term disability and undergoing rehabilitation, early return to stable employment is related to the duration of unemployment beforehand. General practitioners should therefore refer such patients at the earliest opportunity for medical and vocational rehabilitation (Sheikh and Mattingly, 1981).

Recently, it has been proposed by the Government that responsibility for sick pay during the first eight weeks of incapacity should be borne by employers (Department of Health and Social Security, 1980). The objectives of this new policy are to enable sickness payments to be taxed and to avoid duplication of provisions by the state and the employer. It was calculated that the saving in public expenditure would be over £400 million. However, there have been objections to these proposals. The Confederation of British Industry criticized them for offering inadequate compensation to industry. Other criticisms include the difficulty of ensuring that small firms comply with the regulations, the lack of safeguards against unscrupulous employers and the extremely low level of the proposed statutory sick pay. In addition, those who suffer from chronic ill health or disability will find it even more difficult than at present to gain employment, because employers will be more reluctant to take them on. It is disturbing to note that the proposals do not contain any reference to the needs of the sick. Major changes of the kind suggested require careful consideration on the part of doctors to ensure that the interests of patients are not neglected.

Considering its importance to the country in economic and medical terms, sickness absence has been the subject of remarkably little research. Within this apparently mundane and unglamorous field of study it is likely that there are important clues both to future directions of public health policy and to causative factors in illness behaviour. General practitioners and their colleagues in occupational medicine should undertake collaborative investigations in this area.

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Episiotomy: has familiarity bred contempt?

EPISIOTOMY has been described by Llewellyn-Jones (1977) as one of the least considered and most painful of all operations performed on the human female; far too many women leave hospital with the memory of perineal pain which they say is far worse than the pain of parturition. A series of essays published by the National Childbirth Trust (Kitzinger, 1981), together with the recent studies by Kitzinger and Walters (1981), on the attitudes of 1,800 women to episiotomy, and by Reading and colleagues (1981) of women's views of post-episiotomy pain, has focussed attention on this further example of a medical practice which has become routine on the basis of assumptions rather than evaluation. Although episiotomies are now undertaken in 30 to 70 per cent of all deliveries (and approach 100 per cent in certain units), there is apparently no scientific evidence that the procedure has any of the benefits claimed for it. Extraordinarily enough, no study has been undertaken to compare the effects on mother or baby of doing or not doing episiotomies, and there had been no previous research into women's experiences of the procedure.

Amongst the reasons for performing an episiotomy are that it has been thought to reduce the likelihood of a tear, but not only is this unproven, there is indeed some evidence to suggest the contrary (Fox, 1979). Post-episiotomy pain is frequently significant and prolonged and Kitzinger and Walters (1981) found that mothers having an episiotomy suffered more discomfort a week following delivery and had a higher incidence and duration of dyspareunia than those with lacerations. An episiotomy cuts across natural skin fold and muscles—factors which are associated with poor healing—and House (1981) has stressed that if the complications of

pain, bleeding, infection and wound breakdown are to be avoided, the temptation to regard its repair as a minor procedure after the major event of delivery is safely over must be resisted. However, suturing is usually undertaken by junior members of the medical team, often medical students, and frequently after considerable delay, all of which indicates either lack of awareness or indifference to these factors.

It is essential that the debate about episiotomy is allowed to develop, because it is an issue that relates directly to the overall management of labour. During the last 20 years, as the responsibility for the conduct of labour has shifted from the midwife and general practitioner to the obstetrician, the permissible duration of the second stage, especially for primigravidae, has become progressively shorter. Partograms are now used in many hospitals, and a slower than average progress in expulsion is an indication for obstetric intervention. In 62 per cent of deliveries in Kitzinger and Walters' study, an episiotomy was performed within 45 minutes of the onset of the second stage. The reason for shortening this stage of labour is the belief that it is a period of great stress for the fetus, but Caldeyro-Barcia (1979) has shown that it may be holding the breath for a long time and strenuous pushing which interfere with the oxygenation of the fetus, rather than the length of time in the second stage. The benefits which may be derived by allowing the second stage of labour to proceed without active encouragement should not be prematurely discounted, and Beynon (1957) showed long ago that women who were not directed to push had a higher rate of spontaneous delivery. Chloe Fisher (1981), a community midwife, has expressed the belief that to retain an intact perineum should be one of the objectives of those managing labour, but points out that we have now reached a stage where a small tear is considered evidence of poor delivery technique, whereas to perform an episiotomy is absolutely acceptable.

The recent joint report of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners (1981) on general practitioner obstetric training has strongly supported the growing involvement of the general practitioner in intra-natal care. A hoped-for and significant effect of this development may be that it will help the midwife to regain her central role in the management of labour, and so shift the emphasis once more towards non-intervention.

It is apparent that there is a real need for a complete reappraisal, not only of the indication for episiotomy, but for the way in which labour is to be conducted. In this the general practitioner may indeed have an important role to play. It is significant, if slightly chastening, that the present stimulus for reassessment has in large part come from groups representing the receivers of care. Rather than adopting a defensive position we should be grateful to them. The onus of responsibility for undertaking the necessary clinical research now rests clearly with the medical and midwifery profession. Let us hope that we can and will rise to this challenge.

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