official texts such as *Williams Obstetrics* but rather for the reasons women heard physicians say shortly after giving birth. What did women hear? White health feminist activist Lolly Hirsch recalled the "jabbing pain" following the birth of her third daughter as the needle stitched up her episiotomy. When she questioned the physician "through clenched teeth" how many more stitches there would be "he kidded about wanting to make me tight for my husband."[82] Another woman, quoted by

80. Michelle Murphy, *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience* (Durham, N.C.: Duke University Press, 2012), 76, 80, 81.

81. Kline, *Bodies of Knowledge* (n. 56), 1–3, emphasis original.

82. Lolly Hirsch, "A Clean White Room," in *Birth Stories: The Experience Remembered*, ed. Janet Isaacs Ashford (Trumansburg, N.Y.: Crossing Press, 1984), 34–39, quotation on 39. Hirsch's asking how many stitches were used to repair the episiotomy was apparently not uncommon, for physicians noted in books for pregnant women that women often asked how many stitches were used, according to physician Robert E. Hall in his 1972 book. Hall, *Nine Months' Reading: A Medical Guide for Pregnant Women* (Garden City, N.Y.: Doubleday, 1972), 107–8. Physicians Alan Guttmacher in 1973 and Clark Gillespie in 1992 also noted this as a common question. Guttmacher, *Pregnancy, Birth, and Family Planning* (New York: New American Library, 1973); Gillespie, *Your Pregnancy Month by Month* (New York: Harper Perennial, 1992). These physicians considered the question, according to Hall, to be "meaningless" since it was "all one piece of thread." Hall, *Nine Months' Reading*, 107–8. Physicians, at least not here, did not discuss why women asked this question; they did not

historian Judith Walzer Leavitt, recalled how her physician simply told her he would perform an episiotomy. She remembered him performing a "huge episiotomy" upon her, and while he was sewing her up, he said "kind of jokingly" to her husband, "'well I put in an extra stitch for you,' meaning that he sewed me up tighter than I probably was before. And so it was [for her husband's] benefit."[83] And multiple *OBOS* editions included this story from a woman whose doctor said, "I did a beautiful job sewing you up. You're as tight as a virgin. Your husband should thank me."[84]

Despite what physicians such as David Danforth, Michael Hughes, and Arnold Wagner asserted in 1983—that it was "wrong to presume" the "frequent use" of episiotomy "by obstetricians is motivated by any consideration other than the mothers benefit," or per Herbert Brant in his 1985 *Childbirth for Men* that the "cut is made in the interests of the mother and the baby"—some women, such as the authors of *OBOS*, argued there was instead an underlying reason for the use of routine episiotomies: "Some physicians believe that they are performing a service to the woman's [presumably male] partner."[85] This underlying reason for episiotomies was similarly articulated by white childbirth reform activist Suzanne Arms in her best-selling 1975 book, *Immaculate Deception: A New Look at Women and Childbirth*, as "insidious": "After birth husbands will be unable to enjoy sexual intercourse with their wives if an episiotomy has not been performed, because the vagina will be permanently enlarged and misshapen."[86] Evidence for this being the foundational reason for episiotomy and its repair was found within women's experiences.[87]

---

consider it in relation to making women "tighter" for their male partners—something these women may have been thinking.

83. Leavitt, *Make Room for Daddy* (n. 3), 42–43.

84. BWHBC, *OBOS* 1973 (n. 67), 187; BWHBC, *OBOS* 1976 (n. 67), 286–87; BWHBC, *OBOS*, 2nd ed. rev. (New York: Simon & Schuster, 1979), 287; BWHBC, *The New OBOS* (n. 68), 383.

85. David N. Danforth, Michael J. Hughey, and Arnold L. Wagner, *The Complete Guide to Pregnancy: An Authoritative Manual for Pregnant Women* (Norwalk, Conn.: Appleton-Century-Crofts, 1983), 239; Herbert Brant, *Childbirth for Men* (New York: Oxford University Press, 1985), 178; BWHBC, *OBOS* (1984) (n. 68), 383.

86. Suzanne Arms, *Immaculate Deception: A New Look at Women and Childbirth in America* (New York: Houghton Mifflin Harcourt, 1975), 100–101.

87. Some women expressed concern regarding the effects of childbirth on the tightness of their vaginas, worried this negatively affected their and their husbands' sexual responses. As K. C. Cole wrote in her 1980 book, a "sloppily performed" episiotomy "can seriously hinder your sex life." Cole, *What Only a Mother Can Tell You about Having a Baby* (New York: Anchor, 1980), 169. Similarly, Sharron Hannon in her 1980 book noted painful sex for women when sewn "too tight or too loose." Hannon, *Childbirth* (New York: M. Evans, 1980), 165. For more examples, see Lucienne Lanson, "The Truth about Intercourse and Orgasm,"

The discovery and exposure, through the gathering of women's experiential evidence, of the hidden reason for the practice of episiotomy and its repair, grew, probably starting in the mid-1970s, to include describing the repair as sometimes including an "extra" stitch. To illustrate, in her article "Childbirth in America" for the majority-culture women's magazine *McCall's* in 1976, Alice Lake noted that "some feminists suspect that the real reason" for an episiotomy was "to keep the vaginal opening tight to enhance the sexual pleasure of the male partner." Feminists point out, Lake wrote, that "many obstetricians used to call an episiotomy repair the 'husband's stitches.'"[88] Feminists labeling the procedure as such served to make explicit what had been implied. If physicians were deceptive in their reasons for the repair of an episiotomy, naming the practice the husband's stitch (or stitches) served to expose and to amplify the previously hidden reasons for the practice of the episiotomy and its repair: the perhaps jokingly asserted, but nonetheless asserted, power between men regarding authority over a woman's body, of "correcting" a woman's body to, as white childbirth reform activist Diony Young stated in her 1982 book *Changing Childbirth*, make "women better sexual partners" for men.[89] Labeling the episiotomy repair the husband's stitch named the anger women felt regarding the reasons for episiotomy repair: it was meant not just to repair the cut but also to make a woman's body "better" for someone else.

The concern regarding an episiotomy repair as benefitting men sexually seems to have been raised mostly by feminists in the women's health movement, and these women were predominantly white and middle class. As the overmedicalization of childbirth and patronizing, dismissive, and sexist physicians were concerns expressed as well by women who did not fall within this demographic, why was the "husband's stitch" one that seems to have been a concern largely for white middle-class feminist health activists? Does this mean it was less of a concern for women who were not white and/or middle class? Could it mean their experiential evidence was regarded to be not as "good" of evidence as evidence from white middle-class women? Was it that for women of color regardless of economic position and working-class white women the "husband's stitch" did not quite illustrate the full scope of their concerns with poor medical

Cosmopolitan, February 1976, 158–62; Joanne Tyson, "Your Sexual Health," *Essence*, April 1976, 7; Victoria Andrews, "The Little Operation That Saved My Sex Life," *Ladies Home Journal* 91 (1974): 18, 138.

88. Alice Lake, "Childbirth in America," *McCall's*, January 1976, 83, 128–30, 142, quotation on 129.

89. Diony Young, *Changing Childbirth: Family Birth in the Hospital* (Rochester, N.Y.: Childbirth Graphics, 1982), 112.

care and poor treatment at the hands of mostly white male physicians? As Black health activist Beverly Smith wrote in 1982, when Black women navigated medical care, they also had to navigate "racism, sexism, and class oppression."[90] Black health activists like Smith and Byllye Avery often centered their work around concerns stemming from sexism but also racism, poverty, violence, lack of quality child care, worse health outcomes compared to white women, a lack of access to health care, and the inadequate and even outright abusive health care they experienced when they did receive medical attention.[91] Perhaps the sexist reasons for episiotomy repair were a concern for women like Smith and Avery, but the procedure may not have been as representational in the same way as it was for some white middle-class feminist women. Perhaps too it was more of a concern for white feminist health activists because white middle-class women were maybe more likely to hear the "extra stitch" joke being told, a possibility I will now consider.

Husbands Joke, Doctors Chuckle

> They take the baby so that they may fix me where they cut. They give me something that makes me sleepy, delivered through a mask pressed gently to my mouth and nose. My husband jokes around with the doctor as he holds my hand.
> —How much to get that extra stitch? he asks. You offer that, right?
> —Please, I say to him. But it comes out slurred and twisted and possibly no more than a small moan.
> Neither man turns his head toward me.
> The doctor chuckles. You aren't the first—
> —Carmen Maria Machado, "The Husband's Stitch"[92]

Machado here relates a moment of humor in the clinical encounter, but the joking is between the two men—the doctor and the husband, two men the laboring woman should have been able to trust—at the expense of

90. Beverly Smith, "Black Women's Health: Notes for a Course," in *All the Women Are White, All the Blacks Are Men, But Some of Us Are Brave*, ed. Gloria Hull, Patricia Bell Scott, and Barbara Smith (New York: Feminist Press, 1982), 103–14, quotation on 105.

91. Byllye Avery, interviewed by Loretta Ross, "Voices of Freedom Oral History Project," Smith College, Sophia Smith Collection 2006, https://www.smith.edu/libraries/libs/ssc/vof/transcripts/Avery.pdf.

92. Carmen Maria Machado, "The Husband's Stitch," *Granta*, October 28, 2014, https://granta.com/the-husband-stitch/.

the woman.[93] It is a joke she hears, but it is not shared with her. Historian Susan Lederer has noted that medical humor as expressed within medical practice "has been little discussed" by historians, though it "represents a largely untapped resource for understanding" features of medical practice.[94] One feature of medical practice is medical knowledge, and the joke here shared between two men illustrates a third location, laymen, in the production of knowledge regarding the purpose of the episiotomy repair.

As in DiLeo's story, the husband in Machado's story initiates the telling and shares what can be considered a sexual or dirty joke with the male doctor regarding the body of his wife, specifically her vagina. The "extra stitch" procedure here is seen as either making the vagina smaller than it was prior to vaginal delivery or returning it to its size predelivery; in either scenario, the concern is with the size of the vagina. As Gershon Legman in his 1968 history of the dirty joke noted, many dirty jokes about women reduced them to their vaginas, most commonly that the organ was "too big." These jokes represented, Legman argued, an expression of anxiety about sexual performance and a fear a penis was "too small" to perform. But rather than admit to this fear "it was far simpler to state that the vagina was 'too big.'" Legman discovered the too-big vagina was most often found in jokes regarding multiparous women, tying vaginal childbirth with increased vaginal size and certainly framing the extra stitch joke.[95]

Legman attempted to explain that dirty jokes were, as Sarah Lash argued, the "raconteur's attempt to deal with sexual tension," that such jokes enabled "the teller to get away with attacking the victim of the joke"; for Legman, they were "a vehicle for men to express hostility to women."[96] In this sense the joke can also be seen as a form of "locker-room talk," a discussion that sexually objectifies women. Sexual objectification "serves as a means by which women are reduced to their sexual body parts, seen as an object for the sexual pleasure of others and lacking their own humanity." Such talk often "reinforces heterosexist masculinity."[97]

93. Jane Dykema, "What I Don't Tell My Students about 'The Husband's Stitch,'" *Electric Lit*, October 17, 2017, https://electricliterature.com/what-i-dont-tell-my-students-about-the-husband-stitch/.

94. Susan E. Lederer, "'Porto Richochet': Joking about Germs, Cancer, and Race Extermination in the 1930s," *Amer. Lit. Hist.* 14, no. 4 (Winter 2002): 720–46, quotation on 741.

95. Gershon Legman, *Rationale of the Dirty Joke: An Analysis of Sexual Humor* (New York: Grove Press, 1968), 374–78.

96. Sarah Lash, "Titling the Ivory Tower: The Life, Works, and Legacy of Gershon Legman," *Folklore Historian* 27 (2010): 25–42, quotation on 29.

97. Sarah Gervais and Sarah Eagan, "Sexual Objectification: The Common Thread Connecting Myriad Forms of Sexual Violence Against Women," *Amer. J. Orthopsychiatry* 87, no. 3 (2017), 226–32, quotations on 227, 228.

Scholars have only recently begun to study locker-room talk among men, and though male physicians' locker-room talk appears to have received little scholarly attention, more attention has been given to the use of humor by physicians, both the so-called backstage gallows humor shared between clinicians and the sympathetic humor engaged in between physician and patient.[98] But when physicians joke about patients, this can be seen as reinforcing their position of power over patients. And since humor is intended to be shared, this sharing of humor regarding an extra stitch reinforced the positions of power of both the doctor and the male partner over the female patient.[99] Making and participating in the joke implies a shared background knowledge.[100]

What was the shared knowledge regarding adding an extra stitch? Was it the perceived normative desire for a tight vagina to support male sexual response, a concept "with wide cultural circulation within the United States but rarely formerly recorded"?[101] Was this (expected) desire commonly shared and discussed among men, physicians included? Was it a recognition between men of the importance of penetrative sex as representative of male virility? Was it based on a shared male fear of a decline in vaginal intercourse following childbirth? For many heterosexual couples, vaginal intercourse following vaginal childbirth can be challenging; in a 1980 study, many women *and* men reported being scared about resuming sex, and other studies published that decade reported the sexual relations of couples were poor for years following childbirth.[102] So perhaps the joke about adding an extra stitch can be read most broadly as a fear of men's

98. Brian Cole, Emily Tyler, and Ryan Willard, "Predicting Men's Acceptance of Sexual Violence Myths through Conformity to Masculine Norms, Sexism, and 'Locker Room Talk,'" *Psychol. Men Masculinities* 24, no. 4 (2020): 508–17; Katie Watson, "Gallows Humor in Medicine," *Hastings Cent. Rep.* 41, no. 5 (September–October 2011): 37–45; Jeffrey Berger, Jack Coulechan, and Catherine Belling, "Humor in the Physician-Patient Encounter," *Arch. Intern. Med.* 164, no. 8 (2004): 825–30; Linda Francis, Kathleen Monahan, and Candyce Berger, "A Laughing Matter? The Uses of Humor in Medical Interactions," *Motiv. Emotion* 23, no. 2 (1999): 155–74.

99. Carter Hardy, "Humor and Sympathy in Medical Practice," *Med. Health Care Philos.* 23 (2020): 179–90; see also the essay by Anonymous, "Our Family Secrets," *Ann. Intern. Med.* 163 (2015): 321, and the accompanying editorial, "On Being a Doctor: Shining a Light on the Dark Side," *Ann. Intern. Med.* 163 (2015): 320.

100. Oliver Curry and Robin Dunbar, "Sharing a Joke: The Effects of a Similar Sense of Humor on Affiliation and Altruism," *Evol. Hum. Behav.* 34 (2013): 125–29.

101. Sarah Rodriguez, "Restoring 'Virginal Conditions' and Reinstating the 'Normal': Episiotomy in 1920," in *Heterosexual Histories*, ed. Rebecca L. Davis and Michele Mitchell (New York: New York University Press, 2021), 303–30, quotation on 316.

102. Kirsten von Sydow, "Sexuality During and After Childbirth: A Metacontent Analysis of 59 Studies," *J. Psychosom. Res.* 47, no. 1 (1999): 27–49.

sexual lives worsening after birth, the belief male physicians would sympathize and try to prevent that change (or even improve the husband's sexual experience) by adding an extra stitch, using humor to cover their fears. Perhaps the joke was shared for all these reasons, but I want to stress here how DiLeo recalled hearing it "many times," and so it seems unlikely the joke was a spontaneous creation by individual men: the joke, and the knowledge it was based upon, was shared not just between men in the delivery room but also among male networks outside that room.

Humor can reinforce shared knowledge, identities, and hierarchies, here between two (presumably) heterosexual men, by excluding the woman and treating her as the shared joke.[103] But how often was this joke shared, and was it shared most often between two white men? Between white men of similar class backgrounds? Or was this joke shared at the laboring woman's expense a bridge that momentarily united men across racial or class lines in this intimate space? It is unclear whether this shared humor occurred between men from different racial, ethnic, economic, or language backgrounds, whether there was a shared sense of power between men that transcended these differences. Such a possibility, however, is hinted at by reports of women obstetricians currently practicing being asked to add an extra stitch by their patient's male partner, suggesting the possibility that male partners regard themselves as being in a shared position of power with the doctor over their female partners despite not sharing a gender identification with the doctor.[104]

In addition to being unclear how often, and between whom, this joke was shared, it is equally unclear who heard the joke and if there were racial, ethnic, language, or class differences regarding who most often was the subject of this joke. The demographics of who participated in, and who was subjected to, this joke are as unclear as the frequency of its telling; does the fact most of my female sources for this joke appear to be white middle-class women suggest this demographic heard the joke more, because their presumably white middle-class husbands shared a background most similar to the majority of doctors and thus were more likely to share this joke with each other? For many women, including some white middle-class women, it may have been just one more example of medical care that showed little care for them, and not worth singling out. But for

103. There is surprisingly little research on this joke, but see Franca Pizzini, "Communication Hierarchies in Humor: Gender Differences in the Obstetrical/Gynecological Setting," *Discourse Soc.* 2, no. 4 (1991): 477–88.

104. Korin Miller, "What Is a 'Husband's Stitch'?," *Health*, updated September 14, 2023, https://www.health.com/condition/pregnancy/what-is-a-husband-stitch. I do not have the space to consider laboring women asking for an extra stitch.

some women who heard it, or who heard of it, this joke about "making you tight again for your husband," per an unsigned letter written to the white feminist health newsletter the *Monthly Extract* in late 1975, it was "an inexcusable ribaldry" worth singling out because it served as evidence regarding the purpose of the episiotomy repair as having little to do with supporting the laboring woman and everything to do with supporting the club of male heterosexual privilege.[105] By labeling an episiotomy repair as the "husband's stitch," women who used the term accurately interpretated how some men understood the vagina as a "problem" after childbirth, an understanding that took the form of a joke regarding the correction of the problem through the procedure.

Conclusion

I began with a quotation from a 2002 book, with the physician author naming the "husband's stitch" a "myth." Naming it as a myth "imposes a reading" of the husband's stitch as an "untrue or erroneous story or belief" and thus imposes a power to question that it happened.[106] But was it an "untrue" or even an "erroneous story" women shared about physicians routinely performing episiotomy repair and/or adding an extra stitch for the sexual benefit of male partners?

Historians rely on material sources, but if we look for evidence produced and published by physicians that they repaired an episiotomy for the sexual benefit of male partners, we come up rather short. In the published medical literature, there are no cases of physicians writing about the husband's stitch or an extra stitch: within PubMed, the National Library of Medicine's online database of over thirty million citations and abstracts in the biomedical literature, searching for publications using the terms "husband's stitch" (or "husband stitch") or "sex and episiotomy and husband," "sex and episiotomy and men," or "extra stitch and episiotomy" reveals nothing relevant.[107] Published evidence documenting physicians' use and understanding of episiotomy repair as a male sexual benefit are difficult to find beyond brief but clear comments by DeLee in 1920 about episiotomy and its repair restoring a woman to "virginal conditions"; by physician Wallace Shute in 1959 that an important "though seldom mentioned" benefit of episiotomy repair was that it "ensures restoration of

105. "From California," *Monthly Extract: An Irregular Periodical*, December 1975 / January 1976, 16, L Femina Serial Am M7893, Deering (n. 51).

106. Michel-Rolph Trouillot, *Silencing the Past: Power and the Production of History* (Boston: Beacon, 2015), 114.

107. Search performed August 30, 2021.

conjugal as well as anatomical normalcy"; by obstetrician Gideon Panter in 1980 that since "considerable more direct stimulation is often needed if an older man is to maintain an erection," an episiotomy repair was best "described as being done as much for the husband's sake in later life as it is for the wife's benefit."[108] Moreover, recall one of the common clinical reasons for the procedure was that it prevented overstretching of the vagina, suggesting physicians saw this as a problem to be avoided. Though we have no published evidence physicians added an actual extra stitch, evidence we do have from authoritative, influential sources in wide circulation strongly suggests sexual capacity was a reason for episiotomy and its repair.

Even if physicians did not regard this as the primary reason for episiotomy and its repair, physicians knew men regarded the repair to be "for the husband's sake" and knew men looked for it. DiLeo, for example, advised husbands against asking for an extra stitch, as "during that holy and profound experience of witnessing the first precious moments of your child's life, your wife will never forget that all you were worried about was how you might feel even better when getting laid."[109] Understandings of episiotomy repair were tied to male sexual response: physicians mentioned it in their writings, and if only some did so to sometimes dismiss it, this recognized the procedure was understood to be performed for that reason; husbands raised it as a possibility not spontaneously or separately but "many times," often enough to consider they learned about it from other men and so they too shared in creating knowledge it existed for their benefit; and women who heard the joke regarded it as evidence the procedure was not intended to benefit them. The "famous 'husband's stitch'" that "transforms you into a virgin again," nurse Connie Marshall wrote in the late 1980s, was something "we have all heard about."[110]

108. DeLee, "Prophylactic Forceps Operation" (n. 13), 43; Wallace B. Shute, "Episiotomy: A Physiologic Appraisal and a New Painless Technic," *Obstet. Gyn.* 14, no. 4 (October 1959): 467–72, quotation on 468; Gideon G. Panter, "Episiotomy: The Question of Informed Consent," *Parents*, May 1980, 86, 88, quotation on 88. On DeLee's comment, see Rodriguez, "Restoring 'Virginal Conditions'" (n. 101).

109. DiLeo, *Anxious Parent's Guide to Pregnancy* (n. 1), 240–41.

110. Connie C. Marshall, *From Here to Maternity* (Citrus Heights, Calif.: Conmar, 1988), 134. For examples of recent stories, see Carrie Murphy, "The Husband's Stitch Isn't Just a Horrifying Childbirth Myth," *Healthline*, updated September 27, 2018, https://www.healthline.com/health-news/husband-stitch-is-not-just-myth#1; Tanaya Kollipara, "Female Genital Mutilation in the US: The 'Husband's Stitch,'" *Women's Republic*, April 28, 2020, https://www.womensrepublic.net/female-genital-mutilation-in-the-us-the-husband-stitch/; Mary Halton, "The 'Husband's Stitch' Leaves Women in Pain and Without Answers," *Vice*,

Physicians, husbands, and laboring women "all heard about" it and all created and shared knowledge about why it was performed.

While it is unclear if the sharing or overhearing of the joke between doctors and husbands crossed racial, ethnic, class, or language lines in the United States, or when (if) it was shared it stayed among women with common racial, ethnic, or class identities and/or language backgrounds, many American women did (and do) share similar experiences with medicine: experiences of poor, neglectful, hostile treatment, often from white male physicians. Labeling episiotomy repair the "husband's stitch" acknowledged the reality of such treatment of women and their bodies, then and now, from male physicians and a patriarchal society.[111] Based on their individual and collective experiences of such treatment, some women challenged the routine use of episiotomy as an illustrative example of it. For these women, episiotomy repair was never solely about the stitches, extra or otherwise.

Roy Porter noted in his seminal 1985 article that it "takes two to make a medical encounter—the sick person as well as the doctor."[112] In this story it took three, and all three participated in the production of knowledge regarding the reasons for an episiotomy repair. Using a procedure like episiotomy and its repair as a lens through which to view the medical encounter enables us to see how medical evidence is generated and how, and by whom, medical knowledge is created and shared. It emphasizes the benefits of listening not just to patients, as Porter emphasized, but also for the networks of knowledge creation and circulation between doctors and doctors, doctors and patients, patients and patients, patients and family members, and family members and doctors. By paying attention to how laypeople and physicians understood medical interventions—even those that are seemingly small, routine, or part of a larger standard of care—we can see and follow the multiple networks involved in the creation of medical evidence, in sharing medical knowledge, and in how this knowledge shaped the clinical encounter.

April 26, 2018, https://www.vice.com/en_us/article/pax95m/the-husband-stitch-real-stories-episiotomy; see also Dykema, "What I Don't Tell My Students" (n. 93).

111. As Kollipara wrote in 2020, "The 'husband's stitch' is nothing more than an outdated and misogynistic practice that continues to violate women within the healthcare system." Kollipara, "Female Genital Mutilation in the US" (n. 110).

112. Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory Soc.* 14, no. 2 (March 1985): 175–98, quotation on 175.

Sarah B. Rodriguez is an associate professor of instruction in Global Health Studies in the Weinberg College of Arts and Sciences, a lecturer in medical education in the Feinberg School of Medicine, and a faculty member of the Medical Humanities and Bioethics Graduate Program at Northwestern University. She studies the history of reproductive health, the history of clinical care, and the history of the ethics of clinical research in the twentieth century. She is the author of two books: *Female Circumcision and Clitoridectomy in the United States: A History of a Medical Treatment* (2014) and *The Love Surgeon: A Story of Trust, Harm, and the Limits of Medical Regulation* (2020). She is currently working on a history of hysterectomy and on a history of maternal mortality as a global health concern.